Committee on Health

Sara Liss, *Senior Counsel*

Harbani Ahuja, *Senior* *Counsel*

Emily Balkan, *Senior Policy Analyst*

Lauren Hunt, *Financial Analyst*

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

**COMMITTEE REPORT**

**OF THE HUMAN SERVICES DIVISION**

Jeffrey Baker, *Legislative Director*

Andrea Vazquez, *Deputy Director, Human Services Division*

**COMMITTEE ON HEALTH**

Hon. Mark Levine, *Chair*

December 8, 2021

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

**Title:** 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

1. **INTRODUCTION**

On December 8, 2021, the Committee on Health, chaired by Council Member Mark Levine, will hold a vote on Proposed Introduction Number 1625-B (Proposed Int. No. 1625-B). The legislation was previously heard at a joint hearing of this Committee with the Committee on Women and Gender Equity, chaired by Council Member Helen Rosenthal, on October 28, 2020, at which the Committee received testimony from 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**

**Proposed Int. No. 1625-B**

This bill would require the Department of Health and Mental Hygiene (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 and 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 which also offer services relating to the diagnosis and treatment of sexually transmitted diseases. DOHMH would also be required to offer cultural competency trainings to its employees.

Since its initial hearing, the bill was amended to require LARC services only at facilities that have the infrastructure to do so, and to require timely referrals at all facilities.

Proposed Int. No. 1625-B

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

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 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 medications, 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 unprotected or inadequately protected vaginal receptive 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, including, but not limited to, intrauterine devices and subdermal contraceptive implants, to be inserted or removed by trained clinicians in accordance with accepted standards of medical practice, in a manner intended to prevent pregnancy for an extended period of time without user action, and which has been found safe and effective for such use by the United States food and drug administration.

b. Availability. The department shall make available non-surgical contraception which has been found safe and effective for such use by the United States food and drug administration, emergency contraception [at each], and long-acting reversible contraception, to all patients served by health [center] centers, health [station] stations, health [clinic] clinics or other health [facility] facilities operated or maintained by the department which also [offers] offer services relating to the diagnosis and treatment of sexually transmitted [diseases. 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.] infections. The department shall provide information on free or low-cost access to the administration, insertion, and removal of long-acting reversible contraception methods. Timely referrals will be provided to such health centers, health stations, health clinics, or other health facilities which offer long-acting reversible contraception, as well as to qualified family planning providers, if needed, for other services.

c. Cultural sensitivity 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 infections. 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 sensitive 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 1 year after it becomes law.

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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](https://web.archive.org/web/20070714111432/http%3A//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)
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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)
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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)
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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)