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THE ICPD AND NEW JERSEY: BRINGING INTERNATIONAL STANDARDS FOR  
HUMAN RIGHTS AND GENDER EQUALITY TO STATE POLICY

By

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## ABSTRACT OF THE THESIS

The ICPD and New Jersey: Bringing International Standards for Human Rights and Gender

Equality to State Policy

by MARIEL DIDATO

The International Conference on Population and Development (ICPD) in Cairo helped to fuel the narrative that women's rights are human rights, and that gender equality is crucial to the goals of sustainable population growth and development. Twenty-five years later, the ICPD+25 Summit in Nairobi reaffirmed those values, and called on the international community to achieve goals such as ending gender-based violence and ensuring full access to comprehensive reproductive healthcare where legal. While the United States is not an ally to the goals of the ICPD+25 under the Trump administration, individual states can take responsibility in ensuring these goals are met. In particular, the state of New Jersey is in a position to take action and establish full human rights for all. To do this, crisis pregnancy centers must be regulated, buffer zones must be instated for reproductive healthcare clinics where necessary, the racial disparities in maternal mortality must be reduced, and gender-based violence must be addressed for the most vulnerable populations. This paper explores how the international community came to a consensus on gender equality as it relates to population and development, why these rights are important, and specifically, how and why New Jersey can improve to ensure the full range of human rights for its citizens.

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## **Introduction**

In 1994, the International Conference on Population and Development (ICPD) in Cairo shifted discourse on international development towards reproductive rights and the empowerment of women as a fundamental goal. This conference introduced the narrative that gender equality was inextricably related to positive outcomes for population and sustainable development as a whole. In addition, where prior conferences on population and development focused on reproductive health in terms of population control, the ICPD also asserted that access to comprehensive family planning services was a human right.

In 2019, ICPD+25 in Nairobi reassessed global progress for these goals. This foundation was expanded on to include a new sexual and reproductive rights (SRHR) agenda, and set specific Sustainable Development Goals (SDGs) for reproductive healthcare, gender equality, and ending all forms of gender-based violence. These goals involve reducing the global maternal mortality ratio, ensuring universal access to sexual and reproductive rights and healthcare services, and eliminating sexual violence, domestic violence, genital mutilation, and human trafficking. The United Nations Population Fund recommends governments to work towards these standards; both for the benefit of population and development, but also because equitable access to healthcare and safety from violence are human rights. However, under the Trump administration, the United States has removed itself as a supporter and ally of this conference and the goals it has identified; leaving the most vulnerable Americans at great disadvantage.

Without the leadership of the federal government, individual states do have the power to work towards these changes within their own borders. New Jersey in particular is in a unique position to take up these challenges. Within the state, there are still great barriers to realizing the full extent of these human rights. Through the deceptive practices of crisis pregnancy centers and

the lack of protections for patients seeking abortion, residents do not have full access to comprehensive reproductive healthcare services. The state also ranks as one of the worst states in the country for its high maternal mortality rate and the stark racial disparities in these preventable deaths. Lastly, state legislation on sex work and human trafficking is not competently addressing gender-based violence that exists for both demographics. Through criminalizing sex work, both sex workers and trafficking victims experience lifelong disadvantages; additionally, state policies to prosecute human trafficking have resulted in additional barriers to justice. Through identifying these issues within New Jersey, I argue that the state is not fulfilling international standards for gender equality as recognized by the ICPD+25, and I offer policy solutions to address the human rights concerns therein.

## **Chapter 1: Cairo, Nairobi, and New Jersey: Bringing a Changed Narrative to State Policy**

### **Introduction**

Over the past few decades, measurable strides have been taken to address gender inequality, increase economic opportunities, and allow women to take control of their bodies and reproductive futures. Alongside this progress, the world has seen advancements for health, economics, and development. When women have higher social status in public and private life, have access to comprehensive healthcare and control over their reproductive futures, and can live without the threat of gender-based violence, societies as a whole ultimately benefit. Yet, gender equality, reproductive rights, and sustainable development were not always viewed as mutually beneficial.

The United Nations' International Conference on Population and Development in 1994 marked the point in history at which gender equality entered mainstream discourse on population and development. The conference stressed the importance of human rights as it relates to sustainable development, and advocated for access to family planning healthcare, ending gender-based violence, and other targets for increasing the status of women in the world. 25 years later, the International Conference on Population and Development Summit in Nairobi built upon this foundation and set a sexual and reproductive health and rights agenda for the international community to work towards.

The United States, once a strong ally of these ideals, was a vocal opponent of Nairobi's proposed agenda under the conservative Trump administration. This leaves a burden on state governments to make up the gaps left by the federal administration to improve the lives of their residents and ensure full access to care. This chapter explores the history of international conferences as they relate to gender equality and sustainable development, why these rights are

important, and how New Jersey in particular can improve to ensure the full range of human rights for its residents.

#### A History of Conferences on Population and Development, and the Significance of Cairo

Throughout the 1900's, international communities struggled with how to best approach sustainable population growth and development. The United Nations sponsored their first conference on this topic in Bucharest in 1974. Family planning was discussed as a means to curb rapid population growth in developing countries, but that idea was never extended past a potential solution to countries with high fertility rates. Neo-Malthusians at Bucharest believed that all-out population control would be a more effective method than simply making family planning methods widely accessible. Feminists and delegations from developing countries were distrusting of these sentiments of reproductive control and pushed the narrative that increasing economic aid to developing countries is favorable compared to fertility control programs (Hodgson & Cotts Watkins 489). In an analysis of the 1994 ICPD and conferences leading up to it, University of Manchester professor Jocelyn DeJong writes of the Bucharest conference, "A statement of the Indian delegation has gone down in history as the major descriptor of the conference: 'development is the best contraceptive'. In the end, international support for family planning was only granted with a rationale of individual rights to reproductive autonomy" (DeJong 943). Bucharest established some connection between sustainable development and reproductive healthcare, and also established reproductive autonomy as a human right. While this gave the relationship between reproductive rights and development an international platform, the connection between the two still needed work. This set the stage for fully incorporating gender equity and the importance of reproductive healthcare into the context of population and development.

The following 1984 UN population and development conference in Mexico City built on some of the progress made in Bucharest, but did not prioritize issues of reproductive healthcare to the same extent. A formidable power motivated by politics under Reagan, the United States, “adopted the extreme position of ‘let the market decide’ and argued that population was a ‘neutral’ factor in development. Population problems were seen as the result of failures in the development process, for which excessive government intervention was to blame” (DeJong 943). Being that the United States was a main leader on the international stage, this was a shift from the Bucharest narrative of reproductive rights as a main topic. In fact, it was at this conference that the United States’ infamous Mexico City policy was founded, which restricts funding from nongovernmental organizations (NGOs) that provide or make referrals for abortion care (Finkle & Crane 12). However, human rights of the individual and the family were still reasserted at the conference (“Outcomes on Population”), and family planning was not left off of the table. Gender equity was discussed in terms of increasing access to education for women (Okazaki & Kono 67) and one recommendation from the Mexico City document was to make family planning services “universally available as a matter of urgency” (Finkle & Crane 1). While this conference had mixed success in promoting comprehensive reproductive healthcare, some progress was still made in terms of asserting its importance and the importance of empowering women.

In 1993, the World Conference on Human Rights in Vienna gave gender rights and equality an international spotlight. The conference touched on a number of topics relating to gender discrimination and focused heavily on the issue of violence against women. In fact, it was at this conference that the phrase, “Women’s rights are human rights” was coined (Bunch & Reilly 3). Although the Vienna Declaration did also address gender equality as it relates to

economic and social development, “The conference did not, however, consider means for more effective implementation of women's economic, social and cultural rights” (Sullivan 161).

Though this was the first time that a human rights perspective was applied to discussions about economic and social growth, the Vienna conference did not provide any practical solutions to address the problem. The connection between gender rights and population and development still needed to be strengthened.

The 1994 United Nations International Conference for Population and Development (ICPD) in Cairo marked this crucial turning point. One of the main factors in making Cairo monumental was that “a new definition of population policy was advanced, giving prominence to reproductive health and the empowerment of women while downplaying the demographic rationale for population policy” (McIntosh & Finkle 223). Dr. Radhika Balakrishnan, Rutgers University director of the Center for Women’s Leadership, explains this paradigm shift:

The document recognized that women's empowerment and improvement in status are important ends in themselves and essential to the achievement of sustainable development. This is in direct opposition to the prevailing notion in the population field that women are merely a means to reach a preordained target of population growth. (Balakrishnan 85).

Instead of making the argument that high fertility rates are incompatible with sustainable development, Cairo made an official departure from notions of population control and solidified a deeper importance for the empowerment of women. The Cairo document recognized that attitudes towards population and fertility control are in direct opposition to the rights of people to have agency over their own bodies and reproductive futures, and abandoned this argument in favor of a human rights perspective. It also reaffirmed the connection between improving the status of women and their access to reproductive healthcare with sustainable development in a stronger way than previous conferences had done.

The ICPD Programme of Action adopted at Cairo is reflective of this shift. Fifteen Principles were laid out that frame the priorities of the Conference. Principles 4 and 8 are of particular significance. Principle 4 discusses women's empowerment, the elimination of violence against women, and agency over reproductive health as "cornerstones of population and development-related programmes" ("Programme of Action..." 12). Principle 8 again emphasizes equality between sexes, but also the importance of universal access to healthcare (and specifically, comprehensive, noncoercive reproductive healthcare). Other principles, while not outright focused on gender, still portray population and development within a human rights framework. Principle 1 establishes at the onset that all humans are born equal and deserving of rights, and Principle 3 establishes a link between the fulfillment of human rights and sustainable development. In addition, the family, rights of immigrants, education, and the eradication of poverty were also prioritized to promote the betterment of society. Tying it all together, the last Principle reaffirms that, "Sustained economic growth, in the context of sustainable development, and social progress require that growth be broadly based, offering equal opportunities to all people" ("Programme of Action..." 13). Following this introduction to the document, two separate chapters are devoted entirely to the importance of gender equality and access to quality, comprehensive reproductive healthcare as they relate to population growth and development. This reflected the deep importance placed on women's rights and equality.

The other unique factor in the success of Cairo was the depth in participation of NGOs into the conference. This participation went further than just conference attendees; these NGOs, many of whom were feminists and advocates for the women's movement, were also involved in the conference preparation and the creation of the Cairo document. This involvement in a United Nations conference was unprecedented, and it was the reason that the Programme itself centered

women and gender so deeply. A United Nations report points out the critical role of NGO's at international conferences, stating, "UN summits are places where measures are discussed and planned—but not implemented. Within the setting of a UN world conference, NGOs act mainly as advocates—lobbyists—while in everyday situations they often focus on more operational work" (Sadoun 3). At international conferences, NGOs are in a sweet spot for advocacy. They are usually hyper-focused on a specific issue or issues, and do not have to consider sensitive political differences in the same way that governing bodies do when forming international policy. After the conference is over, these organizations are also in a position to go back to their respective nations, advocate for the messages promoted at the conference, and then actually do the work necessary to realize these goals. Because each NGO is already tailored to their own population and culture's needs, they are more capable of engaging their own communities in this work rather than outside organizations coming in and advocating for policy changes.

Whereas these concepts were viewed as "women's issues" prior to the ICPD, feminists advocated for their inclusion in mainstream discourse for the first time. They made the case that these issues were not just related, but connected inherently, and that women must be centered in order to solve larger problems of population. Nafis Sadik, the Executive Director of the United Nations Populations Fund, met with these NGO's often during preparation for the Conference, and felt compelled to advocate for their direct inclusion into the Cairo document. She is often credited with how deeply Cairo centered the needs of women and became a central advocate herself in fighting for these ideas.

Though the Cairo document does not require nations to follow these principles, it creates a standard for nations to refer to when creating their own policies. These documents can catalyze norm cascades within international communities. McIntosh and Finkle note that, "If reaffirmed

often enough by countries or other international bodies, these recommendations gradually take on the qualities of an international norm that exerts its own pressure to conformity by the global community” (226). For Cairo, this was aided by the 1995 United Nations Fourth World Conference on Women in Beijing. This conference reinforced gender equality as worthy of mainstream international discourse, notably with Hillary Clinton’s nod to the Vienna Conference proclaiming, “Human rights are women’s rights, and women’s rights are human rights.” The inclusion of the Cairo ideals into yet another UN document bolstered their importance and provided another source from which nations would refer to. Over time, these norms did make their way into national policies across the globe. By 1999, over half of countries surveyed by the Women’s Environment and Development Organization, “reported that reproductive health is an explicit part of national health policy” (DeJong 949). This shows that Cairo did have a large effect on the framework of population and development and blazed a trail for feminists to find their voice in this global context. Because of a combination of these factors, the ICPD was the turning point for the international community to take gender issues as a serious component of population and development.

#### Higher Goals: ICPD+25

Where the ICPD in Cairo shifted the narrative to issues on gender and human rights, the 2019 ICPD+25 Conference in Nairobi built on this foundation and the work of subsequent conferences to focus on issues of gender equality and reproductive healthcare entirely. In assessing progress for women and girls since the Cairo conference, notable improvements had been made worldwide in poverty reduction, access to reproductive healthcare, and maternal mortality (“Sexual and Reproductive Health...” 15). However, a main component of the Nairobi conference was the topic of Cairo’s “unfinished business.” In varying degrees, countries around

the world still needed to work to provide access to high-quality, comprehensive reproductive healthcare and close their margins to realize gender equality.

At Nairobi, an ambitious list of recommendations for the international community was introduced. It was established that ensuring access to reproductive healthcare and equality for women were crucial to attaining the goal of universal health coverage (UHC) by 2030, as had been recommended by the United Nations. To this end, the Nairobi Summit introduced specific goals for a sexual and reproductive health and rights (SRHR) agenda. Among other SRHR targets, by 2030 nations should aim to reduce the maternal mortality ratio to under 70 per 100,000 births, eliminate violence against women and girls, and ensure universal access to sexual and reproductive healthcare services (“Sexual and Reproductive Health...” 7). Alongside these goals, it is also made clear that disparities in healthcare access must be eliminated, and that high-quality care must be provided to all individuals. It details that access to healthcare services is a human right, and that states must work to ensure that all citizens have equal access to this care regardless of demographic.

Most significantly, the ICPD+25 document lays out a comprehensive definition of SRHR to include access to safe abortion. While the work at the first ICPD did lay out protections for women from unsafe abortion, Cairo more cautiously approached the procedure in efforts to seek widespread international agreement on their goals. Cairo placed emphasis on reducing the incidence of unsafe abortion by improving access to family planning methods and modern birth control. It was affirmed multiple times that access to abortion was to be contingent upon each nation’s laws and should not be promoted as a method of family planning (“Programme of Action...” 69). The ICPD+25 Nairobi Statement also emphasizes the importance of reducing unsafe abortions by improving access to family planning. It says that safe abortion should be

accessible to the fullest extent of the law, allowing for different nations to absorb this recommendation in a way that makes sense for them and their existing legislation. However, it goes further than that and points out why safe abortion is just as important. It says that access to safe abortion is often overlooked and underfunded, “despite the large recognized need and despite the evidence of impact on mortality and ill-health over time” (“Sexual and Reproductive Health...” 19).

For the first time, the international community asserted a bold position in that access to safe abortion was critical in order to fulfil human rights for individuals. The preparatory report for the Summit states, “Sexual and reproductive health and sexual and reproductive rights are centred around individual autonomy and the ability to make choices regarding individuals’ own reproduction and sexuality to enjoy the highest attainable standard of health” (“Sexual and Reproductive Health...” 15). This confirmed what feminists have fought for decades; that bodily autonomy and the right to decide one’s own reproductive future are human rights. Access to safe abortion is essential; both for the good of societal development, and in respect to providing full human rights for individuals. Although the ultimate goal is to reduce unplanned pregnancies, and thus reduce the incidence of abortion, this was a huge step for progress in reproductive rights.

The results of Nairobi were largely a success. Delegates from 170 countries committed to over 1,200 commitments to advance the ICPD+25’s SRHR agenda (“3 Things to Know...”). Three “zeros” were decided upon to strive for in the Nairobi Statement – zero preventable maternal deaths, zero unmet need for family planning information and services, and zero tolerance for gender-based violence (“Nairobi Statement on ICPD25...”). While there was no agreed upon Nairobi document as there was for Cairo, the Summit was still successful in pushing

the topic of reproductive rights forward; not just to finish Cairo's "unfinished business," but to solidify a deeper meaning of reproductive and sexual health and rights.

### The ICPD and the United States

Over the years, the United States' involvement in the ICPD has changed. In 1994, the United States played a substantial role in the Cairo conference. Bill Clinton was elected president in 1993, and this itself showed promise for reproductive rights. Within a month of being sworn in, Clinton reversed the Mexico City policy instated by Reagan. The Mexico City policy had devastating effects on NGOs, and the restriction of funding for organizations that provided abortions or abortion referrals meant that those organizations had to choose between operating under a lack of necessary funds or forgoing the procedure altogether. In either option, this meant that less women would have access to abortion and other comprehensive healthcare services. In revoking it, Clinton stated that the policy, "undermined efforts to promote safe and efficacious family planning programs in foreign nations" ("AID Family Planning..."). Whereas prior leaders were willing to politicize abortion at the expense of some of the world's most vulnerable women, Clinton showed early on to be an advocate for reproductive healthcare and gender equality.

This was reflected in the United States' involvement at Cairo. President Clinton appointed former U.S. Senator Timothy Wirth to Counselor at the Department of the State, in charge of population issues. Both Clinton and Wirth were known to care deeply about population and the environment, and also held favorable views towards access to reproductive healthcare (McIntosh & Finkle 240). In preparation for the conference, Wirth worked diligently to develop a strong position for the United States, surveying the views of advocacy groups and ordinary American citizens. Months before the ICPD took place, Wirth, "told a UN audience of US support for sustainable development, which includes issues of women's rights, reproductive

health care, and rapid population growth. He mentioned that women's rights, well-being, and empowerment are key to attaining population and sustainable development goals” (“State Department Leader...”). These are major themes which made the Cairo conference so monumental. In working with other international leaders and women’s groups, Wirth was able to promote women’s rights as directly connected with the benefit of population and development in preparation for the conference.

At the conference itself, the United States delegation was successful in advocating this message under Wirth’s leadership. Knowing that not every leader would agree with the more controversial aspects of these goals, Wirth, “worked around the clock with developing country delegations to produce acceptable language in the short time available...the United States, the Holy See, and the women's movement were the three most organized, best disciplined, and effective participants in the conference” (McIntosh & Finkle 242). Needless to say, the United States had a large role in support of the ICPD and in the agreements made in the final document. This played a substantial part in the careful negotiations that took place that allowed relatively controversial language about reproductive rights and abortion to be included, and officially change the course of population and development narratives.

The United States has not remained a supporter of the ICPD. Support for reproductive rights and gender equality has ebbed and flowed throughout the years due to political leadership, but the election of Donald Trump in 2016 saw considerable rollbacks. The President followed the lead of previous Republican administrations and reinstated the Mexico City policy; once again, funds were cut off to NGOs that provide or make referrals for abortion. Trump then instated a domestic gag rule similar to the Mexico City policy with changes to Title X, the only federal program in the United States dedicated to funding for family planning healthcare

services. These new changes resulted in the federal defunding of Planned Parenthood across the country, as well as the defunding of other independent clinics who continued to provide abortion care and referrals. Going further, the Trump administration removed reproductive rights data completely from their annual report on human rights (“Stop the Trump Administration...”). Many Americans also fear stronger restrictions on access to reproductive health. With the President’s power to appoint Supreme Court judges, there might be a successful challenge to *Roe v. Wade* before the end of the Trump administration, impacting millions of Americans’ ability to access safe abortion.

When the Nairobi Summit in 2019 was held, the United States was a vocal opponent. President Trump, who had made the decision to defund the United Nations Population Fund in 2017 (Banwell 1), was not in attendance. At the Summit, Valerie Huber represented the United States for global women’s health. She asserted that the United States did not support the Summit because of the views on safe abortion. The U.S. Department of Health and Human Services soon after published a statement in response to the Summit, calling for a return to the more nuanced messages initially promoted at the Cairo conference. It reads:

We do not support references in international documents to ambiguous terms and expressions, such as sexual and reproductive health and rights (SRHR), which do not enjoy international consensus, nor contemplates the reservations and caveats incorporated into the Cairo outcome. In addition, the use of the term SRHR may be used to actively promote practices like abortion (“Joint Statement on...”).

Though the parameters of sexual and reproductive health and rights were defined in great detail, it opened up a dialogue concerning safe abortion procedures and other forms of reproductive healthcare that the federal government is not in support of. The statement went on to criticize promoting comprehensive sex education that was not considerate of parental rights, and which would promote abortion as a method of family planning.

While the ICPD+25 made headlines in recognizing that access to safe abortion is a human right, it also clarified that the ultimate goal is to reduce the amount of abortions necessary by improving the global status of women and increasing access to modern birth control. Trump's Department of Health and Human Services is persistent on promoting "natural family planning methods" as an effective method of birth control ("Fact Sheet: Final Title X...") – even though this method involves timing intercourse around a woman's menstrual cycle and, as such, is not an effective method for people trying to avoid pregnancy (Trussell 24). The Trump administration also increased funding for abstinence-only sex education throughout the United States, even though comprehensive sex education in schools is correlated to lower rates of STI's and unintended pregnancy (Stanger-Hall & Hall 1). Additionally, women who have experienced violence are at higher risk of unintended pregnancy (Hessini 90), leaving them vulnerable and erased through abstinence-only programs. Higher rates of unintended pregnancy ultimately lead to higher rates of abortion. When safe, legal abortion is unavailable or inaccessible, dangerous "back-alley" abortions are the result (Haddad & Nour 125). Though the ICPD+25 promotes access to safe abortion as a human right, it also promotes access to modern, effective birth control methods such as the IUD, which has over a 99% effectiveness rate (Trussell 24). As involved and supportive of the ICPD as Clinton's administration was, the Trump administration was adversarial, and it is to the detriment of both American citizens and women worldwide who depended on the U.S. to receive family planning.

