Mayor's Office to
End Domestic and
Gender-Based Violence

REMARKS OF

HANNAH PENNINGTON

ASSISTANT COMMISSIONER FOR POLICY AND TRAINING

MAYOR'S OFFICE TO END DOMESTIC AND GENDER-BASED VIOLENCE

BEFORE THE NEW YORK CITY COUNCIL COMMITTEE ON WOMEN

December 12, 2018

Good morning Chairperson Rosenthal and members of the City Council Committee on Women. I am Hannah Pennington, Assistant Commissioner for Policy and Training for the Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV). Thank you for the opportunity to speak with you about our Office's engagement on the issue of Female Genital Cutting (Mutilation/Circumcision) or FGC.

On September 7, 2018, Mayor de Blasio signed Executive Order 36, which expanded the authorities and responsibilities of the Mayor's Office to Combat Domestic Violence (OCDV) and changed the Office name from OCDV to the Mayor's Office to End Domestic and Gender-Based Violence (ENDGBV).

While the Office continues to develop and coordinate a citywide response to intimate partner and family violence, it now has the expanded authority to address gender-based violence. Gender-based violence includes sexual violence, trafficking, stalking as well as FGC. Under this expanded scope, we continue to create bridges across criminal justice and social services to coordinate New York City's approaches and system responses to ensure that all survivors of domestic and gender-based violence have streamlined access to inclusive and critical resources and services. Additionally, we seek to implement best practices and policies,

develop and strengthen services and intervention initiatives, enhance coordination across agencies and disciplines and employ methods for data and information sharing. The expansion of our mission is a multi-stage process that begins with feedback and information gathering from advocates, community stakeholders, and survivors that will inform our advocacy efforts and recommendations for policies, programming, data and best practices citywide.

The practice of female genital mutilation or cutting , as defined by the World Health Organization, is "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons." It impacts girls and women throughout the United States and in New York City, with a 2016 report by the Population Resource Bureau finding that there were almost 66,000 women and girls (aged 15-49; including almost 22,000 girls under the age of 18) at risk of FGC in the New York City metropolitan area. The data for the NYC metropolitan areas represents 13% of the total number of women and girls at risk of FGC in the United States.

There is a strong network of community-based organizations throughout the City that are providing direct services to survivors of FGC and advocating for enhanced resources and awareness. We partner closely

with many of these organizations, which generally provide services to survivors across the spectrum of domestic and gender-based violence. For example, several organizations providing services related to FGC are on-site providers at the NYC Family Justice Centers, which are operated by ENDGBV. Through partnerships with community based organizations, we have developed a training for providers and advocates that educates staff on the dynamics and impacts of FGC, best practices for working with survivors and available resources. We are currently in the process of expanding these training efforts across the centers.

We wanted to highlight one recent victory by a City contracted provider working with a FGC client. Ms. K, filed an asylum application with the assistance of the New York Legal Assistance Group, and its LegalHealth immigration project at Lincoln Hospital, based on FGC, forced marriage, and severe domestic violence she had suffered in her home country of Côte d'Ivoire. Ms. K had undergone FGC as a young child and has suffered lifelong complications. She was forced by her family to marry an abusive husband, and together they had three sons, one of whom was murdered by her husband's first wife. Ms. K fled to safety in the United States, where she gave birth to her fourth child, a baby girl. Her fears of returning home were magnified further because now she would be powerless

to protect her newborn daughter from undergoing FGC. The team extensively prepared Ms. K for her interview and in July, Ms. K was granted asylum. Ms. K was connected to refugee resettlement services to help her get settled here in the United States and then applied for her sons to join her from Côte d'Ivoire. Ms. K is overjoyed she is able to remain safely with her daughter in the United States and will be able to reunite with her sons. Ms. K's story demonstrates the need for multi-disciplinary services to support New Yorkers who have experienced FGC and other forms of gender-based violence.

