State of Women in Central Indiana:

Reproductive Health in Indiana

From Data to Dialogue

Women's Foundation of Indiana | The Polis Center

February 2026

Maternity care: uneven access and geographic barriers

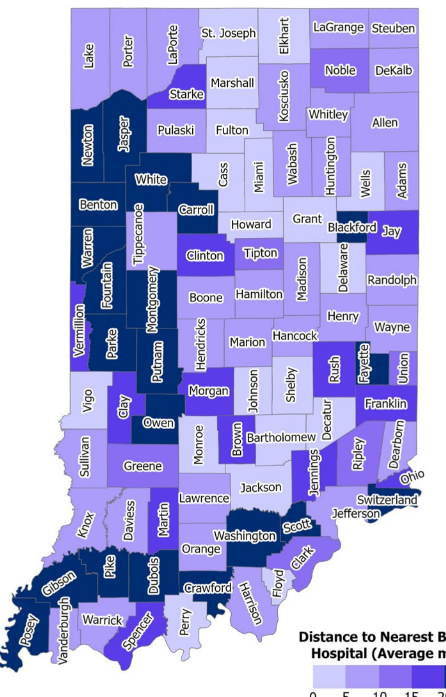
Across the United States, over 2 million women of childbearing age live in areas without access to birthing facilities or maternity care providers, known as maternity care deserts.[1,2] In Indiana, 24% of counties are classified by the March of Dimes as maternity care deserts, compared to 33% nationally.[1] Although Indiana has fewer maternity care deserts than the national average, there are still women in nearly a quarter of Indiana's counties with no local access to birthing hospitals, obstetrician-gynecologists (OB-GYNs) or certified nurse-midwives. Less reliable access to maternity care is associated with less favorable health outcomes. For instance, studies show that longer travel distances are linked to higher risks for moms and babies, including stillbirth and neonatal intensive care unit (NICU) admission.[3,4]

In 2024, the most recent year with available data, women in 21 of Indiana's 92 counties traveled an average of 20 to 32 miles to reach a birthing hospital.[1] Across the state, the average distance women travel to the nearest birthing hospital is almost 8 miles, while women in rural areas travel farther for care, averaging 13 miles.

Rural hospital infrastructure in Indiana has seen reductions in facilities and services over time, which is similar to national trends.[5,6] Between 2015 and 2025, Indiana has reported closures of 3 rural hospitals and reductions in services at 16 additional hospitals. Since then, Greene County General Hospital closed in January

Distance to birthing hospital by county and average miles, 2024

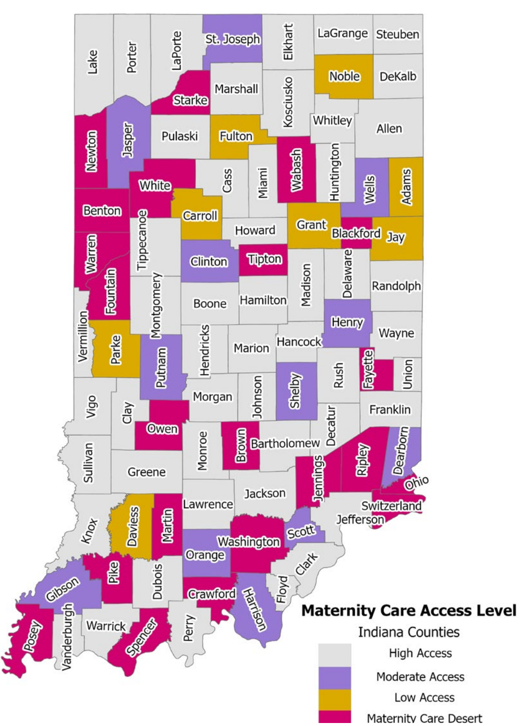
Average distance to birthing hospitals ranges from 0-5 miles to as much as 20-32 miles



Source: The Polis Center Analysis of Healthcare Cost and Utilization Project State Inpatient Database. Indiana Agency for Healthcare Research and Quality, 2020. Web. 1 Nov 2022. American Hospital Association, 2021; American Board of Family Medicine, 2017-2020; U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2022; Graphic by the Polis Center.

Maternity care deserts by county and level of access, 2024

Maternity care access tends to be lower where distance to a birthing hospital is longer



Source: The Polis Center Analysis of U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2022; American Board of Family Medicine, 2017-2020; National Center for Health Statistics, 2021 final natality data; Graphic by the Polis Center.