### The Evidence

Cairo and Nairobi were objective wins for women's rights advocates around the world. It is clear that when women have equal opportunities and rights to healthcare, their qualities of life benefit. Promoting these ideals, though, promised more than just widespread benefit for women.

Within this human rights approach to population and development, the world as a whole is projected to reap positive outcomes that will ensure sustainable growth for the future.

Fortunately, there is much evidence that points to this linkage, and underscores just how deeply gender equality and development are correlated.

Improving the health of women through education, nutrition, and increased economic opportunity has a direct impact on the health of families and children. This, in turn, has long-term impacts on the health of children and future generations. When mothers have better nutritional status and higher levels of educational achievement, their children are more likely to have better outcomes for longevity and quality of health as well (“World Development Report...”). The health of mothers has also been linked to increased educational opportunities for their children (Dankelman & Blerta 37). This also goes for decreasing maternal mortality. When mothers are alive and healthy, they raise a stronger generation that is more likely to be healthy and successful. Sustainable population growth is reliant upon this continued betterment of future generations, as are economies; there can be no healthy economy without a healthy workforce.

In addition, the combination of healthier mothers and more equal economic opportunities leads to a more robust and participatory workforce. A 2012 report by the World Bank on gender equality and development notes that when maternal mortality fell in the 1930’s due to lifesaving medical technology, American women entered the workforce at record numbers. The report states, “Improvements in the conditions of childbirth were the biggest force behind the rise in married women’s labor force participation in the United States between 1920 and 1950...Households, markets, social norms, and formal institutions are inextricably connected, and the key is to find ways to stimulate progress in all domains” (“World Development

Report...”). Labor and consumption both stem from the household. Empowering everyone inside that household means that economic activity goes up – both for supply and demand.

Research on economic growth and gender inequality bolsters why increasing economic opportunities for women is an objectively good thing for economies and for development as a whole. It has been shown that, “globalization that produces job opportunities for women increases growth and produces a long run steady state with higher per capita consumption than would prevail either without globalization, or with globalization that creates jobs only for men” (Rees & Riezman 107). An agenda that does not take women and gender into consideration is an agenda that is destined to fail, as that agenda is only empowering half of the population to reach their full potential. In line with these findings, a cross-country study in 2009 found that “gender gaps in education and employment considerably reduce economic growth” (Klassen & Lamanna 91).

Possibly the most direct correlation between the ICPD goals and sustainable development is seen in providing access to family planning healthcare services. The Guttmacher Institute, a leader in research and advocacy for SRHR, found that costs from unintended pregnancies cost the United States \$21 billion per year (“Public Costs From...”). Unintended pregnancies for teenagers have additional impacts and are correlated with lower educational success and lower wages (Yazdkhasti et al. 15). When public investments are made to increase access to family planning healthcare, direct savings are seen. A study conducted in California found that every dollar invested in family planning healthcare resulted in savings of \$2.76 in two years, and \$5.33 in five years (Amaral et al. 1980). The CDC affirmed these findings with a nationwide study on the cost-effectiveness of funding comprehensive reproductive healthcare. According to this study, every dollar invested in family planning healthcare centers like Planned Parenthood saves

\$7 every year by preventing unplanned pregnancy, STI's, and providing cancer screenings (Frost et al. 667). By investing in family planning healthcare and increasing access to these services, states can kill two birds with one stone by saving money in the long-term, and also by empowering their citizens to access crucial healthcare that will allow them to take control of their bodies and health.

Lastly, governments who do not work to free their citizens from sexual assault and human trafficking are not fulfilling their obligation to provide the full range of human rights. This has impacts on not just survivors of this violence, but also on the growth and development of our world. Domestic violence and sexual assault have a tremendous impact on the economy each year. Peterson et al. reported that each rape in the United States costs the survivor \$122,461 over the course of their lives, leading to a total \$3.1 trillion loss nationwide (Peterson et al. 5). These losses were attributed to a number of factors such as increased medical costs, both for immediate injuries and long-term health impacts, and loss of work productivity. For victims of human trafficking, this burden is tenfold. They live under conditions of extreme control and manipulation, and their access to contraception and ability to reproduce or not reproduce may also be controlled by their trafficker. A report of human trafficking in the United Kingdom found that on average, victims are trafficked for 9 months, and experience repeated physical and sexual assault throughout this time period (Reed et al., 2018). This has a tremendous impact on survivors' ability to thrive, both health- and economy-wise. Ensuring that all citizens are healthy, empowered, and free from violence are essential to the sake of human rights, and to the strength of a growing society.

### Why New Jersey?

The federal administration's refusal to cooperate with the recommendations of ICPD+25 undoubtedly has an impact on the realization of those goals. Nonetheless, these goals are still achievable, as much of what the SRHR agenda and SDG's recommend can actually land in the hands of state government. States have the right to decide how accessible abortion should be, as long as the restrictions do not result in an undue burden to patients trying to access care (*Whole Women's Health v. Hellerstedt*). State health departments also are charged with deciding public health priorities, which are largely in step with their governor's legislative and political priorities. This has an impact on issues such as childhood and maternal mortality, Medicaid access, and access to reproductive healthcare. Additionally, each state has different criminal justice laws concerning gender-based violence, harassment, and human trafficking.

New Jersey is in a unique position to tackle these issues at the state level, and has already seen the relationship between population, development, and access to reproductive healthcare centers like Planned Parenthood. Planned Parenthood plays an important role for American citizens and provides affordable services to patients who might not otherwise have access. They are widely used and trusted, with one out of every five American women seeking care at Planned Parenthood ("This is Who We Are"). 78% of their patients have incomes at or 150% below the poverty level ("By the Numbers"). Upon entering office in 2010, New Jersey Governor Chris Christie became the first governor in the nation to defund Planned Parenthood at the state level. This led the way for other states to defund reproductive healthcare for their citizens. Christie's budget cuts led to a decrease in access for these patients, with six family planning healthcare centers forced to close their doors, and 14 more to reduce their hours and services ("Local Impact Of Cuts..."). Between 2009 and 2015, the period in which Planned Parenthood was

defunded, New Jersey's bacterial STI rate rose by 35%. ("Access at Risk..." 2). This rise in STI's had a clear correlation to the budget cuts. Not only does New Jersey's rise in the STI rate line up with the timing of the elimination of state funding; in four out of the five counties where a family planning healthcare center had closed, the increase in STI rate bypassed the state average. In particular, Cumberland and Morris Counties saw rises above 60% when compared with years prior to the funding elimination ("HIV, STD, and TB Services").

These statistics represent more than just a negative public health impact – they represent an economic loss. A study was done on the cost-effectiveness of preventing chlamydia, gonorrhea, and syphilis in the United States. Not only did they find racial disparities in that Black Americans were more likely to contract these diseases, but "The cost burden was US\$69.7 million for 2 years at 2007 prices...they may have underestimated costs because many STD cases are not reported and remain undiagnosed" (Saha & Gerdtham 10). This points to both inequity in access to high-quality, comprehensive healthcare for Black Americans, and a likely underestimated financial burden that could be prevented. When combining this with the CDC study on the cost-saving effects of investing in reproductive healthcare, Christie's efforts to save money in the short-term didn't just have a devastating impact on New Jersey's most vulnerable residents. These policies ended up costing New Jersey taxpayers sevenfold in the long run.

Luckily, the state is on an upswing. The Planned Parenthood Action Fund of New Jersey endorsed Phil Murphy for Governor in 2017, who was elected in November of that year. Upon entering office, his first act as Governor was to fully fund family planning healthcare services at the state level (Landergan). In response to the federal government's new Title X regulations restricting federal funding to family planning healthcare centers, the Legislature passed additional state funds for family planning services in order to compensate for the loss of federal

funds. This ensured that those healthcare centers can continue to provide abortion care and referrals, while not compensating for a loss of other staff or services (“Governor Murphy Signs...”). Not only does this signify that reproductive healthcare is a priority for the state, but it also demonstrates a willingness to oppose the federal government’s policies and protect New Jersey residents from its harmful actions.

New Jersey has also taken on legislative priorities that address other goals that the ICPD+25 Summit recommends. With the advocacy of the New Jersey Coalition Against Sexual Assault, the state has passed laws which create a bill of rights for survivors of sexual violence, expand the civil statute of limitations to report sex crimes, and created a statewide taskforce to prevent child sexual abuse (“Current and Past...”). Additionally, First Lady Tammy Murphy has taken an active role in shaping statewide policy. She has announced that her priority for this Administration was reducing maternal mortality and racial disparities in healthcare outcomes (“Governor Murphy Signs Legislation...”). These priorities make New Jersey a state frontrunner in espousing the ideals that the Cairo and Nairobi claim essential. Between a strong state Legislature, a Governor and First Lady prioritizing reproductive healthcare, and strong partnerships with New Jersey-based advocacy groups, the state is in a position to effect huge changes for its citizens and realize an effective SRHR agenda through policy.

With this said, New Jersey still has room for improvement. On the face, all forms of reproductive healthcare are legal and protected services in New Jersey, and people have the right to both healthcare and safety from violence. However, the state’s problems are illuminated through a reproductive justice framework. “Reproductive justice” is a term that was coined in 1994 after the Cairo conference by Sister Song, a product of the National Black Women’s Health Project (Overbeck 197) who recognized that the discourse on reproductive rights was largely

shaped by white, middle-class women (Ross 9). While much of the emphasis at Cairo was placed on the ability for women to choose their own reproductive futures, the issues facing women of color required a different perspective. This presented a divide between the global North and South at Cairo, and that debate carried forward after the conference. In *Undivided Rights*, a book describing reproductive justice and advocacy by women of color, Silliman et al. writes, “‘Choice’ implies a marketplace of options in which women’s right to determine what happens to their bodies is legally protected, ignoring the fact that for women of color, economic and institutional constraints often restrict their ‘choices’” (Silliman et al. 5). While White women were campaigning for the right to choose birth control and abortion, women of color were fighting for the right to have a child against eugenic practices such as forced sterilizations for Black and Brown communities (Davis 360). With a reproductive rights framework, middle-class White feminists often focus on the legality of abortion care. A reproductive justice framework fills in the gaps that a strictly legal argument fails to address by including, “the social contexts in which individuals make choices,” and focusing on, “better lives for women, healthier families, and sustainable communities” (Ross 2). To that end, the three main point that a reproductive justice framework advocates for is the right to have a child, the right not to have a child, and the right to parent their children in safe environments as well as controlling their birthing options (Ross 1).

Using this framework, it can be seen that there are still measurable barriers to accessing comprehensive reproductive healthcare and achieving a reduction in gender-based violence. Much of these barriers include stark racial disparities for New Jersey citizens. Women of color are disproportionately likely to be low-income in the United States (“Ethnic and Racial Minorities...”) and as such are more reliant upon subsidized healthcare and public health

insurance to access reproductive healthcare services. New Jersey has also not yet recovered from the eight years of state funding that were cut from family planning health centers, leaving citizens in certain areas of the state with reduced access to a center. However, this is only the tip of the iceberg.

New Jersey does not currently regulate crisis pregnancy centers, which are religious, anti-choice organizations that are designed to trick or convince women out of receiving abortion care. These centers often pose as medical facilities and have untrained and unlicensed volunteers dress in white coats to pose as medical professionals. For young patients seeking a timely medical procedure, this can have serious impacts on the ability to access care.

When a patient does find their way to an actual comprehensive reproductive healthcare clinic, they are often met with crowds of anti-choice protestors screaming at them not to go inside. Even though there is a known, documented history of anti-choice violence and terrorism, New Jersey does not have adequate protections for reproductive healthcare patients through buffer zones to ensure access to care without the threat of harassment or violence from anti-choice protestors. This stigma and harassment attached to reproductive healthcare, particularly to abortion care, can be an effective deterrent for people who would otherwise seek this care in a safe environment.

When a mother does decide to carry to term, the healthcare outcomes are dependent upon that person's demographic. White maternal mortality in New Jersey is relatively low, with the most recent available data citing under 14 deaths per 100,000 births. However, the maternal mortality rate for Black women is almost five times higher at 46.5 deaths per 100,000 births ("Trends in Statewide Maternal Mortality"). These racial disparities are found to be consistent,

even when controlling for differences in socioeconomic status (Vilda et al. 1), which compound adverse healthcare experiences for low-income women of color.

Finally, although New Jersey has made progress to end gender-based violence, there is still work to be done. While sexual and domestic violence can be prevented, many New Jersey residents are still at great risk. The most vulnerable among these residents include sex workers and victims of human trafficking. The state is a hotspot for sex trafficking due to its location and condensed population and sees hundreds of trafficked women each year. Victims are often confused with consenting street sex workers and tried in court for crimes they were forced to commit. Further, women who are consenting sex workers are left unprotected from sexual and physical assault, even though they experience exponentially higher rates of violence, because of New Jersey's criminalization of prostitution. Current state laws are also not optimized to assist the most marginalized victims of gender-based violence.

When discussing population and sustainable growth at large, considerable improvements can be made. New Jersey ranks 7<sup>th</sup> in the nation for income inequality (McNichol 5). The state also ranks poorly in terms of racial segregation in schools. New Jersey is 6<sup>th</sup> in the nation for highest rates of segregation for Black students, and 7<sup>th</sup> in the nation for highest rates of segregation for Latino students. This segregation is also correlated with poverty, with the majority of Black and Latino students attending poorer schools; these educational disparities have resulted in long-term race and class inequalities across the state (Orfield et al. 10). New Jersey also has trouble keeping its citizens; an annual study also claimed that more people moved out of New Jersey than any other state in the nation in both 2018 and 2019 ("2019 National Movers Study"). Given that there are distinct gaps in what the state government can provide for gender equality and access to reproductive healthcare, and how these factors are tied to positive

economic and social outcomes, the state has an opportunity to see vast improvements and steps towards full equality for all.

These factors point towards inconsistencies in what New Jersey is providing for its citizens, and what the ICPD+25 Nairobi Summit recommendations uphold as essential. It is one thing to fund family planning healthcare at the state level, ensuring that no more healthcare centers close or reduce their hours and services. Yet, this funding alone is insufficient to remove all barriers to care, and access depends on more than just the existence of current centers. If a patient cannot get to a healthcare center because they were mistakenly led to a crisis pregnancy center, or cannot get inside of a Planned Parenthood because of protestors, New Jersey cannot say that family planning is universally accessible. If Black mothers have rates of dying that are four to five times higher than White mothers, New Jersey cannot say that high-quality maternal healthcare is universally accessible. When survivors of sexual assault and human trafficking are disregarded by law enforcement, the court system, and the law itself, New Jersey cannot say that it has zero tolerance towards gender-based violence.

Since the United States is currently not committed to realizing the goals of the ICPD+25 Summit, individual state governments must take it upon themselves to ensure that these goals are met. The health of women, families, and society as a whole depend on closing these gaps in equality and access to healthcare services. The ICPD legacy has shown that providing quality, comprehensive reproductive healthcare and empowering all citizens is the key to unlocking sustainable population growth and development. New Jersey has the capacity to take this on, and to lead the country in a better direction for all Americans. Now, it is a matter of recognizing those gaps, and working to pass effective state legislation.

## Chapter 2: Crisis Pregnancy Centers

### Introduction

Access to safe abortion is critical for the fulfillment of human rights and for the sake of sustainable development, as outlined in the ICPD+25's SRHR agenda. Abortion is a legal medical procedure in the United States, protected by monumental Supreme Court case *Roe v. Wade*. However, how easily citizens are able to access abortion is dependent on a number of factors. A time-sensitive procedure, pregnant Americans often must travel long distances, incur burdensome medical costs, or endure mandatory waiting periods that can make accessing abortion difficult, if not impossible for people with a lower socioeconomic status.

Fortunately, New Jersey does not impose these burdensome regulations onto its residents and is one of the friendliest states in the nation for people looking to access abortion care. While not all insurance plans cover abortion services, the procedure is covered under New Jersey Medicaid so that many people who are low-income can still access the procedure. In fact, the state's Constitution protects abortion rights more so than the U.S. Constitution does; New Jersey Supreme Court case *Right to Choose v. Byrne* decided that any state interest in fetal life does not supersede the state's interest in pregnant women's lives and health, allowing public funds to be used for abortion (*Right to Choose v. Byrne*). In contrast, the Hyde Amendment prevents federal funds from being used towards abortion services. This was a federal statute enacted in 1976 and has been renewed consistently since then ("S.142 - 113th Congress...").

Yet, only looking at the legality of abortion care in New Jersey creates blind spots as to how available and accessible it really is. New Jersey is not free of barriers to safe abortion services, and crisis pregnancy centers are a prime example. By not regulating these deceptive centers and allowing them to take advantage of vulnerable patients, New Jersey is not providing

full access to reproductive healthcare services – and therefore, not providing the full spectrum of human rights as outlined by Cairo and Nairobi. New Jersey must take legislative action to provide transparency to the actual practices and intentions of these centers.

### What Are Crisis Pregnancy Centers?

Crisis pregnancy centers (CPCs) are organizations that pose as comprehensive medical facilities to dissuade (and sometimes attempt to prevent) women from seeking or receiving abortions. CPCs have popped up across the United States since 1967, when Robert Pearson founded the first CPC in Hawaii after the state lifted its ban on abortion (Spencer 76). Most of these organizations have a religious affiliation and rely on outdated or false information about abortion in order to pressure women into carrying unwanted pregnancies to term. While most are not licensed medical facilities, many, “will adopt the ‘appearance’ of an unbiased, comprehensive health care clinic. For instance, many CPCs require clients to fill out paperwork upon arrival, or center volunteers and staff to wear white lab coats or medical scrubs” (Holtzman 83). Certain CPC’s offer limited medical services such as ultrasounds and STI screening, which can contribute to deceptions about whether or not these facilities are licensed medical organizations. However, many CPC’s are exempt from government regulation as they are not legitimate medical practices and do not charge for services. Further, they operate under freedom of speech protections to provide misleading information. Because of this, many patients are under the impression that they are being served by a comprehensive family planning healthcare clinic, and not in a religious nonprofit. Exact numbers are hard to pin down because these centers are generally unlicensed and unregulated, but estimates range from 2,500 to 4,000 CPCs in the United States (Lin & Dailard 4). In contrast, a study from the Guttmacher Institute counted just 1,671 abortion providers in the United States in 2014 (Jones & Jerman 4).

What makes CPCs so sinister are the deceitful practices that they employ in order to steer women away from abortion. These practices range from perpetuating abortion myths, to using strategic advertising techniques, to the actual locations of the centers. As many of these centers nationwide received federal funds, Congressman Henry Waxman prepared a report in 2006 to shed light on these practices and illuminate CPCs for what they are. For this report, Congressman Waxman worked with the Special Investigation Division to survey 25 CPCs, and had female investigators pose as underage pregnant women considering abortion. The report found that 87% of the clinics relayed medically inaccurate or false information about abortion, most often citing unproven links between abortion and breast cancer, infertility, or adverse effects to mental health (Comm. On Gov't Reform 7). The report also found that CPCs employed deceptive advertising practices to attract women into their centers. They may advertise in yellow pages books under "abortion services" while not clearly stating that abortion was not a service they provided; others, "purchase advertising on internet search engines under keywords that include 'abortion' or 'abortion clinics.'" Other advertisements represent that the center will provide pregnant teenagers and women with an understanding of all of their options" (Comm. On Gov't Reform 2). Someone looking for affordable, safe abortion would not necessarily be expecting to have to dodge these hurdles in order to access care. Strategies like these make it easy for someone to accidentally walk through their doors.

After the Waxman report was released, other groups and individuals began to collect similar findings on CPCs. The pro-choice advocacy group NARAL conducted their own investigation in 2017. In addition to corroborating the Waxman findings on the misinformation given to pregnant clients, NARAL identified other harmful patterns of deception used to trick vulnerable women into first coming in, and then talking them out of seeking abortion care. CPCs

use “co-location strategies” to trick patients into walking into a CPC by opening in medical buildings or in very close proximity to actual comprehensive family planning healthcare centers. Sometimes, CPCs are right next to these healthcare centers or right across the street and use similar names to these healthcare centers (“The Truth About ...” 8). They often have names that indicate that they are a comprehensive clinic, including words like “Women’s Health” or “Choice” (Chen 951)

Of greater concern, CPCs also rely on “delay tactics” to convince someone that an abortion isn’t necessary, or that the pregnant person should delay seeking the procedure. These tactics included exaggerating rates of miscarriage in order to convince the person that abortion might not even be necessary, or that the person should take more time and wait before making such a potentially regretful decision (“Crisis Pregnancy Centers Lie...” 9). These practices can have devastating effects on someone seeking abortion, which gets more invasive, expensive, and inaccessible as pregnancy continues. Further, telling someone to wait needlessly to receive an abortion, “when delivered in the context of discouraging women from seeking abortion...can have damaging effects on a woman's ability to successfully obtain the procedure” (Duane 358). A medication abortion cannot be used by someone who has been pregnant for more than 10 weeks (“Medication Abortion Information”); after that point, a surgical abortion is required. While a medication abortion can be taken at home and can be distributed by more healthcare centers, a surgical abortion must be done at a clinic. New Jersey does not have specific restrictions on when someone can obtain an abortion, but regulations increase with how far along the pregnancy is. At 14 weeks, the abortion must be performed in a licensed hospital or licensed ambulatory care facility; after 14 weeks, the abortion can only be performed in a licensed hospital. After 18 weeks, the doctor performing the abortion must have admitting privileges at a

hospital within a 20-minute drive from the abortion clinic (N.J. Admin. Code tit. 13, § 35-4.2).