ENDGBV has been a proud member of the New York Coalition to End FGM since it was launched in 2016 and this past October we co-sponsored the inaugural V-March spearheaded by the Coalition and other advocacy groups to raise awareness in New York City about FGC. We look forward to continuing to strengthen, support and amplify the work of the Coalition, its member organizations, and other community based partners leading a larger movement to bring attention to this critical issue. We also look forward to continuing to partner across City agencies to strengthen City programming and responses to FGC.

Thank you for the opportunity to speak to this issue. I welcome any questions that this committee may have.

Sauti Yetu
CENTER FOR AFRICAN WOMEN AND FAMILIES
Giving Voice To Our Potential

Presentation of Zeinab Eyega, Executive Director
Sauti Yetu Center for African Women, Inc.

Submitted to:	New York City Council, December 12, 2018
Oversight Hearing:	Female Genital Cutting
Committee:	Women
Chairs:	Helen Rosenthal

I'd like to thank the New York City Council for providing this opportunity to the public to share its concerns. My name is Zeinab Eyega and I am the founder and Executive Director of Sauti Yetu Center for African Women, Inc. Sauti Yetu, whose name means "Our Voice "in Swahili, is a community-based nonprofit organization dedicated to mobilizing African immigrant women to improve the quality of their lives, strengthen their families, and develop their communities. Sauti Yetu's direct services, public education and advocacy programs promote immigrant girls' safe transitions into adulthood, curb violence in the family, and give poor and low income women access to life skills and leadership opportunities. We serve families throughout New York City's five boroughs in two locations in the Bronx and on Staten Island.

Since our inception in 2006, Sauti Yetu has worked prevent the practice of female genital cutting (FGC) and to support girls and women impacted by the practice access quality services. Over the years, Sauti Yetu has partnered with city agencies and worked to ensure equal and quality access to services for women and girls impacted by the practice. We have worked to ensure that city agencies and policies recognize the myriad challenges that impact immigrant women and girls living in New York City. These factors range from language access to immigration stress and trauma to the culturally-specific manifestations of domestic violence and sexual assault. The City of New York and its agencies have made much progress in providing culturally and linguistically competent services to immigrants.

What would women say about female circumcision (FC) if they did not feel attacked by another culture, if they did not have to defend their bodies/ culture and or if they felt safe to speak their truth and confident talking about it? The fear of being targeted and survelanced. Sauti Yetu has worked to find out the answer to some of these and many other questions so since our inception in 2004, we talked to and continue to speak to women, girls, boys, and fathers from many of the communities we work with. I will share example of our work with the Sudanese community. Being a Sudanese who speaks the same language as these women and living most of my life in the similar culture I found that they were more than willing to talk openly about FC. In the

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traditional setting of *wanasa* (long friendly female chats) we sat with a tape recorder, sipping tea or coffee and treating ourselves to Sudanese pastries, and talking for hours.

For the purposes of this testimony, I will share an example of Sauti Yetu's work within the Sudanese women in New York. The work involved focus group discussion with women and groups were separated based on age. The first group was of older women who are here with their grown children (sons or daughters or both); they were all over the age of 60. The second group comprised married women of ages 29-49; the third group consisted of young single women 21-29 years old. I held several sessions with each group and final sessions that brought the three groups together. I chose one woman from each group to conduct in-depth interviews that raised more questions for the group sessions. In this short testimony, I will summarize salient points made by the older women's group, specifically my interview with Hajja Fatma to show the process of attitude and behavioral change.

Hajja Fatma is the most isolated of the women participating because she does not speak English and depends on others to communicate. Therefore, she has experienced the most dramatic change of life. She has lost the independence, friends, relatives and sense of belonging she had back in Sudan with little compensation in this far away land. Although a pious woman who follows her religious duties carefully and with awareness, she is a faithful follower of Sudanese customs even when they clearly clash with religion. She believes in keeping the fabric of society in-tact.

