NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Ashwin Vasan, MD, PhD
Commissioner

Testimony

of

Laura Louison , MSW, MSPH
Assistant Commissioner of the Bureau of Maternal, Infant, and Reproductive Health
New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Women and Gender Equity

on

Reproductive Rights

and

Introductions 458, 465, 466, 475, 507 and Resolutions 195, 196, 197, 200, 208, and 245

Good morning, Chair Caban, and members of the committee. My name is Laura Louison, Assistant Commissioner for the Bureau of Maternal, Infant and Reproductive Health at the New York City Department of Health and Mental Hygiene. I am joined today by my colleague, Dr. Tara Stein, Medical Director for the Bureau of Maternal, Infant, and Reproductive Health. On behalf of the Administration, we thank you for the opportunity to speak today on the critical, timely, and historic topics of abortion access and reproductive health.

As we're all painfully aware, the Supreme Court overturned Roe v. Wade, and with it, the U.S. Constitutional right to a safe abortion, a right that was in place for half a century. Over half of all U.S. states are expected to restrict or fully prohibit abortions now that Roe is overturned. New York State has become one of the few states where pregnant people can seek safe, legally protected abortions.

I want everyone to hear me state this loud and clear: **abortion is still legal in New York State, and this city is – and will remain – a safe haven for people who need an abortion. Abortion is health care. And access to abortion is a public health issue.**

Abortion is a safe, common health care procedure; one in four women in the US will have an abortion by the age of 45. The evidence is clear: people are hurt when they do not have access to abortions. When someone is forced to continue a pregnancy against their wishes, they are also forced to take on the risks of pregnancy and labor. Those risks are more significant for some communities. For example, as the Council is acutely aware, the United States has the highest maternal mortality rate among developed countries, with a terrible, preventable disparity in maternal mortality and morbidity for Black women.

Overturning Roe will have foreseeable consequences in increasing the risk of death or significant illness for people across the country. Limiting access to abortions also has negative consequences for people's long-term economic wellbeing and safety. Patients who do not obtain an abortion when they want one are four times more likely to live in poverty afterwards and experience long lasting effects on their educational attainment and job opportunities. Ensuring safe, legal access to abortion care is a public health necessity. Without access to abortions, Americans' health and wellbeing will be severely harmed.

And although most Americans support safe and legal access to abortion, the minority opinion has prevailed over evidence, science, and public opinion. Nearly 50 years of escalating anti-abortion campaigns and policies set the stage for the situation we are in today. Thus, it is on us – the localities and states that continue to guarantee access to safe and legal abortion services - to take on the operational, emotional, and fiscal responsibility of providing it for the rest of the country. We should not have to do that, but we absolutely will.

We will do so because we are committed, as a city, to ensuring sexual and reproductive justice for all New Yorkers and for those who travel to our city seeking refuge. Sexual and reproductive justice exists when all people have the power and resources to make healthy decisions about their bodies, sexuality and reproduction.

Our commitment to maintaining New York City as a safe haven for abortion access stems from our deeply held belief that all people have the right to choose to have or not have children and control their own bodies. We are prepared and committed to improving access to abortion for New Yorkers as well as any people who travel to the city to get a safe abortion. As the City announced last week, we've updated and enhanced our public websites and 311 to provide clear and accurate information about abortion services, and we are standing up a citywide abortion call line and navigation hub, so information will be

centralized and easily accessible. We will also be increasing provider capacity and will add medication abortion at our sexual health clinics. Information about abortion services in New York City is available on our website nyc.gov/abortion.

And while we are committed to maintaining New York City as a safe haven for abortion access for all people, we must acknowledge that this country, including New York City, still has a long way to go in guaranteeing equitable access to reproductive health care services for all. Our nation and city's shameful, longstanding history of structural racism hangs over our systems of care. The people most affected by limiting abortion access are those who have been excluded and marginalized through individual discrimination and systemic barriers. This includes Black, indigenous and other people of color, people with disabilities, LGBTQ people, people with low incomes, and young people.

The ongoing work of the City – including at the Health Department and at NYC Health + Hospitals – in conjunction with Council's robust package of bills being heard today, will help facilitate equitable access for all New Yorkers and for those traveling to New York for safe abortions and other reproductive health care services. Our work will prioritize ensuring that all communities can afford and obtain the high quality sexual and reproductive health care services they need. Our current work in reproductive health demonstrates our ability to achieve impact: the historic decline in adolescent pregnancy rates over the past decade is just one example of the Health Department's record of success.

We want to thank Council for this historic package of reproductive health bills. The Administration fully supports the goals of Introductions 458, 465, 466, 475 and 507. It is essential that the City do everything within its power to protect the rights of people to get abortions in this City and ensure access to sexual and reproductive healthcare services. We look forward to discussing the specifics of each bill after the hearing and continuing these conversations with Council to ensure our mutual goals are met to best serve New Yorkers at this pivotal moment in history. We know your work does not end here.

In closing, I want to reflect on this moment in time for those of us who work in, advocate for and amplify public health. To work in public health is to dedicate your life to preventing morbidity, mortality, and disparities in health outcomes. We go to work every day to save and improve lives, to ensure communities are protected from deadly diseases now and in the future, and to build on evidence with which decision makers can execute policies and programs to further enhance health and well-being. The Supreme Court's decision aims to do precisely the opposite. In this historic moment, we have a moral imperative to uphold the rights of all people to have access to safe, affordable health care, which includes abortions. The Department of Health is prepared to lead that work. Why? Because it is our job. We place the sanctity of the health, dignity, and well-being of those we serve above all else.

We do this standing on the shoulders of those who came before us, hand-in-hand with those who are here with us now, and for the millions that will come after. Thank you for the opportunity to testify, we look forward to taking your questions.

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Testimony of Council Member Shahana Hanif to the Committee on Women & Gender Equity- July 1, 2022

I'm Council Member Shahana Hanif and I represent the 39th District in Brooklyn. Thank you to the Committee on Women & Gender Equity and to my sister Tiffany Cabán, for holding this essential hearing and for including my bill, Intro. 475, on today's agenda.

I want to express gratitude to the co-prime sponsors who introduced this bill alongside me: Chair Cabán, Public Advocate Williams, and Council Members Louis, Rivera, Hudson, and Farías. I also want to thank all of the other Council members, including Speaker Adams, for bringing us to 22 sponsors on this bill. Finally, I want to thank the thousands of everyday New Yorkers who have taken to the streets over the past week to support abortion rights in response to our illegitimate Supreme Court's despicable decision to overturn *Roe v. Wade*. Your voices are powerful and absolutely necessary during this difficult moment.

As we know, this decision will result in severe restrictions or bans on abortion in states governed by conservatives. This will in turn mean that many people seeking abortions will be traveling to New York City, given our strong protections around reproductive rights. Even prior to the decision, the percentage of New York abortion patients who are out of state has increased from 4% in 2009 to 9% in 2019, according to the Centers for Disease Control. This number will inevitably spike in the coming months and years.

Thankfully, our providers are stepping up to meet the demand. Planned Parenthood of Greater New York has already increased its capacity for appointments by 20%. And we are working closely with our colleagues to secure Council funding to provide practical support such as travel, lodging, and childcare for those coming to New York for abortions.

However, despite support from the City, these folks are vulnerable to being subject to civil suits for accessing care that is legal in New York City, but illegal in their home state or municipality. For example, an abusive partner or the Executive Director of a quote-unquote "pro-life" group could sue someone from, say, Missouri who comes to the City to receive an abortion.

Intro. 475 addresses this issue by first, establishing these suits as "interference with medical care", an appropriate designation given that these suits intimidate and dissuade people from obtaining care that is legal in New York City. Notably this would also apply to trans-affirming care in addition to reproductive care. Second, it establishes a right to private action around

“interferences with medical care”- allowing people to counter sue for damages under New York City law. This right to private action has important legal precedent in Connecticut and New York state law.

If passed, this bill would cement New York City as a sanctuary for abortion rights. It would be a statement to people saying our doors are open, we will provide you with the care you choose, and we will do everything we can to protect you from those who try to get in your way to receive care.

Thank you and I look forward to hearing from the administration, my colleagues, and the public.

PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

Jumaane D. Williams

TESTIMONY OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS
TO THE CITY COUNCIL COMMITTEE ON WOMEN AND GENDER EQUITY
JULY 1, 2022

Good afternoon,

My name is Jumaane D. Williams and I am the Public Advocate for the City of New York. I would like to thank Chair Cabán and members of the Women and Gender Equity Committee for holding this hearing and for the opportunity to share testimony.

With an immense sense of urgency, I write to you as institutions in our country are failing people everywhere, especially those who will be directly affected by this assault on reproductive rights with the overturning of Roe v. Wade by the Supreme Court. As elected officials, we owe it to New Yorkers to turn our words into action, ensuring that our city will safeguard reproductive rights for all, and keep our state and federal governments accountable to this as well.

New York City is no stranger to protecting the right to seek an abortion, amongst other reproductive health services. In 2011, the City Council passed Local Law 17 that ensures New Yorkers have access to comprehensive information and timely access to all reproductive health services. LL17 also prevents pregnancy services centers that engage in deceptive practices from continuing to do so.[1] In 2019, in my former capacity as a member of City Council, my bill–Intro. 0863–that prohibits discriminatory harassment or violence based on one's reproductive health choices, was enacted into law (Local Law 20), providing another measure of security over one's bodily autonomy.[2]

It is reassuring to know that the city has a track record of upholding reproductive rights, but as we have seen on the federal level and in other municipalities, opposition will find ways to poke holes in current reproductive rights legislation across the board. As a result, we need to strengthen and back up laws currently in place, hence the number of bills that will be heard in today's hearing, including a number that I have co-introduced.

One of these bills is Res. 0245, calling on the United States Senate to pass and the President to sign the Women's Health Protection Act (WHPA).[3] The WHPA would protect the right to abortion care throughout the United States. At this time, it has only passed the House of Representatives, with passage in the Senate deterred by a lack of 60 votes to overcome a filibuster.[4] There has never been a more necessary and urgent time than now to apply pressure on the Senate and the President to enshrine abortion access

[1] https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=777861&GUID=F7F0B7D7-2FE7-456D-A7A7-1633C9880D92
[2] https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=3486193&GUID=11DC0C25-02CE-4AEF-9846-D6ABAF0D2965
[3] https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=5698263&GUID=1ED92D48-53AC-4B74-8CFC-3A71896384B5&Options=&Search=
[4] https://reproductiverights.org/the-womens-health-protection-act-federal-legislation-to-protect-the-right-to-access-abortion-care/

into federal law. As for what can be done on the local level, I urge my colleagues to join me in passing this resolution as a way to keep our federal government accountable.

Furthermore, it has been disturbing to see states taking prosecutorial action against individuals who have sought an abortion or have aided others in doing so. In April 2022 in Texas, Liz Herrera was arrested and charged with murder, after hospital staff made a call to police. She was accused of causing "the death of an individual by self-induced abortion" even though there was no legal justification for the arrest following Texas statute.[5] The charges were dropped, but the damage was done, signaling potential ramifications against all those who even consider an abortion. Nobody should be criminalized for what is at its core healthcare. We must never get to a point where this kind of reality occurs in our city and we must welcome our neighbors from other states and protect them just like we do for New Yorkers. Int. 0466 would be a step in this direction; it would prohibit city agencies from using city resources to detain individuals who performed or aided with abortions as well as prohibit city agencies from cooperating with out-of-state entities in relation to abortions performed in New York State.[6]

In addition to Int. 0466, Int. 0475 would allow a person to bring a claim of interference with medical care when a lawsuit is commenced against them on the basis of medical care that is legal in New York City, preventing laws like Texas's SB 8–which allows lawsuits against doctors who perform abortions, or anyone who aids or abets a person seeking one–from taking place in our city.[7]

And finally, Res. 0197, which declares New York City a safe city for all those in need of abortion-related care, would provide the far-reaching announcement to the world that NYC is here for all birthing people, and that access to abortion and reproductive healthcare is a right dutifully owed to the people. I am steadfast in my commitment to all who currently feel failed by our country with this rolling back of rights. We as a city can at least be one beacon of hope in these daunting times and lead the country by example. For all the bills I have co-signed onto and shared with you today, we must pass them as soon as possible; the longer we wait, the more is at stake.

Thank you.

[5] https://www.nbcnews.com/news/us-news/woman-faces-texas-murder-charge-self-induced-abortion-rcna23739
[6] https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=5669012&GUID=692D1176-37B9-446A-8027-CD2671F7B308&Options=&Search=
[7] https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=5669027&GUID=0DE4E63E-3943-471A-8934-872506189B31&Options=&Search=

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

Regarding

Oversight: Reproductive Rights

July 1, 2022

The New York Civil Liberties Union (NYCLU) is grateful for the opportunity to submit the following testimony regarding New Yorkers' access to reproductive health care. 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 this Committee that would expand and protect access to reproductive health care, and we provide these comments on the bills and resolutions on the agenda today.

