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**The Council of the City of New York**

**COMMITTEE REPORT**

**OF THE HUMAN SERVICES DIVISION**

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**COMMITTEE ON WOMEN & GENDER EQUITY**

Hon. Helen K. Rosenthal, *Chair*

**COMMITTEE ON HEALTH**

Hon. Mark Levine, *Chair*

October 28, 2020

**Oversight: Sexual and Reproductive Health in New York City**

**Proposed Int. No. 1625-A:**  By Council Members Rivera, Chin, Ampry-Samuel, Adams, Ayala, Levine, Rose, Moya, Louis, Rosenthal, Barron, Lander, Koslowitz, Cumbo, Gibson and Cornegy

**Title:**  A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene to make available FDA-approved methods of non-surgical contraception and long-acting reversible contraception at its health centers, health stations, health clinics and other health facilities

**Administrative Code:**  Amends § 17-184

**Int. No. 1662:**  By Council Members Cornegy, Levin, Cumbo, Kallos, Ampry-Samuel, Adams, Ayala, Lander, Louis and Brannan (by request of the Brooklyn Borough President)

**Title:**  A Local Law to amend the administrative code of the city of New York, in relation to training and inspections regarding lactation rooms

**Administrative Code:**  Amends § 17-199.1

**Int. No. 1748:** By Council Members Dromm, Rivera, Van Bramer, Ayala, Louis, Rosenthal, Menchaca, Constantinides, Richards, Kallos and Chin

**Title:** A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene to implement a public information and outreach campaign regarding medically unnecessary treatments or interventions in infants born with intersex traits

**Administrative Code:** Adds § 17-199.12

**Int. No. 1828:** By Council Members Ampry-Samuel, Rosenthal, Cumbo, Chin, Koslowitz, Ayala, Louis, Kallos, Adams, Gjonaj and Rivera (by request of the Brooklyn Borough President)

**Title:** Local Law to amend the administrative code of the city of New York, in relation to establishing a committee on female genital mutilation and cutting, and technical amendments in connection therewith

**Administrative Code:** Amends Subchapter 7 of Chapter 1 of Title 3

**Int. No. 2064**: By Council Members Rosenthal, Public Advocate Williams, Chin, Louis, Rivera and Cumbo

**Title:** A Local Law to amend the administrative code of the city of New York, in relation to the creation of an advisory board for gender equity in hospitals

**Administrative Code:**  Adds § 17-199.14

**Preconsidered Int. No.:** By Council Members Rosenthal and Louis

**Title:** A Local Law to amend the administrative code of the city of New York, in relation to culturally competent training on recognizing the signs of female genital mutilation

**Administrative Code**: Amends Subchapter 7 of Chapter 1 of Title 3

**Res. No. 919:**  By Council Members Ayala, Rosenthal, Chin, Adams, Koslowitz, Rivera, Gibson, Ampry-Samuel, Kallos, Cornegy, Levine, Rose, Louis, Moya, Barron, Lander and Cumbo

**Title:**  Resolution calling on the Federal Government to dismiss the change to Title X funding, specifically to prohibit recipients from using Title X funds to perform, promote, refer for, or support abortion as a method of family planning.

**Res. No. 920:**  By Council Members Chin, Rivera, Rosenthal, Adams, Ayala, Koslowitz, Cumbo, Gibson, Ampry-Samuel, Kallos, Menchaca, Levin, Louis, Rose, Lander and Barron

**Title:**  Resolution urging the United States Congress and the New York State Legislature to support a woman’s right to abortion, and to oppose a ban on sex-selective abortions, which perpetuate racial stereotypes and undermine access to care.

1. **INTRODUCTION**

On October 28, 2020, the Committee on Women and Gender Equity, chaired by Council Member Helen K. Rosenthal, and the Committee on Health, chaired by Council Member Mark Levine, will hold a joint hearing on the oversight topic of *Sexual and Reproductive Health in New York City*, as well as consider a package of legislation. The package of legislation, including six bills and two resolutions, covers a range of issues pertaining to reproductive health, such as access to contraception and abortion, eliminating unnecessary and harmful surgeries, lactation services, and other topics. Witnesses invited to testify include the New York City (NYC) Department of Health and Mental Hygiene (DOHMH), the NYC Commission on Gender Equity (CGE), advocacy groups, health professionals and other interested parties.

1. **BACKGROUND**

*Reproductive Health*

Reproductive health, broadly defined, refers to the health and social conditions of human reproductive systems during all life stages.[[1]](#footnote-2) This includes, but is not limited to:

* Family planning services and counseling, terminating a pregnancy (also known as abortion), birth control, emergency contraception, sterilization and pregnancy testing;
* Fertility-related medical procedures;
* Sexual health education;
* Access to medical services and information; and
* Sexually transmitted disease prevention, testing and treatment.[[2]](#footnote-3)

While this Committee Report adopts a broader definition in the interest of understanding the full spectrum of issues relating to reproductive health, it should be noted and is perhaps not surprising that many definitions of reproductive health focus more narrowly on addressing the reproductive health needs of women.[[3]](#footnote-4) These definitions include, but are not limited to, those addressing reproductive decisions—whether a woman seeks to reproduce or avoid reproduction, the impact of the process of reproduction on health and the associated issues related to a woman’s autonomy, privacy and agency over such decisions.[[4]](#footnote-5)

The World Health Organization (WHO) identifies 17 “Reproductive Health Indicators” which further provide a framework for assessing the state of reproductive health.[[5]](#footnote-6) These WHO indicators include:

1. The total fertility rate;
2. Contraceptive prevalence;
3. The maternal mortality ratio;
4. The percentage of women attended by health personnel during pregnancy;
5. The percentage of births attended by skilled health personnel;
6. The number of facilities with basic obstetric care;
7. The number of facilities with comprehensive obstetric care;
8. The perinatal mortality rate;
9. The percentage of live births with low birth weight;
10. The positive syphilis serology in pregnant women;
11. The percentage of anemia in pregnant women;
12. The percentage of obstetric admissions owing to abortion;
13. The percentage of women with genital cutting, also known as female genital mutilation or female circumcision (“FGM/C”)[[6]](#footnote-7);
14. The percentage of women who report trying for a pregnancy for two years or more;
15. The incidence of urethritis in men;
16. HIV prevalence in pregnant women; and
17. Knowledge of HIV-prevention practices.[[7]](#footnote-8)

Research has shown that deficiencies in these indicators are largely conditions that can be alleviated with a combination of better access to health services, improvement in economic and social conditions and increased protections for those seeking reproductive health care services.[[8]](#footnote-9) Accordingly, in recent years, important measures have been established at the federal, state and local levels to ensure that the right to receive reproductive health services are protected, a process often referred to as reproductive justice.[[9]](#footnote-10) Generally speaking, reproductive justice seeks to ensure reproductive rights,[[10]](#footnote-11) or the rights of individuals to have access to sexual and reproductive healthcare and autonomy in sexual and reproductive decision-making.[[11]](#footnote-12) The Council currently provides approximately $1.3 million in discretionary funding for a range of services related to reproductive and sexual health services.[[12]](#footnote-13)

1. **ISSUES AND CONCERNS**
2. *Contraception / Non-Surgical & Long-Acting Reversible Contraceptives (LARC)*

Long Acting Reversible Contraception refers to several FDA-approved methods of birth control that are intended to last for at least several years without requiring any user action (such as taking a daily pill).[[13]](#footnote-14) Long Acting Reversible Contraceptive (LARC) methods include intrauterine contraceptives, implants, and injections, and are considered the most effective form of birth control in preventing unwanted pregnancy, beside abstinence.[[14]](#footnote-15) Despite its efficacy, only 5.8% of adolescents and women ages 15–19 have ever used a LARC method, with 3% ever using an IUD and 2.8% ever using a contraceptive implant.[[15]](#footnote-16) Some barriers to use of LARC methods by young women and adolescents include lack of familiarity or understanding about LARCs, lack of access, low parental acceptance, high costs of initiation, and obstetrician–gynecologists’ and other health care providers’ misconceptions about the safety of LARC use in adolescents.[[16]](#footnote-17) When cost barriers were eliminated and the LARC method was explained, research found that more than two thirds of females aged 14–20 years chose a LARC method.[[17]](#footnote-18)

