Ending a Pregnancy in Kentucky:
State policy, abortion access, and public health

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Content warning: suicidal ideation, self-harm, child abuse, medical complications

INTRODUCTION | Ending a Pregnancy in Kentucky

Pregnancies end. Some people end their pregnancy before carrying it to term for a variety of personal and medical reasons. Pregnant people have two main options when they need or want to end a pregnancy: self-managed abortion (SMA) or clinical abortion care. Self-managed abortion involves ingesting medication or herbs to end a pregnancy or physical removal of the pregnancy without the supervision of a medical provider. In clinical abortion care, there are two ways a patient can end their pregnancy. One option is medication abortion, during which the pregnant person takes a sequence of two FDA-approved pills, Mifepristone and Misoprostol, to dispel the products of conception. A second option is procedural abortion, during which a medical provider physically removes the pregnancy-related tissue from the uterus.

Many state governments in the US heavily regulate abortion care. Policymakers often limit abortion access through laws affecting how and when providers offer care, as well as how people access that care. Over the past decade, Kentucky lawmakers passed a series of restrictive abortion laws, including a near-total abortion ban[1] enacted after the U.S. Supreme Court's 2022 *Dobbs v. Jackson Women's Health Organization* decision. Kentucky's rapidly changing legal landscape offers an example of how restrictive abortion laws can have serious public health implications.

This white paper focuses on the ways Kentucky's state policies directly impact peoples' experiences of abortion care, with emphasis on the periods leading up to and after the *Dobbs* ruling. The following sections trace the policy trajectory that led to Kentucky's hostile abortion environment and examine the real-world effects of Kentucky's abortion laws on individuals and families:

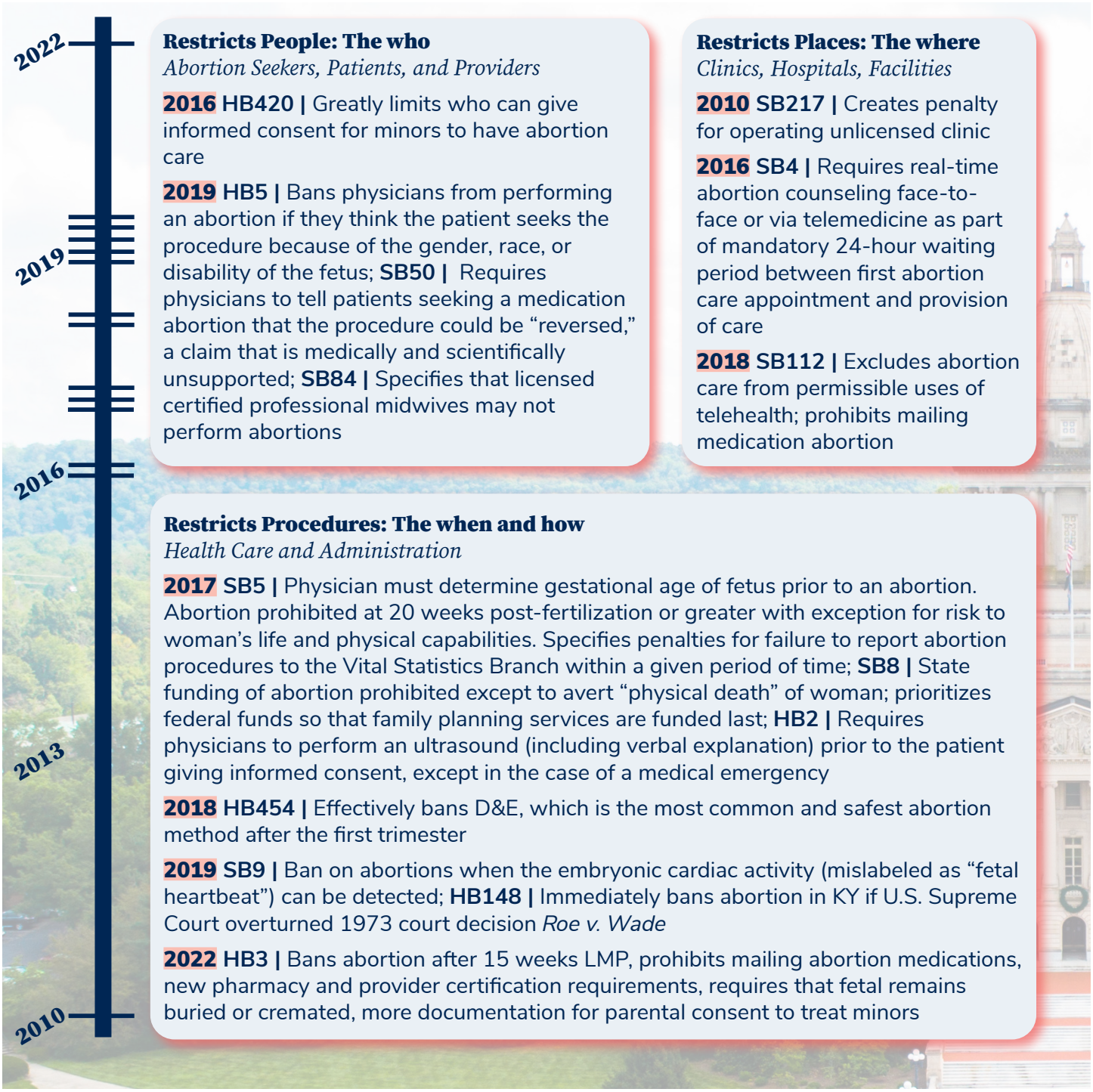
I. Abortion Policy in Kentucky
II. Ending a Pregnancy: Self-Managed Abortion
III. Ending a Pregnancy: Clinical Care
IV. Public Health Implications