In the wake of the *Dobbs v. Jackson* decision overturning *Roe v. Wade*, we expect that states will seek to not only prohibit abortion within their borders, but also to impose civil and criminal consequences on those who seek, provide, and facilitate care extraterritorially, in places like New York City. It is critical that New York does everything in its power to limit the impact of such efforts so that this city and state remain safe points of access for those around the country seeking abortion care. The NYCLU supports Intro. 0466, Intro. 0475, and Resolution 0245 to this end. However, these measures will likely be scrutinized by those who oppose abortion access, and it is essential that protective laws are carefully drafted to withstand legal challenges. The NYCLU is grateful for the opportunity to collaborate with the Council to ensure that all protective measures are effectively written and constitutionally sound. Additionally, it is of the utmost importance that the City continues to be clear with

members of the public regarding the extent of its ability to protect them from legal consequences in other states. The measures discussed today do not—and indeed, cannot—entirely insulate abortion-related activities in New York City from all consequences sought to be imposed under other states' laws. Accordingly, the City must not offer anyone—New Yorkers providing or aiding in care for out-of-state patients or those traveling to New York to seek care—a false sense of security that could lead them to unknowingly expose themselves to legal risk.

With these limitations in mind, we suggest that the City be particularly careful to ensure that the private medical information of those obtaining care here remains private. Accordingly, Intro. 0465 should not move forward without serious consultation with clinics, privacy experts, and defense counsel. We appreciate the importance of mapping trends in abortion access, ensuring the needs of those coming to New York for care are being met, and gauging additional burdens on New York providers; however, this cannot come at the expense of inadvertently exposing anyone for seeking or providing abortion care. The bill would require the Department of Health and Mental Hygiene to identify the number of abortion seekers coming to the City from New York municipalities, as well as from other states. Sharing this information, particularly where there are very few travelers from a given location, could constructively identify individuals, expose them to legal risk, and, indeed, be used against them. Mere compliance with existing privacy laws is insufficient, and the bill should be amended to require data to be aggregated and pseudonymized and/or deidentified with technical and policy measures in place to prevent re-identification. Furthermore, the City must not report data when the number of abortion seekers from a given location is low enough to risk identifying any individual. Relatedly, the City should consider publicizing information about digital privacy best practices and how people can access information about reproductive health care services via secure platforms and communications.

As New York positions itself as an access state for people around the country seeking reproductive care, the City must ensure that such care is accessible to all who need it. The NYCLU therefore supports Resolution 195 calling on the Legislature to pass, and the Governor to sign, The Reproductive Freedom and Equity Program (S.9078/A.10148A), which would provide funding to New York abortion providers and non-profit organizations. Enhancing funding for abortion access will be especially critical as we expect hundreds of thousands of pregnant people will turn to New York as the nearest state where they can access care, and additional resources will be

necessary to meet the increased demand.[1] We applaud the City's leadership dedicating funding for abortion seekers who cannot afford care since 2019; this concrete support will be more important than ever as we anticipate a surge in need. The NYCLU also supports efforts to expand the availability of medication abortion and grow the pool of qualified abortion providers offering care in this state; however, the Council must consult with all relevant stakeholders, including clinics and providers, to ensure that its proposals will be administrable and effective in New York City.

Furthermore, the City should take this opportunity to make information more widely available about how people can efficiently and securely effectuate their reproductive choices. Indeed, as we expect an influx of people traveling to New York City to seek abortion care, it is more important than ever that the City inform pregnant people about where and how to obtain comprehensive reproductive health care within our borders. It is essential that this information is accessible to all communities, and we support Intro. 0485 that would expand language access services for abortion providers.[2] We further encourage the City to work collaboratively with community members and leaders to ensure that information about reproductive health resources, rights, and protections most effectively reaches New York's many diverse communities.

As the dust settles on the Supreme Court's recent opinion, new needs and challenges will surely emerge. We appreciate the City's swift response to this reproductive health crisis and encourage it to continue recalibrating its approach as the legal and practical landscape evolves. While this is a uniquely devastating moment for abortion access, reproductive health, justice, and equity have been, and remain, a fiction for many New Yorkers since long before the fall of *Roe*. New York City must maintain its commitment to improving accessibility, safety, cultural-sensitivity, and respect for human dignity and autonomy throughout its health care system, particularly for Black, Brown, Latinx, immigrant, and low-income pregnant New Yorkers.[3] The NYCLU is grateful for the Council's attention to these important issues, and we are eager to continue working with you in support of these ongoing efforts.

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[1] Now that *Roe v. Wade* has been overturned and many states are prohibiting abortion, there may be an increase of 190,000-280,000 women from other states whose nearest abortion provider is in New York. Guttmacher Institute, *If Roe v. Wade Falls: Travel Distance for People Seeking* Abortion (2022), https://web.archive.org/web/20220602102345/https://states.guttmacher.org/#new-york.

[2] We further encourage the Council to provide language access for all medical providers in New York City.

[3] *See generally*, New York Civil Liberties Union, *Written Testimony to the New York City Council Committees on Health and Hospitals*, Oversight Hearing: Maternal Health, Mortality, and Morbidity (June 29, 2022) (addressing ongoing problems of racial disparities in maternal mortality and discriminatory non-consensual drug testing and treatment of pregnant patients).

Winnie Ye, Senior State Strategies Manager, All* Above All
Testimony in Support of Resolution 195 and Initiative 507
New York City Council Committee on Women and Gender Equity
Hearing on July 1, 2022 at 1:00 pm EST

Thank you Madam Chair and the committee for the opportunity to testify today. My name is Winnie Ye and I am the senior state strategies manager at All* Above All. As a campaign that unites individuals and over 140 organizations across the country to build a future where abortion is affordable, available, and supported for anyone who needs it, All* Above All strongly supports Resolution 195 and Initiative 507 as well as the full package being considered today.

In its decision in *Dobbs v. Jackson Women's Health Organization* on June 24th, the Supreme Court destroyed the last shreds of our national right to abortion, without concern for our dignity and basic human rights. The decision was the result of a decades-long scheme to dismantle access to abortion care, which has always disproportionately impacted communities of color, people working to make ends meet, immigrants, LGBTQIA+ individuals, and young people. People of color already bear the brunt of systemic racism, bans on abortion coverage like the Hyde Amendment, and the ongoing pandemic. The ripple effects of the ruling will be felt far and wide, in every state across the country, including here in New York.

In the midst of this abortion care crisis, the New York City Council has an opportunity to push for bold solutions for abortion justice by approving Resolution 195 and Initiative 507.

The first proposal, Resolution 195, would call on the New York State Legislature to pass, and the Governor to sign, The Reproductive Freedom and Equity Program (S.9078/A.10148A), which would establish a grant program to provide funding to New York abortion providers and non-profit organizations to increase access to abortion care. Each of us should be able to make decisions about whether and when to become a parent but abortion coverage bans and low wages can make it impossible for New Yorkers to pay for care. In many cases, people working to make ends meet are forced to delay care in order to raise the funds to pay for their abortion or additional expenses like transportation, hotel accommodations, or child care. Indeed, the Federal Reserve Board finds that 40% of Americans don't have enough savings to pay for a $400 emergency expense like an abortion.

Thankfully, here in New York, grassroots and non-profit organizations like the New York Abortion Access Fund and Brigid Alliance help people overcome financial and logistical barriers

ALL ABOVE ALL CATALYSTS FOR ABORTION JUSTICE

to accessing abortion care. The Reproductive Freedom and Equity Program would provide them much needed funding so they can continue to support people in making decisions about their health and futures, with dignity and economic security.

The second proposal, Initiative 507, would make medication abortion available free of charge at city health centers, stations, clinics and other facilities. Medication abortion is a safe and effective option for ending an early pregnancy. A growing share of people who end their pregnancy are choosing medication abortion care – in fact, a February 2022 report by the Guttmacher Institute found that medication abortion now accounts for more than half of all U.S. abortions. In the aftermath of the Supreme Court decision that will force people to delay their abortion care or carry an unwanted pregnancy against their will, it's critical that the New York City Council take steps to make abortion affordable and available, including increasing access to medication abortion.

In this moment, we need bold solutions for abortion justice that address the realities of getting an abortion in the United States and break down the barriers for people of color working to make ends meet. Resolution 195 and Initiative 507 are important proposals that will ensure abortion is there for anyone who needs it without barriers based on who they are, where they're from, or how much they earn. I respectfully urge you to approve these measures along with the full package of legislation being considered today. Thank you again for the opportunity to testify.

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Testimony of Arab-American Family Support Center Before the New York City Council Committee on Women & Gender Equity

Friday, July 1st, 2022

I would like to begin by thanking the Committee Chair, Councilmember Tiffany Cabàn, the Committee on Women & Gender Equity, and the New York City Council for holding this hearing at such a crucial time. My name is Salma Mohamed, and I am the Partnership & Capacity Building Specialist at the **Arab-American Family Support Center (AAFSC).** With 36 languages on staff, 14 physical locations, and 27 years of experience, **AAFSC** brings a trauma-informed, culturally responsive, linguistically competent, and research-driven approach to serving New York's growing immigrant communities. While we serve everyone who walks through our doors, we specialize in serving AMENAMSA (Arab, Middle Eastern, North African, Muslim, and South Asian) and AAPI (Asian and Pacific Islander) communities—communities that for centuries have been underrepresented and underserved.

The Arab-American Family Support Center submits this testimony to address the abridgement of fundamental rights in the U.S. Supreme Court's recent decision, gutting rights to privacy, bodily autonomy, and self-determination for women, girls, transgender, and gender non-conforming people, especially those who are further marginalized because of their race, class, ability, and/or immigration status.

On **June 24th, 2022,** the United States Supreme Court in *Dobbs v. Jackson* held that the right to abortion is not protected under the U.S. Constitution, overturning decades of precedent established by *Roe v. Wade* and *Planned Parenthood v. Casey.*

Despite *Roe* and *Casey*, over the past few decades, women, girls, transgender, and gender non-conforming people, and others who may get pregnant have faced various barriers to accessing reproductive healthcare. Many states have worked diligently to chip away at the Court's decisions in *Roe* and *Casey*, making the right to abortion care almost obsolete. For example, many states have instituted physician and hospital requirements, waiting periods, state-mandated counseling, criminal punishments for fetal harm, etc.

These burdensome and obstructive regulations have impacted minority women, girls, transgender and gender non-conforming individuals, especially those who are survivors of sexual violence, in severe and distinct ways. They must navigate the intersection of race, gender, and class (and at times ability) discrimination when trying to access abortion care. This decision comes at a particularly troubling time for survivors of sexual violence. In 2021, **AAFSC's Anti-Violence Program** experienced a **40%** increase in demand for case-management services and a doubling in high-risk cases–cases where there is a homicidal or suicidal risk. *Dobbs* reinforces various barriers to reproductive healthcare, especially for vulnerable groups.

The Court's decision has not only further exacerbated barriers for marginalized communities, but also, it has created particularly dangerous and, in many cases, life-threatening hurdles to accessing abortion care. Some states have already outlawed abortion, compelling many people to travel across state lines to receive abortion care or carry the fetus to term against their will. The U.S. Supreme Court, however, does not see forced childbirth as a violation of the fundamental rights of girls, women, transgender, gender non-conforming people, and others who are able to get pregnant.
To access reproductive health services, AMENAMSA and AAPI immigrant communities must navigate a labyrinth of barriers, including, but not limited to, wealth inequity, disproportionate access to healthcare, fear of deportation, punitive measures with a *de facto* discriminatory impact on immigrants/ communities of color, as well as the lack of culturally and linguistically competent resources and services.

The *Dobbs* decision, and the precedent cited, further strengthens and reifies historically racist, patriarchal, ableist, anti-LGBTQIA+, and classist systems. Under the guise of impartiality and justice, the U.S. Supreme Court has

greenlighted increased government obfuscation and overreach in reproductive healthcare, particularly for marginalized groups and survivors of sexual violence.
Perhaps the most troubling element of the decision is the Court's reasoning. The majority used an originalist framework, arguing that because the right is not mentioned in the constitution or "deeply embedded in the Nation's history," it is not protected. Our nation's history is embedded with centuries of legally authorized (and at times created) inequity, rendering the framework inherently discriminatory.
In 1927, the U.S. Supreme Court found that a woman was not protected by the constitution when she was forcefully sexually sterilized in a state mental health institution, arguing in the decision that, "three generations of imbeciles are enough."[1] The Court's decision remains a part of contemporary jurisprudence. It is appalling that a case involving state-sanctioned eugenics and violence has not been explicitly overturned but the right to an abortion has.