Hajja Fatma always talks about isolation in a far away land. This feeling of isolation has greatly affected her attitude towards Sudanese traditions. When asked whether she thought FC should continue to be practiced her first answer was "yes, it is our mothers' *`ada* [custom] and girls would be better off circumcised." When I pointed out "the isolation" that the girls might suffer in this country if they were circumcised, her countenance changed and she waived her arms in the air, "Not good, worst thing in the world is to be isolated, being a *ghareeb* [stranger or foreigner] is a painful experience, they are better off without it."

While Hajja Fatma's daughter Samira who leaves with her has totally different idea and opinions about the practice. Samira thinks it is the worst thing a human being could do to another. Samira has three children – two girls and a boy. She is adamant about not circumcising them and does not want them even know anything about the practice. Asked why, Samira remembers the humiliation she experienced hearing about the practice in a class while in college. Samira said, they way it was described and spoken about by the professor was far removed from what knew and had experienced. Hajja Fatma has never discussed the practice with her daughter nor has Samira asked her mother. Both spoke about it for the first time with me. In the age cohort of 29-49, none of the women circumcised any of their daughters. The above example was to illustrate the diversity of the practice, experiences, opinions within the various immigrant families and communities. Yes, it is factually correct that over the years, immigrants like Hajja Fatma from countries where the practice of female genital cutting is a social norm have settled in New York City and the United States. It is also correct that among the immigrants are women and some girls who have already bee circumcised and some may have both physical and emotional challenges related to the procedure. However, process of migration, level of integration/segregation (support vs. rejection), length/time of residence since migration, parent's background and ethnicity and size.

FINALLY GIRLS MATTER

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Dear Friends,

My name is Assetou Sy. I am the Executive Director for USA-MALI Charitable Association of New York City (UMACA). UMACA is one of the foremost organizations founded and run by African women to combat Female Genital Mutilation (FGM). Our primary focus is on eradicating FGM in Africa, among the African Diaspora in the United States, and internationally through our vast network of partners.

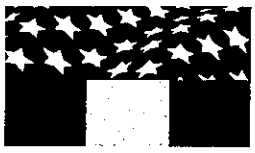
UMACA was founded right after the adoption of a landmark United Nations Resolution of 2012 on eradicating FGM. At that time I organized a delegation to Mali to investigate and understand the issues surrounding FGM. I met with officials and community members. We produced an awareness raising video to show case views and concerns about FGM. I also used this visit to educate officials, practitioners, and parents about the health risks associated with FGM.

UMACA is a New York State registered not-for-profit organization that seeks to assist children and women in realizing their potential to contribute to society in the United States and around the world. UMACA also holds nongovernmental consultative status with the United Nation's ECOSOC. As a concerned mother and Malian born United States citizen, I am committed to improving the lives of women and children in the United States and internationally. I am also a triple time New York City Award Winning recipient of New York City Council's Proclamation, an award winning recipient of Humatrodomes Women Humanitarian International, and an activist.

I would like all of you to join me to stop Female Genital Mutilation by giving human and financial capital to stop damaging the lives of babies, young girls, and women. Please join UMACA and donate for this special cause against Female Genital Mutilation.

The practice of FGM predates religion and has no religious significance in either Islam or Christianity. However, communities of both faiths in various regions of the world continue to circumcise their daughters, believing it will cleanse and purify them; ensure they remain sexually chaste; prevent cheating on their future husband; and keep them behaving well.

FINALLY GIRLS MATTER



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FEMALE GENITAL MUTILATION (FGM) – NYC Council Women's Health Committee Overview, December 12, 2018

Testimony by Patricia Burkhardt, DrPH, LM, (pb8@nyu.edu; cell 718-644-8963) for the New York State Association of Licensed Midwives (NYSALM)

Greetings and thank you

I would, first, commend you on your willingness to learn more about this reality as it exists in NYC. My testimony today reflects both the global and the local reality. The many and varied voices raised in opposition to FGM have been documented and published by the World Health Organization and multiple associated organizations of the United Nations. WHO began in 1992 to collect information and data on FGM. Since then that knowledge has expanded to constitute a vast array of information and data from countries, cultures and peoples.