In May 2016, then Speaker Melissa Mark-Viverito published the Young Women’s Initiative (YWI) Report and Recommendations.[[18]](#footnote-19) One of the recommendations in the report was to “create a dedicated fund for access to contraceptives, including long-acting reversible contraception (LARC), which incorporates culturally relevant counseling, focuses on patient choice and integrates age- and developmentally-appropriate support for young people.”[[19]](#footnote-20) At the time of this announcement, of the 145 School Based Health Centers (SBHCs) serving over 345 schools in the five boroughs of New York City, only 50 high school sites provided comprehensive reproductive health services including “on-site dispensing of hormonal and long-acting reversible contraception.”[[20]](#footnote-21) At around the same time, DOHMH began a “#MaybetheIUD campaign” to promote LARC methods as an accessible option for young people wanting to prevent unwanted pregnancy.[[21]](#footnote-22) The YWI fund utilized Colorado’s privately-funded Colorado Family Planning Initiative as a model.[[22]](#footnote-23) In total, the fund set aside $365,000 to provide LARCs at no cost to clients who were uninsured, ineligible for Medicaid, or otherwise lacking the resources to pay out of pocket.[[23]](#footnote-24) Funding was used to cover applicable LARC service fees or to purchase LARCs, using the Title X Family Planning Program, the 340B Drug Pricing Program, and any other cost-saving programs available.[[24]](#footnote-25)

Currently, DOHMH maintains several health clinics centered on patient sexual health, immunization, and Tuberculosis (TB) services.[[25]](#footnote-26) The Department’s eight sexual health clinics provide low- to no-cost services for sexually transmitted infections (STIs), and accept all types of insurance, including:

* Medicare Part B
* Fee-for-Service Medicaid
* Medicaid Managed Care
* Affinity Health Plan
* AmeriChoice
* Amerigroup
* EmblemHealth (GHI/HIP)
* Healthfirst
* HealthPlus Amerigroup
* MetroPlus.[[26]](#footnote-27)

Additionally, if an interested party has no health insurance or cannot pay the fee, they may still receive health services through these clinics.[[27]](#footnote-28) Currently, due to the COVID-19 pandemic, these sexual health clinics are only serving patients at a reduced capacity, as sites are being utilized for COVID testing.[[28]](#footnote-29)

1. *Breastfeeding*

In 2018, the City Council passed Local Law 185, which requires employers covered by the Human Rights Law to provide lactation rooms, as well as refrigerators, in reasonable proximity to work areas for the purposes of expressing and storing breast milk,[[29]](#footnote-30) and Local Law 186, which requires employers in the City to establish, and distribute to all new employees, policies describing lactation room accommodations, including the process by which an employee can request such accommodation.[[30]](#footnote-31) Additionally, Local Law 186 requires the NYC Commission on Human Rights to establish and make available a model lactation room accommodation policy.[[31]](#footnote-32)

These laws, which went into effect in March 2019, expand the rights of working mothers in the workplace.[[32]](#footnote-33) This includes acknowledgement of workplace barriers to expressing breast milk, including allowing for milk expression in the work schedule, accommodations to express and store milk, and workplace support.[[33]](#footnote-34) While efforts to improve breastfeeding practices are often stymied by a lack of information, cultural and family traditions, and stigmatization of women in public places and at the workplace, studies consistently show that breast milk is generally safe, clean and includes antibodies,[[34]](#footnote-35) and that breastfed children are more likely to survive and thrive.[[35]](#footnote-36) Moreover, breastmilk substitutes constitute a $70 billion industry dominated by a few American and European companies, and increasing breastfeeding rates for infants younger than six months of age to 90 percent in the U.S. could save the American healthcare systems at least $2.45 billion.[[36]](#footnote-37)

According to DOHMH, breastfeeding rates differ by race/ethnicity, poverty, neighborhood poverty and age in NYC.[[37]](#footnote-38) As such, the City has been working to promote breastfeeding through several initiatives, including a Baby Café in Brownsville, Brooklyn, to provide spaces for pregnant and breastfeeding mothers to meet other parents and to learn from lactation consultants on staff, the compilation of an online accessible breastfeeding toolkit for businesses, as well as a list of breastfeeding-friendly spaces throughout the five boroughs.[[38]](#footnote-39) Improving access helps to normalize breastfeeding, which is beneficial for both mother and baby.[[39]](#footnote-40)

1. *Unnecessary and Harmful Medical Procedures: Preventing Surgeries on Intersex Youth*

People who are intersex are born with sex characteristics that do not fit typical binary notions of male or female bodies.[[40]](#footnote-41) Intersex is an umbrella term used to describe a wide range of natural bodily variations, including variations concerning one’s genitals, gonads, and chromosome patterns.[[41]](#footnote-42) Intersex traits can be visible at birth, become apparent at puberty, or may not be physically apparent at all.[[42]](#footnote-43) According to estimates listed by the United Nations, between 0.05 percent and 1.7 percent of the population is born with intersex traits.[[43]](#footnote-44)

Children born with variations in their sex characteristics are often subjected to "normalizing" surgeries that are irreversible, risky, and medically unnecessary.[[44]](#footnote-45) Such procedures can cause permanent infertility, pain, incontinence, loss of sexual sensation, and lifelong mental suffering, including depression.[[45]](#footnote-46) The surgeries are often performed when the child is too young to consent.[[46]](#footnote-47) Despite their risks and lack of medical necessity, surgeries continue today, including in New York City.[[47]](#footnote-48) There is much advocacy around promoting education and awareness of the harms of such surgeries, resulting in more medical professionals and institutions condemning the practice, as well as cities and states attempting to outlaw the surgeries outright.[[48]](#footnote-49)

1. *Female Genital Cutting*

Female Genital Cutting (FGC), also known as Female Genital Mutilation, is defined by the WHO as “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.”[[49]](#footnote-50) FGC is a historical and cultural practice performed in over 30 countries, including in the United States.[[50]](#footnote-51) FGC is practiced in households across educational and socioeconomic divides, and occurs among many religious groups[[51]](#footnote-52) for various sociocultural reasons, varying from one region and ethnic group to another.[[52]](#footnote-53) While FGC is condemned as a human rights violation by many international treaties and conventions,[[53]](#footnote-54) where it is practiced, FGC is often performed in line with social norms “to ensure that girls are socially accepted and marriageable, and to uphold their status and honor and that of the entire family.”[[54]](#footnote-55) Other historical reasons and purposes expressed for the practice, beyond safeguarding virginity before marriage or enhancing fertility, range from cleanliness and beauty to acting as a rite of passage into adulthood.[[55]](#footnote-56)

However, FGC has no known health benefits, and women and girls who have undergone FGC procedures are at great risk of suffering both short- and long-term health complications, including increased risks during childbirth, psychological trauma, and even death.[[56]](#footnote-57) Further, the painful and traumatic procedure is performed mainly on children and adolescents between the ages of infancy and 15 and without anesthetic.[[57]](#footnote-58) It is therefore also frequently performed without full, informed consent, with or without coercion.[[58]](#footnote-59) Accordingly, FGC has been widely recognized as a violation of basic human rights, including the principles of equality and non-discrimination on the basis of sex, the right to life when the procedure results in death, and the right to freedom from torture or cruel, inhumane or degrading treatment or punishment, as well as the rights of the child.[[59]](#footnote-60)