2026 and Johnson Memorial Health closed in February 2026.[5] Both hospitals cited insufficient insurance reimbursement rates as the primary driver.[7] Another eight rural hospitals were identified in January 2026 as being at risk of immediate closure due to sustained financial losses and insufficient reserves by the Center for Healthcare Quality and Payment Reform.

The Indiana Hospital Association, as well as hospital leadership for Greene and Johnson Memorial, have stated that policy conditions present financial challenges for labor and delivery services, particularly as Medicaid reimbursements cover about 54-57 cents of every dollar of actual care costs.[5] Additionally, hospital leaders raise concerns that federal Medicaid funding decreases tied to the One Big Beautiful Bill Act are expected to further reduce Medicaid reimbursements as fewer individuals seeking care are enrolled in safety-net insurance programs.[8]

Research on birthing center closures found that more than half of rural Indiana hospitals no longer offer labor and delivery services.[6] Beyond access to facilities, access to providers is also uneven. Twenty-eight Indiana counties do not have a practicing OB-GYN, with 16 of these being non-metro counties. Nine counties have no reported maternity care providers at all.

Stakeholders from both clinical and community settings described the challenges this way:

> **"If hospitals in Newcastle and Richmond shut down, that volume is coming in. It's going to get ugly fast. In obstetrics, time is outcome."**
>
> *- Dr. Karla Loken*

> **"One-fourth of our counties are maternity care deserts, and another one-fourth have shortages – and that's going to be exacerbated as fewer trained physicians want to practice in this state."**
>
> *- Angie Carr Klitzsch, Women4Change*

Infant and maternal outcomes: recent patterns

Maternity care deserts are associated with negative birth outcomes for both infants and mothers.[9] Research shows higher risks for women living in maternity care deserts, with maternal mortality rates 36% higher than in areas with full access to care. Data show that women in counties without inpatient obstetric services had higher mortality rates than those in counties with delivery services. In 2021, 9% of all Indiana births occurred in counties without inpatient delivery services, and these same counties accounted for 11% of all pregnancy-associated deaths.[10]

Clinicians we spoke with discussed how access and timing relate to maternal and infant outcomes:

> **"We have lots of people who are presenting quite late in pregnancy because it's actually difficult to get a first prenatal appointment, and that increases maternal and infant morbidity and mortality."**
>
> *- Dr. Caitlin Bernard*

> **"When you think about just baseline numbers of maternal mortality, we know Indiana by itself, without breaking down any further demographics, is the third worst in maternal mortality in the nation. But when you consider Black women, those numbers are three times as high."**
>
> *- Dr. Nicole Carey, Just Community, Inc*

Indiana has one of the higher maternal mortality rates in the country, with significantly worse outcomes for Black women.[10] Research shows that Black women often face higher risks during pregnancy because of unequal treatment in healthcare, discrimination and differences in access to supportive resources.[11,12] Studies also point to gaps in how healthcare professionals are trained to care for patients from different racial and

cultural backgrounds, which can affect communication, trust and the quality of care delivered.[13,14] These differences appear even among Black women with higher incomes or similar medical conditions as their peers.[15,16,17] These issues can influence how quickly health concerns are taken seriously and how easy it is to get needed care. Collectively, these research findings provide context for the continuing higher rates of pregnancy related complications among Black women.

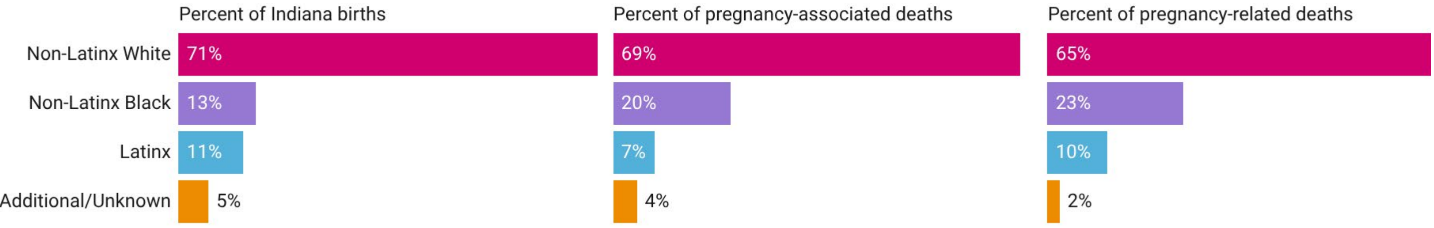
Several interviewees discussed this challenge; one noted:

