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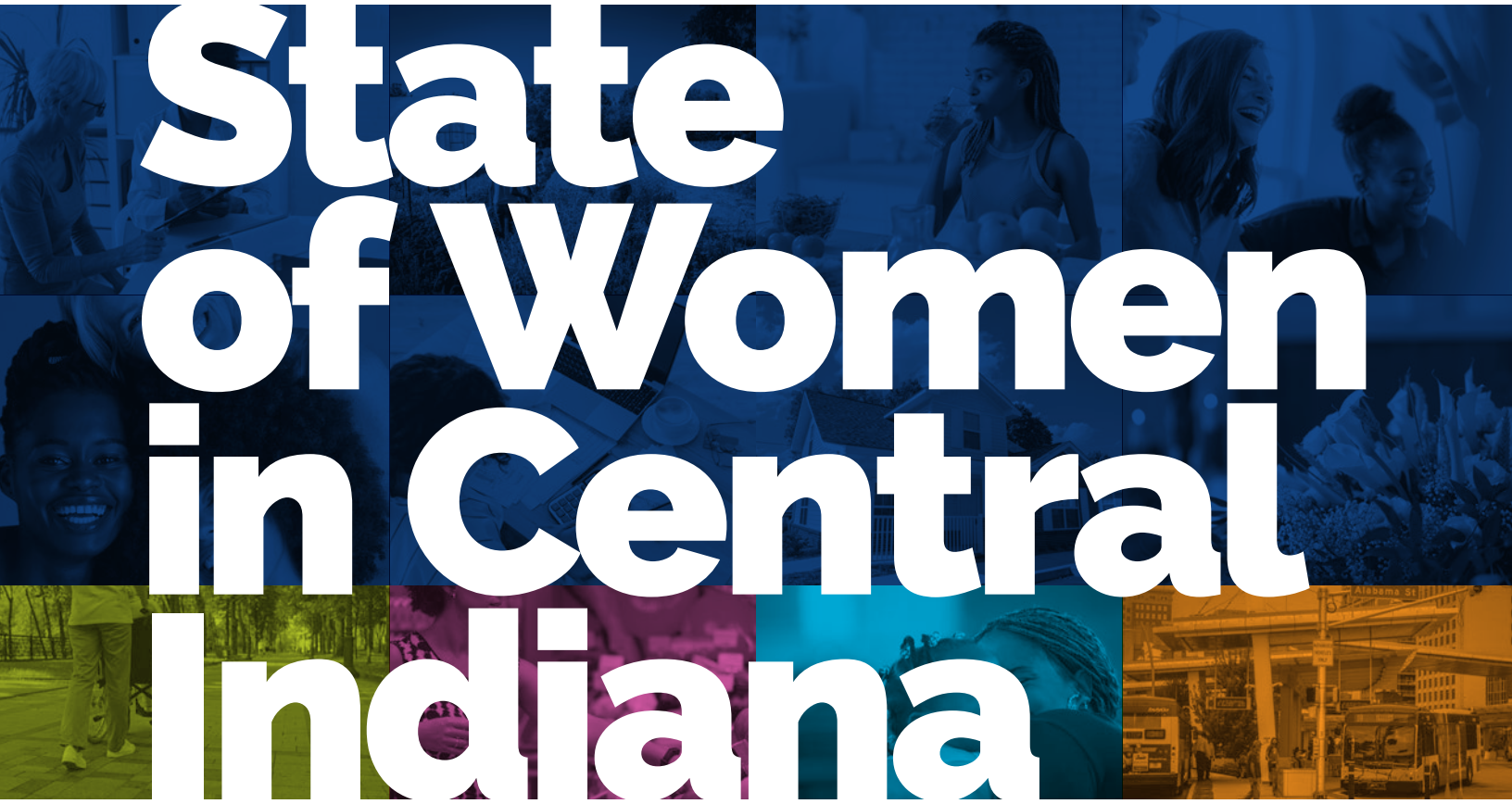
The State of Women in Central Indiana Report



Women's Fund of Central Indiana

State of Women Report | 2024

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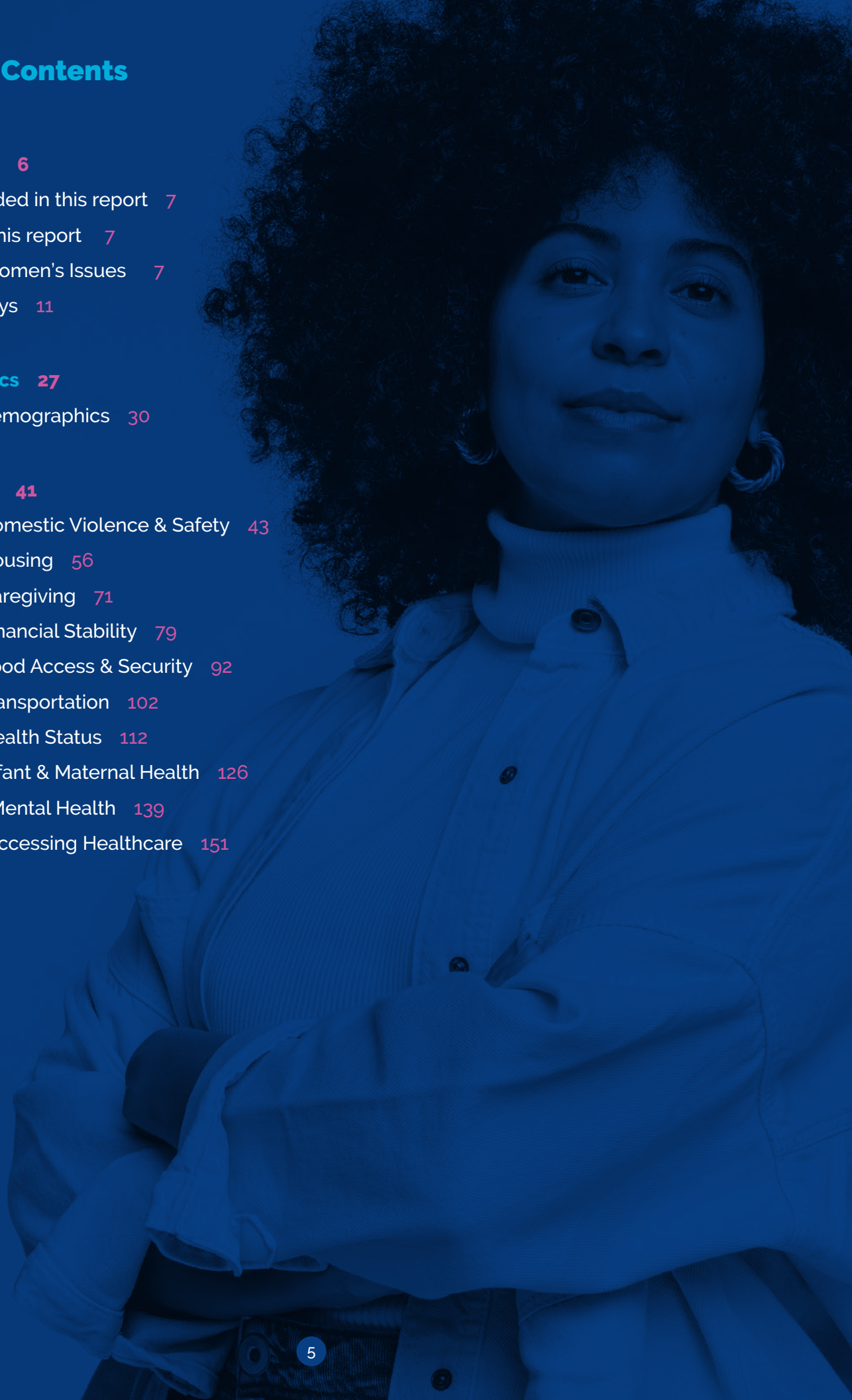


Introduction

Can women thrive in Central Indiana? We cannot know the answer to that question without a full picture of what it means to identify as a woman here, informed by data and women's own voices. Only when we can name the inequities, problems or opportunities for women can we address them. That is why Women's Fund of Central Indiana, with support from Marion County Public Health Department, audiochuck, Glick Philanthropies and The Indianapolis Foundation, commissioned the Polis Center at Indiana University Indianapolis to develop a State of Women in Central Indiana Report.

Throughout this report, we explore publicly available data for two major topics important for understanding the "state of women" in Central Indiana: Basic Needs and Health & Wellbeing. What did we learn? Overall, being a woman in Central Indiana is complicated and there is much room for improvement.

Through our analysis, we uncover three major themes: equity, strength & abundance, and barriers & biases. You will see them reflected across chapters. When we think of equity in this report, we are thinking about gender equity and the gap between men and women in Central Indiana and the ways that intersected identities like race or immigration status further complicate the gender gap. That gender inequities still exist, while not surprising, is important to note. There have been improvements in closing the gap, and there are areas where women are doing better than men, but those are few and far between.

The theme of strength & abundance evolved from our key informant interviews and focus groups. There are remarkable women doing remarkable work to better the lives of women and girls in Central Indiana. We lift those moments up throughout this report to highlight the strength and abundance women in Central Indiana possess. While there is a gender equity gap, that does not negate the strength and power that women bring to our community. Finally, we uplift the potential biases and barriers at play that may be affecting women's outcomes. It is important to acknowledge the systems and structures that impact all of us, and women, specifically. You will see "callouts" for these themes in each of the chapters to tie the topic of each chapter to these themes.

Strength & Abundance

This is an example of what the Strength & Abundance "callouts" will look like throughout the chapters in this report.

Here is where we will highlight themes that we learned directly from the community in relation to Strength & Abundance.

Keep an eye out for these features to hear about the ways Women in Central Indiana are growing and learn about the uplifting happenings in women and girls' lives.

Barriers & Biases

This is an example of what the Barriers & Biases "callouts" will look like throughout the chapters in this report.

Here is where we will highlight themes that we learned directly from the community in relation to Barriers & Biases.

Keep an eye out for these features to hear about the potential hinderances that Women in Central Indiana are facing and acknowledge systems are structures that are at play for all, but especially for women and girls.

Who is included in this report

For the State of Women in Central Indiana Report, we include all adults (age 18 and older), who live in Central Indiana (Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, and Shelby counties), and who identify as women. For information on girls under age 18, we encourage you to explore the Indiana Girl Report provided by the Girl Coalition of Indiana. We know how vital it is to tell the story of women in Central Indiana; however, we also know that women are not a monolith. There are additional intersectional identities (such as race, sexuality, nationality, etc.) that lead to different lived experiences. We attempt to capture those intersectional identities as much as possible in this report. When we are not able to access public, secondary data, we try to supplement it with lived experiences, stories and quotes. We note limitations in each chapter, but it is important to reiterate that we acknowledge the limitations of secondary data and hope that data related to women continues to develop in the future.

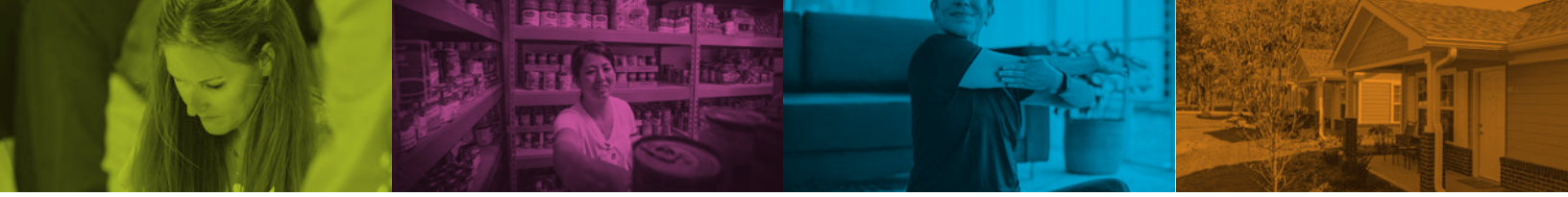
How to use this report

For the development of the State of Women Report, the Polis Center team used a variety of public secondary data sources, such as: the U.S. Census, Public Use Microdata Sample (PUMS), American Community Survey, and many more. Data sources are cited within the narrative and in associated data visualizations. The team conducted data analysis, created visualizations, and wrote about their findings in the report. Additionally, the Polis Center conducted 23 key informant interviews to identify topics needing a deeper dive, and to collect related stories and quotes. Once preliminary findings were in hand, field validation was conducted with seven focus groups made up of community leaders from different sectors (e.g. Health, Business, Immigration, etc.). After receiving feedback from the focus groups, the team drafted and shared the report with the State of Women Advisory Committee and the Women's Fund Advocacy Committee for feedback (See Contributor's List). After a final round of editing, the report was launched in November 2024.

The State of Women Report is relevant to a variety of audiences, including policymakers, researchers, grant makers, grant seekers, community-serving organizations, and government agencies. The report's findings help reveal areas where increased resources and efforts are needed to support women's issues.

Policy and Women's Issues

While this report does not provide policy recommendations, it sheds light on how Hoosier women understand and are affected by policy, and it can serve to inform future decisions that impact the women of Central Indiana.



We spoke to women leaders across Central Indiana to better understand how supported they feel by current policies around healthcare, the economy and other critical issues. Ultimately, we learned: 1) The many problems and inequities uncovered in this report require policy changes, 2) Women we spoke to do not feel served by existing policy in several areas, especially in the area of reproductive health, and 3) Governance of women's lives cannot be effective without data, context, and the input of women.

> **"I cannot say with full confidence that policymakers have my best intentions in their heart."**
>
> ***- Terri Lee,*** *MPH, CCHW, Public Health Leader*

> **"The rights of women are not a given in Indiana."**
>
> ***- Wendy Noe,*** *CEO of Dove Recovery House for Women*

Mackenzie Pickerrell, Executive Director of Girl Coalition of Indiana, speaks to why women may not feel supported: "Unfortunately, Indiana has not adequately addressed the needs of women, especially in light of the challenging political environment. While some awareness exists, systemic changes are lacking, leaving women, particularly Black, Indigenous, and People of Color (BIPOC), feeling unsupported and vulnerable. The wellbeing of women in Indiana has not been the priority."

The issue that was mentioned the most in interviews was reproductive access. Citing state laws like the 2022 abortion ban[1] and birth control access[2], many of the women interviewed felt the policymakers of Indiana were not interested in protecting their reproductive rights. The recent limitations of reproductive access seemed to carryover to our interviewee's overall opinion of what it means to identify as a woman in Indiana.

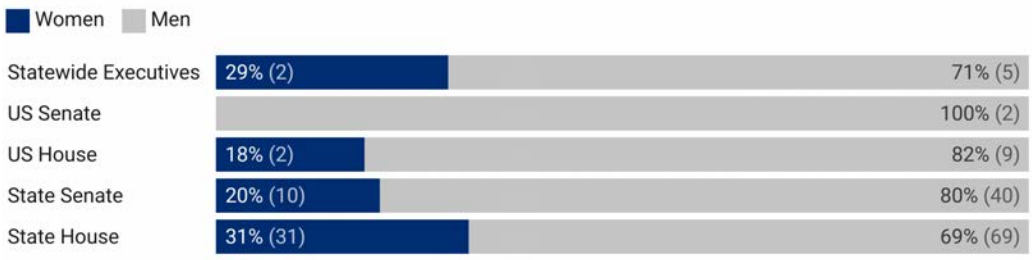
> **"I actually think in a lot of ways, we're moving backwards, obviously with reproductive justice and healthcare and all of those things. I think it's harder now. So, I don't think systemically we're advancing women in the state. I don't think it's a good state to be a woman."**
>
> ***- Anonymous***

It is crucial for our community to know how women feel regarding recent reproductive access legislation.

> **"I think that we do a huge disservice to girls and women with the conservative environment as it relates to reproductive rights and reproductive justice, access to contraception, abortion, etc. The whole gamut of comprehensive women's reproductive care should be available to the women and girls of Indiana. It has implications on the wellbeing of their entire lives."**
>
> - ***Dr. Tucker Edmonds,*** *Professor of Obstetrics and Gynecology*

Indiana elected offices held by women

National and state offices



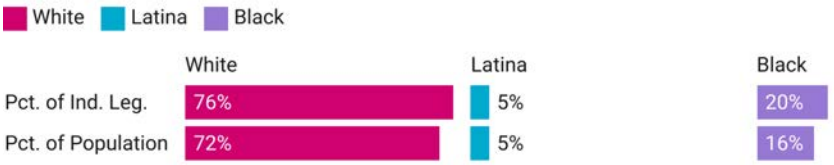
Note: Parenthesis clarifies the number of seats, only for Indiana federal offices

Source: Center for American Women and Politics; Graphic by the Polis Center

Additionally, the racial breakdown of Indiana Women State Legislators for 2024 is explored. 76% of Indiana Women State Legislators were White, while 20% were Black, and five percent were Latina. As shown in the Demographics Chapter, 72% of women in Indiana were White, 16% were Black, and 5% were Hispanic. While there is a need for more women in the Indiana legislature in general, the racial diversity of the current women legislators is representative of the population. While women in the legislature are representative of the state's demographics, men were not. In the latest data available (2020), 89% of legislators who identify as men were White, 9% were Black, and 1% were Latino.

Women in **Indiana legislature mirror** Indiana's **racial diversity**

Women in Indiana legislature are representative of state demographics



Source: 2024 Center for American Women and Politics, 2022 ACS 5-year average; Graphic by the Polis Center

Interviewees also were asked, in their eyes, what policymakers should be doing to support women. Overall, interviewees want policymakers to listen to their communities more.

> **"Policy makers should be listening to women in order to support women. I think a lot of times, we see policymakers focusing more on numbers, statistics, and data and things like that to support their arguments instead of actually talking to women to understand what women need. As you know, data can tell many different stories, and it can tell whatever story that you want it to tell. And so, if we're not careful and not actually listening to women and their needs, you will continue to do a disservice"**
>
> - ***Doneisha Posey,*** *Esq., CEO of Impact Strategies and Co-Founder of Women's Equity (WE) Brunch*

Beyond listening, women felt that policymakers should actively pass laws that protect women's rights, particularly around reproductive access.

> **"We should be passing laws that support women's reproductive rights and freedoms and justice."**
>
> - ***Dr. Tucker Edmonds,*** *Professor of Obstetrics and Gynecology*

We hope that the stories and lived experiences of women in our community help to support the data in this report and, ultimately, help to support women.

Key Takeaways

Chapter 1

Demographics

In Greek, demography means "describing people[1]," and demographic analysis refers to population structure and the study of population characteristics and how those trends change based on migration, gender, birth, age, race, income, rates of marriage, and other socioeconomic indicators[2]. Exploring the demographics of women is essential as it helps us to understand women's issues in a broader socioeconomic and political context[3].

This chapter defines Central Indiana as a combination of eight counties: Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, and Shelby. Currently, there are 981,307 women in Central Indiana; that is 52% of the total Central Indiana population. Since 2012, the total number of Central Indiana women has increased by 105,760— a 12% increase. That's a larger increase than was experienced in either the state as a whole (4% increase) or the nation (seven percent increase) during the same time frame. This chapter offers key population trends and demographics, highlighting the diverse composition of women in Central Indiana in terms of race, ethnicity, age, household composition, marital status, disability, socioeconomic status, and other characteristics.

Key Takeaways:

- Currently, there are 981,307 women in Central Indiana, which is 52% of the total Central Indiana population. Since 2012, the total number of women has increased by 105,760—a 12% increase.
- In general, middle-aged women (age 35-64) are the largest group (38%) of Central Indiana's women's population, followed by younger women (23%) and seniors (15%).
- According to 2022 Census data, nearly 72% of the women's population in Central Indiana is White, followed by Black (16%), Hispanic (five percent) and Asian (three percent).
- In Marion County, nearly 36% of households consist of married couples and eight percent cohabiting couples. In addition, 20% are women householders living alone compared to 17% male householders.
- In Central Indiana, four percent of households are single mothers with their own children under age 18 compared to one percent of those who are single fathers in 2022. In Marion County, seven percent of households are single mothers compared to one percent of single fathers,.

- Nearly 20% of Black women in Central Indiana had at least one of six disabilities, compared to 16% of White women, 13% of Hispanic women and 10% of Asian women.

- Among women, ambulatory difficulty is the most common disability, followed by cognitive disability and independent living disability. Among all age groups, senior females (age 65+) ranked highest for all six types of disabilities (i.e., ambulatory, cognitive, hearing, independent living difficulty, self-care difficulty and vision disability)

Chapter 2

Domestic Violence & Safety

In a world rich with stories of strength and resilience, the reality of violence against women remains a shadow that lingers. This is not an event confined to one culture or socioeconomic background; it's a narrative shared by women from all walks of life. Violence takes many forms, weaving its way through the lives of women through domestic and intimate partner violence, sexual violence, emotional abuse, and coercive control. It can occur within intimate relationships, in the public sphere, or as part of systemic and institutional discrimination. Women subjected to violence often fear for their safety and can even face severe physical injuries, with the psychological and emotional damage being just as profound. The trauma from such experiences can lead to long-lasting impacts on mental health, self-esteem, and overall quality of life and sense of safety. The ripple effects extend beyond the individual, reaching families and communities, contributing to a cycle of harm and inequality that lasts for generations.[4]

Key Takeaways:

- Intimate Partner Violence (IPV) occurs between romantic partners who may or may not be living together. This is the most common form of violence against women. Intimate Partner Violence may also be referred to as Intimate Partner Domestic Violence (IPDV), meaning the parties share a household.
- The cycle of violence starts early. The number of Indiana high school girls who reported having experienced sexual violence in 2021 was 17.2%, which is an increase from 4.9% in 2015.
- When looking at Marion County, there were an estimated 10,105 victims of domestic violence (one percent of the population) in 2020, with 71% of the victims being women.
- Due to systemic racism, policies, and societal structures, Black men and women experience domestic violence at a higher rate than their White counterparts.
- In Central Indiana, many service providers responded to COVID-19 by moving programs - including advocacy - to online platforms. This shift proved to be problematic for many as virtual platforms often present safety risks for those experiencing domestic violence. The need for safety is one reason why offering virtual services was not common practice before the pandemic.

- Statistics show that eight out of ten incidents of sexual assault are committed by someone known to the victim, and in Indiana, one in five women have been sexually assaulted while only one in 38 men have been sexually assaulted.[5]

- 63% of sexual assault cases in Indiana go unreported to the police.[7]

- The biggest barriers survivors face in Central Indiana include lack of basic needs being met, limited education on DV and IPV or where resources for these can be located, financial stability, lack of reliable and affordable childcare, lack of transportation, and lack of access to physical and mental healthcare.

Chapter 3

Housing

Women face the same housing challenges as the overall population, with housing costs increasing and homeownership become more challenging for first-time buyers. And yet, women are often in a unique position related to housing. It is only recently that property ownership was possible for women in the United States. A married woman could not own property under her own name until the mid-19th century, and a woman could not get a home loan without a male co-signer until 1974.[6]

Now, homeownership rates are similar between men and women, but women do face particular challenges to homeownership and affordable housing in general: They earn less than men on average (even with the same education and occupation—see the Financial Stability chapter), and often lead households with children as the sole income earner , leaving less income to pay for housing.

Key Takeaways:

- Since homes are often owned jointly by household members, it is difficult to establish a gender gap in homeownership, but single mothers do have a lower homeownership rate (51%) than single fathers (57%) and a much lower rate than married couples (86%).
- Homeownership rates are lower in Central Indiana than in the state overall but higher than the U.S. For single mothers, the region's rate of 51% falls between the U.S. rate of 50% and the Indiana rate of 53%. For married couples, the regional rate of 86% is higher than the U.S. (82%) but lower than Indiana (87%).
- 54% of Central Indiana renters are women. This exposes women to more risk when rent prices increase. Rents have increased 35% in five years in the Indianapolis metro area.
- According to estimates from Eviction Lab, 61% of evictions in Marion County are filed against women, but only 52% of Marion County renters are women.
- Single mothers who rent pay 48% of their income in housing costs, more than any other household type.

- Home prices have increased 60% since 2019, building equity for women who are homeowners but making it harder for first-time homebuyers to purchase a home. Single mothers who are homeowners pay 29% of their income toward housing, on average—again, more than any other household type.

Chapter 4

Caregiving

Caregiving is an immense role encompassing a wide range of activities needed to assist individuals who cannot fully care for themselves due to age, illness, or disability. This role may include personal care tasks such as bathing, dressing, and feeding, managing medical care and appointments, coordinating with healthcare providers, and handling financial and legal matters. Caregiving responsibilities can be short-term, such as assisting someone recovering from surgery, or long-term, such as caring for an individual with a chronic illness or dementia.

Key Takeaways:

- In Indiana, nearly one in four women (24.3%) and roughly one in five men (17.9%) reported providing care to someone with health issues.
- While Black women make up 26.1% of female caregivers in Indiana, a disproportionate 31.1% of these women are providing care for more than 40 hours per week, highlighting a significant racial disparity in caregiving burdens.
- Nearly half of care recipients under women caregivers need help with personal care; 80% require assistance with household tasks.
- The "sandwich generation" (45 to 64 years old) constitutes the highest percentage of women caregivers in Indiana.
- Childcare needs in Central Indiana far exceed available licensed spots. In Marion County there are only enough spots to meet 84% of demand, while Hamilton County can only meet 46% of demand.
- 60% of family caregivers in Indiana experience stress, and 40% report anxiety or depression.
- Over 30% of caregivers feel socially isolated or lack sufficient support from family and friends.

Chapter 5

Financial Stability

Financial stability for women is a crucial pillar in fostering gender equality, enhancing individual autonomy, and ensuring societal wellbeing. It empowers women to make informed decisions about their lives, careers, and families, reducing their vulnerability to economic shocks and social injustices. By achieving financial stability, women can access better education, healthcare, and career opportunities, which collectively contribute to their personal development and the prosperity of their communities. Moreover, women's financial independence is integral to breaking the cycle of poverty and promoting sustainable economic growth. This section of the report focuses on financial stability, including income, employment, poverty levels, education, economic vulnerabilities and support programs of women in Central Indiana.

Key Takeaways:

- Median earnings for Central Indiana women are 70 cents on the dollar compared to men. A gender pay gap exists for part-time workers and for full-time workers. It persists for every race and every level of education. A gender pay gap of at least 10% is present for 19 out of 24 occupations.
- More women are earning college degrees. College attainment for women has increased 10 points since 2010, closing the gender gap with men. In 2022, 39% of women aged 25 or older have a bachelor's degree.
- Women graduate high school at a higher rate than men, but graduation rates are declining. In 2022, 90% of Central Indiana women graduated high school compared to 86% of men. In 2013, the graduation rate for women in Central Indiana peaked at 95%.
- Young women are more likely to live in poverty than any other age group: 17% of Central Indiana women aged 18-34 are in poverty compared to 11% of the overall population of Central Indiana.
- Single mothers are exposed to increased economic vulnerability. This group is more likely than other households to fall below the Asset Limited, Income Constrained, Employed (ALICE) threshold of financial stability and less likely to have a bank account.

Chapter 6

Food Access & Security

Two issues are crucial to the health of women in Central Indiana: food access and food security. Food access is the availability of fresh, healthy food in a location close enough to make convenient access feasible. Food security is a result of having the financial resources to buy enough healthy food. These issues often intersect––poor food access can force people to buy more expensive and unhealthy food because the location is convenient (such as a convenience store) or use more time and money to get to a grocery store (spending more gas money or hiring a rideshare service), stretching an already tight budget.

Key Takeaways:

- There are 100,000 women living in food deserts in Central Indiana. Food deserts are concentrated in Marion County, particularly on the northwest side, the northeast side, and the southeast side. 15% of Marion County residents live in a food desert.
- In the outlying counties, Three percent of the population lives in a food desert, but this varies by county. In Hendricks, Boone, and Hamilton counties, two percent or less of the population lives in a food desert. The rate is five to six percent in Morgan and Johnson counties, but 21% in Shelby County.
- Black, Indigenous, and People of Color (BIPOC) are more likely to live in a food desert than White residents. In Marion County, nearly one quarter of Black and one sixth of Latino residents lived in a food desert in 2022, compared to one tenth of White residents.
- Food deserts have an outsized impact on women because they are likely to be the primary shopper in their household—80% of U.S. women are the primary shopper, and women are seven times more likely than men to be responsible for meal planning.
- One-in-four women live below 185% of the poverty threshold in Central Indiana. Nationally, women at this income level have a 38% chance of low food security.

Chapter 7

Transportation

Women make up most transit riders and account for most car trips, according to researchers. This means that every transportation issue, from traffic to transit service, has an outsized impact on women.

Key Takeaways:

- In 2022, women made up 57% of weekday transit ridership and 62% of weekend ridership. Women who take transit tend to be employed full-time (55%) or part-time (17%). Most women (54%) earned below $25,000 per year.
- There is not a significant difference in vehicle access between men and women. However, working-age women are more likely to live in one-car households (23% compared to 18% of men). This could contribute to women's use of transit or carpooling.
- Commutes tend to be shorter for women in Central Indiana—42% of women have a commute under 20 minutes compared to 35% of men.
- National studies find that women make more household support trips—single mothers spend 65% more time than men on household support travel and married mothers spend 50% more time than men.
- Household related trips, like picking up children, attending appointments, or making household purchases, must often be performed at specific times and places. This limits the opportunities available to women. As a result, women in one study had access to 44% fewer destinations—locations like shops, jobs, or offices—compared to men.

Chapter 8

Health Status

The health and wellbeing of women in the United States are significantly influenced by socioeconomic and demographic disparities, which are further exacerbated by persistent exposure to stressors. This phenomenon, known as the "weathering hypothesis," posits that enduring stress accelerates the aging process and undermines health, particularly among marginalized groups.[7] Women who are Black, Indigenous, and People of Color (BIPOC) bear a disproportionate burden of chronic diseases such as diabetes, heart disease, and obesity and encounter substantial barriers to accessing healthcare and achieving positive health outcomes.

The cumulative effects of financial instability, healthcare barriers, and racial discrimination underscore the challenge of weathering. Systemic inequities in healthcare, economic opportunities, and social determinants of health are shaped and sustained by political determinants of health. Through government action or inaction and policy decisions, structural conditions such as environmental hazards, inadequate transportation, unsafe neighborhoods, unstable and substandard housing, limited access to healthy food options, and underfunded and inadequate educational opportunities have contributed to and exacerbated health disparities, life expectancy, and overall quality of life.[8]

Key Takeaways:

- In Indiana, women report experiencing poor physical health more frequently than men. A higher percentage of men (64.8%) report having zero days of poor physical health, while a significantly lower percentage of women (55.6%) indicate the same.
- Black women in Indiana have significantly higher rates of Human Immunodeficiency Virus (HIV) prevalence (440.2 per 100,000 in 2022) compared to White Women (32.8 per 100,000).
- Economic barriers prevent 10.2% of women in Indiana from seeking medical care, with Hispanic women (20.8%) being the most affected by financial constraints, followed by Black (12%) and White women (8.5%)
- From 2018 to 2022, heart disease and cancer consistently ranked as the top two causes of death among women in Central Indiana, with crude death rates fluctuating between 150 and 170 per 100,000 population.

Chapter 9

Infant & Maternal Health

Maternal and infant health are vital indicators of a community's overall wellbeing, as they reflect the quality of healthcare, access to services, and the impact of social and economic conditions on health outcomes. Healthy pregnancies and positive birth outcomes are influenced by medical care and broader societal factors such as education, income, housing, and environmental conditions. Communities that prioritize maternal and infant health typically experience lower rates of chronic diseases, reduced healthcare costs, and improved long-term outcomes for children. In contrast, disparities in these areas often highlight significant gaps in healthcare access and support systems. As a result, maternal and infant health serve as a critical measure of both healthcare effectiveness and social equity.

Key Takeaways:

- In Central Indiana, Black mothers lacking access access to first-trimester prenatal care dropped from 46.4% in 2018 to 44.3% in 2022.
- Residents of Morgan County travel an average of 19.5 miles to the nearest birthing hospital, compared to just 4.4 miles in Johnson County.
- Black women in Indiana experienced the highest maternal mortality rates from 2018 to 2021, with 135.6 pregnancy-associated deaths per 100,000 live births.
- Shelby County had the highest smoking rate during pregnancy at 12.1% in 2021, while Hamilton County had the lowest at 0.6%.
- Black infants had the highest low birth weight rates, peaking at 15.1% in 2020.
- The infant mortality rate for Black infants in Central Indiana was 14.2 deaths per 1,000 live births in 2016, compared to 4.8 for White infants in 2020.

Chapter 10

Mental Health

Mental health is a critical aspect of overall wellbeing, affecting how individuals think, feel, and interact with the world around them. However, mental health is not a one-size-fits-all issue; it is deeply influenced by gender, with women often experiencing mental health challenges that are both distinct and more nuanced compared to men. Biological, social, and cultural factors all intersect to shape the mental health experiences of women, leading to unique patterns in the prevalence, manifestation, and treatment of mental disorders.

Women's mental health in Central Indiana has emerged as a critical concern, with alarming trends in depression, frequent mental distress, and substance use disorders. Recent data highlights the urgency of addressing these issues, particularly among younger women and women who are Black, Indigenous, and People of Color (BIPOC), who face the compounding effects of chronic stress and socioeconomic disadvantages that exacerbate mental health disparities over time.

Key Takeaways:

- 29.7% of women in Central Indiana reported experiencing depression, with the highest rates among women aged 18-34.
- Frequent mental distress affected 20.3% of women, particularly those aged 18-24..
- The drug overdose mortality rate among Black women in Central Indiana rose to 47.2 per 100,000 in 2022, surpassing the rate among White women (42.4 per 100,000).
- Women in Central Indiana consistently have higher rates of emergency interventions for mental health crises compared to men.

Chapter 11

Accessing Healthcare

Access to healthcare in the United States remains a critical issue, influenced by a variety of policies that shape socioeconomic factors, leading to widespread disparities. Policies that have historically enforced racial residential segregation and disinvestment in communities of Black, Indigenous, and People of Color (BIPOC) have created enduring barriers to healthcare access by contributing to economic instability, inadequate transportation, underfunded education, substandard housing, and poor infrastructure. These structural conditions, in turn, impact health outcomes across populations.[9,10]

Research shows that the lack of investment in predominantly Black and minority communities—often a direct consequence of discriminatory housing and lending policies like redlining—leads to disparities in economic stability. This disinvestment leaves these communities with fewer job opportunities, lower wages, and limited resources for healthcare services. As a result, individuals in these neighborhoods are often uninsured or underinsured, further limiting their ability to access care.

