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ABOUT THE JOURNAL

The Public Purpose is a peer-reviewed interdisciplinary journal presenting the work of American University graduate students from the Departments of Government; Justice, Law, and Criminology; and Public Administration and Policy. Founded in 2003, The Public Purpose is supported by the SPA Graduate Council with involvement and guidance of Faculty Review Board, consisting of some of American University's most distinguished professors. In addition to an annual print journal, The Public Purpose also manages a public policy blog at thepublicpurpose.com. The journal is entirely student run and currently has a staff of about 20 students.

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FROM THE EDITORS

Dear Readers,

We are honored and delighted to present the 17th edition of The Public Purpose Journal. This journal is an academic journal led by graduate students in American University's School of Public Affairs. Every year, our executive team and faculty board work together to review academic research of the highest caliber across a broad range of policy and administrative topics.

This year, The Public Purpose Journal received a record number of submissions representing every program in the American University School of Public Affairs. The papers presented here demonstrate the range of topics that AU's graduate community is tackling in the classroom and the workplace. From domestic policy affecting the lives of some of the most vulnerable members of our communities to the impact of international economic development practices, the work of our authors demonstrates the breadth and depth of this university's academic passions.

We are grateful to the Graduate Student Council and to the Dean's office for their continued personal and financial support as we work to add the American University voice to the public academic discourse. We could not do this increasingly-valuable work without their support. We thank our student writers and editors for their hard work in developing a peer-reviewed publication. Thank you so much to the executive team, who has been working so hard behind-the-scenes to make this happen and for their continued dedication to the mission of The Public Purpose Journal.

And thank you, reader, for your commitment to continuing to learn about the issues of the world around us. Our democracy is ever-changing, and requires the best of all of us. We hope that this journal contributes, in some small way, to that national discourse and the fostering of our shared democracy.

Sincerely,

Indira Bhattacharjee & Sarah Henry
Editor in Chief & Managing Print Editor

THE PUBLIC PURPOSE
2018-2019

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BARRIERS TO ABORTION ACCESS FOR ACTIVE-DUTY SERVICEWOMEN STATIONED DOMESTICALLY AND ABROAD

Annaliese Johnson

INTRODUCTION

Once barred entirely from military service, women now make up 15.2 percent of active-duty personnel and 18.2 percent of Reserve and National Guard forces.[1] Thousands of women had served as nurses during World War I and were eventually allowed to volunteer for non-combat roles in 1942 through the Women's Auxiliary Army Corps (WAAC).[2] The number of active-duty women in the military has grown from 42,000 in 1973[3] to 204,628 in 2016.[4] Since 2016, women are now able to undertake all occupational specialties,[5] apply for combat positions[6], and made up 17.3 percent (39,603) of active-duty officers in that year.

Despite these achievements, women in all branches of the military continue to face hurdles in accessing a vital component of reproductive healthcare – abortion care. The lack of coverage through the military's insurance program, TRICARE, and the federal ban on abortion services within military treatment facilities (MTFs) conspire to create financial and logistical burdens that delay abortion care for active-duty servicewomen and military dependents. Stigma and confidentiality concerns further complicate servicewomen's ability to navigate the complex process of obtaining abortion care while serving their country. Servicewomen stationed abroad face additional obstacles, depending on the abortion restrictions in the host country and their ability to travel to another country to access this care. This paper delves deeper into how lack of insurance coverage, the MTF ban, stigma, and confidentiality concerns work in tandem to prevent servicewomen from obtaining access to necessary reproductive healthcare.

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[1] Braun, Lisa A., Kennedy, Holly P., Womack, Julie A. and Wilson, Candy. (2016, January). Integrative Literature Review: U.S. Military Women's Genitourinary and Reproductive Health. *Military Medicine, 181*(1). 35-49. Retrieved April 6, 2018 from: http://vg5ly4ql7e.scholar.serialssolutions.com/?sid=google&auinit=LA&aulast=Braun&atitle=Integrative+Literature+Review:+US+Military+Women%27s+Genitourinary+and+Reproductive+Health&id=doi:10.7205/MILMED-D-15-00242&title=Military+medicine&volume=181&issue=1&date=2016&spage=35&issn=0026-4075

[2] Spring, Kelly A. (2017). In the Military: During World War II. *National Women's History Museum.* Retrieved March 12, 2019 from: https://www.womenshistory.org/resources/general/military

[3] Patten, Eileen, and Parker, Kim. (2011). Women in the U.S. Military: Growing Share, Distinctive Profile. *Pew Social & Demographic Trends.* Retrieved on April 27, 2018 from http://assets.pewresearch.org/wp-content/uploads/sites/3/2011/12/women-in-the-military.pdf

[4] Department of Defense. (2016). *2016 Demographics: Profile of the Military Community.* Retrieved on April 27, 2018 from http://download.militaryonesource.mil/12038/MOS/Reports/2016-Demographics-Report.pdf

[5] McGraw, K., Koehlmoos, Tracey P. and Ritchie, Elspeth C. (2016, January). Women in Combat: Framing the Issues of Health and Health Research for America's Servicewomen. *Military Medicine, Supplement, 181*(1S). 7-11. Retrieved April 6, 2018 from: http://vg5ly4ql7e.scholar.serialssolutions.com/?sid=google&auinit=K&aulast=McGraw&atitle=Women+in+combat:+Framing+the+issues+of+health+and+health+research+for+America%27s+servicewomen&id=doi:10.7205/MILMED-D-15-00223&title=Military+medicine&volume=181&issue=suppl_1&date=2016&spage=7&issn=0026-4075

[6] Silva, Jennifer. (2017, March 15). Women in the Military: Through the Decades. *The Huffington Post.* Retrieved April 6, 2018 from: https://www.huffingtonpost.com/entry/women-in-the-military-through-the-decades_us_58c9630fe4b05675ee9c5c55

BACKGROUND

Until recently, TRICARE only covered abortion procedures if a woman's life was at stake. In 2013, Congress included the Shaheen Amendment in the annual National Defense Authorization Act, which expanded TRICARE coverage to include abortion care in cases of rape and incest.[7] In all other cases, any aspect of abortion care is not covered, including services, counseling, and referrals. This includes cases of pregnancy terminations due to severe fetal abnormalities and psychological reasons.[8] The limited coverage of reproductive healthcare under TRICARE reflects the long-held practices that block federal funds from being used to pay for abortion care, as echoed in the Hyde Amendment and other federal insurance programs.[9]

While the TRICARE funding ban directly impacts active-duty servicewomen, it also affects servicemembers' dependents, who may rely on TRICARE for health insurance. As of 2017, TRICARE provides insurance for nearly 9.4 million individuals, around 5.5 million of whom are either family members of active-duty service members, survivors of deceased active-duty members, National Guard and Reserve family members, or family members of retired service members.[10] In 2015, there were 1.4 million women of reproductive age who received their insurance coverage through TRICARE, including both servicewomen and military dependents. For 64.28 percent of these women, TRICARE was their only form of insurance.[11] Millions of dependents and servicewomen seeking abortion care are left to finance *every aspect of their procedure* due to the TRICARE funding ban, which could lead to delays in care as they get the necessary funds together.[12]

For women who lack insurance coverage, the struggle to find resources to pay for abortion care can force delayed procedures, which may increase the costs and potential

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[7] Grindlay, K., Seymour, Jane W., Fix, L., Reiger, S., Keefe-Oates, B. and Grossman, D. (2017, December). Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study. *Perspectives on Sexual and Reproductive Health, 49*(4). 245-252. Retrieved April 6, 2018 from: https://onlinelibrary-wiley-com.proxyau.wrlc.org/doi/abs/10.1363/psrh.12044

[8] TRICARE. (2014, October 9). Abortions. *Department of Defense.* Retrieved April 6, 2018 from: https://tricare.mil/CoveredServices/IsItCovered/Abortions

[9] Salganicoff, A., Rosenzweig, C. and Sobel, L. (2017, October 16). The Hyde Amendment and Coverage for Abortion Services. *Kaiser Family Foundation.* Retrieved April 9 2018 from: https://www.kff.org/womens-health-policy/perspective/the-hyde-amendment-and-coverage-for-abortion-services/

[10] Military Health System. Beneficiary Population Statistics: Patients by Beneficiary Category. *Department of Defense.* Retrieved on April 9 2018 from: https://health.mil/I-Am-A/Media/Media-Center/Patient-Population-Statistics/Patients-by-Beneficiary-Category

[11] Donovan, Megan K. (2017, January 5). In Real Life: Federal Restrictions on Abortion Coverage and the Women They Impact. *Guttmacher Policy Review, 20.* Retrieved April 9 2018 from: https://www.guttmacher.org/gpr/2017/01/real-life-federal-restrictions-abortion-coverage-and-women-they-impact

[12] Ibis Reproductive Health. (2016, September). *Research brief: The impact of out-of-pocket costs on abortion care access.* Retrieved on April 23, 2018 from https://ibisreproductivehealth.org/publications/research-brief-impact-out-pocket-costs-abortion-care-access

health risks of a later abortion.[13] Though abortion is one of the safest medical procedures in the US,[14] the risk of complications increases later in pregnancy,[15] as does cost. In 2014, the average costs for a first trimester aspiration procedure and a medication abortion were $506 and $461, respectively. The procedure costs increase with gestational age, with an average cost of $860 at 14 to <20 weeks, and $1,874 at or after 20 weeks.[16] Studies have shown that in addition to using insurance, women seeking abortions frequently use organizations like abortion funds[17] to finance their procedures, indicating that the out-of-pocket cost is substantial for a significant proportion of women. Similar to other types of healthcare, findings suggest that access to insurance may reduce the delays in access to abortion care.[18]

Because of its limitations, servicewomen and military dependents covered by TRICARE must foot the bill for their abortion procedures, which creates a substantial financial barrier for some. In the only study of US servicewomen's experience with abortion, Grindlay et.al observed that almost a quarter of participants "noted the financial burden of paying for an abortion out of pocket," with some servicewomen spending an entire paycheck on their care. Junior enlisted women in particular may find financing their abortion procedures difficult, due to their lower pay grade.[19] Junior enlisted servicemembers usually enter service at the lowest pay grades (E1-E2)[20], making between $1,514.70 and $1,836.30 monthly in basic pay,[21] while commissioned officers make substantially more. It is not unreasonable, therefore, to assume that junior enlisted servicewomen may face difficulties in trying to finance their abortion procedures.

The out-of-pocket costs servicewomen incur for abortion procedures are considerable. Due to lack of data, it is difficult to pinpoint the exact out-of-pocket cost active-duty servicewomen shoulder or the population's abortion rate. Because

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[13] Roberts, Sarah C.M., Gould, H., Kimport, K. Weitz, Tracy A. and Greene Foster, D. (2014). Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States. *Women's Health Issues, 24*(2). Retrieved on April 9 2018 from: https://ac-els-cdn-com.proxyau.wrlc.org/S1049386714000048/1-s2.0-S1049386714000048-main.pdf?_tid=b2c33d2b-e0f3-4722-8671-80edc629b763&acdnat=1523286703_c8a7402e313d07544fd9505de01d07e4

[14] Guttmacher Institute. (2018, January). *Fact Sheet: Induced Abortion in the United States.* Retrieved on April 9 2018 from: https://www.guttmacher.org/fact-sheet/induced-abortion-united-states

[15] Guttmacher Institute. (2018, February). *Targeted Regulation of Abortion Providers (TRAP) Laws.* Retrieved on April 9, 2018 from: https://www.guttmacher.org/evidence-you-can-use/targeted-regulation-abortion-providers-trap-laws

[16] Roberts, Sarah C.M., Gould, H., Kimport, K. Weitz, Tracy A. and Greene Foster, D. (2014). Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States. *Women's Health Issues, 24*(2). Retrieved on April 9 2018 from: https://ac-els-cdn-com.proxyau.wrlc.org/S1049386714000048/1-s2.0-S1049386714000048-main.pdf?_tid=b2c33d2b-e0f3-4722-8671-80edc629b763&acdnat=1523286703_c8a7402e313d07544fd9505de01d07e4

[17] National Network of Abortion Funds. *All Funds.* Retrieved on April 23, 2018 from https://abortionfunds.org/need-abortion/

[18] Roberts, Sarah C.M., Gould, Heather, Kimport, Katrina, Weitz, Tracy A., and Greene Foster, Diana. (2014). Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States. *Women's Health Issues, 24*(2). Retrieved on April 23, 2018 from http://vg5ly4ql7e.scholar.serialssolutions.com/?sid=google&auinit=SCM&aulast=Roberts&atitle=Out-of-pocket+costs+and+insurance+coverage+for+abortion+in+the+United+States&id=pmid:24630423

[19] Grindlay, K., Seymour, Jane W., Reiger, S., Keefe-Oates, B. and Grossman, D. (2017, December). Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study. *Perspectives on Sexual and Reproductive Health, 49*(4). Retrieved on April 9, 2018 from: https://onlinelibrary-wiley-com.proxyau.wrlc.org/doi/epdf/10.1363/psrh.12044

[20] Military Rates. (2018). *Military Pay Charts.* Retrieved on April 27, 2018 from https://www.militaryrates.com/military-pay-charts

[21] Defense Finance and Accounting Services. (2018, March 31). *Military Pay Chart 2018.* Retrieved online on April 27, 2018 from https://www.dfas.mil/militarymembers/payentitlements/military-pay-charts.html

servicewomen, particularly those stationed abroad, face increased obstacles when accessing abortion care, it is likely that the rate at which they seek abortion care is lower than the overall national rate. On the other hand, due to the high rates of sexual assault within the military[22] and documented gaps in contraception availability for deployed servicewomen,[23] their incidence of abortion could be higher than the national rate. The scarcity of data on this issue make a BOTEC calculation appropriate to give a rough estimate of the rate and average cost of unintended pregnancies resulting in abortion for servicewomen.

How Much Do Servicewomen Spend on Abortion Procedures?

This calculation assumes that TRICARE failed to pay for any abortion procedures. If TRICARE were to fund abortion procedures in cases of rape, incest, or threat to the mother's life, this number would be lower. This calculation also does not include the number of *intended* pregnancies that ended in abortion, in which case the estimate would be higher.

In 2011, the unintended pregnancy rate of 18-44-year-old active duty servicewomen was 72 per 1,000, or 7.2%.[24] This means there were an estimated 14,739 *unintended* pregnancies among the 204,714 active-duty servicewomen in 2011.[25] While there is national data on the amount of unintended pregnancies that result in abortion for the general population, there is no study as of yet that calculates this rate for servicewomen. Using the national rate of unintended pregnancies ending in abortion (42%)[26] to calculate the estimated rate for servicewomen, around 6,190 unintended pregnancies of active-duty servicewomen ended in abortion in 2011.

To calculate the cost of these procedures, the average costs of abortion procedures at different gestational periods was used to create a range of potential costs. Using the 2014 average costs of abortion care, I estimate that abortions due to unintended pregnancy for active-duty servicewomen cost the group as a whole between $2,853,590 and $5,323,400 in 2014 alone.

The first figure ($2,853,590) represents the cost if each of the 6,190 procedures were medication abortions (the least expensive option, available up to 10 weeks

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[22] Rico, Antonieta. (2017, December 12). Why Military Women Are Missing from the #MeToo Moment. *TIME.* Retrieved April 9 2018 from: http://time.com/5060570/military-women-sexual-assault/

[23] Grindlay, K. and Grossman, D. (2013). Contraception access and use among US servicewomen during deployment. *Contraception, 87.* Retrieved April 9 2018 from: https://ac-els-cdn-com.proxyau.wrlc.org/S0010782412008293/1-s2.0-S0010782412008293-main.pdf?_tid=4c34e64c-8839-41eb-904d-18ad43bb122d&acdnat=1523287624_c7470df23809fc9f663669a2c0cc9f60

[24] Grindlay, K. and Grossman, D. (2015, December). Unintended pregnancy among active-duty women in the United States military, 2011. *Contraception, 92*(6). Retreived on April 9 2018 from: http://vg5ly4ql7e.scholar.serialssolutions.com/?sid=google&auinit=K&aulast=Grindlay&atitle=Unintended+pregnancy+among+active-duty+women+in+the+United+States+military,+2011&id=pmid:26345183

[25] Department of Defense. (2012, November). *Profile of the Military Community: Demographics 2011.* Retrieved on April 13, 2018 from: http://download.militaryonesource.mil/12038/MOS/Reports/2011_Demographics_Report.pdf

[26] Guttmacher Institute. (2016, September). *Unintended Pregnancy in the United States.* Retrieved on April 9 2018 from: https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states

gestation)[27] and the latter ($5,323,400) represents the cost if each procedure were performed at 19 weeks.