It is estimated that over 200 million women and girls worldwide have experienced FGC.[[60]](#footnote-61) According to the United Nations Population Fund (UNFPA), if the current rate continues, a further 68 million girls could be subjected to FGC by 2030.[[61]](#footnote-62) In the U.S., the risk for FGC is especially high in areas with substantial ties to countries where FGC is legal or frequently practiced.[[62]](#footnote-63) According to the Population Reference Bureau (PRB), a nonprofit organization specializing in statistical collection and supply, approximately ten percent of the at-risk women and girls in the U.S. (or 48,000) live in New York, which is second only to California.[[63]](#footnote-64) Additionally, most women and girls at risk of FGC in this country reside in cities or suburbs of large metropolitan areas, and the New York-Newark-Jersey City Metro Area ranks first among all metropolitan areas in the country, with an estimated 65,893 women and girls at risk of FGC.[[64]](#footnote-65)

1. *Access to Abortion*

While New York was the first state in the country to make abortion legal in 1971, if a pregnant woman requested it,[[65]](#footnote-66) it was not until the New York state legislature passed and Governor Cuomo signed the Reproductive Health Act (RHA)[[66]](#footnote-67) into law in 2019 that the full protections provided under *Roe v. Wade*[[67]](#footnote-68) were codified into New York state law.[[68]](#footnote-69) The RHA did not enact any major changes in the way abortion is provided in New York, but it is significant in that it brought New York into line with *Roe v. Wade* by:

* Removing abortion from the state Penal Code,[[69]](#footnote-70)
* Legalizing abortions performed after 24-weeks’ gestation in cases of fetal non-viability or threat to a woman’s health;[[70]](#footnote-71)
* Expanding upon those who can provide abortions to include health-care professionals other than doctors, such as nurse practitioners and physician assistants;[[71]](#footnote-72) and
* Repealing Public Health Law § 4164,[[72]](#footnote-73) which required an abortion after the 12th week of pregnancy be performed in a hospital and only on an in-patient basis, and repealing Penal Law §§ 125.40, 125.45, 125.50, 125.55 and 125.60, related to homicide, self-abortion, and related offenses.[[73]](#footnote-74)

It is estimated that nearly one in four women in the U.S. will have an abortion in their lifetimes.[[74]](#footnote-75) In an age where the cost of unintended pregnancies continues to be high, and can be prevented through proper sex education, access to contraception and abortion,[[75]](#footnote-76) and surgical abortion is one of the safest surgical procedures for women in the U.S,[[76]](#footnote-77) the RHA provides enhanced protections for women and ensures access to safe, legal abortion in New York.[[77]](#footnote-78)

1. *Title X*

Title X, officially known as Public Law 91-572 or “Population Research and Voluntary Family Planning Programs,” is the sole federal program dedicated to family planning services.[[78]](#footnote-79) Title X was created to promote positive birth outcomes and healthy families by allowing individuals to decide the number and spacing of their children, and provides funds assist low-income patients with accessing services such as contraceptive counseling and testing for sexually transmitted infections.[[79]](#footnote-80) Title X has recently undergone substantial changes, the effects of which are still being ascertained.

On June 1, 2018, the Trump Administration issued a proposed rule change for the federal Title X family planning program that would make significant changes to the program and to the types of providers that qualify for funding.[[80]](#footnote-81) A final Title X Rule was issued by the Department of Health and Human Services (HHS) on February 22, 2019 and finalized on March 4, 2019.[[81]](#footnote-82) The current regulation has five major provisions: (1) service;[[82]](#footnote-83) (2) training;[[83]](#footnote-84) (3) research;[[84]](#footnote-85) (4) information and education;[[85]](#footnote-86) and (5) the prohibition of abortion.[[86]](#footnote-87) While the Administration highlights that non-directive pregnancy counseling, including non-directive counseling on abortion, is permitted under the rule,[[87]](#footnote-88) reproductive health advocates have expressed concerns about restrictions to health providers that receive federal Title X funds under the regulations and the “domestic gag rule” created by the rule’s provision on abortion.[[88]](#footnote-89) Advocates explain that in addition to restricting abortion access, the regulations:

* Block the availability of federal funds to family planning providers like Planned Parenthood that also offer abortion services;[[89]](#footnote-90)
* Curtail counseling and referrals to abortion services by Title X funded providers;[[90]](#footnote-91)
* Eliminate current requirements that Title X sites offer a broad range of medically approved family planning methods and non-directive pregnancy options counseling that includes information about prenatal care/delivery, adoption, and abortion;[[91]](#footnote-92) and
* Direct new funds to faith-based and other organizations that promote fertility awareness and abstinence as methods of family planning.[[92]](#footnote-93)

When the Federal government implemented the “gag rule” that would have undermined the integrity of family planning programs in August 2019, at least six states,[[93]](#footnote-94) including New York,[[94]](#footnote-95) and a number of organizations, such as Planned Parenthood and Public Health Solutions,[[95]](#footnote-96) who receive funding through Title X, formally withdrew from the Title X program.[[96]](#footnote-97) To help make up for the $25 million per year in Title X grants that the two grantees of Title X in New York, Public Health Solutions (PHS) and the New York State Department of Health (NYSDOH), were no longer receiving,[[97]](#footnote-98) and ensure that New Yorkers continued to have access to sexual and reproductive health services, New York State included $14.2 million in funding for such services in the Fiscal 2021 State Budget.[[98]](#footnote-99) However, funding gaps remain, and advocates have expressed concern that limiting providers has major repercussions for low-income women across the country that rely on them for their family planning care.[[99]](#footnote-100)

1. **BILL ANALYSIS**

**Int. No. 1625-A**: A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene to make available FDA-approved methods of non-surgical contraception and long-acting reversible contraception at its health centers, health stations, health clinics and other health facilities

This bill would require DOHMH to make available FDA-approved methods of non-surgical contraception, as well as long-acting reversible contraception (LARC), which includes, but is not limited to, intrauterine devices, injections or injectable, or subdermal contraceptive implants. DOHMH would be required to make non-surgical contraception and LARC available at health centers, health stations, health clinics and other health facilities operated or maintained by DOHMH. DOHMH would also be required to offer cultural competency trainings to its employees. This law would take effect 180 days after it is signed.

**Int. No. 1662**: A Local Law to amend the administrative code of the city of New York, in relation to training and inspections regarding lactation rooms

This bill would require DOHMH to provide mandatory annual training to staff at locations required to make lactation rooms available, including protocols for providing access to the rooms and cleaning and maintaining them. In addition, DOHMH would be required to inspect the lactation rooms at least quarterly for cleanliness, safety and accessibility. This law would take effect 90 days after it is signed.

**Int. No. 1748**: A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene to implement a public information and outreach campaign regarding medically unnecessary treatments or interventions in infants born with intersex traits

This bill would require DOHMH to create informational resources that may be distributed when an infant is born with intersex traits—that is, a person born with reproductive or sexual anatomy that does not fit the typical definitions of male or female. DOHMH would design the resources for parents and/or guardians as well as medical practitioners. The materials would specifically address important considerations when deciding whether medical intervention may be safely delayed until the infant is older and can voice thoughts about the procedure. This law would take effect immediately.

**Int. No. 1828**: A Local Law to amend the administrative code of the city of New York, in relation to establishing a committee on female genital mutilation and cutting, and technical amendments in connection therewith

This bill would establish a committee on female genital mutilation and cutting (FGM/C) within the Mayor’s Office to End Domestic and Gender-Based Violence (ENDGBV). The committee, headed by the ENDGBV director or a designee, would be responsible for preparing and implementing a comprehensive strategy aimed at preventing and eliminating the practice of FGM/C among individuals and communities in the City. The mayor or a designee would appoint committee members from various fields, including City government, healthcare, and non-profit organizations, among others. The committee would be required to meet a minimum of four times per year and to submit an annual report detailing its activities to the Mayor and Speaker of the Council. This law would take effect 90 days after it is signed.