> **"It's not simply the inequity of socioeconomic status or because they don't have a specific education, we know that even Black women with PhDs have more chance of dying around pregnancy and childbirth than a white mother without a high school education. So, it's impossible to deny the inequities that exist."**
>
> *- Dr. Nicole Carey, Just Community, Inc*

In 2021, the most recent single year with available maternal mortality data segmented by racial group, Black mothers in Indiana represented only 13% of all live births, yet experienced a maternal mortality rate more than 50% above the state average and 73% higher than the average for White women.[10,18]

Black women are overrepresented in pregnancy-associated deaths, and even more overrepresented when looking only at deaths caused by pregnancy

Rates of pregnancy-associated and pregnancy-related deaths by race and ethnicity in Indiana, (2018-2022)

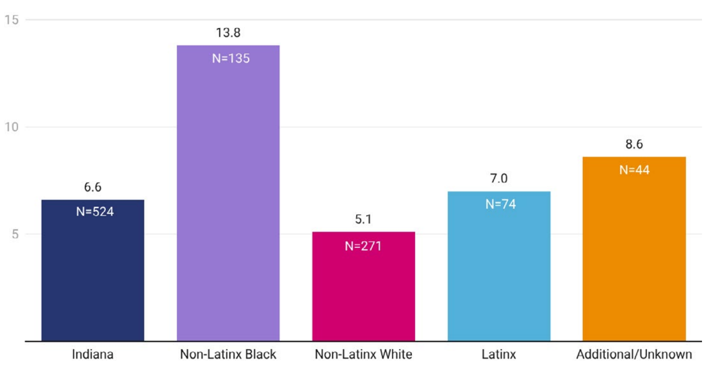


Source: The Polis Center Analysis of Indiana Maternal Mortality Review Committee 2024 Annual Report, 2018-2022; Graphic by the Polis Center.

Infant mortality rates follow a pattern similar to that of maternal mortality. In the same year, 2021, the infant mortality rate for babies born to Black mothers (13.2 per 1,000 live births) was nearly twice the state rate (6.7 per 1,000) and nearly two and a half times the rate for White infants (5.4 per 1,000).[19] Since infant mortality rates are collected differently than maternal mortality, we can see infant mortality remained unevenly distributed by racial identity of the mother in 2023, with infants born to Black women experiencing a mortality rate nearly three times the rate of White infants, at 13.8 and 5.1 per 1,000 live births, respectively. However, in 2024, Indiana's overall infant mortality numbers fell to a historic low of 6.3 for every 1,000 births .[20]

Infant mortality by race and ethnicity, Indiana 2023

Rate per 1,000 live births



Source: Source: The Polis Center Analysis of Indiana Maternal Mortality Review Committee 2023; Graphic by the Polis Center.

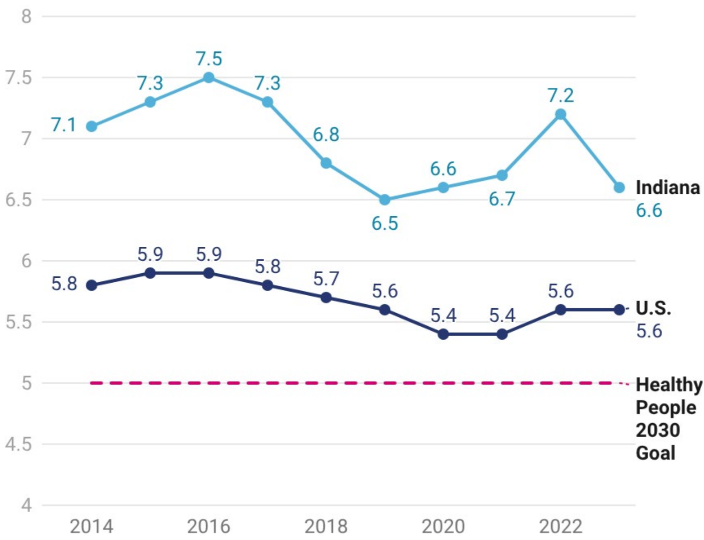
Some Indiana community programs offer doula support during pregnancy, birth, and the postpartum period.[21,22] Studies have found that doula services are associated with better experiences and outcomes for many families, with especially positive results reported when doulas share racial or cultural backgrounds with the parents they serve.[22,23,24] Indiana has authorized Medicaid reimbursement for doula services, but the program has not yet been funded.[11,25,26] Experts and community organizations have expressed interest in additional support for doula services.