WHO states that FGM "includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons." Most critically the population most impacted by FGM are girls between infancy and 15. Some choose to equate FGM with male circumcision and, in fact, call it female circumcision. It is not, unless one considers the removal of the penis as circumcision.

Physically, the type of cutting will leave results that range from bad to horrendous. When the goal is to curb women's desire or to take away the enjoyment and pleasure of sex it may be only the excision or removal of the clitoris. Added cutting removes the labia minora, i.e. the external tissue around the vagina and/or the labia majora, the external tissue further out from there. Healing may fuse these tissues or they may be purposefully sutured together resulting in what is called infibulation. As you can imagine, menstrual bleeding will be held inside or barely able to leak out. Sexual intercourse will give no pleasure and may, be painful, certainly for her and maybe for him.

Culturally the practice exists in many countries and is valued in different ways. However, even in countries where this is practiced there are objections to its continuing. A midwife colleague from Malawi told me, when I was there, that the Ministry of Health had identified cultural practices that were harmful. FGM is one of those. It has also been characterized as violence against women.

There are many myths, both true and false, about FGM.
Among the false are:

- Men do not support the abandonment of FGM: In fact, in most countries where data exist, the majority of boys and men think FGM should end,
- Only girls who undergo FGM can enter womanhood and be considered respectable: In fact, cultural norms are changing and alternative rites of passage into womanhood that do not involve FGM are increasingly accepted.
- FGM is a religious obligation: In fact, FGM is not supported in any major religious texts and moreover, many religious leaders believe that this tradition should end.
- If FGM is performed by a health-care professional, there is not risk of harm: In fact, damage is irreparable no matter who does it

- FGM can improve fertility: this is a wish or an excuse, not a fact.

Common true myths are:

- FGM can cause pain during sexual intercourse for both women and men
- FGM can negatively affect a relationship.

Given the multicultural nature of NYC, It is probable that FGM occurs here. If we have no data on FGM occurring in NYC, we need to collect it. Data should include prevalence, but also qualitative data regarding attitudes and reasons for choosing to have the procedure done and under what circumstances. Collaboration between academic institutions and the Department of Health might be the model to utilize for this. The collection of data aside, initial infibulation must be made illegal. This will be a process, not a dictum. Communities in which this occurs and the health care providers of these communities must be involved in the process of removing it.

It is also clearly true that women's health care providers encounter women who have already been victims of FGM. In this case, if deinfibulation, i.e., the opening of the sutured or fused tissues, is done during birth to allow for the passage of the baby, the women or her family might request re-infibulation. Honoring this patient choice presents a dilemma for most health care providers including midwives. It also needs addressed within communities and ultimately needs to be made illegal.

In summary, this act of violence against women is strongly opposed across many cultures and levels of multiple societies, the elements of which are explicated in UN documents. Here in NYC there are two female populations that must be recognized in the policies that this Council elaborates. First, and foremost, there are those young girls whose sexual anatomy and physiology are still intact. These young girls must be protected from the mutilation that is irreversible and has lifelong consequences and implications especially if they are too young to share in the decision-making, and therefore it is not their choice.

Second, there are those for whom the decision to cut is in the past and the effects are present and irrevocable. However, to care for them while pregnant or seeking gynecology care, providers critically need to know, or learn how, to care for these women, not only physically but also psychologically and in their spirits, while discouraging the re-establishment of infibulation. Educational materials, developed in conjunction with communities in which the practice exists, are essential and should be developed.