**Int. No. 2064**: A Local Law to amend the administrative code of the city of New York, in relation to the creation of an advisory board for gender equity in hospitals

This bill would require DOHMH to create an advisory board to study gender equity in healthcare and inequities related to gender at hospitals in New York City, and to analyze factors and social determinants leading to such inequities. The advisory board would consist of a multi-disciplinary panel of representatives and be required to submit a report including recommendations for addressing and eliminating such inequities by December 1, 2021, and December 1 annually thereafter. This law would take effect immediately.

**Preconsidered Int. No. \_\_\_**: A Local Law to amend the administrative code of the city of New York, in relation to culturally competent training on recognizing the signs of female genital mutilation

This bill would require the Department of Education, the Department of Health, the Police Department, the Administration for Children’s Services, the Mayor’s Office to End Domestic and Gender-Based Violence and service providers who work with families and contract with such agencies to conduct culturally competent training for all staff on recognizing the signs of female genital mutilation and cutting, including with regard to information on resources for individuals who have undergone physical or psychological trauma. This bill would take effect immediately.

1. **CONCLUSION**

At this hearing, the Committees will seek information on the current state of sexual and reproductive health in NYC, including issues related to the impact of COVID-19 on access to care, contraception, lactation and breastfeeding, medically unnecessary and harmful treatments, gender equity in hospitals, and access to abortion.

Proposed Int. No. 1625-A

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

A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene to make available FDA-approved methods of non-surgical contraception and long-acting reversible contraception at its health centers, health stations, health clinics and other health facilities

Be it enacted by the Council as follows:

Section 1. Section 17-184 of the administrative code of the city of New York, as added by local law 19 for the year 2003, is renamed and amended to read as follows:

§ 17-184 Availability of [emergency] contraception. a. Definitions. For the purposes of this section, the following terms have the following meanings:

Emergency contraception. The term "emergency contraception" means one or more drugs, used separately or in combination, to be administered to or self-administered by a patient in a dosage and manner intended to prevent pregnancy when used within a medically recommended amount of time following sexual intercourse and dispensed for that purpose in accordance with professional standards of practice, and which has been found safe and effective for such use by the United States food and drug administration.

Long-acting reversible contraception. The term “long-acting reversible contraception” means one or more reversible contraceptive methods, used separately or in combination, including, but not limited to, intrauterine devices, injections or injectable, or subdermal contraceptive implants, to be administered to or self-administered by a patient in a dosage and manner intended to prevent pregnancy for an extended period of time without user action when dispensed in accordance with medically professional standards of practice, and which has been found safe and effective for such use by the United States food and drug administration.

b. Availability of contraception. The department shall make available FDA-approved non-surgical contraception and emergency and long-acting reversible contraception at each health center, health station, health clinic or other health facility operated or maintained by the department which also offers services relating to the diagnosis and treatment of sexually transmitted diseases. The department shall provide information on free or low-cost access to the administration and insertion of LARC methods as well as LARC removal services. Timely referrals will be provided to qualified family planning providers if needed for other services. [For purposes of this section, the term "emergency contraception" shall mean one or more prescription drugs, used separately or in combination, to be administered to or self-administered by a patient in a dosage and manner intended to prevent pregnancy when used within a medically recommended amount of time following sexual intercourse and dispensed for that purpose in accordance with professional standards of practice, and which has been found safe and effective for such use by the United States food and drug administration.]

c. Cultural competency training. The department shall annually offer training to all employees of health centers, health stations, health clinics and other health facilities maintained by the department which also offer services relating to the diagnosis and treatment of sexually transmitted diseases. The training should include, but not be limited to:

1. The history of the provision of long-acting contraceptive, including the history of sterilization abuse;

2. Comprehensive, scientifically accurate information about the full range of contraceptive options in a medically ethical and culturally competent manner; and

3. Implicit and explicit biases which can result in the harm of a patient, particularly those which can impede the fair and equal treatment of all patients.

§ 2. This local law takes effect 180 days after it becomes law, except that the commissioner may take such measures as are necessary for the implementation of this local law, including the promulgation of rules, before such date.

SIL

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1/24/20

Int. No. 1662

By Council Members Cornegy, Levin, Cumbo, Kallos, Ampry-Samuel, Adams, Ayala, Lander, Louis and Brannan (by request of the Brooklyn Borough President)

A Local Law to amend the administrative code of the city of New York, in relation to training and inspections regarding lactation rooms

Be it enacted by the Council as follows:

Section 1. Subdivision f of section 17-199.1 of the administrative code of the city of New York, as added by local law number 94 for the year 2016 and renumbered by local law number 184 for the year 2018, is amended to read as follows:

[f.] h. The department may promulgate rules to implement the provisions of this section including, but not limited to, establishing training programs for staff working at locations required to make a lactation room available pursuant to [subdivision b] this section, and providing guidelines concerning the location of a lactation room.

§ 2. Section 17-199.1 of the administrative code of the city of New York is amended by adding new subdivisions f and g to read as follows:

f. The department shall provide mandatory training to all staff members working at each location required to make a lactation room available pursuant to this section. Such training shall be provided no less frequently than annually and shall include, but need not be limited to, protocols for making such lactation rooms available to individuals who request to use them and cleaning and maintaining such lactation rooms.

g. The department shall conduct an inspection of every lactation room required to be made available pursuant to this section. Such inspections shall be conducted no less frequently than quarterly and shall assess the cleanliness, safety and accessibility of such lactation rooms.

§ 4. This local law takes effect 90 days after it becomes law.

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Int. No. 1748

By Council Members Dromm, Rivera, Van Bramer, Ayala, Louis, Rosenthal, Menchaca, Constantinides, Richards, Kallos and Chin

A Local Law to amend the administrative code of the city of New York, in relation to requiring the department of health and mental hygiene to implement a public information and outreach campaign regarding medically unnecessary treatments or interventions in infants born with intersex traits

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.12 to read as follows:

§ 17-199.12. Public information campaign on medically unnecessary treatments on infants born with intersex traits. a. Definitions. For the purposes of this local law, the following terms have the following meanings:

Intersex. The term “intersex” means sex characteristics, including genitals, gonads, hormones and chromosome patterns, that do not conform with a binary construction of sex as either male or female.

Medically unnecessary. The term “medically unnecessary” means a treatment or intervention on the sex characteristics of an infant born with intersex traits that may be safely deferred until that individual can provide informed consent. For purposes of this local law, psychological factors do not constitute medical necessity for a treatment or intervention on the sex characteristics of an individual born with intersex traits.

b. The department of health and mental hygiene shall implement a public information and outreach campaign designed to address the provision of medically unnecessary treatments and interventions performed on infants born with intersex traits. Such outreach shall at a minimum include (i) creating educational materials for parents and guardians of infants born with intersex traits; (ii) creating resources for medical practitioners; (iii) identifying outreach partners and opportunities; and (iv) distributing materials and resources.

§ 2. This local law takes effect immediately.

SG

LS #8826

9/11/19

Int. No. 1828

By Council Members Ampry-Samuel, Rosenthal, Cumbo, Chin, Koslowitz, Ayala, Louis, Kallos, Adams, Gjonaj and Rivera (by request of the Brooklyn Borough President)

A Local Law to amend the administrative code of the city of New York, in relation to establishing a committee on female genital mutilation and cutting, and technical amendments in connection therewith

Be it enacted by the Council as follows:

Section 1. Subchapter 7 of chapter 1 of title 3 of the administrative code of the city of New York, as added by local law number 38 for the year 2019, is renumbered subchapter 8.

§ 2. Section 3-170 of the administrative code of the city of New York, as added by local law number 38 for the year 2019, is renumbered section 3-180 and amended by adding a new definition of “female genital mutilation and cutting” in alphabetical order to read as follows:

Female genital mutilation and cutting. The term “female genital mutilation and cutting” means the circumcision, excision or infibulation of the whole or any part of the labia majora or labia minora or clitoris. Such term does not include circumcision, excision or infibulation that: (i) is necessary to the health of the person on whom it is performed and is performed by a person licensed in the place of its performance as a medical practitioner; or (ii) is performed on a person in labor or who has just given birth and is performed for medical purposes connected with that labor or birth by a person licensed in the place it is performed as a medical practitioner, midwife or person in training to become such a practitioner or midwife.