Abortions can also become more costly the longer the patient waits (“Medication Abortion Information”). By persuading patients to delay seeking abortion care, CPCs make accessing the procedure more difficult for some, and potentially out of reach for others.

As with any other social issues, the actions of CPCs hurt women of color disproportionately. Kimberlè Crenshaw is well-known in Black feminist academia for documenting this fact, coining the term “intersectionality” to refer to the ways in which axes of power interact to produce oppression of Black women. She writes, “Because the intersectional experience is greater than the sum of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated” (Crenshaw 140). It is crucial to apply an intersectional framework to any conversation about reproductive healthcare and abortion access, as patients who seek abortion often have multiple intersecting identities that put them at a higher risk for violence. A 2016 study by the Guttmacher Institute found that about 75% of those seeking abortion in 2014 were women living below the poverty line (Jerman & Onda 11). Compounded by the fact that low-income people are disproportionately likely to be women of color (“Ethnic and Racial Minorities...”), low-income Black and Brown women bear the brunt of these tactics.

This underscores the need to look at reproductive health in New Jersey not from a reproductive rights perspective, but from a reproductive justice perspective. As Jael Silliman writes, “Women of color in the US negotiate their reproductive lives in a system that combines various interlocking forms of oppression. As activist, scholar, and co-author Loretta Ross puts it: ‘Our ability to control what happens to our bodies is constantly challenged by poverty, racism, environmental degradation, sexism, homophobia, and injustice in the United States.’” (Silliman

11). Yes, abortion is technically a legal procedure in New Jersey and available to all of its citizens. But how accessible is it if CPCs are strategically placed near clinics, using false advertising methods, and delaying patients from receiving actual abortion care? All of this must be taken into consideration when looking at what choices are truly available to women of color.

CPCs specifically target those who are the most vulnerable pregnant people – young, low-income, and women of color. Alongside co-locating CPCs near family planning health centers, CPCs are also strategically located near high schools, colleges, and low-income neighborhoods (“Crisis Pregnancy Centers Lie...” 8). This is done to attract younger populations and populations of color into their doors, who they refer to as “abortion-minded” (“The Truth About Crisis Pregnancy Centers” 8). Care Net, a nationwide CPC network with a location in Hackettstown, New Jersey, has a detailed “Urban Initiative” that lays out their plan to target Latina and African American women. These initiatives including buying advertising time on Black Entertainment Television (BET), co-opting messages about reproductive healthcare and slavery, and advertising in communities of color (“Crisis Pregnancy Centers Lie...” 16). This has a direct impact on the ability to access abortion care. “Because later abortions are more difficult to procure and carry higher risks, delaying abortions may effectively prevent them from occurring. Teenage, poorly educated, and low-income women generally take longer to confirm suspected pregnancies, and these are the women who most often seek care at CPCs” (Duane 357). Thus, young women of color are at highest risk of CPCs having an effect on their ability to access abortion. If seeking abortion care is already delayed for these populations, any additional unnecessary delays could mean a total loss in the ability to access care. Making an additional appointment to seek abortion care could require taking time off of work, after potentially already taking time for the appointment unknowingly at a CPC, which translates to a loss of income that

many people cannot afford. This is compounded on top of the increased costs and barriers to abortion in later trimesters; “after visiting a CPC, [they] may not have the resources to properly explore their full range of reproductive health options, some of which might be less financially or geographically accessible” (Chen 951). While evidence states that African American and Latina women are more likely to experience unplanned pregnancy than White women (Kim et al. 427), evidence also suggests that this is due to lack of access to other family planning methods and lack of health insurance (Dehlendorf et al. 5). CPCs could have filled in a gap in these communities by providing affordable access to other family planning methods in order to reduce abortion. Instead, they have been found to provide misinformation about the effectiveness of contraception (“Crisis Pregnancy Centers Lie...” 11). As CPCs do not provide their clients with any form of assistance in exercising bodily autonomy or accessing healthcare, it is apparent that there is a need to regulate these centers.

### CPCs in New Jersey: A Closer Look

#### *Who Are They?*

There are 73 known centers in New Jersey that either self-identify as crisis pregnancy centers, or that are listed as crisis pregnancy centers on CPC directories. These online directories differ based on each organization’s definition of what constitutes a CPC. The website “[www.CrisisPregnancyCenterMap.com](http://www.CrisisPregnancyCenterMap.com)” is a national database of CPC’s, and strictly lists centers that pose as medical clinics to steer women away from abortion. This website is led by Dr. Andrea Swartzendruber, a professor at the College of Public Health at the University of Georgia. It lists 37 CPCs in New Jersey (Swartzendruber, 2018). The New Jersey Right to Life, a pro-life advocacy organization, has a broader definition within the confines of the state for their directory. Their directory lists religious charity organizations that provide care and resources to

new/expecting mothers in need without a focus on abortion or unplanned pregnancy. Facilities such as the spirituality-based substance rehabilitation center Great Expectations were also found on their list. As such, their number of CPCs in New Jersey was much higher at 63 centers (New Jersey Right to Life). HelpInYourArea.com, a pro-life network, lists 43 CPCs in New Jersey (Help In Your Area). There is some overlap between the three directories. After cross-checking between the three CPC directories, accounting for CPCs that have closed, and religious charity organizations whose mission was not to dissuade pregnant women from abortion, 38 operating CPCs were found (Table 1).

*Table 1: List of CPC's in New Jersey, their locations, the % of residents of color, residents of poverty in those locations, and distance from the nearest comprehensive reproductive healthcare clinic.*

<b>Name</b>	<b>Town</b>	<b>Nearest Repro Clinic</b>	<b>% of Color</b>	<b>% Poverty</b>
1st Way	West Collingswood	<3 miles	18.70%	6.00%
1st Way Life Center	Woodbury	<4 miles	43.00%	21.20%
1st Way of Burlington	Burlington	5 miles	43.20%	13.90%
Abba House and Pregnancy Resource Center	Palmyra	<5 miles	27.20%	10.30%
Birthright	Red Bank	.32 miles	44.60%	14.10%
Birthright	Freehold	<3 miles	15.10%	5.30%
Birthright	Dover	.76 miles	76.40%	12.70%
Birthright	Barnegat	>20 miles	15.20%	7.00%
Birthright	Maywood	<2 miles	27.20%	6%
Birthright	Toms River	<4 miles	12.50%	7.50%
CareNet Pregnancy Resources	Hackettstown	.78 miles	21.00%	12.20%
ChoiceOne Pregnancy	Lawrenceville	<3 miles	19.90%	4.90%
Choices of the Heart	Turnersville	<5 miles	10.20%	3.90%
Cornerstone Women's Resource Center	Salem	6.33 miles	67.50%	46.20%
Cornerstone Women's Resource Center	Mobile	N/A	N/A	N/A
Crisis Pregnancy Services	Egg Harbor City	<10 miles	26.70%	10.00%
Destination Choice (MOBILE)	Glassboro	N/A	27.90%	22.30%

Table 1 (cont.)

<b>Name</b>	<b>Town</b>	<b>Nearest Repro Clinic</b>	<b>% of Color</b>	<b>% Poverty</b>
First Choice	Montclair	<1 mile	34%	7.60%
First Choice	Newark	<1 mile	86%	28%
First Choice	Morristown	.19 miles	38.40%	5.90%
First Choice	Jersey City	<1 mile	53.00%	18.3
First Choice	Plainfield	1 mile	86.80%	19.60%
Friendship Center for New Beginnings	Flemington	<3 miles	35.11%	20.40%
Gateway Pregnancy Center	Elizabeth	.16 miles	83.10%	18.40%
Gateway Pregnancy Center	Union	2.36 miles	49.20%	4.90%
Hope Pregnancy Center	Ocean City	<15 miles	10.50%	8.00%
Hope Pregnancy Center	North Cape May	<15 miles	12.96%	4.96%
Life Choices Resources Center	Metuchen	<5 miles	12.10%	1.60%
Life Choices Medical (MOBILE)	Phillipsburg	.5 miles	25.70%	17.40%
Lighthouse Pregnancy Resource Center	Hackensack	0.5 miles	63.10%	12.90%
Lighthouse Pregnancy Resource Center	Paterson	<2 miles	87.40%	28.10%
Lighthouse Pregnancy Resource Center	Wayne	<8 miles	14.30%	4.30%
Options Pregnancy Care Center	Cherry Hill	<1 mile	13.90%	5.90%
Our Gift of Hope	Englewood	150 feet	56.80%	11.80%
Pregnancy Aid & Information	Raritan	<2 miles	7.78%	5.20%
Solutions Health and Pregnancy Center	Shrewsbury	<1 mile	2.60%	1%
The Open Door	Toms River	.3 miles	12.50%	7.50%
Today's Choice Women's Resource Center	Newton	528 feet	21.00%	13.60%

Sources: U.S. Census Bureau QuickFacts: New Jersey, datausa.io, crisispregnancycentermap.com, New Jersey Right to Life, helpinyourarea.com

This number is similar to the amount of abortion clinics in New Jersey. The New Jersey Family Planning League, which distributes federal Title X funds to family planning healthcare centers in the state, reports 49 healthcare centers in New Jersey (NJFPL, 2020). These do not comprise the entirety of clinics in New Jersey; these are only the clinics that receive Title X

funds, and not all of these clinics provide abortions. In 2017, Guttmacher reported that there are 76 centers in New Jersey that provide abortion, 41 of which were clinics (“State Facts About Abortion”).

### *Locations*

Many of these CPCs follow the deception tactics seen across the country. 28.9% of the clinics had the word “choice” in their name, and 36.8% of centers had “Pregnancy Resource Center,” “Pregnancy Services,” or “Pregnancy Care Center” in their title. This bears the implication that patients seen there would be given the full range of options and care associated with a pregnancy. 78.9% of clinics were five miles or less away from the nearest comprehensive family planning health center; 39% of the clinics were located less than one mile from the nearest healthcare center. Three CPCs have mobile units, offering free ultrasounds to patients at various locations. Some of the CPCs were part of a larger network; Birthright has six locations, Lighthouse Pregnancy Center has three locations, Gateway Pregnancy Center has two locations, and First Choice has five locations. CareNet has only one location in New Jersey but is part of a nationwide network of CPCs.

The most recent US Census data estimates that 54.9% of New Jersey residents are White without Hispanic origins, 15% are Black, and 20.6% are White or non-White Hispanic; 9.5% of New Jersey residents live in poverty (“Census Bureau Quick Facts”, 2019). Going off of this data, 39.4% of CPCs were located in cities or towns in which had an overrepresentation of Black and Hispanic residents, and 23.6% of CPCs were located in cities or towns which have a majority of residents of color. 50% of CPCs were located in communities where the percentage of residents in poverty surpassed the statewide average.

### *Services Offered*

All of the CPCs offered pregnancy testing on their websites. 12 CPCs offered STI screening but did not necessarily specify STI treatment, which leaves one to wonder what happens to someone that tested positive for an STI at a site that cannot prescribe anti-viral or antibiotic medication. 20 CPCs offered free ultrasounds. Lighthouse Pregnancy Resource Center states that their ultrasound services will, “medically confirm pregnancy” (“Home: Lighthouse Pregnancy Center”), and Choices of the Heart states that their services “are provided by medical professionals & overseen by a licensed physician” (“Free Pregnancy Testing...”). Similarly, Life Choices Medical offers family planning care, “in a clean and safe medical environment. Our staff understands what its [sic] like to make choices. Our resources and understanding approach will empower you” (“Abortion? Confidential, Compassionate Care...”). 23.6% do not have disclaimers on their websites that they do not provide or refer to abortion care; Life Choices Medical is one of those CPCs. The only CPC that is medically licensed by the New Jersey Department of Health is Solutions Health and Pregnancy Center in Red Bank (Health Facilities); all other facilities are not regulated medical centers.

### *Misinformation*

55% of CPCs list misinformation or exaggerated risks about abortion directly on their websites, and 82% offer “options counseling.” Solutions Health and Pregnancy Center and Hope Pregnancy Center both list the “morning after pill” as a form of abortion (“Abortion Information & Options”; “What is the Morning-After Pill?”). Gateway Pregnancy Center states that, “25%-30% [of women who have had abortions] become permanently infertile” (“Gateway Pregnancy Centers”). There is no such scientifically significant link between abortion and infertility, especially in the first trimester when the majority of abortions are performed (Atrash & Hogue

391). Life Choices Resource Center states that “complications may happen in as many as 1 out of every 100 early abortions (4-7 weeks) and in about 1 out of every 50 later abortions (8 weeks and beyond),” and that there was a “7-30% risk of suicide attempt” after abortion (“Abortion: Choices, Options...”). The safety of abortion procedures has been well-documented; a 2015 study found that less than 1/4<sup>th</sup> of 1% of abortion procedures led to a major complication, and that the total complication rate for second-trimester abortions was 1.5% (Upadhyay et al. 175). Additionally, there is no link between suicide risk and abortion care (Steinberg et al. 1).

Five CPCs recommend obtaining an ultrasound at their centers to test for viability, citing miscarriage as a reason why abortion might not even be necessary. Solutions Health and Pregnancy Center states on their website, “If you are considering an abortion, it is very important to determine whether you have a viable pregnancy. Why endure an intrusive medical procedure that you may not need” (“Free Pregnancy Ultrasound...”) Options Pregnancy Care Center has a similar advertisement, saying, “If an ultrasound reveals that the pregnancy will end naturally, abortion will not be necessary” (“FAQ: Options for Women”). Ultrasounds are not 100% accurate for predicting viability, and factors such as the skill of the ultrasound practitioner affect the accuracy of the ultrasound reading (Kearin et al. 129). New Jersey does not require licensure to perform ultrasounds (“State Licensure”). The person performing ultrasounds at unregulated CPCs may have little to no training on sonography, leading to false or inaccurate predictions about the viability of pregnancies.

#### Regulating CPCs: What Has Worked?

Though the deceptive practices and misinformation used widely by crisis pregnancy centers are not well-hidden, successfully challenging them in court has proven difficult. The protection of freedom of speech and religion by our First Amendment is both ingrained into the

fabric of American culture, and heavily guarded by American courts. Thus far, each attempt to regulate CPC practices has been met with a challenge, with the insistence that these regulations infringe upon rights given by the First Amendment (Campbell 84). In order to craft successful policy, it is important to look at what has worked, what hasn't worked, and why.

Generally, past regulations to address the deceptive practices of CPCs have been status disclosures, government message disclosures, or service disclosures. Beth Holtzman, attorney and advocate for access to reproductive health, explains each type of disclosure. Status disclosures “require CPCs disclose whether or not they are licensed medical facilities with a licensed medical provider on staff” (Holtzman 88). Government message disclosures require CPCs to inform if the local government “has a recommendation for where pregnant women should seek care, such as a licensed medical provider” (88). Finally, the service disclosure requires CPCs to disclose, “whether they provide, or give referrals, for certain services, such as abortion or contraceptives” (88). One thing to remember about these regulations is that different kinds of speech are held to different standards in court, depending on the reason for the speech. Any kind of ordinance compelling speech, such as a disclosure ordinance applied to CPCs, is held to a standard of “strict scrutiny,” meaning that a law will be found constitutional only if it is “narrowly tailored to promote a compelling Government interest” (*United States v. Playboy Entm't Grp*). Under this standard, a law compelling speech is constitutional if it is structured in the least restrictive way possible, protecting the freedom of speech of the entity in question. When applied to commercial speech, the law must be, “reasonably related to the State's interest in preventing deception of consumers” (*Milavetz, Gallop & Milavetz, P.A. v. United States*), and thus the burden is more relaxed. Because CPCs are nonprofit organizations and do not charge for their services, disclosure ordinances generally fall under the standard of strict scrutiny.

Inherently, legal challenges to ordinances requiring that CPCs state whether or not they are medical facilities, or whether or not they provide abortion care or contraceptives, should serve to highlight the deceptive nature of CPCs. If these centers are strictly just for providing help to expectant mothers in need, these regulations should not be a problem. Unfortunately, the law has not always agreed.

With mixed success, multiple local and state governments have tried to regulate CPCs using these methods. Three years after the Waxman report, the city of Baltimore was the first in the nation to pass an ordinance regulating CPCs. They enacted Ordinance 09-252, which was a service disclosure mandating that CPC's display in their waiting rooms that they do not provide or refer for contraceptive or abortion services (Balt., MD., Health Code. 3-501-506). This was struck down by the U.S. District Court in *O'Brien v. Mayor of Baltimore* for religious discrimination, as it was only applicable to CPCs with certain views on contraception and abortion (*O'Brien v. Mayor of Baltimore*). A year after the Baltimore ordinance was enacted, Montgomery County, Maryland enacted a status disclosure and a government message disclosure for CPCs (Duane 361). The status disclosure was found to be constitutional because it was, "narrowly tailored to meet the government's interest in public health because it did 'not require any other specific message and in neutral language states the truth'" (Holtzman 91). However, the government message disclosure did not hold up in court. The court found that it was a likely violation of the First Amendment, and that the second disclosure would be unnecessarily compelled speech, "because the County's interest in ensuring that women will not forgo medical treatment 'might be satisfied once women were aware that [a pregnancy resource center does] not staff a medical professional'" (*Centro Tepeyac v. Montgomery County* 13). In the court's view, the status disclosure was sufficient in ensuring that women would have better access to

care, and that attempts by CPCs to pose as medical clinics would be prevented. While this was a stepwise win for reproductive healthcare, in 2014 the status disclosure was overturned in an appeal. In this appeal, the court failed to find that CPCs displayed a pattern of deception towards women, and that, “the need for regulation of those centers is not as pressing as the city asserts” (*Greater Bait. Ctr. for Pregnancy Concerns, Inc. v. Mayor of Balt.* 14). Even though there was documented evidence that CPCs pose as medical clinics, present misinformation about reproductive healthcare, and utilize deceptive advertising practices, the court found that requiring CPCs to disclose whether or not there was a medical professional on staff was a violation of the First Amendment.

In 2011, New York City passed Local Law 17 (N.Y.C. Admin. Code. Sec. 20-815-20-816). Local Law 17 included a status disclosure, a government message disclosure, and a services disclosure for CPCs. After a number of appeals, the licensure status disclosure was the only provision found to be constitutional. The government message disclosure was found unconstitutional because the court decided that there were less restrictive routes the city could take to inform women of reproductive healthcare clinics in the area (*Evergreen Ass’n v. City of N.Y.*). Similarly, the service disclosure was found unconstitutional because requiring the centers to disclose whether or not they provide abortions, “may overly burden CPCs’ freedom of speech rights by fundamentally altering the way CPCs discuss the topics of abortion or birth control” (Holtzman 94). Once again, the court favors the rights of CPCs to mislead people, specifically and most often young women of color, against their rights to access comprehensive reproductive healthcare.

In 2012, Austin, Texas attempted to pass a status disclosure against CPCs (Austin Tex. City Code Chapter 10-10, 2012). Instead of laying out specific healthcare procedures, the

language in the status disclosure was vague and kept referring to the term “medical services” instead. The CPC would be required to display prominently on their entrance, “whether or not they provided ‘medical services,’ and if so, whether those ‘medical services’ were conducted under the direct supervision of a licensed health care provider and whether the CPC was licensed to provide those ‘medical services’” (Holtzman 92). Aside from confirming pregnancy or performing an ultrasound, the city never specified what would be included under the term “medical services.” During the ensuing legal battle, the court found that the ordinance was unconstitutional – not because of a First Amendment violation, but because of the vagueness of the law.

In 2015, California became the first state government to take action to regulate CPCs. The Reproductive Freedom, Accountability, Comprehensive Care, and Transparency (FACT) Act was signed into law, concerning both licensed and unlicensed CPCs (CAL. Health & Safety Code § 123470-123473). The FACT Act required a government message disclosure for licensed CPCs, and a status disclosure for unlicensed CPCs. This act was unique and tailored to each kind of CPC, and it was upheld in lower court challenges. Then, in 2018 the Supreme Court struck down the law in *National Institute of Family Life and Advocates v. Becerra* with the claim that both types of disclosures were overly burdensome and targeted to CPCs without a justified cause. As such, they concluded that it was a violation of their First Amendment rights (*NIFLA v. Becerra*). Again, the court downplayed the harm caused by CPCs in favor of allowing them to hide the true nature of their practices.

Of particular importance, in 2011 San Francisco passed the Pregnancy Information Disclosure and Protection Ordinance (San Francisco Admin. Code. Sec. 93.1-93.5) which was unique in that it focused on deceptive practices by commercial speech from both licensed and

unlicensed “limited pregnancy service centers.” It required that CPCs refrain from making any statements that would appear to be untrue or misleading. If a CPC was found to break this ordinance, they would have 10 days to remedy their false advertising. If they failed to do so, they would be subjected to service and status disclosure ordinances and a fine. As expected, the ordinance was challenged by a CPC but was able to withstand constitutional requirements and held up in court (*First Resort, Inc. v. Herrera*). When the U.S. Supreme Court denied a review, city attorney Dennis Herrera affirmed the importance of the San Francisco ordinance, stating, “False and misleading advertising by these clinics is a deceitful practice that preys on women when they least suspect it. The delays these centers can cause interfere with women’s time-sensitive, constitutionally protected right to choose what is best for them. Reproductive rights are human rights” (“U.S. Supreme Court Denies...”). Where other ordinances failed, San Francisco was successful in passing an ordinance that stood firmly against legal challenges. The city understood the importance of full access to comprehensive reproductive healthcare, including access to safe abortion, and created a regulation that both impedes the ability of CPCs to deceive people and helps their citizens access constitutionally protected care.