In closing, I would ask that you all listen to Mariya Karimjee's story and her personal view of its meaning in her life, found in the podcast site below along with other resources.

http://www.thisamericanlife.org/radio-archives/episode/586/who-do-we-think-we-are?act=1

https://www.who.int/reproductivehealth/topics/fgm/en/

https://www.who.int/en/news-room/fact-sheets/detail/female-genital-mutilation

December 12, 2018
The New York City Council - Committee on Women
Re: Oversight Female Genital Mutilation/Cutting and Health Care for Women in New York City
December 12, 2018 10:00am in the Committee room - City Hall
Testimony by Voices of Women (VOW) member Elizabeth Cohen

Approximately 50% of women suffer from Pelvic Organ Prolapse (POP) according to the Cleveland Clinic. In pelvic organ prolapse muscles and ligaments in the pelvic floor can no longer hold essential organs such as the bladder, rectum, and uterus up in place because they have been severely injured or destroyed usually by pregnancy and childbirth. These unsupported organs drop down into the pelvis and into the vagina or bulge (prolapse) through the front or back of the vaginal wall sometimes out of the vaginal opening. The result is often the leakage of urine or feces or incontinence or the inability to completely void.

Stress Urinary Incontinence is the involuntary leakage of urine. Of the 18 million adults who suffer from stress urinary incontinence 85% are women. Even minor physical activities of daily living like laughing, coughing or lifting can trigger incontinence.

This kind of injury greatly impacts a woman's ability to function sexually and may make sex impossible for her. Every area of a woman's life is impacted and diminished including her life at home and at work. Yet millions of women are suffering in silence and due to shame and embarrassment about their condition don't talk about it publicly. U.S world and News Reports recently said pelvic organ prolapse is "something of a secret epidemic, given that it's rarely talked about in polite company."

Just as not that long ago breast cancer was not discussed in public and women with few treatments options often died from it. What made the difference was that women demanded research and better treatment options and that insurance companies cover diagnosis procedures such as mammograms for early detection. I know four people, family members and friends who are still with us today because of the actions women took to improve this situation.

There is a tremendous need for women to do the same for pelvic organ prolapse. We need better treatment options that are safe and restore women's organs to being able to functioning normally and last for a lifetime. Treatment options have changed little. Pessaries one of the few non surgical options were used to prolapse in the 1st century CE by Soranus the most notable gynecologist of his day. A french royal surgeon Ambroise Pare invented the modern pessary in the 16th century.
In 1844 Charles Goodyear invented and patented vulcanized rubber which was then used to make pessaries. Today they are still in use made out of silicon.

In the 21 century we have seen the introduction of polypropylene mesh to suspend organs but the FDA has found problems with it and is investigating. Endoscopic surgery is the other advance.

In an area that has progressed little since the 1930's when treatment shifted predominantly toward surgery, and often incorporating hysterectomy.

Hysterectomy is the second most common operation performed on women in the United States and it is usually done as part of repair for prolapse along with removal of the ovaries. The Hers Foundation calls thus female castration, and has collected testimony from women who's organs were removed without their consent by their doctors during surgery and who's lives have been negatively impacted by it. 1 in 3 women will have a hysterectomy by the time they are 60 years old, and this increases the chances of stroke and getting cancer. It is widely acknowledged the hysterectomy is widely overused especially in treating pelvic organ prolapse, where the removal of these organ may contribute to the prolapse of other organs.

A successful surgery is one that lasts more than one year. In the best case scenario a surgical repair may last 5-10 years, but surgical repair is temporary. It is common for women to have to undergo surgery prolapse repair surgery over and over again. When you consider that a woman may require surgery in her 30's or 40's that's a significant number of operations.

Insurance company are not required to pay for the treatments that exist, including physical therapy and and related equipment. Insurance companies seem to have more sympathy for men who have erectile dysfunctions and urinary problems after prostate surgery than women, men get coverage. The insurance companies are also not required to pay for hormone therapy. The insurance companies to not see this women's health problem as important just as they used to not cover routine mammograms.