§ 3. Sections 3-171, 3-172 and 3-173 of the administrative code of the city of New York, as added by local law number 38 for the year 2019, are renumbered sections 3-181, 3-182 and 3-183, respectively.

§ 4. Subchapter 8 of chapter 1 of title 3 of the administrative code of the city of New York, as renumbered by section one of this local law, is amended by adding a new section 3-184 to read as follows:

§ 3-184 Committee on female genital mutilation and cutting. a. Committee established. There shall be a committee on female genital mutilation and cutting established by the mayor or the mayor’s designee. The committee shall prepare a comprehensive strategy designed to eliminate the practice of female genital mutilation and cutting among individuals in the city and prevent the reemergence of such practice.

b. Duties. The strategy the committee prepares and implements shall include but need not be limited to:

1. Developing guidelines and trainings for educators, non-profit organizations, law enforcement and healthcare providers to assist in the identification and protection of at-risk individuals;

2. Creating and implementing culturally specific public information and outreach campaigns aimed at prevention of female genital mutilation and cutting;

3. Drafting policy recommendations for agencies to adopt in order to address the practice of female genital mutilation and cutting;

4. Making recommendations to improve the city’s collection of data concerning the practice of female genital mutilation and cutting among individuals and communities in the city;

5. Developing recommendations to improve the coordination of systems and services for individuals and communities affected by the practice of female genital mutilation and cutting;

6. Developing recommendations to improve the response of agencies to the practice of female genital mutilation and cutting and improve coordination among such agencies; and

7. Providing opportunity for input from as well as soliciting and considering the recommendations of stakeholders, including but not limited to community and faith-based groups, advocacy organizations, survivors of female genital mutilation or cutting, and social service providers.

c. Membership. 1. To the extent practicable, the committee shall include but need not be limited to the following members, who shall serve for four-year terms:

(a) The director of the office to end domestic and gender-based violence or such director’s designee, who shall serve as chair;

(b) The commissioner of children’s services or such commissioner’s designee;

(c) The commissioner of health and mental hygiene or such commissioner’s designee;

(d) The director of the office of immigrant affairs or such director’s designee;

(e) The police commissioner or such commissioner’s designee;

(f) A representative of the department of education;

(g) A representative of the commission on gender equity;

(h) A representative from each borough’s office of the borough president;

(i) A representative of the New York city health and hospitals corporation;

(j) Three licensed physicians who have extensive experience working with patients who have undergone female genital mutilation or cutting and training healthcare providers on related issues;

(k) Three representatives from non-profit organizations that work with individuals who have undergone or are at risk of female genital mutilation or cutting; and

(l) An expert in the field of public health data collection and analysis.

2. At the discretion of the director of the office to end domestic and gender-based violence, the committee may also include one or more representatives of the office of the district attorney of any county within the city.

3. The mayor shall make all appointments required by this section no later than 90 days after the effective date of the local law that added this section.

4. Members of the committee shall serve without compensation.

d. Meetings. The committee shall meet at least four times per year.

e. Report. No later than October 1 of each year, the committee shall submit to the mayor and the speaker of the council a report detailing its activities and recommendations.

f. Agency support. Each agency affected by this section shall provide appropriate staff and resources to support the work of such agency related to the committee.

§ 5. This local law takes effect 90 days after it becomes law.

SG

LS #9294/11623

12/17/19

Int. No. 2064

By Council Members Rosenthal, the Public Advocate (Mr. Williams), Chin, Louis, Rivera and Cumbo

A Local Law to amend the administrative code of the city of New York, in relation to the creation of an advisory board for gender equity in hospitals

Be it enacted by the Council as follows:

Section 1. Chapter 1 of title 17 of the administrative code of the city of New York is amended by adding a new section 17-199.14 to read as follows:

§ 17-199.14 Gender equity advisory board.

a. Definitions. For the purposes of this section, the following terms have the following meanings:

Direct care worker. The term “direct care worker” means any employee of a hospital that is responsible for patient handling or patient assessment as a regular or incident part of their employment, including any licensed or unlicensed health care worker.

Doctor. The term “doctor” means a practitioner of medicine licensed to practice medicine pursuant to article 131 of the education law.

Hospital. The term “hospital” means an institution or facility operating in New York city possessing a valid operating certificate issued pursuant to article 28 of the public health law.

Nurse. The term “nurse” means a practitioner of nursing licensed to practice nursing pursuant to article 139 of the education law.

Physician assistant. The term “physician assistant” means a person licensed as a physician assistant pursuant to article 131-b of the New York state education law.

b. There shall be a gender equity advisory board to advise the mayor and the council on issues relating to gender equity in the provision of healthcare services in hospitals. Factors that such advisory board may consider include, but need not be limited to:

1. Factors that contribute to gender inequity in hospitals, especially in relation to employment decisions and patient care;

2. Existing protocols hospitals use to address such inequity, including but not limited to actions taken by hospital leadership to promote gender equity for hospital staff;

3. Recommended measures to address gender inequity in hospitals; and

4. Methods for raising awareness about gender inequity in hospitals and ways to address it at the local, state and national levels, including but not limited to strategies to support legislation addressing such inequity.

c. The advisory board shall consist of thirteen members, as follows:

1. The speaker of the council or their designee;

2. The commissioner of the department or their designee;

3. The executive director of the commission on women and gender equity or their designee;

4. The chair of the New York city commission on human rights or their designee;

5. Nine public members, eight of whom shall be appointed by the mayor and one of whom shall be appointed by the speaker of the council. Public members shall represent a diverse range of individuals, of whom at least one member shall represent advocates who specialize in gender equity, and at least three members shall be nurses, doctors, physician assistants or direct care workers employed by a hospital, or representatives from an employee organization representing nurses, doctors, physician assistants, or direct care workers.

d. The advisory board shall hold its first meeting no later than 60 days from the appointment of all its public members and at such meeting shall elect a chairperson.

e. The advisory board shall meet at least biannually and keep a record of its proceedings, and determine the rules of its own proceedings with special meetings to be called by the chairperson upon his or her own initiative or upon receipt of a written request signed by at least four members of the board. Written notice of the time and place of such special meetings shall be given to each member at least two weeks before the date fixed by the notice for such special meeting.

f. No later than December 1, 2021, and annually on December 1 thereafter, the advisory board shall submit a report to the mayor and the speaker of the council, and post on the department’s website, the results of its review and recommendations pursuant to this section.

§ 2. This local law takes effect immediately.

BM

LS # 14257

8/14/2020 4:00 pm

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Preconsidered Int. No.

By Council Members Rosenthal and Louis

A Local Law to amend the administrative code of the city of New York, in relation to culturally competent training on recognizing the signs of female genital mutilation

Be it enacted by the Council as follows:

Section 1. Subchapter 7 of chapter 1 of title 3 of the administrative code of the city of New York, as added by local law number 38 for the year 2019, is renumbered subchapter 8.

§ 2. Section 3-170 of the administrative code of the city of New York, as added by local law number 38 for the year 2019, is renumbered section 3-180 and amended by adding a new definition of “female genital mutilation and cutting” and a new definition of “relevant agencies” in alphabetical order to read as follows:

Female genital mutilation and cutting. The term “female genital mutilation and cutting” means partially or totally removing clitoral or labial tissue or altering the structure or function of clitoral or labial tissue for non-medical purposes, including, but not limited to, circumcision, clitorectomy, clitoroplasty, clitoral reduction, clitoral revision, clitoral recession, excision or infibulation of the whole or any part of the labia majora or labia minora or clitoris. Such term does not include a procedure immediately necessary to preserve the health of the person on whom it is performed in the course of medical treatment or for gender affirming treatment as requested by the person on whom it is performed when either procedure (i) is performed by a person licensed in the place of its performance as a medical practitioner; or (ii) is performed on a person in labor or who has just given birth and is performed for medical purposes connected with that labor or birth by a person licensed in the place it is performed as a medical practitioner, midwife or person in training to become such a practitioner or midwife.