If the Supreme Court is going to dictate the rights of our communities based on the "original intent" of the founders, our communities, communities who have been historically marginalized, will continue to bear the brunt of these rulings. The onus is on all of us to address the systemic inequity that is part and parcel of the U.S.'s history and encapsulated in our systems. As long as the U.S. Supreme Court continues to weaponize the original intent of the founders, we must ensure adequate protection for those who were not considered people, deserving of rights, at our country's inception.
As the dissenting judges indicate, with this ruling as well as the majority's cherry-picking of precedent and history, other civil rights and liberties are under threat, from purchasing and using contraceptives to same-sex marriage and likely much more.

We call upon our leaders to address this egregious human rights violation and strengthen protections for all residents of New York and beyond, and to enact comprehensive, robust legislation at the local, state, and national level for the safety and security of those most vulnerable. Specifically, we are requesting the following from the NYC City Council:

- Advocate for federal legislation to codify the right to an abortion and bodily autonomy along with enhanced protections for marginalized communities, who face added barriers that prevent them from fully exercising their legal rights.
- Advocate for federal data protections for women using reproductive health apps.
- Advocate for the codification of sexual and reproductive freedom in the NYS constitution.
- Expand NYC municipal abortion funding from $250,000 to $1m.
- Advocate for legislation and additional funding to increase the availability of in-language, culturally responsive, and trauma-informed information and services pertaining to reproductive healthcare in NYC.
- Regardless of immigration status, protect access to public benefit programs, healthcare, and economic justice, all of which are crucial to accessing abortion care.

Thank you. As always, the **Arab-American Family Support Center** stands ready to work with you in ensuring that all New Yorkers have access to the services they need to lead safe and fulfilling lives.

New York City Council
Committee on Women and Gender Equity

Oversight Hearing: Reproductive Rights
July 1, 2022

Written Testimony of The Bronx Defenders[1] by
Jessica Prince - Interim Family Defense Practice Policy Director
Isamaris Santiago - Parent Advocate Supervisor, Family Defense Practice

Today's hearing comes at a particularly tense moment for reproductive rights. Last week, the highest court in this country made final what reproductive justice advocates have been warning us could happen–birthing people were stripped of their fundamental right to privacy and bodily autonomy.[2] The opinion of the Supreme Court is the most recent strike of a continued assault on the dignity, autonomy, and fundamental human rights of women and pregnant people. However, the decision did not represent what the vast majority of us believe– that we should all be able to make for ourselves the decisions that impact our lives, health and futures. It is critical that we look back at how we arrived at this moment.

Reproductive justice activists, in particular Black activists, have been telling us for decades that reproductive justice is not just about the right to an abortion. It is also the right to continue a pregnancy to term without your bodily autonomy and integrity violated. Any violation of that autonomy, dignity and integrity paves the path for abortion restrictions. Just as the right to terminate one's pregnancy is a core reproductive justice rights issue, so too is

[1] The Bronx Defenders ("BxD") is a public defender non-profit that is radically transforming how low-income people in the Bronx are represented in the legal system, and, in doing so, is transforming the system itself. Our staff of over 350 includes interdisciplinary teams made up of criminal, civil, immigration, and family defense attorneys, as well as social workers, benefits specialists, legal advocates, parent advocates, investigators, and team administrators, who collaborate to provide holistic advocacy to address the causes and consequences of legal system involvement. Through this integrated team-based structure, we have pioneered a groundbreaking, nationally-recognized model of representation called holistic defense that achieves better outcomes for our clients. Each year, we defend more than 20,000 low-income Bronx residents in criminal, civil, child welfare, and immigration cases, and reach thousands more through our community intake, youth mentoring, and outreach programs. Through impact litigation, policy advocacy, and community organizing, we push for systemic reform at the local, state, and national level. We take what we learn from the clients and communities that we serve and launch innovative initiatives designed to bring about real and lasting change.

Our Family Defense Practice has been in place since 2005 and represents parents in family regulation and all of the related Family Court proceedings that arise out of an abuse or neglect case. Since New York City first funded institutional parent representation in 2007, we have represented more than 16,000 parents in the Bronx and helped thousands of children either safely remain at home or safely reunite with their families. Our multidisciplinary staff of more than 50 attorneys, social workers, and parent advocates represents 1,000 to 1,500 new parents each year.

[2] *See Dobbs v. Jackson.*

being able to be pregnant without criminalization and to have and raise children with dignity and safety. The family regulation system[3] ("FRS") is a fundamental threat to reproductive rights. Drug testing pregnant people and their newborns, monitoring and surveilling them precisely because they are pregnant and parenting are examples of ways the government creates a system where it deems pregnant and parenting people as less deserving of rights. The Bronx Defenders has long recognized that the foster system is a punitive mechanism used to surveil and control low-income communities. In our practice, representing parents in the South Bronx–a community where system involvement is concentrated and rates of child removal are high–we see how this state monitoring of parents results in reproductive oppression for entire communities.

We support and applaud the birth justice bills proposed by the city council. We also encourage the city council to expand its framing of reproductive justice to include concrete steps to shift power back to families and reduce the harmful impacts of the family regulation system

I. The Reproductive Justice Movement Calls Us to Interrogate the Policing of Pregnant and Parenting People by the Family Regulation System

The family regulation system (FRS) must be viewed through a reproductive justice lens. Reproductive justice ("RJ") is a vision that broadens the landscape of the reproductive rights movement to include larger issues of racial and social justice.[4] Reproductive rights have come to be limited by the popular narrative of "choice," which has become primarily focused on access to abortion and contraception.[5] RJ places equal importance on the reproductive rights to decide to have a child, to not have a child, and to parent the children one chooses to have with dignity and respect.[6] Viewing reproductive politics by integrating "analysis of race, class, and immigration status," better exposes the multitude of power structures that inhibit people from realizing their full range of reproductive rights and achieving broader RJ.[7] In order to fully address the reproductive rights of birthing people, we must interrogate this city's reliance on the FRS and ACS to investigate, surveille, separate, and prosecute families, particularly, low-income families of color.

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[3] Many, including scholar Professor Dorothy Roberts, have come to refer to the so-called "child welfare" system as the family regulation system, given the harms historically and currently perpetuated by the system. *See e.g.*, Dorothy Roberts, *Abolishing Policing Also Means Abolishing Family Regulation*, The Imprint (June 16, 2020), https://imprintnews.org/child-welfare-2/abolishing-policing-also- means-abolishing-family-regulation/44480.

[4] *See* Loretta Ross, *Understanding Reproductive Justice: Transforming the Pro-Choice Movement*, 36 OFF OUR BACKS, no. 4, 2006, at 14, 14-19; *see also* Zakiya Luna & Kristin Luker, *Reproductive Justice*, 9 ANN. REV. L. & SOC. SCI. 327, 328-30 (2013) (discussing the reproductive justice movement and its relationship to law, academic scholarship, and social movements); *see generally* ASIAN COMMUNITIES FOR REPRODUCTIVE JUSTICE, A NEW VISION FOR ADVANCING OUR MOVEMENT FOR REPRODUCTIVE HEALTH, REPRODUC- TIVE RIGHTS AND REPRODUCTIVE JUSTICE (2005), http://strongfamiliesmovement.org/ assets/docs/ACRJ-A-New-Vision.pdf [https://perma.cc/6QZW-E7K6] (discussing the organization's role in the Reproductive Justice movement and discussing the move- ment's placement within a social justice framework).

[5] Luna & Luker, *supra* note 4, at 328.

[6] Ross, *supra* note 4, at 14; DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 6 (1997).

[7] Luna & Luker, *supra* note 4, at 335.

The FRS is a reflection and reinforcement of a system of stratified reproduction in this country. The term "stratified reproduction" is a way of understanding that whether one's reproductive choices are celebrated or condemned depends on one's position in other social hierarchies such as race and class.[8] In short, certain categories of people are encouraged to reproduce and parent, but others are not.[9] There is a long history in this country of coercive and violent treatment towards those society deems less deserving of motherhood–enslaved Black women, Latine, Indigenous women and women of color.

II. FRS reflects and reinforces Stratified Reproduction

There are structures in place at every level that reinforce the reproductive stratification that we see on the ground in the Bronx. These structures unequivocally target low-income families of color. As renowned scholar Dorothy Roberts told us over twenty years ago:

> *If an outsider looked at the American child welfare system, she would likely conclude that this is not a system designed to promote the welfare of America's children. Rather, it is a system designed to regulate, monitor, and punish poor families, especially poor Black families.*[10]

A. Poor Families and Families of Color Are Targeted by the FRS

It is a common misconception that parents accused of maltreatment by the FRS have abused or abandoned their children. Poverty is actually the leading predictor of system involvement and studies show that families who are "below the poverty line are twenty-two times more likely to be involved in the child protection system than families with incomes slightly above it."[11] Allegations of neglect which include a parent's failure to provide adequate food, shelter or medical care compose the majority of child welfare cases in New York City despite salacious media stories that single out isolated stories of child abuse. High poverty rates mean these families are less likely to have access to necessary resources such as stable housing, counseling, and childcare services without which they may be determined neglectful by the child welfare system.[12] Research shows that 30% of America's foster children could be safely in their own homes if their parents had safe, affordable housing,[13] and yet another shows housing to be more important than substance abuse in determining whether children remain with their families. Nearly half of families (47%) whose children are removed from their homes have trouble paying for basic necessities.[14]

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[8] Harriet M. Phinney et al., *Obstacles to the 'Cleanliness of Our Race': HIV, Reproduc- tive Risk, Stratified Reproduction, and Population Quality in Hanoi, Vietnam*, 24 CRITICAL PUB. HEALTH 445, 446 (201

[9] *Id*.

[10] Dorothy E. Roberts, *Poverty, Race, and New Directions in Child Welfare Policy*, 1 WASH. U. J. L. & POL'Y 63, 64 (1999), https://openscholarship.wustl.edu/law_journal_law_policy/vol1/iss1/7

[11] Martin Guggenheim, *General Overview of Child Protection Laws in the United States*, *in* Representing Parents In Child Welfare Cases: Advice and Guidance for Family Defenders 1, 17 (Martin Guggenheim & Vivek S. Sankaran eds., 2015)

[12] Elisa Minoff, Entangled Roots: The Role of Race in Policies that Separate Families, Center for the Study of Social Policy (2018); Fluke, *et al.* A Research Synthesis on Child Welfare Disproportionality (Jan. 2011).

[13] Deborah S. Harburger & Ruth Anne White, Reunifying Families, Cutting Costs: Housing_Child Welfare Partnerships for Permanency Supportive Housing, 83 Child Welfare 493 (2004)

[14] National Survey of Child and Adolescent Well-being (2005, April). CPS Sample Component Wave 1 Data Analysis Report http://www.acf.hhs.gov/programs/opre/abuse_neglect/sscaw/reports/cps_sample_report_revised_090105.pdf.

This plays out in the Bronx with devastating consequences for the borough's children. The Bronx has the highest rates of eviction, unemployment, and public benefits enrollment in the City. According to the 2014 American Community Survey, 43.3 percent of children under 18 live below the poverty line. Community District 1, encompassing much of the South Bronx where our office is located, has a median income of just $16,800 per year, with 60 percent of residents receiving some kind of public assistance. According to data provided by the Office of Court Administration, in 2017 1,191 Bronx children were separated from their families; Bronx children represent over 30% of the children separated from their families in New York City.[15] Because of their relative poverty, Bronx children are particularly vulnerable to family separation and its short term distress and long lasting negative consequences.

The extent to which children of color are disproportionately vulnerable to the consequences of FRS involvement is profound. In the state of New York, African American children make up 16% of New York's general population and 48% of New York's foster care population.[16] In New York City, African American children accounted for 27 percent of the children under the age of eighteen in the city but a staggering 57.1 percent of the children separated from their families in foster care. In contrast, 24 percent of the children in New York City were white, but white children comprised only four percent of the foster care population.[17] In addition to being more likely to have contact with New York City's child welfare system, families of color fare worse than white families once a case has been opened. Studies show that children of color are more likely to be separated from their families than white families, even under the same circumstances of risk.[18] Furthermore, the harm of separation is more likely to be exacerbated for children of color because they spend longer time separated from their families, change placement more frequently, are less likely to receive necessary services, less likely to ever reunify with their families, and they are more likely to age out of foster care without being adopted.[19] Although the intention of New York City's child protection system may not be to separate children of color from their families, children of color are the most likely to suffer the consequences.

Given that poverty is the main driver of a family's FRS involvement and family separation, that the system is plagued by deep historical racial disproportionality, the negative impact of family separation on children in the short and long term, and the inhumane ways that families are separated on a daily basis, we can and must do better. We must do nothing less than ensure that there exist adequate safeguards against unnecessary traumatic family separation, so that it is a system we would trust to investigate our own families.