Additionally, inadequate transportation systems in disinvested areas, such as limited public transit options and poor infrastructure, make it difficult for residents to travel to healthcare facilities. Many neighborhoods in these areas lack basic infrastructure like sidewalks and safe walking spaces, making it dangerous or impossible to walk to nearby clinics or hospitals. This geographic isolation worsens the healthcare access gap, particularly for those who cannot afford private transportation or live in healthcare deserts—areas with few or no healthcare providers.

Substandard housing conditions, such as overcrowding, exposure to environmental toxins, and unsafe living environments, exacerbate health issues like asthma, hypertension, and mental health disorders. These factors, combined with limited access to healthy food options—commonly known as food deserts (See Food Access and Security Chapter)—result in higher rates of chronic diseases like diabetes and cardiovascular conditions, which require consistent medical attention. However, due to the economic and geographic barriers shaped by policies, residents of these communities are often unable to receive the necessary preventive care, leading to higher rates of acute health episodes.

Research shows that disparities in healthcare access, driven by these socioeconomic and policy-driven factors, lead to varied health outcomes across different populations.[11] Health insurance, when available, enhances access to primary and preventive healthcare, which is essential for managing

chronic conditions and reducing acute health episodes.[12,13] However, until policies address the systemic disinvestment in communities of BIPOC and the resulting socioeconomic inequities, access to healthcare will remain deeply unequal, perpetuating health disparities.

> **"Accessing quality healthcare is an issue for women, especially Black women. Although providers and healthcare systems have publicly acknowledged racial and gendered issues are a concern, there still aren't enough systemic changes to address the poor service many women receive due to bias and bigotry."**
>
> ***- Rhonda L. Bayless,*** *Executive Director, Centers of Wellness for Urban Women (CWUW)*

Key Takeaways:

- In Indiana, women have higher rates of insurance coverage compared to men, with the uninsured stats for men at 13% and for women at only nine percent as of 2023.
- Hispanic women had the highest percentage (20.8%) of those who avoided accessing care due to cost, compared to Black women (12%) and White women (8.5%).
- Access to personal healthcare providers is notably poor among Hispanic women, with 26.2% lacking a regular provider, compared to 8.2% of White women and 12.4% of Black women.

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WOMEN'S FUND
OF CENTRAL INDIANA
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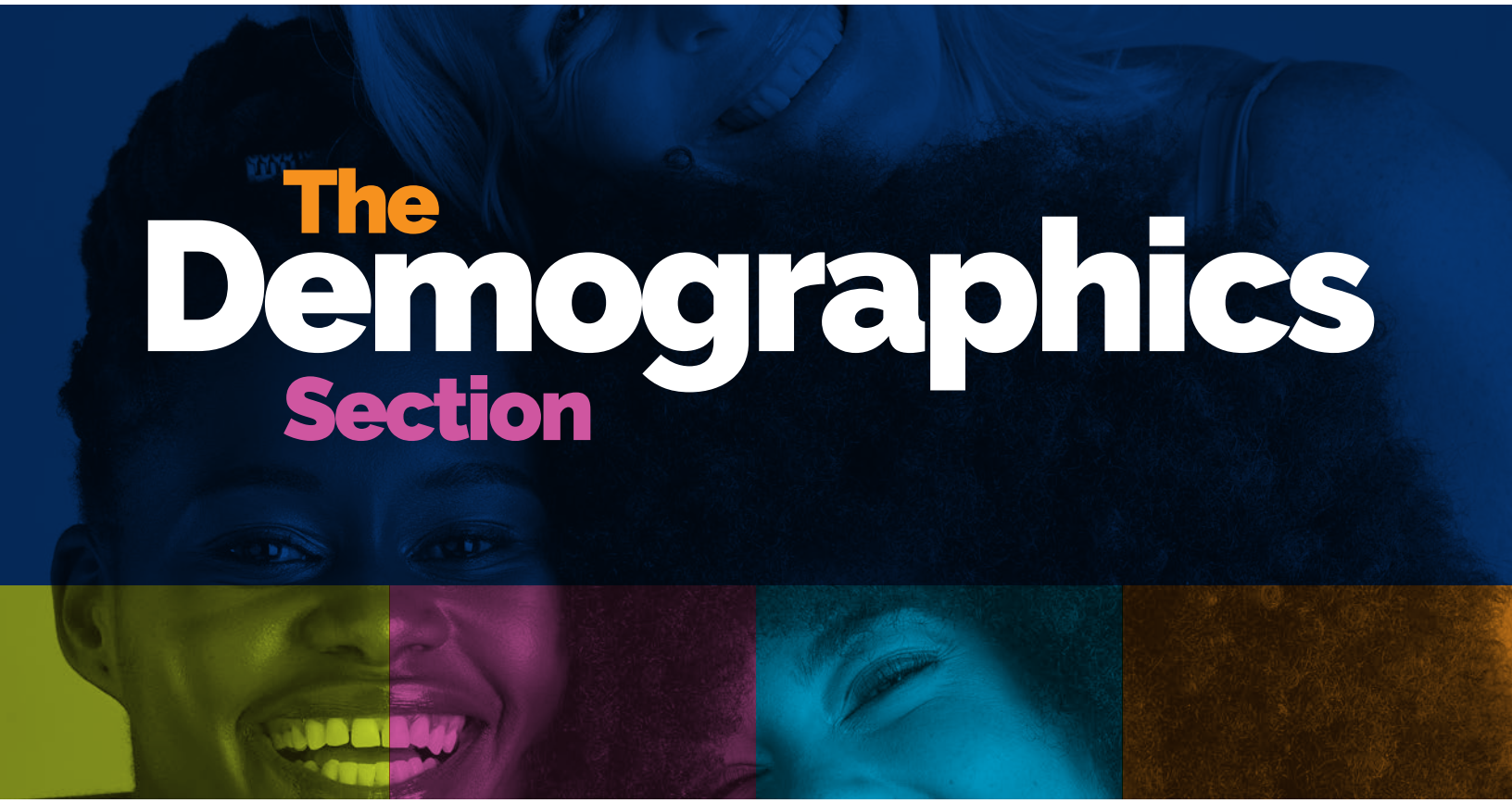


The Demographics Section

Women's Fund of Central Indiana

State of Women Report | 2024

Persona

Ashley Andrews

Personas are sketches of fictional people that represent real challenges and circumstances highlighted in this report. They are a useful way to imagine how these statistics impact the lives of individuals and families.

42 years old

Children & mother's caretaker

Marketing consultant

Ashley Andrews is a 42-year-old White woman living in Noblesville with her husband, Evan; her children, Jude (4) and Summer (8); and her mother, Eileen, who just turned 75 and has Parkinson's disease. Eileen moved in three years ago, soon after her husband died of a heart attack. Her Parkinson's symptoms, which have worsened since she moved in, include trouble walking and occasional dizziness. She has also fainted on two occasions, fortunately without injury.

Ashley is a consultant with an advertising and marketing firm based in downtown Indianapolis. Her commute is 30 to 45 minutes each way, depending on traffic. She and Evan, who works for an accounting firm in Carmel, trade off the responsibility for taking Jude to day care. On days when she drops him off, her commute can easily take an hour or more.

The family is doing well financially, at least in relative terms. Their household income of $140,000 is above the median for their area. Yet Ashley feels squeezed by costs that seem to keep increasing. Because of her mother's condition, she hires a home healthcare provider to check in with her for an hour each weekday. Those visits, along with Jude's daycare, are nearly $25,000 a year. They will save about half of that total when Jude begins kindergarten next year. But the costs of Eileen's care will probably increase, if and when she requires more extensive care.

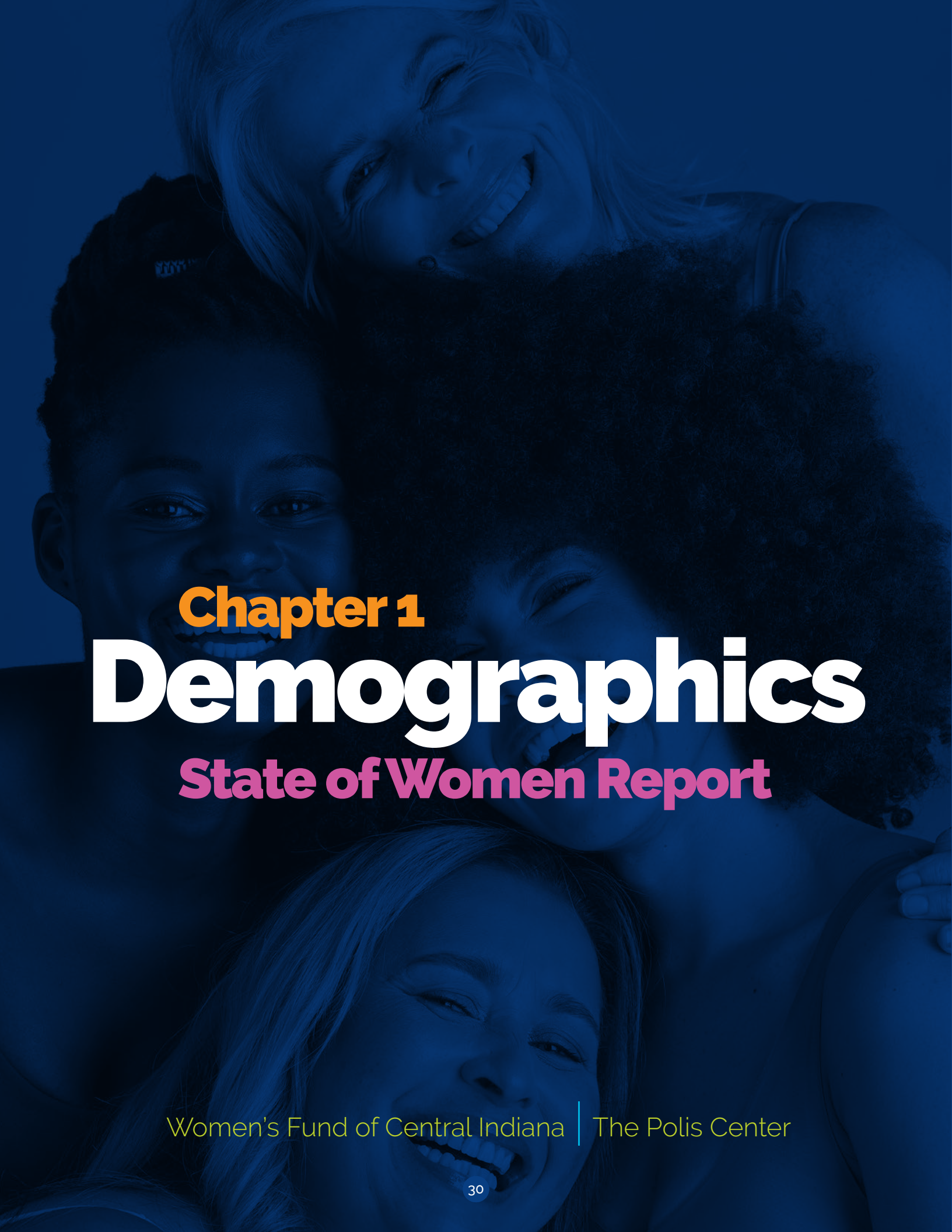
Ashley feels squeezed by other economic and emotional stressors as well. The family lives in the same house that she and Evan bought 10 years ago, soon after they got married—when it was just the two of them and both had jobs in Noblesville. Now, the house is too small for the five of them, and it's also distant from their workplaces. But housing prices have increased so much in recent years—and their current mortgage interest rate is so low—that buying a bigger house in a better location isn't a practical option.

With her commute, her work, and her caregiving responsibilities related to Eileen—on top of trying to be a good mother to her kids and a good partner to Evan—Ashley feels pulled in multiple directions. And she often feels guilty about not giving the most important people in her life the kind of time and attention she would like to. She recently missed Summer's violin recital, for example, because her mother had a health scare and wanted someone close by, in case she needed a ride to the hospital. At the same time, Ashley often feels resentment about the way family commitments limit her career opportunities. When she had Summer, for example, she established a policy of not taking on

Persona

Ashley Andrews

work on projects that would require hours beyond the normal workday. She believes this policy has held her back significantly, as she sees coworkers who are able and willing to work longer hours move up in the firm or launch out on their own. In her darker moments, Ashley wonders whether a selfish approach to her career, most likely at the expense of home obligations, would have paid off in terms of better projects at work, more money, and a better overall living situation for her family.



Chapter 1
Demographics
State of Women Report

Women's Fund of Central Indiana | The Polis Center

Demographics

In Greek, demography means "describing people[1]," and demographic analysis refers to population structure and the study of population characteristics and how those trends change based on migration, gender, birth, age, race, income, rates of marriage, and other socioeconomic indicators[2]. Exploring women's demographics in Central Indiana is essential as it helps us to understand women's issues in a broader socioeconomic and political context[3].

This report defines Central Indiana as a combination of eight counties: Boone, Hamilton, Hancock, Hendricks, Johnson, Marion, Morgan, and Shelby. Currently, there are 981,307 women in Central Indiana, which is 52% of the total Central Indiana population. Since 2012, the total number of women has increased by 105,760— a 12% increase. That's a larger increase than was experienced in either the state as a whole (four percent increase) or the nation (seven percent increase) during the same time frame. This chapter offers key population trends and demographics, highlighting the diverse composition of women in Central Indiana in terms of race, ethnicity, age, household composition, marital status, disability, socioeconomic status, and other characteristics.

Key Takeaways:

- Currently, there are 981,307 women in Central Indiana, which is 52% of the total Central Indiana population.
- In general, middle-aged women (age 35-64) are the largest group (38%) of Central Indiana's women's population, followed by younger women (23%) and seniors (15%).
- According to 2022 Census data, nearly 72% of the population of women in Central Indiana is White, followed by Black (16%), Hispanic (five percent) and Asian (three percent).
- In Marion County, nearly 36% of households consist of married couples and eight percent cohabiting couples. In addition, 20% are women householders living alone compared to 17% householders who are men.

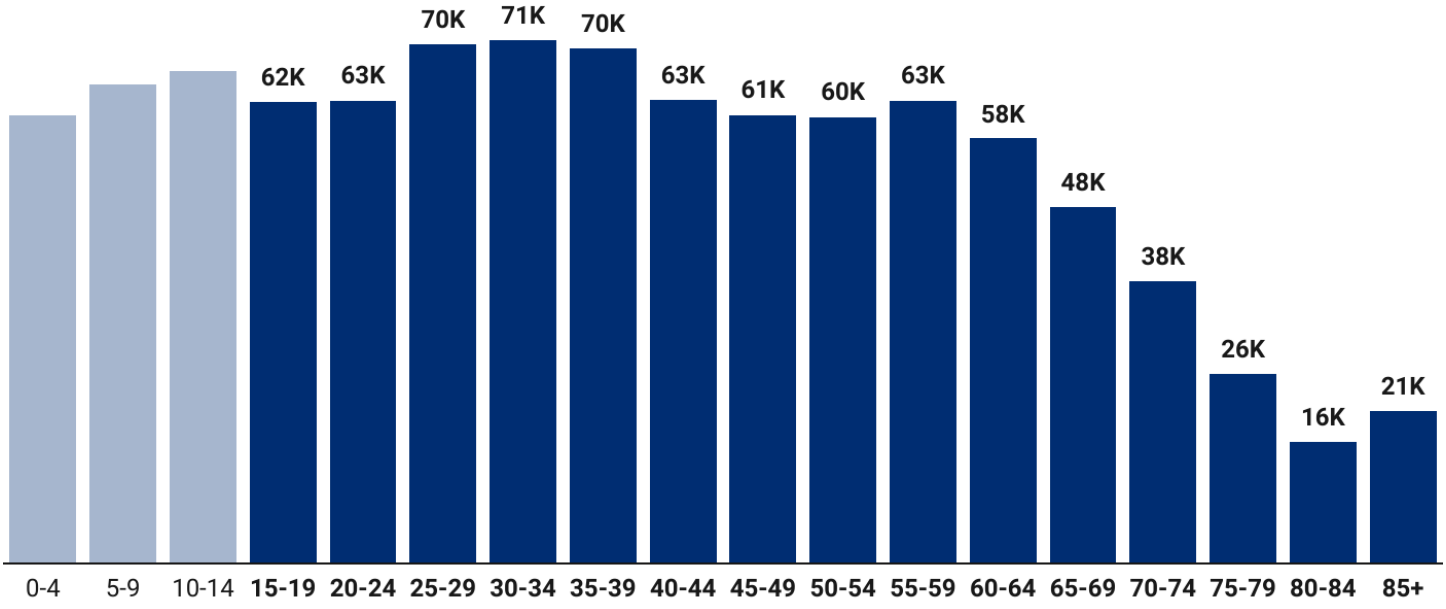
- In Central Indiana, four percent of households are single mothers with their own children under 18 compared to one percent of those who are single fathers in 2022. In Marion County, specifically, seven percent of households are single mothers compared to one percent of single fathers.

- Nearly 20% of Black women in Central Indiana had at least one of six disabilities (i.e., ambulatory, cognitive, hearing, independent living difficulty, self-care difficulty and vision disability), compared to 16% of White women, 13% of Hispanic women and 10% of Asian.

- Among women, ambulatory difficulty is the most common disability, followed by cognitive disability and independent living disability. Among all age groups, senior females (age 65+) ranked highest for all six types of disabilities (i.e., ambulatory, cognitive, hearing, independent living difficulty, self-care difficulty and vision disability)

Middle-aged women (age 35-64) are the **largest age group of women**

Population of women by age, 2022



Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

Women in Central Indiana

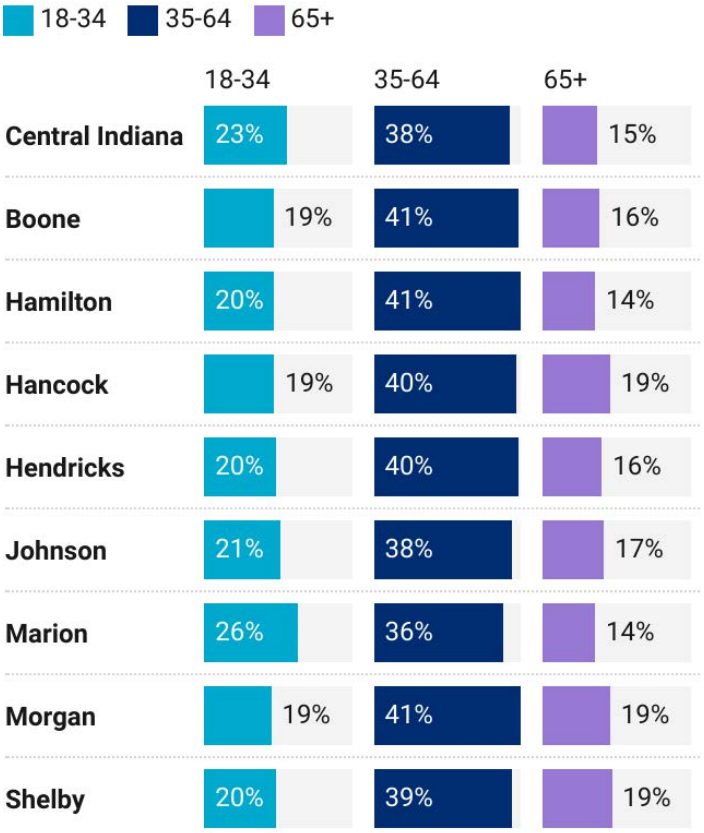
In general, middle-aged women (age 35-64) are the largest group (38%) of Central Indiana's women's population, followed by 23% of younger women (age 18-34) and 15% of seniors (age 65+). Although this trend is consistent across all the Central Indiana counties, there are some variations. For example, Marion County has the highest percentage of younger women (26%) and the lowest percentage of seniors (14%). Morgan County has the highest percentage of middle-aged women (41%), and Shelby County has the highest percentage of seniors (19%).

According to 2022 Census data, 69% of Central Indiana women are White. Sixteen percent are Black, seven percent are Hispanic, and four percent are Asian. The racial composition is consistent for Black and Asian females between 2018 and 2022. Since 2018, the White portion of women has declined while the share of Asian, Hispanic, and other races has grown. The Black share has remained consistent.

When comparing men and women by 10-year age groups, we see some interesting patterns in Central Indiana. For age groups 0-9 and 10-19, there are more boys than girls; however, as they age, the

Marion County has the **highest portion** of **young women**

Central Indiana women by county and age



Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

women population surpasses the male population in all other age groups. The men-women difference is highest for the age 80+ population. In Central Indiana, 37,097 women are age 80+ compared to 21,197 men.

Indiana's population is projected to grow by 5.6% between 2020 and 2060, with most metropolitan counties expected to experience greater growth (greater than nine percent), while all rural and micropolitan counties are expected to have population losses (-10% & -6% respectively) (Kinghorn 2024). The projected 40-year growth (5.6%) for Indiana is about one-quarter of the projected national growth rate of 21.6%. This also represents a significant decline in Indiana's growth rate of 23.7% from the previous 40 years (1980-2020). The report indicates that much of this decline is expected to be from decreasing population of Boomers (people 60-78 year olds in 2024), plummeting drops in 'natural increase' (residents having children), and slow net migration (in-migration from outside of Indiana).[4]

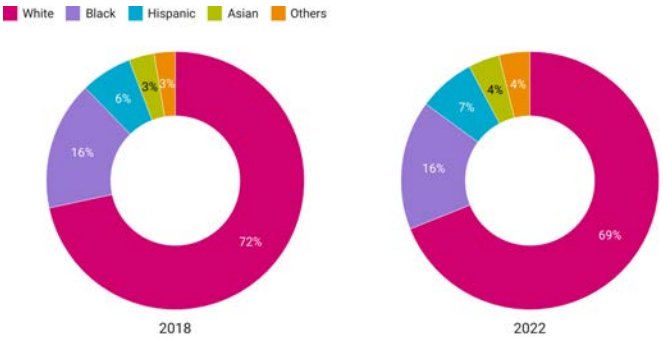
Household Type by Relationship

Family relationships are vital in shaping an individual's wellness through psychosocial, behavioral, and physiological pathways[5]. Family members are more important as individuals age and need more caregiving resources and social support (i.e., providing love, care, and advice)[5,6]. In Central Indiana, nearly 56% of households consist of married couples and seven percent are cohabiting couples. In addition, 14% are women householders living alone compared to 11% who are men. This trend of higher numbers of women living alone is visible in individual counties, too.

Across Central Indiana, Marion County has the lowest percentage of married couple households (36%) and the highest rate of women households (20%) who are living alone in 2022. Hamilton County has the highest percentage (63%) of married couple households. In addition to that, in Central Indiana, four percent of households are single mothers with their own children under 18 compared to one percent that are single fathers in 2022. In Marion County, specifically, seven percent of households are single mothers compared to one percent of single fathers. Women in Central Indiana are more likely than men to live alone.

The **racial composition** is **consistent** for **Black** and **Asian females** between **2018** and **2022**

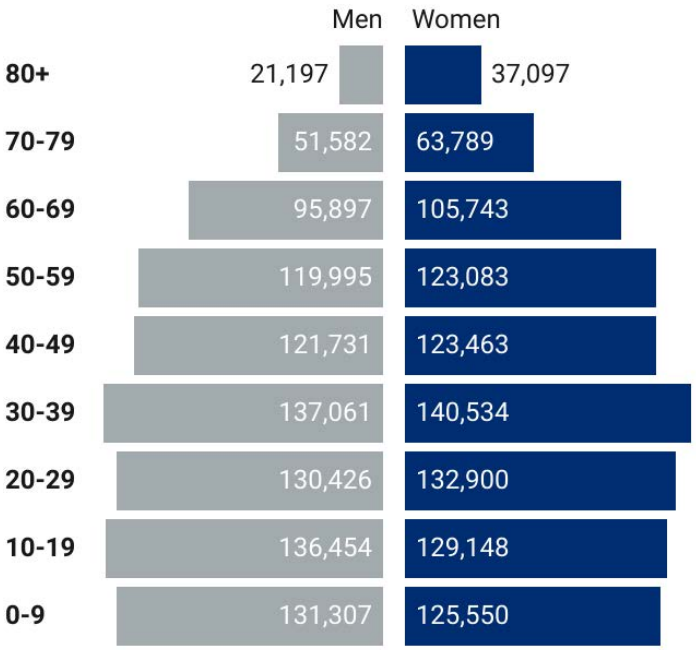
Women population by race and ethnicity, 2022



Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

As residents age, the **women population surpasses** the **male population**

Central Indiana population by age and sex



Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

Most Central Indiana households are married couples but in Marion County household type is more diverse

Household type by county

County	Married Couple Household	Cohabiting Couple Household	Men living alone	Women living alone	Single Fathers	Single Mothers	Others
Central Indiana	56%	7%	11%	14%	1%	4%	7%
Boone	62%	6%	10%	11%	1%	5%	4%
Hamilton	64%	5%	8%	12%	2%	4%	5%
Hancock	58%	7%	10%	14%	2%	3%	7%
Hendricks	61%	7%	8%	11%	1%	4%	7%
Johnson	56%	8%	10%	14%	2%	3%	7%
Marion	36%	8%	17%	20%	1%	7%	11%
Morgan	57%	7%	9%	12%	2%	4%	9%
Shelby	53%	8%	14%	14%	1%	4%	6%

Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

Coupled Households by Partner

Eighty-eight percent of coupled households in Central Indiana are made of opposite-sex spouses, followed by opposite-sex unmarried partners (10.8%), same-sex spouses (0.7%), and same-sex unmarried partners (0.6%). Hamilton County has the highest percentage of opposite-sex spouses (92%), and Marion County has the lowest (80%). Marion also has the highest same-sex spouses (1.5%) and the highest same-sex unmarried partners (1.5%).

Marital Status of Women

In Central Indiana, nearly 54% of women (age 15+) are currently married, followed by never married (25%), divorced (12%), widowed (eight percent) and separated (one percent). Marion County ranked lowest in the category of married (40%) and highest in never married (38%). Morgan has the highest percentage of widowed (10%), and Shelby has the highest divorce rates (14%) compared to other counties.

Hamiltion County has the highest percentage of opposite-sex spouses at 92%

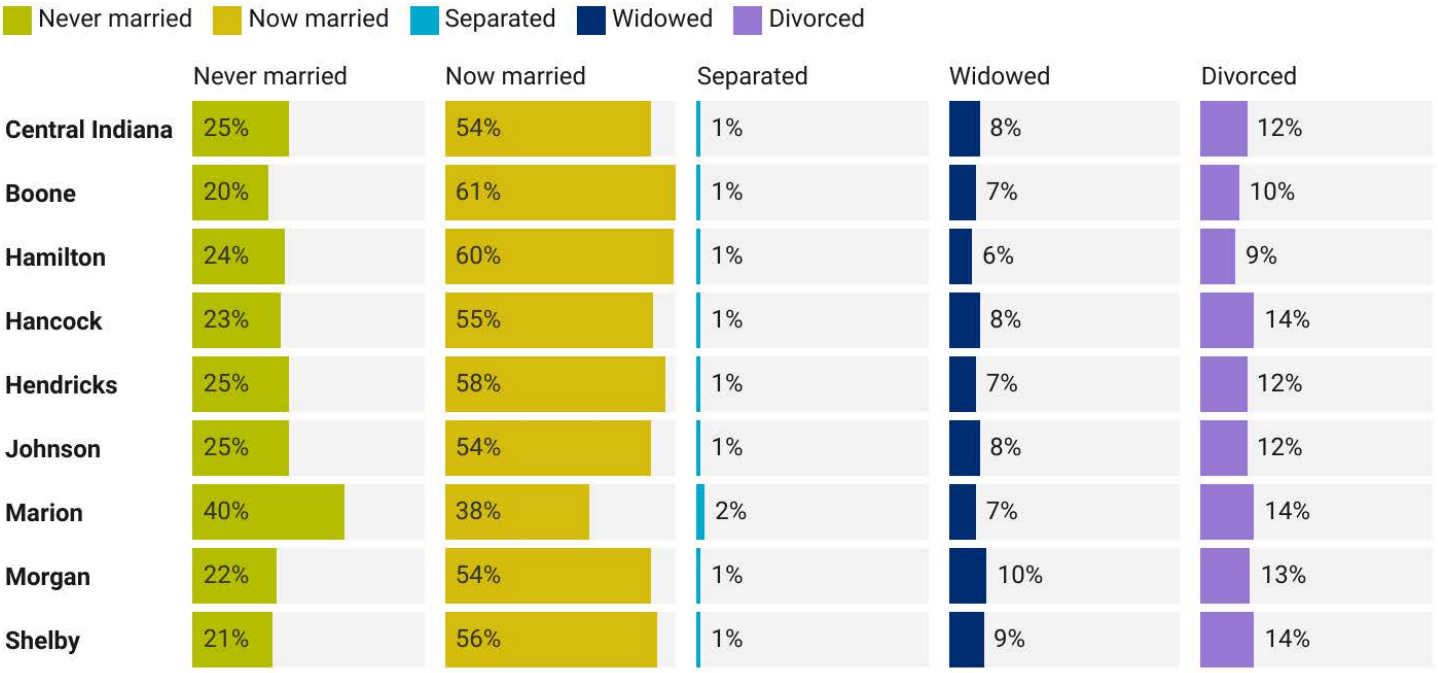
Percentage of Couples Households by Partner Type

	Opposite-sex spouse	Same-sex spouse	Opposite-sex unmarried partner	Same-sex unmarried partner
Central Indiana	87.8%	0.7%	10.8%	0.6%
Boone	90.0%	0.9%	9.0%	0.1%
Hamilton	92.0%	0.3%	7.4%	0.3%
Hancock	88.3%	0.5%	10.6%	0.7%
Hendricks	89.3%	0.5%	9.7%	0.5%
Johnson	87.8%	0.4%	11.3%	0.5%
Marion	80.6%	1.5%	16.5%	1.5%
Morgan	87.6%	1.0%	11.0%	0.4%
Shelby	87.2%	0.8%	11.0%	1.0%

Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

In **Central Indiana,** nearly **54% of women** (age 15+) are **currently married**

Marital Status of Women (15 years and over) in Central Indiana, 2022

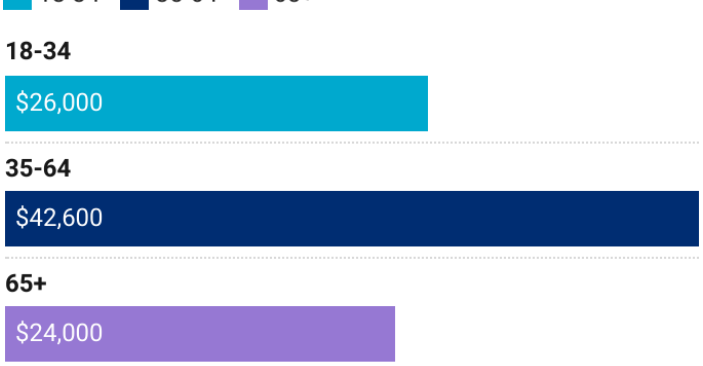


Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

Women's Median Income

Among women, **middle-aged women** have the **highest income**

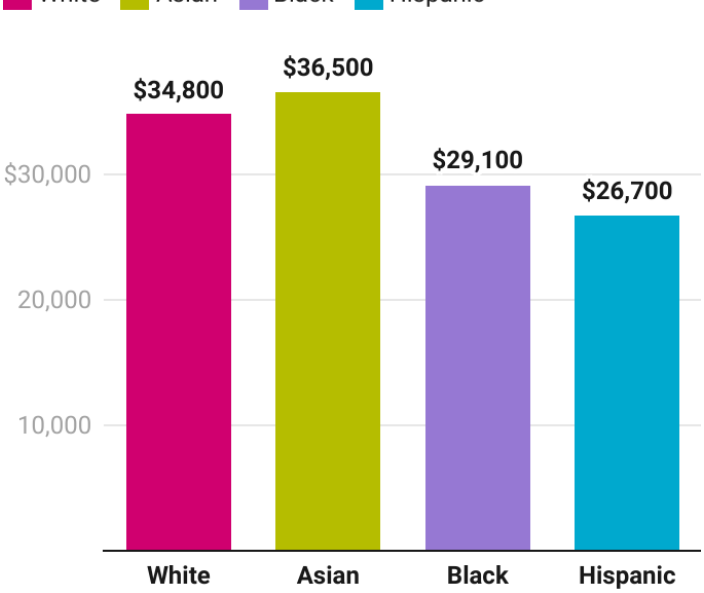
Median individual income for Central Indiana by age, 2022



Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

Among women, **Asian women** have the **highest median income**

Median individual income for Central Indiana by age and race, 2022



Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

Women's Educational Attainment

There is a large gap in educational attainment by race for women in Central Indiana. Hispanic women (28%) and Black women (26%) are more likely to not move beyond a high school diploma compared to White (23%) and Asian (13%) women. When it comes to a college education, both Hispanic women (25%) and Black women (25%) have the lowest rate of bachelor's degrees or higher compared to White (41%) and Asian (54%) women. Studies have indicated several reasons, including lack of resources[7], access to quality education[8], financial struggles[9], disparities in school funding[10], immigration status, and socioeconomic[11] status that make Black and Hispanic people underrepresented across all sectors of higher education in the USA.

Women's Disability by Age and Race

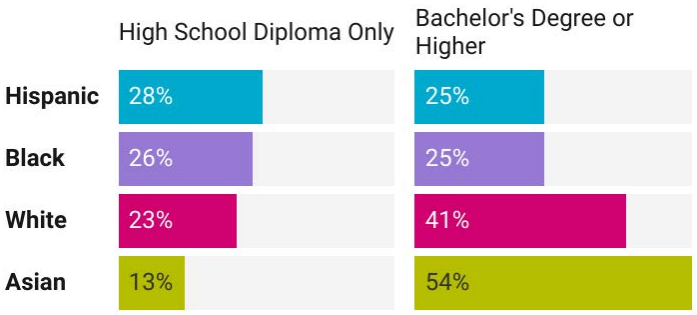
Nearly 36 million women in the U.S. have a disability[12] , and the rate is highest for those age 65 or over. Women with a disability may need additional care.[13] Studies have shown that many women with disabilities lack regular health screenings with recommended guidelines[14,15]. Among women in Central Indiana, ambulatory difficulty is the most common disability, followed by cognitive disability and independent living disability. Among all age groups, senior females (age 65+) ranked highest for all six types of disabilities. The disability rate also varied by race, as nearly 20% of Black women had at least one of six disabilities (see on the right), compared to White women (16%) and Hispanic women (13%).