Reproductive health workforce: projected shortages

National groups such as the American College of Obstetricians and Gynecologists foresee there will be a nationwide shortage of OB-GYNs, estimating a gap of about 22,000 providers by 2050.[27] Across the United States, nearly half of all counties have no OB-GYN, and about 6 in 10 counties (62%) have no certified nurse-midwife or certified midwife.[28]

Infant mortality rates (IMRs), 2014-2023

Rate per 1,000 live births



Source: The Polis Center Analysis of Indiana Maternal Mortality Review Committee 2023; Graphic by the Polis Center

Interviewees offered perspectives on workforce availability and scheduling:

> **"I could go anywhere I want to in this country and find a job in obstetrics and gynecology. Anywhere. Because there's a shortage everywhere. We have never been where that's happened before."**
>
> *- Dr. Karla Loken*

> **"We've always been in a crisis for reproductive health workers at all levels, and that's just being exacerbated right now in the current social and political climate."**
>
> *- Doneisha Posey, Ascentra Strategies*

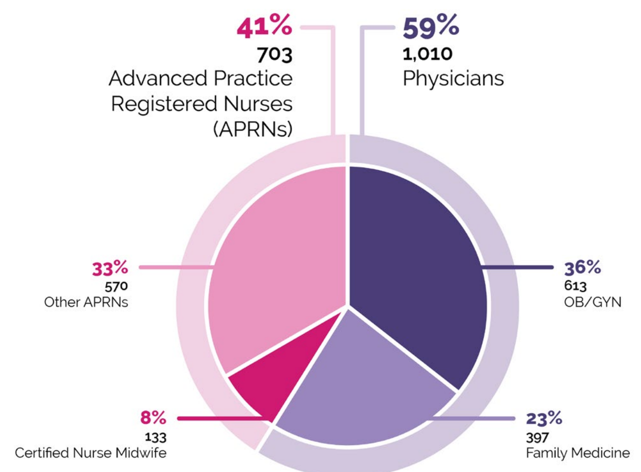
> **"Healthcare providers that are available, their schedules are booked months and months and months out."**
>
> *- Dr. Wanda Thruston, Artois Mae Consulting, LLC*

The Bowen Center for Health Workforce Research & Policy (2023) identified 1,713 maternity care providers in Indiana, consisting of physicians (59%), advanced practice registered nurses (APRNs, 41%), and certified nurse-midwives (8%).[29] Out of nearly 2,900 family medicine physicians in Indiana, about 200 provide labor and delivery services. In Indiana, there are 28 counties without a practicing OB-GYN, and 9 counties have no reported maternity care providers of any kind.

In response to maternity care shortages, in 2022, the federal government established Maternity Care Target Areas (MCTAs).[30,31] These are designated regions within existing health professional shortage areas (or HPSAs) that lack adequate maternity care providers, based on population-to-provider ratios and other health indicators. When applying federal MCTA criteria, only 14 Indiana counties have sufficient maternity care professional capacity.

Fewer family physicians now provide obstetric care than in past decades, which adds to the provider shortage in some areas. In the 1980s, more than 45% of US family physicians delivered babies; today, about seven percent still do, and Indiana mirrors this national trend.[28]

All maternity care practitioners in Indiana by type



Source: The Polis Center Analysis of Bowen Center for Health Workforce Research & Policy 2023; Graphic by the Polis Center.

Sexual health education & access to accurate information

Indiana emphasizes abstinence in its sex education policies and is one of less than a dozen states that do not require comprehensive sex education or HIV education in schools.[32] About two dozen states require schools to teach about healthy relationships and sexual consent. Indiana has recently reinstated a proposal requiring K–12 instruction on consent as part of sex education.[33,34]

Indiana also has fewer publicly supported family planning clinics per capita than the national average.[1] While publicly-supported family planning clinics, including Title X providers, serve as critical access points for reproductive healthcare, their availability and capacity vary significantly across the state. For instance, Indiana has just 2 Title X clinics per 100,000 women, versus the national average of 5.3 Title X clinics per 100,000 women.[35] According to data from the Guttmacher Institute, available services differ across clinics, including whether same-day IUD insertion or extended office hours are offered.[35]

Defining Title X

Title X Family Planning Program is a federal grant program that provides funding to public and nonprofit agencies for family planning services, research and training. The services often include contraceptives, reproductive health-related cancer screenings, STI testing and treatment, and pregnancy testing and prenatal care.[36]

Statewide contraception & pregnancy services

Organizations including Planned Parenthood and specialized programs like PATH4YOU (Pregnancy at a Time that is Happy and Healthy for You) at Indiana University School of Medicine work to fill gaps in contraceptive education and access, providing access to reversible birth control methods along with pregnancy intention screening and contraception counseling.

