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Access or Exclusion? An Analysis of State Reproductive Rights and Comprehensive Sex Education

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Abstract

In 2009, Colorado successfully decreased their abortion rate among minors and at-risk teenagers through a privately-funded trial. This outcome was realized by offering affordable, accessible, and comprehensive reproductive healthcare options, specifically long-acting reversible contraception, to young women. Reproductive rights is an issue at the forefront of political discussion, often a determining factor for party identification. The controversy of reproductive rights—in particular, abortion—leads to a higher reliance on hear-say, instead of peer-reviewed literature, statistics, and legislation. In order to gain a well-balanced understanding of abortion politics, I compare three Midwestern states—Illinois, Indiana, and Minnesota—to determine their respective policy successes and shortcomings. I examine each state's abortion related policies including sex education and contraception access in order to determine how these factors affect the abortion rate. Determining what factors work in each state, and whether that is a pattern among the states, guides my proposed policy reforms. The purpose of this exploration is to encourage and promote the significance of women's health education—specifically, reproductive rights. Considering the majority of information portrayed regarding sexual health occurs at a high school level age, there is a more structured focus on the abortion rate of minors. Access to information and birth control, coupled with mandated comprehensive sex education in schools, are key to re-shaping America's current, complex state of healthcare. Change needs to be inspired, and that is the purpose of this thesis: to improve women's reproductive healthcare system; lower abortion rates would simply be an added benefit.

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Chapter 1: Introduction

Modern society has pushed the advancement of many aspects of society; however, the concept of motherhood has not yet been affected by modernization (Iu, 2001, 70). This stagnation stems into ideas directly associated with motherhood such as reproductive rights and comprehensive sex education. States have the ability to, and should, shape gender roles and their associated behaviors in order to bring motherhood and the associated components to the modern era (Iu, 2001, 78).

A life where reproductive freedom is a reality is not only possible, it has already been realized. Colorado is one state to successfully implement affordable, comprehensive reproductive healthcare options, which, in turn, has decreased teen pregnancy and abortion rates. Since Colorado began offering low cost, and often free, intrauterine devices to young women in 2009, the birth rate among teenagers in the state plummet further than the national rate. Colorado's success with birth control and abortion is an important example to look to when analyzing ethically sound, scientifically backed ways to improve reproductive healthcare. With that being said, it is essential to note that this legislative success was sponsored by a 28 million dollar investment from Warren Buffet's family to the state health department's family planning program (Colorado Department of Public Health and Environment, 2017; Brown, 2017). Warren Buffet is an American business magnate and investor, the second highest donor to philanthropic causes in the world, and has promised to donate 99% of his fortune (Forbes). Colorado's official web portal states that, because of this investment, the state-wide program was able to "train health care providers, support family planning clinics and remove the financial barriers to women choosing the safest, most effective form of contraception" (Colorado Department of Public Health and Environment, 2017). Additionally, the state also saved nearly 70 million

dollars that would have gone to prenatal care and health assistance (Brown, 2017). Colorado's policy outcome begs several questions: what variables affect abortion rates within a state? And, does each state need their own "Warren Buffet" in order to provide proper reproductive care? However, what is crucial in Colorado's case is that the decrease in the abortion rate was the result of autonomy and knowledge, not oppression.

Researchers agree that abortion policies are controversial: Mooney (1995, 600) argues that abortion policies beg several moral and ethical questions:

1. Which sexual practices are inherently sinful?
2. When does a right to free speech conflict with a right to privacy?
3. When does life begin?
4. When does the right to life of a fetus conflict with the right of a pregnant woman to control her own body?

The complexity of this issue makes it difficult to define in the courts, especially given that there is a disagreement on whether life begins in the womb before or after implantation (Uberoi and Bruym, 2013, 162). Colorado is one of only a few states that has recently implemented more progressive reproductive policies, including providing young women long acting birth control. The access to birth control was a monumental factor that led to Colorado's decrease in teen pregnancy and abortion rates. Besides the readily available intrauterine devices, it is likely that other variables, including political ideology, religious views, socioeconomic status, and comprehensive sex education may also affect abortion rates. Therefore, a comparative analysis of a state's abortion rates and reproductive healthcare policies can improve our understanding of these policy intersections, the related policy outcomes, and guide future research and policy implementation.

As figure 1 indicates, 2014 saw a historic low in the number of reported abortions. In fact, there were fewer than a million recorded abortions performed in 2014, which happened for the first time in almost 40 years, noted in figure 1 below (Crockett, 2017). Furthermore, the birth rate in the nation from 2009 to 2016 fell 37.9 to 24.2 births per 1,000 teenaged women, and in Colorado it decreased from 37.5 to 19.4. The birth rate in Colorado fell 4.4 points more so than the national birth rate, due in part to the aforementioned policy alteration. In addition to the decrease in birth rate, the teen abortion rate decreased a notable 64% in that same time frame (Brown, 2017).

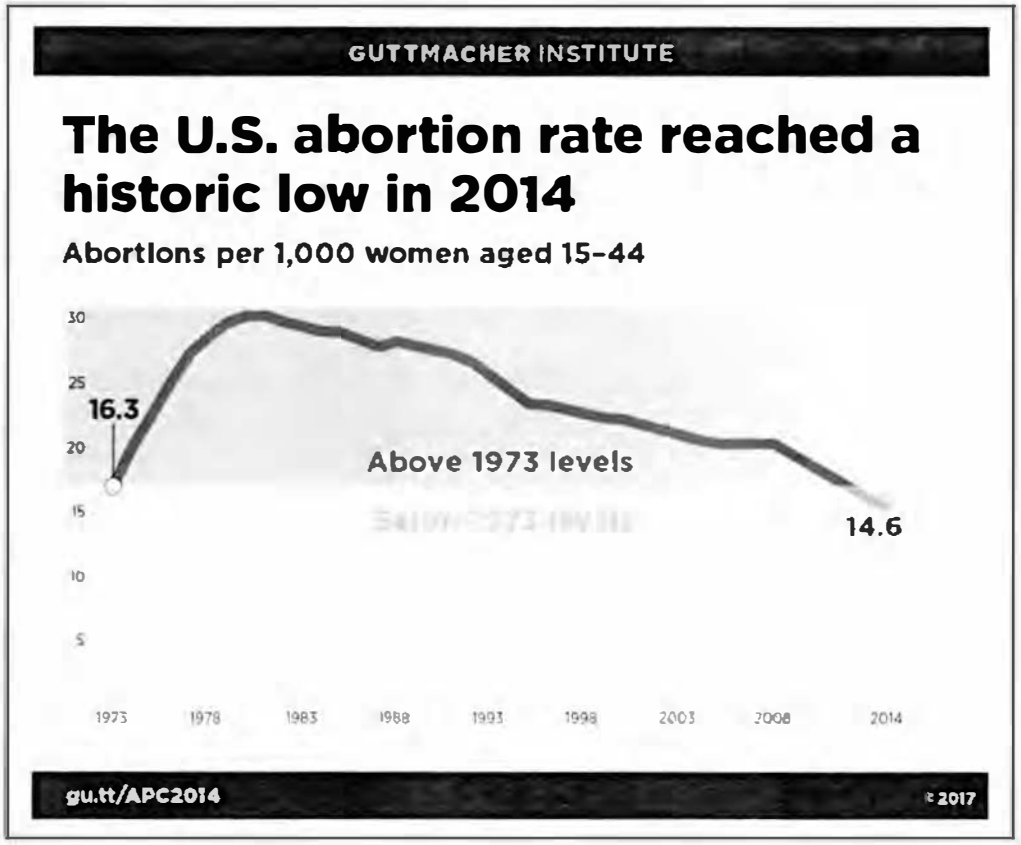

Figure 1

The decrease in abortions occurred around the same time frame that anti-abortion policy was passed—indicating that there could be a connection between these policies and decreased