This estimate is so broad mainly because there is no data available on the timing of servicewomen's abortion procedures. Were this data available, it would be possible to assess costs more precisely. On a national level, 89 percent of abortions in the US occur within the first 12 weeks of gestation (the first trimester), 6.2 percent occur between 13-15 weeks, 3.8 percent between 16-20 weeks, and 1.3 percent at or after 21 weeks.[28] Because active-duty servicewomen stationed internationally and domestically face delays in care, it is difficult to determine whether their abortion timeframe mirrors this national trend, though it is likely most are not procuring care at or after 19 weeks. This estimate assumes that the number of abortions procured by active-duty servicewomen remained constant through 2014 and that no servicewoman had an abortion performed at or after 20 weeks gestation.

Whether active-duty servicewomen shouldered the entire cost of their procedures or used abortion funds is also unknown. Regardless, the TRICARE funding ban clearly imposes significant financial costs on the 1.4 million women of reproductive age who receive TRICARE insurance.[29]

The Ban on Abortion Procedures in Military Treatment Facilities (MTFs) and Other Domestic Barriers

In addition to the funding ban, active-duty servicewomen are burdened by the federal law's ban of abortion care in military treatment facilities (MTFs), except for cases of rape, incest, or life endangerment. In these instances alone may a servicewoman receive abortion care in an MTF. An estimated average of 3.8 abortions per year were performed in MTFs between 1996 and 2009, though it is unclear how the extended coverage of procedures allowed under the Shaheen Amendment has impacted that rate.[30]
The MTF ban extends to abortion procedures that are privately funded by servicewomen, who cannot access TRICARE funding due to the restrictions. This ban forces most servicewomen seeking abortion care to leave their military bases, even those stationed overseas or in combat zones.[31] Pushed off base in search of abortion care, domestically-based active-duty servicewomen must contend with the abortion restrictions of the states where they are stationed.

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[27] Planned Parenthood. *The Abortion Pill.* Retrieved April 23, 2018 from https://www.plannedparenthood.org/learn/abortion/the-abortion-pill

[28] Guttmacher Institute. (2018, January). *Induced Abortion in the United States.* Retrieved on April 13, 2018 from: https://www.guttmacher.org/fact-sheet/induced-abortion-united-states

[29] Donovan, Megan K. (2017, January 5). In Real Life: Federal Restrictions on Abortion Coverage and the Women They Impact. *Guttmacher Policy Review, 20*. Retrieved April 9 2018 from: https://www.guttmacher.org/gpr/2017/01/real-life-federal-restrictions-abortion-coverage-and-women-they-impact

[30] Grindlay, K., Seymour, Jane W., Reiger, S., Keefe-Oates, B. and Grossman, D. (2017, December). Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study. *Perspectives on Sexual and Reproductive Health, 49*(4). Retrieved on April 9, 2018 from: https://onlinelibrary-wiley-com.proxyau.wrlc.org/doi/epdf/10.1363/psrh.12044

[31] National Abortion Federation. (2016, April 26). *Facilities Ban Coalition Letter.* Retrieved on April 9 2018 from: http://prochoice.org/wp-content/uploads/Facilities-Ban-Coalition-Letter-Final.pdf

State-level abortion restrictions such as ultrasound requirements, mandatory delays, and TRAP Laws (Targeted Regulation of Abortion Providers) make access to timely abortion care more difficult. Servicewomen are particularly affected by these abortion restrictions. Active-duty servicewomen face logistical barriers to abortion access, such as organizing transportation, requesting leave from their duties, and maintaining confidentiality throughout the process, in addition to navigating state restrictions. These logistical concerns compound the problems created by ultrasound requirements, mandatory delays, and TRAP Laws, and make accessing off-base abortion care more challenging for servicewomen.

Domestic active-duty servicewomen face unequal abortion access, with a large portion of them stationed in states that are hostile to abortion rights. The Guttmacher Institute, a research and policy organization focused on sexual and reproductive health and rights, studies abortion restrictions and determines whether states can be considered extremely hostile, hostile, middle-ground, or supportive of abortion rights.[32] Of the ten states with the largest numbers of active-duty military personnel (CA, TX, NC, VA, GA, FL, WA, SC, HI, CO),[33] five are considered extremely hostile to abortion rights (TX, VA, NC, FL, SC), one is considered hostile (GA), two are considered middle-ground (CO and HI), and two are considered supportive (CA and WA).[34] Of the ten aforementioned states, six have at least two types of ultrasound requirements (TX, VA, NC, FL, SC, GA), six impose mandatory delays before a woman can have an abortion (TX, VA, NC, FL, SC, GA), and eight currently enforce at least one form of TRAP Law (TX, VA, NC, FL, SC, GA, WA, HI).[35] Large numbers of active-duty service women are burdened by these abortion restrictions, on top of the TRICARE funding and MTF restrictions imposed by the military. These restrictions create delays and logistical issues that are particularly burdensome for active-duty servicewomen, who must fund their own care, arrange transportation off-base, and request leave from their duties to receive time-sensitive reproductive healthcare. I will briefly describe each of these restrictions and their impacts on servicewomen's abortion access.

Ultrasound Requirements

There are many uses for ultrasounds in reproductive healthcare, but states that are hostile to abortion rights often impose ultrasound requirements without considering the best interest of the patient. Often times, these procedures are neither medically necessary

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32 Nash, Elizabeth, Benson Gold, Rachel, Mohammed, Lizamarie, Ansari-Thomas, Zohra, and Cappello, Olivia. (2018, January 2018). Policy Trends in the States, 2017. *The Guttmacher Institute.* Retrieved online on April 27, 2018 from https://www.guttmacher.org/article/2018/01/policy-trends-states-2017

33 Governing. (2017, September 31). Military Active-Duty Personnel, Civilians by State. *e.Republic.* Retrieved on April 9, 2018 from: http://www.governing.com/gov-data/military-civilian-active-duty-employee-workforce-numbers-by-state.html

34 Guttmacher Institute. (2018, January 2). *States Hostile to Abortion Rights, 2017.* Retrieved on April 9 2018 from: https://www.guttmacher.org/infographic/2018/states-hostile-abortion-rights-2017

35 National Partnership for Women & Families. (2018, March). *Bad Medicine: How a Political Agenda Is Undermining Abortion Care and Access*. Retrieved on April 9, 2018 from: http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf

nor desired by the patient, flouting medical ethics. Some states impose additional requirements, such as mandatory delays after the ultrasound or that the ultrasound and abortion be performed by the same provider. By mandating additional procedures, which require multiple doctor visits, states with ultrasound requirements create unnecessary delays and additional logistical hurdles for women seeking abortion care.[36] Not only must women schedule additional transportation for these mandated ultrasounds, but they may be required to pay for them as well. This is certainly true for servicewomen, as no portion of their abortion procedure is covered by TRICARE. The many active-duty servicewomen stationed in states with ultrasound requirements face rising costs of care and increasing delays in accessing care.

Mandatory Delays

Mandatory delay laws require patients to wait a specified number of days after their first doctor's visit before being able to obtain abortion care. Mandatory delays not only delay time-sensitive care but require additional logistical planning and unnecessary trips to a clinic, increasing the cost of transportation and time away from work. In a qualitative study of military womens' experiences seeking abortion care, most servicewomen travelled about an hour each way to the clinic, with three women in Louisiana and Texas having to make two trips to the clinic due to their state's abortion restrictions.[37] Accessing abortion care is already difficult for active-duty servicewomen, and mandatory delays further complicate the process.

TRAP Laws

Targeted Regulation of Abortion Providers (TRAP Laws) require abortion clinics and providers to adhere to onerous, medically unnecessary requirements. TRAP Laws include requiring providers to have admitting privileges or alternative agreements with a nearby hospital, the facility to have a transfer agreement with a nearby hospital, clinics to satisfy specific facility requirements or fetal tissue to be buried or cremated, as well as stipulations that only physicians may provide abortions. TRAP Laws often force clinics that cannot afford to meet these unreasonable requirements to close, raising the cost of care and increasing the distance women must travel to obtain abortion care.[38]

A recent analysis of Texas' law HB-2 (struck down by the Supreme Court in *Whole Women's Health v. Hellerstedt*) revealed that clinic closures as a result of HB-2 substantially increased the distances most women had to travel to procure care and

[36] National Partnership for Women & Families. (2018, March). *Bad Medicine: How a Political Agenda Is Undermining Abortion Care and Access.* Retrieved on April 9, 2018 from: http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf

[37] Grindlay, K., Seymour, Jane W., Reiger, S., Keefe-Oates, B. and Grossman, D. (2017, December). Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study. *Perspectives on Sexual and Reproductive Health, 49*(4). Retrieved on April 9 2018 from: https://onlinelibrary-wiley-com.proxyau.wrlc.org/doi/epdf/10.1363/psrh.12044

[38] National Partnership for Women & Families. (2018, March). *Bad Medicine: How a Political Agenda Is Undermining Abortion Care and Access*. Retrieved on April 9, 2018 from: http://www.nationalpartnership.org/research-library/repro/bad-medicine-third-edition.pdf

decreased the number of clinics available to the same population of women.[39] As a result, abortion rates declined across the state, and the researchers estimate that there would have been almost 15,000 more abortions performed in Texas in 2014-2015 had access to abortion care remained at the rate before HB-2 was signed into law.[40] Though there is no research to document what happened to these "missing" abortions, Cunningham et al. hypothesize that while some women decreased their risky sexual behaviors, others may have resorted to self-induced abortions, by procuring over-the-counter abortifacients in Mexican pharmacies.[41] The data collected in Texas shows how similar TRAP Laws in other states can impede timely access to care.

TRAP Laws make care more expensive and harder to procure. In 2014, almost 60% of women who experienced a delay in obtaining abortion care cited that the time it took to arrange the procedure and raise funds were reasons for the delay.[42] One servicewoman noted that, "You have enough to go through. And then you also have to think about the cost of it and… the extra steps, instead of it just being taken care of like [other health services] normally would." An officer in the Army said, "In the evenings, I didn't have any freedom. I was on training in Georgia, and so I didn't have a car. And so that's why I had to wait all the way until the weekend to go get a pregnancy test, and then I had to wait until the following weekend [for the abortion]."[43] After being forced off-base and outside of their regular healthcare facilities (MTFs) to access abortion care, active-duty servicewomen must contend with TRAP Laws that single out abortion care with medically unnecessary restrictions.

Stigma Surrounding Abortion and Confidentiality Concerns

In addition to these state-specific barriers, active-duty servicewomen seeking abortion care off-base must request time off. Though higher ranking servicewomen may be able to obtain leave without request, servicewomen of lower ranks will have to submit a request to their commanding officer. This process may require them to divulge personal health information they would otherwise not share with fellow service members or superiors.[44]

In the latest qualitative study on the topic, the fear of a lack of confidentiality was frequently cited by servicewomen who sought abortion care while on active duty. Many of these servicewomen discussed the stigma surrounding abortion in the military and the

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[39] Cunningham, Scott, Lindo, Jason M., Myers, Caitlin, and Schlosser, Andrea. (2018, January). How Far is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions. *National Bureau of Economic Research.*

[40] Ibid.

[41] Ibid.

[42] Jones RK and Jerman J, *Time to Appointment and Delays in Accessing Care Among U.S. Abortion Patients,* New York: Guttmacher Institute, 2016, https://www.guttmacher.org/report/delays-in-accessing-care-among-us-abortion-patients.

[43] Grindlay, K., Seymour, Jane W., Reiger, S., Keefe-Oates, B. and Grossman, D. (2017, December). Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study. *Perspectives on Sexual and Reproductive Health, 49*(4). Retrieved on April 9 2018 from: https://onlinelibrary-wiley-com.proxyau.wrlc.org/doi/epdf/10.1363/psrh.12044

[44] Grindlay, K., Seymour, Jane W., Reiger, S., Keefe-Oates, B. and Grossman, D. (2017, December). Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study. *Perspectives on Sexual and Reproductive Health, 49*(4). Retrieved on April 9 2018 from: https://onlinelibrary-wiley-com.proxyau.wrlc.org/doi/epdf/10.1363/psrh.12044

potential negative impact disclosing their pregnancy or abortion decision would have on their careers. Three participants reported that their commanding officers learned of their pregnancy without their disclosing the information, highlighting the very real fear of some servicewomen that their pregnancy status may not be kept confidential. The fear of disclosing personal healthcare information led some servicewomen to schedule their appointments during non-work hours, which adds to the logistical burden in accessing care. Others postponed their appointments until their next scheduled leave, delaying time-sensitive healthcare.[45]

Concerns of a lack of confidentiality also influence some servicewomen's choice of abortion method and how they follow their post-care instructions. One study participant noted that the rule requiring service members to report all prescription medications to their Commanding Officers influenced her decision about her abortion method – she opted for a surgical abortion without anesthesia to better protect her privacy. In fact, of the 17 servicewomen participants who opted for surgical abortions, five did so because of the quicker recovery or minimal follow-up, which required fewer visits off-base and would better protect their privacy. One participant reported that because she did not disclose her abortion decision, she could not follow proper post-abortion care and ended up using tampons after her procedure, although tampon use is not recommended, due to her infrequent access to a restroom. A total of five respondents noted that the military's abortion policy had specifically negative health consequences for servicewomen, while almost all participants reported that the policy had overall negative effects on servicewomen.[46] Active-duty servicewomen not only face myriad state abortion restrictions, but fears of stigma and lack of confidentiality within their organizations. The combination of these factors leads to logistical hurdles, delays in care, and healthcare decisions that may not be in the best interests of the patient.