B. Reproductive Stratification Is Reflected in and Reproduced by the FRS

[15] Data provided by the Office of Court Administration. (2017) Table 10: Family Court Disposition of Original Abuse (NA) & Neglect (NN) Petitions: Temporary Removal of Children From Home 2017. Retrieved from: http://ww2.nycourts.gov/sites/default/files/document/files/2018-06/Family-Court-statistics2017.pdf

[16] New York Profile Transition-Age Youth in Foster Care (Distributed by Indigent Legal Services in November of 2018 and on file with The Bronx Defenders).

[17] Tina Lee, Catching A Case: Inequality and Fear in New York City's Child Welfare System, at 5-6 (2016).

[18] *See*, *e.g.*, U.S. Gov't Accountability Office, GAO-07-816, African American Children in Foster Care: Additional HHS Assistance Needed to Help States REduce the Proportion in Care 8 (2007).

[19] *See* Elisa Minoff, Entangled Roots: The Role of Race in Policies that Separate Families, Center for the Study of Social Policy (2018); Fluke, et al. A Research Synthesis on Child Welfare Disproportionality (Jan. 2011).

The FRS reifies a system of stratified reproduction through various laws, policies and practices. Laws define who is worthy of parenting, policies destin some children for foster care, and in practice, entire communities are marked as unfit and harmed for generations.[20] The FRS, reflects and reinforces reproductive stratification by not only policing people's ability to parent their children, but actively presuming that children born to system involved parents will continue to live under this regime of family policing.

Moreover, today's family regulation system is the vestige of decades of racist and classist public policy. The War on Drugs and the so-called "crack epidemic"– which peddled the grossly exaggerated "crack baby" mythology– led to laws, policies, and practices that continue to inform how reproductive care is administered and regulated to this day. These laws increased federal funding to states for separating families while simultaneously decreasing funds for basic necessities for families such as health care–including mental health and drug treatment–housing and child care.[21] The policies and practices created during this era continue to inform how parenting people are regulated. Examples include, the rapid expansion of state laws surveilling pregnant people reinforced and expanded in response to the Child Abuse Prevention and Treatment Act (CAPTA)[22], and the Comprehensive Addiction and Recovery Act (CARA).[23] Congress also enacted legislation that makes material assistance scarce while simultaneously passing laws that explicitly define categories of parents not worthy of reunification efforts, shortening the timeframe in which parents eligible for services must regain custody of their children, and explicitly articulating a greater preference for adoption whenever possible.

Perhaps no policy or practice evidences the over-regulation of pregnant and parenting people better than Child Safety Alert 14 (CSA 14).[24] CSA 14 is an ACS Policy that determines the fate of infants born to parents with older children in foster care.[25] This policy reflects and recreates stratified reproduction by making certain assumptions about any parent with children in foster care who becomes pregnant. Strangely, the policy does not require ACS or the foster care agency to take steps to ensure that the pregnant person has a safe pregnancy and a healthy baby. Instead, the policy could better be described as preparing

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[20] *See* Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115 (1997)

[21] *Id.*

[22] 42 U.S.C. § 5106; U.S. Dep't of Health and Human Srvs., Admin. for Children and Families, *About CAPTA: Legislative History* (July 2011), https://www.childwelfare.gov/pubPDFs/about.pdf (Enacted in 1974, CAPTA provides federal funding to states to support the "prevention, assessment, investigation, prosecution, and treatment" of child abuse, in exchange for states' fulfillment of certain requirements. In the last twenty years CAPTA has been amended to require states to have policies in place to "notify" child welfare agencies of babies who fall into one of the three enumerated categories: being "affected by substance abuse," affected by "withdrawal symptoms resulting from prenatal drug exposure" or having Fetal Alcohol Spectrum Disorder.[#] While these notifications neither legally require child protective reports, nor require hospitals to drug test pregnant people, people who give birth, or newborns, studies confirm that doctors and hospitals frequently misunderstand their responsibility under CAPTA, and states have widely expanded the scope of legal requirements to further consecrate the practice of routine and medically unnecessary drug testing and reporting in hospital settings.)

[23] 42 U.S.C. § 5106; U.S. Dep't of Health and Human Srvs., Admin. for Children and Families, *About CAPTA: Legislative History* (July 2011), https://www.childwelfare.gov/pubPDFs/about.pdf.

[24] *See* Memorandum from John B. Mattingly, Comm'r, N.Y.C. Admin. of Children's Servs., Safety Planning for Newborns or Newly Discovered Children Whose Siblings Are in Foster Care: Child Safety Alert #14 (Revision) (June 5, 2008) [hereinafter "Child Alert 14"], https://nycfuture.org/images_pdfs/pdfs/NewbornsPolicy.pdf [https://perma.cc/L2CZ-Z64X].

[25] *Id.*

for the child to enter foster care.. Under this policy, the foster care agency holds a pre-birth conference; however, ACS, the primary decision maker about whether the child will be removed at birth, is not present at the conference. Throughout the pregnancy, the foster care agency inserts itself into the birth planning without any respect for the parent's autonomy or privacy. When the child is born, ACS holds a separate conference to determine whether the family should be separated and whether a case should be filed in court alleging that the parent has neglected the newborn baby. This creates a situation where the ACS decision to separate a newborn baby from its mother is longer about safety but about compliance and whether a parent has jumped through every hoop that ACS has put in their path. After the baby is born and these conferences take place, ACS determines whether to file a case in court to get court supervision over the Newborn baby.

This practice and approach to pregnant people with children in foster care perpetuates the view that system-involved parents are fundamentally flawed individuals who need constant government supervision. It is a practice that ignores individual strengths and other positive things happening in their families' lives in favor of focusing exclusively on the fact that the parent has older children in foster care.

III. Fear of the FRS Prevent Pregnant and Parenting People from Seeking Medical Care

The FRS causes irreparable damage to parents, children and communities. Viewing the FRS through a reproductive justice lens requires us to examine the impact of how practices that abrogate the rights of an individual also harm communities. Because of ACS prevalence in low-income communities of color, ACS practices of separating families are well known to pregnant and parenting people. When family separation is a looming threat, pregnancy can become a stressful time, especially when that parent is already involved in the family regulation system. There are times when one of our clients suspects they are pregnant and their first call is to their lawyer instead of a doctor.

In fact, pregnant people who are surveilled by systems often fear seeking out treatment. For example, knowing that hospitals regularly report families to ACS, a person who uses drugs who finds out they are pregnant has good reason to fear interacting with healthcare professionals. The National Perinatal Association warned in a recent statement that treating perinatal drug use in pregnancy "as a deficiency in parenting that warrants child welfare intervention" is problematic because it can create the consequence that "pregnant and parenting people [avoid] prenatal and obstetric care and [put] the health of themselves and their infants at increased risk."[26] As they put it, the "threats of discrimination, incarceration, loss of parental rights, and loss of personal autonomy are powerful deterrents to seeking appropriate prenatal care."[27]

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[26] Nat'l Perinatal Ass'n, Position Statement, Perinatal Substance Use (2017).
[27] *Id.*; *see also* Shelly Gehshan, Southern Reg'l Project on Infant Mortality, *A Step Toward Recovery: Improving Access to Substance Abuse Treatment for Pregnant and Parenting Women* ii, 5 (1993); Steven J. Ondersma et al., *Prenatal Drug Exposure and Social Policy: The Search for an Appropriate Response*, 5 Child Maltreatment 93, 99 (2000) ("[B]ringing high levels of coercion to bear on parents increases the likelihood that contact with outside agencies and hospitals will be avoided by pregnant mothers.").

The healthcare system in New York City is complicit in violating the reproductive rights of pregnant people. This is evident in the drug testing of pregnant and birthing parents, often without their knowledge or consent; the reporting of parents to the state central registry of child abuse and maltreatment–often when there is no indication of harm; and by placing social holds[28] preventing newborns from leaving the hospital–even when medically ready for discharge–to allow ACS time to investigate reports. This active collaboration with the family regulation system creates a "womb-to-foster-care" pipeline.[29]

The family regulation system reproduces stratified reproduction. It is critical to understand that the regulation of pregnant and parenting people is a violation of reproductive rights. In order to achieve reproductive justice for all New Yorkers, we must interrogate ACS practices of regulating pregnant and parenting people.

IV. BxD calls on the City Council to Expand Its Frame on Birth Justice

The Bronx Defenders supports the birth justice bills proposed by the City Council. We applaud its efforts to ensure access to reproductive health care to all people. Further, we challenge the City Council to expand its understanding of reproductive justice to include the full frame of decisions that birthing people and parents encounter. Taking steps towards reproductive justice must include ensuring that power and resources are shifted back to families in order to reduce the harmful impacts of the family regulation system. We look forward to partnering with this committee going forward to work towards reproductive justice for all New Yorkers.

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[28] It is illegal for hospitals to place a baby on social hold. Under the family court act, a physician has the power to remove a child who is at imminent risk of serious harm. The law, however, requires the physician to seek a court order within 24 hours of removing the child. N.Y. FAM. CT. ACT § 1026(c) (McKinney 2005). A hospital cannot hold a baby who is otherwise ready for discharge without a parent's consent without a court order. Routinely, however, hospitals refuse to allow mothers to take their newborns out of the hospital based on the fact that ACS is investigating or might investigate.

[29] For more information on the womb-to-foster-care pipeline, *see* Emma Ketteringham, et al., *Healthy Mothers, Healthy Babies: A Reproductive Justice Response to the Womb to Foster Care Pipeline*, 20 CUNY L. Rev. 77 (2016). Much like "school-to-prison" pipeline, a term used to describe the ways in which marginalized and at-risk school children are pushed out of the public education system into the juvenile and criminal justice systems, the womb-to-foster-care pipeline refers to the policies and practices of the current family regulation system that push impoverished newborns, especially babies born to system-involved families, who are predominantly low-income and of color, out of the womb and into the foster system. This pipeline reflects the systemic inequality within which the family regulation system operates and the disregard for the critical bond between a newborn and its childbearing parent. The fear of having one's newborn taken often causes system-involved pregnant women to not access prenatal care and seek essential services, ultimately making them even more vulnerable to family disruption and other adverse effects.

Testimony of Rebecca Charles
Policy & Advocacy Associate
Citizens' Committee for Children of New York

Provided to the New York City Council Committee on Women and Gender Equity
June 29, 2022

Since 1944, CCC has served as an independent, multi-issue child advocacy organization dedicated to ensuring that every New York child is healthy, housed, educated, and safe. CCC does not accept or receive public resources, provide direct services, or represent a sector or workforce. We document the facts, engage, and mobilize New Yorkers, and advocate for New York City's children.

I would like to thank Chair Cabán and the Committee on Women and Gender Equity for hosting this hearing on child care and these recently introduced child care bills. Over the past eight years, the City and State have made major strides in enhancing access to early care and education, but there is much work to be done to ensure true universality of care from birth to five years old. CCC recognizes and appreciates the efforts of Councilmembers Cabán, Gutiérrez, Hudson, and Menin for championing bills that will address impediments to child care access that exist within the City's child care system. CCC's testimony below addresses recommendations related to bills Int 0485-2022, Int 0486-2022, Int 0487-2022, Int 0488-2022, Int 0489-2022, and Res 0069-2022. Our recommendations are also informed by the recently released City Blueprint for Child Care and the Early Education System.

Int 0485-2022 To establish an electronic child care directory

CCC supports the intent of Int 0485 to strengthen education and access to information on licensed child care providers. However, a searchable child care directory already exists and is operated by the Office of Children and Family Services (OCFS) at the state level and managed at the city level by the Department of Health and Mental Hygiene (DOHMH). Instead of replicating existing efforts and developing a brand new system, **CCC recommends the City Council work with DOHMH and OCFS to identify ways in which to improve and strengthen the current directory drawing on input from providers, parents, and other critical stakeholders.**

Int 0486-2022 To establish a child care advisory board

CCC supports the establishment of a child care advisory board or equivalent. Mayor Adams's newly released Blueprint for Child Care and Early Education in NYC also outlines a plan to

establish a child care advisory board. We are glad to see the common interest **and we hope the City Council can work closely with Mayor Adams's administration to ensure the voices of parents, providers, advocates are included in this body.** The success of the advisory board will be dependent on inclusion of diverse members with lived experiences working within or relying upon the city's child care and early education system.

Int 0487-2022 To establish a child care subsidy information portal

Mayor Adams' Blueprint also calls for the establishment of a child care subsidy portal, offering an opportunity for **collaboration between the City Council and the Administration, to ensure this resource for families will eliminate administrative burdens and delays faced when applying for child care subsidies.** However, it is important that strong consideration be given to language accessibility and cultural competency of the portal and what role providers of service might play to assist parents with its utilization.