abortion rates. Researchers Jones and Jerman of the Guttmacher Institute suggest that contraception was likely the leading factor for this decrease, especially considering "more than 60% of the decline in the abortion rate took place in states that had not enacted new hurdles to getting the procedure" (Redden, 2017). Similarly, a Vox analysis reported that 62% of the decrease in abortions came from 29 states and Washington, D.C., that did *not* pass restrictive legislation (Crockett, 2017). State-level restrictions on abortion access and an overall decrease in abortions, in the majority of cases, is a correlation, but likely *not* a causation. Therefore, a potential decline in abortions after the passage of restrictive abortion laws may actually be the result of an increased use of contraception. Furthermore, women without access to a general practitioner or other vital resources may be forced to receive unsafe, unregulated abortions, and are then left out of national statistics.

According to Vox, women are not only using contraception more, but they are using long acting reversible contraception (LARCs), such as implants and IUDs, instead of short term options, such as the birth control pill. Because of the increased use of reliable contraception, significantly fewer women are facing unintended pregnancies, therefore decreasing the number of abortions. The Guttmacher Institute goes to greater lengths than some federal institutions such as the Centers for Disease Control and Prevention (CDC) to collect data about abortions (Crockett, 2017). Considering abortion clinics and providers are not required to report the numbers of abortions they provide to the federal government, it can be difficult to collect accurate data. The disparity between known providers coupled with the amount of illegal abortions that take place indicates the accuracy of reported data for abortions may have a greater information gap than that of other medical procedures.

In 2011, the Human Rights Council demanded that a "human rights approach" be taken for the specific purpose of reducing mortality and morbidity (Uberoi and Bruym, 2013, 161). Further, the United Nations noted that, in order to decrease the amount of maternal morbidity and mortality rates that can be prevented, governments should implement national public health policies which *include* taking steps to ensure access to legal and safe abortion (Uberoi and Bruym, 2013, 166). While these policy recommendations would decrease the amount of unwanted pregnancies carried to full term, the root of this issue is the lack of comprehensive sex education. Comprehensive sex education coupled with increased access to birth control and legal, safe abortion procedures would result in a significant decline in the level of maternal morbidity and mortality rates.

In order to decrease the amount of maternal morbidity and mortality rates, it is essential to understand the link between access to birth control, sex education, and abortion rates. This cross-state analysis explores the connections present, and looks to states such as Colorado and Oregon to shape future policies. We must work to increase access to birth control, comprehensive sex education, and public, legal access to abortion because of the undeniable benefits and access it provides to women and girls in America. This thesis provides a case study analysis of state based abortion policy and sex education policy, as two factors that influence state abortion rates. Chapter 2 provides a policy history in order set a foundation of past laws and public response to reproductive rights and abortion laws. Chapter 3 discusses the methodology of analysis utilized in Chapter 4, which is the cross-state analysis of Illinois, Indiana, and Minnesota. Chapter 5 addresses the successes and shortcomings of current policies and draws on states with proven successes to prescribe solutions to the issues present in the states examined.

Chapter 2: Policy History

In order to determine the probability of an autonomous future, it is imperative to examine the history of sex education, contraception, abortion, and public opinion on reproductive rights. By studying the successes and shortcomings of the policy history, researchers and legislators can be equipped to guide both the present and future battle for reproductive rights.

SEX EDUCATION

Before birth control and abortion access can be properly discussed, we must first examine America's standards for sexual education. When the youth are deprived of information having to do with their bodies, they are more likely than sexually educated youth to misuse or disuse contraception, contract and/or spread sexually transmitted diseases or infections (STDs/STIs), and become pregnant (Blackman & Scotti, 2016). It is hypocritical to tell our youth to "make responsible decisions," when we neglect to inform them what those responsible choices might look like.

In the United States, the integration of sex education into schools did not receive wide-spread public support until the 1980s amidst the human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDs) crisis (Hall et al., 2016, 595-597). Because of the tragically high death polls from this crisis, sex education was viewed to be potentially life-saving, which warranted the increase in support (Amory, 2011). Recently, there is a divide among citizens and legislators alike between comprehensive sex education and abstinence only sex education. While each framework for sex education has its respective benefits, the benefits of comprehensive sex education have proven to be more beneficial to society as a whole, particularly young people (Hall et al., 2016, 595-597).

CONTRACEPTION

Contraception is an essential aspect of reproductive rights because it reinforces one's autonomy and personal freedom of choice. To decrease the rate at which abortions occur, it is crucial to gain an understanding of the various forms of birth control that exist, working to destigmatize the conversations surrounding birth control, and increase the accessibility to these options.

Margaret Sanger (1879-1966), a birth control activist, argued that freeing women of the ignorance about their body and the control they have over it is the first step in the fight for women's equality. Sanger stressed that large families often coincide with higher abortion rates, stressing the detrimental role of socioeconomic class in reproductive rights (Sanger, 1917, 5-11). It is then assumed that the larger a family, the higher chance they are of working class and therefore cannot afford access to education about reproductive freedom. She continued, saying that birth, coupled with withheld knowledge of bodies and science, is what keeps women subordinate in culture (Sanger, 1917, 5-11). Once that freedom is granted, women will be able to not only have control over the number of children she wants to have—if she even wants to have kids—but she will also be allowed and *encouraged* to have dreams and aspirations of her own, rather than only producing children, and nothing more (Sanger, 1917, 5-11).

Access to birth control goes hand in hand with the right to abortion, given both issues deal directly with the reproductive freedom of women. The Supreme Court case of *Griswold v. Connecticut* in 1965 ruled that women should have the right to obtain birth control and/or contraceptives under the newly outlined right to marital privacy (*Griswold* v. *Connecticut*). This implicit interpretation of the United States Constitution set the grounds—and potentially the reform—for the women's rights movement and reproductive freedom.

Some of the most common forms of contraception include birth control pills and condoms; however, there are long term, more effective options on the market that help prevent pregnancy. Long-term options for contraception include the IUD, or intrauterine device, the birth control patch, and Depo Provera, the birth control shot. While long term options for contraception prove to be more effective in preventing pregnancy, any contraception use helps aid in pregnancy prevention, in turn lowering abortion rates. In fact, The Guttmacher Institute found that the use of contraception is a determining factor when examining the likelihood of a woman having an abortion in her lifetime (2018).