### What Has New Jersey Done?

To the detriment of its residents, there is no legislation in New Jersey that regulates CPCs. In the last legislative session (2018-2019), some legislators in the New Jersey state government began to act against deceptive practices that serve to undermine access to safe and legal reproductive healthcare. Assemblywoman Lisa Swain introduced A4399, and Senator Teresa M. Ruiz introduced parallel bill S2983. These bills would have required family planning healthcare centers (including CPC’s) to provide ultrasounds by a health care professional licensed to do so (“Assembly No. 4399”; “Senate No. 2983”). With these bills, the state could protect against

unqualified volunteers from providing ultrasounds to pregnant people under the guise of a medical setting. This would prevent CPCs from using deceptive practices to trick patients into thinking the services they were receiving from untrained volunteers was medical care from trained professionals, and thereby could serve to curb any misinformation that they might receive about the viability of their pregnancies due to an ultrasound. Requiring that only licensed professionals conduct ultrasounds is a generally noncontroversial stance to take, yet, both bills did not pass. A4399 died in the Assembly Women and Children Committee, and S2983 died in the Senate Health, Human Services and Senior Citizens Committee.

AR182 was sponsored by Assemblywoman Swain and Assemblywoman Verlina Reynolds-Jackson as a resolution to condemn the deceptive practices of crisis pregnancy centers (“Assembly Resolution No. 182”). The resolution acknowledges that CPCs are known to disseminate misinformation, false advertising, and creating a barrier to accessing safe and legal reproductive healthcare services. This bill also died in the Assembly Women and Children Committee but has been reintroduced in the 2020-2021 legislative session by the same Assemblywomen under AR68 (“Assembly Resolution No. 68”).

Most thoroughly, A4402 had been introduced in 2018 by Assemblywoman Swain to require a status disclosure, a government message disclosure, and a services disclosure on CPCs. Like other CPC legislation, it died in the Assembly Women and Children Committee, but was reintroduced in 2020 by Assemblywoman Swain under A3261. If passed, this bill would require, upon admission into the CPC, that clients be provided with a list of all of the services and referrals provided by the center, whether or not a medical professional provides or supervises the services provided, and that the state’s Department of Health encourages women who are or may be pregnant to seek care from a licensed healthcare professional (“Assembly No. 3261”).

While these actions by the state Legislature are well-meaning, they fall short of protecting New Jersey's most vulnerable citizens from the deceptive practices of CPCs. First, a bill must be passed in order to create meaningful changes. The introduction of bills to address crisis pregnancy centers is a start, but it means nothing if almost no members of the Legislature are willing to co-sponsor and pass the bill. Additionally, a resolution by the Legislature is symbolically important, but even if it passes it carries little to no weight. Resolutions can assert the opinions of government, but they are not legally binding and do not require any action on the part of CPCs. Simple resolutions, such as those proposed, do not even need to be signed by the Governor in order to pass ("Our Legislature"), and as such the weight of its efficacy and whether or not it is cost-effective to focus on deserves to be questioned.

The disclosure legislation proposed in A3261, while thorough, will not succeed in the inevitable legal challenge that would take place after it passes. As seen in the past, government message disclosures do not hold up in court as constitutional under the First Amendment, and have been found to create unnecessarily burdensome, compelled speech for CPCs. Service disclosures have also been hard to uphold due to the singling out of CPCs and their religious beliefs. Because this legislation is aimed specifically at CPCs, it is likely to follow the same path that prior ordinances have followed. The status disclosure is the only part of the bill that could hold up in court, as it is much more specified than the Austin ordinance, and status disclosures on CPCs have generally been found to be constitutional. Though, the state must better demonstrate how CPCs cause direct harm to citizens, as courts are wont to downplay harm done to people seeking reproductive healthcare, specifically women of color. The Department of Health currently carries no data on CPCs, and thus the Legislature should not risk passing a bill without information to support the legal necessity for these regulations. It would prove to be

much more difficult to pass a law that had previously been struck down than it would be to first surveil CPCs for deceptive and harmful practices.

### Recommendations for New Jersey

New Jersey must take action against CPCs. However, legislators must first look to court precedent when writing policy. Legislative efforts have no benefit to citizens if they are found to be unconstitutional, and the time spent on writing and lobbying for a doomed bill could be better spent on crafting creative, strong policy that will last through the legal challenges that CPCs present. With that said, there are a number of actions that the state can take that will both help to keep citizens safe, and also hold up in court.

New Jersey must pass disclosure legislation on CPCs. However, government disclosure laws and service disclosure laws have not survived strict scrutiny standards and have been found to be violations of the First Amendment. The state should not waste time mandating something that has a long precedent of losing legal battles, and so the government message disclosure and service disclosure should be removed. As such, A3261 should be rewritten to include only a status disclosure. In addition, the status disclosure on A3261 should be expanded. As the bill is written, it would only require CPCs to disclose, in English and Spanish, whether or not a licensed medical professional is on staff to provide or supervise the services provided at the center. Because there are unlicensed CPCs in New Jersey that have the guise of medical clinics, the disclosure law should also include whether or not the CPC is a licensed medical facility. Since only one CPC in New Jersey is a medically licensed facility, this would have far-reaching effects on the large majority of CPCs and their ability to deceive clients.

A4399/S2983 requiring licensure for ultrasounds should be reintroduced in the current legislative session. This bill did not single out CPCs, leaving no room for a religious

discrimination argument, and does not involve a First Amendment violation. On top of that, legislation requiring that ultrasounds be performed by licensed professionals has already passed in New Hampshire, New Mexico, Oregon, and North Dakota (“State Licensure”). The passing of this legislation would at least require that CPCs use a trained professional to administer their ultrasounds, ensuring a higher standard of care provided by CPCs. This would also ensure a higher standard of care for other facilities that administer ultrasounds, providing a wide benefit for New Jersey citizens. For currently credentialed but unlicensed sonographers in the state, there would not be much of an added burden for licensure. The American Society of Echocardiography, an organization which advocates for ultrasound technicians and works closely with states crafting sonography legislation, suggests that licensing would add only a small fee after receiving credentials to conduct ultrasounds (“Sonography Licensure FAQs”). The Society also predicts potential benefits to licensure, saying that it “is likely to raise the bar of all areas of sonography education and standard setting”. Ensuring that patients receive a high standard of care provided by healthcare professionals is well within the state’s interest, and this would be low-hanging fruit for legislators to pass.

Lastly, New Jersey can take action against CPCs under consumer protection laws. CPCs may claim that they do not sell their products or services, and therefore are not required to comply to consumer protection laws. However, just because they do not sell a product or service does not necessarily mean that they are exempt, as, “courts have held that laws governing deceptive acts apply any time an entity engages in a transaction involving goods or services, regardless of whether the exchange is for money” (Campbell 101). CPCs advertise for and provide goods and services to clients, such as pregnancy tests and ultrasounds. Because there are CPCs in New Jersey that do not clearly state that they do not provide abortion care or referrals,

yet have misleading information on their websites that point to abortion as an option, the state can hold CPCs responsible in this way.

### Conclusion

The ICPD and the ICPD+25 are clear in that access to comprehensive reproductive healthcare is crucial for a society to thrive. Both documents assert that nations must remove barriers to accessing this care where it is legal, and abortion is a protected procedure by both the United States and the New Jersey state Constitution. All citizens must be able to make informed choices about their own lives and their reproductive futures; without this, human rights are not wholly fulfilled, and society as a whole is at a disadvantage. To this end, we must focus specifically on increasing care to those who need it most. Young women, low-income women, and women of color are at the biggest disadvantage when seeking affordable, quality healthcare, and ensuring that they have full access will help ensure access for all New Jersey citizens.

As long as CPCs are unregulated in New Jersey, the state is not fulfilling its obligation to provide complete and total access to reproductive healthcare. CPCs have displayed a long and widespread pattern to trick their clients – first that these centers are medically legitimate facilities that provide contraceptives and abortion care, and second that abortion is a dangerous procedure carrying incredible physical and mental health risks. These centers shame clients and try to manipulate them into making a permanent decision about their reproductive health. They have no legal obligation to maintain client confidentiality if they are not medically licensed, and present legitimate concerns to the communities they are founded in. They most often target young, low-income women of color, who are more likely than other New Jersey citizens to need access to affordable reproductive healthcare. Because of the law's general lack of protections to vulnerable

groups, specifically to women of color, regulations must be carefully crafted and hold a strong legal argument in order to be effective.

Religious organizations are, and should be, allowed to operate and disseminate their views as they see fit. Regulations on CPCs would not prevent that from happening. However, a legal line should be drawn between a harmless religious message, and a calculated measure to prevent someone from obtaining healthcare. While the recommended policy steps will not prevent all CPCs from operating, they will prevent CPCs from engaging in tactics that deliberately serve to steer women away from a safe and legal healthcare procedure.

## **Chapter 3: Buffer Zones**

### **Introduction**

The right to safe abortion where legal is a human right as put forth by the ICPD. It is a constitutionally protected medical procedure in the United States, especially so in New Jersey. Yet, the ability to access abortion and other reproductive healthcare services often comes with fear due to harassment and violence threatened by anti-choice protesters. It is not uncommon for anti-choice protesters to be seen outside of clinics, trying to intimidate and scare patients out of receiving an abortion. Buffer zones, politically neutral areas in front of reproductive healthcare clinics, provide a level of relief for patients trying to access care. However, like regulations on CPCs, ordinances to enact legally protected areas known as “buffer zones” have been difficult to hold up in court and are consistently challenged on the basis of the First Amendment rights of anti-choice activists.

The buffer zone in front of Metropolitan Medical Associates in Englewood, New Jersey highlights why these zones are critical for the protection of clinics and their patients. The city of Englewood enacted an ordinance to place a small buffer zone in front of the clinic entrance in response to escalating anti-choice harassment and violence. This buffer zone has been challenged repeatedly in court, while providing minimal protections for patients with a span of only eight feet.

There are clear legal disparities in what is permitted to occur in public spaces, and there is a line between freedom of speech and freedom to violate. In order to ensure that New Jersey citizens experience the fullest extent of their human rights, these legal discrepancies must be addressed, and sufficient buffer zones must be maintained for reproductive healthcare clinics where necessary.

### Clinic Violence and Impact

Accessing abortion can be dangerous; not because of any danger associated with the procedure itself, as major complications related to abortion are exceedingly rare. Rather, accessing abortion can be dangerous because of the trend of violence against abortion clinics, reproductive healthcare providers, and patients seeking care. During 1977 and 1988, “the National Abortion Federation reported the following violent acts against clinics: 222 clinic invasions, 220 acts of clinic vandalism, 216 bomb threats, 65 death threats, 46 assault and batteries, 20 burglaries, and 2 kidnappings” (Grimes et al. 1263). Since then, violence has only continued to escalate. In 1993, Dr. David Gunn was the first abortion provider to be murdered. This was followed by many acts of deadly violence committed in the name of anti-choice protest. These murders have not just included doctors, but also receptionists (Butterfield), police officers (Bragg), and clinic escorts (Verhovek). Countless others have been wounded in these murders and other attempted murders at clinics. The most recent and notorious incident of clinic violence took place at a Planned Parenthood in Colorado, where a gunman killed three people and injured several others (Turkewitz). To get an idea of the scope of this violence, the National Abortion Federation released an updated report on trends of clinic violence, documenting 3,991 cases of violence against clinics between 2010 and 2018. This included 3,038 cases of obstruction to clinics in 2018 alone (“2018 Violence and Disruption Statistics” 1). In New Jersey, the threat of harassment and violence against clinics was so significant that the state’s Address Confidentiality Program was expanded to include reproductive healthcare staff and their patients. This act prevents the addresses of providers and patients from being posted online and provides them with a public “substitute address” in order to prevent harassers and violent persons from finding people at their homes or jobs (NJ 47:4-4).

This all has had an impact on accessibility to abortion care. Deborah Ellis and Yolanda Wu, two attorneys on staff at the National Organization for Women, describe the effect that this has on patients seeking care, stating, “A significant barrier is pervasive anti-choice violence consisting of harassment, blockades, vandalism, arson, death threats and even murder... It is partly responsible for the fact that eighty-three percent of counties in the United States do not have an abortion provider” (Ellis & Wu 548). Despite the fact that New Jersey is one of the more friendly states in the nation towards abortion care, the state is not safe from these statistics. The number of abortion providers in New Jersey has decreased over the past few decades. In 1992, there were 88 abortion providers in New Jersey; in 2000 there were 86 (Finer & Henshaw 10). In 2017, that number dropped to 41, with about 1 out of every 4 New Jersey women living in a county with no abortion provider (Jones et al. 17). For women who may have to seek care outside of their county and might not have convenient modes of transportation, patients must take into account travel expenses, potential lost wages at work due to medical appointments, and the cost of the procedure itself (which may or may not be covered by insurance). Because of this, and historically hindered access to affordable, preventative reproductive healthcare services, low-income women and women of color are already left at extreme risk of not being able to access the procedure at all. Once they actually make it to the clinic, they are met with a level of harassment and violence unseen in any other area of medicine.

In response to this uptick in violence, Congress passed the Freedom of Access to Clinic Entrances (FACE) Act of 1994. The FACE Act states that no person may threaten or carry out the physical obstruction of or violence against clinics, clinic staff, and patients, and that no person may try to intimidate someone out of receiving reproductive healthcare services (“Freedom of Access to Clinic Entrances Act”). This was the beginning of governments

attempting to regulate protests activity near reproductive healthcare clinics to try and protect the right to access healthcare. Many states with clinics facing threats of violence have taken actions modeled by that of the FACE Act in order to further protect patients and staff. For onsite physical protection to keep providers and patients safe, some governments have looked to buffer zones.

### What Are Buffer Zones?

Buffer zones play a specific role in American society. Within the context of an abortion clinic, buffer zones are completely neutral, politics-free areas dedicated specifically to the safety of reproductive healthcare providers and patients, and the ability for patients to access healthcare. There are two types of buffer zones; “fixed zones” refer to unchanging and unmoving areas of protection in designated areas in which protesters cannot step foot. “Floating buffer zones” or “bubble zones” prevent protesters from coming within a certain distance of patients within a certain number of feet from the clinic.

These zones are often framed as a restriction of speech only for protesters, but buffer zones restrict all types of “political” speech, including speech that is pro-choice. This is crucial for the constitutionality of buffer zones; if only one perspective or argument is limited, then it is an unfair targeting and silencing of speech. Because clinic staff and volunteers must utilize the buffer zone to do their jobs, they are allowed to step inside the buffer zone as long as they refrain from any political or “convincing” speech. American governments have a substantial need to protect First Amendment rights, and so tailoring buffer zone ordinances can be tricky. An ordinance cannot completely restrict the speech of protesters, nor can it keep patients completely safe from harassment. Additionally, local governments must prove that their interest in

protecting women's access to healthcare is great enough to warrant limiting speech to certain areas in front of clinics.

Buffer zones are not just a legal issue; they are also a gender-based violence issue and a reproductive justice issue. When the environment outside of a reproductive healthcare clinic is so threatening that it not only can deter patients from seeking healthcare, but also result in actual bodily harm and death, reproductive healthcare is not accessible or safe to choose for all citizens. The right to not have a child is being directly limited through the actions of these protesters, in addition to having the right to a safe and healthy community to live in. By limiting how close protesters are allowed to get to clinics and the people trying to get inside of clinics, buffer zones can be helpful in removing some barriers to accessing healthcare.

#### Legal Precedent

Not surprisingly, efforts to control anti-choice protesters have been continuously met with legal battles. In 1994, a Florida court had blocked anti-choice protesters from getting within 36 feet of a clinic entrance, enforced a noise ordinance outside the clinic for their hours of operation, and even went as far as to ban protesters from getting within 300 feet of clinic employees' homes (Bencivenga 696). This 300-foot "no approach zone" also applied to the front of the clinic to prevent protesters from harassing patients near the entrance, in addition to preventing protesters from displaying certain images on protest signs within that distance. This gave the clinic both a fixed and a floating buffer zone. The very fact that a law was introduced to prevent protesters from getting near the private homes of reproductive healthcare providers signals that this population of protesters is especially dangerous and committed to their cause in a way unseen in most other areas of society. However, the amount of danger conveyed by abortion providers was not enough to convince higher courts to rule completely in their favor. In

the resulting court case *Madsen v. Women's Health Center, Inc.*, the 36-foot buffer zone and the noise ordinance were upheld, but the 300-foot “no approach zone” was deemed to restrict more free speech than was necessary to protect workers and patients. The prohibition of certain kinds of images used by protesters in front of clinics was deemed unconstitutional as well (*Madsen v. Women's Health Center, Inc.*).

Another case just three years later resulted in a similar conditional upholding of an abortion clinic's buffer zone, with *Schenck v. Pro-Choice Network of Western New York* making its way up to the Supreme Court. District Judge Araca implemented a temporary restraining order (TRO) that prevented protesters from getting within fifteen feet of Pro-Choice Network, a reproductive healthcare clinic that provides abortion. The TRO also enacted a fifteen-foot floating buffer zone for patients attempting to access or leave the clinic, and also mandated that protesters immediately break contact with patients who requested not to be approached or talked to (a “cease and desist” order). This was challenged by Paul Schenck, an active anti-choice Catholic priest, on the basis of his freedom to speech and religion.

The defendants detailed why the buffer zones were necessary. Ellis and Wu quote the case and comment, “‘Demonstrators frequently and routinely congregated in or near the driveway entrances... yelled at patients, patient escorts and medical staff... crowded around people trying to enter the facilities in an intimidating and obstructive manner’... The court stated that the harassment and intimidation caused stress and sometimes physical injury to patients and staff” (Ellis & Wu 554). It is for this reason that buffer zones are necessary to mitigate the violent and confusing climate created outside of clinics. Though buffer zones don't necessarily prevent this hostile environment from occurring, they at least reduce the impact proportional to the distance that protesters cannot get within. Additionally, while speech is protected under the

United States Constitution, harassment and assault are both considered crimes. Ellis and Wu continue to describe the effect on patient safety, “The protestors’ conduct sometimes so intimidated and confused patients that they could not enter the clinic, thereby suffering a delay in obtaining medical care. Even if the patients were able to survive the gauntlet, they ‘usually entered the medical facilities visibly shaken and severely distressed’” (554). By creating a barrier to access healthcare, these protesters are impeding the ability for patients to access the full extent of their human rights. Delays in healthcare, especially in abortion care, make accessing the procedure even more difficult, and these protests are common experiences that happen every week in varying degrees for clinics across the country. Sufficient delays, especially for low-income women, can mean an increased likelihood of these services becoming completely inaccessible. By not regulating the extent to which protesters can harass and threaten patients, the state is inherently participating in a barrier to accessing healthcare. Even for patients that were able to get inside, anti-choice protests are so aggressive and extreme that it visibly affects patients who are solely attempting to access healthcare. This is not consistent with the standard of human rights that the international community asserts are necessary for citizens. The examples of violence in front of Pro-Choice Network was enough to find the fixed fifteen-foot buffer zone constitutional, but the floating buffer zone and the “cease and desist” order were lifted and deemed to be an unjust infringement upon freedom of speech.

In 2000, a rare legal win for reproductive rights was claimed through *Hill v. Colorado*. The state of Colorado passed a 100-foot fixed buffer zone around healthcare facilities, and an eight-foot floating buffer zone for patients and providers within the fixed zone. The key language used in this legislation was that it did not restrict all speech within these zones – it prohibited protesting and leafleting in these zones without the consent of the person being

approached. The legislation also did not prohibit specific kinds of speech or viewpoints and was truly content neutral, in that, “the statute applies equally to used car salesmen, animal rights activists, fundraisers, environmentalists, and missionaries. Each can attempt to educate unwilling listeners on any subject, but without consent may not approach within eight feet to do so” (*Hill v. Colorado* 18). This law covered all possible bases. The speech of protesters was not so restricted that they could not deliver their chosen message, it was just restricted to use towards people who did not wish to engage with it. It was narrowly tailored and specifically placed restrictions on harassment of healthcare providers and patients, and there was a demonstrated need and government interest to protect the rights to access healthcare. Because of all of these factors, the Court determined that no more speech than necessary was restricted to ensure the safety and wellbeing of patients. Both the fixed and floating buffer zones were upheld.