Relevant agencies. The term “relevant agencies” means the department of education, the department of health, the police department, the administration for children’s services, the mayor’s office to end domestic and gender-based violence, and service providers who work with families and contract with such agencies.

§ 3. Sections 3-171, 3-172 and 3-173 of the administrative code of the city of New York, as added by local law number 38 for the year 2019, are renumbered sections 3-181, 3-182 and 3-183, respectively.

§ 4. Subchapter 8 of chapter 1 of title 3 of the administrative code of the city of New York, as renumbered by section one of this local law, is amended by adding a new section 3-184 to read as follows:

§ 3-184 Training on recognizing the signs of female genital mutilation and cutting. Relevant agencies shall conduct culturally competent training for all staff on recognizing the signs of female genital mutilation and cutting. Such training shall include information on resources for individuals who have undergone physical or psychological trauma.

§ 5. This local law takes effect immediately.

ZH/BM

LS # 9293

10/20/2020 3:45 pm

Res. No. 919

Resolution calling on the Federal Government to dismiss the change to Title X funding, specifically to prohibit recipients from using Title X funds to perform, promote, refer for, or support abortion as a method of family planning.

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

Whereas, According to the U.S. Department of Health & Human Services, Title X family planning clinics ensure access to family planning and related preventative health services for millions of low-income and uninsured individuals and others; and

Whereas, According to the Kaiser Family Foundation, Title X was first enacted in 1970, and it is the only federal program specifically dedicated to supporting the delivery of family planning care; and

Whereas, In 2017, nearly 4,000 clinics across the nation relied on Title X funding to help serve four million people, and Title X was funded at $286.5 million for Fiscal Year 2018; and

Whereas, According to National Public Radio (NPR), Planned Parenthood serves about 40 percent of Title X patients; and

Whereas, According to Planned Parenthood, Title X funding allows clinics to provide wellness exams, lifesaving cervical and breast cancer screenings, birth control, contraception education, testing and treatment for sexually transmitted diseases, HIV testing, and other services; and

Whereas, In 2016, Title X clinics were able to provide more than four million tests for sexually transmitted diseases, including HIV tests, as well as nearly one million breast exams and 720,000 pap tests; and

Whereas, According to Planned Parenthood, publicly funded birth control services, including Title X, help people avoid 1.9 million unintended pregnancies every year, 440,000 of which are teen pregnancies; and

Whereas, According to Planned Parenthood, 32 percent of Title X patients identify as Hispanic or Latino and about 21 percent identify as Black or African American; and

Whereas, According to Planned Parenthood, nearly 80 percent of patients who receive services through Title X funding are low income, with incomes less than 150 percent of the federal poverty level; and

Whereas, According to NPR, nearly half (42 percent) of Title X patients in 2017 were uninsured and 38 percent were covered by Medicaid or another public health program; and

Whereas, On March 4, 2019, the Federal Administration published new final regulations to change the way Title X funding is dispersed; and

Whereas, According to Kaiser Family Foundation, the key goal of the new regulations is to block funding from family planning providers that also offer abortion services and/or refer patients to other providers for abortion services; and

Whereas, According to Kaiser Family Foundation, the new regulations require clinics with Title X funded activities to have full physical and financial separation from abortion-related activities, bans clinics from providing pregnant patients with referrals for abortions, severely limits when a staff member at a clinic can even mention or discuss abortion as an option, amongst other things; and

Whereas, The Administration intends to implement such rules despite current policies excluding abortion services from Title X funding and limiting providers from promoting abortions, scheduling appointments for abortions, negotiating abortion rates, or arranging transportation for people desiring abortions; and

Whereas, If the changes are implemented, it would be devastating to millions of Americans, including patients and families, clinicians, and clinic staff; and

Whereas, The new regulations would significantly reduce the network of family planning providers across the country, and would limit access to preventative and reproductive health care to those who are low-income and uninsured; and

Whereas, The proposed regulations would severely limit access to family planning services for millions of people, including access to contraception and abortions; and

Whereas, The proposed regulations would disproportionally affect individuals who are Latinx, Black, uninsured, enrolled in public health insurance, and/or low income; and

Whereas, Although a federal judge in Washington state blocked the Administration’s plans, the block is only temporary; now, therefore, be it

Resolved, That the Council of the City of New York calls on the Federal Government to dismiss the change to Title X funding, specifically to prohibit recipients from using Title X funds to perform, promote, refer for, or support abortion as a method of family planning.

EB

LS 10537

05/02/2019

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Res. No. 920

Resolution urging the United States Congress and the New York State Legislature to support a woman’s right to abortion, and to oppose a ban on sex-selective abortions, which perpetuate racial stereotypes and undermine access to care.

By Council Members Chin, Rivera, Rosenthal, Adams, Ayala, Koslowitz, Cumbo, Gibson, Ampry-Samuel, Kallos, Menchaca, Levin, Louis, Rose, Lander and Barron

Whereas, In 2013 and 2014, sex-selective abortion bans were the second-most proposed abortion ban in the United States (U.S.); and

Whereas, Bans on sex-selective abortions were introduced in 26 states to date, and passed in 10 states, including Illinois, Pennsylvania, Oklahoma, Kansas, North Carolina, North Dakota, Arizona, South Dakota, Indiana, Arkansas;; and

Whereas, In 2019, a bill to ban sex-selective abortions was introduced in the New York State Assembly; and

Whereas, A sex-selective abortion ban prohibits abortions performed on the basis of sex, and a doctor who performs such a procedure may face the threat of jail time, fines or lawsuits from a patient or the patient’s spouse, parent, sibling or guardian; and

Whereas, A doctor or nurse who suspects a patient is seeking a sex-selective abortion is required to report them to authorities; and

Whereas, A sex-selective abortion ban is a restriction that scrutinizes a women’s reasons for making the decision to terminate a pregnancy, thus opening the door to additional abortion bans based on a woman’s personal choice; and

Whereas, Lawmakers across the country who advocate for sex-selective abortion bans perpetuate false and harmful racial stereotypes about women of color, especially Asian American women, including xenophobic claims that Asian American and Pacific Islander (AAPI) communities do not value the lives of women; and

Whereas, Sex-selective abortion bans encourage racial profiling of women by medical providers, harm the doctor-patient relationship, potentially lead to the arbitrary delay or denial of reproductive health services, and further the stigmatization of women, particularly those of Asian American descent; and

Whereas, Some versions of sex-selective abortion bans have also included a race-selective ban that would ban abortions performed on the basis of race, allowing abortion providers to act on false and racist agendas; and

Whereas, In 2008, 2009, 2011, 2013, 2015, 2017 and 2019, the Prenatal Nondiscrimination Act (PRENDA), a sex-selective abortion ban, was proposed in the U.S. Congress; and

Whereas, PRENDA highlighted India and China as countries where individuals seek out sex-selective abortions, thus implying that law enforcement would target and more closely scrutinize these communities in the U.S.; and

Whereas, New York City is home to the second-largest AAPI community in the country and they, along with reproductive health and justice advocates, have called for an end to such bans, condemning the deeply offensive, discriminatory rhetoric perpetuated by anti-choice advocates who support them; and

Whereas, With 70 percent of AAPI immigrants in the U.S. having limited English proficiency and facing a high insurance and public benefits enrollment gap, AAPI women should not have to face more barriers to reproductive health care; and

Whereas, Access to safe abortions is necessary to ensure that women can plan their lives and families without risking their health in a way that makes most sense for themselves and their families; now, therefore be it

Resolved, That the Council of the City of New York urges the United States Congress and the New York State Legislature to support a woman’s right to abortion, and to oppose a ban on sex-selective abortions, which perpetuate racial stereotypes and undermine access to care.