There is a serious lack of money and interest in researching better solutions for women's health issues. The amazing advances in other areas of research & medicine are not being applied to women's pelvic floor prolapse, an area greatly in need of innovation.

For example, there is work being done right now with stem cells on regrowing connective tissue such as ligaments. This is something that could benefit women suffering from prolapse greatly by providing a safer and more permanent fix than polypropylene mesh, but the companies developing this product are interested in using it to treat sports medicine injuries not women's injuries.

This needs to change if we are to improve the lives of 1/2 of all women, and I am speaking from personal experience.

Thank you for this opportunity to speak on this important hidden issue.

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Testimony of Sanctuary for Families
before the New York City Council, Committee on Women
Chair, Council Member Helen Rosenthal
December 12, 2018

Good morning. My name is Mariama Diallo, and I am the Program Director of the African Initiative at Sanctuary for Families, New York City's largest provider of comprehensive services exclusively for survivors of domestic violence, sex trafficking, and related forms of gender violence. I am also founder and chair of the New York Coalition to End FGM. We are so grateful to the City Council's Committee on Women for the opportunity to testify today—and to Council Member Rosenthal for taking the lead in bringing attention to female genital mutilation and to address the urgent needs of the countless women and girls affected by this devastating, and often life-threatening, practice. We applaud this leadership in standing up for survivors of gender violence in all its forms—particularly at a time when the health and well-being of survivors of FGM and at-risk girls is at stake.

FGM is a global public health crisis that has affected over 200 million women and girls worldwide. While it is most commonly practiced in Africa, Asia, and the Middle East, FGM is not confined to distant shores. In the United States, it is estimated that over 500,000 women have experienced FGM. And here in our own city, around 65,000 girls are at risk. In fact, New York has among the highest number of immigrants from countries that practice FGM. However, immigrants are not the only ones affected: thousands of U.S.-born girls are also at risk or have already been subjected to FGM. For many, the threat of FGM comes from a practice known as "vacation cutting"—where girls are sent to their family's home country, where they are forced to undergo FGM, generally without prior knowledge that this was the purpose of their trip.

I met Fatima and Nala—both sisters and U.S. citizens—when they came to Sanctuary in 2010. Their parents came to the U.S. for a better life. When Fatima and Nala were 7 and 8, respectively, they were told that they would be going to Africa to visit their extended family, and to learn their culture and language. That summer, they were sent alone, and during that time they were subjected to FGM by their grandmother. They were taken to another location where they were held down and blindfolded while their genitals were cut off—without anesthesia. Fatima and

Nala had never heard of the procedure and were intensely traumatized. When we met, the girls were 15 and 16, and it was the first time they had disclosed what had happened to them. They felt betrayed, ashamed, and isolated. They had withdrawn from their peers. They expressed that they wanted to see a gynecologist, but they had been scared to ask for help.

Indeed, FGM causes severe physical and psychological consequences—and many persist throughout a survivor's entire life. Girls and women who have undergone FGM can experience several physical pain, infections, hemorrhaging, and heightened risk for HIV. Psychological impacts often include depression, anxiety, phobias, memory loss, and PTSD.

Another client, Nicole, was subjected to FGM when she was 7 years old. At 10, she moved to the U.S. from Asia to attend school and was referred to Sanctuary by a friend and former client. When I first met Nicole, she disclosed having panic attacks, lack of sleep, nightmares, difficulty concentrating in school, fear of intimate relationships, shame seeking medical help, and uncertainty about her future. However, through trauma-informed counseling, intensive case management, and legal assistance, as well as a referral to partner medical service providers, Nicole got the support and services she needed to help her to build hope for the future.

We cannot continue to allow FGM to devastate girls and young women living in our communities. Given the recent decision by a federal judge in Michigan, ruling the 1996 federal law banning FGM unconstitutional, it is more imperative than ever that the City take the lead in ensuring that survivors and at-risk girls have access to the protections, resources, and services they so desperately need.