In contrast, *McCullen v. Coakley* made national news when it struck down a Massachusetts buffer zone which barred protesters from stepping within 35 feet of a reproductive healthcare clinic. The foundation of this case began in 2000 when Massachusetts passed the Reproductive Health Care Facilities Act, establishing an 18-foot fixed buffer zone and a 6-foot floating buffer zone in front of all reproductive healthcare clinics in the state (“Reproductive Health Care Facilities Act”). This buffer zone was later struck down by Judge Edward Harrington, who displayed clear bias in his ruling. Harrington describes what he considered a double standard in buffer zone legislation, pointing out that anti-choice protesters cannot enter buffer zones, but clinic escorts can roam freely. Harrington comments on his decision, “Pro-life advocates must be given as equal an opportunity as their opponents to express to those seeking an abortion their sincere message of respect for the sanctity of innocent human life” (*McGuire v. Reilly* 6). Harrington’s perspective here is flawed, and it resulted in the loss of protection for

patients trying to access care. The goal for clinic staff and volunteers isn't to persuade women to receive abortion care, it is to help get patients to the entrance of a clinic for a medical procedure that they had already chosen for themselves. Protesters, on the other hand, have a specific mission to convince women against receiving abortion care, either through "sidewalk counseling," intimidation, harassment, and all but physically obstructing the clinic entrance. Yet, for a period of time, an American law that impacted mostly women of color was enacted by a man who had already betrayed his bias towards reproductive healthcare. Somehow, this situation was viewed as more constitutional and just by the American legal system than a buffer zone enacted to protect patients from harassment and violence.

In 2001 this ruling was reversed, and the buffer zone was reinstated. Then, in 2007, Attorney General Martha Coakley successfully argued for the buffer zone to be expanded from 18 feet to 35 feet. As was to be expected, the law was again challenged on the basis of infringing upon the First Amendment rights of religious protesters. Eleanor McCullen, a self-described "sidewalk counselor" sued Attorney General Coakley in order to try and get the Reproductive Health Care Facilities Act removed. After months of hearing arguments, a unanimous decision was made to strike down the buffer zone on the basis of restricting more free speech than necessary to protect patients. In comments on the Court's decision, Justice Alito echoed the sentiments that Judge Harrington had expressed over a decade prior towards a perceived double standard towards clinic escorts. He says, "It is clear on the face of the Massachusetts law that it discriminates based on viewpoint. Speech in favor of the clinic and its work by employees and agents is permitted; speech criticizing the clinic and its work is a crime. This is blatant viewpoint discrimination" (*McCullen v. Coakley* 2). By once again ignoring the actual purpose of the buffer zone, in that it is a protection to help patients access a procedure that they have already chosen,

the state fails to remove significant barriers that affect the ability to access healthcare. In doing so, the state fails to fulfill the full spectrum of human rights for its citizens in defense of the idea that freedom of speech should supersede the safety of patients. Though this didn't outright overturn the decision in *Hill*, the outcome of this case made it more difficult for other buffer zones to be enacted and upheld. Lucinda Finley, an attorney specializing in reproductive rights and women and law, commented on the case in the *National Law Journal*. She says, "The elevation of a protestor's right to her most preferred and effective means of targeting individuals for unwanted harangues over an individuals' right to be left alone or the public's interest in the most effective means of protecting public safety should concern us all, no matter what one's personal views on abortion" (Finley). Regardless of one's political or ideological stance on reproductive healthcare, the ability to access it is a human right and the safety of patients is viewed under a pattern of disregard. Even with the number of documented instances of violence and harassment that clinics face every day, it still wasn't enough to convince the Court to protect patients.

Lastly, the city of Pittsburgh, Pennsylvania enacted a 15-foot buffer zone outside of a Planned Parenthood clinic in response to protesters. As expected, anti-choice protesters sued the city to get the buffer zone removed. Building upon precedent set by *McCullen*, the court found that, "the city cannot burden [speech] without first trying, or at least demonstrating that it has seriously considered, substantially less restrictive alternative that would achieve its legitimate, substantial, and content-neutral interests" (*Bruni v. City of Pittsburgh* 4). This set specific boundaries for the legality of buffer zones. If cities can prove that enacting a buffer zone is their last-resort measure, and that the buffer zone prevents all political speech and not just certain viewpoints, then that buffer zone will be deemed as constitutional. The outcomes of these cases

have had far-reaching effects for clinics trying to instate (and keep) a buffer zone across the country, including for New Jersey.

### Turco v. City of Englewood

Englewood, a New Jersey suburb of New York City, is home to a majority of residents who are people of color and has a higher percentage of residents living in poverty than the statewide average (“U.S. Census Bureau...”). Englewood is also home to the state’s only buffer zone. The buffer zone is in front of Metropolitan Medical Associates, a reproductive healthcare clinic providing abortion care up to 24 weeks and referrals for other needed healthcare services (Metropolitan Medical Associates).

The need for a buffer zone in front of the clinic was apparent. Concentrated on each Saturday morning, the clinic experienced a range of anti-choice protesters. Some prayed silently near the clinic. Others described themselves as “sidewalk counselors” and handed out pamphlets for Our Gift of Hope, the CPC strategically stationed across the street. Most worrisome were the abortion abolitionists from an organization called the Bread of Life, an anti-choice movement of protesters that relies on fear and intimidation in order to prevent patients from seeking abortion care. Their tactics included crowding near the clinic entrance and shouting at patients, preaching about abortion using microphones near the clinic entrance, and holding up large, graphic images depicting abortion remains. The protests created such a climate of chaos for the clinic that volunteer teams of clinic escorts were assembled to help get patients safely inside (Crockett).

It is known that low-income women of color are disproportionately likely to need access to affordable reproductive healthcare services (Haider et al. 96) and experience more unplanned pregnancies due to these disparities (Kim et al. 427), which is why being able to access the care provided by Metropolitan Medical Associates is so crucial. In response to escalating protests and

harassment, the city of Englewood proposed an amendment to City Code § 307-3. Code § 307-3 originally restricted protesters from standing outside of clinics to obstruct or block the doorway, in accordance with the FACE Act, and was established in 1990 as a response to initial protests in front of the clinic. The amendment Ordinance #14-11, which the city council voted unanimously in favor of in March of 2014, established an eight-foot buffer zone in front of healthcare clinics in Englewood to prevent protesters from stepping within this boundary during business hours. The amendment also specifically allows clinic patients, staff, and volunteers to enter the buffer zone in order to do their jobs or receive care, as long as they refrain from politically charged language (Englewood § 307-3, 2014). In 2015, self-described sidewalk counselor Jeryl Turco sued the city in claims that her First Amendment rights to approach patients had been violated by this ordinance.

The lawsuit against the city acknowledged the hostile and violent behavior committed by anti-choice protesters in front of Metropolitan Medical Associates. However, Turco's methods to approach patients were described as more peaceful, and thus required close contact with clinic patients in order to hand them pamphlets, rosaries, and other materials to ask them to consider options other than abortion. In November of 2017, the court ruled in favor of Turco and found that the buffer zone was unconstitutional (*Turco v. City of Englewood*). The Court cited a number of reasons as to why this verdict was given. First, the Court ruled that the ordinance was overbroad. During the time that the buffer zone was in place, Turco was required to abide by the ordinance even though she did not display the same behaviors as the "militant, aggressive protesters" that created the need for the buffer zone in the first place. Additionally, going off of precedent set by *McCullen v. Coakley*, the Court asserted that the buffer zone was not narrowly tailored enough to stand through First Amendment scrutiny, as it was applied to all healthcare

clinics in Englewood and not just Metropolitan Medical Associates. Using precedent set by *Bruni*, the Court also found that less restrictive means were available instead of first enacting a buffer zone, such as enhancing police presence on Saturday mornings when protesters were present. This argument was found to be valid, even though Englewood testified that it did not have the resources to spare to place officers at that location each week. The Court then asserted the right to freedom of assembly and the New Jersey Constitution's protections to freedom of speech as worthy of the highest legal protection. It is worth noting that just two months prior to the buffer zone being struck down, Metropolitan Medical Associates received a bomb threat (DeMarco 2017).

Just days after the court's decision, the mayor of Englewood asserted that the ruling violates the rights of women and urged fellow councilmembers to consider appealing the case ("City Council Meeting Minutes" 8). The decision was made to appeal, and the case was taken to the U.S. Third Circuit. Whereas the previous case focused more so on Turco's peaceful actions that were being stifled, the Third Circuit highlighted the real dangers posed by the Bread of Life protesters and why the buffer zone was critically important in protecting access to reproductive healthcare. The court opinion pointed out that, "Bread of Life had ties to other radical antiabortion organizations including those which support violent reprisal against abortion providers" (*Turco v. Englewood* 3) and described their protest tactics as "extremely aggressive, loud, intimidating, and harassing" (3). Defense for Englewood also argued that less restrictive measures didn't have a significant effect on protesters, with police presence "temporarily easing tensions" (5) and aggressive protesting immediately resuming after police left. Ironically, the Third Circuit also referred back to precedent set by *McCullen v. Coakley*, in that the fixed buffer zone was upheld due to McCullen's ability to engage protesters from outside of the buffer zone.

Applying this principle to Englewood, an eight-foot buffer zone was not sufficiently large enough to reasonably prevent Turco from engaging with patients outside of that zone. The Court reasserted the government's interest in protecting the safety of patients, and the fact that the precedent set by *Hill v. Colorado* explains that, "protection afforded to offensive messages does not always embrace offensive speech that is so intrusive that the unwilling audience cannot avoid it" (*Turco v. Englewood* 15). Because anti-choice protesters crowd together at the entrance of the clinic, shout at patients, use microphones to give their message, and carry huge graphic signs, it is virtually impossible for patients and staff to avoid their behavior. This has a direct impact on the ability to access reproductive healthcare, which is a human right, and the Third Circuit reversed the District Court's opinion to reinstate the eight-foot buffer zone. Although this was a unilateral win for reproductive rights and for Metropolitan Medical Associates, the question remains if eight feet is a sufficient amount of distance to protect access to reproductive healthcare.

### Legal Double Standards

Abortion clinics are not the only places where buffer zones have been enacted. Other situations which have required buffer zone ordinances have been at political polling places and pro-labor demonstrations. These buffer zones have been enacted for the same reason as reproductive healthcare clinic buffer zones – to protect the targets of these protests from potentially dangerous situations. In *Milk Wagon Drivers Union of Chicago, Local 753 v. Meadowmoor Dairies*, labor union protesters began to frequently escalate their protests to threats and violence. The Court responded by preventing, "picketing near stores where the companies' products were sold...the Court explained that the state has the power and perhaps even the duty to 'protect its storekeepers' from violence and coercion" (Nasrallah 866). This 1940 case argued

that if the threat of violence is severe enough, that the state has the right to infringe on speech in the interest of public safety. Aside from the FACE Act, which prevents only the obstruction of clinic entrances in America, no such laws prevent aggressive protesters from demonstrating very near to reproductive healthcare clinics.

In 1991, *Burson v. Freeman* was brought to Court to challenge the legality of a 100-foot buffer zone in front of a political polling place. In an article in the Georgetown Law Journal discussing the case, Rachel Entman writes, “[T]he Court upheld a Tennessee statute that banned picketing within 100 feet of a polling place...The Court held that the statute was necessary to serve the State's purported interest in preventing voter intimidation and election fraud” (Entman 2583). *Burson v. Freeman* also relied on arguments that documented the violence of polling protesters to uphold the need for a buffer zone this large. This shows that if the safety and rights of a group of people is taken seriously enough, the speech of protesters in question can come secondary. This statute in Tennessee reflects voter protections in New Jersey. Different kinds of actions and speech are restricted 100 feet away from a voting booth, such as electioneering (NJ 19:34-15) and even wearing or giving out political materials such as buttons or badges (NJ 19:34-19). Doing so is worthy of a disorderly persons offense. Most relevant, New Jersey law states that a person is guilty of a third-degree crime if on Election Day, they, “tamper, deface or interfere with any polling booth or obstruct the entrance to any polling place, or obstruct or interfere with any voter, or loiter in or near the polling place, or, with the purpose to obstruct or interfere with any voter or to unduly delay other voters from voting” (NJ 19:34-6). If the human right to reproductive healthcare and bodily autonomy were taken as seriously by the government as the right to vote, buffer zones would be much easier to uphold and boast stronger protections. A 100-foot political buffer zone bears a stark difference to the smaller 18-foot and 36-foot buffer

zones that were deemed sufficient to protect patients from protesters in front of abortion clinics; never mind the eight-foot buffer zone granted to Englewood. Voter intimidation and preventing voter delay is seen as a reasonable government interest to protect the rights of voters, but accessing reproductive healthcare is not given the same benefit.

The much more recent and highly occurring acts of violence against reproductive healthcare clinics seem to be consistently ignored. Entman continues, stating, “Despite the recent history of extremely violent conduct by abortion opponents...the Court has allowed protesters as close as thirty-six feet to the abortion clinics. This difference in distances is disproportional to the overwhelming disparity in the statistics, which show much more recent violence at abortion clinics than polling places” (2588). If violence is the metric from which we are starting to justify a basis for a buffer zone, then abortion clinics should be a top priority. Isolated acts of violence were taken seriously enough for the government to take legal action and protect voters, even at the expense of restricting freedom of speech. Why is it that voters en masse are considered to be important enough to protect, but patients seeking abortion and other reproductive healthcare services are not? A clear disparity is at work here.

Exactly, then, why are patients seeking abortion, who are overwhelmingly women of color, disregarded when it comes to protecting them from violence and harassment at clinics? It is simple – women, especially women of color, are not people – at least according to American law. This is why applying Kimberlé Crenshaw’s theory of intersectionality is so important. Developed to discuss the ways in which Black women experience erasure in anti-discrimination law due to the combined impact of racism and sexism, Crenshaw exposed the weakness of the law’s protection against people it was never originally designed to protect – Black people and women. She writes:

By accepting the bounds of law and ordering their lives according to its categories and relations, people think that they are confirming reality - the way things must be. Yet by accepting the view of the world implicit in the law, people are also bound by its conceptual limitations. Thus conflict and antagonism are contained: the legitimacy of the entire order is never seriously questioned (1352).

Freedom for white men has been bound into the very fabric of American law in a way that never was for women or people of color. This is the groundwork from which all subsequent law was laid. The First Amendment was given as a constitutional right before women or people of color were granted full citizenship rights. As such, that freedom is viewed as paramount, especially when reflected against the safety and rights of people who were not initially viewed as human. Compounded by their race and gender, women of color are at serious risk. As seen with CPCs and their disproportionate targeting of young, low-income women of color, anti-choice protesters have the biggest impact on the same demographic that is most likely to need these services the most – young, low-income women of color. In both cases, government inaction is a highlight onto how laws do not prioritize the safety of these people. By continuing to uphold protections for protesters to harass patients and impede their access to care, even through repeated threats and acts of violence towards patients and clinics, states are building upon a legal foundation that was never meant to protect women of color. They are failing to question the “legitimacy of the order,” as Crenshaw writes, because this social hierarchy is applied through law as a given. By stating that an eight-foot buffer zone is first unconstitutional, and then that only eight feet are sufficient to protect patients, New Jersey is complicit in this pattern.

In the book *Gender and Political Theory*, Mary Hawkesworth explains this reality in the context of the state’s tolerance of violence against certain groups. She says, “States routinely claim that their first priority is to provide order—to protect and secure the lives and livelihoods of their citizens...women, people of color, ethnic minorities, and LGBTQ citizens are routinely insecure in ways that privileged male citizens are not” (Hawkesworth 153). Applying an

intersectional framework here, it is easy to see why states have not succeeded at protecting patients from clinic violence. If the state's responsibility is to protect order, then one of their first steps should be to take action to reduce the utter disorder and chaos that occurs outside of abortion clinics. Instead, this chaos is taken as a fair sacrifice to preserve the First Amendment for all citizens, even as polling places and labor protests are secured with large buffer zones often boasting far less violent environments. A violent ideological war is permissible, as long as it's fought on the bodies of women of color.

Hawkesworth takes this a step further and infers that a refusal to intervene in cases of violence is actually the state making a decision to condone this violence. She says, "[S]tates are involved through their incapacity or unwillingness to address violence against women and citizens whose lives are shrouded by precarity. Laws prohibiting gender- and race-based violence may be in place, but when they are not implemented, states afford impunity to the perpetrators of violence" (Hawkesworth 266). Of course, harassment and intimidation are illegal, and not protected under the First Amendment. But such is life outside of an abortion clinic. Madness ensues as business-as-usual for reproductive healthcare clinics, and patients who are mostly women of color are forced to endure a traumatic environment to access safe and legal medical care. For a clinic that has experienced repeated threats and aggressive harassment, New Jersey has settled for eight feet to be determined as significant enough to protect clinic patients and staff. If New Jersey is truly committed to the health and safety of all of its citizens, and to the equality of all citizens regardless of race, sex, and class, then it would elevate concern for the aggression and intimidation that takes place outside of Metropolitan Medical Associates every Saturday morning. By not doing so, they are inherently participating in these acts of harassment and violence.

### Recommendations for New Jersey

In order to fulfill the human rights standards of having full access to safe reproductive healthcare, New Jersey must reconsider its ties to allowing threats and violence to persist in the name of free speech. The U.S. Third Circuit stood with patients' human rights by allowing the Englewood buffer zone to be reinstated, but more must be done.

Not all reproductive health centers are necessarily in need of buffer zones. Many clinics have a substantial amount of private property where protesters are not allowed to step foot, leaving a safe pathway for healthcare providers and patients to get in and out of clinics. Thus, while protests may occur outside of these clinics, they do not pose the same dangers as the protesters in Englewood. Metropolitan Medical Associates has no parking lot and relies on street parking and drop-offs for patients to gain access, which is why their patients are especially vulnerable. For this reason, a statewide buffer zone as seen in Massachusetts and Colorado would be unnecessary and might be considered overbroad or burdening more speech than necessary.

However, there are lessons that can be taken from statewide legislation. Because there has been mixed success in upholding buffer zones, municipalities can write strong legislation that keeps parts of previous laws that have been deemed constitutional and throws out parts that have repeatedly failed legal challenges. Since Metropolitan Medical Associates has little private property outside of the building itself, it is difficult to expand the existing buffer zone to apply to public streets and sidewalks. The protected eight feet stretches from the clinic entrance to the curb of Engle Street; everything past that is public property and difficult to regulate acts of speech or assembly. With that said, as stated in *Hill*, speech does not necessarily have to be protected when it is so offensive and intrusive that one cannot escape from it. Here is where a

floating buffer zone could be introduced. Though floating buffer zones have been hard to uphold in court, *Hill* is an example of a constitutionally-sound floating buffer zone. *Hill* was also not overturned with the decision on *McCullen*. Protesters may engage with patients, but only if they first have consent. Otherwise, they must stay eight feet away from protesters. Given the harassing and unrelenting behavior of the Bread of Life protesters, and with how close they gather together near the buffer zone perimeter, this floating buffer zone would mean de facto that they cannot crowd as close as they do near the entrance. It would allow them to continue their protests, but only with consent or from a proper distance where patients would not have to feel as intimidated or fearful for just going to their doctor. This floating zone could be within 15 feet of the clinic entrance; still not a lot of free space for providers and patients, but would allow for much more dispersed protests rather than having patients and escorts fighting to get from the edge of the buffer zone to the clinic entrance. Additionally, since legal battles have both upheld and struck down buffer zones, it could be argued that having a smaller initial space for the floating buffer zone could mean that there is no more restriction of speech than necessary.

When these battles are brought to court, New Jersey needs to have more judges that value the lives and rights of women and women of color. In New Jersey, municipal judges are appointed by town councils, and New Jersey Supreme Court judges are appointed by the State Senate (“The New Jersey Courts”). Women make up only 35% of judges in New Jersey (“2019 US State Court Women Judges”). Only 31.6% judges are people of color, and women of color comprise even less at 15.8% (“Examining the Demographic Compositions...”). In 2019, women held 27% of city council seats (“2019 New Jersey County...”). Women also represent just 25% of the State Senate, 60% of whom are women of color (“Women in New Jersey Government”, 2020). America has seen what happens when judges do not value the lives of citizens equally and

have undone important legislation that disproportionately affects the lives of women of color. More diverse representation needs to be seen at all levels of government, and in seats of power in the courts. If this does not happen, New Jersey will continue to prioritize speech over immediate threats and bodily harm of citizens who are already at most risk.

### Conclusion

The First Amendment lays the foundation of American law and culture and is one of the most fiercely protected aspects of our Constitution. At the same time, governments also cannot allow violence against clinics and patients to go unchecked, as the right to life and liberty should also extend to abortion providers and patients. The right to vote without fear of harassment and intimidation is just as important as the right to access healthcare, including abortion. In that respect, voters and reproductive healthcare patients should be treated no different in terms of how well they are protected. Buffer zones, and adequate buffer zones at that, offer just one practical solution to this problem by minimizing the proximity to violence that patients have to experience. But at the end of the day, this violence against patients who are most often low-income women of color, and the state's refusal to ensure protections for them, stems from a basic devaluing of them as people. Once we address this fact, then New Jersey can move towards removing protections for harassment and intimidation, and begin to provide sufficient protections for the sake of safety and the human right to access reproductive healthcare.

## Chapter 4: Black Maternal Mortality

### Introduction

Reproductive healthcare does not just encompass family planning services such as contraception, STI testing, and abortion care; reproductive healthcare also includes health during reproduction for both mothers and infants. As the reproductive justice framework points out, there is also the right to have a child and the right to be able to parent that child in a safe and healthy environment (Ross & Solinger 9). Being that the health of mothers is crucial for the health of families and for the sustainable growth of populations, decreasing the maternal mortality ratio (deaths per 100,000 live births) has been a target for international communities to improve upon. The Cairo Programme of Action initially called for, “a rapid and substantial reduction in maternal morbidity and mortality and reduce the differences observed between developing and developed countries and within countries” (“Programme of Action...” 87). 25 years later, the ICPD Summit at Nairobi called for the more concrete goal of reducing maternal deaths to less than “70 per 100,000 live births by 2030” (“Sexual and Reproductive Health...” 7).