LS #855

05/21/2019

CGR

1. National Institute of Environmental Health Sciences, *Reproductive Health*, the National Institute of Health (n.d.), *available at* <https://www.niehs.nih.gov/health/topics/conditions/repro-health/index.cfm>; *See* NYC Commission on Human Rights, *FACT SHEET: Protections Against Employment Discrimination Based on Sexual and Reproductive Health Decisions* (n.d.), *available at* <https://www1.nyc.gov/assets/cchr/downloads/pdf/publications/SexualReproHealthDecisions_KYR_8.20.2019.pdf>; *See, e.g.,* Mahmoud Fathalla, *Promotion of Research in Human Reproduction: Global Needs and Perspectives*, 3 HUM. REPROD. 7, 7 (1988) (defining reproductive health as requiring, among other things, “that people have the ability to reproduce and the ability to regulate their fertility”). [↑](#footnote-ref-2)
2. NYC Commission on Human Rights, *FACT SHEET: Protections Against Employment Discrimination Based on Sexual and Reproductive Health Decisions* (n.d.), *available at* <https://www1.nyc.gov/assets/cchr/downloads/pdf/publications/SexualReproHealthDecisions_KYR_8.20.2019.pdf>. [↑](#footnote-ref-3)
3. *See* Rebecca Cook, Bernard Dickens & Mahmoud Fathala, *Reproductive Health and Human*