Without insurance, contraception can be expensive, and accessible only to those in the middle to upper class. The National Women's Health Network examined, compiled, and found the average cost for various forms of contraception without the aid of insurance (Kosova, 2017). The most commonly used form of contraception, the birth control pill, ranges anywhere from $20-$50 per month leading to a yearly total of $240-$600 for a year of protection—if used consistently and correctly (Kosova, 2017). Implants were found to cost over $800 each and IUDs came in at over $1,000 each. Fortunately, implants and IUDs can last for several years, however, if someone cannot afford to spend upwards of one thousand dollars all at once, they may be forced to utilize shorter term, less effective options such as the aforementioned birth control pills (Kosova, 2017). The Depo-Provera shot adds up to over $240 per year, and the NuvaRing costs over $1,000 per year (Kosova, 2017). The National Women's Health Network stresses the fact that these numbers are simply the cost for protection, and do not include the costs of visits to doctors or clinics, which would increase the cost of reproductive healthcare significantly (Kosova, 2017). Based on these numbers alone, it is clear that reproductive healthcare is currently a privilege not all can afford in the United States.

ABORTION

Throughout America, and even the world, the legality of abortion has been a fairly recent addition to legal policy. However, the practice of abortion has always been allowed within and among communities and cultures.

Abortions during the 1800s and earlier were allowed only before quickening—or, when the mother could feel the fetus moving inside her uterus—as this was the defining feature of pregnancy. Artificially induced abortions were disallowed, however, "therapeutic" abortions—completed through natural means—were justifiable if the woman's life was in danger (Mooney and Lee, 1995, 602). The independency of most doctors and physicians coupled with the medical stagnancy at large, performing abortions did not gain the wide-spread attention that it receives today. As medicine and technology advanced, the likelihood that a woman would die in childbirth decreased. Because of the advancements of American society and medicine, abortion policies became stricter when following the ideology of "illegal until fatal" (Mooney and Lee, 1995, 602). The origin of "illegal until fatal" in the late 1800s was due to the fact that abortifacient drugs were often fatal to the pregnant woman taking them. (Van de Warker, 1873, 23-28, 33-34). While this ideology was rooted with the health of the woman in deep consideration, it has morphed over time to be an argument against abortion access. Modern anti-choice advocates argue that unless a woman's life, or that of the fetus, is in danger, the right to abortion should be nullified. This current ideology is likely a result of the "illegal until fatal" mentality which originated over 200 years ago.

As a whole, abortion was becoming normalized towards the turn of the century; however, that does not minimize the fact that illegal abortions were still happening across America. One particular case discusses a pregnant, teenage woman seeking an abortion. The man who

impregnated her took her to an fraudulent doctor, who advised her to take upwards of 40 pills in less than a week. In addition to this, he "probed" her uterus in attempt to induce the abortion; the young woman ended up dying several weeks later (Caves, 1896). This violent, unsafe, and fatal abortion is only a reminder that the policies that shape our ability to be autonomous has had detrimental, and sometimes fatal, effects on those most vulnerable to a lack of comprehensive sex education.

In 1959, the American Law Institute created a legality system for abortion in which abortion would be considered legal in more cases than only if the life of the mother was in danger. Other factors such as rape, incest, physical or mental defects in the infant, and in cases where the mother's mental or physical health was at stake were also considered to be permissible under this system (Mooney and Lee, 1995, 602-603). While this was a more comprehensive step for abortion access, the underlying reasons why a woman is allowed to get an abortion rely on her being sick or a victim of abuse.

The period from 1966 to 1972 saw the most reproductive reform across the United States since the late 19th century. In 1969, the Center for Disease Control and Prevention (CDC) began collecting data on abortion access and rates (Center for Disease Control and Prevention, 2018). Abortion was not a hotly contested issue in the years leading up to the nationwide legalization of abortion from *Roe v. Wade* and *Doe v. Bolton* in 1973. *Roe v. Wade* focused on a Texas law which stated that women could only terminate pregnancy when her life was in danger. *Doe v. Bolton* discussed a law from Georgia in which a woman was legally allowed to terminate her pregnancy if her life or health was in jeopardy. While both Supreme Court decisions were important to the rights of women, Roe was ultimately more influential to Americans at the time of its decision because this case "concluded that constitutional rights to privacy and liberty

protected a woman's right to terminate her pregnancy" (Liu, 2013). Considering pregnancy is an issue concerning personal freedom and autonomy, it became unclear when states could legally interfere with a woman's right to abortion. Supreme Court Justice Blackmun, writing for the majority, outlined the time frames in which state intervention would be legal:

1. During the first trimester of pregnancy the state cannot limit access to abortion,
2. From the end of the first trimester to approximately the 28th week of pregnancy (the point of viability) the state is allowed to regulate abortion in order to protect the health of women,
3. And finally, the state may completely ban abortions after 28 weeks as long as they provide women the option of abortion if their health and life is at risk (Liu, 2013).

Roe. v. Wade set legal standards regarding access to abortion, bringing this issue to the public eye, therefore many conversations about abortion policy were met with high opposition. *Webster v. Reproductive Health Services* (1989) discussed a Missouri statue that claimed that public health workers and public facilities could not perform abortions unless the life of the woman was in imminent risk. While controversial, the Supreme Court of the United States ruled this statute as constitutional based on the precedent of *Roe v. Wade* not including or discussing the involvement of public health officials and abortion. Furthermore, it was found that there is not an undue burden imposed onto women seeking abortion who are required to undergo a viability test after 20 weeks (Liu, 2013). More conservative regulations on abortion policy were brought about in the 1992 Supreme Court case of *Planned Parenthood of Southeastern Pennsylvania v. Casey.* This case discussed laws such as a 24-hour waiting period, informed consent, parental consent for minors, and spousal notification of plans to get an abortion (Liu, 2013). While these mandates were determined to be constitutional, minus the spousal notification law, the Supreme

Court ultimately upheld Roe v. Wade's decision, solidifying the significance of bodily autonomy in future debates over abortion policy (Liu, 2013).

Hill v. Colorado (2000) discussed a Colorado statute that made it illegal for a person to approach a person getting services from a health care facility—in particular, abortion clinics. This was to prevent the intrusion of personal space for people, particularly women, when they were attempting to get services regarding their reproductive health. This case ruled that anti-abortion protesters cannot be within 100 feet of a health care facility and cannot be within 8 feet of a person with the intention of talking to them or handing them any sort of pamphlet (Freedom Forum Institute, 2011). This ruling made going to an independent abortion clinic or a Planned Parenthood much safer than it previously had been. In the same year, *Stenberg v. Carhart* decided that a Nebraska statute regarding the ban of "partial birth abortions" was unconstitutional (Heffernan, 2001, 618). A partial-birth abortion is considered to be dilation and extraction, "a surgical abortion that is typically performed during the third trimester or later part of the second trimester of pregnancy and in which the death of the fetus is induced after it has passed partway through the dilated cervix" and is language more often utilized by anti-choice individuals (Merriam-Webster). The statute did not include an exception for when the health of the mother was at risk and was arguably too vague to land proper legal footing regarding implementation (Heffernan, 2001, 618).