I. ABORTION POLICY IN KENTUCKY

Kentucky's legislature spent decades incrementally dismantling abortion access through a series of overlapping restrictions (Smith et al., 2023). Although *Roe v. Wade* (1973) created a federal right to abortion until it was overturned in 2022, Kentucky first enacted Targeted Regulation of Abortion Providers (TRAP) laws in the 1990s (KRS § 216B.0431, KRS § 216B.0435). TRAP laws require abortion facilities to follow unnecessary, non-medical legal requirements not required of other health facilities. For example, Kentucky TRAP laws require abortion facilities to obtain special licenses, maintain written agreements with local hospitals and ambulance services, meet special width requirements for hallways and doors, and more. Kentucky ramped up enforcement of TRAP laws in the 2010s, while state lawmakers passed more laws to limit abortion access. These laws can lead to closures of clinics that could otherwise provide safe, necessary medical care (Guttmacher Institute, 2020). Following *Dobbs* in June 2022, Kentucky began enforcing two overlapping abortion bans: its total abortion ban (triggered by the *Dobbs* decision) and its "heartbeat" ban.

1 Kentucky's near-total abortion ban did not include exceptions for rape, incest, cancer patients, fetal abnormalities, etc.(Cameron, 2022). This means medical providers could not treat common pregnancy complications to the highest standard of care.

A Snapshot of Select Abortion Legislation Passed in Kentucky, 2010 - 2022



Calling Kentucky's gestational ban a "heartbeat" ban is misleading: ultrasounds can amplify electrical activity in an embryo around six weeks gestation, a point at which chambers of the heart are not yet developed. Many people do not even know they are pregnant at this point in gestation (Turner, et al., 2022; Nash, 2019). After an injunction temporarily paused the bans at the end of June 2022, Kentucky courts reinstated both bans in August 2022, once again prohibiting clinician-provided abortion in the state.

In November 2022, voters rejected a ballot initiative that would have banned abortion in Kentucky's state constitution (Schreiner & Campbell, 2022). Nevertheless, in 2023, the Kentucky Supreme Court declined to block the trigger and gestation bans when a lawsuit challenged their legality. The Court, however, did not rule on whether the state constitution protects abortion rights.

In the 2025 legislative session, Kentucky state legislators continued to push for stricter abortion regulations. House Bill 316 and Senate Bill 106 propose criminal penalties and civil liability for the distribution of medication abortion drugs like Mifepristone (KY House of Representatives, 2025, HB316; KY Senate, 2025. SB106). House Bill 203 would reaffirm the state's abortion ban while designating exceedingly narrow exceptions (KY Senate, 2025, HB203).