Int 0488-2022 To establish a child care program fund

This bill authorizes grants to child care centers up to $1,000 per full-time employee for a maximum of 20 employees. Though CCC appreciates the intention of offering resources to struggling child care providers, we feel it is not the best use of funds with so many programs at risk of closure or displacement. **There is an urgent need for the DOE to register and pay FY'22 contracts timely. Hundreds of programs have yet to be paid for services rendered since last July 2021 and others are fronting six month or more of costs because reimbursement is so delayed. The advocacy community is urging DOE and Mayor Adams administration to register contracts timely, and ensure providers are kept whole in FY22 and FY23.**

Int 0489-2022 To establish a child care certification program

We are not prepared to take a position on this bill at this time and seek further clarification on how the bill interacts with existing licensing and health and safety requirements that involve Fire Department inspection and DOHMH codes and licensing requirements, among others.

Res 0069-2022 Calling on the State to pass legislation supporting the provision of financial assistance to families and child care providers

CCC strongly supports the local resolution urging passage and implementation of state bills S.7595/ A.8623 (Brisport/Hevesi), S.6706B/ A.7582A (Brisport/Hevesi), and S.7615/A.8625 (Ramos/Dinowitz) at the state level. These bills would expand access to child care and fund a path toward universal child care. CCC stands ready to advocate for these bills alongside the City Council.

In addition to our above recommendations, CCC, in partnership with the Campaign for Children, urges the City to continue to champion the following priorities:

- **Build on initial pay parity agreements by achieving permanent pay parity for CBO preschool special educators and center directors and addresses compensation for teachers and workers in the sector taking into consideration both longevity and seniority as well as benefits and pension.**
- **Register and pay contracts timely – keeping provider contracts whole in FY22 and FY23; ensuring DOE child care and early education contracts benefit from Indirect reimbursement just as their human service peers do.**
- **Allow for community-based enrollment**

New York City's recovery depends on a strong, stable system of high-quality early care and education system that takes into account the needs of children, parents, and service providers. Thank you for your interest in strengthening the system and improving access for families and for this opportunity to submit testimony.

New York City Council
Committee on Women and Gender Equality
July 1, 2022

Testimony of Medha Ghosh, MPH, Policy Coordinator
Coalition for Asian American Children and Families (CACF)

Good afternoon, my name is Medha Ghosh and I am the Health Policy Coordinator at CACF, the Coalition for Asian American Children and Families. Thank you very much to Chair Cabán for holding this hearing and providing this opportunity to testify.

Founded in 1986, CACF is the nation's only pan-Asian children and families' advocacy organization and leads the fight for improved and equitable policies, systems, funding, and services to support those in need. The Asian American Pacific Islander (AAPI) population comprises nearly 18% of New York City. Many in our diverse communities face high levels of poverty, overcrowding, uninsurance, and linguistic isolation. Yet, the needs of the AAPI community are consistently overlooked, misunderstood, and uncounted. We are constantly fighting the harmful impacts of the model minority myth, which prevents our needs from being recognized and understood. Our communities, as well as the organizations that serve the community, too often lack the resources to provide critical services to the most marginalized AAPI New Yorkers. Working with over 70 member and partner organizations across the City to identify and speak out on the many common challenges our community faces, CACF is building a community too powerful to ignore.

Our country is facing an abortion access crisis which will especially impact our most marginalized communities, including low-income, people of color, and immigrant folks. Cis-women, non-binary, and trans people from these communities deserve equal access to safe, affordable, comprehensive, and compassionate reproductive health care, which includes abortions. For abortion care to be truly compassionate, it must be linguistically accessible. This is why CACF is in full support of Speaker Adams's Intro Bill 0458-2022 that would require DOHMH to maintain language access services for abortion providers.

Language barriers are a huge obstacle to care faced by many folks in immigrant communities, especially in the AAPI community. In New York City, AAPIs have the highest rate of linguistic isolation of any group, as 46% have limited English proficiency (LEP), meaning that they speak English less than very well, according to a recent report from the New York City Department of Health and Mental Hygiene. Moreover, more than 2 in 3 Asian seniors in New York City are LEP, and approximately 49% of all immigrants are LEP.

Language barriers can prevent folks from accessing vital reproductive health services, including abortion, an important component of public health. Despite there being 76 language access policies targeting healthcare settings in New York, many LEP patients still report facing difficulties like being unable to find an interpreter that speaks their dialect or being unable to fill out paperwork because a translated version in their language does not exist. A lack of linguistically accessible services in all forms of healthcare settings can have grave consequences: 52% of adverse events that occurred to LEP patients in US hospitals were likely

CACF
Coalition For Asian American Children+Families

the result of communication errors, and nearly half of these events involved some physical harm.

A recent Guttmacher Institute study found that AAPI women make up a significant proportion of people who want and need abortion care in New York City. The study also highlighted that within the AAPI community, Indian-American women have the highest rates of abortion in New York City. Considering that many AAPIs seek abortion services and constitute for a significant portion of LEP persons in New York, it is critical that proper language access services are maintained for abortion providers.

In addition to Speaker Adams' Intro Bill 0458-2022, we are also in support of the bills being introduced by Council Members Cabán, Hanif, and Rivera. CACF strongly believes in reproductive justice for the AAPI community, alongside all marginalized communities.

Thank you.

COMMUNITY HEALTH CARE ASSOCIATION of New York State

NYC Council Committee on Women & Gender Equity
Public Hearing: Oversight – Reproductive Rights
July 1, 2022

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to provide written testimony to the NYC Council Committee on Women & Gender Equity oversight hearing on reproductive rights. CHCANYS is the statewide primary care association representing New York's 70+ federally qualified health centers (FQHCs), also known as community health centers (CHCs).

Located in medically underserved communities, CHCs provide high quality primary care to everyone, regardless of ability to pay, insurance coverage, or immigration status. New York City's community health centers serve 1.2 million patients at 490 sites annually. Community health centers are a vital safety net for quality affordable healthcare services for many New Yorkers who otherwise wouldn't have access to healthcare – 93% of NYC patients live below 200% of the federal poverty level. Among NYC health center patients, 40% are Hispanic, 33% are Black, 17% are White, and 10% are other people of color. Inclusive of the comprehensive primary care they provide, most CHCs provide family planning and OB/GYN services, and some CHCs receive state level grants to supplement their family planning programs.

Everyone deserves access to high quality health care, including reproductive health care. However, studies have shown that Black and Indigenous women experience disproportionate poor health outcomes compared to other races for a myriad of health issues, and the disparities are especially stark for pregnancy, delivery, and after birth. Due to systemic and pervasive inequalities, poverty, and racism, Black women are three times more likely to die in and around childbirth as compared to white women, and Indigenous women are twice as likely. Research has shown that these disparities decrease when there is racial concordance between patients and providers. However, more proactive action must be taken to eliminate race-related disparate pregnancy and birth outcomes.

The CHC care model focuses on treating the whole person. CHCs partner with social services providers to meet patients' health and social needs, including connecting them to housing, nutrition services, providing behavioral health care, or referring out to specialty care. As such, CHCs are a natural partner for the NYC government and health system as we look to expand access to comprehensive family planning and pregnancy related services. Efforts to improve reproductive rights must be intersectional and equitable, taking special care to ensure populations most at risk of discrimination are centered.

CHCANYS is supportive of the package of introductions and resolutions in front of the Council Committees to enhance access and protections to abortion and reproductive health care.

CHCANYS remains committed to ensuring access to the full range of services for health center patients. CHCANYS will be a steadfast partner with the NYC government in its goals for achieving gender equity protections and enhancing reproductive rights for all New Yorkers. With additional questions or follow-up, please reach out to Marie Mongeon, Senior Director of Policy with CHCANYS: mmongeon@chcanys.org.

DEMOCRATISM

Testimony of David Gold, Executive Director of Democratism, before the New York City Council Committee on Women and Gender Equity, Hearing Date July 1, 2022

I am a lifelong New Yorker and Executive Director of Democratism, an organization that proposes a way for the New York City Council, together with other local legislatures, to begin a process to remove the right wing bias from our federal election system, and thereby make New Yorkers and other city people full and equal participants in American democracy.

I commend the Committee for responding to the crisis precipitated by the overruling of Roe v. Wade.

I want to draw the Committee's attention to the underlying failure of democracy that has created this crisis, to the implication of that failure of democracy for New Yorkers, and to the power and responsibility of the New York City Council to vindicate the rights of New Yorkers and enable us to build a safe and prosperous future.

Federal protection for abortion rights has ended not because of what the Constitution says, and not even because of smart arguments by right wing lawyers, or because the Federalist Society is so savvy in advancing the careers of right wing judges. Protection for abortion rights is being eliminated because our election system for president and Senate, which nominate and confirm Supreme Court Justices, is marred by a structural bias that undercounts the votes of city people—whose values most Americans broadly share—and instead imposes on all of us the values of a right wing minority.

The reversal of Roe v. Wade is only the beginning. They are already working to ban abortion outright throughout the United States. They are coming for same-sex marriage. They are blocking gun control, blocking climate change legislation, blocking every effort to advance racial justice.

The measures the Committee is considering today are valuable, but they are insufficient, because they're only the defensive side of what we need to do. New Yorkers need the Council to break out of its mindset of acquiescence and include among these bills a first affirmative step towards giving New Yorkers and other city people our fair and equal share of power in determining our future.

Democratism proposes legislation called the Democracy Decree that would do exactly that. A copy is attached to this written testimony. The Committee should introduce the Democracy Decree in this legislative package. We would welcome the opportunity to meet with you about it.

Thank you.

DEMOCRATISM

The Democracy Decree

Preamble

We the people of the United States, in order to establish government by consent of the governed, and in exercise of our right to alter any form of government that is destructive of our unalienable right to life, liberty, and the pursuit of happiness, do hereby decree that the Constitution of the United States of America is revised as follows:

Representative Democracy

1. Popular Election of President and Vice President

The winners of the popular vote for president and vice president shall be elected president and vice president.

2. Proportional Representation in Congress

The relative voting power of parties in each house of Congress shall be proportional to the number of votes that each party or its candidates received in the election for the relevant term.

Adoption of the Decree

3. Proposal

Any combination of states, municipalities, or other jurisdictions that together represent a population of at least twenty percent of the population of the United States as of the most recent decennial Census may propose this Decree for ratification.

4. Ratification

(a) Upon proposal under Section 3, all states and the District of Columbia shall conduct a vote of their citizens within a hundred days as to whether this Decree should be ratified.

(b) During the sixty days following the hundred-day period under subsection (a), any municipality or other jurisdiction within the United States whose citizens did not have an opportunity to vote on ratification under subsection (a)

may conduct a vote of its residents as to whether this Decree should be ratified.

(c) During the thirty days following the sixty-day period under subsection (b), individuals whose state and local governments did not provide an opportunity to vote on whether this Decree should be ratified shall be permitted to vote in a jurisdiction that conducted a vote under subsection (a) or (b) and chooses to conduct a vote for such individuals. The method of voting under this subsection shall be determined by the jurisdiction conducting the vote and may limit the period for voting to facilitate timely counting of the vote.

(d) If a majority of people voting on ratification under subsections (a), (b), and (c) vote in favor of ratification, then this Decree shall take effect and be implemented as provided under Sections 6 and 7 and shall be valid to all intents and purposes, as part of the Constitution of the United States of America, in exercise of the people's right to self-governance, as articulated in the Declaration of Independence.

Initial Implementation

5. Caretaker Replacement for President and Vice President Who Lost Popular Vote

(a) If the ratification period begins during the term of a president who did not win the popular vote in the most recent presidential election, or if a presidential election is scheduled for within the ratification period, then each state or other jurisdiction conducting a vote of its citizens as to ratification shall employ a ballot that additionally prompts voters to choose a party to appoint a caretaker president and vice president. The major parties, and only the major parties, shall be included as choices on the ballot for this purpose.

(b) If a party vote was included under subsection (a) and at the end of the ratification period a president is serving who did not win the popular vote in the most recent presidential election, then within seven days after the close of the ratification period, the party that received the most votes shall choose a caretaker president and a caretaker vice president by a vote of those members of the House of Representatives that caucus with that party. At noon on the tenth day following ratification, the terms of the president and vice president who did not win the popular vote shall end, and the caretaker president and vice president shall take office. The terms of the caretaker president and vice president shall end when the first president elected by the people under this Decree takes office under Section 6(b)(iii).

6. First Presidential Election Implementing This Decree

(a) If at the end of the ratification period a president is serving who won the popular vote in the most recent presidential election, then the

implementational presidential election shall be the next presidential election as otherwise provided for by law.