In 2015, the CDC reported an average rate of 1.8 abortions per 1,000 women of childbearing age (15-44), while the abortion ratio was 188 abortions per 1,000 live births (Center for Disease Control and Prevention, 2018). Furthermore, the abortion rate from 2006 to 2015 decreased by 24%, solidifying the idea that time and policy change has a positive effect on abortion rates (Center for Disease Control and Prevention, 2018).

The legality of abortion is complex, especially considering the state restrictions on abortion often test the scope of their own power. While abortion was not rooted in controversy, this issue quickly became one of public concern, resulting in two very strongly opposing sides: pro-life (anti-choice) and pro-choice.

PUBLIC OPINION

Legislators can often be generally relied upon to gain a comprehensive understanding of the political leanings of a state. However, due to outside influences from Political Action Committees (PACs), specifically regarding abortion policy, legislative leanings are not enough to determine public opinion (Shin, 2004, 143-145). With that being said, an examination of citizen opinion is required to properly assess public opinion on reproductive rights.

Gallup and Pew conducted several surveys regarding abortion rights from 1967 to 1970 and found that instead of the nation being split on the issue, there was a noticeable expansion in support for the legalization of abortion (Rosenburg, 2015, 241-257). Since the Supreme Court decision of *Roe v. Wade*, support and opposition have remained fairly consistent—the majority of the population believing that abortion should be legal under all or some circumstances (Rosenburg, 2015, 241-257). In 2018, PEW found that 58% of the United States population believe abortion should be legal in all or most cases, while only 37% believe abortion should be illegal in all or most cases (Mitchell, 2018). Furthermore, Gallup reported that 29% of Americans believe abortion should be legal in all circumstances, 50% believe abortion should be legal in only under certain circumstances, while 18% believe abortion should be illegal in all cases (Gallup, Inc., 2018). While this may sound promising for reproductive rights, it is important to note that those in favor of abortion in "some cases" might only approve of abortion

if the pregnancy resulted from rape and/or incest, or the health of the fetus or mother is at risk. On the surface there is wide-spread support for abortion; however, the combination of "all" and "some of the times" leads to some confusion. This gap in the standards for abortion acceptance opens the door to policy loopholes that could gain support from the "some cases," which could be detrimental to abortion rights. Given the fact that states possess an influential degree of autonomy from the federal government, opposition to abortion has been realized in recent years in the form of state-wide regulations and legislative reform (O'Connor, Tareen, 2017, 95 and Rosenburg, 2015, 241-257). There has been an increase in laws that oppose abortion not because there is an increase in American citizens who disagree, but because those who oppose abortion do so more intensely than those who support abortion (Rosenburg, 2015, 241-257). The vocalization of opposition is what reopened and propelled the conversation about the degree to which women have autonomy in the eyes of the law.

As of 2012, 37 states have parental involvement laws in cases where a minor, anyone under 18, seeks an abortion (Kavanagh et al., 2012, 159-166). Those with a positive or negative view on parental consent laws tend to speak on behalf of "the best interests of minors," yet consistently exclude the opinions of the minors themselves (Kavanagh et al., 2012, 159-166). Through a qualitative study of minors seeking abortions in the Chicago-land area, opinions about these laws were collected from those who it affects the most: minor women seeking abortion. Proponents to these laws stress the importance of minors having support through this emotionally exhausting process, which is why it is beneficial for minors to be required to inform their parents about their abortion. However, this opinion is rooted in privilege because it does not consider the idea that a supportive family structure is not a commonality for many minors. Interviewees stated that they would be terrified to tell their parents about their abortion for fear

of physical or emotional abuse, fear of eviction from their home, and fear that their parents would never be able to look at them without thinking of the abortion (Kavanagh et al., 2012, 159-166). Opponents argue that these laws take away the physical autonomy of minor women seeking abortions—teaching them that they need permission from others to make decisions about their own body.

Factors such as religion, political ideology, and education all determine the likelihood of an individual's support or opposition to abortion. Public opinion on abortion is often more commonly referenced by the average citizen than Supreme Court decisions. Not everyone is familiar with the legalities of abortion, but most people have at least a semi-accurate understanding of what it is and base their opinions on their own perspective and experiences. The more information people accessed about abortion, the more religion and other moral factors influenced their respective opinions. With modern technology, researchers have access to opinions, patterns, and statistics in order to help understand public opinions on abortion and reproductive rights as a whole. Some states, such as Colorado, are exploring how to deliver better health care services to women and are excellent tools to reference when expanding the analysis of reproductive healthcare in other states.

Chapter 3: Methodology

This research will use a structured, focused case comparison. This method consists of carefully selecting a roster of questions, and gathering "systemic, consistent data" to answer those questions (Powner, 2015, 129). To ensure these findings are controlled, "multiple cases ... have been selected to be as similar as possible on as many variables as possible so as to logically preclude these variables as possible causes" for differentiation (Powner, 2015, 124).

I will compare three mid-western states that vary in political ideology: Illinois, Indiana, and Minnesota. Illinois and Minnesota are both strong democratic states; Indiana is a competitive state with a slight preference for the Republican Party (Saad, 2018). Based on state ideology, Illinois and Minnesota should have more liberal laws, while Indiana should have more conservative legislation.

I chose these states not only because they differ in political tendencies, but also because they approach reproductive rights differently. By analyzing the policy differences, we can determine the most feasible way to approach abortion rights. Variables of consideration are the ideology, the socioeconomic status, and the religiosity of individuals in these states. The policies I will be analyzing include those regarding comprehensive sex education and abortion laws. Further, the states drastically differ in terms of education—abstinence only or comprehensive sex education—and whether or not sex education is even required.

The questions of analysis include the following:

1. How are sex education and abortion interconnected?
2. How are women's rights affected by reproductive rights?
3. What policies should be implemented in order to reduce the abortion rate per capita?

In order to examine information, the data must first be collected in an objective manner. I determine a state's ideology by examining the political identification of each state's citizens. Considering not everyone votes in direct alignment with their preferred party, their ideological identification provides consideration for morals and politics alike. Regarding religiosity, I examine one's personal identification as religious, their certainty in God, and how important religion is in their lives to determine a state's religious influence. These three factors will illustrate the significance religion has in citizen's personal lives, and in turn, their political tendencies and legislative preferences. To determine socioeconomic status, I evaluate the percentage of people living without health insurance, those unemployed, and in those in poverty. This will assist in understanding the importance of access to women's healthcare. The data collected relies heavily on self-identification—especially for ideology and religiosity—and it should be noted that these numbers reflect only the current operations of the states.