Enacted in 2025, House Bill 90 attempts to clarify that treating ectopic pregnancies, managing miscarriages, and providing emergency care for life-threatening pregnancy complications do not constitute illegal abortions under state law (KY General Assembly, 2025). However, providers raise concerns that medically inaccurate language, and the limited list of possible medical exceptions in the law, could delay emergency care or expose providers to legal risks (Buczek, 2025).

Altogether, Kentucky's extensive abortion regulations and legal environment create profound barriers for those seeking to end a pregnancy. These restrictions disproportionately harm people living with financial insecurity, Black people and other people of color, young people, and those living in rural areas (Dehlendorf & Weitz, 2011).

II. ENDING A PREGNANCY: Self-Managed Abortion

Self-managed abortion (SMA) is an umbrella term that refers to abortion care options that people pursue without the formal medical system (Self-Managed Abortion, 2024). SMA is a globally prevalent option for ending a pregnancy and has existed throughout human history. Methods vary in safety and effectiveness. Taking abortion pills without medical supervision is the most prevalent form of SMA. Other methods include using herbs, vitamins, drugs, instruments, or physical trauma (Self-Managed Abortion, 2024). People often source medication abortion pills for SMA through direct service organizations or international online pharmacies.[2] Some services provide pills that replicate the medications provided in clinics, while others rely on different protocols, such as Misoprostol alone. Medication abortion is a safe, effective option for many people seeking to end a pregnancy (Moseson et al., 2023).

Kentucky Policy Snapshot

2022 | Omnibus Restrictions (HB 3): Bans abortion after 15 weeks, blocks mailing abortion pills, increases reporting requirements, and mandates fetal tissue burial or cremation (KY General Assembly, 2022).
2025 | HB 316 (Introduced, Not Passed): Would have criminalized sending abortion medications into Kentucky by mail and allowed civil lawsuits against providers (KY House of Representatives, 2025, HB216).

What the Data Shows

In the United States, researchers have less data about SMA than about abortion in clinical care settings. However, a 2020 study estimates as many as 7% of women in the United States will engage in SMA during their lifetime (Ralph et al., 2020). Some findings suggest that within the SMA umbrella, self-managed medication abortion has increased in response to reduced clinic access during COVID, increased abortion restrictions, and expanded accessibility of medication abortion drugs (Friedrich-Karnik et al., 2024). In the six months post-*Dobbs*, nearly 28,000 more people self-managed abortion than would have been expected pre-*Dobbs* (Aiken et al., 2024).[3]

Emerging research suggests many people may not be aware that SMA is an option (McFarland et al., 2025). Among those who are familiar with SMA, misinformation is common (McFarland et al., 2025). Further, people fear criminalization, or getting into legal trouble, connected to SMA. Law enforcement has prosecuted people on suspicion of engaging in SMA, often based on laws that were not intended to

2 Guttmacher Institute notes that there is a "…blurry line between SMA and…telemedicine" because some SMA services work with clinicians (Friedrich-Karnik et al., 2024). For the purposes of this white paper, medication abortion prescribed through US telehealth providers is discussed as a form of clinical care.
3 Accounting for non-use of provided abortion pills, estimated increase of self-managed medication abortion is 26,055 (Aiken et al., 2024).

apply to abortion (Paltrow & Flavin, 2013). The risk of prosecution is higher for those who police already disproportionately scrutinize, such as Black and brown communities (Friedrich-Karnik et al., 2024).

As told by Kentuckians[4]

Gemma's story

Gemma is a white adult in her 20s from north-central Kentucky

Gemma, a college student, was upset to learn that she was pregnant in mid-August 2022 after previously taking Plan B. She felt she couldn't balance her classes, her job, and a child, and did not want to risk passing her family's mental health struggles on to a child. She decided ending the pregnancy was the best option for her and her future. Gemma knew the laws were changing in Kentucky, so she first ordered abortion pills online and planned to have them shipped to a friend in a different state since they could not be mailed to Kentucky at that time. After calling a clinic in Kentucky, whose staff referred her to clinics in Indiana, she canceled the online pill order. Gemma felt traveling to Indiana was both legally and medically safer than taking pills received by mail. While she was able to get the abortion in Indiana, she had worried about getting the abortion before Indiana law changed, too. She also worried about traveling while balancing her school and work responsibilities. Ultimately, she needed to pick up additional shifts at work to pay for the appointment and travel. Prior to her appointment, Gemma took hot baths and ingested vitamins and ibuprofen to try to induce the abortion on her own. She shared that she would have considered suicide if she had not been able to end the pregnancy. After receiving care, she was looking forward to graduating from college and starting a new career.