Problems Add Up for Servicewomen Stationed Abroad: The MTF Ban and No Good Options

Difficulties in procuring abortion care are particularly severe for active-duty servicewomen who are stationed abroad. The federal law prohibiting abortion procedures in MTFs forces active-duty servicewomen stationed abroad to seek abortion care off-base, similar to their domestically-stationed counterparts. But while US-stationed servicewomen have their right to an abortion reaffirmed by the Supreme Court, servicewomen stationed abroad are subject to the abortion regulations of their host country. As such, servicewomen deployed overseas face varied levels of off-base abortion access. For example, servicewomen stationed in Japan can legally obtain

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[45] Grindlay, K., Seymour, Jane W., Reiger, S., Keefe-Oates, B. and Grossman, D. (2017, December). Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study. *Perspectives on Sexual and Reproductive Health, 49*(4). Retrieved on April 9 2018 from: https://onlinelibrary-wiley-com.proxyau.wrlc.org/doi/epdf/10.1363/psrh.12044

[46] Grindlay, K., Seymour, Jane W., Reiger, S., Keefe-Oates, B. and Grossman, D. (2017, December). Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study. *Perspectives on Sexual and Reproductive Health, 49*(4). Retrieved on April 9 2018 from: https://onlinelibrary-wiley-com.proxyau.wrlc.org/doi/epdf/10.1363/psrh.12044

abortions on socioeconomic grounds, to save their health or life, and in the case of rape.[47] Servicewomen stationed in Afghanistan, however, may only obtain an abortion to save their lives, while those in Iraq will find no legal abortion access, even in the case of rape or life endangerment.[48]

Servicewomen stationed in countries with significant abortion restrictions may choose to travel to a different country with less restrictive laws, such as Germany, Italy, or Turkey, where abortions are available without restriction as to the reason.[49] Like their US-stationed counterparts, active-duty servicewomen abroad must request time off in order to leave their bases to seek abortion care, and face similar issues of seeking care while maintaining confidentiality and avoiding stigma. Deployed and overseas servicewomen have a number of reasons to not disclose their pregnancy to anyone in their organizations. One significant reason is the standard protocol to remove pregnant servicewomen from their deployment. Many surveyed servicewomen feared that disclosing their status could result in loss of income, formal reprimands, and negative treatment from peers or supervisors.[50] For example, one servicewoman revealed that after she sought abortion care in the US following an unintended pregnancy during deployment, she received a formal letter of reprimand from her brigade commander, who attempted to use her pregnancy as a reason to bar her re-enlistment.[51]

Therefore, it is unsurprising that deployed and overseas servicewomen face pregnancy and abortion stigma in their organizations just as their domestically-stationed peers do. A former military officer reported that it is a commonly held view among service members that active-duty servicewomen intentionally become pregnant to avoid deployment, avoid physical labor and training requirements, or to leave the barracks and move into off-base housing.[52] In an effort to maintain their privacy and reduce costs, some servicewomen overseas choose to wait until their next scheduled leave to procure an abortion in the US, delaying time-sensitive care. One servicewoman enlisted in the Navy explained, "I did not tell my chain of command at all. Part of that was because I'm one of the very few females that works within my department…There's a lot of like

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[47] Center for Reproductive Rights. (2018). *The World's Abortion Laws Map.* Retrieved on April 13, 2018 from http://www.worldabortionlaws.com/map/

[48] Center for Reproductive Rights. (2018). *The World's Abortion Laws Map*. Retrieved on April 13, 2018 from http://www.worldabortionlaws.com/map/

[49] Center for Reproductive Rights. (2018). *The World's Abortion Laws Map*. Retrieved on April 13, 2018 from http://www.worldabortionlaws.com/map/

[50] Ibis Reproductive Health. (2017, February). *Sexual and reproductive health of women in the US military. Issue brief 4: The impact of unintended pregnancy on servicewomen and the military*. Retrieved on April 13, 2018 from: https://ibisreproductivehealth.org/sites/default/files/files/publications/Military%20Brief%204%202017-02-21_0.pdf

[51] Manski, R., Grindlay, K., Burns, B., Holt, K., and Grossman, D. (2014, June). Reproductive Health Access Among Deployed U.S. Servicewomen: A Qualitative Study. *Military Medicine, 179 (*6). Retrieved April 16, 2018 from http://vg5ly4ql7e.scholar.serialssolutions.com/?sid=google&auinit=R&aulast=Manski&atitle=Reproductive+health+access+among+deployed+US+servicewomen:+a+qualitative+study&id=doi:10.7205/MILMED-D-13-00302&title=Military+medicine&volume=179&issue=6&date=2014&spage=645&issn=0026-4075

[52] Ibis Reproductive Health. (2017, February). *Sexual and reproductive health of women in the US military. Issue brief 5: Former and retired military officers' perspective on military reproductive health access and policy*. Retrieved on April 13, 2018 from: https://ibisreproductivehealth.org/sites/default/files/files/publications/Military%20Brief%201%202017-02-10.pdf

negative stigma that goes along with that…I was recently promoted…and this was right before my promotion."[53] Others may seek unsafe or illegal abortions in their assigned country, potentially risking their health and lives.

The recent study of Texas' TRAP Law, HB-2, by Cunningham et al. shows how policies that curtail abortion access may inadvertently create back channels whereby women seek to self-induce their abortions or seek illegal abortion care.[54] In fact, interviews conducted with former and retired military officers indicate that the possibility of deployed servicewomen seeking unsafe abortions is a very real concern.[55] One servicewoman who was interviewed about the military's abortion policy commented that, "We can be stationed all over the world, and… for other places that aren't up to par with their health care standards,… you're putting women in a really dangerous situation where they're probably not getting the safest health care, they probably don't have access to the most modern technology, and it's just putting them in a really bad situation overall."[56]

Abortion Care in the Context of Military Sexual Assault

The difficulty active-duty and deployed servicewomen face when obtaining abortion care is especially troubling when one considers the high rate of sexual trauma servicewomen experience. It is estimated that between one-fourth and one-third of servicewomen experience sexual assault while enlisted,[57] though experts hypothesize that only around 32% of victims (both men and women) report their assaults.[58] The prevalence of sexual assault coupled with the fear of stigma and lack of confidentiality on pregnancy and abortion decisions put servicewomen in difficult positions.

Although servicewomen are entitled to an MTF abortion procedure and TRICARE coverage in the case of rape, they may not seek care. It is important to note that not every sexual assault results in pregnancy and not every survivor will choose to terminate their pregnancy. However, the low reporting rates of military sexual assault could indicate that servicewomen experiencing pregnancy as a result of sexual assault choose not to report their assaults, even though it would help them access abortion funding or care at their MTFs. A survey of servicewomen in 2010 who experienced unintended pregnancy revealed that 4% of their pregnancies stemmed from sexual assault

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[53] Grindlay, K., Seymour, Jane W., Reiger, S., Keefe-Oates, B. and Grossman, D. (2017, December). Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study. *Perspectives on Sexual and Reproductive Health, 49*(4). Retrieved on April 9 2018 from: https://onlinelibrary-wiley-com.proxyau.wrlc.org/doi/epdf/10.1363/psrh.12044

[54] Cunningham et al.

[55] Ibis Reproductive Health. (2017, February). *Sexual and reproductive health of women in the US military. Issue brief 5: Former and retired military officers' perspective on military reproductive health access and policy.* Retrieved on April 13, 2018 from: https://ibisreproductivehealth.org/sites/default/files/files/publications/Military%20Brief%205%202017-02-21.pdf

[56] Grindlay, K., Seymour, Jane W., Reiger, S., Keefe-Oates, B. and Grossman, D. (2017, December). Abortion Knowledge and Experiences Among U.S. Servicewomen: A Qualitative Study. *Perspectives on Sexual and Reproductive Health, 49*(4). Retrieved on April 9 2018 from: https://onlinelibrary-wiley-com.proxyau.wrlc.org/doi/epdf/10.1363/psrh.12044

[57] Suris, A., and Lind, L. (2008, October). Military Sexual Trauma: A Review of Prevalence and Associated Health Consequences in Veterans. *Trauma, Violence, & Abuse, 9*(4). Retrieved on April 16, 2018 from http://journals.sagepub.com.proxyau.wrlc.org/doi/pdf/10.1177/1524838008324419

[58] Department of Defense. (2016). *FY16 Annual Report Statistics Highlights.* Retrieved on April 16, 2018 from http://www.sapr.mil/public/images/FY16_Annual/SAPRO_2016_AR_Report_Statistical_Highlights_Info_Graphic.jpg

(18% did not report a reason for their pregnancy). Some of these respondents explained that they did not seek abortion care at their MTF due to concerns that they would be blamed for their assault, or not believed, potentially risking their careers.[59] Unable or unwilling to report their sexual assaults or pregnancies, servicewomen in need of timely healthcare are left to their own devices, putting their health at risk.

CONCLUSION

For active-duty servicewomen stationed domestically and those deployed abroad, accessing abortion care is logistically challenging, and may result in delays that increase costs and chances of complications.[60] Servicewomen seeking abortion care shoulder a serious financial burden due to the TRICARE funding ban, and those stationed in abortion-hostile states must contend with a slew of abortion restrictions designed to impede their access to care. Servicewomen stationed overseas and those deployed face additional distance, costs, and delays in accessing care, as well as the potential of being removed from duty upon disclosing their pregnancy status. For servicewomen who have experienced sexual assault, the negative consequences of reporting their experience may serve as a deterrent from accessing the care they are entitled to. The process of seeking abortion care costs servicewomen considerable time, resources, and energy, in addition to fears of disclosure, stigma, and negative impacts on their careers. The TRICARE funding ban and the MTF procedural ban deny servicewomen timely access to the comprehensive reproductive health services they are entitled to as Americans.

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[59] Ibis Reproductive Health. (2012, February). *Sexual and reproductive health of women in the US military. Issue brief 1: Contraception, unintended pregnancy, and abortion*. Retrieved April 16, 2018 from https://ibisreproductivehealth.org/publications/sexual-and-reproductive-health-women-us-military-issue-brief-1-contraception-unintended

[60] Ibis Reproductive Health. (2017, February). *Sexual and reproductive health of women in the US military. Issue brief 4: The impact of unintended pregnancy on servicewomen and the military.* Retrieved April 16, 2018 from https://ibisreproductivehealth.org/publications/sexual-and-reproductive-health-women-us-military-issue-brief-4-impact-unintended

CRACKING DOWN ON SENTENCING DISPARITIES: THE FEDERAL SENTENCING ACT OF 2010'S IMPACT ON COCAINE OFFENDERS

Meghan Ballard

ABSTRACT

Crack cocaine's growth in the United States during the mid-1980s was accompanied by a suite of deterrence-driven criminal justice policies. One such policy was the Anti-Drug Abuse Act of 1986 (ADAA), The ADAA was the first federal criminal law to differentiate crack from other forms of cocaine and imposed a 100:1 sentencing ratio (Palamar, Davies, Ompad, Cleland & Weitzman, 2015). The ADAA's general imposition of longer prison sentences for all cocaine offenders had a disparate and devastating impact on communities of color. By the 2000s, African Americans had served almost as much time in prison for non-violent drug offenses as Whites had for violent offenses (Vagins & McCurdy, 2006). The Fair Sentencing Act of 2010 (FSA) attempted to remedy such disparities by, among other things, lowering the sentencing ratio for crack and powder cocaine from 100:1 to 18:1. Using secondary data from the United States Sentencing Commission, this study examines the FSA's impact on sentencing disparities of African American and White cocaine offenders. Results from difference-in-difference regression analyses indicate that the FSA not only lowered the average prison sentence length for all cocaine offenders, but also report an average of a 7 to 11 months reduction in prison sentences for crack cocaine offenders. Additionally, results indicate that the reduced effect on sentence lengths was stronger for African American than White cocaine offenders. This study aims to supply policymakers with research about unjust disparities in sentencing.

INTRODUCTION

Cocaine abuse is responsible for millions of emergency room visits and overdoses every year in the United States. Most prevalent among the wealthy elite in the 1970s, cocaine was once a symbol of affluence. Its popularity exploded when crack, a smokable rock form of cocaine, hit the Los Angeles drug scene in 1981 (Beaver, 2010). Crack was cheaper, sold in smaller quantities than powder cocaine, and was peddled in inner-city drug markets (Vagins & McCurdy, 2006). Consequently, crack became associated with communities of color. In 1985, major newspapers began differentiating powder from crack cocaine. By 1986, major news outlets declared crack an "epidemic" (Gross, 1985). Media reports disproportionately linked African Americans with crack in conjunction with violence (Cobbina, 2008). This fueled a false black threat narrative, and misleadingly portrayed crack as more dangerous than powder cocaine.

President Ronald Reagan harnessed media attention to garner congressional support for his most significant "War on Drugs" legislation, the Anti-Drug Abuse Act of 1986 (ADAA). The ADAA had unanimous House and Senate support, and created mandatory minimum sentences for federal drug offenders that varied by amount and type of drug involved. It was the first federal criminal law that differentiated crack from other forms of cocaine by imposing a 100:1 ratio for the sentencing of crack versus powder cocaine offenses (Palamar et al., 2015). Additionally, the ADAA created harsher sentencing guidelines for possession offenses of crack cocaine. Simple possession of powder cocaine was a misdemeanor and carried up to a one-year sentence, whereas simple possession of crack was a felony and carried a mandatory five-year sentence (Beaver, 2010).

Justification for the sentencing disparity stemmed from a number of myths associated with crack that have since been dispelled. Crack was believed to be more addictive than powder cocaine. However, a 1996 study in *The Journal of American Medicine* that the first to dispute this myth when it concluded that the effects of cocaine are similar regardless of form (Hatsukami & Fischman, 1996). Crack was also believed to cause violent physiological behavior. This myth was initially challenged by a 1988 study of homicides in New York City that found 85% of all deaths involving crack resulted not from the drug, but rather from the inherently violent illegal drug market (Goldstein, Brownstein, Ryan, & Bellucci, 1989). Perhaps the most persuasive myth was that crack, unlike powder cocaine, posed a unique danger to fetuses (i.e. "crack babies") (Vagins & McCurdy, 2006). However, Doctor Hallam Hurt and colleagues' (2011) decades-long study that followed 224 babies born to crack-addicted mothers in Philadelphia reported almost no differences between babies born to addicted-mothers versus non-addicted mothers. In a National Public Radio interview, Doctor Hurt stated that the issues identified resulted from poverty, not crack cocaine (Martin, 2013). A sentiment that has sense been reinforced.

Within years of the ADAA's passage, it became clear that the Act had a disparate impact on African Americans. In 1986, before the enactment of the ADAA, the "average federal drug sentence for African Americans was 11 percent higher than for Whites. Four years later, the average federal drug sentence for African Americans was 49 percent higher" (Vagins & McCurdy, 2006, p. ii). In 2004, the United States Sentencing Commission (USSC) argued that the crack-powder sentencing disparity contributed "more to the differences in average sentences between African American and White offenders than any possible effect of discrimination," and remedying the disparity "would better reduce the [sentencing] gap than any other single policy change" (USSC, 2014, n.p.).

Program Description

On August 3, 2010, President Barack Obama signed into law the Fair Sentencing Act of 2010 (FSA). The FSA reduced the sentencing ratio for crack and powder cocaine offenses from 100:1 to 18:1. Prior to the FSA, 5 grams of crack (or 500 grams of powder cocaine) carried a 5-year mandatory minimum, and 50 grams of crack (or 5,000 grams of powder cocaine) carried a 10-year mandatory minimum. After the FSA, 28 grams of crack (or 500 grams of powder cocaine) triggered a 5-year sentence, and 280 grams of crack (or 5,000 grams of powder cocaine) triggered a 10-year sentence (Grindler, 2010). In 2011, the USSC voted to retroactively apply the new guidelines to individuals sentenced before the law was enacted.

The primary goal of the FSA was to reduce the severity of crack cocaine sentences and to "reduce unjust disparities in sentencing for similar offenses involving different types of drugs" (Holder, 2014, n.p.). In turn, it was theorized that these changes would reduce sentencing disparities among African American and White cocaine offenders.

Research Question & Hypothesis

This study seeks to answer the following questions: What impact has the FSA had on sentencing disparities for crack and powder cocaine offenders? In particular, has the FSA achieved its goal of reducing the sentencing disparity between African American and White offenders? It is hypothesized that:

- *H1: After the passage of the FSA, crack cocaine offenders experienced a greater reduced effect on sentence length relative to powder cocaine offenders.*
- *H2: The reduced effect on sentence lengths was stronger for African Americans than Whites.*

An impact analysis of the FSA on sentencing disparities provides insight into how the application of sentencing practices, like mandatory minimums, harmfully and disproportionately impacts historically marginalized populations. Michelle Alexander (2012) argues in *The New Jim Crow* that laws like the ADAA perpetuate a system of racial control. The African American men in America's prisons are not exclusively impacted by mass incarceration, as their family and community members who rely on them feel the impact as well. To avoid the missteps of past politicians, who allowed myths and media to dictate justice policy, research like this study must be conducted to encourage the promotion of equitable and data-driven policies.

METHODS

Data & Sample

To determine the FSA's effect on sentence lengths of cocaine offenders, a natural experiment was conducted utilizing secondary datasets that captured information about two naturally-occurring sample groups from two years prior to (2008) and two years after (2012) the FSA's enactment. These datasets originated from the USSC Annual

Monitoring Reports of Federal Criminal Sentences, which include data on individual federal criminal cases received by the USSC that were assessed as constitutional.

The control group consists of federal drug offenders sentenced in both fiscal year 2008 ("FY08") and fiscal year 2012 ("FY12") where powder cocaine was involved without the presence of crack, and where the defendant's race was recorded as African American or White. The treatment group consists of federal drug offenders sentenced in both fiscal years where the primary or secondary drug involved was crack cocaine, and where the defendant's race was recorded as African American or White. The FY08 and FY12 datasets were appended to form a third dataset, with an added treatment dummy variable for fiscal year. Table 1 contains the variable definitions, and Table 2 contains descriptive statistics broken down by fiscal year.

Statistically significant differences of prison sentence length means in the control and treatment groups, by substance type and race, indicate that the gaps were not attributable to chance. In both FY08 and FY12, crack offenders received significantly longer sentences than powder cocaine offenders, and African American cocaine offenders received significantly longer sentences than their White counterparts. In FY08, on average, crack offenders received sentences that were 20 months longer than their powder cocaine counterparts, and African American cocaine offenders received sentences that were 43 months longer than their White counterparts. In FY12, while there was a reduction in the sentencing gap by substance type and race, crack offenders and African American cocaine offenders still received sentences that were significantly longer. Crack offenders, on average, received sentences that were eight months longer than powder cocaine offenders, and African American cocaine offenders received sentences that were 37 months longer than their White counterparts. Perhaps most jarring, however, is that even when comparing the sentences of offenders within a drug type and across fiscal years, African Americans received significantly longer prison sentences. Regardless of when the offense occurred and whether it involved crack or powder cocaine, on average African American offenders received sentences that were 30 months longer than their White offenders.