Globally, rates of maternal mortality have declined (WHO et al. 2019). In contrast, the maternal mortality ratio in the United States has consistently increased. While the United States’ mortality rate is below the target set by the ICPD+25, the steady increase in deaths is concerning. However, the bigger issue is made apparent when looking at racial disparities within the maternal mortality rate. Mothers of color are consistently dying at higher rates than White mothers across the United States, with Black mothers at especially high risk of maternal mortality. New Jersey mirrors both this rise in maternal mortality rate and racial disparities in deaths that are seen across the nation at alarming rates.

The ICPD+25 targets assert that there must be equity in access and quality of care regardless of one's ethnicity, income status, gender, or other demographics ("Sexual and Reproductive Health..." 11). Yet, the maternal mortality rate for Black mothers is consistently much higher than that of White mothers. While New Jersey meets the ICPD+25 SRHR target of a maternal mortality rate under 70, the state is not meeting standards to ensure equity in access and healthcare quality across race. Further, as the maternal mortality rate continues to increase, New Jersey risks the possibility of failing to meet the ICPD+25 target rate of less than 70 deaths per 100,000 live births. In order to fulfill the full extent of human rights as determined by ICPD+25, New Jersey must work to lower the maternal mortality rate by closing racial disparities.

#### Outlining the Problem

Maternal mortality is defined by the United Nations Children's Fund as "deaths due to complications from pregnancy or childbirth" ("Maternal Mortality"). Despite evidence that Americans are paying the highest healthcare costs in the world (Anderson et al. 87), mothers in the United States are at higher risk of dying from pregnancy-related causes and childbirth than in every other high-income country ("Pregnancy-Related Deaths"). The maternal mortality ratio in the United States has more than doubled between 1987 and 2016, with the latter year recording a maternal mortality ratio of 16.9 ("Pregnancy Mortality Surveillance System"). These numbers are compounded when race is analyzed. The CDC reports that Black mothers are 2.5 to 3.1 times more likely to die than White mothers across the United States (Hoyert & Miniño 1). If there was equity in access and quality of healthcare across the board, mothers of all races would have similar mortality rates. This is clearly not the case.

New Jersey is seeing especially serious data. Using the CDC WONDER Online Database, a hub for various public health data points for the United States, the United Health Foundation reports that the maternal mortality rate for the United States as a whole was 29.6 in 2018, while the maternal mortality rate for New Jersey was 46.4; leaving New Jersey ranking 47<sup>th</sup> in the nation for maternal death (“Health of Women and Children”). According to the New Jersey Department of Health’s latest report, racial disparities also exceed that of national statistics. Despite Black citizens making up only 15% of New Jersey’s population (“U.S. Census Bureau...”), Black mothers made up 46.2% of the state’s pregnancy-related deaths between 2009 and 2013 (“Trends in Statewide...”, ii). This means that Black mothers in New Jersey are dying at a rate 5 times higher than that of White mothers (17).

New Jersey’s Department of Health has only analyzed maternal mortality data up until 2013. However, the CDC WONDER Online Database is available for public use. The WONDER Online Database collects data on maternal deaths as well as live births and can delineate this data by race. By replicating the equation used by the Department of Health below, as recommended by the CDC (“Maternal Mortality Rate”), the maternal mortality rate can be calculated.

$$\frac{\text{Number of Resident Maternal Deaths}}{\text{Number of Resident Live Births}} \times 100,000 = \text{Maternal Mortality Rate}$$

Selecting to view “Birth” data from the state of New Jersey for the years 2014, 2015, 2016, 2017, and 2018 yields a total of 511,552 births (Figure 1).

Figure 1: Total births between 2014 and 2018 in New Jersey by race.

Mother's Single Race ↓	Births ↑↓
American Indian or Alaska Native	507
Asian	38,373
Black or African American	51,359
Native Hawaiian or Other Pacific Islander	444
White	210,396
More than one race	4,041
Not Available	206,432
<b>Total</b>	<b>511,552</b>

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2007-2018, on CDC WONDER Online Database, September 2019. Accessed at <http://wonder.cdc.gov/natality-current.html> on Sep 6, 2020 1:02:14 PM

In a search under “Detailed Mortality,” data from the state of New Jersey was selected for the years 2014, 2015, 2016, 2017, and 2018. Under ICD-10 Code for cause of death, code O00-O99 was selected to indicate “Pregnancy, childbirth, and the puerperium.” This yielded a total of 216 maternal deaths (Figure 2).

Figure 2: Total maternal deaths between 2014-2018 in New Jersey by race.

Race ↓	→ Deaths ↑↓	↔ Population ↑↓	← Crude Rate Per 100,000 ↑↓
Asian or Pacific Islander	10	4,577,272	Unreliable
Black or African American	87	6,991,327	1.2
White	119	32,868,297	0.4

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2018 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Sep 6, 2020 1:06:34 PM

Utilizing the maternal mortality rate equation, these numbers lead to:

$$\frac{216}{511,552} \times 100,000 = 42.2$$

This is relatively similar to the rate provided by *America's Health Rankings* using the same database. Though looking closer, the numbers become more alarming when race is a factor. Between 2014 and 2018, the maternal mortality rate for White women was 36.6  $[(77/210,396) * 100,000]$ , but the maternal mortality rate for Black women was 163.5  $[(84/51,359) * 100,000]$ . Not only does this replicate the statistic that Black mothers are still over four times more likely to die from pregnancy and childbirth in New Jersey, but it also means that New Jersey is actually not meeting its goal of a maternal mortality rate under 70 for Black women. In fact, it is surpassing it by more than double. For 2018, the most recent year that data is available, the WONDER database reports that its statistics are unreliable when separated by race. This is because there were 16 deaths of non-Hispanic Black women and 19 deaths of non-Hispanic White women, and the CDC states that any death counts under 20 have a standard error rate of 23% or more ("Underlying Causes of Death"). However, this data still indicates that Black mothers are overrepresented in maternal mortality data, given the racial makeup of New Jersey. The New Jersey Department of Health also states that while the maternal mortality rate is usually calculated over a given calendar year, only using data from one year is likely to lead to small and unreliable numbers; calculating over three or five years leads to "more reliable rates for analysis" ("Maternal Mortality Rate"). Worse, these statistics may be even higher as a 2005 study suggests that maternal mortality data is vastly underreported, leading to a minimalization of the problem (Horon 478). These numbers indicate that New Jersey is providing a high standard of maternal healthcare for non-Hispanic White women, but a standard comparable to that of developing countries for non-Hispanic Black women ("Country Comparison...").

Much of these deaths can be avoided. It is estimated that up to 63.2% of maternal deaths are preventable, "with 68.2% of cardiovascular and coronary deaths and 70.0% of hemorrhage

deaths estimated to be preventable” (“Building U.S. Capacity...” 22). While exact cause of death is not specified in the WONDER Database, the New Jersey Department of Health reports that the top 5 causes of pregnancy-related deaths in the state between 2009 and 2013 were cardiac, pregnancy-related cardiomyopathy, embolism, septic shock/sepsis, and cerebral hemorrhage, respectively (“Trends in Statewide...” 13). These causes are among the conditions that have been determined to be the most preventable of maternal deaths, suggesting that New Jersey’s high maternal mortality rate can be fixed. However, in order to significantly decrease New Jersey’s maternal mortality rate, the specific causes of maternal deaths for Black women must be identified.

#### Causes of Maternal Mortality

There is some debate on how best to reduce rates of maternal mortality since there are a wide range of causes of death. There is also evidence to suggest that non-Hispanic Black women have a broader range of causes of pregnancy-related deaths than non-Hispanic White women (“Building U.S. Capacity...” 17). Taking from the Department of Health’s report on maternal deaths between 2009 and 2013, “the most commonly reported labor and delivery factors were gynecological issues (e.g., fibroids, uterine atony, infertility), preeclampsia/eclampsia, and other labor and delivery factors (e.g., breech, cholecystitis, chorioamnionitis)” (“Trends in Statewide...” 10). These causes alone, though, do not explain the stark racial disparities in the mortality rate.

One factor that increases the risk of maternal mortality is the delivery method during childbirth. Cesarean sections have been associated with an increased risk for severe maternal morbidities and maternal mortality (Liu et al. 541; Deneux-Tharaux et al. 455). Maternal morbidity due to infection is also four times higher among mothers who have delivered via

cesarean section (Hebert 944). This higher risk has been identified in New Jersey, with the Department of Health stating, “The rate of cesarean deliveries is substantially higher for pregnancy-related maternal deaths than that of the general population of deliveries (50.8 percent vs. 37.7 percent) (“Trends in Statewide...” 8). New Jersey also performs cesarean sections at a rate 12% higher than the national average, and the percentage of live birth deliveries resulting in cesarean sections jumped from 22.7% in 1990 to 35.9% in 2017 (“New Jersey State Health...”). Evidence also suggests that Black women are more likely to undergo cesarean deliveries than White women (Washington et al. 128); one California study found that the rate for cesarean delivery was 32.7% for White women and 36.8% for Black women (Huesch & Doctor 956). Another study found that Black ethnicity and lower parity were both independently associated with a higher rate of cesarean delivery (Hebert 944). Using the WONDER Database to look at birth and cesarean rates in New Jersey for 2018 by race, these disparities are replicated. On average, non-Hispanic White women had a cesarean delivery rate of 30.98%, whereas the rate for non-Hispanic Black women was 37.05%.

Social determinants of health also play a role. Social determinants of health are defined by the World Health Organization as “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local level” (“Social Determinants of Health”). Some of these social determinants of health for Black mothers have found to include, “stress, environment, genetics, economic resources and socioeconomic status, health behavior, access to and availability of health care services, and quality of health care” (Hogan et al. 15).

There is also evidence that insurance status and quality of insurance plays a role in the quality of care that people of different races receive. Severe maternal morbidity resulting in

prolonged hospitalization or readmission has been shown to be higher among women enrolled in Medicaid (Hebert 946). According to WONDER data, White mothers on Medicaid accounted for 18.1% of White live births, while Black mothers on Medicaid accounted for 51.7% of Black live births in 2018. Mothers who are uninsured are more likely to also be low-income, and therefore more likely to enter their pregnancies with chronic conditions that come with increased risk. If they are eligible for Medicaid, they often face barriers in finding providers that accept Medicaid (Bingham et al. 190). It has also been found that private insurance has been associated with a higher quality of care when compared to Medicaid or those who are uninsured, and Black and Brown people are more likely to rely on either publicly-funded health insurance or to have no insurance at all (Smedley et al. 77). However, Smedley et al. also notes that when studies control for insurance, “race and ethnicity remain significant predictors of the quality of care” (78). This was replicated in the WONDER Database for New Jersey rates in 2018; the rate of cesarean delivery stayed higher for non-Hispanic Black women regardless of public or private insurance. In fact, the rate of cesarean delivery for White mothers on Medicaid was 27%, while the rate for Black mothers with private insurance was 43.9% (Figure 3, Figure 4, Table 2).

*Figure 3: Total births in 2018 for non-Hispanic White and non-Hispanic Black mothers by insurance.*

Mother's Single Race 15 ↓		Source of Payment for Delivery	Births ↑↓
White		Medicaid	8,275
		Private Insurance	35,568
		Self Pay	1,421
		Other	211
		Unknown or Not Stated	25
Black		Medicaid	7,180
		Private Insurance	5,420
		Self Pay	1,181
		Other	91
		Unknown or Not Stated	14

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2016-2018, on CDC WONDER Online Database, September 2019. Accessed at <http://wonder.cdc.gov/natality-expanded-current.html> on Jun 18, 2020 5:38:50 PM.

*Figure 4: Total cesarean sections in 2018 for non-Hispanic White and non-Hispanic Black mothers.*

Mother's Single Race 15 ↓	Source of Payment for Delivery	Births ↑↓
<b>White</b>	<b>Medicaid</b>	2,236
	<b>Private Insurance</b>	12,078
	<b>Self Pay</b>	425
	<b>Other</b>	70
<b>Black</b>	<b>Medicaid</b>	2,596
	<b>Private Insurance</b>	2,301
	<b>Self Pay</b>	391
	<b>Other</b>	32

Source: United States Department of Health and Human Services (US DHHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics, Natality public-use data 2016-2018, on CDC WONDER Online Database, September 2019. Accessed at <http://wonder.cdc.gov/natality-expanded-current.html> on Jun 18, 2020 5:38:50 PM.

*Table 2: Percentage of cesarean births for non-Hispanic White mothers and non-Hispanic Black mothers as based off of CDC WONDER Database information.*

Race	Insurance	Cesarean	All Births	% Cesarean
<b>White</b>	Medicaid	2236	8275	27.00%
	Private	12078	35568	33.90%
	Self-Pay	425	1421	29.90%
	Other	70	211	33.10%
	Unknown	N/A	25	30.98%
<b>Total Average</b>		14809	45500	30.98%
<b>Black</b>	Medicaid	2596	7180	36.10%
	Private	2301	5420	43.90%
	Self-Pay	391	1181	33.10%
	Other	32	91	35.10%
	Unknown	N/A	14	37.05%
<b>Total Average</b>		5320	13886	37.05%

Further, even when controlling for factors such as health insurance, education, and socioeconomic level, Black women still receive a lower quality of care and have poorer health outcomes (“Evidence of Trends...” 6; Smedley et al. 160). Studies have found that racial disparities in maternal mortality remain between Black and White mothers even after controlling for education and socioeconomic status (“Research Overview of...” 3). In New York City, Non-Hispanic Black mothers who graduated college had worse maternal health outcomes than mothers of other races who never graduated high school (“New York City Department...” 15). A 2018 study found that Black women who were not low-income still experienced worse health quality than White women with whom they shared the same socioeconomic status, with Black women experiencing chronic discrimination throughout their lives (Cohen et al. 167). The effect of race on birth outcomes are so pronounced above other factors that studies have found Black mothers with a high socioeconomic status experienced worse birth outcomes than White mothers with a low socioeconomic status (Kothari et al. 862). Each time, the common denominator in determining likelihood of maternal morbidity and mortality is Blackness.

If race is the common denominator in determining health outcomes, then racism is the function by which this plays out. This materializes in a number of ways, and one of these ways is implicit bias from healthcare providers. A literature review of fifteen studies of implicit bias among healthcare professionals found that fourteen out of the fifteen studies found “significant relationships between implicit bias scores and health care outcomes” (Hall et al. 71). This manifests in a variety of different experiences for Black people seeking healthcare. Rooted in beliefs about enslaved Africans having a higher pain tolerance than Whites, it was found that physicians with higher rates of implicit bias also were less likely to prescribe Black patients pain medication than they were for White patients (Sabin & Greenwald 896). Healthcare providers

with higher implicit bias scores were likely to recommend different treatment options based on race, such as being more likely to recommend thrombolysis to White patients than Black patients (Green et al. 1231). Hall et al. summarizes the experiences of Black and Brown patients with biased healthcare providers, stating, “Dominant communication styles, fewer demonstrated positive emotions, infrequent requests for input about treatment decisions, and less patient-centered care seem to characterize patient-provider interactions involving people of color” (Hall et al. 61). Less collaborative, more authoritarian, and an overall negative experience was associated with healthcare providers who hold racist biases towards their patients. These interactions have an effect on the quality of care and health outcomes, especially for Black women. In a study of women of color’s experiences with pregnancy-related healthcare, patients reported disrespect, stressful interactions, inconsistent social support, and unmet information needs from their healthcare providers – much of which was attributed to race (McLemore et al. 129-131). As this literature search shows, it is more likely than not for a Black patient to seek care from a provider that holds these beliefs, leading to the high likelihood of Black mothers experiencing racism (and in turn, poor health outcomes) at multiple points in their lives.

Additionally, the amount of time spent between patients and providers can have negative health outcomes that are compounded by race. It is suggested that appointments that lasted eighteen minutes or longer were ideal in order to allow for the healthcare provider to give substantial information to the patient, patient participation, and preventative health (King 36). Yet, physicians in America are consistently on strict time schedules, spend less than eighteen minutes with their patients per appointment, and spend only 5 minutes discussing major health topics with their patients on average (Tai-Seale et al. 1879). This can exacerbate the already present implicit biases that healthcare providers have, leading to worse health outcomes for

Black mothers. Smedley et al. notes that, “the time-pressed clinician uses available information and past experience about patient characteristics such as race and social class to arrive at a clinical hypothesis. Unfortunately, this practice may lead to systematic over- or under-diagnosis of certain illnesses among certain populations” (Smedley et al. 610). This is just another way in which the current healthcare system specifically impacts Black mothers. Relying on untrue and racist biases to inform decisions about Black patients is a contributing factor to the negative, and often deadly, health outcomes for Black mothers.

By using stereotypes to make medical decisions and treatment options, physicians are creating barriers to good health for their Black patients. Silliman et al. explains just how these biases affect communities of color, stating, “Stereotypes and a lack of accurate knowledge about communities are barriers to interpreting women’s needs. They are also obstacles which prevent women who need information and care from getting it” (Silliman et al. 6). Physicians and medical school faculty, who are overwhelmingly White and male in America (“Diversity in Medicine...”), do not necessarily have the necessary social context that would assist in providing more effective healthcare information and options. They may not listen to Black mothers when a concern is expressed, or prescribe the correct medication, or diagnose the correct disease based on incorrect, preconceived notions they have on their patients. It is an effect of both the constraints of the American healthcare system and of implicit bias in providers that Black mothers are left with less information, less positive relationships with their providers, and worse birth outcomes than any other race.

Worse still, the effects of racism itself have a negative effect on the health of Black mothers. Evidence suggests that the chronic stress of worrying about racial discrimination may be an active contributor in Black maternal health outcomes (Braveman et al. 10). In turn, this

stress may have effects on Black mothers' health at the cellular level. The connection between chronic stress and negative health outcomes, "is significantly associated with higher oxidative stress, lower telomerase activity, and shorter telomere length" (Epel et al. 17315), leading to premature aging, increased rates of certain diseases, and premature death (17315). This stress is not always just racial; by the nature in which Black women's oppression exists in America, stress also comes from a gendered perspective. This racialized, gendered discrimination specifically has links to negative birth outcomes and depression for well-educated Black women (Fleda et al. 330). There is also evidence that this stress during pregnancy can lead to negative birth outcomes not just for mothers, but for infants as well (Send et al. 2407). When Black mothers say that racism and sexism are affecting their health quality, it is not just a mental health stress. At a biological level, this lifelong discrimination is having a measured effect on the health quality of Black mothers.

While implicit bias in healthcare providers plays a main role in maternal health outcomes, the racist and oppressive history of reproductive control over Black women must also be acknowledged. Dorothy Roberts discusses this history, beginning with slaveowners forcing enslaved African women to give birth through sexual assault to provide more enslaved people for labor. She writes, "This feature of slavery made control of reproduction a central aspect of whites' subjugation of African people in America. It marked Black women from the beginning as objects whose decisions about reproduction should be subject to social regulation rather than to their own will" (Roberts 23). Enslaved African women were denied the most basic forms of bodily autonomy and human rights that inform the perspectives of reproductive justice – the right to have children, the right to not have children, and the right to parent those children in safe environments. However, sexual and reproductive control was not just limited to forced

procreation for economic gain. Dr. Marion Sims, often given the title “Father of Modern Gynecology,” began to document “medical research” on the bodies of enslaved Black women who we only know as Anarcha, Betsy, and Lucy. By the very nature of this racial, gendered, and legal power dynamic, Anarcha, Betsy, and Lucy were unable to consent to these procedures, and thus endured enormous physical and sexual trauma under Dr. Sims. He often performed invasive surgeries without anesthesia, operating under the racist belief that slaves’ pain tolerance was high enough for it to not be necessary (Wall 347). Author and scholar Imani Perry writes, “Actions such as Sims’s set the terms of recognition in the hands of those who possessed and acquired accepted forms of knowledge and excluded the subjects of study, the objects of violently produced knowledge” (Perry 55). Dr. Sims has received generations of praise for his work on being the first doctor to surgically repair vesicovaginal fistulas, while only just in 2017 did historians begin to acknowledge the violent practices by which he performed these medical breakthroughs (Vernon 436). The bodies and lives of enslaved Black people were so devalued that not only was their pain and suffering not taken into consideration, but almost erased from history entirely as a minor consequence of advancements in science and medicine.

This began a centuries-long practice of White doctors in America operating on and forcing procedures onto nonconsenting Black women for the supposed benefit of society at large. In 1907, the first sterilization law was passed in Indiana and continued until as recently as the 1970’s. These laws, aimed disproportionately towards Black and Hispanic women, were passed under the guise of a care for the “common good.” Professor Alexandra Stern writes, “California defined sterilization not as a punishment but as a prophylactic measure that could simultaneously defend the public health, preserve precious fiscal resources, and mitigate the menace of the ‘unfit’ and ‘feeble-minded’” (Stern 1130). Bearing a striking resemblance to early sentiments of

population control in early international population and development conferences, forced sterilizations were seen as an easy way for legislators to curb population growth that they felt undesirable. Once again, the bodies of Black women were taken as collateral for the interests of White populations.