Lack of comprehensive sex education has been linked to differences in young people's health and relationship behaviors. Studies show that sex education programs are associated with delayed sexual initiation, fewer sexual partners and greater use of contraception.[37] Without clear information about contraception, sexually transmitted infections (STIs) and reproductive health, young people may have less information to guide their decisions.

Community educators and organizational leaders shared observations about information access and conversation comfort:

> **"We talk about becoming an 'askable parent,' but we also need askable healthcare providers, people who let patients know they're open and willing to talk about sensitive issues or can refer them to someone who is."**
>
> *- **Dr. Catherine Sherwood Laughlin,** Indiana University School of Public Health-Bloomington*

> **"Contraception is a tool and yet it is used as a divisive sword. Awareness of the availability of contraception is often missing for the immigrant community"**
>
> *- **Gurinder Kaur,** Immigrant Welcome Center*

> **"If you don't have access to reproductive care, the first thing is unintended pregnancies."**
>
> *- **Dr. Lucia Guerra-Reyes,** Indiana University School of Public Health-Bloomington*

> **"I'm looking in Facebook groups and social media where women just are clueless and feel hopeless [about how and where to get reproductive care and contraceptives]."**
>
> *- **Doneisha Posey,** Ascentra Strategies*

Studies show many adults are unsure about common reproductive health facts.[38,39] Only 24% of U.S. adults correctly identified medication as the most common method of abortion, while 47% were unsure and 29% incorrectly believed most abortions involve a surgical procedure.[40] Even among women of reproductive age (18-49), only 29% answered correctly. Nearly 4 in 10 adults (40%) reported uncertainty about whether medication abortion is safe when taken as directed by a healthcare provider. In Indiana, providers working with Black and Latinx women have identified lack of awareness of available reproductive health resources as a persistent barrier to care, compounded by language barriers and limited outreach to medically underserved communities.[41]

Policy changes and observed impacts

Indiana became the first state to alter state policy following the 2022 U.S. Supreme Court's Dobbs v. Jackson decision that overturned Roe v. Wade.[42] Indiana's new state policy limits eligibility for abortion to three situations: life or physical health of the mother, cases of rape or incest (up to 12 weeks gestational age) and Lethal fetal anomalies (up to 22 weeks gestational age).[43,44]

In states with abortion restrictions, laws specify potential penalties for performing certain prohibited procedures, including license suspension or criminal charges.[45,46,47] The specific penalties vary by state. Data has revealed that states where abortion is prohibited have fewer OB-GYNs per 10,000 births (92) compared to states where abortion eligibility is wider (138.4).53 States with abortion restrictions have also experienced notable decreases in applications for obstetric residencies due to the inability to provide training in abortion care.[48] Additional concerns for providers include documented burnout and lower compensation relative to other medical specialties. Studies have reported that providers cite liability concerns and the need to interpret evolving legal requirements as factors that affect their ability to deliver care.[27,49] The impact of state eligibility criteria on patient access is also documented in official state data. Indiana's quarterly Induced Termination of Pregnancy reports showed large decreases in in-state procedures following the adjustment of the new criteria's implementation beginning late 2022 and onwards, dropping from 9,529 abortions performed in-state in 2022, to 146 performed in-state in 2024, the most recent full year available.[50,51] Similarly, data show patients traveling out of Indiana to obtain reproductive healthcare, with Illinois often serving as a primary destination.[52]

Some clinicians and community advocates described how patients navigate these policies; some shared:

> **"Even patients who qualify for the [abortion] ban's narrow exceptions often choose to leave the state rather than navigate lengthy and invasive processes at hospital facilities."**
>
> *- **Haley Bougher,** Planned Parenthood Alliance Advocates*

> **"Clients are concerned... 'If I miscarry and go to the hospital, what's that gonna look like?"**
>
> *- **Forest Beeley***

> **"We're mouthing family values, but we're not investing in the infrastructure that actually honors families."**
>
> *- **Angie Carr Klitzsch,** Women4Change*

Studies and provider interviews have identified differences between what some policies are intended to do and what patients experience when seeking care.[45,53,54,55] For instance, healthcare providers report hesitation in providing what they consider life-saving care, including miscarriage management, until situations become unambiguously medically emergent. After implementing the new eligibility criteria, the state launched an investigation into an Indiana OB-GYN's license after she allegedly provided abortion services to a 10-year-old rape survivor.[56] These cases illustrate the legal complexities clinicians may navigate when providing services.