   *Rights: Integrating Medicine, Ethics and Law*, 14-18 (2003) (explaining the importance of gender differences in the context of reproductive health). [↑](#footnote-ref-4)
4. See, e.g., Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375, 383 (1985) (noting that a woman’s ability to control her reproductive capacity is equivalent to her ability to take autonomous charge of her life); Lance Gable, *Reproductive Health as a Human Right*, 60 Case W. Res. L. Rev. 957, 957 (Summer 2020). [↑](#footnote-ref-5)
5. World Health Organization [hereinafter “WHO”], *Reproductive Health Indicators for Global Monitoring*, WHO Second Interagency Meeting, Geneva, Switz., 20-23 (July 17-19, 2000), *available at* <http://whqlibdoc.who.int/hq/2001/WHO_RHR_01.19.pdf>; *See also*, Ritu Sadana, *Definition and Measurement of Reproductive Health*, 80 BULL. WHO. 407 (2002); Lance Gable, *Reproductive Health as a Human Right*, 60 Case W. Res. L. Rev. 957, 957 (Summer 2020). [↑](#footnote-ref-6)
6. Note: This paper utilizes the term “female genital cutting,” rather than “female genital mutilation” to give deference to the affected women and girls, often migrants, who live in the midst of a dominant discourse categorizing them as “mutilated” and sexually disfigured. While “female circumcision” is another common term, “female genital mutilation” is also referenced in recognition of the fact that it is the most commonly used term, including in terms of usage in legislation and treaties. Further, while this paper also utilizes the acronym FGC, FGM is also often shortened to FGM/C in recognition of updated and current language. *See* S. Johnsdotter, *The Impact of Migration on Attitudes to Female Genital Cutting and Experiences of Sexual Dysfunction Among Migrant Women with FGC*, 10(1) Current Sexual Health Reports 18-24 (2018), *available at* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5840240/>; S. Fried, A. Mahmoud Warsame, V. Berggren, E. Isman & A. Johansson, *Outpatients’ Perspectives on Problems and Needs Related to Female Genital Mutilation/Cutting: a Qualitative Study from Somaliland*, 2013(1) Obst. and Gyn. Intl (2013), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3784275/; U.S. Department of Health and Human Services, Office on Women’s Health, *Female Genital Mutilation or Cutting* (n.d.), *available at* https://www.womenshealth.gov/a-z-topics/female-genital-cutting; New York Department of Health, *Female Genital Mutilation/Female Circumcision Reference Card for Health Care Providers* (n.d.), *available at* <https://www.health.ny.gov/community/adults/women/female_circumcision/providers.htm> (explaining why it is “more appropriate” to use FGC/FC than FGM). [↑](#footnote-ref-7)
7. WHO, *Reproductive Health Indicators for Global Monitoring*, WHO Second Interagency Meeting, Geneva, Switz., 20-23 (July 17-19, 2000), *available at* <http://whqlibdoc.who.int/hq/2001/WHO_RHR_01.19.pdf>; *See also*, Ritu Sadana, *Definition and Measurement of Reproductive Health*, 80 BULL. WHO. 407, 407 (2002). [↑](#footnote-ref-8)
8. Lance Gable, *Reproductive Health as a Human Right*, 60 Case W. Res. L. Rev. 957, 957 (Summer 2020). [↑](#footnote-ref-9)
9. *See*, e.g., Elizabeth Nash, Lizamarie Mohammed, Zohra Ansari-Thomas, and Olivia Cappello, *Laws Affecting Reproductive Health and Rights: State Policy Trends at Midyear, 2018***,** Guttmacher Institute (July 2018) , *available at* <https://www.guttmacher.org/article/2018/07/laws-affecting-reproductive-health-and-rights-state-policy-trends-midyear-2018>. [↑](#footnote-ref-10)
10. *See*, e.g., National Council of Jewish Women, *Understanding Reproductive Health, Rights, and Justice* (n.d.), *available at* <https://www.ncjw.org/wp-content/uploads/2017/12/RJ-RH-RR-Chart.pdf>. [↑](#footnote-ref-11)
11. Amnesty International USA, *Reproductive Rights: A Fact Sheet* (2007), *available at* <https://web.archive.org/web/20070714111432/http://www.amnestyusa.org/women/pdf/reproductiverights.pdf>. [↑](#footnote-ref-12)
12. This includes Long Acting Reversible Contraceptives (LARC) and abortion access: $702,900 for the Dedicated Contraceptive Fund, $378,070 for the Reproductive and Sexual Health Services Initiative, and an additional $250,000 for the New York Abortion Access fundThe New York City Council, ”Fiscal Year 2011 Adopted Expense Budget Adjustment Summary / Schedule C,” (June 30, 2020), available at <https://council.nyc.gov/budget/wp-content/uploads/sites/54/2020/06/Fiscal-2021-Schedule-C-Cover-REPORT-Final.pdf>. [↑](#footnote-ref-13)
13. *See, e.g.*, “Long-Acting Reversible Contraception: Intrauterine Device and Implant,” The American College of Obstetricians and Gynecologists, available at <https://www.acog.org/Patients/FAQs/Long-Acting-Reversible-Contraception-Intrauterine-Device-and-Implant?IsMobileSet=false#methods>. [↑](#footnote-ref-14)
14. *See id*; *see also*, “About LARCs,” Planned Parenthood, available at <https://www.plannedparenthood.org/planned-parenthood-mar-monte/patient-resources/long-acting-reversible-contraception-2>. [↑](#footnote-ref-15)
15. “ACOG Committee Opinion,” The American College of Obstetricians and Gynecologists, Number 735, May 2018, available at <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Adolescent-Health-Care/Adolescents-and-Long-Acting-Reversible-Contraception?IsMobileSet=false>. [↑](#footnote-ref-16)
16. *Id*. [↑](#footnote-ref-17)
17. *Id*. [↑](#footnote-ref-18)
18. New York City Council, “New York City Young Women’s Initiative: Report and Recommendations” (May 2016), *availableat* <https://www.ggenyc.org/wp-content/uploads/2018/11/YWI-Report-and-Recommendations.pdf>. [↑](#footnote-ref-19)
19. *Supra* note 15 at 10. [↑](#footnote-ref-20)
20. *Id*. at 33. [↑](#footnote-ref-21)
21. *Id*. at 39. [↑](#footnote-ref-22)
22. *Id*. [↑](#footnote-ref-23)
23. *Id*. at 109. [↑](#footnote-ref-24)
24. *Id*. [↑](#footnote-ref-25)
25. “NYC Health Clinics,” DOHMH, available at <https://www1.nyc.gov/site/doh/services/allclinics.page>. [↑](#footnote-ref-26)
26. “Sexual Health Clinics,” DOHMH, available at <https://www1.nyc.gov/site/doh/services/sexual-health-clinics.page>. [↑](#footnote-ref-27)
27. *Id*. [↑](#footnote-ref-28)
28. *Id*. [↑](#footnote-ref-29)
29. 2018 N.Y.C. Local Law No. 185, N.Y.C. Admin. Code §§17-199.1 [↑](#footnote-ref-30)
30. 2018 N.Y.C. Local Law No. 186, N.Y.C. Admin. Code §8-107. [↑](#footnote-ref-31)
31. *Id.* [↑](#footnote-ref-32)
32. NYC Commission on Human Rights, Law: “Lactation Accommodations” (n.d.), *available at* <https://www1.nyc.gov/site/cchr/law/lactation.page>. [↑](#footnote-ref-33)
33. 2018 N.Y.C. Local Law No. 185, N.Y.C. Admin. Code §§17-199.1; 2018 N.Y.C. Local Law No. 186, N.Y.C. Admin. Code §8-107. [↑](#footnote-ref-34)
34. Nigel C. Rollins, et al., “Why invest, and what it will take to improve breastfeeding practices?” The Lancet (Jan. 20, 2016), *available at* <https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01044-2/fulltext>. [↑](#footnote-ref-35)
35. United Nations, Office of the High Commissioner: *Joint statement by the UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination against Women in law and in practice, and the Committee on the Rights of the Child in support of increased efforts to promote, support and protect breast-feeding*, News (n.d.), *available at* <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20871&LangID=E>. [↑](#footnote-ref-36)
36. Andrew Jacobs, “Opposition to Breast-Feeding Resolution by U.S. Stuns World Health Officials” New York Times (Jul. 8, 2018), *available at* <https://www.nytimes.com/2018/07/08/health/world-health-breastfeeding-ecuador-trump.html>. [↑](#footnote-ref-37)
37. NYC Department of Health and Mental Hygiene, *Epi Data Brief* (Aug. 2015), *available at* <https://www1.nyc.gov/assets/doh/downloads/pdf/epi/databrief57.pdf>. [↑](#footnote-ref-38)
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82. *See* section 1001, U.S. Department of Health & Human Services, Office of Population Affairs, Title X Statutes, Regulations, and Legislative Mandates (n.d.), *available at* <https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates> (explaining that, “grants under Section 1001 assist in the establishment and operation of voluntary family planning projects which provide a broad range of acceptable and effective family planning methods and related preventive health services that include natural family planning methods, infertility services, and services for adolescents; highly effective contraceptive methods; breast and cervical cancer screening and prevention services that correspond with nationally recognized standards of care; STD and HIV prevention education, counseling, testing, and referral; adolescent abstinence counseling; and other preventive health services. The broad range of services does not include abortion as a method of family planning.”). [↑](#footnote-ref-83)
83. *See* section 1003, U.S. Department of Health & Human Services, Office of Population Affairs, Title X Statutes, Regulations, and Legislative Mandates (n.d.), *available at* <https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates> (explaining that, “grants under Section 1003 provide training for personnel working in family planning services projects described under Section 1001. The purpose of this training is to promote and improve the delivery of family planning services. Read more about the National Training Centers.”). [↑](#footnote-ref-84)
84. *See* section 1004, U.S. Department of Health & Human Services, Office of Population Affairs, Title X Statutes, Regulations, and Legislative Mandates (n.d.), *available at* <https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates> (explaining that, “grants and contracts under Section 1004 provide for projects for research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population. Projects under this Section conduct data analysis and related research and evaluation on issues of interest to the family planning field, as well as research into specific topic areas related to service delivery improvement. Research on male reproductive health has been a focus of applied research activities since 1997. All research activities funded under Section 1004 support ensuring and improving the quality of family planning services. Read more about Title X Service Delivery Improvement activities.”). [↑](#footnote-ref-85)
85. *See* Section 1005, U.S. Department of Health & Human Services, Office of Population Affairs, Title X Statutes, Regulations, and Legislative Mandates (n.d.), *available at* <https://opa.hhs.gov/grant-programs/title-x-service-grants/title-x-statutes-regulations-and-legislative-mandates> (explaining that, “grants and contracts under Section 1005 provide for the development and dissemination of informational and educational materials including the OPA website and the Title X family planning clinic locator database.”). [↑](#footnote-ref-86)
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88. *See* U.S. Department of Health & Human Services, Office of Population Affairs, *Title X Service Grants* (n.d.), *available at* <https://opa.hhs.gov/grant-programs/title-x-service-grants>; Office of NYC Comptroller Scott M. Stringer, *Title X Funding in NYC: A Critical Resource That Must Be Protected* (Aug. 2017), *available at* <https://comptroller.nyc.gov/wp-content/uploads/documents/Title_X_Funding_in_NYC.pdf>; Public Law 91-572 (Dec. 25, 1970). [↑](#footnote-ref-89)
89. Note: Sites that do not offer abortion services may still qualify for Title X funds, but may decide not to participate because of concerns about clinical standards of care, medical liability, and burdensome administrative requirements. *See* Laurie Sobel, et al., “Proposed Changes to Title X: Implications for Women and Family Planning Providers” Kaiser Family Foundation (Nov. 21, 2018), *available at* <https://www.kff.org/womens-health-policy/issue-brief/proposed-changes-to-title-x-implications-for-women-and-family-planning-providers/>. [↑](#footnote-ref-90)
90. Laurie Sobel, et al., “Proposed Changes to Title X: Implications for Women and Family Planning Providers” Kaiser Family Foundation (Nov. 21, 2018), *available at* <https://www.kff.org/womens-health-policy/issue-brief/proposed-changes-to-title-x-implications-for-women-and-family-planning-providers/>. [↑](#footnote-ref-91)
91. *Id.*  [↑](#footnote-ref-92)
92. *Id.* [↑](#footnote-ref-93)
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94. Andy Babusik, *New York State Says "No" to Trump's "Gag Rule" for Title X Funding*, FOX (Aug. 28, 2019), *available at* <http://www.wicz.com/story/40976715/new-york-state-says-no-to-trumps-gag-rule-for-title-x-funding>. [↑](#footnote-ref-95)
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96. See Jennifer Calfas, *States Look to Fill Funding Gaps for Clinics Providing Abortions,* Wall Street Journal (Feb. 14, 2020), *available at* <https://www.wsj.com/articles/states-look-to-fill-funding-gaps-for-clinics-providing-abortions-11581718953>. [↑](#footnote-ref-97)
97. PHS sub-grantees included organizations like Community Health Network (CHN) and Planned Parenthood of New York (PPNY), while 11 hospitals in NYC receive funding through NYSDOH. Together, NYSDOH and PHS. [↑](#footnote-ref-98)
98. New York State, Making Progress Happen: FY 2021 Executive Budget (2020), available at (<https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/FY2021BudgetBook.pdf>. [↑](#footnote-ref-99)
99. Ruth Dawson, *Trump Administration’s Domestic Gag Rule Has Slashed the Title X Network’s Capacity by Half* (Feb. 5, 2020*), available at* [https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half#](https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half); Judith M. Orvos, Impact of Title X changes on family planning access for Texas teens, Contemporary OB/GYN (Mar. 5, 2020), *available at* <https://www.contemporaryobgyn.net/view/impact-title-x-changes-family-planning-access-texas-teens>; Laurie Sobel, et al., “Proposed Changes to Title X: Implications for Women and Family Planning Providers” Kaiser Family Foundation (Sep. 20, 2019), available at <https://www.kff.org/womens-health-policy/issue-brief/data-note-impact-of-new-title-x-regulations-on-network-participation/>. [↑](#footnote-ref-100)