Sandra's story

Sandra is a multiracial adult in her 30s from western Kentucky

After recently losing health insurance and, subsequently, access to birth control, Sandra was distraught when she discovered she was pregnant again in late-December 2023 after previously traveling out of state for an abortion earlier in the year. Sandra did research on Vitamin C and using herbs to end pregnancies, although she felt doubtful these methods would work. She decided not to try them and instead tried to schedule an abortion in Indiana, but the laws had changed since her last abortion. Clinic staff from Indiana referred Sandra to clinics in Ohio and Illinois, where she made appointments. Sandra eventually had the abortion in Illinois in early March 2024. The clinic connected her with funds to support the procedure, travel, and a hotel stay. Without these travel funds, Sandra described the 12-hour round-trip drive she and her boyfriend would have had to make as "miserable." Sandra kept her experience mostly private due to abortion stigma in her family, but she did share abortion fund information with a friend who recently reached out for help arranging out-of-state abortion care.

III. ENDING A PREGNANCY: Clinical Care

Clinical abortion care happens in coordination with medical professionals: either in-person at a medical facility or with medical providers prescribing medication abortion through telehealth. Even before Kentucky banned abortion, clinical care in the state was hard to access. With TRAP laws and abortion stigma, abortion clinics faced many barriers to opening and staying open (McGowan et al., 2020). Limited clinical capacity, restrictions on telehealth abortion care, and location of abortion clinics mean some Kentuckians have always traveled out-of-state for care (Smith et al., 2023). Navigating the logistical, emotional, and financial barriers to this safe, common form of health care are inequitably experienced: the more financial, geographic, and social privilege an abortion seeker has, the more easily they overcome the barriers.

4 A limitation of OPEN's qualitative data about self-managed abortion in Kentucky is that the research team was only able to interview people seeking abortion care who reached clinics, meaning they neither successfully complete SMA nor continue pregnancies. As such, the vignettes shared are not fully representative of people's experiences. All names shared are pseudonyms.

Kentucky Policy Snapshot

1980 | Public Hospital Abortion Ban: Kentucky prohibits public hospitals from performing abortions except to save a woman's life (KRS § 311.800).
1998 | Abortion Facility Licensing and Transfer Agreements: Clinics providing abortions must be licensed as abortion facilities and maintain transfer agreements with a hospital and ambulance service (KRS § 216B.0431 & § 216B.0435).
2018 | Ban on Telemedicine Abortion (SB 112): Medication abortions must be prescribed in person; telehealth abortions are banned (KRS § 311.800(6)).
2019 | "Abortion Reversal" Disclosure Requirement (SB 50): Doctors must tell medication abortion patients that the process may be reversible, a scientifically refuted claim (KRS § 311.725(2). **Trigger Ban (HB 148):** Outlaws nearly all abortions immediately if Roe v. Wade is overturned, with exceptions only to save the woman's life (KRS § 311.772). **6-Week Gestational Ban (SB 9):** Bans abortions once embryonic cardiac activity is detected (around six weeks) (KRS § 311.7706); initially blocked, enforceable post-*Dobbs*.
2022 | Trigger Ban Activates: After *Dobbs v. Jackson Women's Health Organization*, Kentucky's trigger ban took immediate effect, banning all abortions except for life-threatening emergencies (KRS § 311.772).

What the Data Shows

Abortion was effectively legal in Kentucky through July 31, 2022.[5] During those seven months, Kentucky clinics provided 2,131 Kentuckians with abortion care and 2,858 Kentuckians obtained abortion care at in-person facilities in 8 other states: Illinois, Indiana, Michigan, North Carolina, Ohio, Tennessee, Virginia, and West Virginia (Ramer, et al., 2024). The most frequently traveled-to states were Indiana (n=950, 33%), Illinois (n=554, 19%), and Ohio (n=807, 18%) (Ramer, et al., 2024).