Following the Federal Girls Protection Act of 2013, New York State addressed the issue with a bill that added FGM to the state's health and wellness education programming, followed by the 2016 bill that makes it a felony for a parent or guardian to allow a minor to be subjected to FGM. However, lack of funding has made effective, widespread implementation impossible. For Sanctuary and our community partners serving affected populations, we welcome support from City agencies, and urge the City Council to make this both a legislative and a funding priority. With that in mind, we have identified three key recommendations to address this concern.

First, while there have been studies on FGM by the Centers for Disease Control in the past, a NYC-focused study addressing gaps in information and the prevalence within the local population is sorely needed. We urge the City to conduct such a study with an expanded scope, extensive data collection, and a needs assessment based on its findings.

Second, support is needed to enhance direct services for this population, including trauma-informed counseling for survivors and those at risk, medical services, and legal assistance. Indeed, these are necessary for survivors to start their healing process, as well as to address the physical impact of FGM.

Third, there is the need for increased preventative outreach and education, particularly for communities that practice FGM, at-risk girls and their parents; and training for service providers (educators, doctors and other healthcare personnel, child welfare workers) to better identify and sensitively address FGM. There is also a corresponding need for multi-level collaboration among service providers, local government agencies, and professionals to establish best practices on how to address this issue.

Above all, funding is imperative to help us realize these recommendations—and to ensure adequate resources and protections are made available to survivors and at-risk girls, and their families.

In closing, we thank the City Council for its commitment to addressing this issue and protecting women and girls here in our community. In doing so, you set an example for other cities and states to take action. Your support for the proposed recommendations, and collaboration with the direct service providers and professionals who work with this affected population will help stretch our efforts further and make a long-lasting impact in the movement to combat FGM in New York City.

Thank you.

Womens Committee Hearing

RE: Oversight of Female Genital Mutilation/Cutting and Health Care for Women in New York City.

Oral Testimony of:

Deborah Ottenheimer, MD, FACOG

Adjunct Assistant Professor, Icahn School of Medicine at Mount Sinai

Chair, NY Coalition Against FGM, Toolkit Committee

Veronica Ades, MD, FACOG

Assistant Professor of OB/GYN, NYU School of Medicine

Director of EMPOWER Clinic for Survivors of Sex trafficking and Sexual Violence

December 12, 2018

Thank you for the opportunity to present our views to this Committee.

FGM/C is practiced around the world, primarily in Africa (e.g., Somalia, Guinea, Egypt), the Middle East (e.g., Iraq and Yemen) and Southeast Asia (e.g. Indonesia), affecting more than 200 million women and girls. Increasingly, due to migration, women and girls affected by FGM/C have become members of societies where the practice is not normative, including the United States (US).[1]

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

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

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

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

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

We urge the Committee to consider implementing and funding programs which would enable:

1. The collection of accurate prevalence data in New York City on women and girls who have undergone FGM/C and on girls who may be at risk of cutting.
2. The education of medical professionals in the identification and proper care of women and girls who have undergone FGM/C. This should include not just Obstetrician/ Gynecologists, but also nurses, pediatricians, internists, emergency room personnel, mental health professionals and any other medical providers who may interact with affected women and girls.
3. The establishment of a holistic specialty clinic focused exclusively on the care of women and girls who have undergone FGM/C, and which can serve as a model for similar care around the nation.
    a. This clinic would provide culturally appropriate gynecologic care, obstetric care, dedicated mental health services for women and their partners and pelvic floor physical therapy as well as linkages with legal and social services.
    b. The clinic services would be designed and implemented in consultation with community leaders and with the guidance of an advisory board comprised of patients, medical professionals, funders, and other stakeholders.
    c. The clinic would conduct research, serve as a center of excellence in the care of women affected by FGM/C, and serve as a model for other similar clinics in other cities /regions
    d. The clinic providers would provide expert consultation services to other clinicians , as well as to other organizations and government entities seeking serve this population of women and girls

We thank the Committee for their time and attention.