Data Limitations

This chapter provides critical demographic insights about women in Central Indiana, including population size, distribution, household composition, education, disability, and marital status. The information included in this chapter will help policymakers understand gender demographics and identify areas where they need to concentrate resources. Although we offer some useful information about the demographic characteristics of women in Central Indiana, some limitations affect our data analysis and findings. For example,

White and Asian women have higher educational attainment than Black and Hispanic women

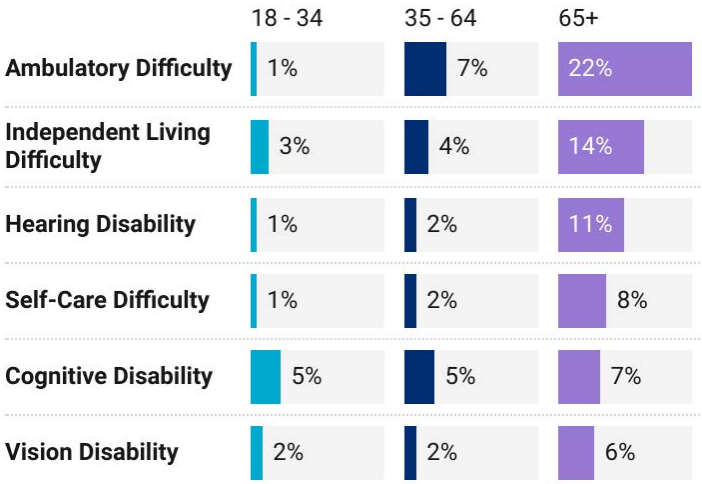
Women Education Attainment by Race in Central Indiana (2022)



Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

Disability rate is highest for those age 65 or over

Disability rates among women by disability type and age, 2022

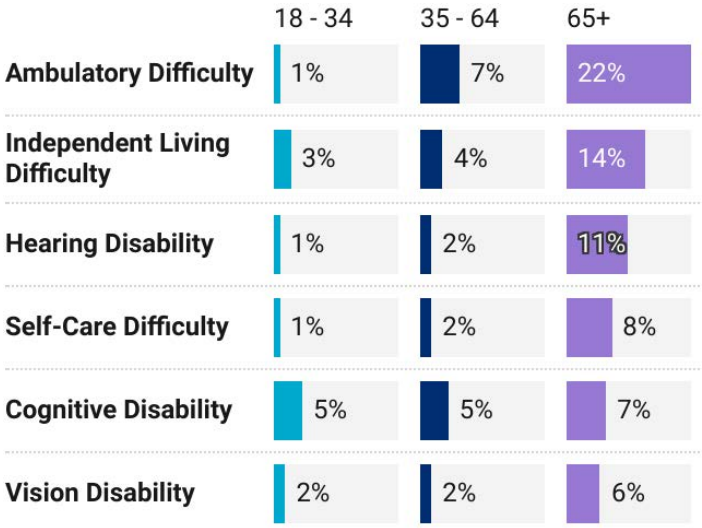


Source: ACS 2022 5-Yr Estimates; Graphic by the Polis Center

most of our data comes from the Census Bureau's American Community Survey (ACS) since it is one of the most reliable resources that offer publicly available demographic information[16]. However, ACS data related to demographic information is often associated with some challenges[17,18,19,20], including undercounting, reporting bias, geographic limitations, some age groups aren't broken down into smaller categories, data collection methodology, temporal limitations, and policy concerns. In addition, some of the categories used by the census to identify the population may not accurately describe the population subgroups. For example, the use of Black/African American is complicated as some African immigrant populations do not identify as Black/African American. The data is also broken down by race and not by immigrants/nationality. Additionally, some communities may identify as Arab (or another race), but they technically fall into the "White" category. Finally, there is a lack of data related to LGBTQ+ women at the county level. We would suggest that future research should incorporate different strategies to overcome those challenges and may use other data sources to offer a comprehensive analysis.

The **disability rate** also **varies** by **race**

Disability rates among women by race and age, 2022



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WOMEN'S FUND
OF CENTRAL INDIANA
A CICF FUND

The Basic Needs Section

Women's Fund of Central Indiana
State of Women Report | 2024

Persona

Crystal Jones

32 years old

Daycare assistant

Mother of 3-year old son

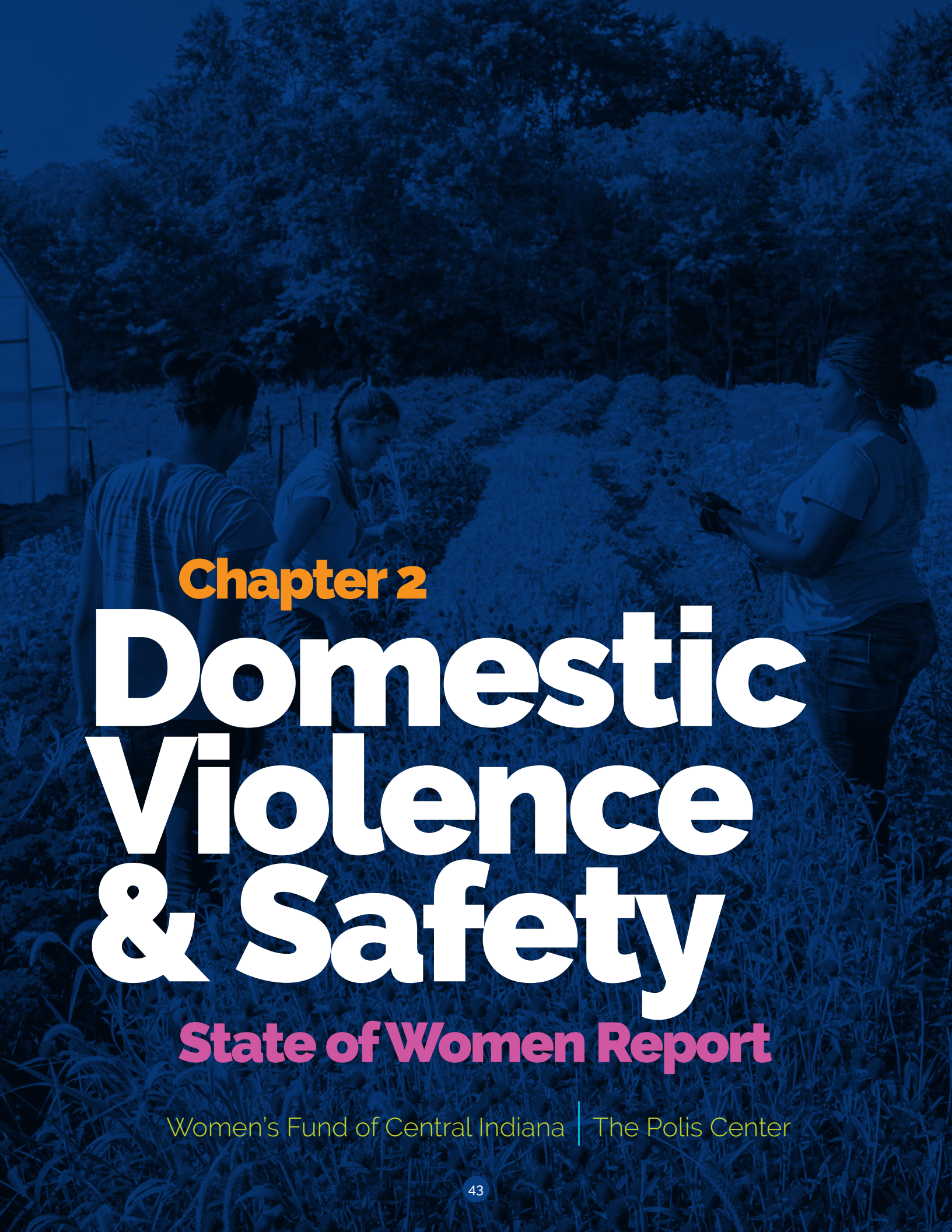
Personas are sketches of fictional people that represent real challenges and circumstances highlighted in this report. They are a useful way to imagine how these statistics impact the lives of individuals and families.

Crystal Jones is a 32-year-old, single Black mother living in the Martindale-Brightwood neighborhood. She works as an assistant at the on-site daycare center her church operates. Her work situation is ideal in terms of providing care for her three-year-old son, Isaiah, since she can take him to work with her and, because she is an employee, Isaiah's care is free. Even so, Crystal faces several significant financial and emotional stressors.

One is transportation. Crystal has a 10-year-old Toyota Corolla and would like to trade it in for a newer and more reliable model. But the car has been paid off for several years, and she can't afford a monthly payment or the spike in insurance rates that a newer car would bring, so her car is regularly in the shop. She lives close enough to a bus route that she can take it to work when the car is being repaired, but her commute spikes from less than 10 minutes to more than half an hour, including time spent walking to the stop and waiting for the bus. Buying groceries is even more problematic, since the nearest grocery store is more than a mile away, and taking the bus there involves a transfer. The total trip of about 1.5 miles can easily take 40 minutes. As a result, Crystal almost always puts off grocery shopping until the car is repaired, buying whatever food is available at a convenience store as a stopgap.

Housing is even more challenging. Crystal's rent has spiked from $750 to $995 per month over the past four years, meaning it is now about 40 percent of her annual income ($32,000). She knows that this is unsustainable. In her mid-20s, Crystal was evicted from an apartment soon after losing her job. For about a year, she was homeless and lived with friends in the area. They helped her get back on her feet, but the trauma of that experience haunts her. She has applied for Indiana's Housing Choice program, which would lower her costs and allow her to remain in her apartment. But it has been nearly two years since she was put on the waiting list, and she has lost hope that help will ever materialize. Recently, she has been searching for an apartment with monthly rent of $800 or less that is also accessible to work. But she's had no luck so far.

Crystal has a hard time imagining how her situation will improve. She carries a balance of several thousand dollars on a credit card, mostly from car-repair bills. That debt will take at least two years to pay off in the best-case scenario. Saving for retirement, much less setting money aside to help Isaiah with college one day, is out of the question. Crystal often thinks about finishing her college degree and becoming a nurse. But in her current situation, she feels nearly hopeless when she thinks about finding the time and money to improve her—and Isaiah's—long-term prospects.



Chapter 2

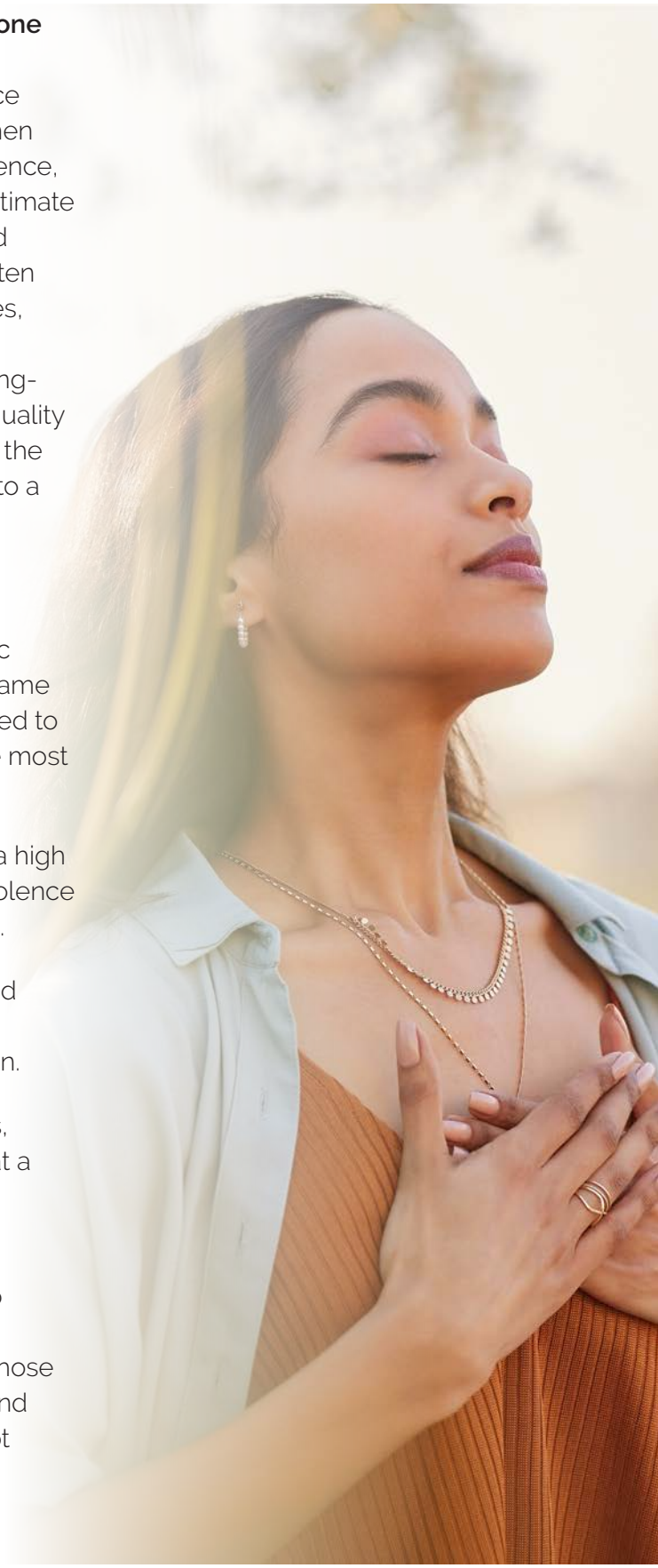
Domestic Violence & Safety

State of Women Report

Women's Fund of Central Indiana | The Polis Center

Domestic Violence & Safety

The story of women in Central Indiana is overwhelmingly one of strength and resilience, but violence is also an all-too-common experience for women of all walks of life. Violence takes many forms, weaving its way through the lives of women through domestic and intimate partner violence, sexual violence, emotional abuse, and coercive control. It can occur within intimate relationships, in the public sphere, or as part of systemic and institutional discrimination. Women subjected to violence often fear for their safety and can even face severe physical injuries, with the psychological and emotional damage being just as profound. The trauma from such experiences can lead to long-lasting impacts on mental health, self-esteem, and overall quality of life and sense of safety. The ripple effects extend beyond the individual, reaching families and communities, contributing to a cycle of harm and inequality that lasts for generations.



Key Takeaways:

- Intimate Partner Violence (IPV) occurs between romantic partners who may or may not be living together in the same household. Intimate partner violence may also be referred to as Intimate Partner Domestic Violence (IPDV), and is the most common form of violence against women.
- The cycle of violence starts early. The number of Indiana high school girls who reported having experienced sexual violence in 2021 was 17.2%, which is an increase from 4.9% in 2015.
- When looking at Marion County, there were an estimated 10,105 victims of domestic violence (one percent of the population) in 2020, with 71% of the victims being women.
- Due to systemic racism, policies, and societal structures, Black men and women experience domestic violence at a higher rate than their White counterparts.
- In Central Indiana, many service providers responded to Covid-19 by moving programs - including advocacy - to online platforms. This shift proved to be problematic for many as virtual platforms often present safety risks for those experiencing domestic violence. The need for privacy and safety is one reason why offering virtual services was not common before the pandemic.

- Statistics show that eight out of ten incidents of sexual assault are committed by someone known to the victim, and in Indiana, one in five women have been sexually assaulted while only one in 38 men have been sexually assaulted.

- 63% of sexual assault cases in Indiana go unreported to the police.

Violence Starts Early

Violence against women often begins long before adulthood. Childhood experiences and environments are crucial in shaping future behavior patterns for both victims and perpetrators. According to Mueller and Tronick, both positive and negative experiences alike affect the socio-economic and cognitive development of a child. Exposure to violence over the first five years of life could have lasting effects on brain development and behavior later in life.[1]

While negative experiences affect all children, girls in Indiana have historically reported experiencing higher levels of sexual and physical violence compared to boys. According to the Youth Risk Behavior Survey (YRBS), The number of Indiana high school girls who reported having experienced sexual violence in 2021 was 17.2%, which is an increase from 4.9% in 2015.[2] [3] But dating violence is not limited to physical or sexual acts, and there have been historically higher rates of non-physical violence among girls as well. 37.2% of high school girls in Indiana reported that someone they were dating purposely tried to control them physically or emotionally. The emotional and physical trauma girls face from these experiences create large barriers, and increase the chances of developing depression, antisocial behavior, suicidal ideation, and illicit drug use that can last long into adulthood, where the cycle often continues.[4]

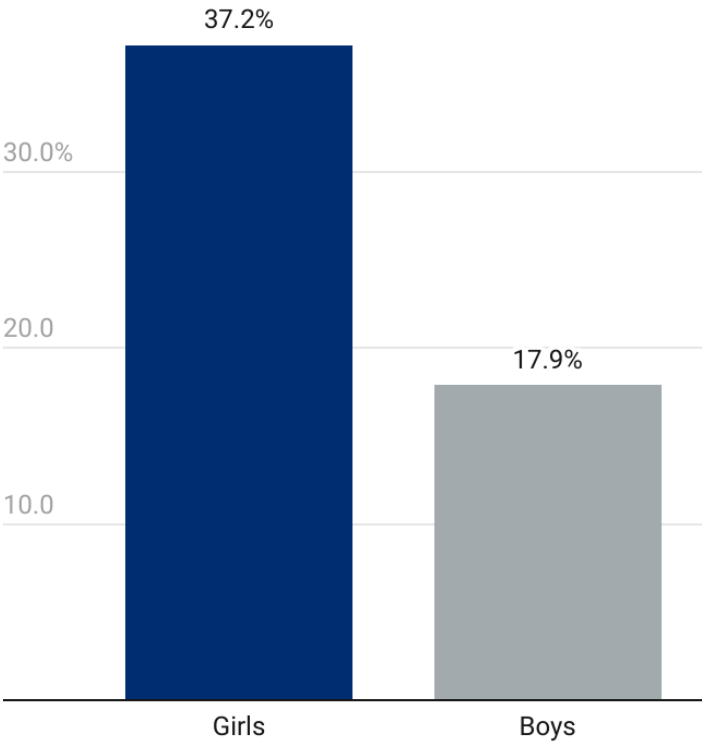
A study of dating violence found that survivors had an increased likelihood of experiencing intimate-partner violence later in life.[5] Putting an end to these behaviors at a young age can help break the cycle of abuse early. Schools have the opportunity to play a vital role for children experiencing violence through early intervention and education programs that teach conflict resolution, healthy relationships, and counseling.

Intimate Partner Violence and Domestic Violence in Central Indiana

Domestic Violence (DV) and Intimate Partner Violence (IPV) are often used interchangeably. While they are similar, there are key differences. According

More than one in three **high schoolgirls** have experienced emotional abuse

Percentage of High School Students Who Reported Someone They Were Dating Purposely Tried to Control Them or Emotionally Hurt Them



Source: Indiana Department of Health, 2023 Indiana Girl Report, Graphic by the Polis Center
Indiana (Statewide)

to the Young Women's Christian Association (YWCA), domestic violence takes place within a household and can be between any two people within that household. Domestic violence can occur between a parent and child, siblings, friends, or even roommates. On the other hand, IPV can only occur between romantic partners who may or may not be living together in the same household.[6] Intimate Partner Violence may also be referred to as Intimate Partner Domestic Violence (IPDV).[7] IPV is the most common form of violence against women.[8]

In both DV and IPV, violence is used by one person to gain or maintain power over another person. This can include sexual, emotional, economic, psychological, or technological actions or threats.[9] It also includes patterns of coercive behavior that influence another person within an intimate partner relationship. Examples of abusive behaviors can include physical, sexual, emotional, economic, psychological, or technological abuse.[10]

In Indiana, 42.5% of women and 27.9% of men experience violence, sexual violence, or stalking from an intimate partner in their lifetimes.[11] These numbers are even higher for Black men and women. In 2020, 47% percent of domestic violence victims were Black. Comparatively, 27% of the population was Black at that time. When looking at Marion County, there were an estimated 10,105 victims of domestic violence (one percent of the population) in 2020, with 71% of the victims being women.[12] Data on domestic violence is not publicly available for other counties in Central Indiana. Terry Lee, a public health leader, noted the disproportionate impact of domestic violence on Black communities: "I think about domestic issues in predominantly Black areas. This issue is severely underreported for both DV, SA, and police brutality."

Many women in Central Indiana (and nationwide) feel they are unable to report domestic abuse to either the police or domestic shelters.[13] This could stem from many factors, including fear of aggressor retaliation or consequences, religious constraints, or fear of harm to their children. Women who stay in abusive relationships may not have the means or resources necessary to leave the relationship.[14]

In 2020, 27% of Indianapolis's population was Black. Despite this, nearly 47% of domestic violence victims in Indianapolis in 2020 were Black.

Violence and Poverty

Poverty disproportionately affects women and single mothers, but what is less recognized is how the intersection of poverty and domestic violence can intensify the impact of abuse. This overlap leads to 1) A heightened severity of the abuse, 2) Significant resource loss for survivors, and 3) Reduced chances of positive outcomes. Poverty traps survivors in abusive situations longer and extends their struggle to break free, keeping them in poverty and continuing the cycle. This intersection poses greater risks not only to survivors and their children but to our communities as a whole. The consequences are even more severe for women who are Black, Indigenous, and People of Color (BIPOC) and immigrants, as safety net systems often fail to address their specific needs. Programs like SafeHouse Center, an organization in Ann Arbor, see a disproportionate number of survivors from these underserved populations.[15]

The maps below compare areas in Marion County with high rates of poverty and a large number of domestic violence incidents. These statistics overlap significantly. On the Eastside, Northeast side, Near Westside, and the South Side, both poverty rates and domestic violence rates are above average. Similar domestic violence data is not available from the surrounding counties.

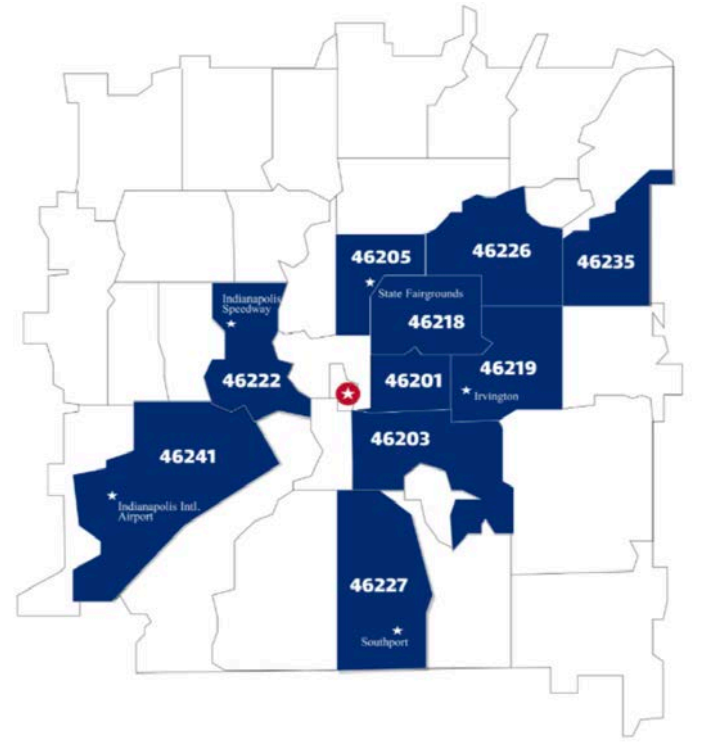
The Effects of COVID-19 and Domestic Violence

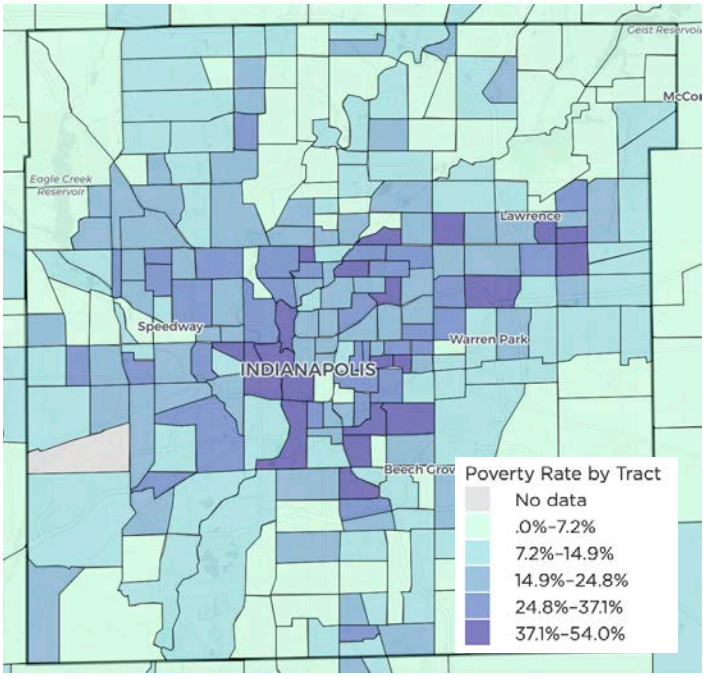
Women who face domestic and intimate partner violence have long struggled with challenges such as meeting basic needs and securing financial stability on their own. These difficulties were exacerbated during the COVID-19 pandemic, particularly with the shift to virtual interactions. In Central Indiana, many service providers responded by moving programs, including advocacy, to online platforms. However, this shift was problematic for many, as virtual platforms often present safety risks for those experiencing domestic violence. The need for safety is one reason why offering virtual services was not common practice before the pandemic.[16]

The pandemic exacerbated an already strained support network for domestic violence victims

High rates of **domestic violence** overlap with high rates of **poverty**

Ten ZIP codes with most requests for domestic violence police dispatches, compared to poverty rate by tract





Source: Indy Public Safety Foundation, American Community Survey; Graphics by the Polis Center

which can still be felt today. Sonya Ware-Meguiar from Girls Inc. in Johnson County noted that mental health was already a growing concern before COVID-19, but the pandemic has intensified the crisis in Central Indiana. These impacts heavily affect women suffering from domestic violence. According to the Indiana Coalition to End Sexual Assault & Human Trafficking, 81% of women in Indiana reported significant short-term or long-term impacts such as Post Traumatic Stress Disorder (PTSD) from violence.[17]

Different Perceptions of Violence in Central Indiana

In Central Indiana, perspectives towards DV and IPV can differ between urban, suburban, and rural communities. Furthermore, assistance can be influenced by various factors such as accessibility to resources and social dynamics. These differing perspectives can also affect how DV and IPV are reported and addressed in each county and highlights the strong need for proper training and tailored approaches to support women and domestic violence survivors.

The counties surrounding Marion have their own unique struggles when helping survivors. In interviews, leaders of domestic violence service organizations across Central Indiana noted similar barriers for DV survivors in suburban counties. Often women lack resources to leave a violent relationship. This includes lack of reliable transportation, childcare, income, and housing. According to Kelly McBride, Executive Director of the Domestic Violence Network, Central Indiana needs "more transitional housing for people who are leaving DV relationships or getting out of homelessness."

These leaders also witnessed an increase in mental health needs but a lack of available service providers. In some suburban or rural areas, it can be difficult to find a mental health provider that accepts Medicaid, and transportation can be difficult for some clients.

According to service providers, in addition to a lack of resources, women are scared to leave violent relationships because of fear of basic needs not

being met and becoming homeless, fear of not being accepted or loved somewhere else, and/or fear for their children.

The risk of leaving a violent relationship can be greater for immigrants and undocumented people, according to Sara H., Community Leader, "For women who are undocumented, they might get taken advantage of/abused, and they may be hesitant to report abuse or seek help due to the fear of deportation and a lack of understanding about their rights based on their immigration status."

Many of the organizations in Central Indiana working with DV and IPV survivors noted an increase in the number of women they are serving, saying the current volume of requests they are receiving is not sustainable. According to these leaders, with more young women becoming homeless after aging out of foster care, more immigrant families coming to Central Indiana, and higher cost of living, the number of women who need help is increasing. It is growing increasingly difficult for these organizations to meet the growing need.

> **"A lot of women go back when they lack understanding and it's a vicious cycle."**
>
> ***- Danyette Smith MHS,*** *Survivor, Director of Domestic Violence Prevention at Indy Public Safety Foundation, Indy Champions*

Sexual Assault Towards Women in Indiana

Sexual assault towards women in Central Indiana can feel like silent suffering often overshadowing the truth. According to the Rape, Abuse and Incest National Network (RAINN), sexual assault is defined as any unwelcome sexual advance, request for sexual behaviors, or any form of verbal or physical aggression of a sexual nature.

While sexual harassment casts a wider net, including any unwanted verbal or sexual attention, sexual assault specifically refers to acts where one

Data Source: ICESAHT, Graphic by the Polis Center

person engages in sexual activity against another's will. Within this, rape stands out as a particularly devastating form of assault, yet it is only one of many forms of violation.[15] Statistics show that eight out of 10 incidents of sexual assault are committed by someone known to the victim, and in Indiana, one in five women have been sexually assaulted while one in 38 men have been sexually assaulted.[18]

Because victims often know their perpetrators, 63% of sexual assault cases in Indiana go unreported to the police.[19] Sexual assault victims, like IPV victims, may fear retaliation or consequences if they come forward. Victims may also fear being de-humanized or judged by friends, family, or the community. Women who are immigrants can also fear deportation, which further discourages reporting. Additionally, some victims may believe their experience is not "serious enough" or may not want to involve family and friends.[20]

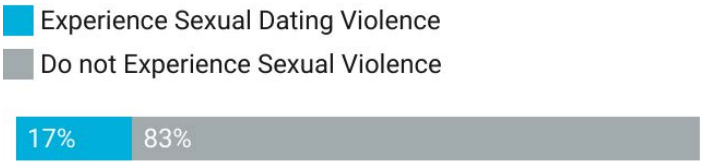
Of those women who felt comfortable enough to report their abuse to the police in Central Indiana, many did not include the relationship to their abuser. This could have been for many reasons, including fear of retaliation. Of all the data reported from Central Indiana to the National Incident-Based Reporting System (NIBRS), 52% of reports did not record the relationship type between the victim and the perpetrator. The reports include assault, forcible and non-forcible sexual assault, and kidnapping. Of the reports that did record the relationship, The most common was an acquaintance, friend, or current/former partner. The least common relationship reported was a former or current employee (one percent).

Violence towards LGBTQ+ Community, Women with Disabilities and Immigrants

Immigrant women, women who are Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex (LGBTQ+), and women with disabilities (including intellectual, psychiatric, and or multiple disabilities) experience higher rates of abuse.[21] In Indiana, nearly half of LGBTQ+ citizens have been sexually assaulted or experienced sexual violence, and people with disabilities are three times more likely to be sexually assaulted than

17 Percent of **high school girls** reported having **experienced sexual dating violence** in 2021

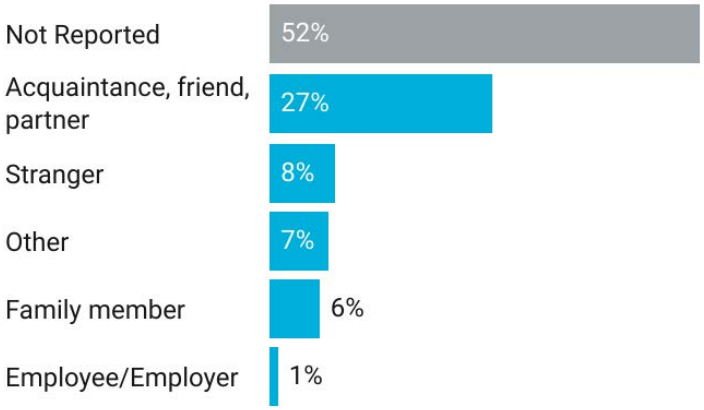
Percent of High School Girls Who Did or Did Not Experience Sexual Violence



Source: 2023 Indiana Girl Report, Graphic by the Polis Center
Indiana (Statewide)

Most abusers are closely related to their victims as **acquaintances, friends, partners or family members**

Relationship between women and their abusers, percent of cases reported to police between 2019-2022



Source: NIBRS, Graphic by the Polis Center
Central Indiana 8-County Area

people without disabilities.[22] This could be because of language barriers, dependence on caregivers or partners, or lack of protection. In Indiana, 4.5% of adults who are 18 and over identify as LGBTQ+; that share is growing. Despite this, very few laws and policies are in place to protect the LGBTQ+ community. Protections vary from county to county and city to city, resulting in some areas of Central Indiana with much lower protections based on sexual orientation or gender identity. According to the Movement Advancement Project, only 33% of the state population has "full protections" against discrimination based on gender identity in private employment, housing, and public accommodations.[23]

Gun Violence in Indiana

Nationally, homicides increased substantially during the pandemic, and Indiana followed this trend. According to the CDC, there were 466 deaths by homicide in Indiana in 2019 and 620 in 2020, an increase of 33%.[24] Since then, the number has fallen, with 553 homicides statewide in 2022 (the latest data available from the CDC).[25] In Indianapolis, the homicide rate followed a similar pattern. In 2019, there were 1.49 homicides per 100,000 people per month in Indianapolis. That grew to 2.41 in 2020 but has fallen to 1.79 per month in 2024 (as of November 2024).[26]

While most homicide victims in Indiana are men, the impact on women remains concerning. In 2024, out of 103 homicide victims in Indianapolis, 12 were women, with 10 of those murders involving firearms. The previous year saw a slightly higher rate for female victims, with 34 out of 203 total homicides. Again, nearly all of these incidents were gun related.[27]

Compounding the issue, Indiana law prohibits domestic violence misdemeanants from possessing firearms, but this restriction does not extend to dating partners. Courts do have the authority to restrict firearm access for individuals under final protective orders, including those involving dating partners, but they are not mandated to do so.[28] This creates gaps in safety that leave many women vulnerable in dangerous situations.

Nearly 50% of LGBTQ+ Hoosiers have been sexually assaulted.