In 2023, the first full year clinic-based abortion was banned in the state, at least 4,490 Kentuckians obtained in-person abortion care by traveling to other states. Among those we know traveled, 42% went to Illinois (n=1,870, a 238% increase from 2022), 40% went to Ohio (n=1,810, a 124% increase from 2022), and 18% to Indiana (n=810, a 15% decrease from 2022) (Maddow-Zimet et al., 2025). After *Dobbs*, Kentucky abortion-seekers lost access not only within their own state, but also in nearby states that banned abortion, such as Tennessee (2022), West Virginia (2022), and Indiana (2023).

Kentuckians travel for care, 2022

Kentuckians travel for care, 2023

Kentuckians travel for care, 2024

In 2024, the most recent full year for which data is available, at least 4,320 Kentuckians obtained in-person abortion care by traveling to other states. Among those we know traveled, 44% went to Illinois (n=1,910, a 2% increase from 2023), 53% went to Ohio (n=2,280, a 26% increase from 2023), and 3% to Virginia (n=130) (Maddow-Zimet et al., 2025).

5 House Bill 3 caused Kentucky clinics to close for about a week in April of 2022, as they were unable to keep up with the new restrictions (including reporting requirements, fetal remains rules, new forms, and more). A federal judge then temporarily blocked the bill, and the clinics reopened (McCammon, 2022).

Traveling from Kentucky to abortion destination states like Illinois and Ohio can be expensive. Those with personal vehicles spend money on gas, and those without may pay for bus or plane fares or rely on others for transportation. Kentuckians traveling out-of-state for care may need to spend the night due to their destination state's distance, clinics' inability to offer same-day care, or recovery time. Abortion care itself is also expensive, with in-clinic abortion care ranging from $600-$2,000 depending on gestation, insurance, and other factors (Planned Parenthood, 2025). Additionally, many abortion patients have previously had at least one birth (Ranji et al.,2025), so they may also have to coordinate childcare. These logistical, financial, and geographic barriers to care also come with psychosocial burdens such as fear of judgment, interpersonal strain, and stress (Odum et al., 2023).

Several states passed "shield laws" in 2023. Shield laws offer legal protection to clinicians who provide telehealth abortion care from the shielding state to those living in states with abortion bans or restrictions. Shield laws enable Kentuckians to receive telehealth abortion care from some out-of-state providers. Over the following year, 2,210 Kentucky residents received medication abortion care through providers operating under shield laws (#WeCount, n.d.).

As told by Kentuckians

Teresa's story

Teresa is a white adult in her 40s from eastern Kentucky

Teresa was surprised to discover she was pregnant at the end of August 2024. Despite financial concerns, Teresa was excited about the pregnancy and sought prenatal care from her OBGYN. After prenatal genetic screening suggested the fetus would have trisomy 21, or Down syndrome, Teresa's OBGYN referred her to a larger medical center for an ultrasound. The ultrasound findings were consistent with the screening results, and a genetic counselor told Teresa there was a 99% chance of trisomy 21 and over 50% chance that if she continued the pregnancy, the baby would be born with multi-organ anomalies requiring immediate surgery. Despite feeling pressure from the genetic counselor to wait until an amniocentesis at 17 weeks, Teresa's experience with child loss, financial hardship, and existing parental responsibilities shaped her decision to seek an abortion.

Teresa visited her OBGYN, who supported her decision and offered guidance on how to find safe abortion care given her medical history. Teresa called multiple clinics in Ohio, Virginia, and Illinois. She scheduled with a clinic in Illinois, as she understood from conversations with Ohio clinics that Ohio state law would not allow them to provide care if there was a trisomy 21 diagnosis and a clinic in Virginia declined to schedule her due to her medical history. The Illinois clinic referred Teresa to an abortion fund that gave her money to pay for the appointment, gas, and a hotel stay. Without this funding, Teresa likely would have had to travel to and from the clinic, three and a half hours each way, on multiple days. Teresa felt that the Kentucky laws were uninformed and ridiculous, and that the Ohio law about trisomy 21 forced her to travel further and be away from home and her children longer.