This history affects how many Black people of childbearing age view reproductive healthcare, and in turn, their health beliefs and behaviors towards birth control. One study found that a third of Black respondents felt that the government uses low-income and ethnic minorities as “guinea pigs” for new birth control methods, and only half of Black respondents said that they believed the government “tells the truth about the safety and side effects of new birth control methods” (Thorburn & Bogart 480). In turn, Black women who had higher scores for distrust also were more likely to pick birth control methods that did not involve the participation of a healthcare provider, which may lead to less effective birth control methods (483). While this study has important implications for the effects of deep-rooted racism and disregard for Black lives, the very nature of the study is dismissive towards these very real concerns of the Black community. Though the introduction briefly examines the history of reproductive coercion and control on Black communities, the study itself is titled “Conspiracy Beliefs About Birth Control.” The word “conspiracy” itself has negative connotations, and can be seen as, “an act of rhetorical violence, a way of dismissing reasonable suspicion as irrational paranoia” (Wood 695). Black communities know all too well that governments have a history of working with the medical community in ways that cause harm. There are hundreds of years of evidence to prove it. By painting these beliefs about malicious government action as conspiracy, the authors of this study undermine the very community they claim to assist; ironically, they are reproducing the pattern of advancing scientific discovery at the expense of Black people. This is why a

reproductive justice framework is critical when discussing reproductive healthcare and Black women. It isn't enough to just advocate for the legality of abortion and birth control. Advocacy for true reproductive choice and freedom must also be included, especially when considering the right to consent and to have children. Perspectives from Black people and Black women must be taken seriously, and not met with dismissive attitudes.

It is also worth noting that it is not specifically African genetics or a factor inherently related to the Black race that determines health outcomes. Rather, it has something to do with the experience of racism in America. In a Black Paper by the Black Mamas Matter Alliance discussing the crisis of Black maternal mortality, it is affirmed that, "African immigrant women have healthier birth outcomes upon arrival in the United States than their Black counterparts, but mirror Black rates of adverse birth outcomes over time (Muse et al. 4). If Black women are having worse outcomes only after experiencing life in America, then it is not Blackness itself that is the problem. Between the already-existing impacts of access to quality healthcare and insurance, the implicit bias of providers, the history of reproductive coercion on Black communities, and cellular evidence of the negative effects of racism, it is no wonder why Black mothers have such high rates of maternal mortality.

#### What Has New Jersey Done?

Credit should be given where credit is due. When Phil Murphy won his election for governor in 2017, First Lady Tammy Murphy pledged to use her platform and proximity to government to end racial disparities in the maternal mortality rate. In 2018, she launched the Healthy Women, Healthy Families initiative through the Department of Health, aimed specifically at reducing racial disparities and improving birth outcomes across the state. The initiative granted \$4.3 million in funds to activities at both the county and municipal levels.

Funds were directed to counties focused on connecting high-risk families and women of child-bearing age with, “access to information and referrals to community services that provide child and family wellness” (Elnahal). The focus on at-risk families and women included those suffering from addiction or other mental health disorders, low-income and uninsured women, victims of domestic abuse; funds directed to municipalities focused on connecting Black women of child-bearing age to community supports, “implementing specific black infant mortality programs, and providing education and outreach to health providers, social service providers and other community level stakeholders” (Elnahal). Through these measures, agencies already working in the communities which are at most need would be the ones increasing access and providing necessary information and resources. In this way, the money would be spent on workers who are familiar with each community’s individual issues and gaps in care, and who have the social contexts to best provide to mothers already at risk.

Alongside these initial grants, added funds were allocated to doula pilot programs in Trenton and Newark, which are areas with some of the highest risk. This was an important step forward; holistic practices such as midwifery and doula care, “are resources that have traditionally been important in communities of color” (Muse et al. 22). Funds were also directed to create an evaluation program to measure the effectiveness of these doula pilot programs over time (Elnahal). In company with these practices having cultural significance to Black women, doula care is also associated with healthier birth outcomes and less likelihood of complications (Gruber et al. 54). This was important because it provided access to culturally significant resources with a proven record of better medical outcomes. With the evaluation program, there is accountability for the state to provide these resources in an effective manner, and additional

doula programs could be implemented in other parts of New Jersey once best practices are measured.

Another initiative from the Department of Health was the “My Life, My Plan” program. “My Life, My Plan” was passed in 2019 with A4938/S3376 in accordance with other states that have implemented the program, such as Maryland and Delaware. The program is an educational initiative to improve education and access to resources in creating a lifelong reproductive health plan. Instead of focusing on health only during a pregnancy, it instead places an emphasis on preconception health. It is focused on women of childbearing age, but specifically targeted to teenagers. The legislation states that the program must provide information on topics like consent and healthy dating, contraceptive options, financial health, and childcare options, among other relevant issues (“New Jersey State...”). Evidence shows that better preconception health has a correlation to healthier pregnancies and birth outcomes, and that, “a reproductive life plan is an effective communication tool with patients” (Mittal 29). While “My Life, My Plan” is not specifically targeted to women of color, it is a tool that will assist New Jersey’s youth in making healthier long-term decisions. Though the legislation was enacted in June of 2019, it has yet to be implemented by the Department of Health.

In 2019, First Lady Tammy Murphy continued her push to reduce racial disparities in maternal mortality with the Nurture NJ campaign. Nurture NJ was a statewide awareness campaign to address racial disparities in maternal and infant health. Unlike the Healthy Women, Healthy Families initiative directed just towards the Department of Health, Nurture NJ encouraged more intergovernmental collaboration on the issue with the Department of Human Services and the Department of Children and Families. It also created an annual Black Maternal

and Infant Health Leadership Summit to further identify state-specific initiatives that can be utilized to address the crisis (“First Lady Tammy...”).

In May of 2019, Tammy Murphy announced that, through the Nurture NJ initiative, a package of bills was signed into law which address Black maternal mortality. A4932/S3365 was passed to establish a care learning network, with the long-term goal of developing a three-year perinatal care pilot program for Medicaid (P.L.2019, c.86). The hope is that this pilot program will lead to both improved birth outcomes for mothers and infants, in addition to lower costs for care. With that, A4933/S3406 was passed to codify practices for Medicaid healthcare providers to complete a Perinatal Risk Assessment form for pregnant Medicaid recipients and immigrant ineligible for Medicaid who receive prenatal care (P.L.2019, c.88). A4935/S3378 was also passed to prevent Medicaid coverage for elective, high-risk birthing procedures such as an elective “cesarean section for purposes or reasons that are not fully consistent with established standards of clinical care as provided by the American College of Obstetricians and Gynecologists” (P.L.2019, c.87). This would prevent unnecessary procedures from being carried out on low-income mothers that lead to worse birth outcomes. Of particular significance, A1662/S1784 was passed to add \$1 million in the state budget to allow New Jersey’s Medicaid program to cover doula care (P.L.1968, c.413), making it more accessible to low-income mothers who might not otherwise be able to receive doula care. Through this package, New Jersey made legitimate strides to close racial gaps in the state’s maternal mortality rate.

#### Recommendations for New Jersey

Although New Jersey has already begun to address this issue through passing meaningful legislation, more work is still needed to ensure that less Black mothers will die during childbirth. The very first recommendation in the Black Mamas Matter paper is that

fixing the problem of Black maternal mortality requires listening to Black women (Muse et al. 7). If the voices of those most impacted in this issue are not centered, then all solutions presented will inevitably be set up to fail. A1837/S1818, or the “Listening to Mothers Survey Act.” was introduced in January 2020 by Asw. Britnee Timberlake and Sen. Teresa Ruiz, two female Legislators of color, in addition to allies Asw. Pamela Lampitt and Asw. Valerie Huttel. If passed, this would require a voluntary survey to be given to all people who were pregnant at the end of that pregnancy, infertility services, or long-term contraception.

According to the bill, the survey is to include questions surrounding:

experiences with maternity care service providers and her perceptions of how she was received by practitioners, how well her questions and concerns were addressed, the responsiveness and availability of service providers, and whether she was offered information and services with regard to key health metrics related to maternity care (“Assembly, No. A1837”).

Since this survey would also include demographic information, this would allow policymakers to more accurately assess the problem from the voices of mothers themselves and identify disparities. Without knowing exactly what is happening to mothers while receiving medical care, the state cannot draw up effective solutions to fix the problem. The act would center the voices of Black mothers to guide further policy solutions to address Black maternal mortality. This is critical and must be passed.

Because race is a consistent factor in birth outcomes regardless of other demographic variables, and because discrimination in healthcare has been shown to be rampant, implicit bias in New Jersey’s healthcare system also must be addressed. A2327/S1662 was introduced in February 2020 to establish a task force on discrimination in health care. The task force would be charged with identifying the aspects of healthcare that are contributing to racial and class disparities, and providing the Legislature with policy recommendations moving forward (“Assembly, No. 2327”). In line with this, A1709/S703 has been sponsored solely by female

Legislators of color to implement implicit bias training in healthcare. Through this, hospitals and birthing centers providing maternity services would be required to complete this training every two years, which would cover subjects such as education of cultural context of communities of color, historic systemic oppression of communities of color, and training to identify and fix implicit biases “at the interpersonal and institutional levels” (“Senate, No. S703”). At the end of the day, healthcare providers are the ones administering care and are responsible for their own implicit biases and racism impacting their quality of care. Even if policy solutions are passed to level the playing field for Black mothers, racism in healthcare must be addressed in order to fix the problem. To see this reality, A1709/S703 must be passed.

One last measure that must be prioritized is passing A706/S1912. Introduced in January 2020, this bill would require New Jersey’s Department of Health to create statewide standards for hospitals providing maternity care. These standards would be informed by the Alliance for Innovation on Maternal Health or a similar program with best practices going off of national data (“Assembly, No. 706”). Currently, no such statewide standards are in place, and existing disparities in healthcare are made worse through hospitals with less resources providing a lower standard of care. Every New Jersey mother should receive the same standard of healthcare, and as such, A706/S1912 must be passed.

### Conclusion

As it currently stands, New Jersey is meeting ICPD standards for its maternal mortality rate as a whole but exceeding the ICPD target specifically for Black mothers. With the maternal mortality rate increasing each year, strong policies must be implemented now in order to meet those targets by the goal of 2030. If the state government is not successful, it will have been responsible for the preventable deaths of thousands of New Jerseyans, leaving a

disproportionately higher rate of Black families without a mother. This is unacceptable at all levels, especially because this state has the resources to do better.

With this said, New Jersey has already identified Black maternal mortality as an area that is in crisis. Steps are being taken in order to close these disparities at both the executive and legislative levels. However, racial disparities will persist so long as policy solutions are not centered around the voices of Black women and fail to address racism among healthcare providers. The proposed bills addressing these issues are currently sitting in committee and must be voted through both houses of the State Legislature before the end of 2021. If and when these bills are passed, grace periods are allotted between the day of passage and the day of implementation; policy solutions recommended by surveys will also take time to produce. The time has passed for New Jersey to act; the time is now. The longer these bills take to get passed, more Black mothers will die because of preventable maternal causes. And as long as this occurs, New Jersey cannot say that its Black residents are able to experience the full range of human rights that should be provided.

## Chapter 5: Gender-Based Violence

### Introduction

Gender-based violence takes many forms, such as sexual harassment, domestic violence, and sexual assault. Public awareness towards this issue has especially grown in the past decade. In 2015, the documentary *The Hunting Ground* catalyzed a wave of activism and resulting policies to address sexual assault on American college campuses (Coker 148). Two years later, the emergence of the #MeToo movement highlighted much of the harassment and sexual assault that women bear the brunt of, particularly in the workplace (Rihal 749). Obstetric violence, the act of medical practitioners coercing mothers into certain medical procedures or committing other acts of abuse during childbirth, has also been identified as a prolific problem in the United States (Diaz-Tello 59). However, one group that has received less focus, especially in New Jersey, is the issue of gender-based violence as it relates to both sex workers and survivors of human trafficking.

Human trafficking is the process of coercing someone into most often what is forced prostitution or forced labor. Victims of trafficking are subjected to extreme violence, isolation, and exploitation, oftentimes for years. On the other hand, voluntary sex workers are those who enter the field of sex work on their own accord. These people can self-employ, and have agency in choosing their pay, their clients, and the exact kind of sex work they engage in. While these sex workers are consenting actors in their chosen field, they are often still at extreme risk for exploitation and violence. These are two very different populations, yet lawmakers make the mistake of conflating the two when writing policy at the expense of both. Lawmakers also often disregard the unique impact that anti-trafficking legislation has on voluntary sex work.

Every person is deserving of the right to lead a life free of violence and exploitation. Without these most basic freedoms, self-determination and the true ability of a population to succeed en masse is unattainable. The international community recognizes these human rights and called for an end to human trafficking and gender-based violence at the first ICPD event in Cairo. Twenty-five years later, the ICPD Summit in Nairobi reaffirmed the need to end this violence and called for the elimination of all forms of violence against women and girls, including human trafficking.

New Jersey is paving the way for much of the nation's anti-sexual violence legislation. However, human trafficking, especially sex trafficking, remains a widespread and serious problem for the state. Sex work is currently illegal in New Jersey, often leading to the criminal justice system misconstruing voluntary sex workers with sex trafficking victims. This has negative consequences for not just trafficking victims in need of assistance, but also for sex workers experiencing violence left with little to no recourse for justice. In addition, because prosecution and criminal laws differ at the state and federal level, the state is not an effective administrator of justice. Prosecutors are more likely to punish sex workers and trafficking victims alike than they are to punish those responsible for the violence and exploitation of these people.

This creates a two-fold problem. New Jersey is not effective at assisting victims of some of the most heinous and violent crimes in the world, but also is complicit in violence against sex workers by criminalizing the very nature of their labor. While sex work is criminalized in this state, the most vulnerable residents suffer and are needlessly exposed to more violence. In order to reduce violence and grant the full extent of human rights to sex workers, sex work must be decriminalized. In addition, the state is not equipped for multiple reasons to prosecute cases of

human trafficking. Local and state-level law enforcement should cooperate with the federal government in identifying human trafficking victims and perpetrators, but prosecution should take place at the federal level.

### Human Trafficking in New Jersey

Though New Jersey has passed a number of progressive bills assisting survivors of sexual assault in recent years, such as expanding the civil statute of limitations for sexual assault and creating a bill of rights for survivors (“Current and Past...”), human trafficking remains a significant problem. In 2012, it was estimated that between 4,000 and 5,000 people are trafficked into New Jersey each year for sexual and labor exploitation, making up between 20% and 30% of the nation’s total victims of trafficking (Curva 568). In 2019, the National Human Trafficking Hotline website found that New Jersey was the 12<sup>th</sup> highest state for reported cases of human trafficking (“Hotline Statistics”). It is also important to remember that human trafficking is highly underreported. The violent and exploitative nature of human trafficking often prevents victims from feeling safe in coming forward, and perpetrators often plead guilty to lesser crimes to avoid the harsher sentences of a human trafficking conviction (McGough 31). Because of this, it is likely that the true numbers are much higher.

Victims usually represent the most marginalized and vulnerable of communities; underage, female, homeless, and previous experience with interpersonal violence constitute many of those who are coerced by traffickers and exploited for financial gain (“The Victims”). There are various factors that make New Jersey a hotspot for this type of crime; it is a densely populated state bordering other densely populated states, it serves as a transportation hub which aides in moving victims from place to place, and it is ethnically diverse which allows immigrant and undocumented victims to blend more easily (Overbaugh 639). Because of these factors,

traffickers can proliferate, while victims are well-hidden in the shadows and are kept secret from law enforcement.

In 2002, *United States v. Jimenez-Calderon* put New Jersey in the spotlight for human trafficking. The Jimenez-Calderon family was found guilty of smuggling underage girls from Mexico to Plainfield, New Jersey where they were beaten, isolated, and made to perform sex acts for up to fifteen hours a day (“DOJ Case Summary...”). The traffickers were highly organized, and targeted girls specifically who lived in poverty who were looking for better opportunities. The sentences for the five defendants ranged from 16 months to 210 months in prison. The case was a wakeup call to New Jersey residents and legislators who thought that such a crime couldn’t take place in their own backyard. Other prominent court cases occurring around the same time, such as *United States v. Tantirojanikitkan*, *United States v. Domingo Gonzalez-Garcia*, and *United States v. Trakhtenberg* all came from New Jersey, and solidified the state’s role as an ideal location for human trafficking.

To address this problem, New Jersey took legislative action three years later. A3352/S2239 was passed to allow victims who were charged with prostitution to claim that they were, in fact, victims of human trafficking as a legal defense. This was done in an effort to avoid prosecuting someone for actions that they had no control over and were actually the victims of (N.J. § 2C:34-1(e)). In addition, New Jersey created anti-trafficking legislation, modeled after federal legislation, making both “involuntary servitude” and “human trafficking” second-degree crimes at the state level (Curva 569). This legislation also set aside state funds for victims of human trafficking and gave protections to victims to ensure access to other forms of government aid and resources (N.J. 2C:13-8, 52:4B-11, 52:4B-44). In 2013, New Jersey passed the Human Trafficking Prevention, Protection, and Treatment Act. This act made it possible for victims of

sex trafficking to expunge wrongful convictions of prostitution due to victimization from their records (“Comprehensive Anti-Trafficking...”). The bill also implemented a Commission on Human Trafficking to assess human trafficking activity in New Jersey, review and improve support for victims, and analyze existing human trafficking legislation to make recommendations for change. These actions were designed to allow victims of human trafficking to seek justice and regain control of their lives. It was thought that cracking down on perpetrators at the state-level would curb instances of human trafficking and discourage traffickers from operating within these borders.

While these were effective illustrations of positive impact, New Jersey has done an extremely poor job of following up on these improvements to create real, tangible advancements for the rights and safety of human trafficking survivors. The Commission on Human Trafficking came out with an Annual Report in 2015 documenting the state of human trafficking in New Jersey. The report highlighted that the state had very few resources dedicated to prevention and victim-assistance aside from case management services (“2014 Annual Report” 11), that populations such as male and LGBTQ+ victims were especially underserved (11), and the need to place higher priority on prosecuting cases of human trafficking (13). Though this Annual Report was the first of its kind to come out of the New Jersey Legislature, it was also the last; no annual reports have since been created even though law requires it. According to its own Department of Treasury, it was also found that the fund which was set up by the Act to assist survivors had a balance of zero (Catalini). New Jersey has also failed to utilize its own anti-trafficking law and has an extremely poor rate of prosecuting human traffickers. When compared to the estimated rate of victims of human trafficking in the state, this suggests that “the majority of victims are not receiving help” (Curva 590).

The intentions of the New Jersey Legislature might be good, but good intentions do not always translate to good policy. To address these gaps, New Jersey can take a number of steps in improving its legislation and treatment of its most vulnerable people. In doing so, the state will move much closer in ensuring that all of its residents are given their full rights to live safe and healthy lives.

### Conflating Victims and Sex Workers

New Jersey has followed the American trend of either conflating women with criminal social burdens, or with victims that are inherently in need of assistance. This is a problem concerning the lack of equal economic opportunities for women and other gender minorities, and the assumptions that are placed on genders based on what they are each “supposed” to do and be. Because subjective and traditional gender norms are deeply entrenched in society, it is assumed that women who do not follow these roles are being victimized and must be assisted (and controlled) with government intervention. When applying this framework to anti-trafficking legislation, norms dealing with gender roles and sexuality have helped to create anti-trafficking legislation that inadvertently denies women the very agency it was meant to restore. It treats all sex workers either as an act of victimhood or an act of criminality and assumes that they are lacking true agency to make the decision to enter sex work to begin with.

These ideas first became incorporated into international legislation in the 1949 Convention on Suppression of all Forms of Trafficking in Persons and the Exploitation of the Prostitution of Others. The Global Network of Sex Work Projects (NSWP) outlines the effect this had on anti-trafficking legislation for years to come, “...Its purpose was to establish prostitution as a practice that is ‘incompatible with the dignity and worth of the human person.’” This endorsed an interpretation of prostitution as an inherent form of exploitation” (“Sex Work is

Not Trafficking” 2). This idea that sex workers are fundamentally denied of their own agency, regardless of whether or not they willingly entered this work, was validated by Article 6 of the Convention of the Elimination of All Forms of Discrimination Against Women, otherwise known as CEDAW. CEDAW, “reiterated the call to end exploitation of women by prostitution, again without defining exploitation” (2). The narrative that all female sex workers are victims actually just serves to deny the freedom of those very people to choose their own lifestyles, sex lives, and ways of making money. It takes away the agency of these people that it desires to give, and this has had impacts for efforts aimed at “helping women” through ending sex work.

This stigmatization of sex workers as solely victims of the patriarchy has only served to further confuse sex workers with trafficking victims. The Trafficking in Persons (TIP) Report is a prime example of this. The purpose of the report is for the United States to encourage foreign governments to take action towards human trafficking, and is the self-described “world’s most comprehensive resource of governmental anti-trafficking efforts and reflects the U.S.

Government’s commitment to global leadership on this key human rights and law enforcement issue” (“2018 Trafficking in Persons Report”). Yet, the Report fails to address voluntary sex work, and has active consequences for sex workers in the name of anti-trafficking measures. In a policy brief, NSWP explains the impact this has had, stating, “The TIP report has consistently ignored harms to sex workers, including arrest and deportation of sex workers, abuse and violence during raids, increased vulnerability to violence, and increased stigma and discrimination resulting from trafficking legislation and initiatives” (“Policy Brief, the Impact” 5). Because the TIP report has both domestic and international implications, it is responsible for the direct mistreatment of sex workers by government agencies, who repeatedly fail to distinguish between worker and victim. This is counterintuitive to what it claims to promote –

the health and safety of all humans. State-sanctioned violence and perpetration of harmful gender norms is not the way to restore human rights or ensure gender equality. Confusing sex workers with victims falsely equates the experiences of someone who chooses this work with the trauma of someone who is forced into it – the visceral difference between exerting agency and being robbed of the very same. By making the important distinction between consenting worker and coerced victim, it becomes clear that legislators must begin to take this into consideration when designing anti-trafficking policy.