Additionally, Cohen's *d* effect size measure was calculated to quantify the size of difference between the control and treatment groups. A calculation performed on prison sentence lengths across samples, irrespective of substance type and powder, revealed a Cohen's *d* of .23. According to Cohen's (1969) guidelines this indicates a small, yet meaningful, effect size.

Measures

The dependent variable in this study is the offender's *ordered prison sentence* in months, which excludes months of alternative confinement. To maintain consistency across datasets, a number of adjustments were made to this variable: total prison sentences were recoded to zero if the sentence was probation, life sentences were recoded

to 470 months, and sentences above 480 months were adjusted to 480. While each of these modifications improve the measurement's reliability and validity, the recoding of sentences above 480 months prevented an effective life sentence, like 2880 months, from skewing the results even when the punishment was not explicitly a life sentence. Additionally, where no sentence length was identified, including even the possibility of probation, the subject was dropped from the analysis.

The independent variables are fiscal year, substance type, and an interaction variable of fiscal year by substance type. In the analysis, *fiscal year* is a dummy, binary variable that differentiates the fiscal year in which the case was sentenced to represent application of the FSA. *Substance type* is a dummy, binary variable that indicates whether the offense involved crack cocaine. To strengthen this measure's validity, any subject whose offense involved both powder and crack cocaine was coded as a crack offense. This default coding ensures a more accurate representation of the legal effects of a crack cocaine sentence. The addition of an *interaction term* to a regression model expands the understanding of relationships among model variables. The interaction term represents the combined effect of substance type (i.e. crack) and treatment application (i.e. offender sentenced under FSA). Inclusion of an interaction term improves the reliability and validity of the effectiveness measure (Horn & Lee, 2016). Statistical significance for this interaction variable would indicate that the effect of the treatment on sentence length is significantly different for crack cocaine offenders.

In addition to traditional demographic controls (i.e. race, age and gender), other variables that play a direct role in determining sentencing guideline enhancements were included to improve the study's reliability and validity. These include criminal history, involvement of a weapon, mandatory minimum application and offense type (USSC, 2016). A trial or plea variable was also added to control for outcomes explainable by a lower sentence offered as a result of an offered plea.

Study Design

This paper employs difference-in-differences (DD) regression analyses to investigate the impact of the FSA on sentence lengths for cocaine offenders. Crime outcomes were evaluated for all cocaine offenders, and then separated by White and African American offenders.

The DD method attempts to measure the effect of a treatment on an outcome variable by comparing a group of those receiving the treatment with a control group not receiving the treatment. Both groups are studied over the same time period which begins before the start of the treatment and ends after the treatment is completed. The difference in the outcome variable between the change in the treatment group, and the change in the control group, is the DD estimate and can be attributed to the treatment. This method subtracts out the effects of broader societal trends that have an influence on the outcome variable not related to the treatment. The DD method is fitting for this study as the

intended goal is to realize the FSA's effect on both crack and powder cocaine offenders over time while accounting for broader societal trends.

RESULTS

OLS Regressions

To determine the effect of substance type and race on ordered prison sentence lengths, ordinary least squares (OLS) regressions were used. Table 3 reports OLS estimates of the coefficients and standard errors of the variables included in the various model, and statistical significance is denoted by one or more asterisks. The r-squared computation was used to determine the percentage of variation in sentence length that can be explained by the model.

Models 1 and 2 report how substance type, when bundled with control variables, associate with sentence lengths in FY08 and FY12. For example, Model 1 shows that in FY08, crack offenders received slightly longer prison sentences than powder cocaine offenders–though it was not statistically significant, so it is possible that the relationship is due to chance. This is contrasted with Model 2, which shows that in FY12, crack cocaine offenders received slightly shorter prison sentences than powder cocaine offenders. Interestingly, when each model is stripped of just the race control, the direction of the coefficients mirror that of Models 1 and 2 but are generally more severe. For example, without a control for race, in crack cocaine offenders in Model 1 received four additional months in sentence length at a statistically significant level. However, when Models 1 and 2 are stripped of all control variables, both FY08 and FY12 crack cocaine offenders received even higher statistically significantly sentences than powder cocaine offenders. While these models provide insight, they only identify effects within rather than across fiscal years. Thus, to appropriately test the first hypothesis, an interaction term was included to perform DD analysis.

Models 3 and 4 report the findings of the DD models. Model 3 reports findings for the regression without controls, while Model 4 reports such findings with controls. In Model 3, every variable is statistically significant at the .001 level. This indicates strong support for rejecting the null hypothesis. However, as indicated by the small r-squared (2.1 percent), variation in sentence lengths are only weakly explained by Model 3. In comparison, the r-squared (39.7 percent) in Model 4 indicates a much stronger explanation of the variation in sentence lengths. This indicates that the control variables play a significant role in explaining the variation in sentence lengths. As was true in Model 3, Model 4's fiscal year and interaction variables are also statistically significant. This suggests that regardless of controls, the FSA played a critical role in reducing sentence lengths.

Finally, Models 5 and 6 report the findings of DD models by race. While both models report significant and negative findings by fiscal year, with Whites (-6.7 months) and African Americans (-11.2 months) on average receiving shorter sentences in FY12,

only the African American model reported a statistically significant finding for the interaction variable. These findings will be discussed further in the discussion section to follow. Other noteworthy differences include the significance levels of each model's control variables. While each control variable in Models 5 and 6 are significant, strength of that significance varies by variable and Model. In the African American model all control variables are strongly statistically significant, while in the White model age and offense type of possession were comparatively less significant.

DISCUSSION

Models 3 and 4 test the first hypothesis, that *crack cocaine offenders in FY12 experienced a greater reduced effect on sentence length relative to powder cocaine offenders*. The fact that both Models' fiscal year and interaction variables were statistically significant, and negative, indicates that the FSA had a greater reduced effect on sentence length relative to all cocaine offenders in FY08 and powder cocaine offenders in FY12. Specifically, Models 3 and 4 report lower treatment effects over time.

Models 5 and 6 test the second hypothesis, that *the reduced effect on sentence lengths was stronger for African Americans than Whites.* The fact that the African American model, when compared to the White model, reports a larger negative and statistically significant finding for the fiscal year variable, suggests support for the hypothesis. However, the strongest evidence in support of the hypothesis stems from the interaction term. Only the African American model reported a statistically significant finding for the interaction variable. This indicates that African American crack offenders in FY12 experienced a significant reduction in sentence length relative to African American crack cocaine offenders in FY08 and African American powder cocaine offenders in FY08 and FY12. The fact that only the African American model reported statistical significance for this variable suggests strong support for the hypothesis, that a reduced effect on sentence lengths was greater for African Americans than Whites.

Limitations

While secondary data analysis has many benefits, the use of secondary data presents potential risks to a study's internal validity. The reliability of secondary data analysis is dictated by the precision and accuracy of the primary data collection process (i.e. "garbage in, garbage out") (Boo & Froelicher, 2013). For example, the risk of measurement error and bias exists when data is collected and coded by researchers, as humans are fallible. For this study, these risks are low as the USSC is an independent government agency that is respected for its collection of high-quality data.

Another threat to internal validity stems from omitted variable bias. Omitted variable bias can occur when there exist unmeasured variables that confound the results. While the secondary datasets used for this study include nearly 15,000 variables, there are a number of variables that were not captured that likely play a role in determining

sentence length. For example, while there used to be a measure of defense counsel type, it was dropped from USSC's datasets starting in 2003 as the information was often unavailable. When such variables cannot be captured in the regression analysis, there exists a risk of omitted variable bias. Precautions were taken in this study to combat this risk through the inclusion of an interaction term. Given the ability of a DD to account for parallel trends, like general changes to drug sentences, the potential for omitted variable bias is lessened as DD analysis can account for influential societal trends.

Additionally, the scope of this study is limited. While the selection of FY08 and FY12 was appropriate, as they capture an equal time period before and after the FSA's implementation, this selection also limits the study's conclusions. Future research should consider using a time-series design to evaluate short-term trends to combat the potential for temporal bias. There are a number of other methodologies that could be used to test the second hypothesis; for example, the use of a three-way-interaction could allow for a test on the entire sample group instead of running two separate models of sample group subsets. While my methodological choices were suitable for this study and my skill level, as researchers we should strive to employ the best and most fitting methods possible. Thus, future research should explore these relationships using various research designs and methodological models.

Future Research

As discussed in the limitations section, there are a number of variables that could explain variation in sentence lengths which were not included in this study. One such variable is the location of sentencing by judicial district. In a recently published article, Pina-Sanchez and Grech (2018) examined court disparities in England and Wales and found that more severe sentencing occurred in courts located in neighborhoods with high proportions of Muslim residents. Given such findings, they concluded that sentencing disparities may, in part, be explained by non-legal contextual factors such as socioeconomic composition of an area. In the context of sentencing disparities for cocaine offenders, given existing demographic disparities, an exploration of non-legal contextual factors could provide policymakers valuable information. If, for example, there exists a disparity in sentencing across judicial districts, this may suggest the need for a process evaluation of prosecutorial decision-making or judicial application of mandatory minimums.

CONCLUSION

All criminal justice interventions should aim to be fair, just, and effective. Unjust differences undermine the judicial system's credibility. Thus, when disparities are identified, all attempts should be made to remedy them. While this paper's analysis suggests the FSA achieved its goal of reducing the sentencing disparity among cocaine offenders, the analysis also confirms historical trends that sentencing ratios

disproportionately disadvantage African Americans. As a sentencing ratio still exists, it is no surprise that sentencing disparities continue to exist as well. Given this, coupled with the fact that myths around exaggerated dangers of crack cocaine have been debunked, the existence of any sentencing ratio for cocaine offenses should be abolished. The goal of this study, and others like it, is to encourage policymakers to acknowledge the harms of sentencing ratios and to act by challenging the validity of sentencing ratios for drug offenses.

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APPENDIX

Table 1. Variable Definitions

Variable Name	**Measurement/Definition**
Ordered Prison Sentence	Continuous variable; total prison sentence ordered by month (470 for Life Sentences; 480 for sentences above 470 but not Life)
Substance Type: Cocaine	Dummy variable; 1 = Crack Cocaine and 0 = Powder Cocaine (if both involved, defaulted 1)
Race	Dummy variable; 1 = White/Caucasian and 0 = Black/African American
Age	Continuous variable; offender's age at time of offense
Gender	Dummy variable; 1 = Female and 0 = Male
Weapon Involvement	Dummy variable; 1 = Weapon Involved and 0 = No Weapon Involved
Criminal History	Dummy variable; 1 = yes, criminal history and 0 = no criminal history
Mandatory Minimum	Dummy variable; 1 = Mandatory Minimum Applied and 0 = Mandatory Minimum Not Applied
Offense Type	Dummy variables generated for each drug offense type (trafficking and possession)
Trial or Plea	Dummy variable; 1 = Settled by Trial, 0 = Settled by Plea
Location of Sentencing	Dummy variables generated for each judicial district in which the defendant was sentenced (12 total judicial circuits)
Fiscal Year	Dummy variable; 1 = 2012 and 0 = 2008

Table 2. Descriptive Statistics

Variable Name	Mean		S.D.	
	2008 (N=8,153)	2012 (N=5,908)	2008 (N=8,153)	2012 (N=5,908)
Ordered Prison Sentence (months)	106.156	87.186	86.650	77.000
Substance Type (Powder/Crack): Crack	.351	.544	.477	.498
Race: White	.207	.225	.405	.417
Age	32.671	34.660	8.884	9.297
Gender: Female	.094	.100	.292	.299
Weapon Involvement	.223	.183	.416	.387
Criminal History	.915	.911	.279	.284
Mandatory Minimum	.428	.357	.495	.479
Offense Type				
Trafficking and Manufacturing	.977	.970	.151	.171
Simple Possession	.010	.007	.098	.081
Trial or Plea: Trial	. 050	.043	.218	.204
Location of Sentencing*				
1st Circuit	.024	.022	.148	.148
2nd Circuit	.077	.097	.296	.300
3rd Circuit	.061	.057	.232	.232
4th Circuit	.209	.186	.407	.389
5th Circuit	.093	.102	.291	.303
6th Circuit	.137	.120	.344	.325
7th Circuit	.084	.072	.278	.256
8th Circuit	.087	.069	.281	.254
9th Circuit	.057	.118	.232	.322
10th Circuit	.022	.018	.145	.135
11th Circuit	.140	.127	.343	.333
DC Circuit	.013	.013	.114	.113

*The geographic boundaries of the United States District Courts are as follows: 1st Circuit – Maine, New Hampshire, Massachusetts, Rhode Island, Puerto Rico; 2nd Circuit – Vermont, New York, Connecticut; 3rd Circuit – Pennsylvania, New Jersey, Delaware; 4th Circuit – West Virginia, Virginia, North Carolina, Maryland, South Carolina, Virgin Islands; 5th Circuit – Texas, Louisiana, Mississippi; 6th Circuit – Michigan, Ohio, Kentucky, Tennessee; 7th Circuit – Wisconsin, Illinois, Indiana; 8th Circuit – North Dakota, South Dakota, Nebraska, Minnesota, Iowa, Missouri, Arkansas; 9th Circuit – Montana, Idaho, Washington, Oregon, Nevada, California, Arizona, Alaska, Hawaii, Guam; 10th Circuit – Wyoming, Utah, Colorado, Kansas, Oklahoma, New Mexico; 11th Circuit – Alabama, Georgia, and Florida; DC Circuit – Washington, D.C.

Table 3. Ordinary Least Squares (OLS) Regressions Model Results

	Model 1 (FY08)	Model 2 (FY12)	Model 3	Model 4	Model 5 (White)	Model 6 (Black)
Fiscal Year (FY)	-	-	-9.857*** (2.118)	-8.885*** (1.666)	-6.665** (2.096)	-11.243*** (2.198)
Substance Type (ST): Crack	2.297 (1.721)	-3.914* (1.671)	19.680*** (1.912)	2.722 (1.578)	1.980 (2.544)	1.700 (1.936)
Interaction (ST x FY)	-	-	-11.633*** (2.879)	-7.079* (2.264)	0.138 (4.333)	-6.186* (2.777)
Race: White	-15.952*** (2.019)	-11.111*** (2.098)	-	-13.610*** (1.463)	-	-
Age	0.588*** (.087)	0.176* (.176)	-	0.399*** (.061)	0.180* (.084)	0.526*** (.078)
Gender: Female	-28.547*** (2.693)	-27.610*** (2.702)	-	-28.139*** (1.927)	-19.700*** (2.258)	-34.258*** (2.710)
Weapon Involvement	35.425*** (1.852)	29.655*** (2.051)	-	33.191*** (1.380)	25.161*** (2.707)	34.604*** (1.578)
Criminal History	22.894*** (2.856)	18.870*** (2.959)	-	20.791*** (2.067)	10.674*** (2.216)	31.168*** (3.142)
Mandatory Minimum	62.093*** (1.625)	62.108*** (1.714)	-	62.085*** (1.188)	67.400*** (2.283)	60.915*** (1.364)
Offense Type: Trafficking	29.505*** (6.552)	24.044*** (5.167)	-	26.621*** (4.163)	22.400*** (5.961)	27.706*** (5.160)
Offense Type: Possession	-28.432** (10.114)	-36.402** (10.826)	-	-32.650*** (7.283)	-20.727* (9.620)	-41.429*** (9.391)
Trial/Plea: Trial	114.298*** (3.516)	112.531*** (3.876)	-	113.715*** (2.616)	98.346*** (5.668)	115.81*** (2.943)
Constant	1.689 (7.639)	15.390* (6.648)	93.377*** (1.541)	12.387* (5.134)	15.328* (6.936)	-0.784*** (6.595)
R^2	0.383	0.400	0.021	0.397	0.427	0.366
N	8,153	5,988	14,061	14,061	3,013	11,048

p<.05* p<.01 p<.001*****

DEPENDENCE, VIOLENCE AND NEGLECT IN WOMEN WITH DISABILITIES

Karlee Naylon

INTRODUCTION

According to the Centers for Disease Control and Prevention, 61 million adults in the United States, or approximately 26% of the U.S. population, report having a disability (CDC, 2018). It is generally understood that people with disabilities experience increased rates of poverty, reduced access to health care services, and social and employment barriers at higher frequencies as compared to the nondisabled population (Vallas, 2018; Rapaport, 2017; NCWD, 2016). According to the National Network to End Domestic Violence, the incidence of domestic and sexual violence is even higher than that of disability, nearing 1 in 3 women (2018). Experiences of sexual violence and abuse in a violent relationship have been associated with food and housing insecurity, losses in education and negative psychological outcomes (NNEDV, 2018). Individuals who have a disability and experience sexual violence are especially vulnerable to compounding injustice.