Stacy's story

Stacy is a white adult in her 40s from central Kentucky

Stacy is a business owner and a mother of three children, living in rural Kentucky. A few weeks after missing her period in February 2024, Stacy was shocked that her home pregnancy test was positive. After talking with her husband and taking time to consider having another child, Stacy felt happy about the pregnancy and planned to continue. Stacy wished to have a home birth and limit the medicalization of her pregnancy. However, after prenatal genetic screening around 10 weeks gestation, she learned the result was positive for trisomy 21. Feeling torn, Stacy decided to do more testing around 13 weeks gestation. While waiting for results, she scheduled abortion appointments in both Illinois and Colorado—just in case. Stacy's results confirmed trisomy 21 diagnosis, and she decided an abortion would be the best choice for her and her family. Stacy's husband stayed at home

with their children while she traveled for her appointment, driving several hours to Cincinnati and then taking an overnight train to Illinois. Because she was traveling alone, Stacy did not receive the level of pain management she would have preferred during her abortion, describing the procedure as more painful than her prior home births. The travel and procedure cost Stacy approximately $1,500, a major cost that impacted her financial planning and pushed her family to sell a piece of work machinery. While Stacy faced many challenges on her path to access abortion care, she recognized that her situation was different from many others, saying: "I definitely think that a lot of things that were speed bumps for me would've been complete roadblocks for other people."

IV. PUBLIC HEALTH IMPLICATIONS

Beyond any individual Kentuckian's experience with abortion care, the landscape of abortion access is inseparable from the health and well-being of Kentucky's communities at large. Restrictive abortion policies impact Kentuckians' social determinants of health, the same factors that impact other aspects of Kentuckians' opportunity for health and outcomes. The US Department of Health and Human Services defines social determinants of health as: "the conditions in the environment where people are born, live, learn work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" ("Social Determinants of Health," n.d.). Health care access, alongside social and community context, are social determinants of health that show how restrictive abortion policies and public health interact.

Health Care Access

Access to health care is a named priority in Kentucky Department for Public Health's 2024-2028 State Health Improvement Plan ("State Health Improvement Plan Committee and Workgroups," 2024). Physically accessing care can be practically impossible for Kentuckians who live in areas with few-to-no medical providers. March of Dimes reports that 46% of Kentucky counties are maternity care deserts – areas without access to medical providers who offer maternity care (Fontenot et al., 2023). Those maternity care deserts are home to 8,499 babies born each year (Fontenot, et al., 2023). The provider shortage may continue with the next generation of medical professionals: Kentucky has seen a 15% drop in residency applications across all specialties and a 23% drop for OBGYN programs since *Dobbs* (Goodman, 2024).

Research suggests living in a maternity care desert may be associated with increased risk of maternal mortality (Wallace et al., 2021). Under an abortion ban, more people in maternity care deserts - and elsewhere - may carry their pregnancy to term. With more people carrying pregnancies to term, maternal mortality and morbidity will also likely increase. An analysis using historical data from the Kentucky Department for Public Health and Kentucky abortion rates can simulate expected changes in maternal mortality and morbidity in Kentucky with the state's abortion ban.

Under the abortion ban, were all pregnancies to be carried to term, Kentucky could expect a 5% increase in maternal mortality and near-misses each year.[6]

Notably, 90% of maternal mortality cases in Kentucky are preventable (Kentucky Department for Public Health, 2024). When an individual has severe health complications or dies, their families and communities are left with long-lasting mental health and financial challenges.

6 We estimated the increase in maternal mortality if all pregnancies that would have been abortions were carried to term. This assumes: 1) patterns of abortion use would be similar to pre-*Dobbs* use; and 2) all abortions that would have taken place in Kentucky are carried to term, rather than taking place elsewhere, being self-managed, or being treated via telehealth. We note that this second assumption is an unrealistic one; data from Guttmacher and WeCount (also included in this brief) show that Kentuckians are traveling out-of-state for care and receiving abortion medication via telehealth. Thus, our analysis depicts a "worst-case" scenario wherein the burdens associated with traveling out-of-state or risks with self-managing are insurmountable.