Moreover, certain words and phrases of consideration need be defined for the purposes of this thesis. Initially, a substantial factor when determining and analyzing reproductive rights, especially for young people, is comprehensive sexuality education. The definition utilized here will closely reflect that of the United Nations' in that comprehensive sexuality education should contain information that "enables young people to protect their health, well-being and dignity" (United Nations Population Fund, 2016). Some factors that are "ideal" in sex education include consent, LGBTQ+ (queer) sex education, contraception use, and healthy attitudes surrounding bodies and sex. There should be an emphasis on respect and gender equality, while simultaneously adapting as children age throughout their schooling. The focus on adaptation suggests that comprehensive sexuality education should be a several year curricula over the course of one's education (United Nations Population Fund, 2016). In addition to comprehensive

sexuality education. abortion laws are another aspect of reproductive rights that need a brief discussion. The level of restrictions a state has regarding abortion will determine the progress and inclusivity of reproductive rights within that state. However, abortion law is inherently subjective and implicational as it is not directly spelled out in the United States Constitution. I examine the types and amount of restrictions placed on abortion access—such as parental restrictions and legally required medical procedures to determine legislative limitations. The severity of the laws is subjective. For the purposes of this thesis, the more laws, the higher chance that state has a regressive education system and fosters negative feelings towards abortion. Comprehensive sexuality education and abortion laws are determining factors when examining the reproductive rights of a state.

Chapter 4: State Policy Analysis

Illinois, Indiana, and Minnesota could all benefit from modeling their reproductive policies after Colorado's successful comprehensive reform. According to the Guttmacher Institute, Illinois provided 42,270 abortions, Indiana provided 8,180 abortions, and Minnesota provided 9,760 abortions in 2014 (2018). While these numbers differ from one another, when compared to the amount of women of childbearing age (15-44), there are more similarities than there are differences. The chart below explores the data.

	Abortions	**Women of Childbearing Age**	**Abortion Rate**
Illinois	42,270	2,577,634	1.64%
Indiana	8,180	663,033	1.23%
Minnesota	9,760	1,054,063	0.93%

Because minors have an additional set of laws to go through in order to receive an abortion, there is significantly less abortions per capita. These restrictive laws make it increasing difficult for minors to access abortion, so while the abortion rate is lower than women of childbearing age, it is not necessarily due to their personal decision. The chart below explores the abortion rates among minors in Illinois, Indiana, and Minnesota (US Census Bureau, 2018 and World Population Review, 2018). (Note that data on abortions for minors includes anyone 19 or younger.)

	Abortions	Minors	Abortion Rate
Illinois	3,111	416,157	0.75%
Indiana	768	114,042	0.67%
Minnesota	841	174,411	0.48%

In order to thoroughly analyze reproductive rights, I explore the ideology, religiosity, socioeconomic status, comprehensive sex education, clinic access, and abortion laws of each state. This will determine factors of influence and set a foundation for the proposition of legislation and education to follow.

IDEOLOGY

One factor that determines the likelihood of support for reproductive rights is the ideology of citizens in each state. Of the states examined, Illinois is the most liberal, just several percentage points more than Minnesota, with Indiana being the most conservative of the states (Gallup, Inc., 2017). The chart below explores the ideology of each state, and compares these findings to the national averages.

	Illinois	Indiana	Minnesota	Nation
Conservative	30	36	32	**33**
Moderate	37	37	36	**36**
Liberal	27	22	27	**24**

Indiana exists above the national average of people identifying with conservative ideologies. On the other hand, both Illinois and Minnesota are above the average amount of

people who identify as a liberal. While the states notably vary in conservative and liberal tendencies, there is a clear similarity on the percentage of citizens who identify as moderate (Gallup, Inc., 2017). Based on the ideological information above, it follows that Indiana would have the most restrictive reproductive rights, while Illinois and Minnesota would encompass fairly similar progressive policies and reproductive rights.

RELIGIOSITY

Religion is another aspect of each state that can help understand their reproductive rights. Considering religious affiliation, or lack thereof, has a sizeable impact on one's likelihood to support abortion, the corresponding policies must follow. The chart below illustrates and compares the religiosity of citizens in Illinois, Indiana, and Minnesota (Lipka, 2016).

	Identify as Highly Religious	**Certain Belief in God**	**Religion is Highly Important in Lives**
Illinois	51	61	50
Indiana	54	63	53
Minnesota	49	56	46

Indiana was the most conservative state ideologically, and is the most religious as well, suggesting an association between religion and politics regarding reproductive rights. Recently in politics, right-wing Christians have taken a very prominent pro-life stance and are predominantly against abortion (Forrester, 2017). With that being said, it should follow that abortion laws in Minnesota lean slightly more pro-choice than their Illinois and Indiana counterparts. Furthermore, specific details on one's religious practices reveal the disparities among each

state's religious individuals. While Minnesota is the least religious state, only 56% of their population is definite about their belief in God (Lipka, 2016). To compare, 61% of Illinois and 63% of Indiana's population are definite about their belief in God (Lipka, 2016 & Pew Research Center, 2015). Furthermore, only 46% of Minnesota's population believes religion to be "very important" in their lives; 50% of Illinois agreed and 53% of Indiana felt the same way (Lipka, 2016 & Pew Research Center, 2015).

In addition to the way religion impacts one's life in general, it is imperative to understand the impact it has specifically on decision making. 26% of Minnesota citizens and 29% of Illinois citizens look to religion to determine what is right and wrong while 36% of Indiana citizens look to religion to make this determination (Pew Research Center, 2015). 68% of Illinois, 63% of Indiana, and 67% of Minnesota reported that their determination of right and wrong is situational, as opposed to being definitively clear (Pew Research Center, 2015). Considering one's stance on abortion often rests on situational factors such as rape and/or incest, it is interesting to see how decision-making lines up with religious affiliation. Because Indiana has the lowest of the situational percentages, it follows that Indiana citizens also believe what is morally right and wrong is predetermined. This rings true when analyzing Indiana's support for abortion in comparison to the support from Illinois and Minnesota. 43% of Indiana citizens believe abortion should be legal in all or some cases, while 51% believe abortion should be illegal in all or some cases (Pew Research Center, 2015). 56% of Illinois citizens, on the other hand, believe abortion should be legal in all or some situations and 41% think abortion should be illegal in all or some situations (Pew Research Center, 2015). Minnesota exists between Indiana and Illinois for their support of abortion. 52% of Minnesota citizens believe abortion should be

legal in all or some circumstances and 45% believe abortion should be illegal in all or some circumstances (Pew Research Center, 2015).

The manners in which religion interacts with one's life vary greatly from state to state. The religious affiliation of a state is not the sole factor in determining the support or opposition of abortion, rather, one's belief in God and the importance of religion in one's life carry more of an influence.

SOCIOECONOMIC STATUS

Socioeconomic statuses are key to understanding the access people have to services, particularly health care. 9.7% of people in Illinois, 16.6% of people in Indiana, and 7.9% of people in Minnesota are all without health insurance (Open Data Network). Health insurance—public or private—is a huge factor in determining one's availability to resources for reproductive health, including birth control and testing for diseases and infections. This data indicates that people in Indiana have a more difficult time gaining access to healthcare than those living in Illinois or Minnesota. Often a factor that ties in very closely to a lack of health insurance is the unemployment rate of a particular state due to job provided insurance options. The Bureau of Labor Statistics found that Illinois has an unemployment rate of 4.2%, Indiana is at 3.5%, and Minnesota is at 2.8% (2018). Although this data does not completely line up with the amount of people without health insurance, it is clear that Minnesota has been able to keep its unemployment rates and people without health insurance relatively low.