People with disabilities are 3x more likely to be sexally assaulted than people without disabilities.

Barriers & Biases

Domestic violence can impact every aspect of a victim's life. We want to highlight one of the many aspects that is affected by domestic violence, housing. Danyette Smith, MHS, Survivor, from the Indianapolis Public Safety Foundation says, "Housing is a big issue, it's very hard to flee a domestic violence situation without housing. It's a part of your wellbeing. Little has been done to help this from a domestic violence perspective." It is clear that more work is needed to address housing barriers for victims of domestic violence. Learn more in the Housing Chapter.

Courts have the authority to restrict firearm access for individuals under final protective orders, but they are not mandated to do so.

Conclusion

Understanding and addressing violence against women requires empathy, support, and systemic change. It's important to create environments where victims feel safe to seek help and where resources and legal protections are in place to support recovery and empowerment to rebuild their lives safely.

The ripple effects extend beyond women, reaching families and communities and creating cycles of harm and inequality that last for generations. Education plays a crucial role in this effort to stop violence, as it helps raise awareness and empowers women to recognize and address violence happening to themselves and others. In Central Indiana, numerous non-profit and grassroot organizations are working tirelessly to make a difference for women, offering support, resources, and advocacy to those affected from all types of violence. These organizations are essential in creating safer communities and fostering a culture where domestic violence is not tolerated.

Strength & Abundance

Beacon of Hope Crisis Center is an organization empowering victims of domestic violence and sexual assault to become self-sufficient by providing safety, education and support. They were a 2023 Women's Fund Grant recipient for emergency financial assistance for the basic needs of survivors of domestic violence. We want to highlight their work because, as we see in this report, domestic violence affects all other aspects of a person's life. Beacon of Hope is one of many organizations working to support victims of domestic violence and sexual assault.

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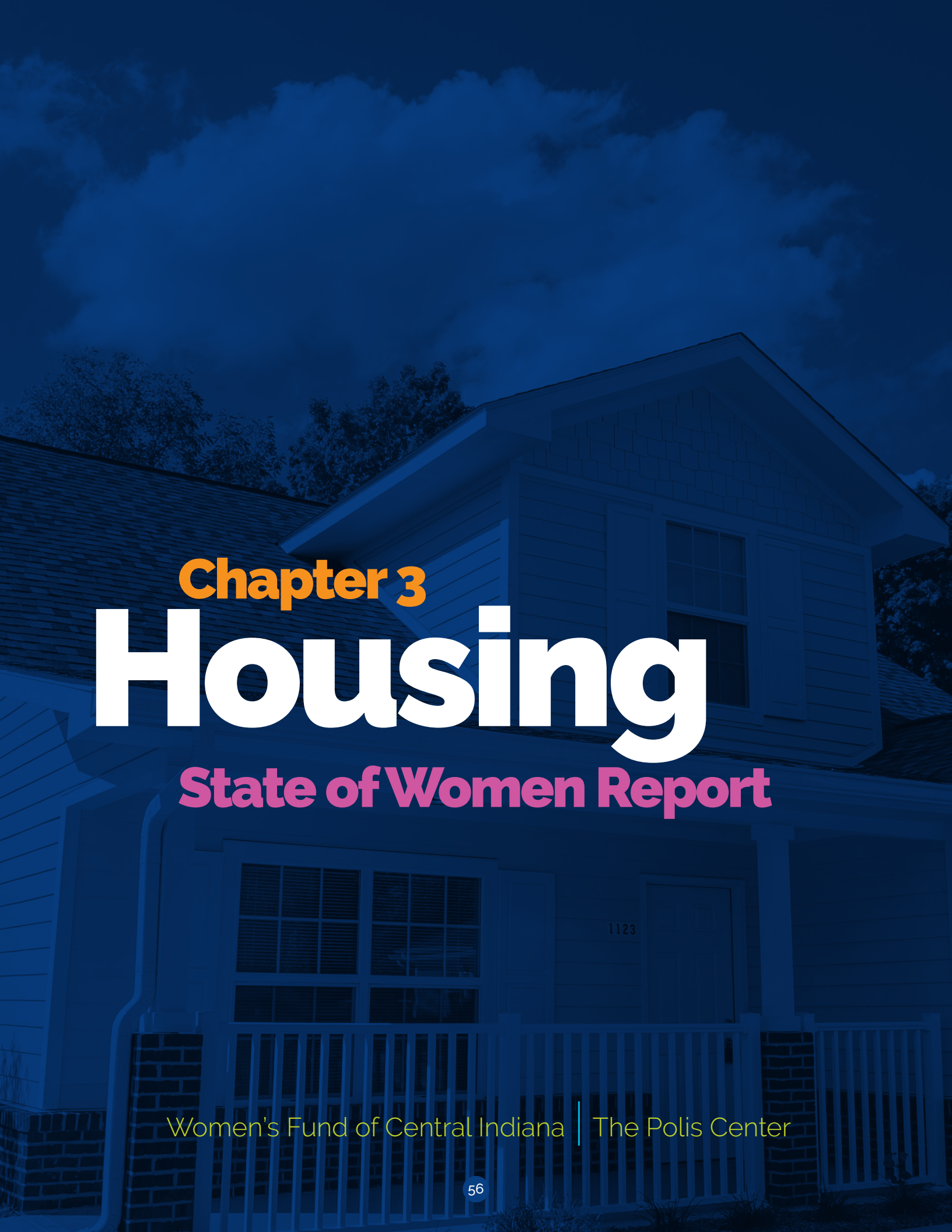


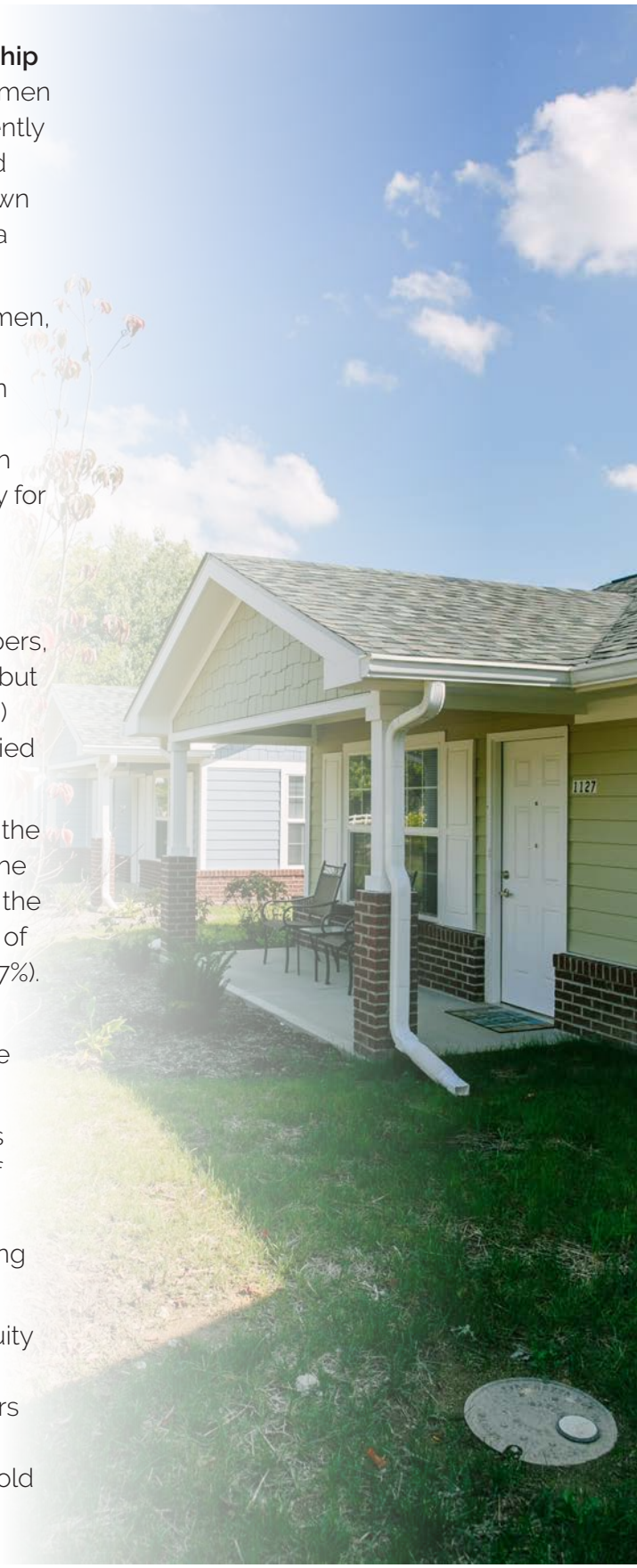
Chapter 3
Housing
State of Women Report

Women's Fund of Central Indiana | The Polis Center

Housing

Women face the same housing challenges as the overall population, with housing costs increasing and homeownership become more challenging for first-time buyers. And yet, women are often in a unique position related to housing. It is only recently that property ownership was possible for women in the United States. A married woman could not own property under her own name until the mid-19th century, and a woman could not get a home loan without a male co-signer until 1974.[1]

Now, homeownership rates are similar between men and women, but women do face particular challenges to homeownership and affordable housing in general: They earn less than men on average (even with the same education and occupation—see the Financial Stability chapter), and often lead households with children as the sole income earner, leaving less income to pay for housing.



Key Takeaways:

- Since homes are often owned jointly by household members, it is difficult to establish a gender gap in homeownership, but single mothers do have a lower homeownership rate (51%) than single fathers (57%) and a much lower rate than married couples (86%).
- Homeownership rates are lower in Central Indiana than in the state overall but higher than the U.S. For single mothers, the region's rate of 51% falls between the U.S. rate of 50% and the Indiana rate of 53%. For married couples, the regional rate of 86% is higher than the U.S. (82%) but lower than Indiana (87%).
- 54% of Central Indiana renters are women. This exposes women to more risk when rent prices increase. Rents have increased 35% in five years in the Indianapolis metro area.
- According to estimates from Eviction Lab, 61% of evictions in Marion County are filed against women, but only 52% of Marion County renters are women.
- Single mothers who rent pay 48% of their income in housing costs, more than any other household type.
- Home prices have increased 60% since 2019, building equity for women who are homeowners but making it harder for first-time homebuyers to purchase a home. Single mothers who are homeowners pay 29% of their income toward housing, on average—again, more than any other household type.

Home Ownership

Home ownership is rarely analyzed in terms of gender. According to University of Michigan's Sherrie Kossoudji, "Studies of home ownership include gender through a variable that denotes a female headed household, gender, or marital status as a control variable but not as a point of discussion."[2] It can be difficult to measure homeownership by gender, because most studies of homeownership are focused on households, not individuals.

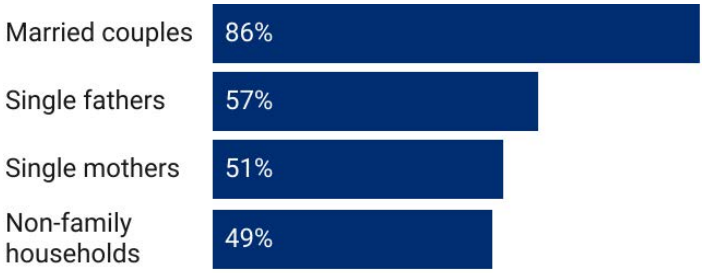
In a survey of 23,000 households, Kossoudji finds that "the most important aspect of the homeownership gap across gender and family type exists for family type itself".[3] This plays out locally, too, according to census data: In Central Indiana (11-county configuration of Boone, Hamilton, Madison, Putnam, Hendricks, Marion, Hancock, Morgan, Johnson, Shelby and Brown counties) 86% of married couples own their home, but only 51% of single-mother households and 57% of single-father households own their home.[4]

Having two incomes makes it more feasible for a household to save for a down payment and, thus, more likely that a household could obtain a mortgage. But because there are more single-mother households than single-father households —there are 169,600 single-father households and 242,600 single-mother households—this difference by household type creates two major differences by gender.

First, more homeowner households include a woman than include a man. There are an estimated 454,700 households in the 11-county metropolitan area that own their home and are either married couples or single-mother households. There are only 415,900 homeowner households that are either married couples or headed by a man. Though most married couples include a man and a woman, same-sex couples do not fit this assumption. Due to limitations in how American Community Survey data is published, we cannot identify homeownership rates same-sex couples compared to other couples. Generally, housing data for LGBTQ+ women is lacking and more is needed.

86% of **married couples** own their home, but only **51%** of **single-mothers** own their home

Homeownership by household type



Source: 2022 ACS 1-Year Averages; Graphic by the Polis Center

Central Indiana 11-county metropolitan statistical area

Second, a slightly higher percentage of households that include men own homes than households that include women. 75% of married couples or male-headed households are homeowners, but when combining married couples and single-mother households, only 72% own a home.

Women own homes at a similar rate to men, but one study finds that their financial returns are lower than for men. A Yale study found that single men earned an estimated 7.9% higher rate of return than single women from home sales. This difference accumulated over the years to account for 30% of the gender gap in household wealth at retirement for single people.[5] Household wealth was analyzed for single individuals in order to analyze by gender but, of course, most households are not single at the point of retirement and share at least some finances. They calculate that 45% of this gender gap in housing returns is attributable to market timing.

This indicates that, similar to issues in the Financial Stability Chapter, women often face worse financial outcomes not only because of direct bias, but also because they are likely expected to bear the responsibilities of family and caretaking and cannot always prioritize strictly financial or career advantages. For example, moving to change school districts or live closer to a parent who needs caregiving could be disadvantageous with respect to market timing, but is deemed worth the financial cost in order to meet these other priorities.

Single men earned a 7.9% higher rate of return than single women from home sales. This difference accumulated over the years to account for 30% of the gender gap in household wealth at retirement for single people.

Renters

A majority of renters in Central Indiana are women. In Central Indiana, 54% of adults who live in rental homes are women. This is because unmarried households are much more likely to rent, and single mothers make up a large portion of unmarried households.

The impacts of this are that women are more exposed to increasing rental costs. When housing costs rise, people who are already homeowners are less likely to be affected. Their mortgage payments may be calculated on a fixed interest rate, while their income is likely to gradually rise. But for renters, every increase in housing costs can be reflected in the new lease they sign each year. Their

housing costs can continue to rise faster than their income.

When women make up the majority of renters, that means they are also more exposed to evictions. Indiana has landlord-friendly laws that attract a lot of investors in multi-family housing, and these investors evict at a higher rate than small-time owners of single-family rentals.[6] This helps to explain why Indianapolis has the fifth-highest eviction rate in the nation as of July 2024.[7] Women are the target of most of these evictions.

According to Eviction Lab, 61% of evictions in Marion County are filed against women, but only 52% of Marion County renters are women.[8] An eviction filing is when a tenant is notified that they need to pay back rent or appear in court with the possibility of an eviction judgement. An eviction judgement is when a judge determines that the tenant must vacate the unit.

Eviction filings do not include data about gender, but Eviction Lab's analysis used the names of defendants to predict their gender. While we only have estimated gender for evictions in Marion County, evictions also occur in surrounding counties. Most evictions in Central Indiana are filed in Marion County (82% of the 33,000 evictions filed in Central Indiana in 2023, according to The Polis Center and New America).[9] The filing rate was about 16% in Marion County in 2023, meaning 16 eviction filings for every 100 renter households. In Johnson County, the eviction filing rate was 11%. In the other six counties the rate fell between five and eight percent.

Eviction filings are concentrated in neighborhoods with large apartment complexes, often located near I-465. For example, there are two census tracts near Eagle Creek (located in Marion County) with more than 400 eviction filings from July 2023 to June 2024, representing more than one filing for every four renter households. Similarly, on the Far Eastside (also located in Marion County), a tract north of Warren Central High School, also has over 400 evictions, one for every four rental households.

Though many low-income renters live in the core of Indianapolis, evictions are not as common there. Though the highest rate was in the Holy Cross/

Barriers & Biases

According to The Eviction Lab, "across the 1,195 counties in our sample, we predicted that 341,756 women were evicted annually, approximately 16% more than 294,908 evicted men." If women are more likely to experience eviction, and we consider the additional familial and caregiving responsibilities they are tasked with, can we really expect women to thrive?

"Bias in the housing system at every level, homeownership loans to apartment applications, home appraisals, and biases about Black women [and] children [exist]. Structural racism impedes Black women's ability to access safe housing."

- Dr. Tucker Edmonds, *Professor of Obstetrics and Gynecology*

Cottage Home neighborhoods—where the eviction rate is 63%—most other neighborhoods on the Near Eastside had eviction filings rates closer to 10-15% of renter households. Single-family rentals and duplexes are common in these neighborhoods.

While eviction filings do not record race or ethnicity, Eviction Lab estimates that 39% of Indianapolis eviction filings are against Black residents,[10] even though Black residents only make up 28% of the population.[11] In large part, this is because Black residents have a much lower homeownership rate. They make up 41% of renters and are therefore at higher risk of eviction.

Housing Costs

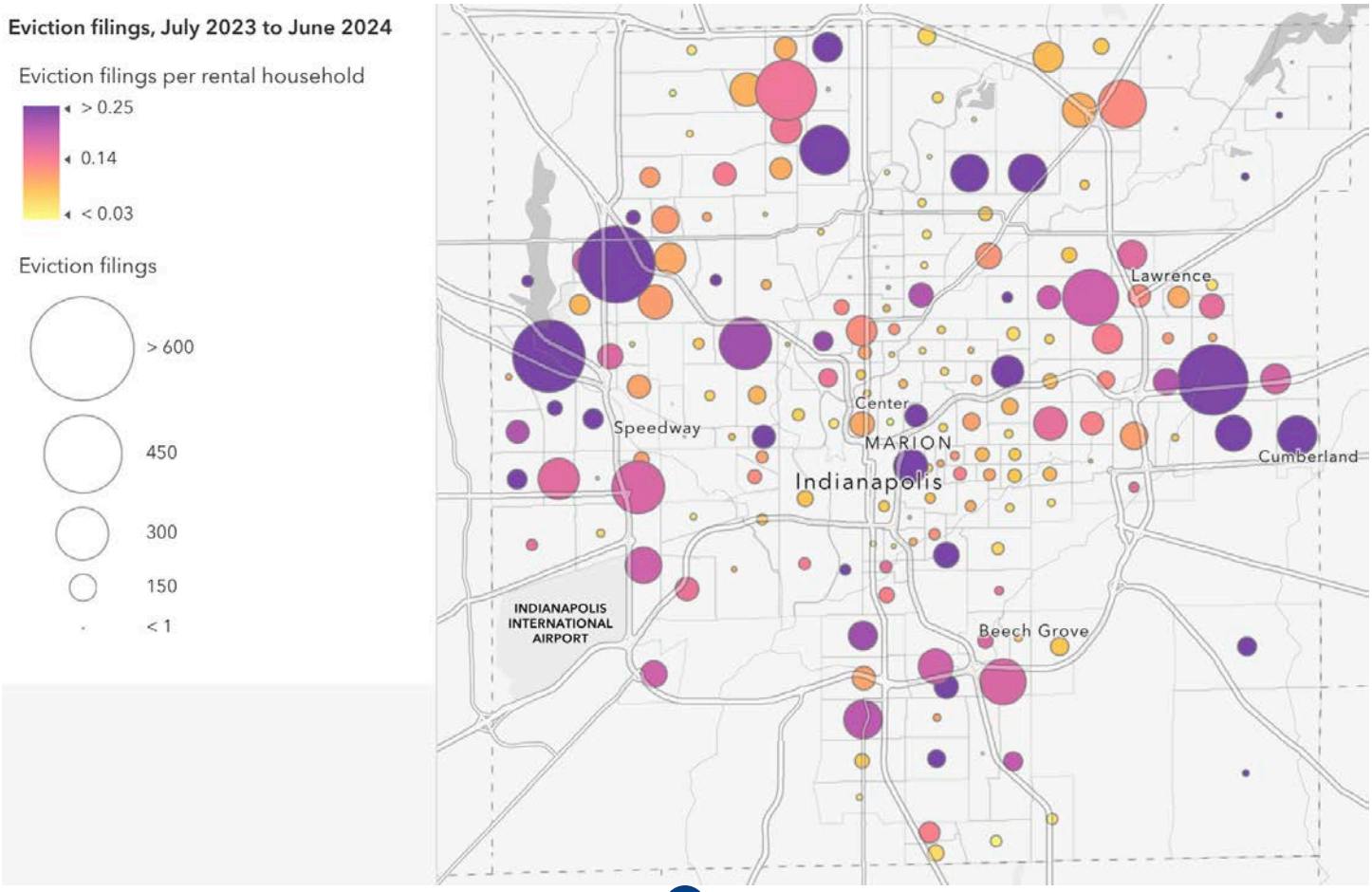
In Central Indiana women tend to pay an average monthly rent between $1,000 and $1,400. Owner

"Being a Black woman may mean you are more likely to have an eviction on your housing record in Indiana than other groups. The lack of homelessness prevention programs and financial support focusing on keeping families housed before an eviction is the heart of this issue. Housing is at the center of economic stability, health, and education for women and their families."

- Rhonda L. Bayless, *Executive Director, Centers of Wellness for Urban Women*

Eviction filings are most common where large apartment complexes are located near Interstate 465

Evictions by census tract, July 2023 to June 2024



Source: Eviction Lab, Graphic by the Polis Center

costs range more widely. The average monthly owner cost for women living alone is just above $1,000, but for married couples it is $1,513. Owning is not always more expensive than renting, and housing costs vary by household type: married households tend to pay more when they own than when they rent. Women who are not married but live with other people tend to pay more when they rent than when they own. Since a large majority of married households own their home, it is likely that those who could afford to buy already have, while those who rent are looking for a more affordable option.

Homeowners tend to have higher incomes than renters, so no matter the family or household type, renters pay a larger share of their income toward housing. On average, women who rent and who are not in a married couple are housing-cost burdened, meaning they pay more than 30% of their income toward housing. In families led by a single mother, women pay an average of 48% of their income toward rent. For homeowners, this falls to 29%.

Housing costs have been increasing quickly since the pandemic. Rental prices have increased 35% from January 2019 to March 2024 according to SAVI's analysis of data from Apartment List.[12] The average monthly rent for an apartment in the Indianapolis metro area went from $915 in 2019 to $1,233 in March of 2024. Data from the census reflects the same pattern: according to one-year American Community Survey estimates, rent increased from $717 in 2017 to $894 in 2022. While these amounts are lower, the pattern is the same: a steep 25% increase in rent.

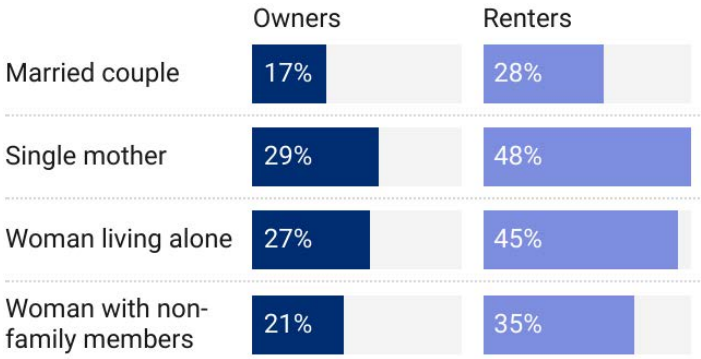
Homebuyers are facing a similar dilemma. According to the Indiana Association of Realtors, the median sale price in the Indianapolis Metropolitan Statistical Area (MSA) was $192,500 in 2019. It is $305,000 as of July 2024, an increase of 60%. For existing homeowners, that represents growing wealth. That is a powerful asset for many women. But for buyers looking to purchase their first home, this represents a significant barrier.

These cost increases have far-reaching impacts. According to focus group participants from across the nonprofit sector, organizations who offer rental

Housing costs for renters and owners by household type

Renters and single mothers are the most burdened by housing costs

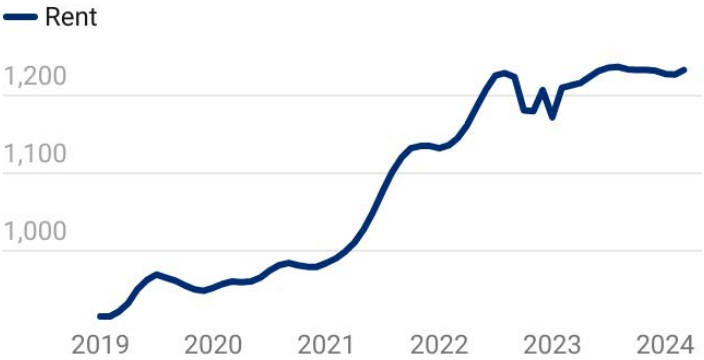
Share of income paid in housing costs for renters/ owners by household type



Source: 2022 ACS 1-Year Averages, Graphics by the Polis Center
Central Indiana 8-county region

Average Rent Prices Increasing in Indianapolis Metro

Monthly average rent, 2019-March 2024

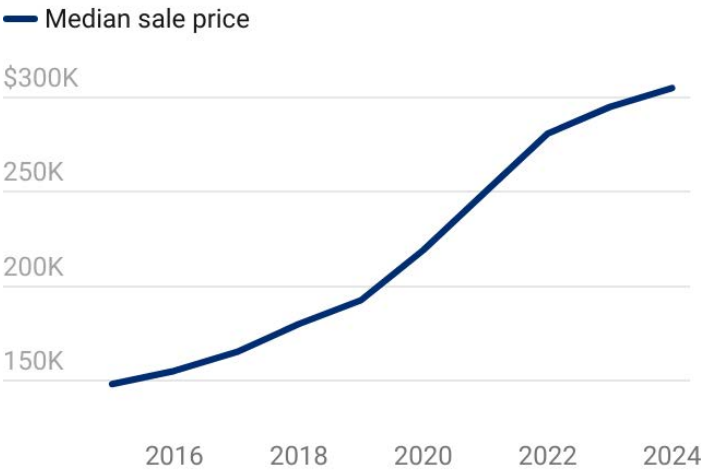


Source: Apartment List, Graphic by the Polis Center
Indianapolis Metropolitan Area

assistance are forced to help fewer households, as their funding does not stretch as far when rents are higher. Other participants described how higher housing costs can increase the risk of domestic violence, keeping women in dangerous relationships because high housing costs make it difficult to move out. Homeowners with fixed incomes or low incomes can be particularly impacted by rising sale prices, as their tax bill increases along with the value of their home. When their home's value increases, they have more household wealth, but increased tax payments can make monthly budgets tight. These cost increases are happening in an environment of overall inflation, where higher food costs and other expenses are all competing for dollars in the monthly budget.

Median sale price has increased 60% since 2019

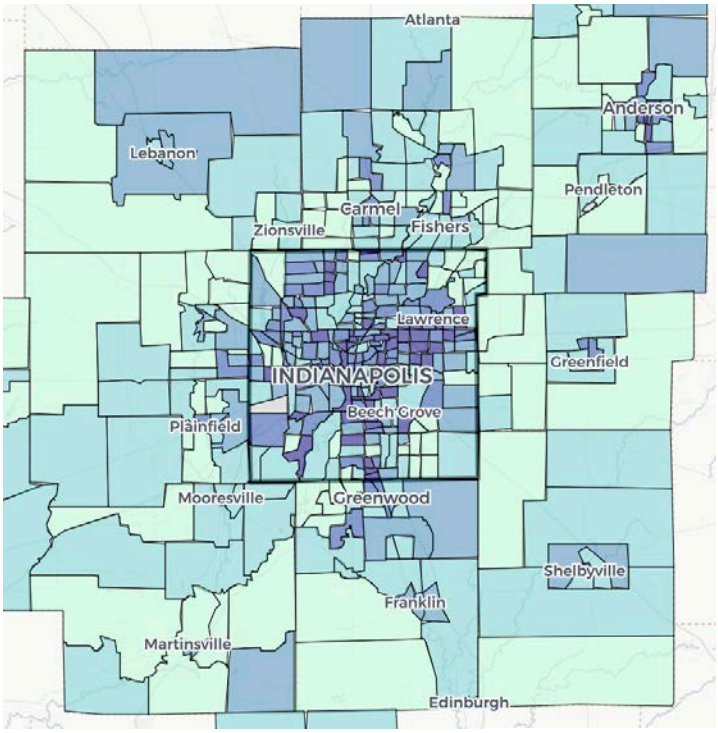
Annual median sale price



Source: Indiana Association of Realtors, Graphic by the Polis Center Indianapolis Metropolitan Area

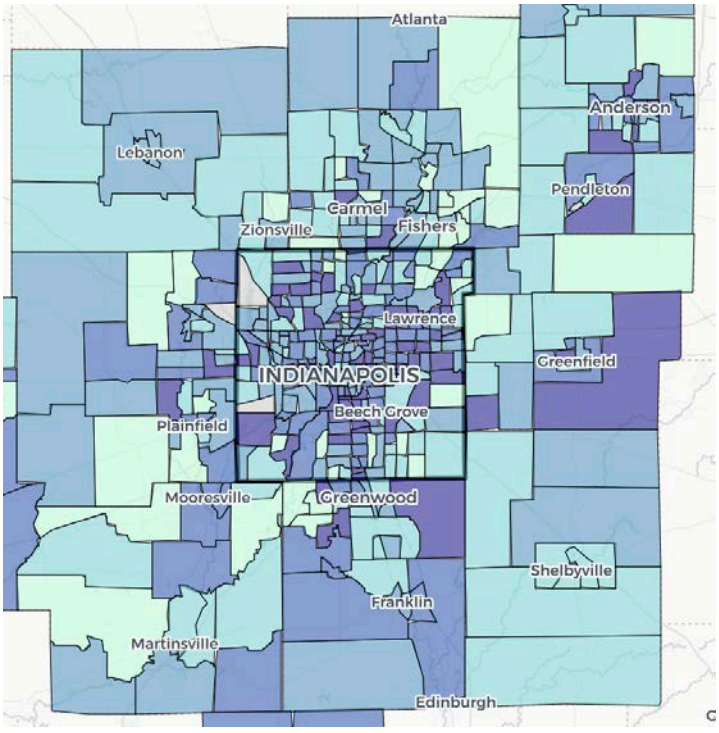
Housing cost burden by neighborhood

For all households



To **explore this map,** visit: https://go.iu.edu/8rxV

For renter households



Source: SAVI, ACS 2022 5-Year Estimates; Graphic by the Polis Center

There are many neighborhoods in the Indianapolis area where around half of the households are burdened by housing costs (paying more than 30% of their income) mostly on the northeast and south side. A few of these neighborhoods are in a ring around the county that follows I-465, where many large apartment complexes are constructed close to the highway.

In many Marion County neighborhoods, more than 60% of renters are burdened by housing costs. Many of these are concentrated on the south side, near Garfield Park but can also be found in the Far Eastside, Lawrence, and Lafayette Square.

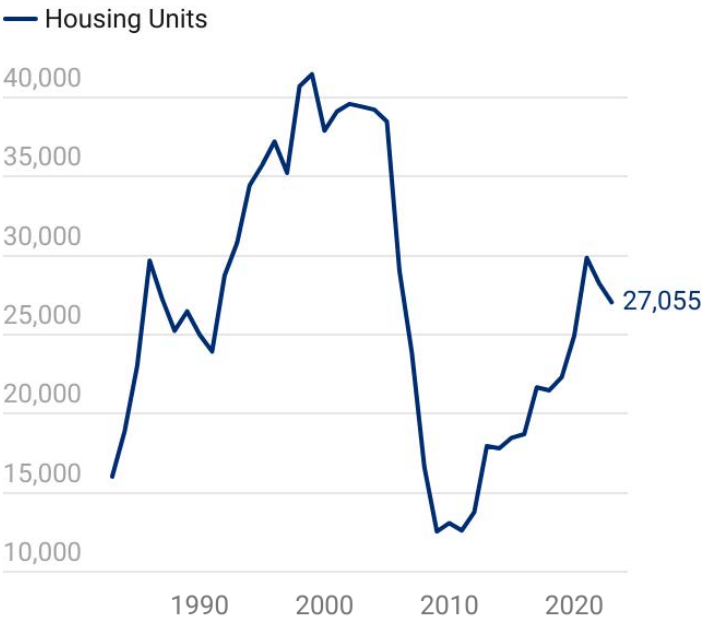
Housing supply is one cause of price increases

Restricted housing supply is understood to be one cause of higher housing prices. The Great Recession caused a precipitous drop in the number of housing units built each year in Indiana, according to the Building Permit Survey from the U.S. Census. From 2000 to 2005, about 39,000 units were built each year. That fell to 12,555 in 2012. Even as construction recovered, it has never reached that high point again. In 2023, 27,055 new housing units were built. That's the same level of construction activity as 1987, even though the state's population has grown by 1.4 million in those 36 years.

In an article in the Journal of Urban Economics, researchers found that when a city's housing supply is reduced by one standard deviation, this caused rents to rise five percent and home prices to rise 10%.[13] Land use regulations, like zoning that only permits single family homes or large lots, can lead to less supply and higher prices.[14] Infrastructure costs can also limit new development and increase home prices. Streets and sewers in new neighborhoods are typically paid for by a developer through a fee, and this is in turn paid for by the customer who purchases the home. In 2023, Indiana created an infrastructure assistance program and revolving loan fund to help cities and developers cover these costs, which should create more affordable housing supply.[15]

After recovering from Great Recession, housing construction only at 1987 levels

Building permits per year, Indiana 1983-2023



Source: U.S. Census Building Permit Survey; Graphic by the Polis Center

Indiana (Statewide)

Homelessness

High housing prices can contribute to increased homelessness. In Indianapolis, as of January 2024, 1,701 people were experiencing homelessness.[16] About one third (37%) of these individuals are women or girls. This is a five percent increase from 2023, but 12% lower than the pandemic peak of 2021. Interpreting changes in the annual Point-in-Time homelessness count can be fraught; increases could reflect a real increase in people experiencing homelessness, or they could reflect a more comprehensive surveying method. Higher counts can even reflect increased service provision. During the pandemic, more shelter beds were made available through federal funding. This led to higher shelter numbers. It is easier to count sheltered individuals compared to unsheltered, because they are in a known location. If previously unsheltered and uncounted individuals are in these new shelter beds, this will increase the homelessness count.