(b) If at the end of the ratification period, a president is serving who did not win the popular vote in the most recent presidential election, then

(i) the implementational presidential election shall be held

(A) concurrently with congressional elections on the first ordinary election day following the date of ratification, if, and only if, those two days are separated by at least six months and no more than twelve months, or else

(B) on the first Tuesday that is at least six months after the date of ratification;

(ii) the caretaker president and vice president under Section 5 shall not be eligible as candidates in the implementational presidential election; and

(iii) on the twentieth day of the second month after the implementational presidential election under this Section, the terms of the incumbent president and vice president shall end, and the candidates newly elected as president and vice president in the implementational presidential election shall take office and shall serve until the beginning of the next presidential term as otherwise provided by law.

7. First Congressional Election Implementing This Decree

(a) The implementational congressional election

(i) shall employ a national party vote that shall lead to the appointment of additional members to each house of Congress if the party membership among members holding geographically based seats is not in proportion to the result of the party vote, and

(ii) shall not otherwise affect the date or manner of the election of geographically based seats.

(b) The implementational congressional election shall be held

(i) concurrently with elections for geographically based seats on the first ordinary election day following the date of ratification, if, and only if, those two days are separated by at least three months and the first ordinary election day is scheduled for a date prior to the date of the implementational presidential election, or else

(ii) concurrently with the implementational presidential election under Section 6.

(c) The ballot for the party vote shall include all political parties (A) whose membership includes at least one person who was elected to serve in the term of Congress in session at the time of the implementational congressional

election and (B) that have published, not later than 30 days prior to the implementational congressional election, an ordered list of candidates for additional member seats for each house of Congress to which it may be eligible to appoint additional members under subsection (A). Other parties shall not appear on the ballot.

(d) Any party vote ballot listing more than two parties shall prompt voters to rank their choice of parties. Party votes shall be tabulated separately as to each house. As to each house, the party vote for each ballot shall be counted towards the party ranked highest on the ballot among those parties at least one of whose members was elected to a geographically based seat in that house for the relevant term. The relevant term means

> (i) the term beginning after the implementational congressional election, if, and only if, the implementational congressional election is held on ordinary election day, or else
>
> (ii) the term in session at the time of the implementational congressional election.

(e) Additional member seats for the relevant term shall be added to either house for any party that won a larger percentage of the party vote than it holds in geographically based seats, following the Jefferson highest averages method for determining proportionality, and excluding parties that do not qualify for additional member seats under subsection (d). In calculating the percentage of geographically based seats held by members of a party under this Section, each party's seats include the seats of all members who choose to caucus with that party at the time of appointing additional members, provided that no party may confer a committee appointment or other benefit of party association at any time during the term on any member who does not caucus with the party at the time of appointing additional members.

(f) Additional member seats shall be filled, in order, from the affected parties' ordered lists, published under subsection (c)(B). If the implementational congressional election is not held on ordinary election day, then the additional members, if any, shall begin their service one week after the results of the party vote are certified and in no case later than 21 days after the implementational congressional election.

(g) Additional members shall serve as ordinary, independent members until the end of the congressional term and may not be removed by the party leader. If an additional member becomes unable to serve during the term, the party leader may appoint a replacement to serve the remainder of the term.

Subsequent Elections

8. Subsequent Modification of Election System

During any term of Congress beginning after the implementational elections under Sections 6 and 7, Congress may alter the election system for subsequent elections by ordinary legislation pursuant to Article I, Section 7 of the Constitution, as limited by other provisions of the Constitution, including but not limited to the First, Fifth, and Fourteenth Amendments, provided that

(a) no such alteration shall conflict with Section 1 or reduce proportionality under Section 2, including by comparison with the methods of Section 7 and any subsequent statutory modifications to the election system, provided that a change in the minimum level of voter support required for a party that is not a major party to benefit from the method of achieving proportionality shall not be considered a change in the degree of proportionality, and

(b) no such alteration shall take effect unless it has been enacted in two consecutive terms of Congress.

9. Election System as Implemented Until Modified

In the absence of any alteration under Section 8, subsequent elections shall be governed by the procedures of the implementational presidential and congressional elections under this Decree, provided that, as to subsequent elections, this Decree shall not govern dates of elections and terms of office for president and geographically based seats in Congress.

Additional Questions

10. Voting Method for Implementational Presidential Election

Each state or other jurisdiction conducting a vote of its citizens as to ratification of the Decree under Section 4 shall employ a ballot that additionally prompts voters to choose between the alternative vote method and approval voting as the voting method for the implementational presidential election. The result shall determine the voting method in the election under Section 6.

11. Terms of Certain Judges

(a) Each state or other jurisdiction conducting a vote of its citizens as to ratification of the Decree under Section 4 shall employ a ballot that additionally prompts voters to choose whether the terms of judges who were appointed during a presidential term to which the president was elected despite losing the popular vote should be ended.

(b) If a majority of those voting under subsection (a) vote in favor, then the terms of such judges shall be determined as follows:

(i) The terms of any such judge serving on the Supreme Court shall end when the president elected under Section 6 takes office.

(ii) The terms of such judges serving on federal courts other than the Supreme Court shall end in the order in which they were appointed, in 96 groups of equal size, on the last day of each of the 96 consecutive months beginning in the first month of the term of the president elected under Section 6. The assignment of end-of-term dates shall be based on which judges are serving when the president elected under Section 6 takes office. If the number of judges to be assigned an end-of-term date is not evenly divisible by 96, then the numbers assigned shall be rounded up in earlier months and down in later months as necessary to assign a whole number to each month.

(c) This Section shall not disqualify affected judges from appointment to life terms with the advice and consent of the Senate.

Application

12. Limitation of Review

This Decree is a sovereign act of the people. It is not within the power of any court or other person or institution to limit or review its validity.

13. Definitions

(a) “additional members” means members of Congress who serve in addition to members elected to geographically based seats, in order to bring the composition of Congress into compliance with Section 2.

(b) “alternative vote method” means a voting method wherein (i) the ballot prompts each voter to rank tickets in the order of the voter’s preference; (ii) if any ticket is highest ranked on a majority of ballots cast, then that ticket is declared the winner; (iii) if no ticket has been declared the winner, then the ticket that is highest ranked on the fewest ballots is be treated as a defeated ticket and the ballots are retabulated, with each ballot counted in favor of the ticket that is highest ranked among the tickets that were not defeated; (iv) if any ticket is highest ranked on a majority of ballots cast, following the retabulation procedure of step (iii), then that ticket is declared the winner; and (v) steps (iii) and (iv) are repeated until a ticket is declared the winner.

(c) “approval voting” means a voting method wherein the ballot prompts each voter to vote for as many tickets as the voter chooses, and the ticket that receives the most votes is declared the winner.

(d) the “Constitution” means the Constitution of the United States of America.

(e) “date of ratification” means the day on which this Decree will have been ratified under Section 4.

(f) the “Decree” or the “Democracy Decree” means this Decree.

(g) “geographically based seat” means a seat in the Senate filled by a vote of the people of that state or a seat in the House of Representatives filled by a vote of the people of a congressional district within a state.

(h) “implementational congressional election” and “implementational presidential election” mean, respectively, the first congressional and first presidential elections governed by this Decree. To the extent that rules for those elections are applied to subsequent elections, “implementational congressional election” and “implementational presidential election” shall be understood to refer to such subsequent elections.

(i) “major parties” means the two parties with the most members serving as members of Congress or, if there are no such two parties, then the smallest number of parties greater than two that have the most members serving as members of Congress.

(j) “ordinary election day” means the day set by law for the general election of federal officials every two years.

(k) “party vote” means a national vote of the people for political party in Congress.

(l) “presidential election” means an election for president and vice president, including one in which the ballot prompts voters to choose among tickets.

(m) “ratification period” means the period during which the states and other jurisdictions hold a vote on ratification under Section 4.

(n) “Section” means a Section of this Decree, unless otherwise specified.

(o) “ticket” means a ballot option for a candidate for president and a candidate for vice president who are running as a pair.

Elizabeth Estrada testimony in favor of the City Council passing Resolution 0195 and that the state pass A10148/S9078.

Committee on Women and Gender Equity

7/1/2022 1pm.

Even in a progressive state like New York, many Latinas/xs and BIPOC face the same hurdles to access healthcare that we see across the country. Although Medicaid does cover abortion in New York State, every day we see how many fellow New Yorkers are excluded and left behind. Some are struggling economically and are still not eligible for Medicaid. Some need to keep their abortion private from a coercive partner or a parent whose insurance coverage they share. At the Latina Institute, we often hear from undocumented immigrants who are scared to provide the personal information required on Medicaid applications for fear of exposing their immigration status. It remains clear that all families need access to essential healthcare including abortion, not more economic barriers, or obstacles due to their immigration status, race, or how much money they make. Abortion restrictions do not change the fact that everyone deserves access to care without stigma or barriers.

In addition to the many barriers folks face when accessing much needed abortion care, living in the Bronx I often see protesters lining the sidewalks in droves protesting outside reproductive healthcare clinics. I have worked in service to reproductive justice for over a decade and have seen how much violence, harassment, and intimidation providers, advocates, clinics escorts, clinic staff, and patients face when entering reproductive health clinics. The same people protesting these reproductive healthcare clinics are also the ones volunteering at Crisis Pregnancy centers to deceive and misinform those seeking abortion care. This deeply impacts Latinxs, and BIPOC disproportionately, specifically in the Bronx since anti-abortion activists target our communities due to an assumed lack of understanding on the issue.

That is why we call for the legislature to pass and the Governor to sign into law the Reproductive Freedom and Equity Fund. This legislation sponsored by Senator Cordell Cleare and Assemblymember Jessica González-Rojas would create a program managed by the Department of Health, which would provide capacity

building to providers, fund uncompensated care due to an individual's lack of coverage or inability to use healthcare and address practical needs of patients. The practical needs that someone might have include air and ground transportation, gas money, lodging, meals, childcare, translation services, and doula support. The right to an abortion on paper without access to one is barely a right at all. We believe that codifying this fund will help New York to truly position itself as the leader and access state for reproductive rights and justice that it has committed to being.

Let the nation see how New York is leading the path for full reproductive justice and self-determination for all New Yorkers by being bold on abortion access.

Thank you,

Elizabeth Estrada

NY Field and Advocacy Manager

The National Latina Institute for Reproductive Justice

New York City Council
Committee on Women and Gender Equity Hearing
Oversight - Reproductive Rights
Testimony of Ellie Miller, CNM, LM, MSN
elliemiller718@gmail.com
July 1, 2022

Council Members Tiffany Cabán, James F. Gennaro, Jennifer Gutiérrez, Kristin Richardson Jordan, Kevin C. Riley and Althea V. Stevens

Good Afternoon,

Thank you for this opportunity to testify today.

My name is Ellie Miller. I'm a Registered Nurse who worked in Obstetrics for nine (9) years in New York City hospitals. I'm a newly Licensed Certified Nurse Midwife in the state of New York.

I'm providing testimony on behalf of, and represent, New York Midwives (NYM). New York Midwives is the professional organization that represents New York State's Certified Nurse Midwives and Certified Midwives, and is the state affiliate of the American College of Nurse Midwives (ACNM).

The ability to choose whether or not to be pregnant is a basic human right. The recent reversal of Roe versus Wade by the Supreme Court created a crisis for all Americans, especially those capable of pregnancy. Abortion care is an indispensible component of comprehensive reproductive healthcare.

New York Midwives, a pro-abortion organization, will collaborate with allied organizations and city and state health departments to provide abortion care within midwifery scope of practice.

New York City's elected representatives have submitted several introductions and resolutions. I would like to offer the support of New York Midwives to these Introductions and Resolutions.

- Providing healthcare in a patients' preferred language is the bedrock of holistic health care and is critical for effective abortion care. New York Midwives supports Introduction 458.

- New York Midwives supports Introduction 465, report on provision of medical services related to reproductive health care. However, resources currently exist that can be accessed to eliminate redundancy in this area.
    - Accurate, timely data collection and dissemination of information on reproductive health care improves services, access and outcomes. The Bureau of Infant, Maternal and Reproductive Health (BIMRH) collects such data. Extrapolating existing data eliminates redundancy and allows for more efficient data distribution.
    - Information regarding types of abortion care, how to find a provider, support services, payment options, and on identifying fake abortion clinics is available on the NYC Department of Health's

website's abortion page.[1] Professional organizations, individual providers, group providers, and hospital systems must be made aware how to access the information and be added as provider resources listed on the NYC Department of Health's Abortion page. The NYC Department of Health's page links to http://www.bookofchoices.org/, a state directory of abortion providers, but only clinics and hospital based programs are listed here. There is an opportunity to make this directory more accurate and robust by expanding the list of providers legally authorized to perform abortions, such as midwives. Expanding the abortion provider capacity should be prioritized in anticipation of the influx of out of state persons seeking abortion care.
    - The NYC Department of Health's abortion website must be made accessible and user friendly to consumers in and out of state by featuring it on the NYC Department of Health's home page, press releases, advertising, social media and community based organizations.
    - Coordination by city and state departments of health and city and state funded hospital systems is needed to make this comprehensive abortion care provider directory possible.
    - New York Midwives supports the prudent use of the city's constrained fiscal resources, reducing redundancy and bolstering existing programs as part of Introduction 465.