Women with disabilities appear to experience sexual violence at an elevated rate as compared to the nondisabled population (Basile, Breiding, & Smith, 2016; Martin et al., 2006). Research performed prior to the 1990's failed to identify contributing risk factors to explain this trend, however, Smith (2007) found that being female, disabled, unemployed, single and under the age of 40 increased one's likelihood of experiencing abuse. Recent studies have identified forms of violence unique to disability and aging, such as manipulation of medication, neglect and withholding of care (Powers, Hughes, Lund, & Wambach, 2009). Like traditional forms of sexual and interpersonal violence, this neglect is characterized by power imbalance and the exercise of control over another person. People with disabilities who rely on family members or personal care assistants to complete activities of daily living (ADLs) may be particularly vulnerable, because these relationships include an inherent imbalance of power between the giver and recipient of care services.

Respective circumstances may increase or decrease an individual's risk of experiencing violence or neglect. Individuals with disabilities each live within their own unique circumstances, thus implying that their levels of reliance on others also vary accordingly. For example, some individuals with disabilities may function completely independently, some may live semi-independently (i.e. an individual with a visual or hearing impairment), and some may exclusively rely on personal care assistants to complete ADLs (i.e. an individual with total paralysis or a severe intellectual disability). These differences in dependence may potentially put an individual at elevated risk of sexual violence and neglect; those who retain a significant level of autonomy may rely

very little on others to complete daily activities, while those with comparatively less mobility may depend on care assistants and thus be more vulnerable to abuse.

The intersection between disability, sex, and level of dependence may have significant implications for disability policy, methods of identifying victims of violence and services available to survivors of neglect and sexual abuse. This study explores the relationship between need for assistance on various tasks and experiences of sexual violence reported by women with physical disabilities and motor impairments.

CONSIDERATIONS

There has been little research done to explore sexual violence and neglect in women with disabilities with the inclusion of level of autonomy as a potential contributing risk factor. These topics (disability, autonomy, sexual violence, and neglect) are independently sensitive. For this reason, several considerations must be established in order to pursue the present study in a respectful manner:

The use of person-first language aims to refer to an individual holistically rather than emphasize observable or non-observable characteristics. Its primary purpose is to avoid the use of one's condition as a label, categorization, or definition of who they are. For example, it is more appropriate to use the phrase "person with a disability" rather than "disabled person" or "handicapped person," so as to preserve the entire autonomous individual. Person-first language is used throughout this paper in accordance with the Disability Language Style Guide (National Center on Disability and Journalism, 2018). Additionally, the potential presence of ableism was continually reevaluated to ensure that the purpose and goals of the study were not corrupted by unintentional discrimination.

While the term "sexual violence" itself is not gendered, research and discussions of sexual violence tend to focus on the experiences of women and girls rather than those of men and boys. The present study also focuses on women's experiences of sexual violence and neglect, due to the disproportionate amount of violence experienced by females. This distinction is not intended to imply that men are the sole perpetrators of violence, or that their sex insulates them from experiencing abuse, but that women are impacted at a higher frequency overall.

Lastly, people with disabilities are often labeled as members of a "vulnerable population," despite many people disagreeing with that categorization. In reality, disability exists on a spectrum and each individual has a differing set of abilities and necessary accommodations. This study continues the discussion of whether 'dependency' is synonymous with 'vulnerability' (Mackenzie, Rogers, & Dodds, 2014), and contributes to the conversation of how women with physical disabilities might preserve their senses of autonomy and forfend unwanted advances.

DATA/METHODS

Data used for the present study was collected by the Developmental Disabilities Institute at Wayne State University and the United Cerebral Palsy Association in Michigan in 2000-2001. This data is publically available on ICPSR through the University of Michigan. The variables of interest for this study are:

1. the types of tasks where assistance is needed (getting out of bed, eating, dressing, toileting, personal hygiene, moving around the home, taking medication, meal preparation and home maintenance)
2. total number of tasks where assistance is needed, and
3. women's reported experience of violence and neglect.

The hypotheses of this study are as follows:

1. Women with a higher level of dependence on others experience sexual violence and neglect at a higher rate than women with a lower level of dependence. [61]
2. Some types of assistance will predict experiences of sexual violence/neglect at higher rates than others. [62]
3. These differences in experiences of sexual violence and neglect will persist when analyses are controlled for age and ethnicity.

177 women with physical disabilities were surveyed in 2000-2001 to identify the types of activities they needed assistance to complete and their experience of neglect and sexual violence. Tables of descriptive statistics are located in Appendix A. Data were standardized prior to analysis, and a summary variable of the total number of tasks where assistance was needed was calculated to serve as an indicator of dependence on others (variable name *ztotal*). Bivariate linear regression analyses were performed on the hypothesized relationships to identify those of significance. All hypotheses were tested at $\alpha = .05$ level of significance.

RESULTS

The results of the primary hypothesis indicate that women with a higher level of dependence on others did not experience violence at a significantly higher rate [$t\ (1,171) = -.75$, $p = .457$], but did experience neglect at a significantly higher rate than women with a lower level of dependence [$t\ (1,170) = 2.14$, $p = .033$]. These results persisted when the regression was controlled for age and ethnicity (Appendix B).

Analyses performed on the variables 'home maintenance,' 'assistance taking medication,' and 'neglect'. Results of the analysis indicate that women who needed assistance with home maintenance reported neglect at a significantly higher rate than those who did not need assistance [$t\ (1,172) = 2.16$, $p = .032$]. Women who needed

[61] H_0: $\mu_{\text{higher dependence}} = \mu_{\text{lower dependence}}$, where μ refers to the average violence or neglect experienced
H_A: $\mu_{\text{higher dependence}} \neq \mu_{\text{lower dependence}}$

[62] H_0: $\mu_{\text{type of assistance}} = \mu_{\text{other types of assistance}}$, where μ refers to the average violence or neglect experienced
H_A: $\mu_{\text{type of assistance}} \neq \mu_{\text{other types of assistance}}$

assistance taking medication also reported neglect at a significantly higher rate than those who did not need assistance taking medication [t (1,174) = 2.07, p = .04], These results persisted when controlled for age and ethnicity (Appendix C).

Women who needed assistance getting in and out of bed also experienced neglect at a higher rate than those who did not need assistance, though this was only significant at the α = .10 level of significance [t (1,173) = 1.95, p = 0.053]. These results persisted when controlled for age and ethnicity (Appendix D).

DISCUSSION

The findings of this study indicate that women who reported needing assistance on a higher number of tasks experienced neglect at a higher rate than women who needed assistance on fewer tasks. More specifically, women who needed assistance maintaining their home, taking medication, and getting in and out of bed reported neglect at higher rates than women who needed assistance on other tasks.

The results of this research are consistent with several studies which found high prevalence rates of maltreatment and neglect in people with disabilities (Sullivan & Knitson, 2000; Findley, Plummer, & McMahon, 2015). Findings of the present study contrast a number of previous studies, however, as this study did not identify a linear relationship between one's level of dependence and experiences of sexual violence (Brownridge, 2006; Erwin, 2000; Martin et. al, 2006;). Previous studies did not attempt to draw a relation between level of dependence and rate of abuse and neglect.

Several, but not all, tasks that rely on a certain threshold of mobility were found to be associated with higher levels of neglect. The extent of neglect experienced by the women (e.g. withholding of care, manipulation) is unclear. Future research may explore the relationship between mobility and abuse and neglect.

LIMITATIONS

The external validity of this study is limited in a number of ways. This study's small pool of participants exclusively consisted of women with physical disabilities, and did not include women with intellectual or cognitive disabilities. The experiences between these two populations may differ significantly. Women with intellectual or cognitive disabilities may perceive power dynamics and experience exploitation in a more pronounced way due to economic dependence, and may experience higher levels of control imposed on their daily lives from others (Benedet & Grant, 2014). Additionally, these findings are not generalizable to men or people who identify as LGBTQ+ with disabilities, as these populations may have unique experiences and considerations.

In addition, the data analyzed was collected in 2000-2001, and just 100 of the 177 participants reported having experienced sexual violence or neglect at least once. This sample is small and prone to self-selection bias due to the sampling method used in the original study (which consisted of sending letters and flyers to disability advocacy

organizations, submitting announcements to newsletters, and sending informational mailings to physical therapists and domestic abuse programs). It is also generally understood that relying on self-reporting by participants to gather data on sensitive topics results in systematic underestimation the true magnitude of prevalence (Garcia & Gustavson, 1997). This may explain why the findings of this study did not identify a relationship between level of dependence and experiences of sexual violence (type II error), as women may hesitate to report experiences due to fear of retaliation or associated stigma. Due to recent increases in discussions surrounding sexual assault (as a result of the #MeToo Movement) and increased visibility and inclusion of people with disabilities, more women may be willing to disclose their experiences of violence and neglect today compared to 2000-2001. Replication of this study may result in a larger sample size, as well as increased willingness among participants to disclose experiences of violence and neglect.

Finally, and perhaps most importantly, this study assumes that one's need for assistance in completing certain tasks is a proxy for their level of dependence on others. In reality, autonomy is a complex indicator and may exist as a spectrum. Due to unexplored confounding factors, people with disabilities who have a low level of dependence on others may remain more susceptible to violence or neglect compared to the nondisabled population. Omitted variables unrelated to dependence may account for increased risk of assault or neglect, such as living environment during childhood, family history of domestic violence, previous experiences of violence, cumulative exposure to violence over the lifetime, level of education regarding preventative interventions, and informal institutions/normative frameworks in the cultural context (Dabby & Poore, 2007; INSPQ, 2019).

POLICY IMPLICATIONS AND CONCLUSION

Despite these limitations, the findings of this study offer insight into several research and policy implications for people with disabilities. This study may help inform future educational and preventative programming meant to protect people with disabilities from sexual violence and neglect. This may include:

- human-centered awareness trainings for personal care assistants or family members who serve in this role.
- trainings oriented toward individuals with disabilities themselves, to include educational programming on signs of neglect and abuse, as well as actions they may take if they are victimized
- internal accountability improvements in institutions that provide patient care

Once an instance of abuse or neglect occurs, it is essential that the survivor has access to the resources they need. While one's level of dependence on others may put an individual at elevated risk of violence and neglect, it may also act as an additional barrier

to seeking safety following an instance of abuse. Many nondisabled survivors of violence endure long periods of abuse before ever seeking help due to many existing barriers, including (but not limited to) stigma, isolation from others, and financial dependence on their spouse. These barriers may be heightened for people with disabilities living in abusive settings, who may be unable to escape their circumstance due to limited physical mobility, unique verbal abilities, and limited access to healthcare (Barrett, O'Day, Roche, Lepidus Carlson, 2009; Saxton et. al, 2001). Prevention measures aside, ensuring that people with disabilities have the means to escape from an abusive environment without enduring further harm should be paramount.

Future revisions to disability policy may include:

- introduction of disability awareness or sensitivity training for responders to domestic violence situations (including EMTs and law enforcement officers)
- instruction of appropriate communication with people with disabilities
- implementation of human-centered approaches that keep survivors in control of their circumstances

Additionally, centers for survivors of domestic violence may not presently be able to accomodate the needs of people with disabilities (i.e. purchasing of equipment, accessible lodging, and disability-related medical services) due to scarce resources (Chang et. al, 2004). Future policy revisions might consider taking steps to:

- increase funding appropriations to emergency shelters for the purchasing of equipment and medical services
- increase the number of ADA-compliant emergency shelters

In conclusion, while visibility and acknowledgement of sexual violence and disability have increased over recent decades, these gains have occurred slowly and research into their overlap is exceedingly scarce in academia. This study attempted to explain one relationship between intersecting identities and compounding experiences of injustice. Ableism, or discrimination against people with disabilities, can take many forms and may not be immediately recognized. Ableism is often unconsciously perpetrated by well-intentioned, nondisabled people in their language and behaviors. To combat ableism, advocacy must at its core ensure that the inclusion of individuals with disabilities is prioritized, and that their voices are not overshadowed by able-bodied advocates. Future research must thoroughly explore the needs of people with concurrent identities in order to push policymakers and legislators to effectively serve all people.

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APPENDIX A

. tab AGE

AGE	Freq.	Percent	Cum.
20-29	14	7.91	7.91
30-34	13	7.34	15.25
35-39	28	15.82	31.07
40-44	34	19.21	50.28
45-49	22	12.43	62.71
50-54	31	17.51	80.23
55-59	19	10.73	90.96
60+	15	8.47	99.44
Unknown	1	0.56	100.00
Total	177	100.00	

. tab ETHNIC

ETHNICITY	Freq.	Percent	Cum.
Caucasian	139	78.53	78.53
African American	28	15.82	94.35
Other	10	5.65	100.00
Total	177	100.00	

. tab DISABIL2

TYPE OF DISABILITY-2	Freq.	Percent	Cum.
None	113	63.84	63.84
Stroke	1	0.56	64.41
Multiple sclerosis	1	0.56	64.97
Visual impairment	5	2.82	67.80
Traumatic brain injury	7	3.95	71.75
Hearing impairment	6	3.39	75.14
Spinal cord injury	3	1.69	76.84
Arthritis	14	7.91	84.75
Other	27	15.25	100.00
Total	177	100.00	

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. tab MULTIDIS
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MULTIPLE DISABILITY	Freq.	Percent	Cum.
No	117	66.10	66.10
Yes	60	33.90	100.00
Total	177	100.00	

APPENDIX B

```
. regress zneglect ztotal

      Source |       SS       df       MS              Number of obs =     171
-------------+------------------------------           F(1, 169)     =    4.60
       Model |  4.4716523     1  4.4716523             Prob > F      =  0.0334
    Residual |   164.3599   169  .972543788            R-squared     =  0.0265
-------------+------------------------------           Adj R-squared =  0.0207
       Total | 168.831552   170  .993126779            Root MSE      =  .98618

------------------------------------------------------------------------------
    zneglect |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
      ztotal |   .1635329   .0762651     2.14   0.033      .012978    .3140878
       _cons |   -.006302   .0754198    -0.08   0.934    -.1551882    .1425842
------------------------------------------------------------------------------

. regress zneglect ztotal zage zethnicity

      Source |       SS       df       MS              Number of obs =     171
-------------+------------------------------           F(3, 167)     =    1.59
       Model | 4.68894668     3  1.56298223            Prob > F      =  0.1937
    Residual | 164.142606   167  .982889855            R-squared     =  0.0278
-------------+------------------------------           Adj R-squared =  0.0103
       Total | 168.831552   170  .993126779            Root MSE      =  .99141

------------------------------------------------------------------------------
    zneglect |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
      ztotal |   .1649107   .0772631     2.13   0.034     .0123724    .3174491
        zage |   .0060609   .0765733     0.08   0.937    -.1451155    .1572373
  zethnicity |   .0357217   .0761638     0.47   0.640    -.1146463    .1860897
       _cons |  -.0060546   .0758286    -0.08   0.936    -.1557608    .1436517
------------------------------------------------------------------------------
```