Last year, the number of unsheltered people was at the second-highest level since 2020. At 339 individuals, this makes up 20% of the total homeless population counted in 2024. Again, this number can increase due to policy changes (pandemic-era funding for increased shelter beds has ended) or from more comprehensive counting. The Coalition for Homelessness Intervention and Prevention (CHIP) called 2024 "the most comprehensive unsheltered count to date."[17]

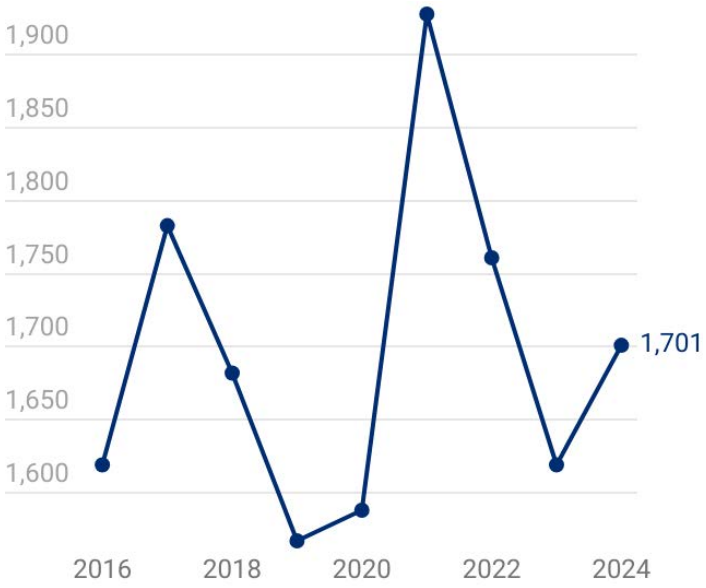
Despite the difficulty in attributing a cause to these fluctuations, the overall pattern is consistent: Each year, there are about 150-200 people experiencing homelessness for every 100,000 Marion County residents.

Opportunities to address homelessness

Indianapolis has a persistent number of people experiencing homelessness, but with investment and the right changes to policy, we can begin to reduce this number. In fact, Milwaukee provides an inspiring example of what is possible. From 2016 to 2021 the number of unsheltered individuals fell from 207 to only 17 due to coordinated efforts of philanthropic partners and state, local, and federal government.[18] According to Lillian Herbers-

Homelessness count increased from 2023 to 2024

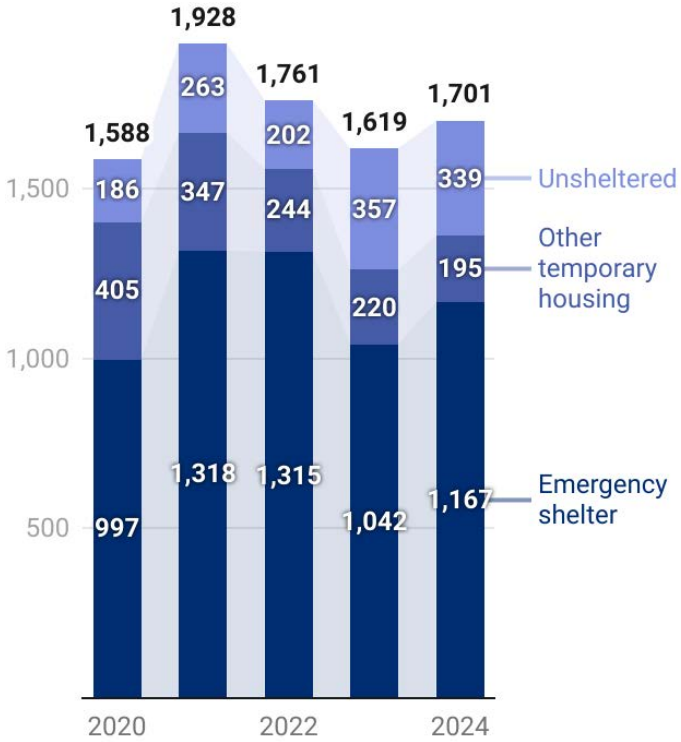
Point-in-time count of people experiencing homelessness, Indianapolis (Marion County)



Source: Coalition for Homelessness Intervention and Prevention; Graphic by the Polis Center

Unsheltered population highest in 2023 and 2024

Point-in-time count of people experiencing homelessness, Indianapolis (Marion County)



Source: Coalition for Homelessness Intervention and Prevention; Graphic by the Polis Center

Kelley, Director of Housing at Horizon House in Indianapolis, three principal efforts could have a substantial impact on the number of people who are homeless: prevention, improving the systems that house people, and expanding affordable housing.

Homelessness Prevention

The group of people who are counted as homeless each year is in constant flux. Some people are chronically homeless, but many enter and exit homelessness each year. When policies can reduce the number of people entering homelessness, the overall homelessness number will fall.

According to Ms. Herbers-Kelley, evictions are critical events that drive many families into homelessness, especially women with children. As noted above, Indianapolis has a high rate of evictions. Indiana is well known among investors as a landlord-friendly state, usually topping lists of landlord-friendly states published by websites that give real estate investment advice, like PropertyClub,[19] RealWealth,[20] and FortuneBuilders.[21] Investment influencers on social media often cite the state's landlord-friendly laws on YouTube with videos like "5 Most Landlord-Friendly States"[22] or "Top states for rental property in 2023"[23] which claims, "The GOAT is Indiana because of its low taxes, it's super landlord-friendly laws, and tons of cheap rental properties." While this perception brings multi-family investment, lax eviction laws put families at increased risk of homelessness. An effort which would have provided more tenant rights failed in the state legislature in 2022. One of the proposed provisions would have allowed tenants to withhold rent if their landlord would not make necessary repairs. Indiana is one of only five states that lack this protection.[24]

Evictions are critical events that can drive a family into homeless. Indiana is known as a landlord friendly state in part due to lax evictions laws.

Improving Voucher Systems

Many people experiencing homelessness in Indianapolis are housed through a voucher program, where a resident is placed in a private rental unit and all or most of the rent is paid through a federally funded Housing Choice Voucher. In Indianapolis the system is administered by the Indianapolis Housing Agency. Broadly, the process of housing a person experiencing homelessness in Indianapolis is as

follows: 1) Acquire a voucher, 2) Find a landlord who will accept it, and 3) Inspect the unit to ensure it meets safety standards. Each step presents obstacles to housing people.

Acquiring a voucher can take years. Residents are added to a waitlist. The Indianapolis Housing Agency (IHA) says it can take anywhere from six months to four years to make it through this waitlist.[25]

Finding a landlord who accepts the voucher is another challenge, because many landlords do not take residents who are paying with a Housing Choice voucher. In 16 states, renters are protected from discrimination based on the source of their payment, but not in Indiana. In fact, Indiana law prevents local municipalities from implementing these protections.[26] Criminal backgrounds, not uncommon among people who have been chronically homeless, can also prevent a landlord from accepting a tenant.

Finally, once these steps are completed, Indianapolis Housing Agency must inspect units to ensure they meet safety and quality standards before the resident can sign a lease. This requirement is in place to protect residents, but its implementation often prevents people from being housed. In April the agency was taken over by the U.S. Department of Housing and Urban Development (HUD) in a "cooperative endeavor agreement". HUD Principal Deputy Assistant Secretary Richard Monocchio told WFYI Public Media in April 2024 that 1,500 vouchers were going unused due to mismanagement.[27] The agency can often take months to inspect a unit. During this time, the resident is still unhoused, and the landlord is earning no revenue. Landlords, of course, can only hold a unit for a limited time without revenue, so they often revoke the agreement to accept the voucher. A resident must then restart the search for a willing landlord.

Milwaukee's example illustrates how things could be done differently. There, the City directly oversees the public housing agency, offering more oversight and more democratic input on the organization's performance. The City also engages landlords in

Acquiring a housing voucher can take years, and then finding a landlord who accepts the voucher is another challenge. In 16 states, renters are protected from discrimination based on the source of their payment, but not in Indiana.

master leases. Under this system, the City leases a pool of many units from landlords—which guarantees their rent—and then subleases these units to individuals. This means the City can hold units for inspection without the risk of the landlord backing out. It also means they can agree to house someone quickly and on a provisional basis while they move forward with inspection and other requirements. Indianapolis launched a master leasing pilot project based on the Milwaukee model in March 2024 and is expanding the program in 2025.

Building Affordable Housing

Housing supply is an issue facing all price points, but particularly units affordable to people with very low incomes. Most affordable housing in Indianapolis is built using Low-Income Housing Tax Credits (LIHTC). These units are set aside for people at certain income thresholds, like 80%, 50%, or 30% of the local median income. In 2023, there were 9,362 units in Marion County funded through these tax credits.

Projects can use both LIHTC and Housing Choice vouchers. In this case, units are set aside for low-income individuals, rents are set at affordable levels, and then vouchers are used to pay for a portion of the rent. Two new projects employ this structure in Indianapolis: Hannah Commons (opened in 2023) and Compass (opened in 2024).

To build such a project requires millions in funding and years of coordinated effort. To increase their likelihood of funding, partners typically develop these projects through workshops provided by the Corporation for Supportive Housing and supported by the Indiana Housing and Community Development Authority.[28]

Projects like these help house individuals who were homeless, but also help prevent homelessness by offering more affordable housing options. Even these recent projects only represent a few dozen new units each year. With hundreds of people living on the street and over a thousand in shelters, the scale of this program must expand to meet the existing need.

Strength & Abundance

Overdose Lifeline is an organization dedicated to carrying the message of hope to individuals, families, and communities affected by the disease of addiction. They were a 2023 Women's Fund Grant recipient for Recovery Housing for Pregnant/Parenting Women. This is one of many organizations helping to support those affected by addiction. We want to highlight their work for pregnant and parenting women for this report, because we know that women have unique experiences and deserve solutions tailored to them.

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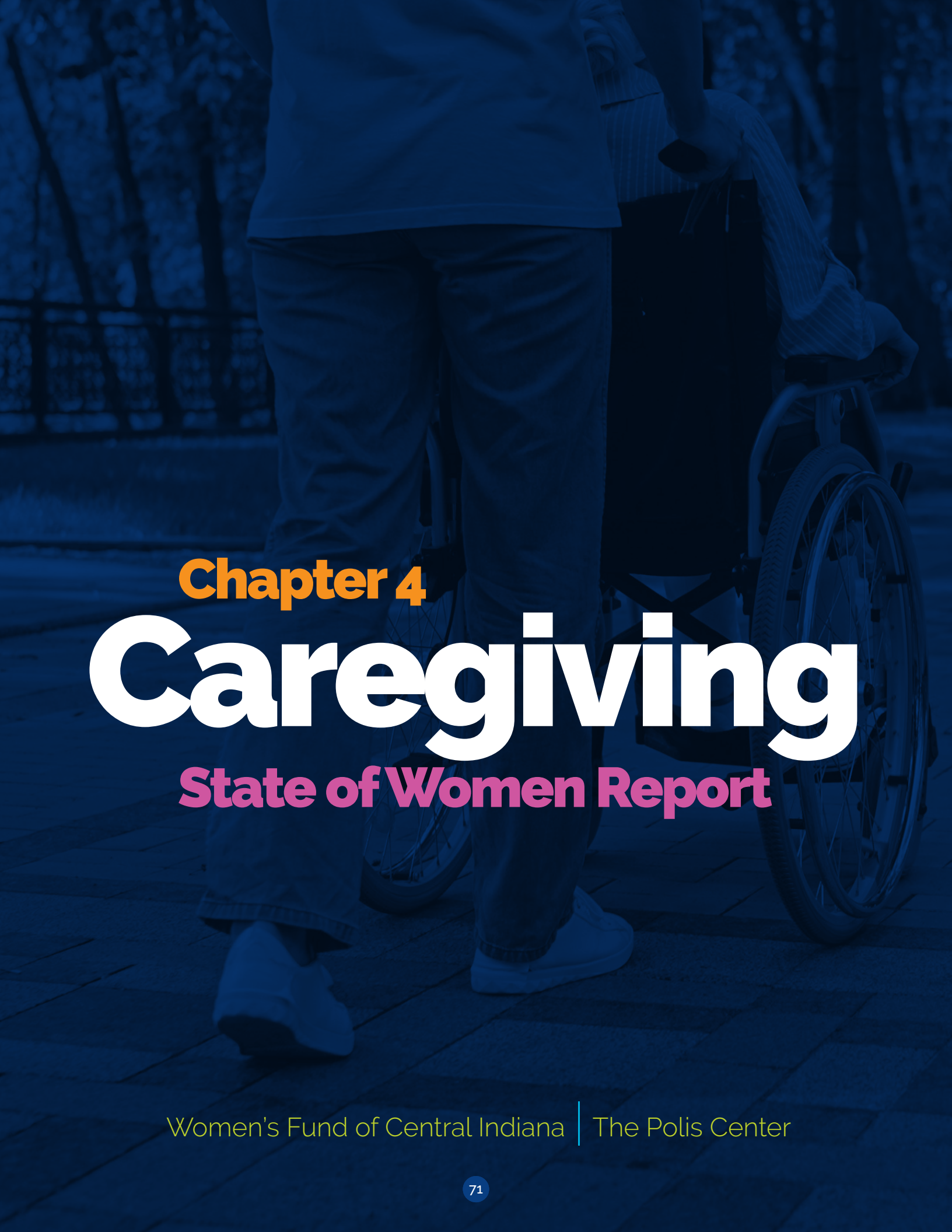


Chapter 4
Caregiving
State of Women Report

Women's Fund of Central Indiana | The Polis Center

Caregiving

Caregiving is an immense role encompassing a wide range of activities needed to assist individuals who cannot fully care for themselves due to age, illness, or disability. This role may include personal care tasks such as bathing, dressing, feeding, managing medical care and appointments, coordinating with healthcare providers, or handling financial and legal matters. Caregiving responsibilities can be short-term, such as assisting someone recovering from surgery, or long-term, such as caring for an individual with a chronic illness or dementia.

Key Takeaways:

- In Indiana, nearly one in four women (24%) and roughly one in five men (18%) reported providing care to someone with health issues.
- In Indiana, while Black women make up 26% of caregivers who are women, a disproportionate 31% of these women are providing care for more than 40 hours per week, highlighting a significant racial disparity in caregiving burdens.
- Nearly half of care recipients under caregivers who are women need help with personal care; 80% require assistance with household tasks.
- The sandwich generation (45 to 64 years old) constitutes the highest percentage of caregivers who are women in Indiana. This generation has young-adult children that still depend on them to some degree, but also have aging parents to care for.
- Childcare needs in Central Indiana far exceed available licensed spots. In Marion County there are only enough spots to meet 84% of demand, while Hendricks County can only meet 46% of demand.
- 60% of family caregivers in Indiana experience stress, and 40% report anxiety or depression.
- Over 30% of caregivers feel socially isolated or lack sufficient support from family and friends.

Caregiving: An Essential Role for Women in Central Indiana

Caregiving is a critical social and economic function, with women bearing the majority of this responsibility in Indiana and Central Indiana, mirroring national trends. The Family Caregiver Alliance reports that approximately 60% of caregivers in the United States are women. These women display extraordinary resilience as they balance caregiving duties alongside their professional and personal lives. In Indiana, Black women make up 26.1% of caregivers who are women, with 31.1% of them providing care for more than 40 hours per week. In contrast, 20.2% of White caregivers who are women provide care at this intensity, highlighting a significant racial disparity in caregiving responsibilities.[1] Nearly half of the care recipients under these women's care require assistance with personal care, while 80% need help managing household tasks.[2]

The caregiving journey varies significantly with age, presenting unique challenges at each life stage. For women under 35, the struggle often lies in balancing the onset of their careers with the demands of raising young children. Middle-aged women, those in their mid-30s to mid-50s, are frequently stretched thin, shouldering the responsibility of nurturing their children while also tending to the needs of their aging parents. Middle to older women (45 and older) face the enduring task of long-term caregiving, often intensified by a need for more substantial financial resources.[3]

According to Behavioral Risk Factor Surveillance System (BRFSS) survey responses, nearly 70% of the women caregivers are between the ages of 35-64 and they constitute 40% of the total caregiver population. While women over 65 years constitute 21% of the total caregiver population.[4] Nearly one-third of these caregivers are caring for a parent, and about one in eight is caring for someone with dementia. These figures vividly depict the considerable weight on middle-aged and older women, who often manage complex caregiving roles while also trying to maintain their personal and professional commitments. The statistics are a

One-in-four women are caring for people with a health problem or disability

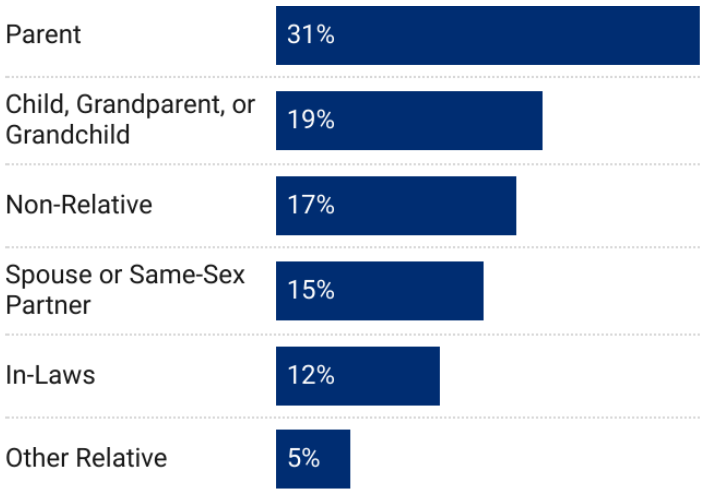
Percent who cared for a friend or family member with a health problem or disability

Source: BRFSS 2021; Graphic by the Polis Center

Indiana (Statewide)

Most of this care is for family members, but one-in-six are caring for someone outside the family

Percent of caregiving women who are caring for each type of relationship



Source: Behavioral Risk Factor Surveillance System. Indiana 2021 Adult LandLine Cellphone Module Variables Report; Graphic by the Polis Center

Indiana (Statewide)

stark reminder of the pressing need for supportive measures for these caregivers, the backbone of family care.

The Economic Value of Caregiving

Most caregivers are unpaid and handle complex medical tasks such as administering injections or managing medical equipment. Their responsibilities include negotiating insurance coverage, navigating government programs, and coordinating care. Many of these caregivers also maintain jobs outside the home and have caregiving responsibilities. Particularly, those in the "sandwich" generation often simultaneously care for their parents and their children.

The most recent estimate for the economic value of family caregiving in the United States remains at $600 billion, based on data from 2021. This figure comes from approximately 38 million caregivers providing an average of 18 hours per week, totaling 36 billion hours of care, with an average value of $16.59 per hour.[5] Although specific gender-based statistics are unavailable, the state's overall monetary value of unpaid caregiving is estimated at a remarkable $10.8 billion annually.[6] This figure is derived from the collective 740 million hours of care provided, valued at an average hourly wage of $14.61. Women caregivers, often the primary providers of unpaid care, play a crucial role in this substantial economic impact, underscoring the importance of recognizing and supporting their contributions to the health and well-being of individuals and the broader Indiana community.

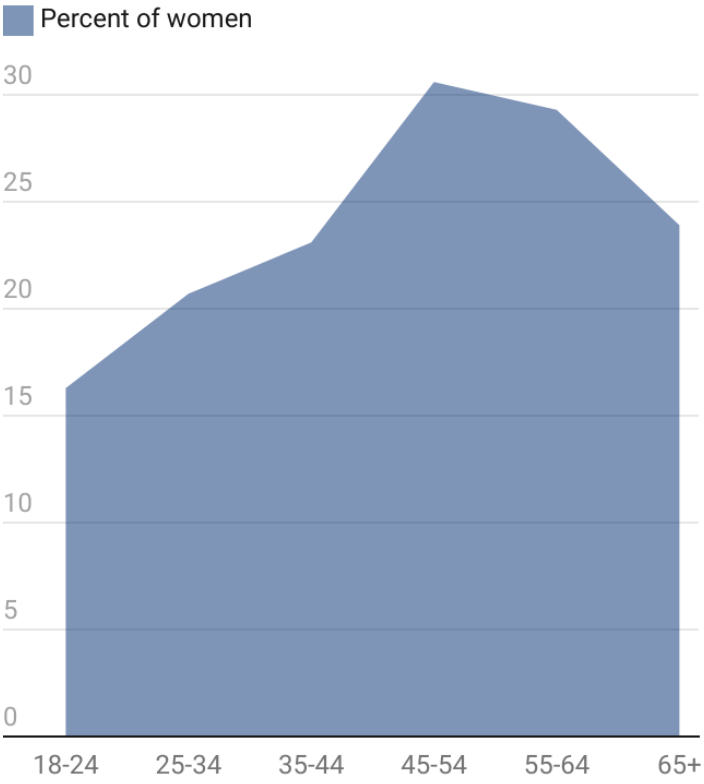
The Impact of Caregiving on Women's Lives

Caregiving demands significant time, affecting women's ability to participate in the workforce, pursue education, and engage in social activities. This time commitment can vary depending on the age of the care recipient.

Overall, women in Indiana spend almost an hour per day caring for other people. This is twice the time men spend on caregiving activities and a larger gap than the nation overall. In addition, Hoosier women spend an average of two hours and 45 minutes

Women between age 45 and 64 are most likely to care for someone with a health problem

Women caring for someone with a health problem or disability



Source: BRFSS; Graphic by the Polis Center

Indiana (Statewide)

Barriers & Biases

Two major barriers exist for both child and adult care: affordability and access. The National Domestic Workers Alliance (NDWA) has dedicated an entire section of their practice to transforming care work in the United States. According to the NDWA, there are 692,000 applicants on waitlists to receive home services through Medicaid, a federal program that provides health care coverage for low-income individuals and families. Meanwhile, according to the Economic Policy Institute, it costs families nearly 40% more to provide infant care than to pay in-state tuition for a four-year public college. With this high fiscal burden, many families are forced to work more leaving less time to care for their children and aging adults. Workplace policies may contribute to the lack of access as well.

per day on other household support activities, like household work and making purchases. Men spend an average of two hours per day on these activities.[7]

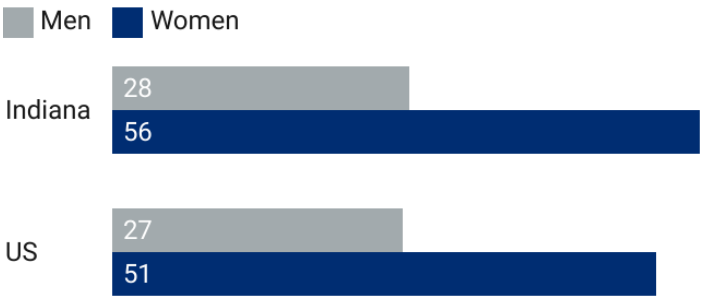
Women spend nearly two-and-a-half hours per day caring for people in their household when they are age 25-34. The time spent on caring for household members declines as women age, but, as we can see from the previous data about caring for people with health problems, women are likely to swap one caregiving activity for another. As they get older, women spend less time caring for household members but are more likely to care for someone with a health problem. This shift, along with societal expectations, frequently compels women to juggle their caregiving duties with their professional roles, forcing them to make challenging decisions between their careers and family commitments. A national study out of Syracuse University showed that women were significantly more likely than men to have negative career impacts from caregiving: time conflicts with work, took a less demanding job, switched from full-time to part-time, lost employment benefits, and lost a promotion.[8] Similarly, women who provide care for at least 20 hours a week were significantly more likely to retire early.[9]

Childcare

Childcare is a crucial aspect of caregiving, especially for women aged 18-50. This includes feeding, bathing, educating children, and managing their health and well-being. The time required for childcare can be extensive, particularly for women with young children or those with special needs. In Indiana, access to affordable and high-quality childcare services is a critical issue, as it directly impacts women's ability to maintain employment and pursue career advancement. In Central Indiana, the need for childcare far exceeds the availability of childcare spots in licensed programs. Overall demand is almost double the supply, with significant variation among counties. Marion County, for instance, can serve 84% of childcare demand, while Hendricks County lags at only 46%. The average cost of childcare also varies, with Marion County having the highest price at 17% of median

Indiana women spend **twice as much time** on **caregiving** than men

Minutes spent per day caring for people, including non-household members

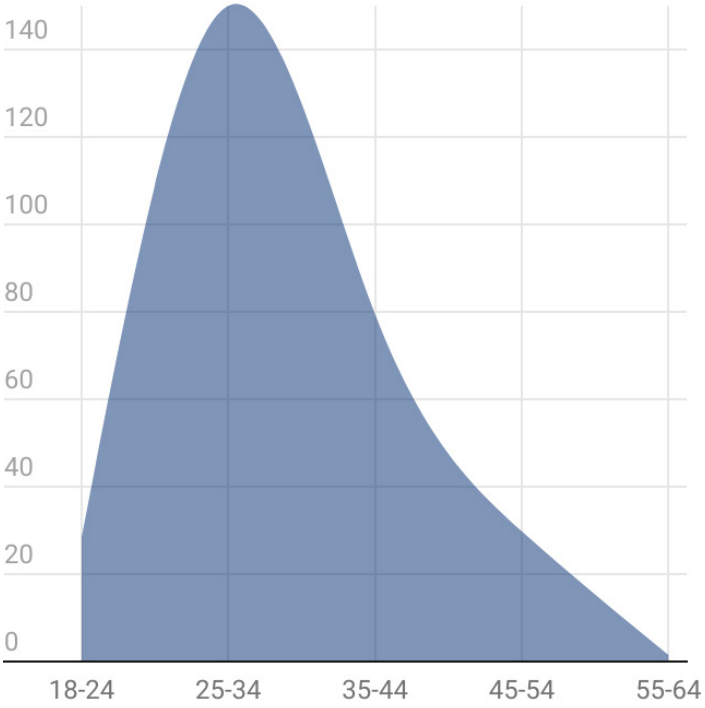


Source: American Time-Use Survey, Bureau of Labor Statistics, Responses from 2022 and 2023; Graphic by the Polis Center

Indiana (Statewide)

Women between **age 25 and 34** spend the most time **caring for someone** in their household

Minutes spent per day by women caring for someone in their household



Source: American Time-Use Survey, Bureau of Labor Statistics, Responses from 2022 and 2023; Graphic by the Polis Center

Indiana (Statewide)

household income, compared to the state average of 13%.[10] Other counties in Central Indiana hover around the state average, except for Hendricks and Shelby counties, with 10% and 9% of median annual income, respectively.

Access to childcare is crucial to Indiana's workforce; 57% of those working in Indiana are parents, and 39% of those parents have young children. 71% of Black mothers with young children are single parents, compared with 33% of Latina mothers and 25% of White mothers with young children.[11]

The financial burden of caregiving can be substantial. Many women reduce their working hours or leave to fulfill caregiving duties, leading to lost wages, reduced career advancement opportunities, and decreased retirement savings. Additionally, out-of-pocket expenses for caregiving supplies and services can strain household budgets. Childcare costs, in particular, often exacerbate this strain, as the high expense forces women to either cut back on work or juggle multiple jobs just to afford basic childcare, further limiting their ability to fully participate in the workforce.

The Mental Health Impact of Caregiving

The impact of caregiving on mental health is particularly significant among women as they serve the primary role of the caregiver. Studies indicate that women who provide care are more prone to experiencing heightened levels of stress, anxiety, depression, and burnout than those who do not engage in caregiving activities. The Indiana Family and Social Services Administration (FSSA) reports that a substantial 60% of family caregivers in the state experience stress, while 40% are affected by anxiety or depression. The challenges faced by caregivers are compounded by feelings of isolation and insufficient social support, with over 30% feeling socially isolated or lacking adequate support from family and friends.[12]

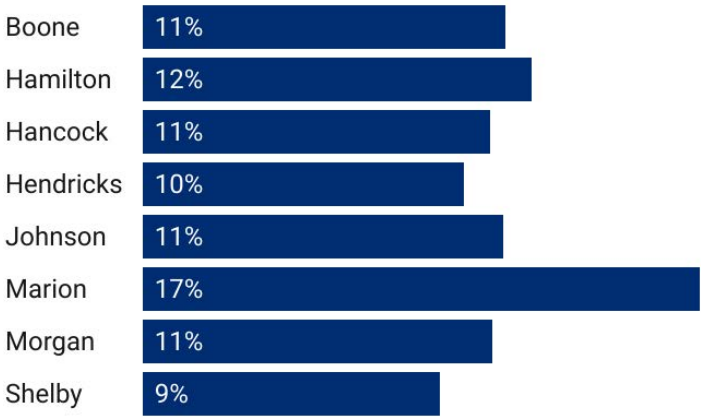
Data Limitations

The data used in this section was obtained from multiple sources, each with distinct limitations that may affect the analysis. BRFSS data utilized is from the Adult Landline Module SAS output

> **"Childcare is so expensive and stops women from entering the workforce or they have to work 2-3 jobs to cover it."**
>
> ***- Kelly McBride,*** *Executive Director, Domestic Violence Prevention Network*

Marion County parents pay the highest share of income toward childcare

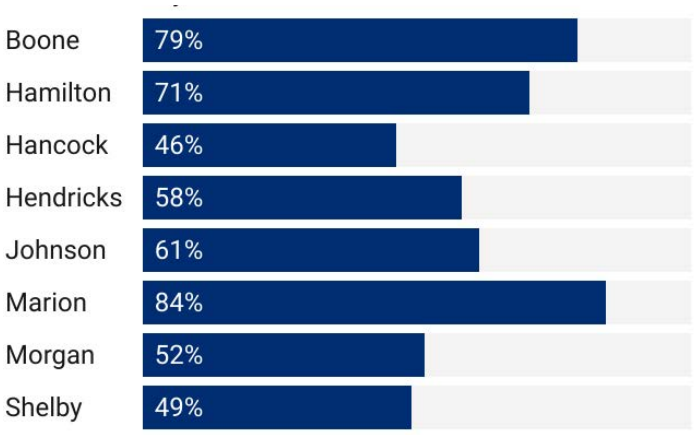
Average annual cost of care as percent of median income



Source: Brighter Future Indiana Data Center (Retrieved 8/12/2024); Graphic by the Polis Center

Hancock and Shelby Counties have the highest need for more licensed childcare

Percentage of children able to be served by any licensed childcare



Source: Brighter Future Indiana Data Center (Retrieved 8/12/2024); Graphic by the Polis Center

files available on the Indiana Department of Health website, and it covers the year 2021. A key limitation is that county-level data is not available, restricting more localized analysis. Where possible, comparisons with national data are provided, but due to time constraints, such comparisons were not available for all metrics.

Childcare data was sourced from the BrightFuture Indiana dashboard. The retrieval date for this data is indicated in the citation, and it is important to note that the data is updated monthly, meaning results may vary based on the time of retrieval.

Additionally, data from the American Time Use Survey (ATUS) was analyzed by the Polis team. While this data provides valuable insights into time use patterns, the analysis may be subject to limitations related to the representativeness of the sample and the scope of the survey.

These limitations, particularly the absence of county-level data, incomplete national comparisons, and the dynamic nature of some datasets, should be considered when interpreting the results of this section.

"There's still a lot of pressure that I feel as a woman to be a good mom and make the right tradeoffs for my job even though I have more flexibility than the average worker in our community."

- Marie Mackintosh, *President and CEO of EmployIndy*

Strength & Abundance

The Castleton United Methodist Church/Still Waters Adult Day Center is an Adult Day Center with a mission is to empower seniors to age in place by offering comprehensive day services that foster social connection, enhance mental acuity, and promote physical wellbeing. They were a 2023 Women's Fund Grant recipient for their Ladies Care Programs to serve women guests and caregivers. While this is one of many organizations serving seniors, we want to highlight the Ladies Care Programs because we know how significant caregiving responsibilities are for women.

Endnotes

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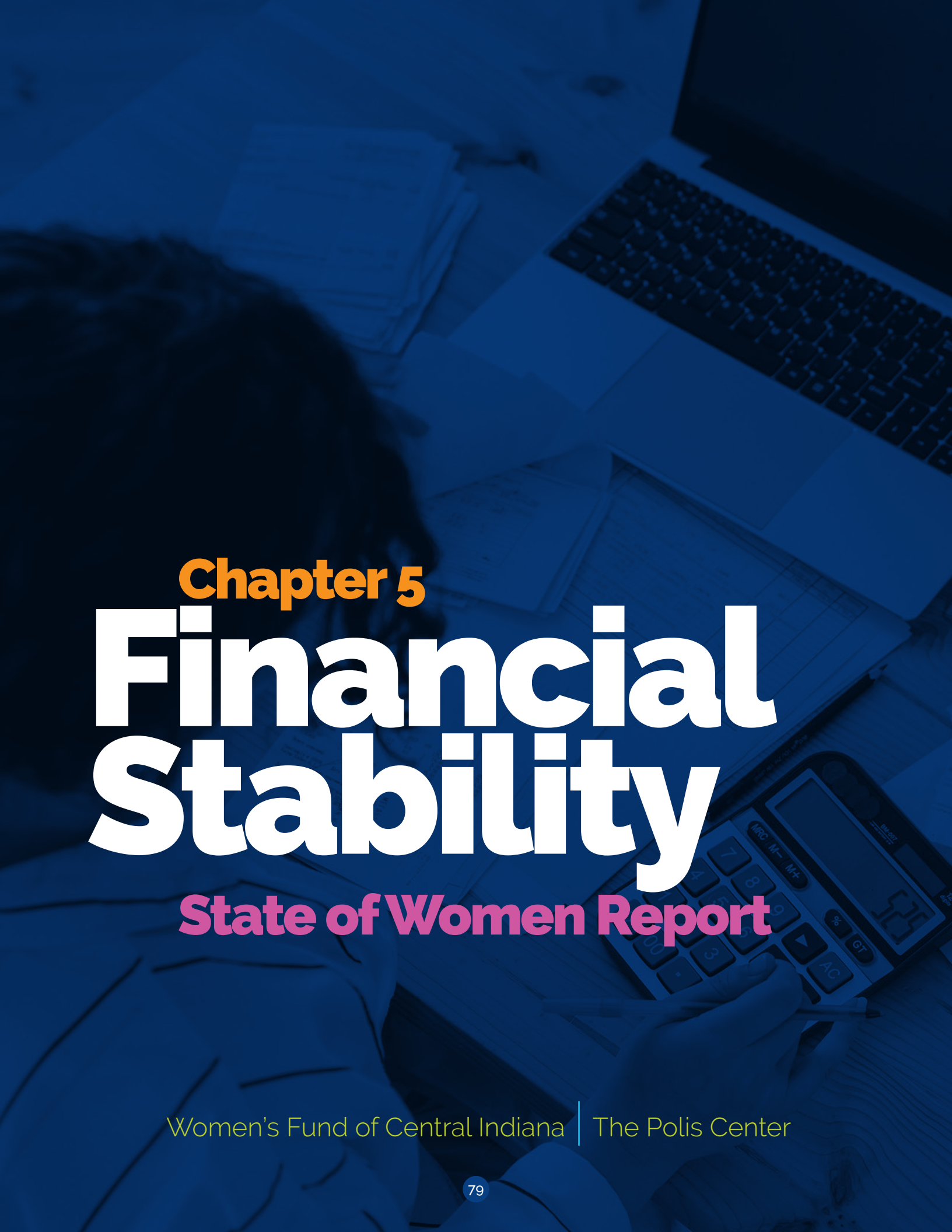


Chapter 5
Financial Stability
State of Women Report

Women's Fund of Central Indiana | The Polis Center

Financial Stability

Financial stability for women is a crucial pillar in fostering gender equality, enhancing individual autonomy, and ensuring societal well-being. It empowers women to make informed decisions about their lives, careers, and families, reducing their vulnerability to economic shocks and social injustices. By achieving financial stability, women can access better education, healthcare, and career opportunities, which collectively contribute to their personal development and the prosperity of their communities. Moreover, women's financial independence is integral to breaking the cycle of poverty and promoting sustainable economic growth. This section of the report focuses on financial stability, including income, employment, poverty levels, education, economic vulnerabilities and support programs of women in Central Indiana.