Over half of abortions provided in Indiana were to patients between the ages of 25 and 34.

Abortions by patient age in 2024

Age	Count	Percentage (%)
< 16	3	2%
16-24	24	16%
25-34	77	53%
35-44	42	29%
≥45	0	0%
Unknown	0	0%

Source: The Polis Center Analysis of Terminated Pregnancy Report 2024, Indiana Department of Health, 2024; Graphic by the Polis Center.

The largest share of abortions provided in Indiana in 2024 were between 14-20 weeks gestational age.

Abortions by weeks of gestation in 2024

Weeks of Gestation	Count	Percentage (%)
≤8 weeks	10	7%
9-13 weeks	27	18%
14-20 weeks	68	47%
≥21 weeks	41	28%

Source: The Polis Center Analysis of Terminated Pregnancy Report 2024, Indiana Department of Health, 2024; Graphic by the Polis Center

Some clinicians and community leaders reflected on how these policy changes shape conversations about reproductive health; one explained:

> **"It's a very Indiana thing to talk about infant mortality and infant health, because we are afraid to talk about women's health and maternal mortality. So, I always want to lean hard into the fact that we're talking about women. Of course, it does also impact infant health, but we can't be afraid or unwilling to talk about needing to care for and make better policies for women themselves."**
>
> *- **Dr. Cara Berg Raunick,** Health Care Education & Training (HCET)*

Recent policy changes have also affected medical education in Indiana. Following the state abortion criteria change, Indiana University School of Medicine reported sending OBGYN residents out of state to complete required training in miscarriage and abortion procedures.[57] Studies have reported fewer applications to obstetric residency programs in states with abortion restrictions, citing limits on available training.[48,58] Some

medical students have reported hesitancy about matching to residencies in states with strict abortion eligibility criteria, noting concerns about training opportunities and legal considerations.[48] Across all specialties, fewer Indiana physicians are being trained locally.[29] Since 2017, the share of physicians with Indiana medical school degrees has dropped 8%, and those who completed Indiana residencies has fallen 9%. Some recent funding changes have also affected the broader reproductive health infrastructure. The recent removal of Planned Parenthood from the Medicaid system reduced the availability of primary and reproductive care at those sites.[59,60,61] Some hospitals have reported financial challenges related to Medicaid reimbursement for women's healthcare services, noting that this affects their ability to maintain certain programs.[62,63]

Indiana's family and maternal health programs include several recent initiatives, though their reach varies across the state. While the state has implemented programs such as the Indiana Pregnancy Promise Program, expanded Medicaid postpartum coverage to 12 months and increased prenatal screening coverage, these initiatives continue to face resource limitations, and the benefits of such programs have reached some communities more than others.[64,65,66] For instance, the federally-funded Maternal Infant and Early Child Home Visiting (MIECHV) programs, including the Nurse Family Partnership, was available in only 24 of 92 counties as of April 2024, the most recent year with available data. Factors such as the lack of required paid family leave for private employers, limited childcare availability and possible changes in Medicaid coverage affect how families navigate pregnancy and postpartum care.

Interviewees shared a range of perspectives on how recent policy changes affect access to care and broader women's health issues; for example:

> **"Patients canceled their appointments [after Planned Parenthood was removed from Medicaid], but came back because they couldn't get care elsewhere."**
>
> *- **Haley Bougher,** Planned Parenthood Alliance Advocates*

> **"By not prioritizing women's reproductive health across the lifespan, we are doing a huge disservice. Women and children are the future, and if we can't prioritize them, it will cost us from every possible perspective."**
>
> *- **Darla Berry,** Lugar Center for Rural Health / Union Hospital*

Perspectives from providers and community leaders on improving care

People we spoke with, including providers, doulas and community leaders, shared several ideas they believe could strengthen reproductive health in Indiana. These perspectives reflect a range of experiences across healthcare and community settings.