APPENDIX C

```
. reg zneglect zhomemain

      Source |       SS       df       MS              Number of obs =     174
-------------+------------------------------           F(1, 172)     =    4.66
       Model |  4.54224685     1  4.54224685           Prob > F      =  0.0322
    Residual |  167.552273   172  .974141123           R-squared     =  0.0264
-------------+------------------------------           Adj R-squared =  0.0207
       Total |   172.09452   173  .994766012           Root MSE      =  .98699

------------------------------------------------------------------------------
    zneglect |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
   zhomemain |   .1621115    .075074     2.16   0.032     .0139266    .3102964
       _cons |  -.0047264   .0748246    -0.06   0.950    -.1524192    .1429664
------------------------------------------------------------------------------
```

```
. reg zneglect zmedications

      Source |       SS       df       MS              Number of obs =     175
-------------+------------------------------           F(1, 173)     =    4.30
       Model |  4.18313737     1  4.18313737           Prob > F      =  0.0396
    Residual |   168.26007   173  .972601563           R-squared     =  0.0243
-------------+------------------------------           Adj R-squared =  0.0186
       Total |  172.443208   174  .991052918           Root MSE      =  .98621

------------------------------------------------------------------------------
    zneglect |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
zmedications |   .1576331   .0760088     2.07   0.040     .0076091     .307657
       _cons |  -.0067945   .0745585    -0.09   0.927     -.153956    .1403669
------------------------------------------------------------------------------
```