Key Takeaways:

- Median earnings for Central Indiana women are 70 cents on the dollar compared to men. A gender pay gap exists for part-time workers and for full-time workers. It persists for every race and every level of education. A gender pay gap of at least 10% is present for 19 out of 24 occupations.
- More women are earning college degrees. College attainment for women has increased 10 percentage points since 2010, closing the gender gap with men. In 2022, 39% of women aged 25 or older have a bachelor's degree.
- Women graduate high school at a higher rate than men, but graduation rates are declining. In 2022, 90% of women graduated high school compared to 86% of men. In 2013, the graduation rate for women peaked at 95%.
- Young women are more likely to live in poverty than any other age group: 17% of Central Indiana women aged 18-34 are in poverty compared to 11% of the overall population of Central Indiana. This is better than the national poverty rate for this group, which is 20%.
- Single mothers are exposed to increased economic vulnerability. This group is the more likely than other households to fall below the ALICE threshold of financial stability—41% of single-mother households in Marion County have incomes below this threshold—and are less likely to have a bank account—one fifth of single-mother households in the Midwest do not have a bank account.

Income and Labor Participation

Like in Indiana and the US, Central Indiana has a persistent gender gap in median annual earnings. The gender gap in earnings is worse in Indiana than in the U.S. and has not improved in the past decade. In 2012, women in Indiana made only 78% of men's wages while women nationally made 81% of men's earnings. By 2022, women had improved to 83% of men's earnings nationally but remained at 78% in Indiana.[1]

Although median annual earnings are higher for women in Central Indiana ($41,053) than for women in Indiana ($35,134) or the U.S ($38,648) and although median earnings for women in the eight-county Central Indiana region have increased steadily since 2010, the gender gap in earnings in Central Indiana remained approximately 0.7 for over a decade, which means for each dollar men earned, women earned 70 cents. According to the Bureau of Labor Statistics, women in Indiana who worked full-time earned a median weekly wage of $861, which is 78% of the $1,109 median weekly earnings of men.[2]

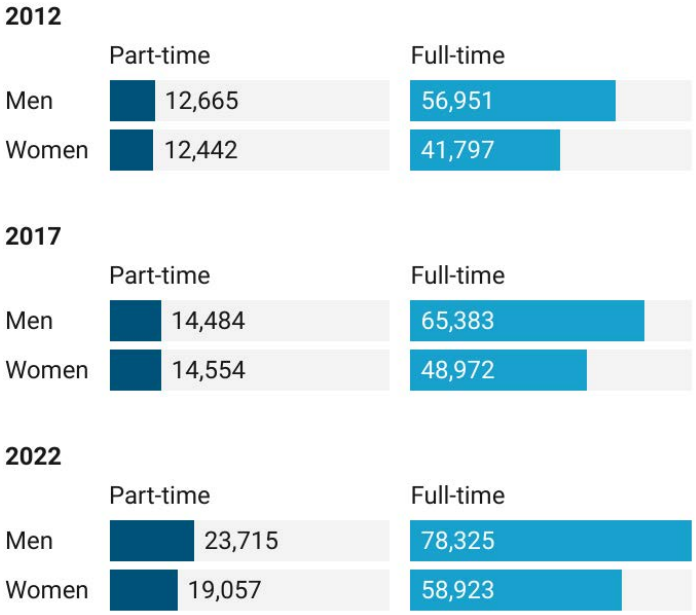
The gender difference in median earnings still exists when comparing only full-time workers or only part-time workers. As of 2022, Central Indiana women who worked part-time earned nearly $4,700 less than men who worked part-time. The difference in hours worked was negligible (22 hours per week for men and 21 hours per week for women)—the average estimated wage for women working part-time $17.45 per hour compared to $20.73 for men.

Women who work full-time earn $19,000 less per year than men who work full-time. Again, this is not mitigated by a difference in hours worked: Men work 44 hours per week on average compared to 42 per week for women.

While the earnings gap for full-time workers was consistently present over the last 10 years, the earnings gap for part-time workers is new. In 2012 and 2017, there was parity in earnings for part-time workers. In 2022, women's part-time pay has fallen behind.

Women earn less than men in both full-time and part-time work

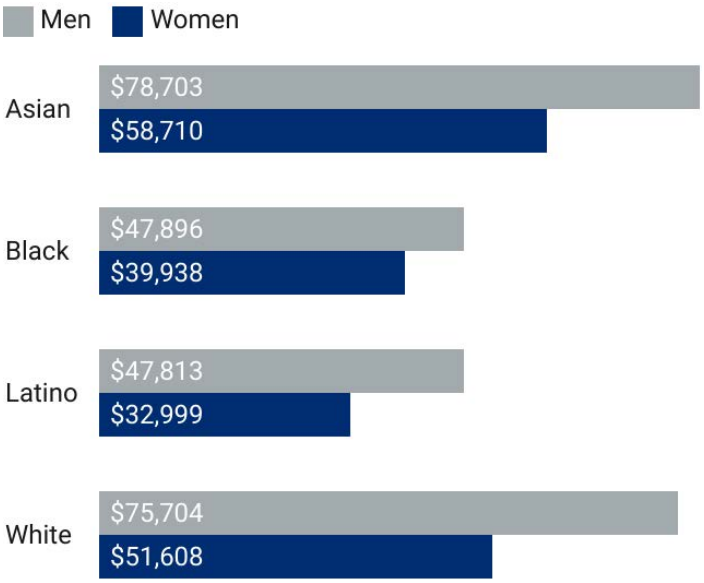
Earnings by gender and work status



Source: 2022 ACS 1-Year Averages; Graphic by the Polis Center
Central Indiana (8-county region)

The gender pay gap exists within every race and ethnicity

Average earnings per person by race and gender



Source: 2022 ACS 1-Year Averages; Graphic by the Polis Center
Central Indiana (8-county region)

Labor force participation rate

The labor force participation rate is the percentage of people over 16 who are working or looking for work. Over the past decade, Central Indiana has consistently outperformed the state average, maintaining a labor participation rate of 68% compared to the state's 64%. On the other hand, a persistent gender gap in labor force participation has remained unchanged—73% of men are in the labor force but only 63% of women are in the labor force. The labor force gender gap closed for many decades in the 20th century as more women joined the labor force, but the labor force participation rate stopped growing for women in the 21st century. Since 2010, the gap has continued to close, but only because men are leaving the labor force—not because women are joining the labor force.[3]

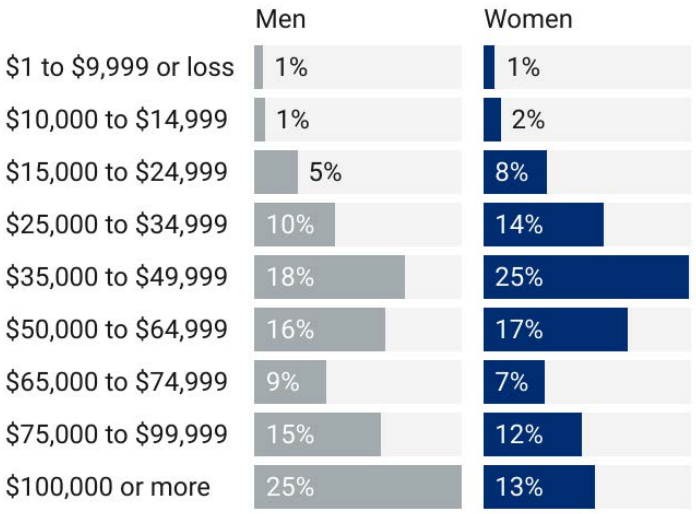
A higher percentage of women than men earn less than $35,000 annually. This disparity indicates that a significant portion of working women are employed in lower-paying jobs. In the middle-income brackets, the percentage of women is still higher than that of men, particularly in the $35,000 to $49,999 range. In the higher income brackets, men significantly outnumber women. The most notable difference is for the highest earners—25% of men earn at least $100,000 compared to 13% of women.

Causes of income disparity

Claudia Goldin, the 2023 economics Nobel prize winner, through an extensive analysis of over two centuries of U.S. data, has illuminated the evolution of gender disparities in earnings and employment. While historical discrepancies in education and occupational choices partially explained the wage gap, her research reveals that the primary contributor to the current earnings differential lies within the same occupations, often manifesting after the birth of a child. This means that in many high-paying professions, such as law and finance, workers who put in longer hours receive disproportionately higher pay. Women, who often seek flexible working hours due to family responsibilities, end up earning less per hour compared to their male counterparts who work

Compared to men, a **higher share** of **women work for $35K-$50K** and a lower share for $100K+

Income distribution for men and women



Source: 2022 ACS 5-Year Averages; Graphic by the Polis Center
Central Indiana (11-county region)

longer hours. This phenomenon is referred to as the "part-time penalty."[4]

Her research challenges the notion that the gap is primarily due to overt discrimination. Instead, she posits that structural issues in the labor market such as factors related to work-life balance, occupational choice, and the structure of jobs play a more significant role in perpetuating the gender pay gap.

Work-Life Balance

Traditionally, women have borne the primary responsibility for domestic and childcare duties. This imbalance often necessitates career interruptions or reduced work hours, hindering career progression and earning potential. Moreover, the lack of affordable childcare and supportive workplace policies exacerbates these challenges. Women are more likely to work part-time or flexible schedules, often associated with lower pay and fewer benefits. For those who are caring for children and aging parents, work-life balance is stretched to the breaking point. For more discussion of this, see the Caregiving chapter.

Occupational Choice

There is a double-digit gender pay gap in almost every occupation, indicating that occupational choice cannot be the main driver of the total gender pay gap. Still, there are interesting trends in occupational data.

Some of the highest paid occupations are relatively balanced in their staffing of men and women, but the pay gap is large. More women than men work in business and finance, but women are paid 20% less than men on average. Slightly more women than men work in legal occupations, but they earn 40% less than men on average. The same pattern persists in the sciences and in sales. Similarly, in the healthcare diagnosis and treatment field which has a relatively high median salary ($80,046), the median earnings for women are 42% lower than for men.

In contrast, in the higher-paying field of mathematics and computers, the median earnings of women are actually two percent higher than for men. However, it is also one of the most male-dominated fields in terms of staffing.

Strength & Abundance

"Women get stuff done." This was a phrase we heard numerous times in our interviews. From running households and families to running non-profit organizations, the people we spoke with underscored the idea that women are the ones who do the work to make change happen. Danyette Smith MHS, Survivor, Director of Domestic Violence Prevention at Indy Public Safety Foundation, Indy Champions, spoke to this: "From organizations, even if a man is leading, there will always be a woman behind the scenes holding all the strings together."

Women are overrepresented in lower-paying sectors such as education, administration, and service industries. Interestingly, in some lower-paying sectors such as the social services (median annual earnings of $50,577), there is more equality in pay with women earning only five percent less than men on average. In the healthcare support sector, there is also more gender parity, but again, wages tend to be low (median earnings of $30,357). Although some lower-paying occupations have better gender equity in pay, there are other lower-paying occupations for which a gender disparity is still seen, such as for the health technician field (median annual salary of $41,812), for which women earn 23% less than men.

Job Structure

The structure of many jobs contributes to the gender pay gap. Jobs requiring long hours, evening or weekend shifts, or extensive travel often correlate with higher pay. These work arrangements are more commonly held by men, while women are disproportionately represented in positions with inflexible schedules and lower compensation. Additionally, the undervaluation of roles traditionally dominated by women, such as caregiving and teaching, further exacerbates the wage gap.

Goldin insists that the gender pay gap also occurs within the same professions. For instance, in professions like pharmacy, the gap is significantly smaller because workers can more easily substitute for each other without a loss in productivity. This flexibility allows women to maintain their careers while managing family responsibilities.[5]

Educational Attainment and Its Impact

The share of women with a bachelor's degree has increased by 10 percentage points since 2010, from 29% to 39%. In 2010, women were less likely than men to have education beyond high school and less likely to have a bachelor's degree, but the gender gap has closed. In 2022, the share of women and men with a bachelor's degree are almost equal, and more women than men have completed education after high school.

Women are more likely than men to graduate high

Strength & Abundance

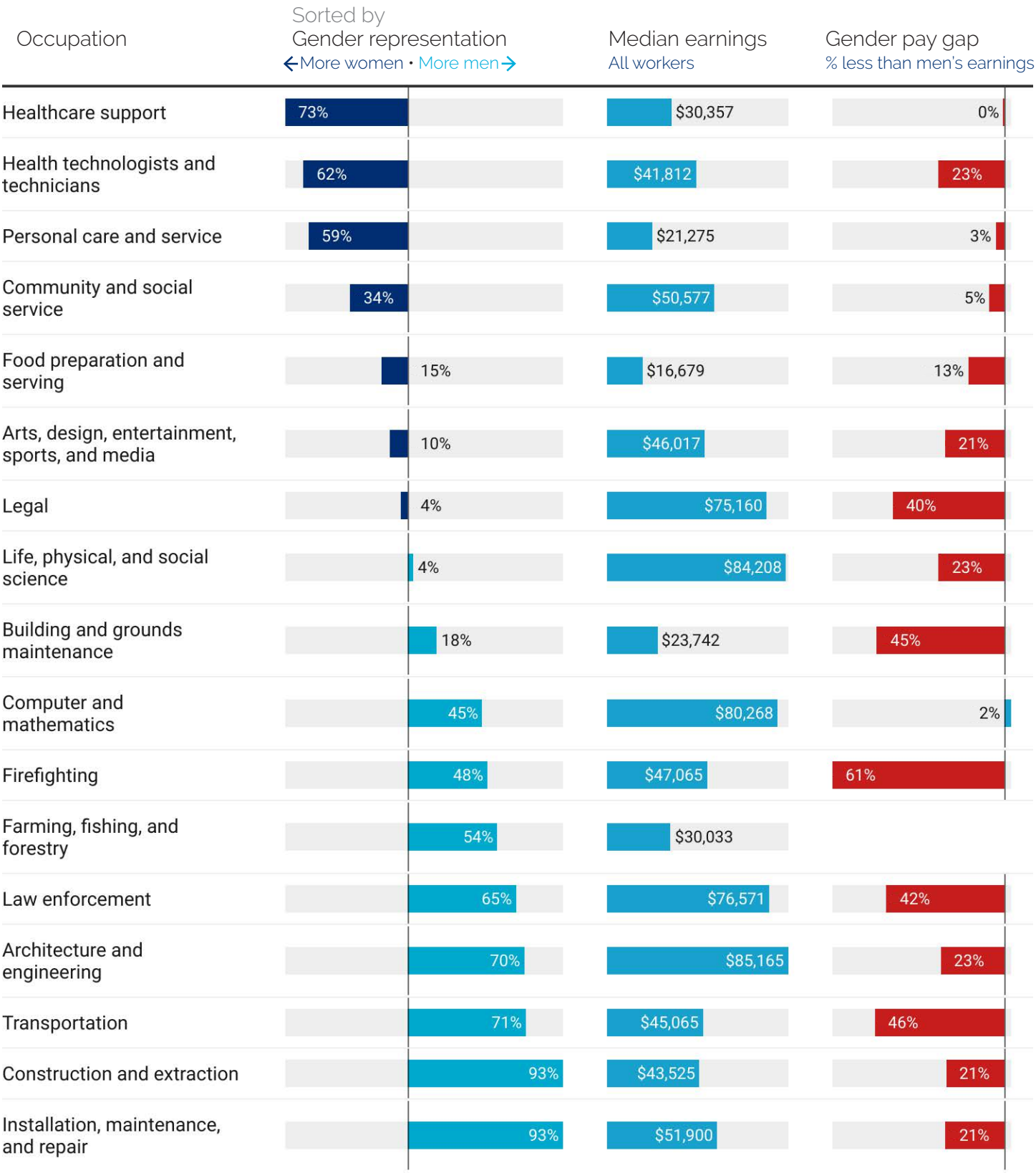
A Seat at the Table is a nonprofit organization with the mission of helping minority women overcome barriers that limit access to leadership roles within corporations, government entities, entrepreneurship, and the community. A Seat at the Table was a 2023 Women's Fund Grant recipient and is one of many organizations supporting women who are Black, Indigenous, and People of Color (BIPOC).

Barriers & Biases

There are real barriers to accessing higher education at any age. While financial barriers are usually the hardest to overcome, the other responsibilities that fall on women are also significant barriers. As discussed in the Caregiving Chapter, caregiving responsibilities tend to fall on the women in families. When we consider caregiving, plus full-time employment, plus taking care of themselves, plus everything else, women have to ask themselves: "Is it realistic for me to get a higher degree?"

There is a **gender pay gap** in almost **every occupation**

Employment and earnings by occupation



Source: 2022 ACS 5-Year Averages; Graphic by the Polis Center
Central Indiana (8-county region)

school, but the graduation rate is declining. In 2022, the average public high school graduation rate for the four-year cohort was 88%--90% for women and 86% for men. This gap has been present for at least a decade. But after women's high school graduation rate reached a high point of 95% in 2013, it has declined five points in the past nine years. Men have experienced the same decline.

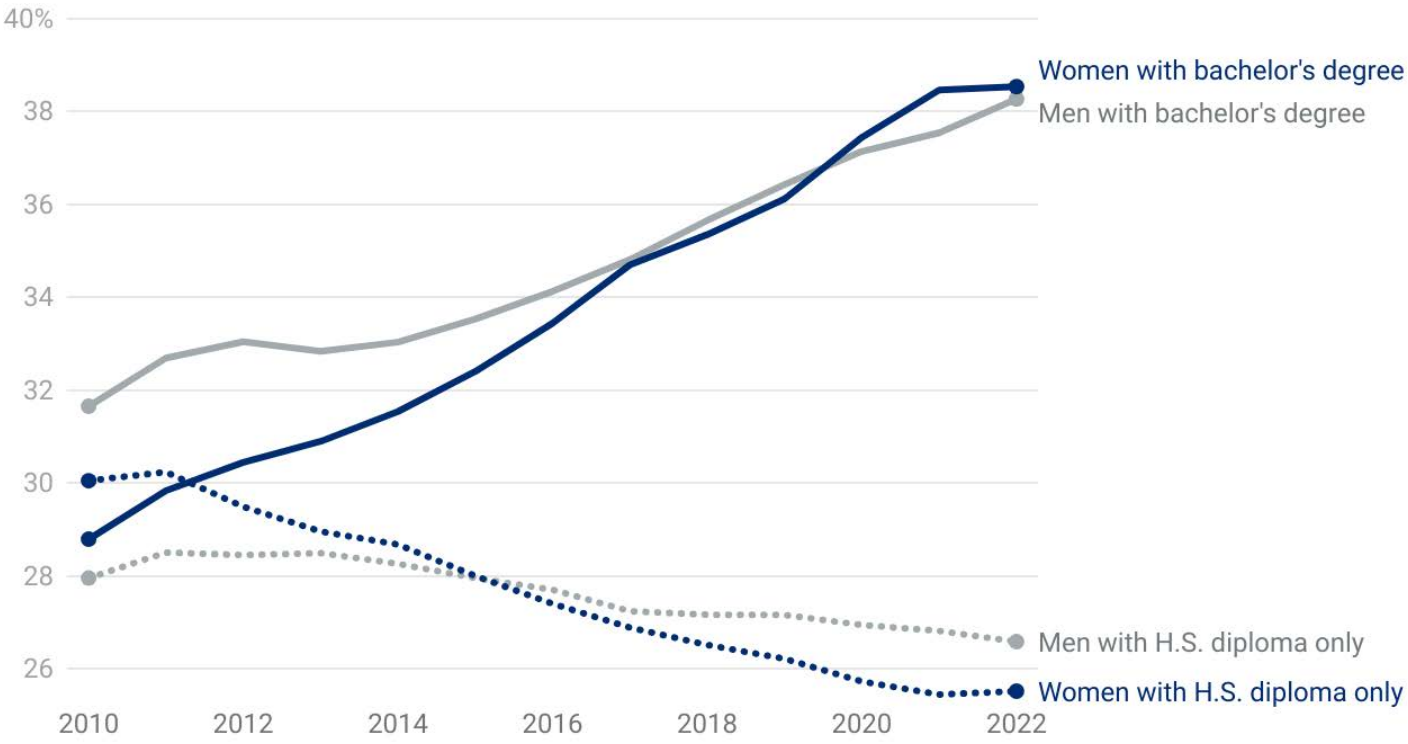
Despite increased educational attainment, the gender pay gap has not closed. Declining educational attainment among men may be leading to reduced labor force participation among men, but labor force participation has not risen among women in recent years.

Racial Disparity in Educational Attainment

Data from Central Indiana reveals a strong correlation between race and educational attainment among women. Hispanic and Black

College attainment for women has **increased 10 points** since 2010, closing the gender gap with men

Percent of adults (age 25+) by education and gender



Source: 2022 ACS 5-Year Averages; Graphic by the Polis Center

Central Indiana (8-county region)

women are more likely to hold only a high school diploma compared to other racial groups. In contrast, Asian and White women have higher rates of attaining bachelor's degrees.

While women in Central Indiana have made significant strides in educational attainment, achieving parity with men in 2022, the economic landscape presents a contrasting picture. The gender pay gap—women earn 70 cents for every dollar earned by men—highlights the challenges women continue to face in translating educational achievements into economic opportunities.

Education and Unemployment

Women's employment prospects vary significantly based on their educational attainment. High school dropouts experience the highest unemployment rates, ranging from eight percent to 18% over the past decade. Those with only a high school diploma fare somewhat better, with unemployment rates between three percent and 10.5%, but still face considerable challenges compared to individuals with more education. Women who hold a bachelor's degree or higher have the lowest unemployment rates, ranging from 1.6% to 3.7%. That comes down to a higher demand for skilled labor, better job security, and typically higher wages associated with advanced degrees.

Education and Income

Women with a bachelor's degree or higher enjoyed a substantial income advantage of $34,643 compared to those without a high school diploma. This significant gap highlights the financial barriers faced by women with limited educational attainment. Moreover, the nearly $20,000 income difference between women holding associate's degrees and those with bachelor's degrees or advanced degrees emphasizes the value of pursuing further education.

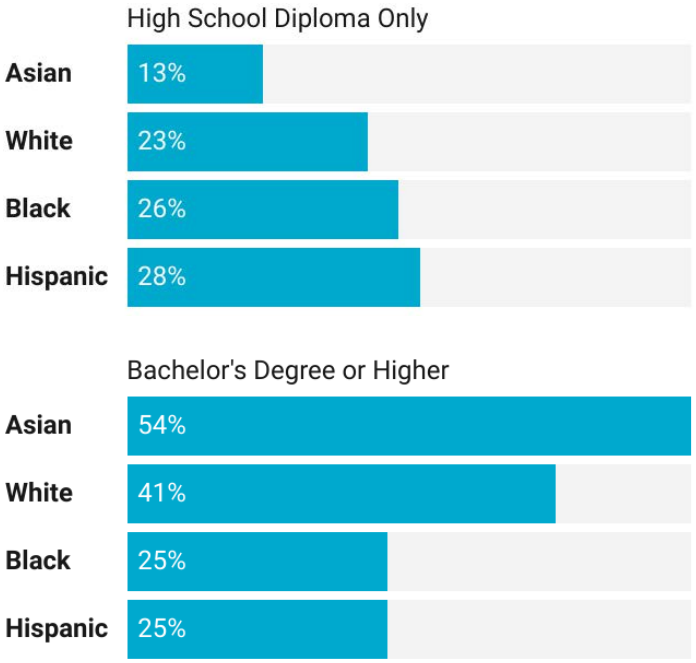
Economic Vulnerabilities of Women

Poverty Rate

The poverty rate among women varies significantly across different age groups, with younger women (aged 18-34) facing the most significant economic

There are large racial disparities in educational attainment for women

Educational attainment of women by race and ethnicity

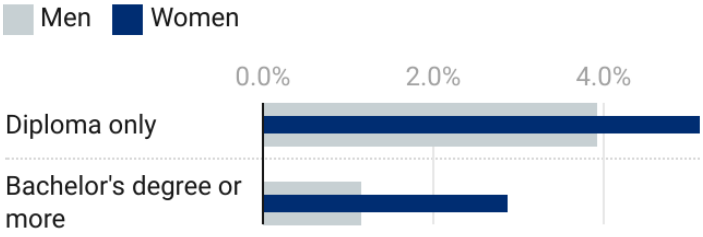


Source: 2022 ACS 5-Year Averages; Graphic by the Polis Center

Central Indiana (8-county region)

Unemployment is lower for women with bachelor's degree, but still higher than men of the same education level

Unemployment rate by educational attainment and gender



Source: 2022 ACS 5-Year Averages; Graphic by the Polis Center

Central Indiana (8-county region)

challenges. At 17%, this age group has the highest poverty rate, which may reflect several contributing factors. Many younger women are in the early stages of their careers, often occupying lower-paying jobs while also balancing education and family responsibilities. The financial strain is further exacerbated by the high costs of childcare for young families and the burden of student debt, creating a challenging financial landscape for these women.

In contrast, middle-aged women (aged 35-64) experience the lowest poverty rate at 10%, indicating greater economic stability. This can be attributed to established careers that typically come with higher income levels, the accumulation of work experience, and professional advancement. Additionally, many women in this age group benefit from dual-income households, further enhancing their financial security.

Older women (aged 65 and above) face a moderate poverty rate of 12%, higher than that of middle-aged women. This suggests that older women encounter economic vulnerabilities, often due to reliance on fixed incomes such as Social Security or pensions that may not keep pace with inflation. Furthermore, higher medical and healthcare costs, combined with a longer life expectancy, contribute to the extended financial needs that older women must navigate.

For context, the overall poverty rate in Central Indiana increased from 12.3% in 2010 to a peak of 14.5% in 2014 and has since declined to 10.6% in 2022.

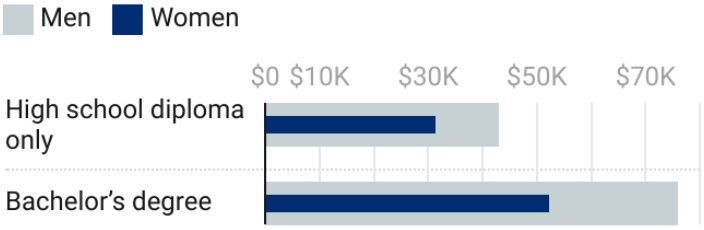
ALICE Households

ALICE —which stands for Asset Limited, Income Constrained, Employed —describes households that earn more than the Federal Poverty Level (FPL) yet are unable to cover the basic cost of living in their county. These households often face financial challenges but do not qualify for public assistance despite their efforts to manage their expenses. In general, ALICE households are those earning between 100% and 185% of the federal poverty line.

According to a 2022 report from United Way of Central Indiana, 32% of families with children in Central Indiana were below the ALICE threshold,

More education leads to more income, but the gender pay gap is still present

Median earnings by educational attainment and gender



Source: 2022 ACS 5-Year Averages; Graphic by the Polis Center

Central Indiana (8-county region)

Among women, poverty is highest for young adults

Poverty rate for women by age

Source: 2022 ACS 5-Year Averages; Graphic by the Polis Center

Central Indiana (8-county region)

including 75% of single mothers. In addition, 76% of the people that received services designed to address the challenges faced by those in the ALICE category and those living in poverty (economic mobility services) were BIPOC (Black, Indigenous, people of color).

Single mothers are the most likely household to fall below the ALICE threshold, but this rate varies significantly between counties. Morgan County has the highest rate of financial insecurity for single mothers: 87% fall below the ALICE threshold (46% in poverty and 41% above poverty but still low-income). Three quarters (76%) of single mothers in Marion County fall below the ALICE threshold (41% in poverty and 35% above poverty but still low-income). In Hamilton County, 57% of single mothers are below the ALICE threshold, and in Boone County 48% fall below this threshold.[6]

Calls for financial or material assistance

Indiana 2-1-1 connects clients in need with referrals to service providers. In the period from July 2023 to July 2024, 71% of Central Indiana 2-1-1 callers were women. The major causes for the call were housing (33%), utility assistance (18%), food and meals (17%), health care (11%) and income support (seven percent). Forty-seven percent of callers were White and 45% were Black, indicating the call rate is higher for Black women than for White women.

Financial literacy

Data on financial literacy is sparse, but the Federal Deposit Insurance Corporation (FDIC) does conduct a comprehensive national survey of household finances that gives us some evidence. Gender is not part of the survey, but household type is, and there is a clear pattern that single mothers are less likely to have a bank account.

Nationally, five percent of households have no bank account, but 16% of households led by a single mother are unbanked. In the Midwest, this rate is even worse: 19% of single mothers are unbanked. In Central Indiana, detailed data about household type is not available, but the FDIC survey does show that eight percent of households are unbanked, substantially higher than the national average, and

this rate increased from six percent in 2017 to eight percent in 2021.[7]

Banked and unbanked populations are just one indicator of financial literacy and access to financial systems. Doneisha Posey, an Indianapolis-based attorney, highlighted a significant gap in financial literacy among women in Central Indiana, mentioning that this lack of knowledge impacts their ability to manage personal finances, start businesses, and plan for retirement.

As a way out, Posey highlighted several strategies for improving financial literacy among women, including creating supportive environments where women feel comfortable discussing finances. Other approaches include incorporating financial education into school curricula, establishing mentorship programs, and providing affordable financial counseling. Additionally, media campaigns can raise awareness about the importance of financial literacy, encouraging women to prioritize their financial education and ultimately empower them to achieve greater financial stability and success.

Endnotes

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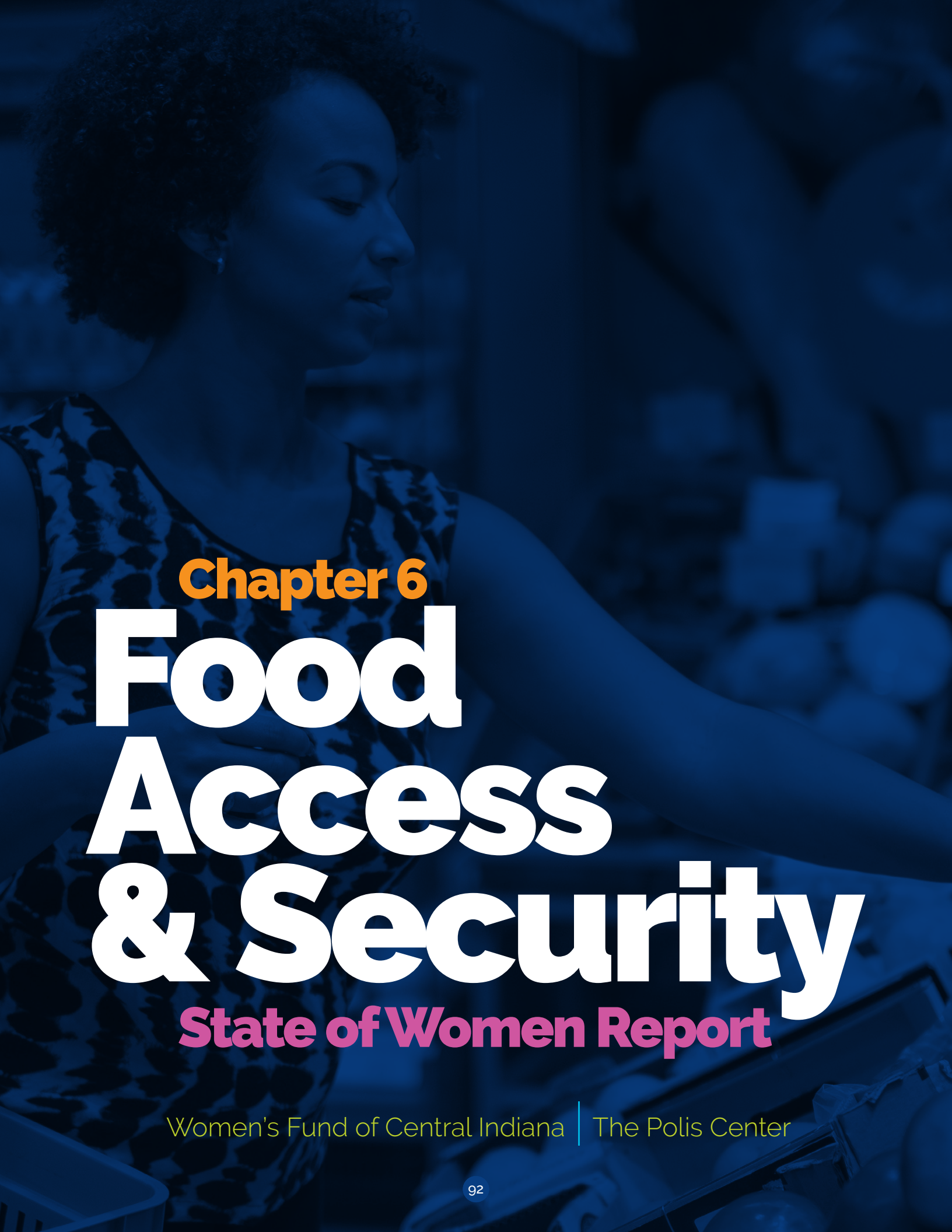


Chapter 6

Food Access & Security

State of Women Report

Women's Fund of Central Indiana | The Polis Center

Food Access & Security

Two issues are crucial to the health of women in Central Indiana: food access and food security. Food access is the availability of fresh, healthy food in a location close enough to make convenient access feasible. Food security is a result of having the financial resources to buy enough healthy food. These issues often intersect––poor food access can force people to buy more expensive and unhealthy food because the location is convenient (such as a convenience store) or use more time and money to get to a grocery store (spending more gas money or hiring a rideshare service), stretching an already tight budget. How these issues affect women, specifically, is explored in detail in the following chapter.