Poverty levels are also indicative of one's opportunities, or lack thereof, to get quality reproductive care. Of all families, 8% in Illinois, 8.7% in Indiana, and 6.4% in Minnesota are living in poverty (Stats Indiana). The poverty levels are even more striking for women with kids

and without a husband: 32.1% in Illinois, 37.6% in Indiana, and 32.6% in Minnesota (Stats Indiana). These percentages alone speak to the lack of assistance women receive after giving birth to a child. Pro-life people advocate for the idea of not depriving a baby of life, yet when that baby is finally born it is clear that many women do not receive support from the man who impregnated her. Due to this lack of support and new financial burden, many women are forced into poverty. Indiana has the highest population of women without a husband and with kids living in poverty, which is reinforced by their high population without health insurance.

COMPREHENSIVE SEXUALITY EDUCATION

Contrary to popular belief, sex education is more than just informing a child about sex in an objective way. Sex education begins at a very young age through a parent's "feelings..., attitudes..., and response[s]" to their child's body, habits, or inquiries (Haims, 1973, 29). Because the information passed from parent to child is often ridden with emotions and potential misinformation, and the information children receive from peers is inaccurate, comprehensive sex education is necessary in schools (Haims, 1973, 29-31). The purpose of sex education is to inform young people about their bodies and openly discuss healthy and safe ways to engage in sex. It is important to bring bodies to the center of the classroom and break down preconceived notions of what information is essential to learn (Alldred and David, 2007, 78).

According to the Illinois State Board of Education, school districts in Illinois are not required to teach sex education (2016). However, a public act which came into effect January 2014, requires that districts deciding to teach sex education to grades 6-12 must provide "instruction on both abstinence and contraception for the prevention of pregnancy and sexually transmitting diseases, including [HIV] and [AIDs]" (Illinois State Board of Education, 2016).

This law is only applicable to any class or curriculum that specifically discusses sexual intercourse and does not apply to discussions on puberty and hygiene (Illinois State Board of Education, 2016). Furthermore, the information provided must be "medically accurate, age appropriate, and as much as possible be evidence-based" (Illinois State Board of Education, 2016). Because the information is not required to be definitively evidence based, school districts may find loopholes to push different agendas while still technically operating within the law.

The Indiana standard for sex education has a strong emphasis on abstinence. Abstinence is taught to be the only way to avoid pregnancy, diseases, or other "associated health problems" (Indiana Department of Education, 2014). Furthermore, it is expected of instructors to teach students that the next best way for disease prevention is to "establish a mutually faithful monogamous relationship in the context of marriage" (Indiana Department of Education, 2014). Not only does this curriculum stifle young people's freedom, it also deprives them of necessary knowledge about their bodies. In addition to the abstinence focused education, schools in Indiana must gain permission from parents to teach each child human sexuality (Indiana Government). The instructor/teacher must provide "teachers' manuals, curricular materials, films or other video materials, tapes, and other materials used for instruction" to the parents before consent can be requested (Indiana Government). If the parent does not consent to their child(ren) learning about human sexuality, the child(ren) will be placed in an alternative curriculum for the duration of the human sexuality curriculum (Indiana Government). The parental consent form takes away the student's ability to freely learn about sex, and places their autonomy in the hands of their parents.

Sex education in Minnesota is referred to as "responsible family life and sexuality education programs" and have a focus on communication, responsibility, and community values

(Minnesota State Legislature, 2017). Minnesota requires that school districts encompass technically accurate information in their curriculum regarding sex education (Blackman and Scotti, 2016). Additionally, school districts must work in conjunction with the commissioner of health and the commissioner of education to determine the best way to prevent diseases (Blackman and Scotti, 2016). Hf 1759 requires that sex education must be "age-appropriate and medically accurate" for the group of students at hand (Minnesota State Legislature, 2017). Like Indiana, instructors/teachers must consult with the parents or guardians of students before teaching the students about sexuality education (Minnesota State Legislature, 2017).

It is difficult to determine which state provides the best comprehensive sex education between Illinois and Minnesota. Indiana is completely out of the question due to the heavy focus on abstinence. This narrow focus, while technically accurate only in regard to preventing pregnancy and disease, is cis-heteronormative and oppressive to sexual freedom. While Illinois does a good job at providing a variety of information, districts are only required to provide said information if they decide to even implement a sexual education course or curriculum in the first place. Minnesota, on the other hand, does not say that districts can opt out of sex education; however, the emphasis on community values leaves certain information up to interpretation. Because community values can be drastically different from person to person, these values in the school systems are often presented in a subjective manner.

CLINICS & ACCESS

As of 2014, Illinois was home to 40 abortion providing facilities—both general providers and clinics—for its over 12.8 million residents (Guttmacher Institute, 2018 and United States

Census Bureau, 2017). Further, roughly "92% of Illinois counties had no clinics that provided abortions, and 40% of Illinois women lived in those counties," making abortion less accessible to women in these counties (Guttmacher Institute, 2018). While Illinois is not the most oppressive of the states examined, it is home to one of the largest cities in America, Chicago, and many rural towns. The difference in urban and rural areas in Illinois leads to strong political controversy among its citizens and legislators.

As of 2014, there were 11 abortion providing facilities in the state of Indiana. Additionally, 95% of counties in Indiana are completely without abortion clinics, and 66% of women live in these same counties (Guttmacher Institute, 2018). While Indiana is similar to Illinois in the percentage of counties without abortion providers, the percentage of women residing in these counties drastically differ. Therefore, women in Indiana are significantly more compromised when in need of an abortion than their Illinois counterparts.

Like Indiana, Minnesota was home to 11 abortion providing facilities in 2014. 95% of the counties in Minnesota were without any abortion providing facilities, which were home to 59% of women. Statistically, Minnesota and Indiana have near identical experiences with abortion providers, with the exception being the percentage of women in disenfranchised counties. Minnesota is only slightly more progressive than Indiana, yet their legislation is significantly less restrictive, and not quite as progressive as that of Illinois.

It is imperative to point out the fact that many women travel to Illinois to receive their abortion due to the more progressive laws in the state. In 2016 alone, 4,543 women traveled to Illinois for their procedure (Lourgos, 2018). This reaffirms the idea that the number of abortions performed within a state should not be the only facet examined when discussing reproductive rights.

ABORTION LAWS

In 2017, the Illinois legislature approved a measure that allows Medicaid coverage for abortion procedures, however, Governor Rauner did not sign the bill until late September that year (O'Connor, Tareen, 2017, 95). Public opinion towards this bill has been controversial as opponents to abortion have stated that it is not in the best interest of taxpayers to have to pay for a procedure that some view as morally reprehensible. On the other hand, supporters of the bill argue that abortions fall under the umbrella of healthcare, and should be supported by taxpayers (Illinois Department of Public Health, 2018). While Rauner has been inconsistent with his public opinion regarding abortion rights, when he signed the bill into law he argued, "a woman living with limited financial means should not be put in a position where she has to choose something different that a woman of higher income would be able to choose" indicating a pro-choice stance (O'Connor, Tareen, 2017, 95). In the case that the Supreme Court overturns *Roe v. Wade*, Illinois women are now protected through legislative action. With the recent confirmation of conservative justice Brett Kavanaugh to the Supreme Court of the United States—a now majority conservative court—many women and pro-choice individuals are weary of this possibility becoming a reality (Biskupic, 2018).