As told by Kentuckians

Whitney's story

Whitney is a Black adult in her 30s from north-central Kentucky

Whitney is a single mother of three young children. She has a history of medical complications during pregnancy, and her pregnancies were designated as high risk. When she found out she was pregnant in early August 2023, she felt sad but considered continuing the pregnancy. She consulted with her OBGYN, and they discussed the risks and her options. Her doctor could not guarantee that she would survive this pregnancy. He also explained that Kentucky law required she become very ill before he could provide her with an abortion, and he provided her with information about abortion clinics in other states. As Whitney's pregnancy progressed, her pregnancy symptoms worsened, causing her to miss work and making it hard to support her children. She decided she would seek an abortion. In late August, Whitney scheduled an appointment in Illinois. She decided to travel to Illinois instead of Ohio because, at the time, Ohio law required patients wait 24 hours after consenting to abortion before obtaining one. She felt arranging childcare for two separate trips to the state would be too difficult. Whitney selected the first available appointment in Illinois that her schedule allowed, an appointment in early November. About one week before her appointment, Whitney contacted several abortion funds. After explaining her needs, the funds provided her with $100 for gas and several hundred dollars to help cover her appointment cost. Whitney felt she would not have been able to get abortion care without this financial support. When asked why she ultimately decided to have the abortion, Whitney said, "My other kids. If I were to die in that pregnancy, I wouldn't want to leave my kids alone."

Kennedy's story

Kennedy is a white adult in her 30s from south-central Kentucky

Kennedy is a stay-at-home mother of three, with two children requiring regular, specialized medical care. Kennedy discovered she was pregnant in early October 2024 after taking several pregnancy tests. Afterwards, she cried for several hours, fearing how the pregnancy might affect her health and her ability to care for her children. Due to a medical condition, any new physical or emotional stress increased Kennedy's risk of requiring an invasive medical procedure. She worried about what the pregnancy would do to her body and did not feel her husband could raise their children without her should her health deteriorate. Kennedy and her husband decided it was too risky to continue the pregnancy. After Kennedy discussed her concerns with her medical specialist, the doctor tried to arrange for her to end the pregnancy in Kentucky but learned that she would not qualify for a medical exemption. Kennedy then searched online and found an abortion clinic in Illinois where she scheduled an appointment for mid-November. The clinic and several abortion funds worked together to cover the costs of her travel and abortion. Without this support, Kennedy worried she would have to choose between paying for the abortion or groceries for her children. Kennedy's husband and children drove to Illinois with her and waited in the car while she was in the clinic. Overall, she felt the children did okay with the long trip despite leaving home at 4:30 in the morning, driving through poor weather, and returning after 11:00 at night—making for a 17-hour day.

Social and Community Context

Interpersonal and community relationships are an important component of people's health (US Department of Health and Human Services, n.d.). A strong support system can make the difference between being able to access care and having to go without. Initial research on Kentuckians' experiences seeking abortion confirms that people often rely heavily on such social networks.

Personal and community networks, which may include family, friends, online groups, and support organizations, play crucial roles in helping pregnant Kentuckians navigate the state's restrictive and complex abortion landscape. People help one another with costs, travel, childcare during appointments, and

emotionally processing options. For those who need additional help, organizations like Kentucky Health Justice Network (KHJN) and A Fund can step in. KHJN is a philanthropic organization that provides financial and logistical support for people seeking abortion care (Smith et al., 2024) and A Fund provides financial assistance to Kentuckians seeking abortion and contraception and raises awareness about the impacts of unwanted pregnancies ("What is A FUND?," n.d.). KHJN processes requests from nearly 1,000 callers each year ("Annual Report," 2024) and A Fund provided hundreds of thousands of dollars in block grants to financially support Kentuckians' abortions (ProPublica, n.d.). This social, financial, and community support is critical for Kentuckians who seek abortion care.