In this chapter, we analyze the eight-county Central Indiana region. At times, data availability necessitates a different definition of Central Indiana, and we note when that is the case.

Key Takeaways:

- One hundred thousand women live in food deserts in Central Indiana. Food deserts are concentrated in mostly Marion County, particularly on the northwest side, the northeast side, and the southeast side. 15% of Marion County residents live in a food desert.
- In the surrounding counties, three percent of the population lives in a food desert, but this varies by county. In Hendricks, Boone, and Hamilton counties, two percent or less of the population lives in a food desert. The rate is five to six percent in Morgan and Johnson counties, but 21% in Shelby County.
- Black, Indigenous, and People of Color (BIPOC) are more likely to live in a food desert than White residents. In Marion County, nearly one quarter of Black and one sixth of Latino residents lived in a food desert in 2022, compared to one tenth of White residents.
- Food deserts have an outsized impact on women because they are likely to be the primary shopper in their household—80% of U.S. women are the primary shopper, and women are seven times more likely than men to be responsible for meal planning.
- One-in-four women live below 185% of the poverty threshold in Central Indiana. Nationally, women at this income level have a 38% chance of low food security.

Access to Healthy Food

Access to healthy food is known to facilitate overall health. Nearby access to a grocery store can decrease the risk of being overweight[1] and lead to a healthier diet[2]. These health behaviors can reduce risk of outcomes such as heart disease and diabetes.

Food deserts are a common way to measure access to healthy food. A food desert is a neighborhood where poor access to food overlaps with financial insecurity. We consider low access to a grocery store to mean further than one mile driving distance from a grocery store with fresh produce. Food deserts must also meet our criteria for low-income neighborhoods—residents of well-off neighborhoods likely have the resources to mitigate the impact of being located far from a grocery store. For more detail about the definition of food deserts, see the "Defining Food Deserts" inset.

Defining Food Deserts

The one-mile distance to a grocery store is measured by "network distance," or the length traveled on roads. It is not a straight-line distance "as the crow flies." Grocery stores are defined as stores that regularly carry a substantial supply of fresh produce. We identified low-income areas as block groups or tracts with a poverty rate of 20 percent or greater, or with a median household income that is less than or equal to 80 percent of metropolitan area median income. We define low food access areas as 1) Block groups that have at least 200 people or 33 percent of people further than one mile from a supermarket, supercenter, or large grocery store or 2) Tracts that have at least 500 people or 33 percent of people further than one mile from a supermarket, supercenter, or large grocery store.

Location of Food Deserts

One hundred thousand women live in food deserts in Central Indiana. Food deserts are concentrated mostly in Marion County, particularly on the northwest side, the northeast side, and the southeast side. There is also a substantial food desert population on the southwest side. While the Near Eastside and Near Westside have many low-income neighborhoods, these areas also have better access to grocery stores, so few neighborhoods are classified as food deserts.

Food deserts are also present in some suburban towns and cities. Over 4,000 women in Shelbyville live in a food desert. Noblesville, Franklin, and Edinburgh also have concentrations of low access and low incomes. Some areas stand out as food deserts even though their population is small. For example, on the north side of Plainfield and the east side of Brownsburg, there are block groups where at least 90% of the population lives in a food desert. This is also the case on the east side of Mooresville and the northwest side of Martinsville. There is an area just south of Main Street in Westfield where 94% of residents live in a food desert, and in Morristown 86% of residents live in a food desert.

Strength & Abundance

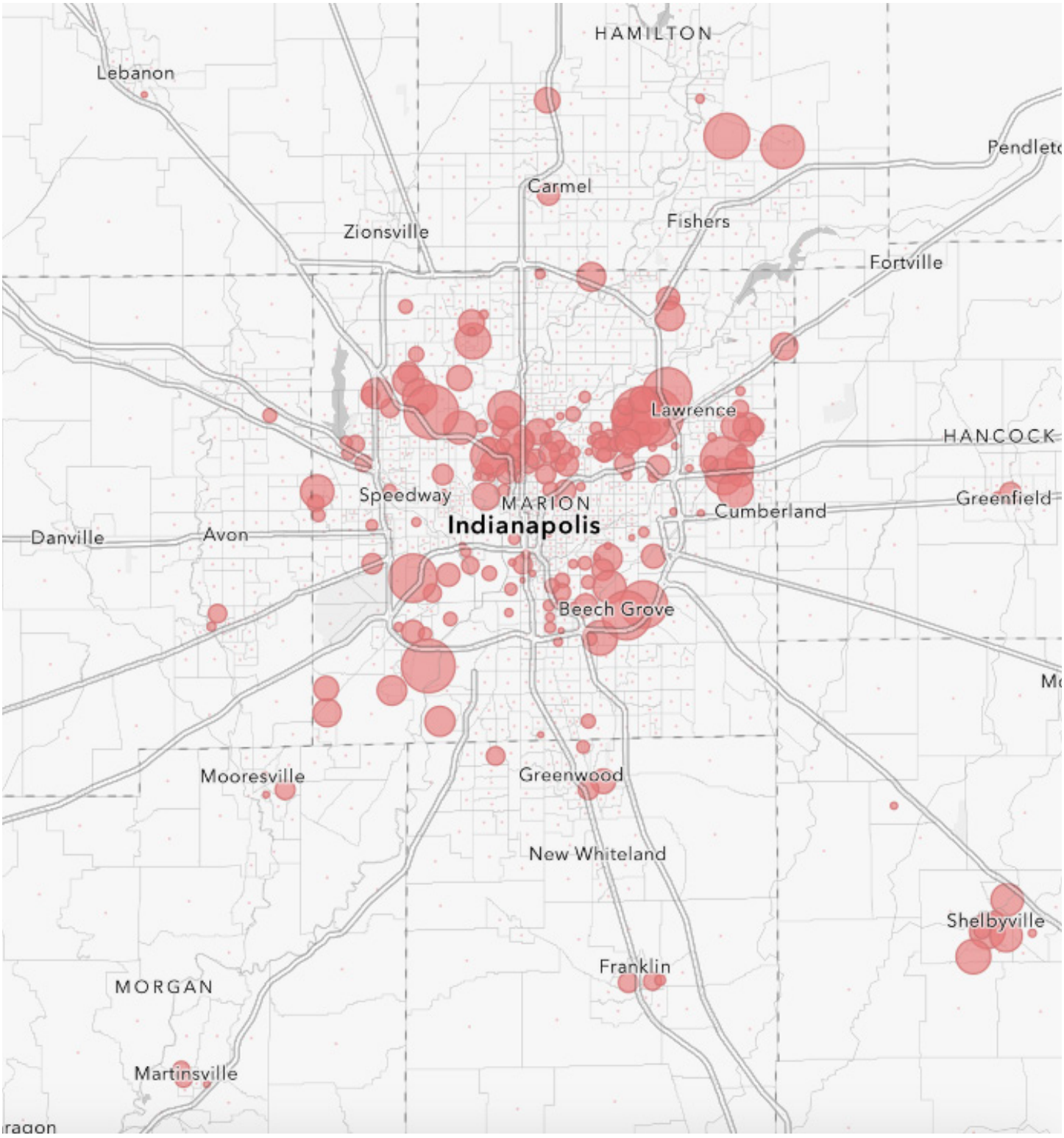
While food deserts are present in Central Indiana, community members have created unique short-term solutions to food insecurity. Neighborhood "caterers" and community food systems are the community's way of making sure their neighbors get fed. Ms. Paulette Fair from Kheprw Institute told us about the neighborhood "caterers" she calls on when she or others she knows need food. While this innovative approach should be celebrated, we also need long-term policy solutions to ensure that everyone is fed.

Women Living in Food Deserts are Concentrated in **Northwest** and **Northeast** Indianapolis

Number of women living in food desert by block group, 2022

To **explore** an **interactive version** of this **map, visit:**

https://bit.ly/473DtcD



Source: SAVI, 2022 ACS 5-Year Averages; Graphic by the Polis Center

The map above details the location of women in food deserts. A larger bubble represents more women in food deserts. The areas in this map are census block groups, small areas used to measure population and demographics.

Demographics of Food Deserts

BIPOC are more likely to live in a food desert than White residents. In Marion County, nearly one quarter of Black and one sixth of Latino residents lived in a food desert in 2022. About one in ten White and Asian residents lived in a food desert in 2022. In the eight-county Central Indiana region, rates are similar for Latino and Black residents (most Black and Latino residents of Central Indiana reside in Marion County), but much lower for White residents.

Why Food Deserts are Important to Women

Food deserts have an outsized impact on women because they are likelier to be the primary shopper in their household. In a 2022 study based on over 9,000 U.S. women, 80% report being the primary shopper.[3] A survey of nearly 3,200 women married to men found that, compared with men, women are seven times more likely to be the main food planner and preparer and five times more likely to be the main shopper.[4]

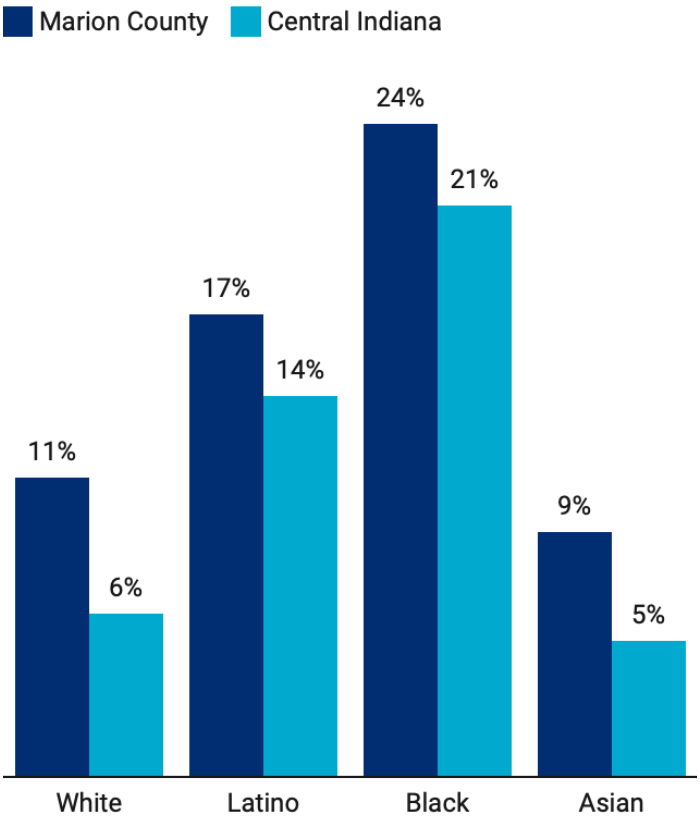
This means that when a trip to get to the closest grocery store is longer, it is likely women making those longer trips. When households without cars access grocery stores via transit, it is likely women making those transit trips. In neighborhoods where low access to grocery stores combines with low access to transit, this can place a significant burden on women.

Food Security

Income is the driver of food security, and wherever poverty is high, food security will be lower. Nationally, food insecurity grew from 10% in 2021 to 12% in 2022.[5] Of particular concern is "very low food security," when someone in the household experiences "reduced food intake...at times during the year because of limited money and other

Black and **Latino** residents are **most likely** to **live** in a **food desert**

Percent of each race living in food deserts



Source: SAVI, 2022 ACS 5-Year Averages, Graphic by the Polis Center
Central Indiana is the 8-county region

resources for obtaining food." This grew from four percent in 2021 to five percent in 2022 but is much lower (one percent) for children.

Food insecurity is higher for households with children and one parent. Households with single mothers experience low food security at a rate of 33% and very low food security at a rate of 13%. Households with single fathers also have higher levels of food insecurity, but not as high as single mothers.

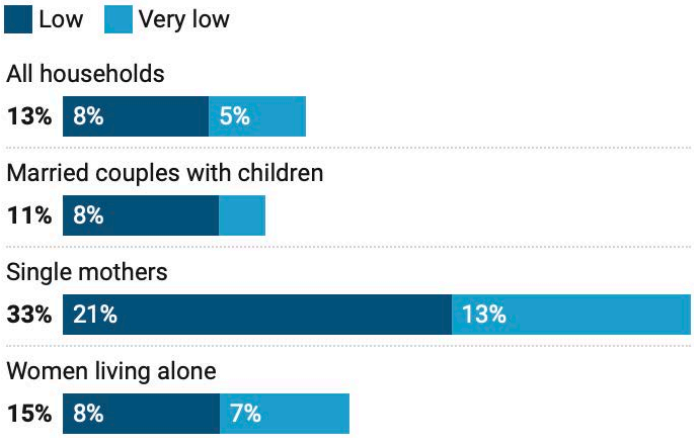
Food security is not measured at a neighborhood level, but because it is so closely tied to income, census tract-level measures of poverty can be an effective substitute. Nationally, 38% of households under 185% of the poverty threshold have low food security. Only nine percent of households with higher incomes have low food security. (For those below the poverty level, 42% have low food access, indicating that 185% is a significant "elbow" in the curve. People below 185% of poverty have similar levels of food security, even at lower incomes. People above 185% of poverty have much lower levels of food security.)

The map on the following page shows where the population with incomes below 185% of the poverty level are concentrated. Similar to the map of food deserts, these individuals tend to live on the northwest or northeast side of Indianapolis, with some concentrations on the southeast and southwest sides. Surrounding town centers tend to have larger low-income populations than the surrounding suburbs. While this map is not specific to women, it does identify where people with low food security are likely to live.

To estimate food security for women locally, we can begin by determining how many women live below 185% of the poverty level. In Central Indiana, that figure was 24% in 2022 (ACS PUMS one-year average), or 249,000 women. If 38% of those have low food security, equal to the national rate, that would be an estimated 94,000 women living with low food security. In much of Marion County, 25-45% of women live below 185% of the poverty threshold, which means an estimated 10-20% of women in these areas have low food access. This includes all

Households with **single mothers** have **lower food security** than any other household type

Share of household with low or very low food security



Source: USDA 2023, Graphic by the Polis Center
This chart represents national rates

Barriers & Biases

Many people struggle to afford their groceries while others may have a challenge accessing healthy, high-quality foods. These present the main barriers to food security in Central Indiana. Not only does the lack of affordable healthy food present a barrier for many communities, but there is a food bias in Central Indiana favoring the standard American diet with food grown for consumption in the U.S. With a growing international community, many newer neighbors may come from parts of the world that produce types of food not commonly grown in Indiana. This limits access to culturally meaningful foods.

of Marion County except Washington Township. The majority of women with low food access (56%) likely live in this area.

Programs to Address Food Security

The most substantial food security program (and poverty elimination program in general) is the Supplemental Nutrition Assistance Program (SNAP). Between 2019 and 2021, 72% of SNAP users were women, underscoring the fact that many women have primary responsibility for shopping and that food insecurity particularly effects women.[6]

When we map SNAP recipients by census tract, we see similar concentrations to our map of the low-

Low-Income Populations are **Most Likely** to Have **Low Food Security**

Population below 185% of poverty by census tract

To **explore** an **interactive version** of this **map, visit:**

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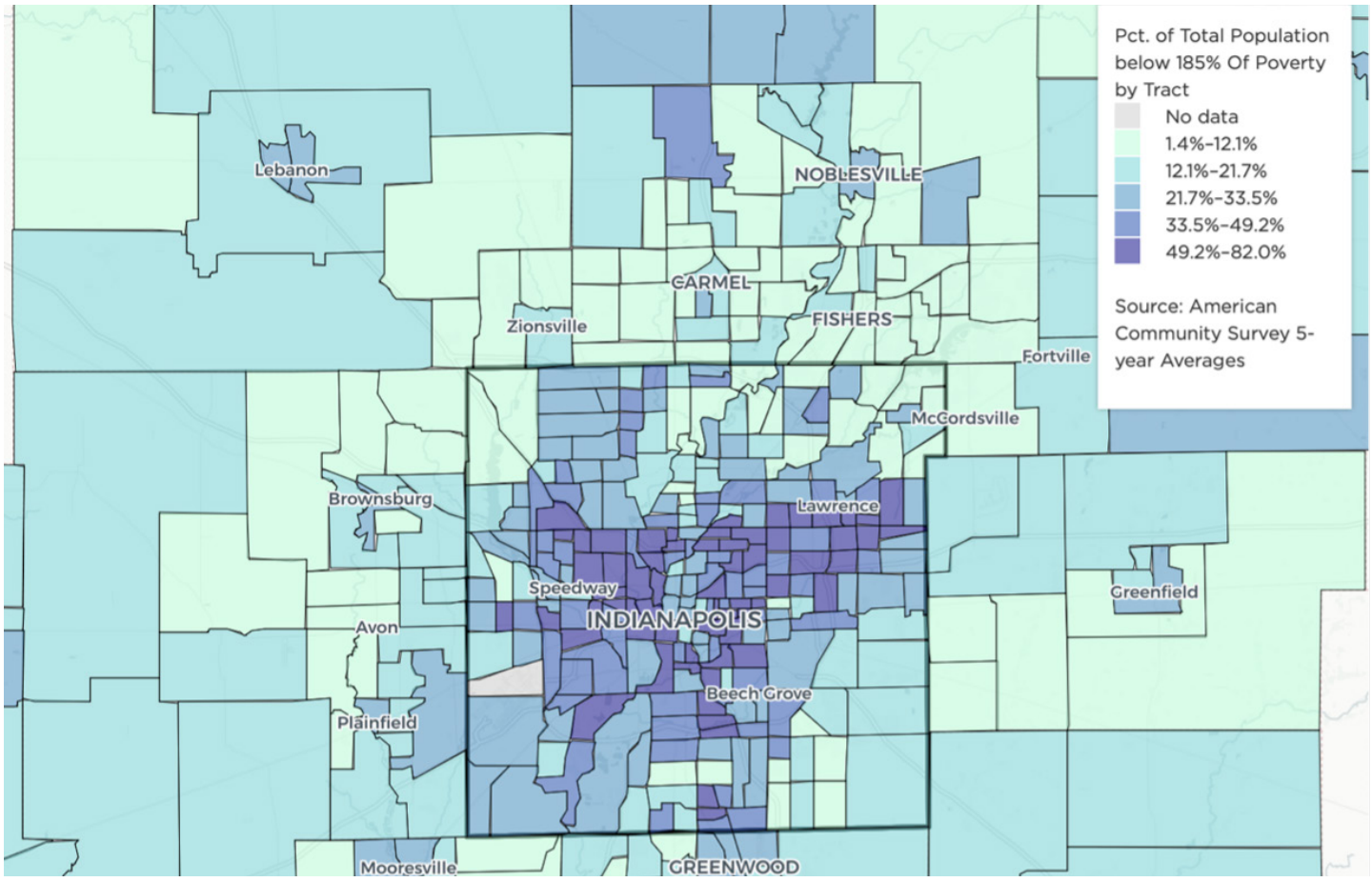

Source: SAVI, ACS 2022 5-Year Estimates; Graphic by the Polis Center

SNAP Utilization is Concentrated in **Marion County**

Percent of households receiving SNAP benefits, 2018-2022

To **explore** an **interactive version** of this **map, visit:**

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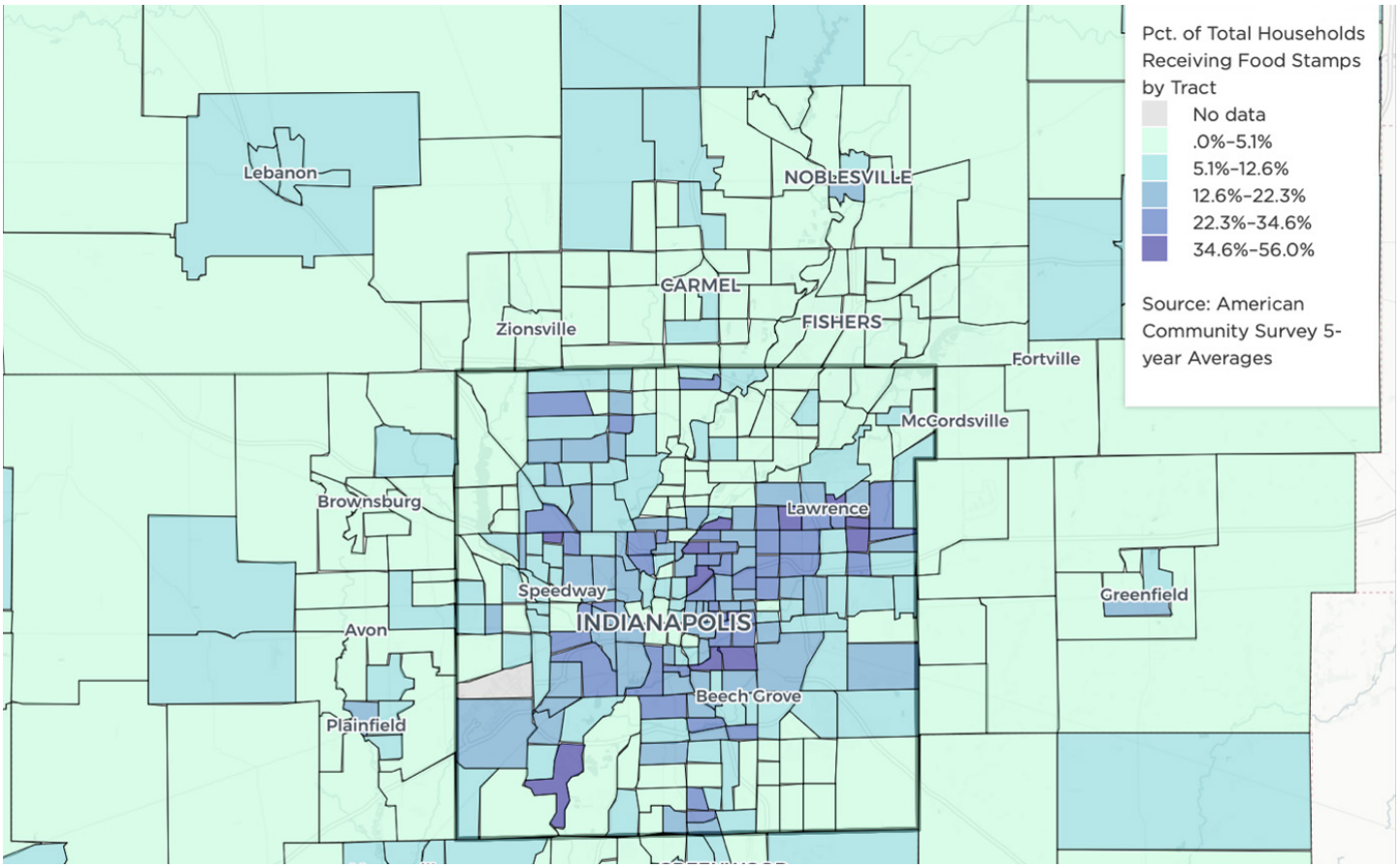

Source: SAVI, ACS 5-Year Estimates; Graphic by the Polis Center

income population, above. However, while a very high share of the population on the northwest side of Indianapolis lives below 185% of poverty, these areas only have moderately high SNAP usage. For example, in the area just east of Speedway, about half of the population lives below 185% of poverty but a little less than one fifth of households use SNAP. For comparison, areas just west of Lawrence have similar rates of low-income population, but over one quarter of households use SNAP.

These areas in northwest Indianapolis are home to many immigrants, and often a lack of information can decrease SNAP enrollment rates for eligible households. In a survey of 100 Latino families in New York City, the biggest deterrents to SNAP and

Women, Infants, and Children (WIC) enrollment were fears and logistical barriers. Respondents were afraid of having to pay back the benefits, being conscripted into the military, becoming ineligible for college aid, having their children removed, and having unauthorized family members reported to the government. When a respondent heard misinformation that SNAP usage could result in unauthorized family members being reported to the government, they were 85% less likely to apply for benefits, even though they were eligible for them.[7]

The WIC program is also an important program to increase food security and mitigate the impacts of poverty. According to the Indiana Department of Health, WIC serves 145,000 women, infants, and children each month (statewide). County-level data was available from the Indiana Department of Health until 2017. At that point, 44% of children under age five in the eight-county Central Indiana region used the WIC program. This ranged from 14% of children in Hamilton County to 59% of children in Marion County.

From August 2022 to August 2024, 12,279 women made over 15,000 calls to Indiana 2-1-1 related to food security and meal assistance. These calls were higher in the summer of 2024 than in the previous two years, potentially reflecting the higher cost of food after months of significant inflation. This represents 18% of the nearly 83,000 calls made by women to 2-1-1 during this period. To learn more about other 2-1-1 calls, please see the Financial Stability chapter. About one eighth (13%) of these calls end with unmet needs. According to Indiana FSSA, this is almost always (77%) because the "client refused referral." When FSSA measures met and unmet needs, they consider a referral to meet the needs of the client, regardless of if any services were rendered from that referral. One in 10 needs went unmet because the client did not meet eligibility.

Call about **food assistance rose** in the **summer** of **2024**

Monthly 2-1-1 calls about food assistance
September 2022 to July 2024

Source: Indiana 211 Dashboard, Graphic by the Polis Center
Central Indiana (8 counties)

Endnotes

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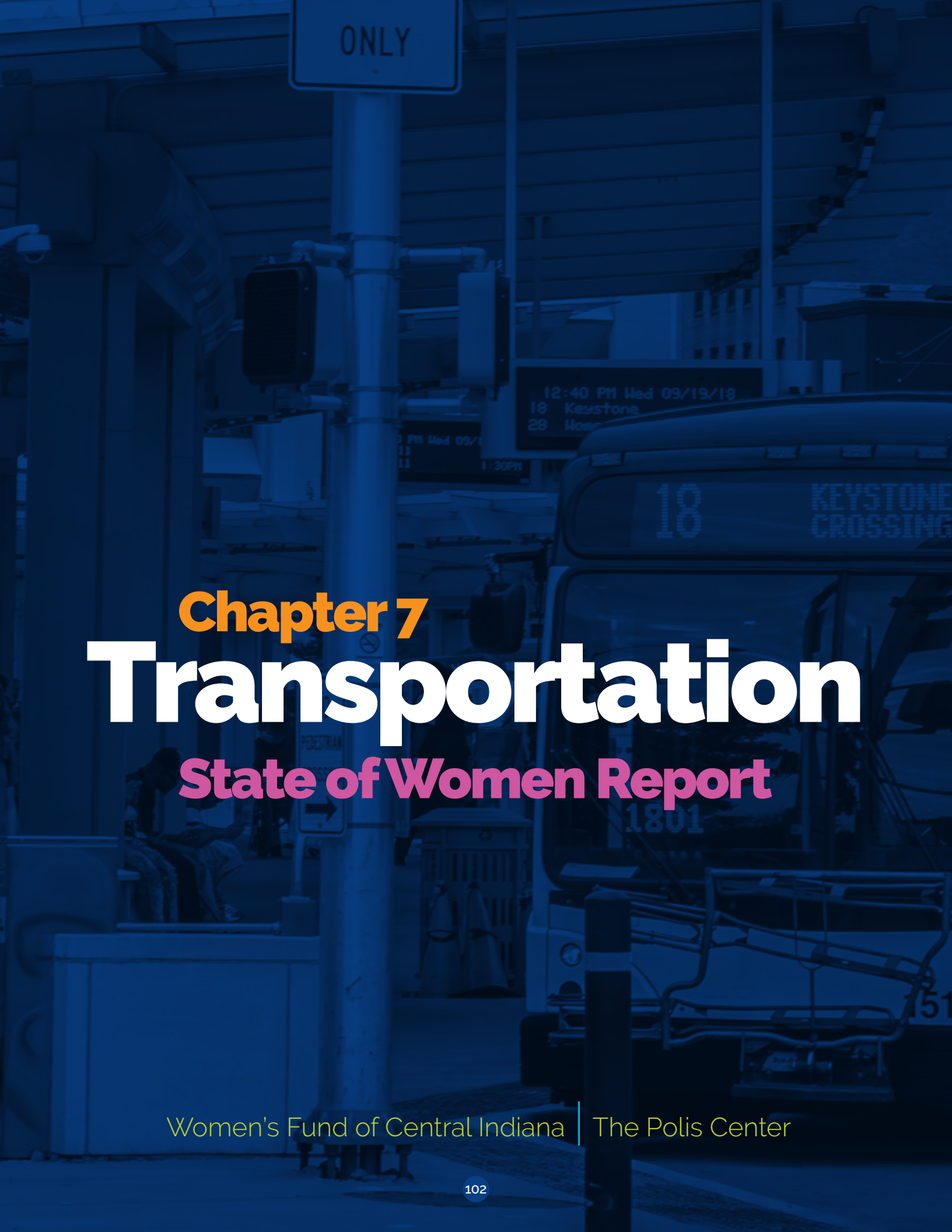

Chapter 7
Transportation
State of Women Report

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Transportation

Women make up most transit riders and account for most car trips, according to researchers. This means that every transportation issue, from traffic to transit service, has an outsized impact on women. In this chapter we explore transit ridership, commutes, and other types of trips.

Key Takeaways:

- In 2022, women made up 57% of weekday ridership and 62% of weekend ridership for IndyGo. Women who take transit tend to be employed full-time (55%) or part-time (17%). Most women (54%) earned below $25,000 per year.
- There is not a significant difference in vehicle access between men and women. However, working-aged women are more likely to live in one-car households (23% compared to 18% of men). This could contribute to women's use of transit or carpooling.
- Commutes tend to be shorter for women in Central Indiana—42% of women have a commute under 20 minutes compared to 35% of men.
- National studies find that women make more household support trips—single mothers spend 65% more time than men on household support travel and married mothers spend 50% more time than men.
- Household related trips, like picking up children, attending appointments, or making household purchases, must often be performed at specific times and places. This limits the opportunities available to women. As a result, women in one study had access to 44% fewer destinations—locations like shops, jobs, or offices—compared to men.

Public Transportation

Women make up a majority of transit riders in Indianapolis. Every several years, IndyGo is required by the Federal Transit Administration (FTA) to perform a ridership survey. A survey firm is contracted to interview thousands of riders while they are on the bus. The interview questionnaire includes demographic information, and this can be linked to the stops where they board and exit the bus and the purpose of their trip. In 2022, women made up 57% of weekday ridership and 62% of weekend ridership. In most years, women made up a slight majority of riders, but recent ridership among women is uniquely high.

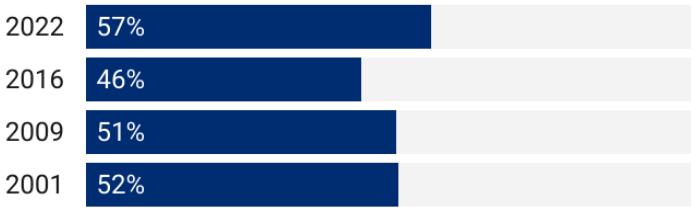
IndyGo is the only transit provider for Indianapolis and Marion County. Other counties in the Central Indiana area also have transit providers. They mostly provide demand response services, which are door-to-door, on-demand rides mostly used by seniors and people with disabilities. Johnson County and Central Indiana Regional Transportation Authority (CIRTA) have fixed bus routes, as well, and CIRTA provides vanpools. In total, these suburban transit services provided 332,000 rides in 2022, compared to 5.6 million rides in the IndyGo system that year.[1] Fixed route transit (like bus systems) is difficult to provide in rural and suburban areas where potential riders are fewer and more spread out. Without bus routes, rural and suburban residents have few affordable transportation options if they do not have a car and have not scheduled a demand response ride in advance with a county transit provider.

Across the country, transit ridership was transformed by the pandemic. Even in New York City, where transit is a much more common mode of transportation, transit trips fell 34% from 2019 to 2022.[2] The same pattern occurred in Indianapolis: Ridership fell from 9.5 million trips in 2019 to a low of 5.2 million trips in 2021. It has since recovered to 6.7 million in 2023 and is on pace to reach about the same number of trips in 2024.

Ridership is down overall, but women make up a larger share of riders. This indicates that ridership fell more for men than it did for women. Women and men tend to make trips for similar purposes. In the 2022 survey, 46% of trips by women were

Women make up their largest share of **IndyGo ridership** in decades

Women as a percent of weekday riders



In 2009, only overall ridership was available by gender, not weekday ridership

Source: IndyGo on-board surveys, Graphic by the Polis Center
Central Indiana is the 8-county region

Barriers & Biases

Lack of reliable transportation is a major barrier, in general. Not only are personal vehicles extremely expensive to own and maintain, but Central Indiana does not provide many alternatives when it comes to public transportation. IndyGo is Marion County's only public transportation system, and the surrounding counties (Hamilton, Hancock, Shelby, Johnson, Morgan, Hendricks and Boone) have much smaller public transportation systems. Travel between counties is difficult on public transit because there is minimal regional transit, even though jobs are growing quickly in suburban counties. It is crucial that transportation barriers are addressed to address inequities in our communities.

commuting to or from work, compared to 45% of trips for men. Personal trips were similar (18% vs. 19% for men and women, respectively), as were shopping trips (10% and 11%) and "other" trips (24% and 23%). This differs from several years ago: In the 2009 survey, women were slightly less likely than men to use transit for commuting and more likely to use it for other purposes.