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

Women's Committee Hearing

RE: Oversight of Female Genital Mutilation/Cutting and Health Care for Women in New York City

Written Testimony of: Natasha R. Johnson, JD

Executive Director/Founder, Globalizing Gender

Assistant Professor, Metropolitan College of New York

Chair, NY Coalition Against FGM, Partnerships and Liaison Committee

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

December 12, 2018

Thank you for the opportunity to present my views to this Committee.

More than 125 million women live with the scars of FGM internationally. Nearly 507,000 women/girls in the US have either undergone or are at risk of FGM and every state has reported cases of FGM (except Hawaii). California, Minnesota, and New York incur the highest incidences, with nearly 65,000 women/girls at threat throughout the NYC metropolitan area.

FGM and Vacation Cutting – the act of returning minor girls to their families' country of origin to get cut during school breaks- are both illegal in NY (there are varying protocols in another 25 states). While NY Penal Law §130.85 (2015) exists, there are no citywide coordinated responses in place to work with the families experiencing this issue. Legislation alone creates a vulnerability to communities experiencing FGM, exposing families to the risk of separation, foster care, incarceration and/or deportation. As a children's rights, women's rights, human rights, immigrant rights, maternal health, public health, and mental health issue to name a few- a more nuanced and sophisticated approach akin to structures that currently exist for survivors of domestic violence (DV) and human trafficking (trafficking) is required.

I urge the Committee to consider the implementation of and funding of programs which would enable:

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

2. The education of medical professionals in the identification and proper care of women and girls who have undergone FGM/C. This should include not just Obstetrician/ Gynecologists, but also nurses, pediatricians, internists, emergency room personnel, mental health professionals and any other medical providers who may interact with affected women and girls;
3. The establishment of a holistic specialty clinic focused exclusively on the care of women and girls who have undergone FGM/C, and which can serve as a model for similar care around the nation. This clinic will provide trainings for service providers and immediate and on-going physical and mental health support. An OB/GYN specified mobile truck outfitted to provide safe, discreet, and culturally-aware examinations for women and girls cut;
4. A policy and advocacy based citywide "think-tank" composed of leading members from the following agencies, including, but not limited to: Globalizing Gender, Department of Health, Council on Gender Equity, NY City Council, Mayor's Office to End Domestic and Gender Based Violence, Department of Education, the Administration for Children's Services, Health and Hospital Corporation, FBI, USCIS, The District Attorney's Office (each borough), The Borough President's Office (each borough).
   This "think-tank" is designed to meet regularly to develop industry-wide practices, resources, and initiatives including The V March: Voices, Victories, and Vitality and mandatory culturally-aware trainings for members of each of the offices.

We thank the Committee for their time and attention.

THE COUNCIL
THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

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I represent: VOV

Address: _____

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Name: Veronica Ades

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I represent: EMPOWER Clinic

Address: 227 Madison St NY NY 10010

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I represent: USA-Mali Charitable Asso of NYC

Address: Same

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Name: DEBORAH ORTENHEIMER

Address: 80 MAIDEN LANE SUITE 901, 10038

I represent: NY COALITION AGAINST FGM

Address: _____

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Name: Mariama Diallo

Address: PO Box 1406, NY, NY 10268-1406

I represent: Sanctuary for Familia

Address: PO Box 1406 NY, 10268-1406

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Overview hearing on FGM ☐ in favor ☒ in opposition

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Name: PATRICIA BURKHARDT

Address: 49 STRONG PLACE, BKLYN 11231

I represent: Midwives, Women & NYSAM

Address: _____

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☐ in favor ☐ in opposition

Date: 12/12/18

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Address: _____

I represent: Sauti Yetu

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