- In order to have accessible, safe abortion care in New York City, it is imperative that individuals performing, aiding or having abortions have legal protection. New York Midwives supports Introductions 466 and 475.

- New York Midwives supports Introduction 507, which addresses barriers to medication abortion, such as cost and accessible locations.

- Additionally, New York Midwives supports Resolutions 195, 196, 197, 200 and 245, which aim to increase the abortion workforce, solidify the city's pro-choice stance, and urge state and federal legislatures to protect abortion. In addition to expediting licensing of out of state midwives, New York Midwives suggests appealing to retired midwives to return to the workforce to provide telehealth medication abortion care.

New York Midwives (NYM) looks forward to collaborating with the city and state to ensure accessible abortion care for all.

Thank you for your time.

[1] https://www1.nyc.gov/site/doh/health/health-topics/abortion.page

NEW YORK STATE ASSOCIATION OF LICENSED MIDWIVES

Roe v. Wade Has Been Overturned by The Supreme Court

Reproductive rights have become a battleground with all the usual players: misogyny, racism, and patriarchy. The right to decide when, whether, and how to have a child is fundamental to a person's autonomy, dignity, and equality. This right affects every aspect of a woman's and person's life – economic status, educational aspirations, career goals, health, and family well-being. Midwives have been present in the battle for reproductive freedom since ancient times. Women and people capable of reproduction have always wanted to decide, for themselves, whether or not to be pregnant, give birth, and raise children. **The ability to choose whether or not to be pregnant is a basic human right.**

The midwifery code of ethics mandates that we engage in a process of non-coercive, evidence-based informed consent, and shared decision-making, empowering reproductive-aged persons to make their own decisions, **inclusive of abortion choices.** New York Midwives (NYM) recognizes the vital role access to comprehensive reproductive and sexual health plays in reducing health and economic disparities. **NYM will continue to voice our opposition** to any regulation, federal or state, that would restrict access to the full-range of sexual and reproductive health services, including abortion, or any activity which would compromise the safety of such care. The world's major health and human rights organizations affirm that when individuals have full autonomy over their reproductive health, entire communities benefit from the increased education and economic leverage of the individual. **As midwives, we trust that reproductive-aged persons are the experts of their own well-being,** and we support each person's right to self-determination, access to comprehensive health information, and active participation in all aspects of care.

The history of who gets to choose whether or not a pregnancy occurs, or can continue, has long been made political in this country. This began in large part with Africans brought to this country against their will to forcibly work, setting the financial foundation for the United States to become a capitalist superpower. Enslaved Africans were some of the first documented women made to forcibly give birth thereby guaranteeing a continued pool of unpaid labor [2]. Massive birth control trials were performed on poor people in Puerto Rico.[3] Unconsented sterilizations of BIPOC people have been documented in America's recent history[4]. The United States has alarming maternal and infant morbidity and mortality

[2]https://nmaahc.si.edu/explore/stories/historical-significance-doulas-and-midwives#:~:text=Early%20African%20American%20midwives%20were,to%20expand%20their%20labor%20force.

[3] https://www.washingtonpost.com/politics/2020/09/25/ice-is-accused-sterilizing-detainees-that-echoes-uss-long-history-forced-sterilization/

[4] https://www.washingtonpost.com/news/retropolis/wp/2017/05/09/guinea-pigs-or-pioneers-how-puerto-rican-women-were-used-to-test-the-birth-control-pill/

rates, and those statistics completely fall off a cliff in non-white populations.[5][6][7] In New York State, women, birthing people, and their families face similar - and often worse - statistics.[8][9][10]

New York Midwives, along with allied organizations, realized that the Reproductive Health Act was needed in New York to codify abortion rights in the state, in the event that *Roe v. Wade* was overturned and the issue of abortion legality returned to the states. That time came today.

The New York State Reproductive Health Act (RHA) (A.1748 / S.2796), enacted on January 22, 2019, the 46th anniversary of the United States Supreme Court's *Roe v. Wade* ruling, amended New York law to ensure that every woman and person can make the family planning decisions that are best for the individual and family. RHA expanded abortion rights, decriminalized abortion, and eliminated several restrictions on abortion in New York State[11].

With the passage of the Reproductive Health Act, advanced practice clinicians (APCs), including physician assistants, nurse practitioners, and **licensed midwives**, are able to lawfully provide abortion services if they have the appropriate qualifications, and if this falls within their scope of practice. By clarifying that APCs may legally provide care, the RHA improved abortion access to traditionally underserved areas such as rural and low-income communities. Empowering these clinicians makes abortion safer and more accessible.

Midwives and other APCs can prescribe mifepristone and misoprostol by ordering them through mail order and brick-and-mortar pharmacies once the FDA accepts the manufacturer's protocols.[12] New York State has no limits on medication abortion provision via teleheath services.[13] This means that providers and pharmacies who are certified to dispense and prescribe these medications will be able to provide medication abortion by telemedicine since these medications can soon be acquired from pharmacies throughout New York State.

New York Midwives will work with allied organizations and the state legislature to remove any obstacles to midwifery-led abortion provision. Prior to the recent leaked supreme court opinion that overturned Roe v. Wade, nine percent of abortions performed in New York State were provided to non-residents.[14] That number is expected to climb drastically.

- In addition to removing obstacles, NYM will work with allied organizations to pinpoint care deserts within NYS, and connect providers with those who choose abortion care.

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[5] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html#anchor_trends

[6]https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2020/maternal-mortality-rates-2020.htm#:~:text=In%202020%2C%20861%20women%20were,20.1%20in%202019%20(Table).

[7]https://www.forbes.com/sites/joshuacohen/2021/08/01/us-maternal-and-infant-mortality-more-signs-of-public-health-neglect/?sh=e8183b33a508

[8] https://www.health.ny.gov/community/adults/women/task_force_maternal_mortality/docs/maternal_mortality_report.pdf

[9]https://nyhealthfoundation.org/resource/complications-of-childbirth-racial-ethnic-disparities-in-severe-maternal-morbidity-in-new-york-state/

[10] https://www.health.ny.gov/statistics/vital_statistics/docs/infant_mortality_report_nys_2002-2012.pdf

[11] https://legislation.nysenate.gov/pdf/bills/2019/s240

[12]https://www.pharmacist.com/Pharmacy-News/fda-expands-access-to-mifepristone-to-mail-order-and-community-pharmacies

[13]https://www.kff.org/womens-health-policy/issue-brief/the-intersection-of-state-and-federal-policies-on-access-to-medication-abortion-via-telehealth/

[14] https://ag.ny.gov/press-release/2022/attorney-general-james-takes-action-expand-abortion-access

- When hospitals and care systems work against free choice in New York, NYM will advocate that a public-facing roster of those entities be maintained on a state website. People deserve to know where they can get safe and supportive care.[15]
- NYM will increase training opportunities for midwives in New York State to provide surgical and medication abortion procedures to increase the provider workforce.
- NYM will participate with state agencies and allied organizations to allocate and distribute the $35 million dollars in funding that the governor has offered.

New York Midwives remains, as ever, a pro-abortion organization. We are working steadfastly with legislators and community members to **ensure New Yorkers continue to have access to the abortion care** that they both desire and deserve. We invite you to join us in this fight.

In solidarity,

Helena A. Grant, MS, CNM, LM, CICP- Acting President of NYM

Cynthia Lynch, LM, CNM- Co-Vice President of NYM

Sherrie Hunter Kelly, MSN, CNM- acting Co-Vice President, NYM, co-chair NYM Legislative Committee

Whitney Hall, CM, MA, MS- President, NYSBCA, Secretary of NYM

Danielle Assibu-Gilmore, MSN, MBA, CNM, LM- Treasurer of NYM

Genevra DiLorenzo, LM, CNM, IBCLC- New York City Representative of NYM

Ellie Miller, LM, CNM, MSN - Student and New Midwife Representative of NYM

Patricia O. Loftman, CNM, LM, MS, FACNM- BILPOC (Black, Indigenous, Latinx, People of Color) Representative to NYM

Debbie Mercer-Miller, MBA- Member At-large, NYM

[15] https://www.nyclu.org/sites/default/files/field_documents/2022_nyclu_abortionaccessroadmap.pdf

New York City Alliance
Against Sexual Assault

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Testimony of Sam Skaller
Senior Campus Coordinator
New York City Alliance Against Sexual Assault
Before the Committee on Women and Gender Equity
July 1, 2022

Good afternoon, Chair Cabán and the members of the Committee for Women and Gender Equity. I want to thank you for convening this critical hearing to expand reproductive rights access in New York City and for allowing me to testify before you today.

My name is Sam Skaller (she/they), and I am the Senior Campus Coordinator at the New York City Alliance Against Sexual Assault. The mission of the New York City Alliance Against Sexual Assault is to prevent sexual violence and reduce the harm it causes through public education, prevention programming, advocacy for survivors, and the pursuit of legal and policy changes. In doing so, the Alliance works to disrupt systems and institutions that, unfortunately, can retraumatize survivors when they most need our support.

I would like to thank Council Member Cabán for her leadership by introducing this package of bills that aim to expand reproductive justice to those in New York City.

I am here today to advocate for the interests of survivors of sexual violence for whom the services and supports offered through this legislative package is critically important.

Bodily autonomy is about power. Power over your own bodies while respecting the power others have over their bodies.

As a sexual violence prevention educator, the entirety of my work revolves around bodily autonomy. I'm invited to colleges and universities all across the city to empower people to understand the right they have to their own bodies and how to respect others' bodies. I provide educational trainings, student conduct support, and referrals to hundreds of students, faculty, and staff in New York City and beyond. Over the last 7 years working in this field, I've spoken with thousands of people who have had their bodily autonomy violated by a spouse, a partner, a stranger, a family member, an employer, a professor, or a politician. The commonality amongst the perpetrators of sexual violence is abusing power. Without informed consent, those perpetrating sexual violence combine their own power and the power they've taken to violate someone's bodily autonomy. On June 24th, 2022, without the informed consent of the

vast majority of Americans, the Supreme Court of the United States overturned Roe v. Wade thus using their power to violate our bodily autonomy. Government institutions spanning from the Supreme Court to this elected body, and everything in between should never replicate the actions of abusers. Eliminating protections for people seeking bodily autonomy after becoming pregnant for whatever reason is an example of an institution abusing its power to violate our bodies. While here in New York State and New York City abortion access remains legal, we should not breathe easy.

According to the CDC almost 3 million women in the U.S have experience rape related pregnancy. Women raped by a current or former intimate partner were more likely to report a rape-related pregnancy. Of women who were raped by an intimate partner, 30% experienced a form of reproductive coercion by the same partner. Specifically, about 20% reported that their partner had tried to forcibly impregnate them when they did not want to or tried to forcibly stop them from using forms of birth control. About 23% reported their partner refused to use a condom. .[1] Reproductive violence is sexual violence.

We at the NYC Alliance Against Sexual Assault know that sexual violence disproportionately impacts people holding historically marginalized identities and intersecting identities. Gender diverse communities, ability diverse communities, Black and Brown communities, AAPI communities, Indigenous communities and every intersection in between have not only historically been purposely excluded from the state's bodily autonomy rulemaking but have and will continue to experience sexual violence at rates higher than that of their cisgender, able-bodied, white counterparts.

While there are no specific data points for NYC to quantify people's experiences with reproductive and sexual violation, we at the NYC Alliance Against Sexual Assault can qualitatively, anecdotally, and humanly argue that one instance of reproductive and sexual violation is too many.

We urge the elected officials sitting here today to use the power and platform they have to take any measures necessary to ensure that despite the overturning of Roe v. Wade, that New York City will be a place for bodily autonomy, choice, and freedom.

With that said, we'd like to share our support for this legislative package (Int0458, Int0466, Int0475, and Int0507.) Each of these Introductions align with our values for bodily autonomy, as they ensure equitable access to reproductive health, protect those seeking abortion services, and track the reproductive needs of New York City.

As this committee moves to take action in strengthening access to abortion and reproductive healthcare, we ask that you consider expanding Int0465 to explicitly require all of DOH-MH annual reporting be anonymous as to not breach the confidentiality or identity of any patients seeking medical care.

Thank you so much for your time today. We look forward to working with you and the whole of the City Council to ensure these important pieces of legislation become law.