As told by Kentuckians

Arianna's story

Arianna is a Black adult in her late teens from southern Kentucky

Arianna gave birth in June of 2023. By September, she was pregnant again. As her pregnancy progressed, she learned that her new partner (the person involved in her current pregnancy) had physically harmed her infant, resulting in severe medical complications. Arianna realized it would not be safe for her to have a child with this person and decided she would seek an abortion. A caseworker from a Kentucky state agency gave Arianna information about abortion in other states, and an ex-girlfriend of the person involved in the pregnancy shared information about clinics and the Kentucky Health Justice Network (KHJN). Still, Arianna felt depressed and unable to take steps to schedule her abortion. At one point, she scheduled an appointment in Illinois but later canceled it due to difficulty arranging transportation. Finally, she contacted KHJN, and they helped her schedule an appointment and arrange travel to an Illinois clinic in January 2024. During this appointment, clinic staff discovered Arianna was beyond the clinic's gestational limit, and they were unable to provide an abortion. However, they helped her schedule at another clinic two hours away. A KHJN representative drove her to that clinic, set up a hotel stay, and helped pay for food and other personal items as she wasn't prepared to stay overnight. Arianna felt that she would have had to ask family members for financial help if KHJN and other abortion funds were not able to cover these costs. Additionally, given that many clinics stop providing care around 20 weeks, KHJN and the Illinois clinic staff were instrumental in ensuring Arianna was seen in one of the few clinics in that state that provides care later in the second trimester. Arianna explained what this support meant to her. Without it, she shared, "I really think I probably just would've been so stressed out [...] because I was already just going through so much in my head. [...] They were really helpful."

Claudia's story

Claudia is a white adult in her 30s from central Kentucky

Claudia and her husband were trying to get pregnant. After months without conceiving, Claudia was about to start fertility treatment. However, at a gynecology appointment in March 2025, she found out she was pregnant. Claudia and her husband were thrilled. She excitedly returned to her doctor's office around 16 weeks for an ultrasound. When the OBGYN came in to share the results, Claudia recognized that she was visibly upset. The OBGYN shared that there was no amniotic fluid, and there were other anomalies. She asked Claudia to have her husband come to the office, so they could have an additional ultrasound and meet with a Maternal Fetal Medicine Specialist (MFM) right away. The OBGYN walked Claudia down a private hall to the MFM's office where the staff let her sit in a private room so that she and her husband could grieve. The MFM identified a major fetal heart defect and a devastating lack of most major bodily organs. She concluded by stating that the pregnancy was "incompatible with life" - there was nothing that could be done.

Claudia accepted her only option was to end the pregnancy. Since a fetal heartbeat was still present, Kentucky doctors determined they could not provide an abortion within the scope of the state law. Instead, the MFM provided her with information about a clinic in Illinois where they refer their patients. Claudia quickly called the clinic and was relieved they had an appointment within days. She felt

grateful to have the abortion as soon as possible and lucky she was able to pay for her appointment, travel, and hotel stay. While the clinic offered to help her find funding, Claudia declined, saying that she preferred those funds be used by those with less resources. Claudia was grateful for the kindness and understanding of each of the providers she interacted with—the initial OBGYN, the MFM, and the clinic staff —and was relieved no providers slowed her access to care. Additionally, she appreciated that both her and her husband's bosses understood their situation. Her boss simply told her not to worry about work right now, and her husband's boss empathized by sharing her own experience with pregnancy loss. Claudia also found support in her sister and friends. She relayed how this support was, "kind of everything" during this experience. In the future, Claudia hoped to get pregnant again. She is determined to have a family.

CONCLUSIONS

When a Kentuckian seeks to end a pregnancy, they have two options: self-managed abortion or clinical care. Both options for abortion care can be safe and effective. Because abortion is banned in the state, both SMA and clinical abortion care come with unnecessary, harmful barriers to access created and furthered by state abortion laws. These burdens stop some people from obtaining abortion care and medical complications can arise.

Restrictive abortion laws like Kentucky's are inseparable from measures of public health in communities across the state. Kentucky's policies exacerbate health care access inequities and increase already high maternal morbidity and mortality rates. Simultaneously, the state's strong social and community context can help mitigate these burdens for some people navigating the many barriers to abortion care. OPEN's research shows social and community context do not erase the burdens Kentucky law creates.

ABOUT OPEN

Ohio Policy Evaluation Network (OPEN) is a research collaborative based primarily at The Ohio State University and University of Cincinnati. The interdisciplinary research team conducts and translates rigorous and forward-thinking social-science research about policies and structural inequities related to abortion and contraception, focused on Ohioans and people in neighboring states. For questions about the research shared in this white paper, please contact the OPEN team: open@osu.edu.

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