Women choosing not to have an abortion are also often subject to a lack of personal and medical autonomy. Depending on the mandates of a particular state, some women may be forced to undergo a Caesarean section against her consent if the court rules it "necessary" (Uberoi and Bruym, 2013, 164). Over a decade ago, Illinois took a stand against this law when an appellate court ruled that a pregnant woman would not have to forcibly undergo a Caesarean section and a blood transfusion on the grounds that "the potential impact upon the fetus is not legally relevant; to the contrary, the … court explicitly rejected the view that the woman's rights can be

subordinated to fetal rights" (Uberoi and Bruym, 2013, 164). In addition to this law, "as of May 1, 2018...a parent of a minor must be notified before an abortion is provided" in the state of Illinois (Guttmacher Institute, 2018). While Illinois is making progress to be more sympathetic towards women and reproductive rights as a whole, the mandate requiring that minors inform their parents before an abortion takes place is still regressive and apathetic. Further, while Illinois does not reflect Colorado's policies, the progress exhibited in this state is unprecedented compared to other states in the Midwest.

An Indiana mandate required pregnant women to get an ultrasound at least one day before they have an abortion. Forcing women seeking abortions to undergo an ultrasound can be an exhausting experience especially given the financial and emotional burdens of the situation. In early 2017, this mandate was overturned by U.S. District Judge Tanya Walton Pratt on the grounds that "the requirement is likely unconstitutional and creates "clearly undue" burdens on women, particularly low-income women" (Callahan, 2017). Forcing a woman to have an ultrasound before she goes through with an abortion has little to no effect on whether or not she will choose to have an abortion (Upadhyay et al., 2017) Indiana is home to a variety of restrictions on abortion, including a law reflective of Illinois' law, requiring that a minor must gain their parent's consent before receiving an abortion.

In regards to healthcare coverage, the use of public funding, private insurance coverage, insurance for public employees, and the Affordable Care Act have restrictions on abortion access. All healthcare options are prohibited from covering the cost of an abortion except "in cases of life endangerment, rape, incest," or when the health of the mother is at serious risk (Guttmacher Institute, 2018). Citizens do have the option of adding an "optional rider" to their preexisting public or private insurance in order to assist with reproductive rights (Guttmacher

Institute, 2018). In regards to the actual process of obtaining an abortion, there are many more hoops women must jump through. Each person seeking an abortion must be counseled at the clinic with information specifically curated to try to prevent the abortion. Further, a mandated 18 hour waiting period is conducted; however, the "counseling must be provided in person and must take place before the waiting period begins, thereby necessitating two trips to the facility" (Guttmacher Institute, 2018). This law specifically oppresses women who do not have the means to travel to receive their abortion, while simultaneously attempting to ostracize any woman seeking an abortion. Further, the abortion provider must force the woman to undergo an ultrasound and must give her the option to view the image before providing the abortion. In addition to this, telemedicine, "the practice of medicine when the doctor and patient are widely separated using two-way voice and visual communication," is prohibited in the administration of abortion medication (Guttmacher Institute, 2018 and Merriam-Webster). The prohibition of telemedicine disallows women, who would have to travel to a clinic, the convenience of speaking with a doctor electronically. This further discriminates against women who do not have the means to easily take off of work and travel long distances, over several days, in order to receive an abortion.

Indiana is home to extremely restrictive abortion legislation, and is arguably one of the most difficult states to apply policy reform to. Like Illinois and Indiana, minors seeking abortion in the state of Minnesota must notify their parents before the abortion is provided. Additionally, the woman seeking an abortion is mandated to go through counseling that disheartens the idea of abortion. She must also wait 24 hours before finally being able to receive the abortion (Guttmacher Institute, 2018). This policy requires women to travel an unnecessary amount in

order to go through a medical procedure, often discouraging poor women from pursuing autonomy.

Minnesota reflects Indiana statistically, and in regard to abortion access. However, in regards to legislation, Minnesota more closely resembles Illinois. An aspect regarding abortion rates that must be addressed is the fact that women travel out of state to get abortions. This is often dependent on the state-specific policies and restrictions surrounding abortion access and procedure. For example, a woman in Indiana may travel to Illinois to receive an abortion due to the less restrictive laws surrounding abortion.

All women considering abortion in the state of Minnesota are required to receive information about "abortion risks, complications, and alternatives; the gestational age of their unborn child, [and] fetal pain information" before they can go through with an abortion procedure. (Andrusko, 2008). With that being said, it is important to note that 37% of women claim that they choose abortion for economic reasons, among others. Further examining the socioeconomic disparities among women in Minnesota is crucial to analyzing reproductive rights and legislation in this Midwestern state. Therefore, forcing a woman to listen to information through a harsh conservative lens is a misuse of power, and problematic to all women seeking abortion, not just those in Minnesota.

These state-by-state explorations result in three very different policy environments for the studying of abortion legislation. Considering Illinois is the most progressive of the states examined, it will require significantly less reform than the more conservative Indiana. Minnesota exists between Illinois and Indiana, and will need a more specific tailoring of policy in order to reflect Colorado's policies.

Chapter 5: Policy Recommendations & Conclusions

In the states examined in this exploration, Indiana would be the least likely government body to encourage such radical reform given its ideologies and current abortion laws. Illinois is the state most likely to welcome radical change. Minnesota could go either way, and is currently unpredictable in its receptivity to legislative reform.

Colorado is not alone in their attempts to reform policy regarding reproductive rights. Another example of comprehensive change enacted on a state level occurred in Oregon (Oregon Legislative Assembly, 2015). In 2016, Oregon's House Bill 2879 became effective, allowing female-bodied individuals to have access to birth control over the counter without a prescription from a doctor (Hayes, 2015). While this policy implementation is a step in the direction of comprehensive reproductive healthcare, it is important to note that Oregon was the *first* state to put this into practice. Considering a doctor's prescription is one of the leading reasons women do not have adequate access to birth control, this step taken by Oregon is instrumental in setting an example for women's reproductive healthcare.

Before pharmacists can provide birth control through this legislation, they are required to go through 5 hours of training in addition to familiarizing themselves with U.S. medical eligibility criteria (Hayes, 2015). One restriction in this program is that women under the age of 18 are barred from this program unless they are refilling a prescription they already have. This particular facet exudes privilege in that it requires access to a doctor or general practitioner, which is potentially exclusionary to poor Americans (Hayes, 2015). This restriction in and of itself has the potential to have a negative impact on the number of teen pregnancies considering the barriers present. Additionally, all women seeking over the counter birth control need to fill out a 20-point questionnaire in order to determine any risks that may need to be addressed

(Hayes, 2015). Hayes continues, stating that pharmacists are permitted to "dispense a month's supply of only the pill and the hormonal contraceptive patch, not the contraceptive ring" (Hayes, 2015). While it would be ideal to have more long term birth control readily accessible, offering the pill and the patch is a notable step in the right direction.