APPENDIX D

```
. reg zneglect zbed

      Source |       SS       df       MS              Number of obs =     175
-------------+------------------------------           F(1, 173)     =    3.79
       Model |  3.69345772     1  3.69345772           Prob > F      =  0.0533
    Residual |   168.74975   173  .975432081           R-squared     =  0.0214
-------------+------------------------------           Adj R-squared =  0.0158
       Total |  172.443208   174  .991052918           Root MSE      =  .98764

------------------------------------------------------------------------------
    zneglect |      Coef.   Std. Err.      t    P>|t|     [95% Conf. Interval]
-------------+----------------------------------------------------------------
        zbed |   .1490637   .0766044     1.95   0.053    -.0021359    .3002634
       _cons |  -.0065947   .0746697    -0.09   0.930    -.1539757    .1407863
------------------------------------------------------------------------------
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GOVERNMENT-LED DEVELOPMENT INITIATIVES IN ZIMBABWE

Rebekah McDowell

INTRODUCTION

This portfolio explores Zimbabwe's various efforts to spur development and how those efforts abound with good intentions, some of which are hampered by unintended consequences and constrained by tensions. In each of the initiatives discussed, the government has been primarily concerned with economic development and growth. I begin by providing a foundational analysis of Zimbabwe's colonial history and Robert Mugabe's aim to liberate the country; I make this analysis through the lens of Amartya Sen's and Paulo Freire's understandings of freedom. Next, I argue that participation in the World Bank's Structural Adjustment Programs (SAPs) led to structural violence in Zimbabwe, particularly in the fields of health and education. Furthermore, SAPs caused the reversal of some of the advancements made by Mugabe in the 1980s. Thirdly, I examine Zimbabwe's Harmonized Social Cash Transfer Program, which has been largely successful and demonstrates that cash transfer programs do not need conditions to produce the desired outcomes. After that, I explore the CAMPFIRE program – aimed at providing economic incentive for conservation – and the degree to which it has shifted resource management authority and benefits to local communities. Lastly, I review Zimbabwe's approach to gender and how efforts have focused on women and girls as a strategy for economic development yet have overlooked men and gender relations.

Conversations about and approaches to development often center around how outsiders – Western countries, international financial institutions, NGOs, volunteers, and other actors – can help a Third World country develop. In this portfolio analysis, I am interested in what the national government of Zimbabwe has done to promote its own development. Mugabe's long-term rule as the revolutionary leader who rebuked British colonial rule and promised Zimbabweans autonomy creates special interest in examining national development efforts. The country, however, has not acted in a vacuum. Factors such as a colonial past, the global dominance of neoliberal economic principles, hegemonic assumptions about the poor, and international discourse about the role of women in development have all influenced Zimbabwe's development policies and initiatives.

How the "Colonized Mentality" has Thwarted Development in Zimbabwe

Zimbabwe gained freedom from British colonial rule nearly forty years ago. Since then, it has received billions of dollars from foreign aid agencies. Despite this aid, the country's poverty levels remain high and the quality of life for its citizens has seen little improvement. Why is this? Zimbabwe's history cultivated a "colonized mentality" that allowed for continued oppression under the rule of Robert Mugabe. While Zimbabwe has

made strides forward since colonial rule, achieving greater development in terms of overall well-being will require increasing citizens' freedoms.

Zimbabwe has a history of oppression and underdevelopment. British colonists arrived at the end of the 19th century and ruled the country (then Southern Rhodesia) until 1980. Following independence, Mugabe, an African nationalist, largely controlled the national government. Mugabe served first as Prime Minister from 1980-87 and then as President from 1987-2017. While the country has an election process, it often has not been free and fair (Banerjee, 2018). Mugabe resigned from office following a military coup in November 2017. Although some celebrate Mugabe as a revolutionary against British rule, and his economic and social initiatives brought varying degrees of improvement to people's lives, he also perpetuated systems of oppression and eventually became a despot (Chandler III & Chandler, 2013).

While Mugabe liberated Zimbabwe from colonial oppression, he also embodied the "colonized mentality," feeling both contempt and admiration toward the colonizer (Freire, 2005). The former president's need for the support of and control over Zimbabweans caused him to lose sight of his goal of restoring the humanity taken under British rule and to instead use violence and fraud to remove opposition and maintain his power for four decades (Frankel, 2017). Freire's theories in *Pedagogy of the Oppressed* explain Mugabe's apparent hypocrisy and elucidate why liberation did not replace oppression in Zimbabwe when British rule ended. Initially, the oppressed almost always become the oppressors, because oppression is their only model and they fail to fight for true liberation. Revolutionary leaders forget that their main goal is to fight "for the recovery of the people's stolen humanity, not to 'win the people over' to their side" (Freire, 2005).

The continued oppression in the country has stunted its development. Amartya Sen defines freedom as both the ends and means of development, arguing that "the instrumental role of freedom concerns the way different kinds of rights, opportunities, and entitlements contribute to the expansion of human freedom in general, and thus to promoting development" (Sen, 1999). He says "instrumental freedoms" – political freedoms, economic facilities, social opportunities, transparency, and protective securities – build upon one another and lead to development. Mugabe limited access to and expansion of instrumental freedoms under his dictatorial rule. For example, opposition to the former president was met with violence and election fraud, while Mugabe's policy of complete redistribution of white-owned land led to famine and poverty (Frankel, 2017). Mugabe promised liberation but instead traded colonial oppression for autocracy disguised as democracy.

A revolutionary leader that frees the people is a false hope. Freire (2005) argues that overcoming oppression requires *conscientizacao*: critical social consciousness; the oppressed must first recognize their humanity and how they have been dehumanized. Once they have attained consciousness, then they can seek liberation together with those

committed to freeing the oppressed. Liberation, then, is a mutual process rather than a gift or self-achievement (Freire, 2005). In trying to give freedom in a top-down, controlled way, Mugabe left a legacy of violence and greed and deprived Zimbabweans of the very liberation he promised them (Frankel, 2017).

While Mugabe did lead many efforts to develop the country, particularly through economic means, he failed in many ways to support full instrumental freedom for Zimbabweans. The colonized mentality has slowed development in Zimbabwe, where underdevelopment has manifested in the lack of instrumental freedoms laid out by Sen (1999). As Freire (2005) argued, true liberation will only come when Zimbabweans have attained *conscientizacao*.

Impacts of Structural Adjustment Programs in Zimbabwe: Health & Education

In the early 1990s, Zimbabwe participated in the Structural Adjustment Programs (SAPs) of the World Bank and International Monetary Fund (IMF), which allowed countries to restructure debt. The neoliberalist tenets of deregulation, privatization, production, and decreased social spending underpinned SAPs, whose conditionalities required debtor countries to shift towards a free-market economy. Contrary to the intended goals, SAPs had social, political, and economic impacts for developing countries that resulted in a "new intensity of immiseration" (Pfeiffer & Chapman, 2010).

In 1991, Zimbabwe announced its participation in a SAP, called the Economic Structural Adjustment Program (ESAP). The Program aimed to promote growth while reducing poverty and unemployment, but it came with hidden costs. The World Bank backed the ESAP agenda with $175 million in structural adjustment credits and loans to support deregulation, trade liberalization, and reduced public spending (World Bank, 2012). International financial institutions protected the interests of creditor countries by enforcing economic policies that would lead to revenue generation (Graeber, 2017), which often meant that countries abandoned social programs to be able to pay back the debt. Graeber described this system as a more sophisticated form of colonialism. In Zimbabwe, the SAPs had a particularly negative impact on the health and education sectors.

Following independence in 1980, Mugabe's government devoted significant resources to the health sector to address socioeconomic inequalities; accordingly, social indicators improved (World Bank, 2012). The 1991 introduction of ESAP in response to the economic crisis, however, led to job cuts in the healthcare sector and imposed service fees which negatively impacted the poor who could not afford to pay for services (Pfeiffer & Chapman 2010). Nurses and female community members noted that quality of care (e.g. clinic fees, wait times, and staff and drug shortages) worsened following the implementation of ESAP (Bassett, Bijlmakers & Sanders, 1997). Farmer (1999) would define this situation as structural violence, in which social institutions and structures deprive individuals of access to their basic needs and rights. SAPs affected Zimbabwe's

healthcare system in a way that negatively and violently impacted health, particularly for the poor. Clearly, the government did not meet its goal of reducing poverty and suffering.

Much like the health sector, the education sector in Zimbabwe flourished under increased investment in the 1980s (World Bank, 2012), and the government introduced free universal primary education. However, many of the gains made in education were lost under the implementation of the SAPs. The government faced debt-servicing obligations and pressure to decrease public funding for social services. From 1991 to 1994, per capita spending on education declined by 32 percent; the reduction impacted primary education in particular (Gordon, 1997). The cuts in public funding transferred the cost burden to citizens. The government imposed tuition fees in urban areas and applied exam, sports, uniform, and other fees in all areas (Gordon, 1997). Increased school fees posed a barrier to education for students of all ages. For example, in 1996, costs accounted for 65 percent of the unenrolled students aged 13-17 not being in school (Gordon, 1997). The imposition of school fees represents another form of structural violence that disproportionately impacted the poor.

Neoliberalism asserts that the free market will allocate goods and services in the most equitable way. The impacts of SAPs in Zimbabwe, however, serve as one case among many that shows this mechanism of debt repayment failed to improve circumstances for developing, debtor countries. Ironically, SAPs in Zimbabwe served only to dismantle gains previously made in health and education, imposing forms of structural violence that worsened conditions for the poor and led to increased inequality and the intensified immiseration Pfeiffer and Chapman (2010) describe.

Zimbabwe's Harmonized Social Cash Transfer Program

Cash transfer programs have arisen as a development strategy over the past few decades. Both conditional (CCT) and unconditional (UCT) cash transfer programs provide a social safety net and are currently seen as effective approaches to poverty alleviation (Son 2008). The development community continues to debate about which approach is preferable. Zimbabwe's Harmonized Social Cash Transfer (HSCT) program demonstrates that positive impacts can largely be achieved without conditions. Furthermore, HSCT provides a means for examining how conditions more broadly contradict principals of human rights and reflect particular assumptions about the poor.

In 2011, Zimbabwe's Ministry of Labour and Social Welfare (MLSW) introduced the HSCT program, a UCT program for food-poor, labor-constrained households. The program covered 10 districts (16,600 households) in 2012; it then expanded to cover 20 districts (55,500 households) by early 2014 (FAO, 2015). Using $10-25 cash transfers, HSCT aims to increase consumption and make education, basic services, and opportunities more accessible to the very poor (Angeles, 2018). Zimbabwe severely needed this program, considering 78 percent of the population lives below the poverty line and 55 percent falls below the food poverty line (Angeles 2018).

Opponents of UCTs argue a lack of conditions will not create sustained poverty-reduction, “hence, the idea is to transfer cash to the poor ‘on condition’ that the poor will commit to empower themselves and help bring future generations of poor families out of poverty” (Son, 2008). The implementation of HSCT in Zimbabwe, however, demonstrates the poor do improve their circumstances without the imposition of conditions. While HSCT has not achieved all its goals, it has shown: increased ownership of livestock/chickens; significant impact on agricultural activities; eased financial constraints; and a positive impact on food security, nutrition, and dietary diversity (FAO, 2015). Furthermore, the transfers resulted in: households’ reduced dependency on family and neighbors; decreased debt; a 1.47 spending multiplier of the transfer amount; improved material well-being for children; and increased protection of youth (Angeles, 2018).

The impacts of HSCT demonstrate that the poor will act to improve their circumstances when given access to money. The “poverty trap” of no assets and negligible income – not a lack of understanding – prevent the poor from escaping poverty (Hanlon, 2009). The beliefs that the poor are responsible for their own poverty, waste money given to them, and must be taught to be “better” people are rooted in 19th century thinking and were revived under neoliberalism starting in the 1980s (Hanlon, 2009). Proponents of UCTs, on the other hand, trust that individuals know their own needs best and view conditionalities as demeaning coercion of the poor (Son, 2008).

The Universal Declaration of Human Rights names an “adequate standard of living” as a universal right and provides a rationale for cash transfers (Hanlon, 2009). The government of Zimbabwe shares the values of this human rights framework, as reflected in the MLSW’s vision of “a social protection system that promotes a decent standard of living for all people in Zimbabwe” (MLSW, 2018). Attaching conditions to cash transfer requires the poor to act in particular ways, making the cash transfer something that must be earned rather than an entitlement.

When an adequate standard of living is framed as a human right, conditionalities become unwarranted control mechanisms over the poor. Evidence shows conditions have little impact on the performance of recipients (Hanlon, 2009), and Zimbabwe’s program has done well without them. Given these considerations, conditions on cash transfers lack compelling justification.

CAMPFIRE: Local Benefit from Resource Management & Conservation?

Zimbabwe is one of the top five African countries for international tourism (AfDB, 2018), much of which revolves around its national parks and wildlife. Following liberation in 1980, the state sought to reverse locals’ dispossession of land that occurred under colonial rule (McIvor 1994). The goal of Communal Areas Management Program for Indigenous Resources’ (CAMPFIRE) is for local communities to benefit from natural resource use. In assessing resource control in Kenya and Indonesia, Peluso (1993) finds

that (1) power struggles exist between the state and communities over resource control, access, and allocation, (2) conservation efforts often benefit the state over local people, and (3) locals are blamed for destroying nature. Zimbabwe provides the opportunity to see if these findings hold true in another context.

Conservation efforts often rely on moral arguments for protecting the environment, with the underlying goal of maintaining a pristine version of nature “for tourist consumption” (Peluso, 1993). In Zimbabwe, however, an economic argument takes center stage. Zimbabwe’s 1975 Parks and Wildlife Act “gave landholders the right to manage wildlife for their own benefit, thus providing an economic rationale to reinforce the scientific, aesthetic, and moral justifications for wildlife conservation” (Murindagomo, 1990). The Act paved the way for the Department of National Parks and Wildlife Management (now the Parks and Wildlife Management Authority) to establish CAMPFIRE in 1989. CAMPFIRE aims to reduce poverty and support the economic participation of rural communities via the sustainable use and management of natural resources (CAMPFIRE Association, 2018).

CAMPFIRE originated within the government and its “original conception aspired to true bottom-up planning with a focus on community input and autonomy” (Logan & Moseley, 2002). The program sought to shift authority over wildlife from the state to citizens and ensure the local community benefitted from the gains from resource exploitation. In reality, however, Rural District Councils (RDCs) control wildlife resources and determine the rights individual households have over these resources (Murindagomo, 1990). Locals possess only partial authority and most remain excluded from decision-making over wildlife management (Mutandwa & Tafara Gadzirayi, 2007).

Results are mixed in terms of who benefits from CAMPFIRE. The government says that “communities will benefit from revenue generated from wildlife-based projects including hunting” (ZPWMA, 2015). In 1990, wildlife (e.g. safari hunting, tourism, etc.) contributed $250 million annually to Zimbabwe’s economy (Murindagomo, 1990). The annual monetary benefit of CAMPFIRE was approximately $8.40 per household in 1996/97; only 52 percent of this, however, was distributed to communities, instead of the 80 percent prescribed by the program (Logan & Moseley, 2002). Furthermore, Mutandwa & Tafara Gadzirayi (2007) found that most community members reported that they did not feel CAMPFIRE had meaningfully improved their livelihoods – despite the creation of employment opportunities, building of infrastructure, and dividend payments – because most activities remained with the RDCs.

Conservationists are often framed as nature’s heroes, while locals are seen as its destroyers or combatants (Peluso, 1993). CAMPFIRE’s goals – such as reducing poverty as a necessary condition of conservation – reflect the belief that the poor are “their own worst environmental enemies” (Logan & Moseley, 2002). Poverty and resource management are understood as mutually-dependent. Development actors, public officials, and others commonly believe that conservation cannot be successfully undertaken by the

poor because they do not know how to manage resources on their own and will act out of individual interest at the cost of larger environmental concerns. The Zimbabwean government's desire to protect the environment from the poor motivated the creation of CAMPFIRE.

CAMPFIRE benefits locals more than some other conservation schemes have, yet it still falls short of its aims. Control has been passed to the local level, but decision-making authority and economic benefits fall largely to the RDCs rather than community members. The government must increase trust in locals' and the poor's ability to manage resources and conserve their environment.

The Limitations of Zimbabwe's Approach to Women and Gender

The Zimbabwean government has increased its focus on gender equality and equity in the last several years. It established the Ministry of Women Affairs, Gender, and Community Development (MWAGCD) in 2005 and the Zimbabwe Gender Commission in 2015. The new Constitution of 2013 recognizes the right for men and women to have equal opportunities and voids all laws and customs encroaching on the rights of women (UK Home Office, 2018). The National Gender Policy and several other pieces of legislation aim to safeguard women and girls. These measures demonstrate a concerted effort by the government to increase gender equality. However, the government's decision to largely take a Women in Development (WID) rather than a Gender and Development (GAD) approach, could inhibit deep, structural change.

WID focuses on equal opportunity for and economic engagement by *women*, while GAD considers gender roles and social relationships pertaining to both *women and men* within the context of structural and institutional power relations. Although the global discourse has shifted towards GAD, the focus has remained primarily on women, while men and male identities remain in the background (Chant & Gutman, 2005). Within the WID approach, investment in women and girls is framed as a development strategy and a means of combatting poverty. Kristoff and WuDunn (2009) argue that aid seems to work best when focused on health, education, and microfinance and is most effective when aimed at women and girls. Zimbabwe's national approaches to "gender" work reflect global patterns of focusing on female members of society and how they can participate in and boost the economy.

In Zimbabwe, the MWAGCD takes a leading role in women and gender efforts. The Ministry focuses on six dimensions relating to: economic involvement of women (two dimensions); educational empowerment; political empowerment; health and well-being; and community development (MWAGCD, 2018). All the dimensions, except community development, refer specifically to women, but never explicitly mention men. Furthermore, the National Gender Policy (produced by MWAGCD) and several other pieces of legislation aim to protect and/or empower women/girls vis-à-vis issues such as gender-based violence, child marriage, inheritance, and reproductive rights. The WID

approach centralizes a focus on and investment in women/girls because adherents believe women/girls will provide a high return and improve economic performance (Kristoff & WuDunn, 2009).

In 2018, the MWAGCD opened the Zimbabwe Women's Microfinance Bank (ZWMB). President Mnangagwa said the bank will "economically empower and transform the lives" of marginalized women (Home Office, 2018). A member of the UN said the ZWMB will go far in combatting violence against women/girls; economic freedom will lead to social and political freedom (Home Office, 2018). While expanding economic freedom for women may increase women's autonomy, it is not a stand-alone solution. WID approaches, such as this one, ignore the impact men have on women and overlook the fact that women will continue to interact with unsensitized men and within patriarchal structures (Chant & Gutman, 2005). Additionally, approaches that disregard men can undermine male identities and status, marginalizing them within the family and creating a new kind of inequality (Chant & Gutman 2005).

The Zimbabwean Government has undertaken several important efforts to improve women's positions and lives. These efforts, however, focus on women and ignore men and broader gender relations. Gender interventions will only get so far without men, while women-focused interventions can produce male-female hostilities and a "crisis of masculinity" (Chant & Gutman, 2005). The government could enhance its approach by looking beyond economics and women only and by increasing attention on gender relations and on men. A truer GAD approach would allow Zimbabwe to start to address the underlying norms and structures that produce and reproduce the gender inequalities, biases, and violence that negatively impact both women and men.

CONCLUSION

As this portfolio has demonstrated, development initiatives led by Mugabe's government in post-colonial Zimbabwe have varied in their levels of success. The Economic Structural Adjustment Program of the 1990s, heavily interlinked with international debt, failed to develop the country or benefit the poor. In fact, it introduced new forms of structural violence that backtracked previous progress made in the areas of health and education. Conservation efforts under CAMPFIRE and approaches to gender have achieved notable successes. At the same time, however, CAMPFIRE could go further to devolve resource management to local communities and approaches to gender could be broadened to include both men and underlying gender relations. The Harmonized Social Cash Transfer program stands as one of Zimbabwe's most prominent successes. It has provided important social safety nets for the poor, while also demonstrating trust in individuals' capabilities to improve their circumstances when provided with the necessary resources.

Mugabe rose to power as the revolutionary leader that released Britain's grasp over Zimbabwe and brought independence to the country. The initiatives discussed in this

portfolio were led by Mugabe's government and represent efforts to develop the country. In trying to liberate Zimbabweans, however, Mugabe lost sight of the importance of many of the instrumental freedoms described by Sen (1999) and the need for people to play an active role in attaining their freedom (Freire, 2005). The overthrow of Mugabe presents an opportunity for Zimbabwe to become truly liberated and pursue a deeper level of development that offers social, political, economic, emotional, and physical well-being. Zimbabwe, like all places, must begin to understand development in more than purely economic terms. In fact, it may be time to shift away from the "development" discourse and focus instead on the grassroots and social movements that have started to dismantle systems of oppression and inequality in various places around the world (Escobar, 1992).

Questions for further exploration include: Will Mnangagwa's presidency diverge from Mugabe's autocratic rule? In which areas and to what extent have grassroots and social movements already impacted and brought change to Zimbabwe? Where does opportunity lie, or where can it be created, for increased participation by community members? In a time when the world is governed and shaped by entrenched national and global systems and institutions that produce and perpetuate inequality, to what extent can post-development and participatory approaches dismantle the status quo, both in Zimbabwe and the world at large?

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MUNICIPAL BROADBAND NETWORKS: A WORK IN PROGRESS

Daniel Emirkhanian

INTRODUCTION

In an increasingly global and connected world, access to the internet has quickly become crucial for many Americans. The Federal Communications Commission (FCC) writes that the internet provides "…access to numerous employment, education, entertainment, and healthcare opportunities" (*2018 Broadband Deployment Report*, 2018). Considering its importance, it's surprising that there are remarkably large areas across the country lacking high-speed broadband capability. One recent FCC study found that "about 41% of Americans living on tribal lands lack broadband access" (*2016 Broadband Progress Report*, 2016). This issue is not limited to tribal lands. The Pew Research Center found that 58% of rural Americans report that reliable internet service "is a problem in their communities" (Anderson, 2018). Overall, a staggering 7% of the country lacks access to high-speed broadband internet and 30% of the country has only one high-speed internet service provider (ISP) in their area ("Fixed Broadband Deployment," 2017). The issue can only be solved when two questions are answered: (1) How can unserved rural areas of the country gain access to high-speed broadband internet, and (2) How can ISP monopolies be challenged? This paper will explore how local governments are capable of providing access to high-speed broadband internet to local, rural, communities through municipal broadband networks. By using current networks as a basis for analysis, this paper will also offer insight into some best practices that local leaders can adopt.

HIGH-SPEED BROADBAND INTERNET

High-speed broadband internet is defined by the FCC as "a method of transmitting information using many different frequencies, or bandwidths, allowing a network to carry more data" and has a minimum speed of 25 megabits per second (Mbps) ("Broadband That Works: Promoting Competition & Local Choice in Next-Generation Connectivity," 2015). The definition of high-speed internet developed with the technology. In 2010, for example, high-speed internet was defined as having a download speed of a mere 4 Mbps. There are a variety of methods to access the internet, including dial-up, satellite, wireless transmissions. One of the most reliable methods is fiber-optic cable, which has an installation cost of "$27,000 per mile" (Aman, 2017). Before fiber-optic cable became widely used, the internet was accessed through phone lines.

When the internet was first invented, most households accessed the service through the phone line, a system known as dial-up. This provided phone companies a natural monopoly on internet services. A natural monopoly is a "monopoly in an industry in which *high infrastructural costs* and other barriers to entry give the largest supplier in