[1] https://www.cdc.gov/violenceprevention/sexualviolence/understanding-RRP-inUS.html

Testimony of
Deidre Sully, MPH
Senior Director of Health Policy and Community Affairs

On Behalf of

Public Health Solutions
Before the

New York City Council Committee on Women & Gender Equity

Regarding

The Importance of Safeguarding Reproductive Health Rights

New York City
Remote Hearing Room (Virtual Room 1)

July 1st , 2022
1:00 p.m.

Public Health Solutions at 40 Worth Street, 4th Floor, New York, NY 10013
(646) 619-6450 | DSully@healthsolutions.org | www.healthsolutions.org

My name is Deidre Sully, I am the Senior Director for Health Policy and Community Affairs at Public Health Solutions (PHS).

To Committee Chair Caban, and the New York City Council Committee on Women and Gender Equity, I thank you for your time today and your commitment to addressing reproductive health and rights. At Public Health Solutions, we are dedicated to improving the health of the public in New York City and beyond through service delivery, research, capacity building and policy analysis. PHS' mission is to support underserved New Yorkers and their families in achieving optimal health and building pathways to reach their potential. We implement innovative, cost-effective and population-based public and community health programs, conduct research that provides insight on public health issues, and provide both services to other nonprofit organizations as well as administer direct service programs to address public health challenges. Our model is based on both direct service as well as contracting and management services that help fund other non-profits and community-based organizations (CBOs).

PHS' Sexual and Reproductive Health Centers (SRHCs) provide affordable, comprehensive, and confidential reproductive and sexual healthcare to more than 3,000 women, men, and adolescents each year. Throughout COVID, while many places closed, our SRH centers (located in Fort Greene and Brownsville, Brooklyn) remained open serving New York City's vulnerable communities. We have been an active public health and social service provider in NYC for over 60 years and are therefore very invested in sexual and reproductive health programming. Given the recent cuts experienced by many Title X recipients across the country, we are in support of actions that establish and/or increase services in sexual and reproductive health.

The recent decision by the US Supreme Court to overturn Roe v. Wade is proof that now more than ever reproductive health and rights of women must be protected. PHS supports regulatory reforms to reflect our commitment to protecting reproductive health and freedom. Every person should be able to make their own decisions about their health and their bodies. For that reason, we must take every action possible to ensure access to abortion, including for those elsewhere in the country where abortion is no longer permissible. This will hit especially hard among people who live in underserved neighborhoods and communities.

Commented [DC1]: Is there language already drafted that specifically describes the work of our SRH unit? I think we wanted to focu more specifically here on the work we do within SRH, but I am not sure where that language might be located

Commented [DS2R1]: There is more information about the SRHCs down below. The first paragraph usually explains the organization

Commented [DS3R1]: I moved up the paragraph about SRCHs does it work here?

Commented [NT4R1]: I think we should include information about being a Title X Grantee and our SRH Capacity Building Program as well to demonstrate the breadth of our commitment to SRH. There is definitely language about our programs on the PHS website.

Women of color are disproportionately affected by adverse sexual and reproductive health outcomes compared with women of other races and ethnicities. PHS has been a Title X Grantee for over 37 years, and stand committed to lending our experience and support to ensure and increase sexual and reproductive health, quality, access, and equity. With recent cuts in Title X funding to NYC, we are pleased to see NYC increasing its support for these services as demonstrated by the package of bills being discussed today.

The loss of Title X funding in NYC will impact NYers ability access contraceptive services as well as other SRH services. PHS' SRHCs made the decision to provide medication abortion in anticipation of a high demand. Given the overturning of Roe v. Wade, we are expecting to receive an influx of clients seeking services and these bills will help us to ensure that we can provide services to New Yorkers in our local communities as well as those who are seeking sanctuary from out of state. Medication abortion is a proven safer option for those seeking abortion services because it happens earlier in the pregnancy, giving clients a larger window to make the decision and can decrease the need for of late-term abortions. With long waiting periods for scheduling appointments becoming an increasing issue at more visible clinics, our SRH centers are more crucial than ever in the effort to provide safer, client-centered abortion services to clients in NYC..

Ensuring safety for abortion providers is also more crucial than ever. It is imperative that providers feel safe enough to do their jobs and don't need to worry about being front and center. The Women's Health Protection Act would prevent states from passing laws that would create or increase barriers to an important part of reproductive health, as well as laws that hinder providers in their work.

PHS' Sexual and Reproductive Health Centers in Brooklyn have been stable and trusted resources in their communities, where they provide critical sexual and reproductive healthcare to some of the borough's highest-need and marginalized residents living in Bedford-Stuyvesant, Brownsville, Crown Heights, East New York, Flatbush, and Fort Greene. Nearly two-thirds of our clients live below the poverty line; more than half rely on public health insurance programs; and almost a quarter lack health insurance altogether. For many, the centers are their only source of

healthcare. The services we provide – including free pregnancy testing, gynecological exams, prenatal care, birth control, teens' sexual healthcare, and STI treatment, among others – help narrow the enormous health disparities among New Yorkers.

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Public Health Solutions - the largest public health nonprofit organization in New York City, improves health among New York City's most vulnerable populations by tackling social, physical, and environmental factors that impact New Yorkers' ability to thrive. Today, PHS serves 200,000+ New Yorkers annually, and we support the work of more than 200 community-based nonprofit organizations. We implement innovative, cost-effective population-based health programs; conduct research providing insight on effective public health interventions; and provide services to government and other nonprofits to address public health issues. Together with our colleagues in the social services sector, government, philanthropy and policy organizations, we are thought leaders and cutting-edge public health professionals in New York City and New York State. To learn more, please visit us at http://www.healthsolutions.org.

To: New York City Council Committee on Women and Gender Equity
From: Mellissa Ungkuldee, National Asian Pacific American Women's Forum (NAPAWF)
Date: July 1, 2022

Dear New York City Council,

My name is Mellissa Ungkuldee. I'm writing as a member of the New York chapter of the National Asian Pacific American Women's Forum (NAPAWF). As a young woman, daughter of immigrants, and a member of New York City's Asian American and Pacific Islander (AAPI) community, last week's Supreme Court ruling on *Dobbs v. Jackson's Women Health Organization* shook me to the core. The freedoms and rights that I grew up being told were mine - namely my right to health care, bodily autonomy, and a lifetime of personal choices - were ripped out from under me. I know millions of other people in and outside of New York City share this pain.

Abortion services are a much-needed piece of health care for our AAPI community: A third of AAPI pregnancies end in abortion. According to a NAPAWF study, eight in 10 AAPI women believe that having control over their reproduction produces more positive family outcomes. And many other communities, particularly those that have been historically marginalized and left behind by our inequitable health care system, will be disproportionately impacted by this ruling and are already feelings the decision's immediate, terrifying effects.

With Intro 458, 466, 507, and Resolution 119, we have an opportunity to build upon New York City's existing infrastructure for reproductive and health care access to position New York as an access state. I implore Council members to vote "yes" on these bills, so that we can codify and expand reproductive health services across our city and protect *everyone* seeking access to care.

Intro 458, which would require the NYC Department of Health and Mental Hygiene to maintain and be accountable for language acc-ess services for abortion providers, is particularly crucial for my community. Six in 10 Asian Americans are immigrants and 66% of Asian Americans and 30% of Native Hawaiian/Pacific Islanders speak a language other than English at home. Asians are the fastest growing racial group in NYC, and AAPI immigrants represent more than 30 different ethnic groups and speak more than 50 languages.

Despite this all, the existing health care system does not work for us, because it was never built for us. Instead, it is littered with linguistic hurdles that make it harder for our historically marginalized community to access the care we need, when we need it. And with last week's Supreme Court ruling, these hurdles to our reproductive health care are just going to be harder to overcome.

That's why passing Intro 458 is so important. Patients deserve to be able to communicate effectively with their health care provider, and they deserve to have all the information they need to make informed personal decisions about their bodies and health care. Expanding language

resources through this bill can help ensure that New York City is meeting the health care needs of the AAPI community, as well as so many other communities that face similar linguistic barriers that prevent them from accessing safe, patient-centered health care.

I also want to highlight the importance of passing Intro 466, which would prohibit the use of City resources to enforce abortion restrictions, including those from other states. There is an inordinate amount of stigma around abortion. Without these protections against criminalization, I fear these stigmas will manifest in unfair policing that disproportionately affects women of color, low-income women, and other marginalized communities. AAPI women in particular face an increased risk of criminalization for their pregnancy outcomes because of racial profiling rooted in anti-immigrant sentiments and false claims that AAPI women end pregnancies because they prefer sons over daughters. In a time of heightened distrust of police and increased violence against Asian people in NYC, it's critical that we pass legislation that helps foster the safe environmental conditions needed for people to access abortion and other reproductive health care without fear for their safety and livelihoods.

Our nation is in a state of emergency, but you have in front of you a whole suite of legislation that can effectively transform our city into a haven for reproductive health care access. Legislation like Intro 119 would help provide practical support funding for those traveling out of state. And Intro 507 would expand access to medication abortion through the Department of Mental Health and Hygiene – which NAPAWF's research shows is notably popular among the AAPI community.

With reproductive health under attack nationwide, it is critical that we move swiftly to codify New York City as a champion for health care access for our residents and birthing people who are seeking a safe place to get the health care services that they need. This legislation can ensure that everyone has the ability to exercise their reproductive rights and that we don't leave behind our low-income communities, communities of color, and most vulnerable New Yorkers. We can't afford to limit one pregnant person's access to abortion, let alone the multitudes of pregnant people who will suffer if this legislation isn't passed. Supporting abortion care is now even more necessary than ever before, and I urge City Council to move swiftly to safeguard our reproductive rights by passing Intros 458, 466, 507, and Resolution 119.

Thank you,
Mellissa Ungkuldee

From: Nirmala Penmatsa <nirmala.penmatsa@gmail.com>
Sent: Thursday, June 30, 2022 7:03 PM
To: Testimony
Subject: [EXTERNAL] Testimony 07/01 - Oversight: Reproductive Rights

Hello, my name is Nirmala Penmatsa and I am here with the National Asian Pacific Women's Forum today in support of Resolution 119 introduced by City Council. As we enter a post Roe world I fear for the lives of the many BIPOC, indigenous, AAPI, working class and immigrant people whose lives will undeniably be altered for the worse. As an access state it is now vital for us to do everything in our power to reduce barriers of access for those in the 26 states who will be losing their bodily autonomy. The path to abortion is already a grueling one but communities such as the AAPI community face additional obstacles such as language barriers, cultural stigmas, and immigration barriers. Many immigrants are unable to access healthcare benefits such as Medicaid for up to 5 years after receiving their permanent residency and traveling for healthcare is made difficult due to restrictive state immigration checkpoints. This is why it is so important to that more funding is allocated to abortion funds and non-profit organizations that help provide in-language information, education and support to those that suffer silently within their communities. As a South Asian woman I know how much difficulty young adults have getting the proper information they need because of how stigmatized abortion is within our communities. I remember being in college and seeing my friends have pregnancy scares unsure of who to go to and afraid of being ostracized. Many of them didn't know what resources existed that could provide them with safe and confidential information. With Roe v Wade being overturned, this will unfortunately become a reality for

the majority of people in our country. The funding that will be provided through the Reproductive Equity and Freedom act will be crucial to make sure there are more easily accessible abortion providers and non-profit organization that provide safe education, information, and support for those who need it.

In the same vein, we also need to think about the language barrier that many of these immigrant communities face when accessing healthcare. The budget justice committee members within NAPAWF has spent the past year working hard to canvas within the New York AAPI immigrant community in Queens and Brooklyn and have found that a majority of these people don't know how to access many safety net programs and healthcare benefits because none of the information provided is in an accessible language. Intro 458 introduced by City Council will be vital in ensuring that these communities don't get left behind as they so often do.

We are at a heartbreaking time in our nation and unfortunately will have to watch so many vulnerable communities be affected by the Supreme Court's decision. New York has the opportunity to be the access state and safe haven that these communities will need. We must step up to that responsibility and do our part to ensure that everyone and anyone who needs it has proper, safe, in-language and inclusive access to abortion care. We ask you to move Resolution 119 as well as Intro 458 forward to be voted on by the next full City Council meeting. Thank you.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

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

☐ in favor ☐ in opposition

Date: 7/1/2022

(PLEASE PRINT)

Name: Laura Lawson (MSW, MSPH)

Address: NYC Health Department

I represent: _____

Address: _____

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Appearance Card

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

☐ in favor ☐ in opposition

Date: 7/1/2022

(PLEASE PRINT)

Name: Tara Stein (MD, MPH)

Address: NYC Health Department

I represent: _____

Address: _____

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Appearance Card

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

☐ in favor ☐ in opposition

Date: 7/1/2022

(PLEASE PRINT)

Name: Ellie Miller

Address: 191 Madison Street Brooklyn

I represent: New York Midwives (NYM)

Address: _____

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