When it comes to states prosecuting for prostitution, law enforcement more frequently arrests and charges sex workers (or those who they see as sex workers) rather than pimps or traffickers (Curva 560). This leads to an overlap in both victims of trafficking or other exploitation and sex workers trying to make a living both being arrested and punished for unjust purposes. Trafficking is typically difficult to prove in courts and requires much more time and resources to prosecute; prostitution does not require the same level of proof for a conviction. Further, though prostitution by nature requires more than one person to participate, “police, prosecutors, and courts have typically viewed pimps and purchasers as trivial or derivative offenders, while targeting prostituting persons for arrest and prosecution (Heiges 437). This leads to an imbalance in who is prosecuted, and as such, who pays lifelong consequences for a permanent criminal record consisting of sex crimes. Because of gender roles and stereotypes, men who purchase sex or who control the sexual activity of women are still seen as criminal, but not as much of a social problem as the women who are selling sex themselves.

### Sex Work as Work

Part of the reason why sex workers are not only given a victim status, but also negatively targeted in anti-trafficking legislation, is because sex work is still not widely seen as a legitimate

form of work. This is apparent in the large majority of states in the U.S., including New Jersey, where the field is criminalized all but entirely. However, throughout the history of women entering the formal economy, women have had to advocate for feminized forms of labor to be seen as legitimate. Society is just beginning to realize the benefits and economic value of affective labor, or social/emotional labor that is performed largely by women. Though affective labor does not always involve a direct transfer of goods or services, companies have been utilizing this kind of work for decades. In an article detailing this shift, Weeks discusses the many sectors of work that are beginning to require at least some form of affective labor. "...processes of production today increasingly integrate the labors of the hand, brain, and heart as more jobs require workers to use their knowledges, affects, capacities for cooperation and communicative skills to create not only material but increasingly immaterial products" (Weeks 238). Weeks then describes flight attendants as an example of an occupation that is not directly selling anything material to the customers, but selling an experience and a personality on behalf of the company. Many companies require this kind of labor, from restaurants to massage parlors, and it is now regularly being regarded as a legitimate form of work.

By this logic, the framing of sex work should follow as such. When discussing the newfound issue of global migration of women from poor countries to rich countries to work in fields providing affective labor, Ehrenreich and Hochschild describe the different ways in which these people – often women – provide something of economic value. This is generally in the positions of nannies, maids, or sex workers. As nannies and maids provide both physical and affective labor, sex workers also provide these types of benefits to their clients. They write, "Sex workers offer the simulation of sexual and romantic love, or at least transient sexual companionship" (Ehrenreich & Hochschild 23, 25). Clearly, women occupy a number of fields

of affective labor to gain a better income for themselves and their families. However, while maids and nannies are seen as work that is worthy of the formal economy, sex work is a field that has yet to be fully legitimized by both society and law. With this in mind, it has been estimated that 64% of human trafficking victims are trafficked into forced labor rather than sexual exploitation, and of that, 24% are trafficked into domestic labor, which is the most populated category of labor by human trafficking victims (“Global Estimates ...” 10-11). Even still, sex workers are continuously singled out by the general public and governmental agencies alike as products of human trafficking, and not as legitimate workers receiving an income.

To that point, sex work is not just simply the process of exchanging sex. Sex workers use this work to take their financial security and agency into their own hands and use it to empower themselves. As Oksala says in her article discussing affective labor and feminist politics, “All forms of labor today must be recognized as socially productive and understood as part of biopolitical production. In other words, all labor produces and reproduces social life, and in the process is exploited by capital” (Oksala 286). Sex work is like any other field in the formal economy that requires time, attention, and thought to produce a product or affect. Given all of the evidence, both from research and firsthand accounts, sex work as a section of the formal economy is in stark contrast to that of the victimization of human trafficking and should be treated as such. It is hypocritical to say that the United States has a zero-tolerance approach to gender-based violence and human trafficking when prosecutors consistently let trafficking cases fall by the wayside in favor of charging women with prostitution instead because it’s easier.

#### Why Decriminalization?

If sex work is work that should be compensated fairly, and if victims of trafficking are at risk of being prosecuted for crimes that are outside of their control, then it only follows that the

profession should be legitimized via removing the criminal status of people who engage in this work. It would serve to not further victimize survivors of sex trafficking who have been forced into prostitution and, for whatever reasons, slip under the radar of possible victims and into the eyes of prosecutors as criminals. It would also serve to provide safety and more legitimate economic opportunity to people who, for whatever reason, have chosen this work.

Many human rights advocates are vocal opponents of legitimizing sex work in any form, including decriminalizing it. One researcher insists that the act of prostitution itself should be understood as violence, and asserts, “unionizing prostituted women makes as little sense as unionizing battered women” (Farley 1089). It cannot be argued that sex work, especially street sex work, can be a dangerous profession. Street sex workers have staggering rates of violence at the hands of their pimps, who are known for exploiting women’s vulnerable positions and taking control of their earnings. Sex workers also experience regular violence by their “johns,” or clients. It is estimated that, “65 percent of women prostitutes are regularly subjected to frequent, severe abuse by customers, johns, and pimps...Most shocking, studies have estimated that 5 percent of female prostitutes die each year due to their work” (Flowers 150). There are few professions that compare to this level of violence for its workers. By legalizing or decriminalizing sex work, some argue that gender hierarchies and violence against women are reinforced, and that sexism and oppression will be codified rather than shunned through criminalization. Worse still, it has been found that countries which have legalized prostitution have seen an increase in human trafficking (Cho et al. 76), and so it is argued that legalizing or decriminalizing sex work will increase the demand. This, in turn, increases both sex workers and human trafficking into that area. Due to this correlation, one must ask if legitimizing sex work will exacerbate the problem it is trying to solve.

It is true that countries which have legalized sex work have seen traffickers take advantage of these new laws in order to hide their victims in plain sight. The Netherlands saw this occur when sex work was legalized in Amsterdam. Traffickers were taking advantage of the legal status of sex work to exploit their victims; the 2008 Sneep case in particular made headlines when traffickers in Amsterdam were charged with forcing at least 78 women to engage in sex work (Wagenaar et al. 103). Further, even though trafficking rates were on the rise after legalization, police were less willing to investigate suspicious instances because sex work was a legalized industry (Mathieson et al. 386). There is also evidence that efforts by the Dutch government to regulate the industry have done more harm than good, and have actually contributed to additional infringements on consenting sex workers' civil and social rights (Outshoorn 242).

However, there is a difference between legalization and decriminalization. Decriminalization is ideal because it removes any government involvement in regulating the industry while still criminalizing trafficking and violence to the fullest extent. New Jersey's criminalization of street-based sex work actually just serves to increase sex workers' proximity to the danger and vulnerability. It creates a strong level of distrust and fear in the criminal justice system among sex workers, which leads to them not having access to legal or medical help when they are affected by violence. The logic here is simple; for a sex worker to report a crime such as sexual assault or robbery during a transaction, this person would also have to admit to committing a crime – the sex work itself. This also translates down to victims of trafficking. If people who are already under extreme control and exploitation believe that they are also at risk of being arrested for a crime, then their ability and willingness to cooperate with law enforcement is diminished. A letter by Amnesty International shows how decriminalization of

sex work actually helps both sex workers and trafficking victims seek justice, “When they are not threatened with criminalization/penalization, sex workers are better able to collaborate with law enforcement to identify perpetrators of violence and abuse, including human trafficking (“Consultation Seeking Views...” 6-7). Decriminalization of voluntary sex work, when still holding forms of violence and trafficking punishable by law, has been repeatedly shown to reduce rates violence against women, (Cunningham & Shah 1684; Bisschop et al. 15) while criminalization marginalizes sex workers and exposes them to an increase risk of violence and poverty (Platt 45).

Criminalization also prevents sex workers from accessing necessary healthcare services, such as HIV prevention and treatment and other reproductive healthcare services. Sex workers “frequently report discrimination and exclusion from healthcare settings” (“Consultation Seeking Views...” 6), and as such, are not able to receive necessary healthcare services to keep themselves and their clients at a lower risk for health issues. To address these barriers, the United Nations has called on countries to, “repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine [an] individual’s or particular group’s access to sexual and reproductive health facilities, services, goods and information” (“General Comment No. 22”). In recognizing that street sex workers are at extremely high risk of violence and health risks, removing the criminal status of their work would assist them in seeking justice and the ability to access their right to healthcare. Because sex workers’ rights are intrinsically linked to the ICPD’s goals of ensuring access to reproductive healthcare and eliminating violence against women, this is a necessary policy change for New Jersey.

Decriminalization would have other benefits aside from providing avenues to justice for violence. Having a prostitution charge on a permanent record also extremely limits sex workers’

ability to leave the profession if they choose to find other forms of work (Albright & D'Adamo 123). Because of the overlap in prosecuting victims of trafficking for prostitution, these charges have additionally detrimental effects on those victims. Many avenues for escaping sex work or trafficking are considerably harder to pursue after a prostitution conviction, such as "a woman's ability to access education, legal employment, and loans" (Mathieson 377). Time spent incarcerated is also time spent without income and adds an additional burden to seeking opportunities outside of sex work. This also impacts a person's ability to contribute to societies in which they live and work in. If the underlying goal for criminalizing sex work is that less women are involved in sex work, then the opposite is actually achieved by limiting the kinds of education and work that women can seek with a prostitution charge on their record. Furthermore, while victims of human trafficking can claim that they were trafficked in order to avoid being found guilty of prostitution, this claim is offered as an affirmative defense in New Jersey courts. Because of this, the burden of proof is on the defendant to show that they were trafficked instead of willingly engaging in prostitution (NJ § 2C:1, 2C:1-13). With survivors of trafficking already in vulnerable situations, many might need to rely on public defenders who, overall, have lower success rates in court ("Private Attorney", 2007). Because sex workers and trafficking victims are the more likely targets of law enforcement rather than male participants in sex work such as pimps and traffickers, this also leads to an imbalance in who all gets higher access to opportunities. Decriminalizing sex work would solve this problem by ensuring that both sex workers and trafficking survivors do not get needlessly picked up and permanently impacted by the criminal justice system.

In line with meeting goals set by the international community to end all forms of violence against women and girls, the United States might be breaking its own standards by prosecuting

victims of human trafficking as criminal prostitutes. Because the margin of error between prosecuting voluntary sex workers and trafficking victims is so large, governments are at risk of infringing upon people's civil and social rights more so than they are protecting them from this violence. The United Nations has recognized this as an area of American law enforcement that needs improvement, "...in a recent review of U.S. compliance with treaty obligations under the International Covenant on Civil and Political Rights (I.C.C.P.R.), the U.N. Human Rights Committee expressed concern over the United States' continued criminalization of victims of sex trafficking on prostitution-related charges" (Dempsey 216). By arresting and incarcerating survivors of trafficking instead of providing them with assistance, the American criminal justice system is flawed. While decriminalizing on a federal level would prove arduous, individual states have the right to decriminalize within their borders. This is an avenue that New Jersey must pursue if it wishes to assist victims of violence and increase access to healthcare, rather than continuing to wrongfully incarcerate its citizens.

#### Recommendations for New Jersey

In order to assist both sex workers and victims of human trafficking, sex work must be decriminalized. With that said, decriminalization alone isn't enough to ensure that both trafficking survivors and sex workers are given opportunities to lead fuller lives.

Decriminalization will help sex workers leave the industry more easily due to clean or expunged criminal records, but there must be better opportunities available in order for sex workers to want to leave the industry. Policymakers must address the fact that many sex workers, the majority of whom are female, enter sex work in the first place because of a lack of already-present alternative opportunities ("Economic Strengthening for..." 3). Amnesty International also points out that in order to achieve Sustainable Development Goals 1 through 8, as has been

recommended by the ICPD, access to resources for women and girls must be increased to, “reduce the extent to which many engage in sex work because they lack options” (“Consultation Seeking Views...” 6). Underlying structural inequalities that create the need for women to enter the sex industry in the first place must be fixed; decriminalizing sex workers alone would be like putting a Band-Aid on a stab wound.

The Nordic Model, adopted by various countries in Northern Europe, has shown to address both the criminalization of trafficking victims and sex workers while also providing avenues to better economic opportunities (Dempsey 227). In contrast to just decriminalizing or legalizing sex work, “the Nordic model is premised on the understanding that women's equity depends on excising structural barriers that preclude women's full economic, social, and political inclusion” (Mathieson 371). By combining decriminalization with social support, leaving sex work is actually practical because there are social safety nets to assist them. Through this model, Sweden has created both a Prostitution Unit and a Trafficking Unit tailored to each group of people in assistance. The Prostitution Unit assists women in finding housing, financial assistance, and mental health recourses, among other forms of support (Mathieson 403), while the Trafficking Unit focuses on targeting and prosecuting traffickers while connecting victims with support services (411). By recognizing that trafficking survivors and sex workers are separate categories of people with their own specific needs, the Swedish government is in a better place to assist both populations in a sustainable way. With that said, the Nordic Model isn't perfect, and is criticized for criminalizing the purchasing of sex rather than the selling of sex (Vuolajärvi 151). New Jersey can rely on the Nordic Model as a foundation, but also take this opportunity to craft groundbreaking legislation which ensures the total decriminalization of sex work while addressing underlying social inequities.

The way New Jersey addresses the prosecution of human traffickers must also change. Human trafficking is a crime at both the state and federal levels, but criminal law for those respective charges is not uniform. As such, there are discrepancies in how effective state and federal courts are at prosecuting traffickers and achieving justice for survivors. Prior to New Jersey's anti-trafficking law, Congress passed the Trafficking Victims Protection Act in 2000 to better assist immigrant and undocumented victims, and to harshen penalties for traffickers (Carr 78). Though states often respond to these kinds of crimes within their own court systems, the federal government invoked the Commerce Clause to pass the Trafficking Victims Protection Act, or TVPA. Through this clause, "Congress has the power to regulate activities that have a substantial relation to interstate commerce" (Mattar 1277), and trafficking falls under this category.

Federal prosecution has advantages that state prosecution does not. This can mean a world of difference for immigrant and undocumented victims of trafficking. Through the TVPA, victims of traffickers that go through the federal process can apply for a T visa, allowing them to stay in the United States and claim asylum to avoid deportation to potentially dangerous situations in their home countries (Nguyen 206). As many of New Jersey's prominent cases of human trafficking have involved both documented and undocumented immigrants ("Combating Human Trafficking..."), and as the state's ethnic diversity is partially what attracts traffickers to New Jersey in the first place, this is a necessary resource in seeking justice for trafficking survivors. Eileen Overbaugh, who recommends the federal prosecution of human traffickers instead of prosecution through New Jersey state courts, writes, "There is a strong possibility that the victims of state human trafficking cases will not qualify as 'federal victims' and will face deportation despite the TVPA's explicit goal of preventing the deportation of victims" (652).

Because immigration is a federal issue, New Jersey courts do not have as much power in protecting immigrant survivors through granting T visas. In choosing to prosecute at the state level instead of the federal level, New Jersey may actually be interfering with survivors' safety and sabotaging their ability to access justice.

On top of these barriers, states simply do not have the resources to handle prosecution of human trafficking cases in the same way that the federal government does. Because trafficking cases require such a haul of time and resources, "...[state] prosecutors rarely charge defendants under these statutes" (Heiges 437). New Jersey follows this trend. Despite passing comprehensive anti-trafficking legislation in 2005, between 2002 and 2012, "New Jersey has prosecuted less than a dozen cases involving human trafficking. All of these cases were tried in federal rather than state courts" (Curva 570). The effects of the criminalization of prostitution also intersect with the discrepancies between state and federal trafficking law. This can have especially devastating consequences for underage victims, as New Jersey joins many states across the U.S. with allowing minors to be prosecuted for prostitution rather than recognizing them as victims of sexual abuse ("State Law Survey..."). As director of University of Michigan Law School's Human Trafficking Clinic Bridgette Carr puts it, "most prostitution cases are prosecuted at the state level, leaving many children caught between being viewed as a victim of trafficking under federal law and a prostitute under state law" (Carr 84). It is impossible for someone to be both a victim and a criminal of the same crime. Yet, this is an issue that presents itself due to legal inconsistencies, and the kinds of crimes that state and federal courts are usually prosecuting. This does not make for a just society and is inconsistent with a "zero-tolerance" approach to human trafficking and gender-based violence.

However, just because federal court is more equipped to handle these cases does not mean that states should remove themselves from these situations entirely. In contrast, state and local law enforcement officers are much more likely to come in contact with human traffickers and their victims. With that said, there is evidence to suggest that these officers require more training in order to effectively identify cases of trafficking, and to assist more victims. Many law enforcement officials are trained to identify cases of trafficking through narrow criteria that applies to the most severe cases of trafficking but ignores the nuanced and subtle effects of power that long-term violence and abuse have on survivors. In this ignorance, law enforcement interactions with victims and traffickers is often ineffective, as, "...adults who are prostituted by means of an 'abuse of power' or 'abuse of a position of vulnerability' continue to be treated as criminals throughout the United States, despite the fact that their experience constitutes sex trafficking under international law (Dempsey 214). Because of this, victims continue to slip under the radar as consenting participants in sex work and are denied safety and justice by the people sworn to serve and protect them. Through more in-depth and proper training for local and state law enforcement, officers can become better equipped to discern between those who need immediate help and those who are choosing to engage in this work.

### Conclusion

Both sex workers and victims of human trafficking constitute some of the most vulnerable and high-risk residents of New Jersey, and the state's response to both of these groups is problematic. The conflation between voluntary sex workers and victims of human trafficking is inherently rooted in archaic gender roles and continues to have detrimental effects to both populations. While both sex workers and victims are treated as criminals, cases of human trafficking do not decrease, and violence against sex workers is allowed to proliferate. A

distinction must be made to separate who is engaging in sex work by choice, and who is being forced into sexual exploitation.

Ending gender-based violence is possible, but much of the efforts to curb these acts of violence have absorbed the toxic gender roles and oppressive attitudes that they claim to fight against. It is necessary for New Jersey to take steps to uphold its obligation to end all forms of violence against women and girls by writing respect for all people – even the ones who break those sacred gender roles in the form of sex work – into its legislation. The state government must ensure that sex workers are not harmed by anti-trafficking policies, and that survivors of trafficking are given every avenue and resource to achieve their own safety and justice from traffickers. This starts with legitimizing sex work as a form of work in the formal economy. Because of this, decriminalization of sex work is recommended to curb both human trafficking and other forms of gender-based violence. The state government must also recognize its inability to help traffickers through its court system, and take more of a supportive role in federal prosecution rather than actively prosecuting at the state level.

New Jersey does not need to start from scratch to achieve these goals. The Commission on Human Trafficking created by the passing of the Human Trafficking Prevention, Protection, and Treatment Act is already in a place to analyze current policy and make necessary recommendations. Each open seat on the Commission needs to be filled, and the Legislature needs to crack down and enforce annual reports as the law requires it. Through this Commission and the resulting annual reports, the training currently provided to law enforcement can be studied to identify specific gaps that exist in effectively identifying human trafficking. The Commission can identify why the state has such a poor rate of prosecution and, if it still wishes to retain power over prosecution of trafficking cases, can recommend the allocation of resources

to allow for a more effective enforcement of its own anti-trafficking law. The Commission can also analyze the effects that criminalization have had on survivors of trafficking, and possibly identify victims that have slipped through the cracks and have been punished for the crimes that they have actually been victimized by. Because of this foundation, New Jersey is actually in an ideal position to make real, meaningful changes for both sex workers and victims of trafficking. Now it is just up to the Legislature to act.

## Conclusion

While human rights should be promoted because they are essential to human value and dignity, they are also the mark of a society that is capable of successful growth and development. The International Conferences on Population and Development have demonstrated why gender equality is crucial to these goals. When over half of a population cannot exercise their bodily autonomy, cannot be saved from preventable deaths, and are not safe from gender-based violence, there is an imperative need for change. The fact that women of color are at even worse risk of these outcomes only validates that these issues derive from an unequal social structure.

No place on this earth has yet achieved full gender or racial equality. A lot of the policy recommendations in this paper are socially taboo; introducing bills that would increase access to abortion or decriminalize sex work might require legislators to risk their re-election in order to do so. However, if the job of policymakers is to better the lives of the residents they serve, and to contribute to the successful growth of the state, these decisions must be considered. We cannot say that New Jersey is providing human rights and freedom consistent with that of the United Nations if our government allows deception, harassment, wrongful criminalization, and preventable death to occur; specifically, for these violations to occur at the distinct expense of women, people of color, and other social minorities.

The New Jersey state government can do better than the United States at the federal level. In the face of an oppressive federal administration that has already staked its claim on the bodies of women and people of color, New Jersey has an explicit obligation to do better. We would do well to learn from our history as to what happens when we prioritize immediate spending concerns over residents' health and overall savings. Prohibiting deception aimed at people attempting to obtain a legal medical procedure is common sense. Recognizing the very real

threat of violent anti-choice protesters and taking steps to protect patients is common sense. Listening to Black women, especially in regard to how we can decrease Black maternal mortality, is common sense. And refusing to further criminalize the most vulnerable residents and open up better avenues for justice against gender-based violence is common sense. There are legal pathways to achieve all of these goals that will ultimately lead to the true fulfillment of human rights and gender equality. In turn, they will have lasting positive impacts on New Jersey's growth and development as a whole, as New Jerseyans will be more empowered to take control of their own bodies, health, and ability to self-determine their futures. Through these policy solutions recommended, New Jersey can better protect its residents and fulfill the goals outlined in Cairo and Nairobi. It will take political courage in the short term, but will have lasting benefits for all in the long term.

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