an industry, often the *first* supplier in a market, an overwhelming advantage over potential competitors" (emphasis added) (Krugman & Wells, 2013). For ISPs, including AT&T and Time Warner Cable, the necessary infrastructure for internet delivery had already been built throughout the country, putting these companies at an enormous advantage and creating a large barrier to entry to smaller, regional corporations. As technology progressed, fiber optic cable spread throughout the country and ISPs started to compete with one another (Eisenach, 2016). Considering the high cost of cable-laying ($27,000 per mile), only large, nationally established companies were able to compete. As the internet spread rapidly across the country, rural and urban disparities in access became greater.

WHY THE DISPARITY?

For internet access to spread to rural communities, telecom companies must believe that building infrastructure is a viable economic investment in those regions. As mentioned above, rural American residents report that internet access is a major problem in their community. As of 2016, "39% of rural America (23 million people)" lacked access to high-speed internet, compared to a mere "4% of urban Americans" (*2016 Broadband Progress Report*, 2016). Solving this disparity does not end by simply drawing ISPs to rural communities. According to the FCC, 30% of the country has only one high-speed internet provider. Without competition, there is little incentive for companies to offer competitive rates and services ("Fixed Broadband Deployment," 2017). There are three issues that need to be considered when determining why rural areas lack high-speed internet: location, population, and competition.

Location

A difficult topography increases infrastructure installation costs and can interrupt wireless signals from radio towers (*2018 Broadband Deployment Report*, 2018). Rural communities that are located in heavily wooded areas or mountainous regions provide a diverse set of development challenges, which increases the cost to ISPs and make the region less attractive for development.

Population

"A key element of the ability to recoup investment in network infrastructure is the economies of geographic population density" (Brake, 2017). In other words, building internet infrastructure has high up-front costs, but once built, it is relatively easy and inexpensive to add a new user. Rural communities cover "97 percent of the nation's land area" but only contain "19.3 percent of the population," lacking the communal density necessary to create a viable market ("New Census Data Show Differences Between Urban and Rural Populations," 2016).

Competition

Densely populated urban areas play host to competitive markets, motivating ISPs to expand and improve infrastructure and lower costs of services. However, rural areas, with only one or no ISPs, are paying more and receiving less (*The Benefits Of Competition And Choice For Community Development And Highspeed Internet Access*, 2015). Even in 'competitive' areas, however, there are typically only two ISPs to choose from ("Fixed Broadband Deployment," 2017).

THE PUBLIC OPTION

Within the last twenty years, access to high-speed internet has become crucial. "A private good with large public spillovers," high-speed broadband significantly benefits communities (Brake, 2017). Economic studies show that "broadband Internet creates significant value for consumers and makes an important and rapidly growing contribution to GDP" (*The Benefits Of Competition And Choice For Community Development And Highspeed Internet Access*, 2015). Further, a 2009 study estimated that broadband creates "$32 billion in annual consumer surplus" (*The Benefits Of Competition And Choice For Community Development And Highspeed Internet Access*, 2015). Broadband internet connection creates new job opportunities, diversifying a community's economy. In one particularly compelling example, a woman who, "after years of fighting an opioid addiction and unemployment," was able to access remote job opportunities offered by U-Haul, ultimately increasing her annual earnings and helping to stabilize herself and, by extension, her locality (DePillis, 2017). In addition to the demonstrated economic benefits, high-speed internet provides a line to an increasingly connected world (Stanley, 2018). Yet there are large disparities in access across the US, and even locations that have access suffer as a direct result of the limited number of ISPs. The high cost of entry into the market means that potential new competitors cannot challenge well-established companies. The only entity capable of accessing the capital needed to fund, build, and manage a large infrastructure project on the scale to provide competition to the ISP companies is local government.

Municipal Broadband Networks

Municipal broadband networks refer to "high-speed internet services provided to consumers by either a public entity, such as a local government or public utility, or a public-private partnership, rather than a private telecommunications provider" (DuPuis, Langan, McFarland, Panettieri, & Rainwater, 2018). Local governments are uniquely positioned to provide high-speed internet access to rural communities, due to the correspondence principle, or the understanding that local government's proximity to its population means it is better at solving local issues. A rural city does not need to provide high-speed access to more than one community and can provide unique solutions for specific geographical limitations. Profit does not motivate local entities when providing

services for their communities, so local governments have much more motivation to serve low-population density areas. Creating a municipal broadband network in a region with only one ISP has already shown to reduce costs and improve services by creating competition with the dominant corporation. Chattanooga, Tennessee's municipal broadband network began offering high-speed internet access at prices significantly lower than Comcast, the only private ISP in the region, causing the company to make an investment of "$15 million in the area to launch the Xfinity Service" (*The Benefits Of Competition And Choice For Community Development And Highspeed Internet Access*, 2015). Unfortunately, there are several roadblocks that local communities need to bypass before being able to adopt this type of policy.

The Legal and Political Perspective

One significant barrier to the launching of municipal broadband networks is existing preemptive state legislation. Preemption is "the use of state law to nullify a municipal ordinance or authority" (DuPuis et al., 2018). As of 2016, there were 21 states that had laws in place that made "it difficult or, in some cases, illegal to create networks or sell internet service to their citizens" (Koebler, 2015). If a law does not outright prevent a locality from providing internet access, it can open them to lawsuits from ISPs. These preemptive laws have resulted in a "chilling effect on municipal broadband projects," but has not completely discouraged localities from trying (DuPuis et al., 2018). One of the most well-known municipal broadband networks is located in Chattanooga, TN, where the city installed "8,000 miles of fiber for 60,000 residential and 4,500 business customers out of a potential 160,000 homes and businesses" in 2015 (*The Benefits Of Competition And Choice For Community Development And Highspeed Internet Access*, 2015). The city had actively been battling Tennessee's ban on "offering services outside" of the city's limits and was even receiving support from the Obama administration and the FCC (Koebler, 2015). The Trump administration and new FCC leadership stopped supporting the town's efforts. Additionally, knowing that a greater number of homes have connection speeds of 10 Mbps, the FCC is attempting to redefine high-speed internet standards from 25 Mbps to 10 Mbps, effectively defining the disparity away. These legal and political blocks prevent localities from finding ways to be innovative and provide high-speed internet access to their communities, making this policy area limited in its understanding. However, by basing analysis on current municipal networks, we can establish best practices for funding and managing networks.

The Fiscal Perspective

Communities with established networks are consistently "underestimating the future costs" associated with network management (Wallsten & Gamboa Sorensen, 2017). A closer inspection of the Chattanooga, TN finances revealed that "repaying the project would take 412 years" due to the networks low profit margin (Yoo & Pfenninger,

2017). Residents now hold about "$1 million in public debt," though local political leaders maintain the economic benefits far outweigh these costs (Wallsten & Gamboa Sorensen, 2017). Other localities ended up selling the infrastructure to local ISPs. Marietta, Georgia sold their network at a "$11 million loss" (Wallsten & Gamboa Sorensen, 2017). What can be done?

Broadband infrastructure funding is not simple, especially when considering that the return on investment depends exclusively on user subscription. Previous localities have opted to pay for broadband projects through "bonds, financial transfers from a municipality or utility, loans, or grants" (Wallsten & Gamboa Sorensen, 2017). In some cases, public-private partnerships were established with deals giving exclusive operating rights to private companies of the network for a set period of years. There is also the consideration of federal support. In the past, the federal government has established numerous funding programs adding up to "nearly $100 billion" to subsidize rural broadband access (Wallsten & Gamboa Sorensen, 2017). Additionally, in states without municipal network preemption laws, state infrastructure funds can be established and specifically reserved for network development, much like what is being done for public transportation initiatives (Pula, Shinkle, & Rall, 2015). However, localities need to consider much more than just initial funding to successfully run a broadband network.

Many cities that implemented municipal broadband networks underestimated long-term costs and overestimated the number of users that would subscribe to their network. These are both problems that can be accounted for. First, proper cost-benefit analysis is a typical best-practice recommendation for any large project. The issue to this point was that those establishing municipal broadband networks were forging through uncharted territory, so to speak. Now though, there are several localities that have received close public and private scrutiny for which funding analysis is readily available. Second, relying on user-subscription is not in it of itself a flawed method of funding a network; rural areas frequently receive poor service quality from ISPs at very high costs, making them eager to switch to a more affordable option. The issue, rather, was the single-level payment plan that many of these cities offered. For example, Chattanooga was dubbed the 'Gig City' because it offered internet speeds of 100 Mbps to all users for a flat rate of "$70 a month" (Wallsten & Gamboa Sorensen, 2017). While certainly a generous offer, it is inefficient and pushes the infrastructure to stressful levels of output. Rather than offering such a high-speed, the city should create a tiered subscription system, in which users pay varying amounts for desired speeds. Users will still receive competitive rates as well as excellent service while reducing stress on the infrastructure. An analysis projects a larger growth of users by adopting this system (Brake, 2017).

The Managerial Perspective

Because of the relative novelty of municipal broadband networks, cities have tried to implement a number of different management strategies with varying success. In

general, one report recommends cities follow three basic principles: “(1) High-speed broadband must be accessible and affordable to all, (2) Community broadband services must protect free speech, and (3) Community broadband services must protect privacy” (Stanley, 2018). The second and third principles emerge from recent privacy and net neutrality concerns and, while important, are not the focus of this paper. Instead, this paper will expand on how a municipal network can be simultaneously affordable and accessible to all.

A tiered subscription model, as mentioned previously, allows users to pay for slower speeds at more affordable prices. Cities then can focus their efforts on connecting as many users as possible. In several cities, proponents have focused on increasing internet speed, which has resulted in diminishing marginal benefits. Instead, public officials should focus on the public good served when high-speed internet becomes easily accessible.

A large reason why ISPs do not develop in rural communities is a lack of population density. One fiber-optic cable that connects to an entire apartment building is a wise investment when compared to a cable that connects to only three or four houses. Municipal networks must first focus on connecting as many individuals to their service before attempting to bring 100 Mbps to individuals who may not need it. A study done in the United Kingdom revealed that “100% coverage at 15 Mbps” earned an estimated “consumer surplus of €2.25” per euro spent, whereas “92% coverage at 50 Mbps” earned an estimated “with a €0.72 surplus per euro spent” (Brake, 2017). A broad approach is better suited for municipal networks for two reasons. First, it allows for an infrastructure system to support a large number of users. Second, it connects high-speed internet for everyone and addresses the existing market failure.

CONCLUSION

The FCC’s 2017 data on national broadband connection is bleak, showing an alarmingly large number of houses either completely lacking high-speed internet connection or limited to only selecting from one ISP in the region. Because the cost to enter into the broadband market is so high, emerging companies cannot hope to compete with the current internet giants. As has been to done to address other types of natural monopolies, the government should step in to offer reliable and cheaper solutions, if only to reduce the disparity between urban and rural areas in the country. Unfortunately, the current political climate seems hostile to this type of innovation and has made establishing municipal broadband networks difficult, as demonstrated by the FCC’s recent shift in policy. Additionally, laws prevent the practice altogether or make cities vulnerable to lawsuits (Koebler, 2015). Even given the robust benefits, a municipal broadband network should not be established unless local leaders carefully consider the financial ramifications of undertaking such a large infrastructure project. In worst case scenarios, “underperforming projects have caused numerous municipalities to face

defaults, bond rating reductions, and direct payments from the public coffers" (Yoo & Pfenninger, 2017). However, with careful management and broad financial support, establishing these networks have shown to benefit local economies and reduce costs directly to users, predominantly through the spill-over effect. In Chattanooga, TN, several businesses located in coastal cities have migrated to the town, citing cheaper internet costs (*The Benefits Of Competition And Choice For Community Development And Highspeed Internet Access*, 2015). Without government intervention, the disparity that exists between urban and rural regions will only continue to worsen, making the need for municipal broadband networks all the more urgent.

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CASE STUDY: INCLUSIONARY ZONING IN WASHINGTON D.C.

Lauren Ricci

INTRODUCTION

Inclusionary zoning (IZ) has grown in popularity in U.S. cities throughout the last several decades. According to a study conducted by the Urban Land Institute, inclusionary zoning policies allow cities to, “encourage developers to create below-market rental apartments or for-sale homes in connection with the local zoning approval of a proposed market rate development project” (Williams, Carlton, Juntunen, Picha, & Wilkerson, 2016). Supporters of IZ programs view the approach is a unique and innovative tool to incentivize the production of affordable housing units in the private market. Incentives vary from city to city, and can include options such as “direct subsidies, tax abatements, density bonuses, and reduced parking requirements” (Williams et al., 2016). As a policy tool, IZ is politically attractive, since incentives are often framed as regulatory concessions by government, rather than direct monetary transfers from taxpayers to private developers.

PROGRAM OVERVIEW

Washington, D.C.’s IZ program, which began in August 2009, has four goals: (1) Create mixed income neighborhoods, (2) Produce affordable housing for a diverse labor force, (3) Seek equitable growth of new residents, and (4) Increase homeownership opportunities for 50 percent MFI and 80 percent MFI households (D.C. Department of Housing and Community Development, 2018). IZ is one aspect of the D.C. government’s attempt to reign in the production of high-priced housing and respond to political pressure to prevent displacement of long-time residents.

The main mechanism through which Washington, D.C.’s IZ program functions is by providing a *density bonus* to real estate developers in exchange for their agreement to set aside a percentage of square footage in a residential development for affordable housing units. These units are rented or sold at below-market rate for the duration of their existence.

Program Eligibility

Program eligibility requirements are calculated based on the Median Family Income (MFI) for a family of four in the Washington, DC Fair Market Rent Area (FMR). The FY 2018 FMR Area Median Family Income is $117,200 (Office of Economic Affairs, U.S. Department of Housing and Urban Development, 2019). As of January 2018, the IZ program targets rental units to households making up to 60% of the MFI ($70,320) and for-sale condos to households making up to 80% of MFI ($93,760). Minimum income thresholds are calculated based on the number of bedrooms in a unit,

while maximum income requirements are tied to household size. For example, to qualify for a three-bedroom IZ apartment, a family of four would need a combined family income between $54,950 and $66,200.

Historical Context

Inclusionary zoning strategies were developed in part as a tool for desegregation, to counteract the effects of racially-motivated exclusionary zoning policies. In the U.S., neighborhood segregation was legally sanctioned until 1948, when the Supreme Court outlawed race-specific covenants in *Shelley v. Kraemer* (1948). After *Shelley v. Kraemer*, communities maintained de facto racial segregation through exclusionary zoning practices, which included strategies such as zoning against multi-family homes and requirements for minimum lot sizes (Schneider, 2018). These strategies suppressed the supply of available residential housing and drove up property prices.

To understand the need for inclusionary zoning policies and determine appropriate indicators for successful implementation, it is critical to acknowledge how zoning practices were used in the recent past to perpetuate racial segregation. Exclusionary zoning maintained the effects of racial covenants after they were outlawed, and prevented construction of affordable housing in cities throughout the U.S., including Washington, D.C. These policies prevented lower-income, disproportionately Black and Brown people from moving into wealthier, typically whiter neighborhoods.

In Washington, D.C. wealthy white families clustered in the Upper Northwest Quadrant of the city. Even today, these neighborhoods are the least diverse and wealthiest in the city. Ward 3, which includes Chevy Chase, Friendship Heights, Palisades, Georgetown and Cleveland Park has the highest average MFI in Washington, D.C. at $190,380, and only 6.8% of the population is Black (80.1% White), according to 2017 American Community Survey Census data. North Capitol Street and the Anacostia River divide the White section of the city from Black Washington, D.C. Ward 8, which includes neighborhoods such as Barry Farm, Sheridan, Congress Heights, Douglass and Shipley Terrace, has the lowest average MFI in Washington, D.C. at $27,979, and 90.8% of the population is Black (5.6% White), according to 2017 American Community Survey Census data. Put another way, the average MFI of Ward 3 is seven times the average MFI of Ward 8.

Demographic Comparison *Highest vs. Lowest Income Washington, D.C. Wards*				
	Ward 2	**Ward 3**	**Ward 7**	**Ward 8**
Population by Race (%) Black	9.1%	6.8%	93.1%	90.8%
Neighborhood clusters	4, 5, 6, 7, 8	10, 11, 12, 13,	29, 30, 31, 32,	36, 37, 38,

		14, 15	33, 34, 35	39
Families				
Average family size	2.55	2.87	3.53	3.63
Average median family income**	$161,197	$190,380	$44,300	$27,979
60% of Avg. MFI (IZ rent baseline)	*$96,718*	*$114,228*	*$26,580*	*$16,787*
80% of Avg. MFI (IZ own baseline)	*$128,958*	*$152,304*	*$35,504*	*$22,383*
Source: D.C. Office of Planning State Data Center (n.d.). ***Source: DC KIDS COUNT data set, Ward Avg MFI calculated by averaging the Average MFI for neighborhoods in each ward. Source for determining Ward/cluster equivalency: http://www.neighborhoodinfodc.org/pdfs/Ward_Cluster.pdf*				

While the stated intent of Washington, D.C.'s IZ program is to ensure that new developments include affordable units (D.C. Department of Housing and Community Development. (n.d.), 2019) the definition of "affordability" used by the city fails to consider the injurious impact of policies that promoted segregation. Racially-restrictive covenants and exclusionary zoning excluded low-income, Black families from benefiting from Washington, D.C.'s economic growth over several generations, resulting in poverty and limited opportunity to concentrate in several neighborhoods. For the IZ program to truly be affordable to residents of neighborhoods that have suffered from consequences of exclusionary zoning policies, IZ would need to address the current economic hardships experienced by these families by tailoring affordability thresholds to their current economic situations. This paper explores the thresholds that would be affordable to residents in Washington, D.C.'s lowest income neighborhoods, which also have the highest percentage of Black residents.

ELIGIBILITY BENCHMARK ISSUES

Although Washington, D.C. geographically lies within the FMR Area, differences in the demographic makeup and income of high-earning surrounding cities make the FMR Median Family Income an inappropriate baseline for the IZ program. The cities factored into the FMR Area MFI calculation include some of the wealthiest cities in the United States. For example, the Median Family Income for the Washington, D.C. HUD FMR Area includes Bethesda, MD, which has a MFI of $232,466 – more than eight times the average MFI for Ward 8 in Washington, D.C. ($27, 979).

Median Family Income of Cities in the Washington-Arlington-Alexandria, DC-VA-MD HUD Metro FMR Area		
Principal Cities	**Median Family Income** (income and benefits in 2017 inflation-adjusted dollars)	**Mean Family Income** (income and benefits in 2017 inflation-adjusted dollars)
Washington, DC	$106,528	$155,436
Bethesda, MD	$232,466	$299,504
Frederick City, MD	$94,921	$105,237
Gaithersburg City, MD	$92,656	$109,905
Rockville city, MD	$118,742	$140,209
Silver Spring, MD	$83,140	$113,269
Alexandria city, VA	$118,757	$146,244
Arlington, VA	$154,926	$194,685
Source: American FactFinder (Accessed 3.18.2018)		

The use of the FMR Area MFI is a major flaw of the design of the IZ program. By targeting rental units to families making 60% of FMR Area MFI and for-sale units to households making 80% of the FMR Area MFI, the city is effectively prioritizing a specific subset of low-income residents.

According to a study by The Urban Institute titled, *The Color of Wealth in the Nation's Capital*, researchers determined that the MFI for Black families in the Washington, D.C. Metropolitan Statistical Area is $72,000, the MFI for Hispanic/Latinx families is $80,000, and the MFI for White families is $110,000 (Kijakazi et al., 2016). While 60% of the White MFI for the Washington, D.C. FMR area is close to the program's benchmark ($66,000), the program is less accessible for Black and Latinx/Hispanic families. For Black family of four in the Washington, D.C. FMR Area to qualify to rent a three-bedroom IZ apartment, that family would need a combined family income between 76% and 92% of the adjusted Black MFI (between $54,950 and

$66,200). A Hispanic family would need to make between 69% and 83% of the adjusted MFI. By basing qualifications on the DC FMR Area MFI, lower income minority residents are less likely to have access the program, since the bar is higher for for these residents.

One potential strength of the current program design related to eligibility requirements is that income minimum requirements do not apply to applicants who receive rental assistance through the Housing Choice Voucher program (Section 8) or other subsidies (Deputy Mayor for Planning and Economic Development, 2017). This has the potential to benefit extremely low income residents (usually below ~30% MFI) who also qualify for additional subsidies, particularly families in the lowest income areas of the city. By allowing "double dipping" the program has the potential to serve a wider range of D.C.'s lowest-income population, even though units are set-aside at 60% of MFI. Unfortunately, the 2017 IZ Annual Report provides data on subsidies for purchased units, but the percentage of renters in IZ units who received other forms of rental assistance is not currently known.

By basing the program eligibility on statistics that incorporate the incomes of wealthier, whiter communities within and outside of the city, the current program eligibility formula erases the economic reality of Black Washingtonians, many of whom have lived in the city for several generations and have been pushed to low-income neighborhoods in Wards 6, 7 and 8. Since eligibility is not based on the income distribution of the population in Washington, D.C., it could be argued that even without considering the racial differences within the city, the program is not adequately tailored to serve the intended population. It is imperative to consider race when assessing the accessibility of the Washington, D.C. IZ program because of the legacy of exclusionary zoning practices that imposed the barriers Black citizens in Washington, D.C. still struggle with today.

DHCD maintains a database of all IZ projects in the planning stages, under construction, completed with a lottery pending, completed with a lottery held, or a subsequent lottery pending. As real estate development continues in Washington, D.C., rents are rising in historically disadvantaged parts of the city, including in Wards 7 and 8. As of November 2017, six residential projects set to produce 14 units were in the pipeline in Ward 7, and another six projects with 19 total units in Ward 8, where the average MFI is $27,979. In the context of rapid development, it is likely that many long-time residents and families will be displaced as the place they call home becomes unaffordable. Inclusionary zoning can only prevent displacement of these residents if it is targeted to their economic situation.

CONCLUSION

Affordability requirements for D.C.'s IZ program are calculated based on a flawed statistic, the Washington, D.C. FMR Area Median Family Income. Although

administrators have an interest in maintaining consistency with federal housing programs whenever possible, the needs of Washington, D.C.'s most vulnerable citizens should come first. The city's failure to truly consider the severity of inequality and the economic reality of the city's lowest income residents undermines the stated objectives of the program itself. If the program truly intends to address the downstream effects of racially-restrictive covenants and exclusionary zoning practices, the relationship between race and socioeconomic status should be closely examined and factored into program design.

That being said, if the city were to commit to implementing an IZ program to meet the needs of the District's most marginalized residents, it is unlikely that the cost of providing that service could realistically be borne by private developers. For IZ programs to work, there must be a balance between the city's interest in providing affordable housing, and cost efficiency for the developer. It is likely that by increasing affordability of units and decreasing prices to a threshold which would be affordable to residents of neighborhoods with a low average MFI (i.e. residents in Wards 7 and 8), private developers would not have sufficient incentive to participate in the program, and could simply opt out.

Instead of relying on the private market to produce affordable housing, Washington, D.C.'s government should commit to producing affordable housing and actively undoing the remnants of exclusionary zoning practices that still exist today. The sheer quantity of affordable housing units needed to meet citizen's needs far exceeds the scale of the IZ program, as currently constituted. Programs such as the National Housing Trust Fund and the DC Housing Production Trust Fund should be strengthened and fully funded.

As long as the supply of affordable housing is suppressed as a result of unnecessarily restrictive zoning practices which limit density and prevent development of affordable units, the cost to rent or own property in the city will continue to increase, causing lower-income residents to be pushed out of the city. It is the responsibility of the city to confront its history and dedicate resources to remedying the its legacy of racist policies that continue to put many Black Washingtonians, especially those who have lived in the city for generations, at a serious disadvantage. It is critical that as a society, we take every step possible to undo the damage done through the discriminatory policies of our past, and ensure that new and innovative policies do not worsen the divide, and actively work to improve conditions for those affected.

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