Considering 90% of abortions are due to an unintended pregnancy, it is imperative to not only implement comprehensive solutions, but to also study the relationship that is offered between contraception access and abortion rates (Thomas, 2016 and Williams, 2012). The contraceptive CHOICE project outlined the benefits and drawbacks of short term (pills, patches, rings) and long term (IUDs and implants) contraception options to over 9,000 at risk young women aged 14 to 15 at in the St. Louis, Missouri area. Those willing to participate in the study had the option of using short term or long term contraception, and subsequently, the abortion rate among these groups was studied (Williams, 2012). This study, conducted between 2007 and 2011, found a clear drop in the abortion ratios in the study group compared to the greater St. Louis area, in addition to the nation-wide rates (Williams, 2012). In fact, the abortion rates among this group, gathered from 2008 to 2010 was 4.4-7.5 per one thousand participants. This accounted for a 62-78% drop in the annual abortion rate for all women in the United States (Williams, 2012). Furthermore, the birth rate among the participants was 6.3 per 1,000 women, as opposed to 34.3 per 1,000 women, both aged 15-19 (Williams, 2012). This dramatic decrease in abortions and births is notable and should not be overlooked when determining future policies for reproductive rights.

When discussing short-term and long-term options for contraception, it is important to note that although birth control pills are the most used, they require consistent accountability in pill taking in addition to having easy access to refills, which is a privilege not all can afford.

Long term contraception options are comparatively costly, being close to $1,000 and are often not covered by insurance, yet provide more consistent protection against pregnancy. The Washington University of Saint Louis discusses the differences between common forms of contraception and the fact that free access to contraception—specifically long acting reversible contraception—would decrease the amount of abortions per live births among at risk youths (Williams, 2012). With that being said, how is it that "at risk" youths are defined? The privileges people have account for the ways in which they view subsets of people, and in turn, how they categorize them—which can lead to problematic language surrounding health assistance. The language surrounding reproductive rights is often problematic, which is why it is so important for education to provide young people with correct information.

This information, coupled with the studies in Colorado and Oregon, make it clear that pro-choice advocates and policy-makers need to make comprehensive information about birth control and abortion readily accessible to people in all socioeconomic classes. Specifically, we might have to rely on wealthy individuals or families to offer funding for contraception programs in order to see an increase in access to reproductive health services, a decrease in abortions, and overall a better understanding of reproductive justice. If this reliance ends up becoming a normalcy, the access to birth control runs the risk of becoming privatized, which could only provide access for those with a certain amount of privilege, and will not be readily accessible to the public. While there is a slight chance that the families looking to help reproductive access might not be in it for the money, the capitalistic economic state of America would likely prove otherwise.

In order to implement these policy changes in self-funded states, an increase in taxes would likely have to occur. While taxes are generally disliked by people on both sides of the

political spectrum, liberal and democrat-leaning states are more likely to support a raise in taxes especially when it benefits humanitarian issues. With that being said, Illinois and Minnesota would be more likely than Indiana to implement an increase in taxes for the purposes of promoting comprehensive sex education and the implementation of progressive reproductive healthcare. In order to make taxes more appealing, the proposed taxes would have to be incremental—slowly increase over time until the proper number is met, at which point it can remain constant. This would be an ideal bi-partisan way to compromise on the method of getting to a point where reproductive information and healthcare is available to everyone, not just a privilege to those who can afford it.

In the case that all 50 states do not implement a tax increase in order to make reproductive care more accessible—which is likely—there comes the possibility of federal sanctions. Federal sanctions can be utilized in order to mandate states to operate at a minimum level for the purpose of accessibility and education. I predict that this has the possibility of coming about through a future Supreme Court decision. If the court finds that the current state of reproductive healthcare is a violation of the 14th amendment of the constitution, there could be legal standing in court. The 14th amendment guarantees life, liberty, and property to all Americans and is often referred to as the "equal protection of the laws" (LII Staff, 2018). Utilizing precedents set forth from *Roe v. Wade* for reproductive rights and *Reed v. Reed* for gender discrimination, it is entirely possible that a well-backed case could stand up in court (LII Staff, 2018).

DRAWBACKS

Any study has potential drawbacks, and this analysis is no different. Some issues in need of addressing include the use of binaristic language, the latitude of individual state analyses, the prominence of privilege, and potential generalizations.

Initially, I relied too heavily on binaries throughout my analysis by using words such as women, men, female, and male. This is exclusionary to transgender, non-binary, and gender non-conforming individuals, especially those who deal directly with reproductive care. The use of this language is harmful in many ways and can potentially deter readers from reading my analysis of reproductive rights. I made the decision to use binaristic language for the purpose of conveying information in a palatable way for readers with different views on gender. I want readers of all political ideologies to feel informed and inspired from this cross-state analysis, in order for reproductive justice to be on a progressive path. I felt that if I were to have used more inclusive language, I would have had to change the focus of my paper to the problems with binaries in reproductive health—which could be a whole paper in and of itself. The purpose of this paper was to explore the successes and shortcomings of reproductive legislation and education in Illinois, Indiana, and Minnesota and end with policy recommendations. I did not want to gloss over the issue of gender binaries and do a disservice to myself and the rest of the queer community by writing only a paragraphs explanation of the problems with binaries. Given the time and opportunity to write a well-explored and thought through paper on the exclusion of transgender, non-binary, and gender non-conforming individuals from reproductive health, I would do it in a heartbeat.

Another shortcoming of this paper is that this three state policy analysis is only a chip in a much larger iceberg when discussing reproductive rights. In order to propose accurate policy recommendations for all 50 states in the United States, an analysis similar to those found in this

paper are necessary. This would take either several years to complete if done by one person, or would require a larger group of political scientists to do a case study on several states each over a shorter period of time. In order to ensure data is gathered from the same time frame, the former would be the preferred option in order to make sure one set of states does not have more up-to-date information, while others are several years behind. However, the benefit of having one researcher would ensure the same methods and sources are used for all states to ensure a fair and equal analysis is conducted. Regardless of the method used, more states are in need of an analysis in order to offer and implement progressive reproductive policies and comprehensive sex education into schools.

Lastly, I would like to discuss the prominence of privilege and generalizations together, as they have some overlap with one another. As a white person, I have the privilege of not knowing what it is like to live in the world as a person of color, and how that impacts access to reproductive care. While the decrease in abortion rate is progress for America, developing countries are still struggling to prevent unintended pregnancies (Guttmacher Institute, 2018). This discrepancy alone opens the door for more research to examine reproductive rights on a global scale. I have done, and will continue to do, research and have had conversations about this intersection, however, that does not give me the platform to speak on behalf of those communities I am not a part of. With that being said, I would like to apologize for any potential generalizations I unknowingly made throughout this paper. I read and learn every day in order to expand my understanding of other cultures, and am always open to listening to others to empathize and grow as a person.

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