1. Community-centered caregiving and doula support

Some organizations in Indiana use community-based caregiving models, including programs that offer doula services during pregnancy, birth, and the postpartum period. Organizations such as the Dieudonne Foundation provide training and certification for doulas at no cost and connect them with mothers who request this type of support.[67] Their model includes regular check-ins from the first week home through a baby's first birthday and places emphasis on supporting the mother's health and recovery. Research indicates that when mothers receive consistent support, families often experience improved health and stability.

2. Innovation in clinical services that connect communities with healthcare

Some Indiana organizations are using new clinical tools to support connections between healthcare providers and the communities they serve. Providers report facing system level pressures such as high patient loads, limited reimbursement, and administrative demands, which can affect how much time they have for patient engagement. Technology is being used in some settings to help address these challenges, including in maternity care deserts. For example, Navigate Maternity, led by Ariana McGee, has developed an FDA-cleared remote blood pressure monitoring system that allows care teams to track patients from home.[68] These tools can support earlier identification of potential complications, like preeclampsia, even when patients live many miles from the nearest provider.

One panelist, who is a community-based maternal health leader, described the importance of postpartum support this way:

"If mom is healthy, if mom is not stressed, you get a healthy baby. Once you have the baby, no one asks the mother, 'How are you doing? How are you healing?'"

- Farah Célestin Chéry,
Dieudonne Foundation

3. Access to sexual health education

Education is another factor that shapes how people understand reproductive health. Research shows that clear, accurate, age-appropriate information can help young people understand their options and make informed decisions. Some organizations, like the Dieudonne Foundation, offer programs that provide reproductive health education to partners and families during pregnancy and birth.[67]

4. Impact on the workforce

Research indicates that Indiana faces an estimated $4.26 billion in annual economic losses with roughly 170,000 fewer women in the workforce each year.[69] That represents an almost 2% gap in labor force participation rate in Indiana. The Center for Women's Policy Research estimates that the national impacts of abortion policies and working-age women is associated with reducing the national GDP by 0.5% and about half a million fewer women participating in the workforce.[69] Latinx and Black women face relatively higher losses in their earnings and labor force participation rates than their white peers.

5. Collaboration across sectors

Interviewees noted that improving reproductive health in Indiana often involves many groups working together, including healthcare organizations, community programs, policymakers and families. They also described how changes in areas such as childcare availability and the status of local healthcare services can influence how communities experience and respond to reproductive health needs. Collaboration and collective impact efforts were highlighted as needed approaches to address the interlocking issues facing Hoosier women and families.

A panelist who is a nonprofit leader and advocate for women's needs in state policy, emphasized how understanding one's own health shapes decision-making:

"If you don't know your body, you don't have agency over it. Full stop."

- ***Angie Carr Klitzsch,*** *Women4Change*

Panelists also reflected on how policy and system factors influence support available to families:

"We need comprehensive sex ed, we need access to birth control, we need family-friendly policies, childcare, SNAP. We cannot stand here and say that we are advocating for better maternal and infant outcomes when we are fighting all of these other policy changes that would support healthy families and healthy pregnancies."

- ***Dr. Cara Berg Raunick,*** *Health Care Education & Training (HCET)*

This document was compiled from a variety of sources. Some of the data appeared in The State of Women in Central Indiana (2024) report produced by the Polis Center on behalf of the Women's Fund of Central Indiana. The expert perspectives and recommendations are drawn from a series of key informant interviews with subject matter experts, and from a related webinar with panel discussion, held in February 2026 and organized by the Polis Center, WFYI, and Mirror Indy on behalf of the Women's Fund.

The webinar panelists were Ariana McGee, CEO of Navigate Maternity; Angie Carr Klitzsch, CEO of Women4Change; Dr. Cara Berg Raunick, Director of Health Strategy & Advancement for Healthcare Education and Training (HCET); and Farah Célestin Chéry, Executive Director and Co-Founder of The Dieudonne Foundation. The panel discussion was hosted by Gail Strong, WFYI, and moderated by Ebony Marie Chappel, Mirror Indy.

In addition, the SAVI Community Information System platform provided valuable insights that were leveraged in The State of Women Report (2024) chapter on maternal and infant health, which this report draws on to understand the needs and assets of women in Central Indiana.

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Thank You!

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For more information, see the 2024 State of Women in Central Indiana Report