Women make up a majority of riders on almost all routes. Of the eight routes with a larger sample size (at least 500 surveys), women made up the majority of riders. This includes Route 8 (Washington Street), the Red Line, Route 10 (10th Street), Route 39 (East 38th Street), Route 37 (Park 100), Route 3 (Michigan Street), and Route 19 (Castleton). Men make up 56% of riders on Route 34 (MLK/Michigan Road).

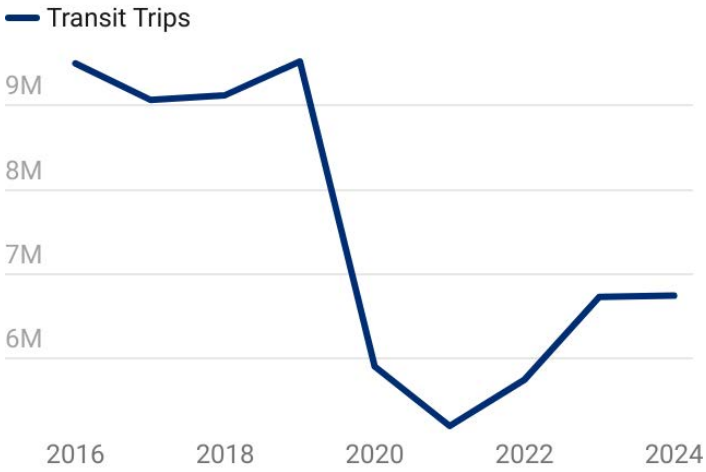
Women who take transit tend to be employed full-time (55%) or part-time (17%). Eight percent are unemployed and 10% are not in the labor force. Most women (54%) earned below $25,000 per year, while 17% earned between $25,000 and $34,999 and 20% earned between $35,000 and $59,999. Fifteen percent of women who use public transit speak a language other than English at home. Of those who speak a different language, 64% speak Spanish, nine percent speak French, and four percent speak Haitian Creole. Arabic, German, ASL, and Italian account for about three percent each.

Vehicle Access

About three percent of Central Indiana working-aged women live in a household without a vehicle. (In this case, due to data restrictions, the Central Indiana region includes 10 counties: Marion, the surrounding counties except Madison, Brown and Putnam.) For families, the census provides data about the number of workers compared to the number of vehicles in each family.[3] Access to vehicles appears much lower when measured in this way. About one tenth of driving-aged people in families have access to fewer vehicles than workers in the family. For example, this would include people living in families with two workers but only one car. This also includes people living in families with no car, even if there are no workers in that family.

Ridership has **recovered 29%** since the pandemic, but is **still down 41%** from before the pandemic

Annual ridership counts, IndyGo

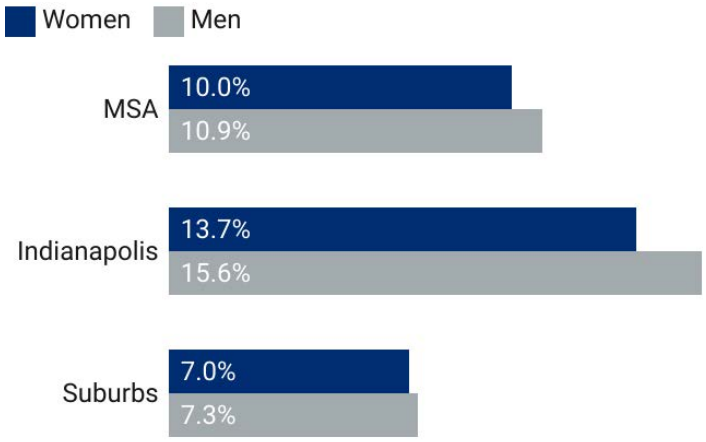


2024 data is the estimated annual total given ridership for the first six months of the year. This data comes directly from IndyGo.

Source: IndyGo, National Transit Database, Graphic by the Polis Center
Central Indiana is the 8-county region

One-in-ten people in families struggle with vehicle access

Driving age people in families with fewer cars than workers



Also includes people with no vehicles

Source: Source: ACS PUMS 2022 1-Year Estimate, Graphic by the Polis Center

The following data concerns the Indianapolis Metropolitan Statistical Area (MSA). This is a census-defined region including Indianapolis and its suburbs. It contains 11 counties: Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, Putnam and Shelby. The rate of people with low vehicle access is about twice as high in Indianapolis as it is in the ten suburban counties. There is not a significant difference in vehicle access between men and women. However, working-aged women are more likely to live in one-car households (23% compared to 18% of men). This could contribute to women's use of transit or carpooling.

Commuting Patterns

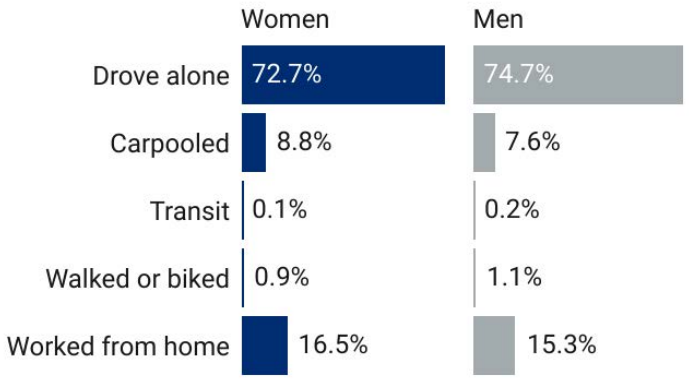
In the Indianapolis MSA, most workers either drive alone to work (14 in 20) or another significant amount (three in 20) work from home. Carpooling is the only alternative mode of transportation that accounts for a large share of workers (2 in 20).

Commuting modes other than driving alone tend to be slightly more common among women and more common in Indianapolis. While 73% of women and 75% of men drive alone to work in suburban counties, that figure is only 70% of women in Indianapolis. Carpooling is more common in Indianapolis, with 10% of women carpooling to work compared to nine percent in the ten suburban counties. Transit only accounts for one percent of commuters in Indianapolis, but virtually zero commuters in the suburbs. Walking or biking to work is about twice as common in Indianapolis as in the suburbs, but women are less likely than men to commute to work by walking or biking.

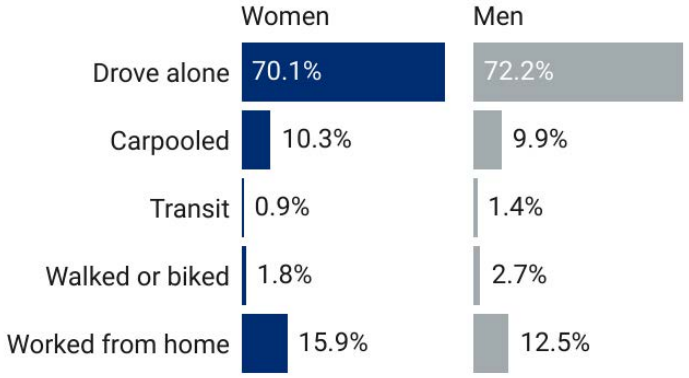
Commutes tend to be shorter for women in Central Indiana. While 42% of women have a commute under 20 minutes, that rate is 35% for men. For women, 33% have a commute of at least half an hour, compared to 40% of men. Women prioritize a short commute to facilitate other trips, like errands or picking up children from school or childcare. As we will explore in the next section, women tend to have more complex travel patterns with destinations other than work.[4]

Commuting mode by gender

Suburban Counties (11-county Central Indiana Region except Marion County)



Indianapolis (Marion County)



Source: Source: ACS 2022 1-Year Estimate, Graphic by the Polis Center

Trips and Travel Patterns

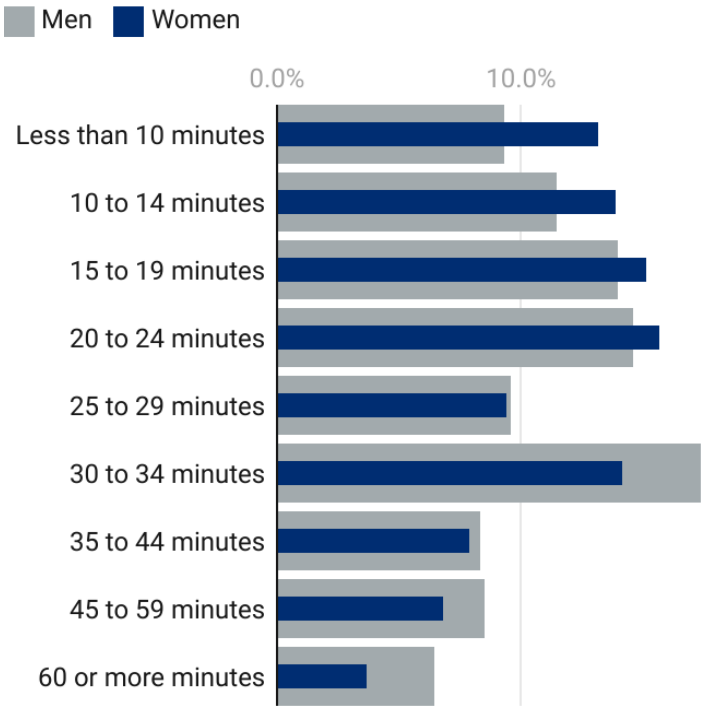
Geographers have found that, because women have more tasks and responsibilities with a fixed time and location (for example, driving a child to an activity or picking them up from childcare) this can limit their access to opportunity. One pre-eminent researcher in this field, Mei-Po Kwan, studied travel patterns of women in Columbus, Ohio and found that women had access to 44% fewer destinations than men.[5] This is because of the constraints placed on women by non-work, out-of-home activities. There is only so much time in the day, and if you need to pick up or drop off people at certain locations and at certain times, that severely limits the range of places and activities that are accessible to you throughout the day. For example, full-time employed women in this study had access to 543 office buildings in Columbus, on average, compared to 778 office buildings accessible by men. This means job opportunities for women are more constrained by the time and location of their other responsibilities.

In another study by Kwan, she found that women made more stops than men in their daily travel. Women who worked full-time made 3.99 stops per day on average, while women who worked part time made 4.26 stops per day. Men made only 3.44 stops per day. That adds up to four to five more stops per week for women than men. These additional stops mean more travel time, but also more constraint to opportunity, because many stops must be at a certain place and time. Women were at least twice as likely as men to make another stop at home during the day before leaving again for another activity. Logically, this would put a constraint on the employment opportunities available to women—they may prioritize a short commute over higher pay or better opportunities, because they need to work close to home to fulfill their other responsibilities.

These studies, while very powerful and detailed, were conducted about three decades ago. But more recent studies still support the same conclusions. In a study using data from 2003-2010, researchers found that while commutes tended to be shorter for women than for men, household support travel—like shopping or caring for family

Women tend to have **shorter commutes** than men

Share of each gender by commute time



Source: Source: ACS 2022 1-Year Estimate, Graphic by the Polis Center

> **"Broader transportation is an issue...I grew up in New York. You could hop on a train or bus and get clear across town in 30 min or so. Here, you know, thank God, there's the Purple Line and other lines going in. But transportation continues to be an impediment, [especially] if the jobs are growing out in Brownsburg and Avon and Plainfield."**
>
> ***- Miriam Acevedo Davis,*** *President/CEO of La Plaza*

members—was longer.[6] The average single mother spent 33 minutes a day on household support travel, compared to 20 minutes a day for single fathers—a 65% difference. For married couples with kids, women spent at least 50% more time than men on household support travel.

This has two main implications. Women spend more time travelling than men, therefore transportation problems, like a lack of public transit service, traffic, and even street condition, have more impact on women than on men. Second, patterns of urban development have a large impact on women's opportunities. When employment, housing, schools, and shopping are located far apart, this makes non-work trips more time-consuming and complex. This has an outsized impact on women, because they make most of the non-work trips. This also limits the places women can go. There may not be enough time to drive to the preferred store, school, job, or childcare based on the constraints of the other locations women must travel to.

Strength & Abundance

"Pathway Resource Center has launched a mini bus service with the help of IndyGo and the United Way of Central Indiana, offering residents $2 rides to grocery stores, jobs, medical appointments and other essential errands. The neighborhood it serves, the Far Eastside, is bounded roughly by I-70, I-465, Lawrence and the eastern Marion County border." We want to highlight this important work that is addressing a major gap in transportation needs. However, a long-term policy solution is needed to ensure everyone in Central Indiana has reliable transportation.

Endnotes

1 Federal Transportation Administration. NTD transit agency profiles [Internet]. 2024. Available from: https://www.transit.dot.gov/ntd/transit-agency-profiles?field_geography_target_id=All&field_address_administrative_area=IN&combine&page=3.

2 Federal Transportation Administration. 2022 annual agency profile – MTA New York City Transit. 2022. Available from: https://www.transit.dot.gov/sites/fta.dot.gov/files/transit_agency_profile_doc/2022/20008.pdf

3 U.S. Census Bureau. American Community Survey 2022 1-year estimate microdata. 2022.

4 Ng WS, Acker A. Understanding urban travel behavior by gender for efficient and equitable transportation policies. International Transport Forum. 2018 Jan. Available from: https://www.itf-oecd.org/understanding-urban-travel-behaviour-gender-efficient-and-equitable-transport-policies

5 Kwan MP. Gender and individual access to urban opportunities: A study using space-time measures. The Professional Geographer. 1999;51(2). Available from: http://meipokwan.org/Paper/PG_1999.pdf.

6 Fan Y. Household structure and gender differences in travel time: spouse/partner presence, parenthood, and breadwinner status. Transportation. 2017;44:271-291. https://doi.org/10.1007/s11116-015-9637-7

Persona

Maria Diaz

27 years old

Expecting her first child

Struggles to balance it all

Personas are sketches of fictional people that represent real challenges and circumstances highlighted in this report. They are a useful way to imagine how these statistics impact the lives of individuals and families.

Maria Diaz is a 27-year-old Latina living in Shelbyville. She and her husband, Marco, are expecting their first child. Although they are eager and excited to be parents, Maria worries not only about the health of the baby but about how how becoming parents will affect the couple's future financially, physically and emotionally.

Maria suffered a miscarriage a year ago. She is now in her sixth month of pregnancy and has had three prenatal-care visits with her doctor so far. She hopes to have more frequent visits during her third trimester but is anxious about going over her insurance plan's coverage limits, especially if complications come up that require special procedures and testing.

Maria's insurance is through her employer, a drugstore chain where she works 45 hours a week as a cashier. She recently signed up for a Sunday shift to help cover baby-related expenses over the next few months. The extra income is welcome, but the work has increased her stress levels in many ways, beyond just the physical toll. She has been unable to attend church most Sundays, which has long been her main source of social support and community. She tries to stay in touch with friends by seeing them during the week, but most of her church friends have young children, so finding a workable time is difficult. One of Maria's good friends from the church—someone who knows about her miscarriage and her history as a victim of childhood physical and emotional abuse by her father—suggested that she should look into professional therapy. Maria often thinks about acting on that advice, but she wonders what Marco would think. With everything else going on—and with money so tight as her due date nears—it's easy to keep putting it off.

Maria's parents live near her brother and sister in Chicago, but she often helps out with Marco's parents, who live nearby in Shelbyville. Both are in their late 60s and rely primarily on Social Security income, though the mom takes house-cleaning jobs as her health allows. The four of them eat meals together regularly, and she and her mother-in-law often cook together. She also spends an hour or two each week assisting them with everyday chores—filling out online forms, calling service providers, etc.—and sometimes drives them to and from appointments. All of this is in addition to Maria's responsibilities in her own home, where she does nearly all of the cleaning and grocery shopping.

Maria is successfully juggling all her work and family responsibilities so far. But she worries about what will happen as her pregnancy

progresses and she becomes a parent. How much time and energy will she have to help with her in-laws when the baby arrives? How will she and Marco afford child care? Will his parents help her out? Should she cut back on her work hours to spend more time with the baby—and save on child-care expenses? If so, how will she and Marco make up the income? And what about her own mental health? When will she able to reconnect with her church? And when, if ever, will she have the time and resources to tend to her mental health?

Chapter 8
Health Status
State of Women Report

Women's Fund of Central Indiana | The Polis Center

Health Status

The health and wellbeing of women in the United States are influenced by socioeconomic and demographic disparities, which are further exacerbated by persistent exposure to stressors. A theory known as the "weathering hypothesis" posits that enduring stress accelerates the aging process and undermines health, particularly among marginalized groups.[1] As is the case for the nation overall, Black women in Central Indiana bear a disproportionate burden of some diseases and encounter substantial barriers to accessing healthcare and achieving positive health outcomes.

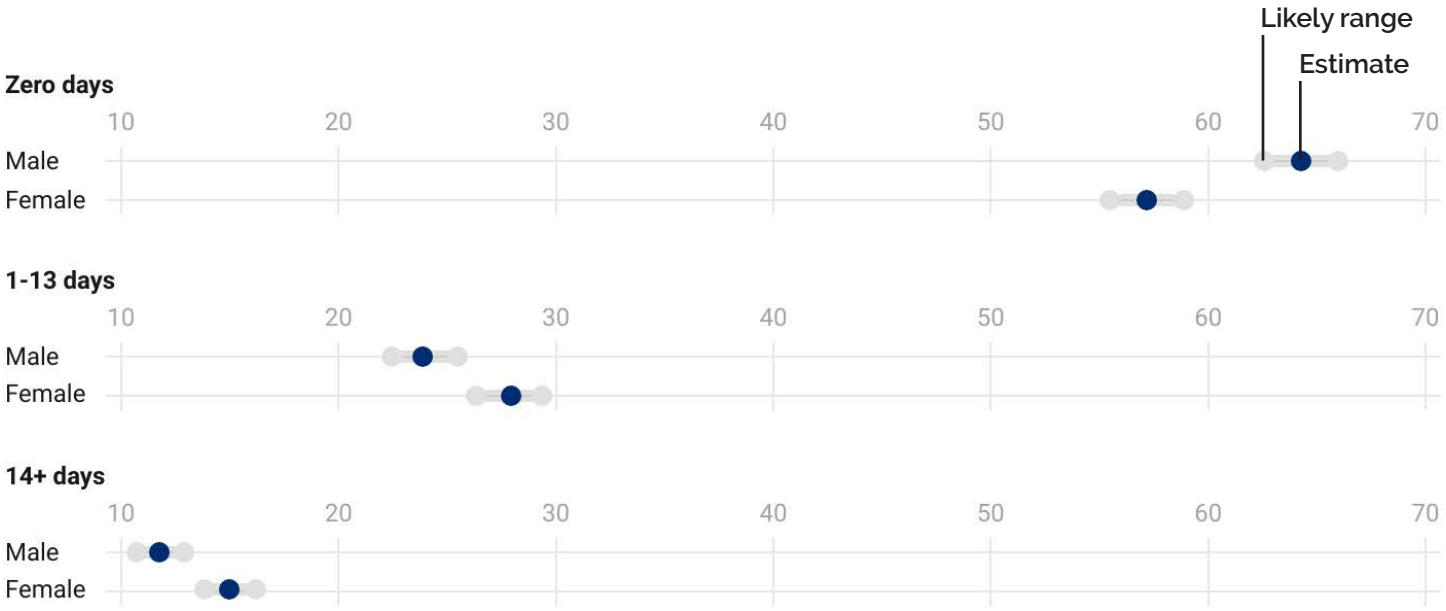
The cumulative effects of financial instability, healthcare barriers, and racial discrimination underscore the challenge of weathering. Systemic inequities in healthcare, economic opportunities, and social determinants of health are shaped and sustained by political determinants of health. Through government action or inaction and policy decisions, structural conditions such as environmental hazards, inadequate transportation, unsafe neighborhoods, unstable and substandard housing, limited access to healthy food options, and underfunded and inadequate educational opportunities have contributed to and exacerbated health disparities, life expectancy, and overall quality of life.[2]

Key Takeaways:

- In Indiana, women report experiencing poor physical health more frequently than men. A higher percentage of men (64.8%) report having zero days of poor physical health, while a significantly lower percentage of women (55.6%) indicate the same.
- Black women in Indiana have significantly higher rates of Human Immunodeficiency Virus (HIV) prevalence (440.2 per 100,000 in 2022) compared to White women (32.8 per 100,000).
- Economic barriers prevent 10.2% of women in Indiana from seeking medical care, with Hispanic women (20.8%) being the most affected by financial constraints, followed by Black (12%) and White women (8.5%).
- From 2018 to 2022, heart disease and cancer consistently ranked as the top two causes of death among women in Central Indiana, with crude death rates fluctuating between 150 and 170 per 100,000 population.

Fewer women report **zero days** of **poor physical health** than **men**

Poor physical health days in the last 30 days by gender (Indiana)



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2023, Indiana; Graphic by the Polis Center

Individuals aged 18 and older, including both men and women

Poor Physical Health Days

Physical health influences quality of life and the ability to engage in daily activities. Findings reveal gender disparities in physical health in Indiana. Fewer women (57.2%) report zero days of poor physical health in the last 30 days than men (64.3%).[3] On the contrary, women report a higher prevalence of poor physical health days in the "one to 13 days" and "14 or more days" categories.

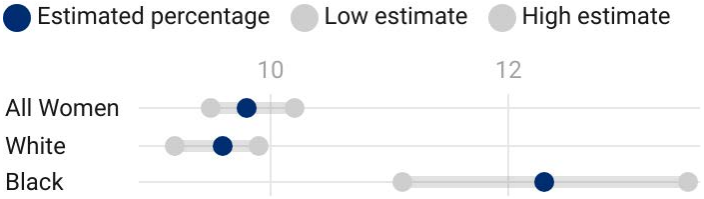
Based on the years 2018-2022, fair or poor health status among women in Indiana (9.8%) is slightly higher than the national rate (9.3%). Black women self-report a higher percentage (12.3%) of fair or poor health as compared to White women (9.2%).

Obesity

Obesity is a public health issue, defined by an excessive accumulation of body fat that poses health risks. The World Health Organization (WHO) identifies obesity as a major risk factor for various chronic diseases, including diabetes, cardiovascular diseases, and certain cancers.[4] In the United States,

Black women self-report a **higher percentage** of **fair** or **poor health**

Self-reported fair or poor health status by race (Indiana)



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2022; Graphic by the Polis Center

Women aged 18 and older by race/ethnicity groups

obesity prevalence has been steadily increasing over the past few decades, contributing to health and economic burdens for both women and men.[4,5] Over the past two decades, Indiana's obesity rate has consistently risen, positioning Indiana as the 12th highest state in the nation for obesity in 2022 and with an obesity rate exceeding the national average.[6] In Indiana, women report a higher obesity rate (40.5%) compared to men (35.2%).[3] This gender disparity may be attributable to various factors, including differences in physical activity levels, dietary habits, and socioeconomic influences.[7]

Black women in Indiana have a higher obesity rate (45.1%) than White women (38.6%) or Hispanic women (37.7%), although the obesity rate for Black women is less in Indiana than it is for the nation (47.9%). In contrast, the obesity rate for White women is eight percentage points higher in Indiana than it is for the nation (30.6%) and the obesity rate for Hispanic women is two percentage points higher in Indiana than it is for the nation (35.7%).[8]

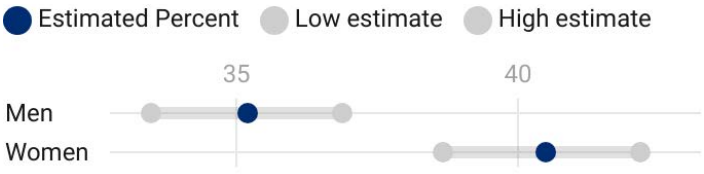
In Indiana, obesity rates are highest among women aged 45-54 years, with nearly half (48.0%) reporting obesity. Women in the 35-44 age group also have a high prevalence of obesity at 44.0%.[3] The lowest obesity rates are seen in the youngest (aged 18-24) and oldest (aged 65+) age groups, at 27.6% and 33.4%, respectively.

Diabetes

Diabetes is a chronic disease that affects how your body turns food into energy. In the United States, diabetes is a major public health issue, impacting millions of people and leading to severe health complications such as heart disease, stroke, kidney failure, and vision loss. The prevalence of diabetes has been increasing steadily over the years, making it one of the top chronic conditions in the country.[9,10] Overall, 11.6% of women in Indiana have diabetes. The prevalence of diabetes varies among different racial groups, with Black women experiencing the highest rate at 16.1%. White women have a diabetes prevalence of 11.4%, while Hispanic women report the lowest rate at 9.2%.[3]

Women report a **higher obesity rate** compared to **men**

Percentage of obesity by gender (Indiana)

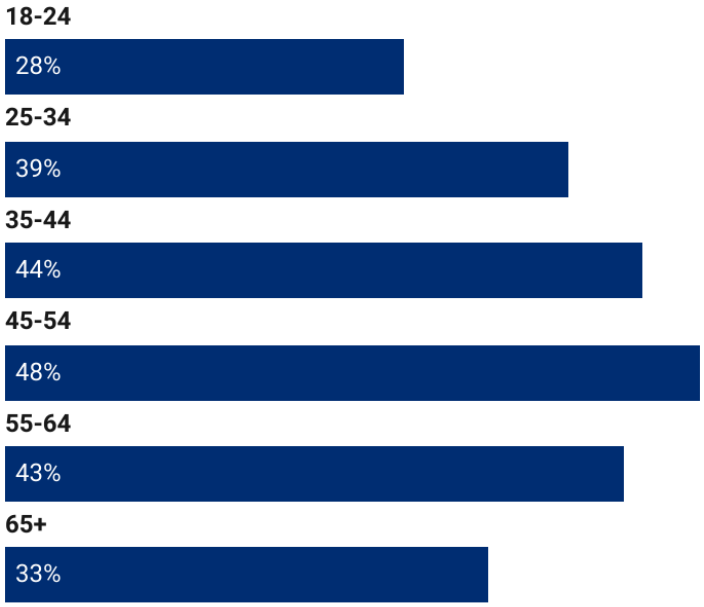


Source: Behavioral Risk Factor Surveillance System (BRFSS), 2022; Graphic by the Polis Center

Individuals aged 18 and older, including both men and women

Nearly half of **women** aged **45-54 years** report **obesity**

Percentage of obesity by age group (Indiana)



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2022; Graphic by the Polis Center

Women aged 18 and older

Heart Disease

Heart disease is a leading cause of death among women in the United States, according to the U.S. Center for Disease Control and Prevention (CDC).[11]The term "heart disease" indicates various conditions affecting the heart, with heart attacks being one of the most critical. Overall, 3.4% of women in Indiana have been diagnosed with a heart attack. While there are racial differences in prevalence, they are not significant. White women have the highest reported history of heart attacks (3.6%) followed by Black women (3.3%). Hispanic women having the lowest rate (1.4%) among the three populations.[3] Studies have shown that women are more likely to experience atypical heart attack symptoms, which can lead to misdiagnosis or delayed treatment.[12] For example, women might experience upper back pressure, dizziness, or lightheadedness rather than classic chest pain.[13] Additionally, heart disease in women is frequently underdiagnosed and undertreated, with symptoms often being misunderstood or dismissed.[14] This can result in women not receiving the necessary care and attention, leading to worse outcomes compared to men."

Cancer

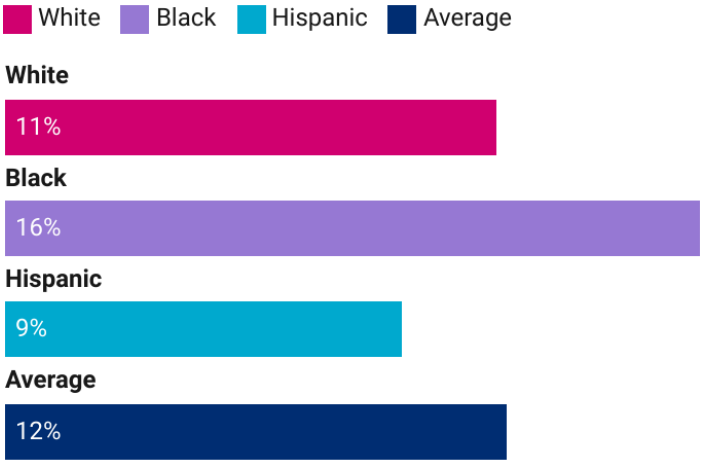
Cancer is a leading cause of death among women in the United States, with breast cancer being the most diagnosed cancer.[15] Early detection through screenings such as mammograms and pap smear tests is crucial for improving survival rates and outcomes. Despite advances in cancer treatment and increased awareness, disparities in cancer detection and outcomes persist among different racial and ethnic groups.

Early detection of breast cancer improves the chances of successful treatment and survival. In Indiana, breast cancer screening rates in women aged 40 and older do not reveal significant disparities among different racial groups.[16]

In 2024, the American Cancer Society projects that approximately 310,720 new cases of invasive breast cancer will be diagnosed in women across the United States. Unfortunately, about 42,250 women are expected to die from this disease, underscoring

Black women experience the **highest rate** of **diabetes** among the different **racial groups**

Percentage of women ever diagnosed with diabetes by race (Indiana)

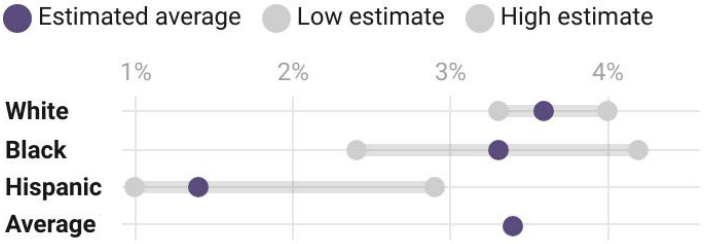


Source: Behavioral Risk Factor Surveillance System (BRFSS), 2022; Graphic by the Polis Center

Women aged 18 and older

Hispanic women have the **lowest rate** of **heart attacks** among the three populations

Percentage of women diagnosed with a heart attack by race (Indiana)



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2022; Graphic by the Polis Center

Women aged 18 and older

the ongoing challenges in breast cancer treatment and outcomes.[17]

In Indiana, breast cancer incidence rates from 2017 to 2021 were relatively similar across racial groups, but 2020 saw a sudden decline, likely due to disruptions in healthcare access caused by the COVID-19 pandemic. Despite similar incidence rates, a significant disparity persists in breast cancer mortality. From 2017 to 2021, Black women aged 20 and older experienced an average mortality rate of 37.0 per 100,000, compared to 28.3 per 100,000 among White women. Between 2017 and 2019, Black women's breast cancer mortality showed a gradual decline—from 42.4 per 100,000 in 2017 to 35.5 in 2019—while White women's rates remained stable, slightly fluctuating from 28.8 to 26.8 per 100,000 over the same period.

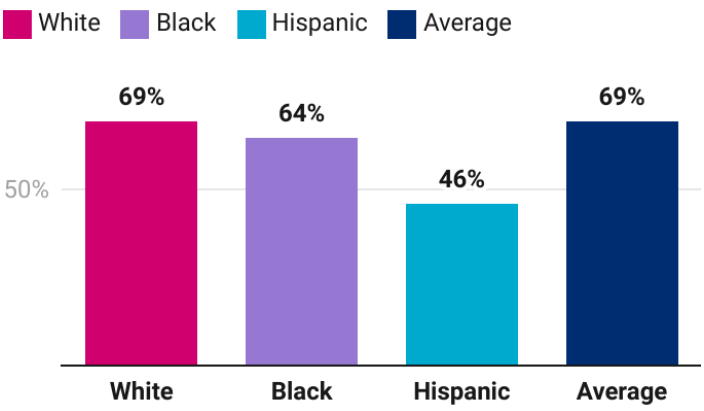
However, 2020 marked a sharp increase in mortality for Black women, rising to 40.0 per 100,000, which was 38.8% higher than the rate for White women (28.8 per 100,000) for this year. This spike likely reflects broader COVID-19 impacts, which disproportionately affected Black communities by disrupting cancer screenings, delaying diagnoses, and reducing timely access to treatments.[16]

Notably, prior studies have consistently documented disparities in time to treatment for breast cancer, with Black women facing longer delays than White women, including in surgical care.[18] During the pandemic, necessary surgery pauses may have exacerbated these disparities.[19] Although data is sparse in this area, early research from a New York City medical center supports these findings that Black and other minority patients experienced greater treatment delays compared to White patients, with Medicaid coverage being an additional factor associated with increased delays.[20]

By 2021, the mortality rate for Black women dropped sharply to 29.7 per 100,000, nearing the rate for White women at 28.2 per 100,000, suggesting a partial recovery in healthcare access and improved interventions targeting Black women. While this narrowing of the gap is encouraging, the sharp rise in 2020 emphasizes the vulnerability of Black women to systemic healthcare inequities, which can be exacerbated during public health crises.

Women **aged 40 and older do not reveal significant disparities** for **breast cancer screening rates** among **racial groups**

Mammogram screening rates by race (Indiana)

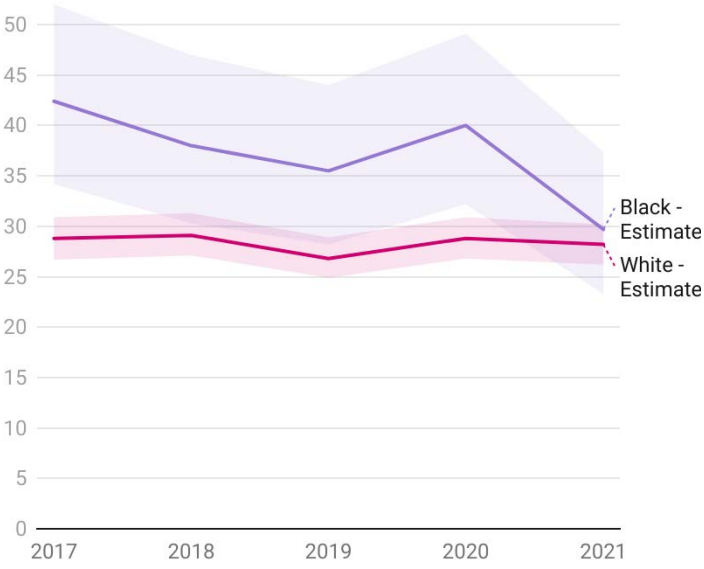


Source: Behavioral Risk Factor Surveillance System (BRFSS), 2022; Graphic by the Polis Center

Women aged 18 and older

The **breast cancer mortality rate gap** is **narrowing** for **White** and **Black women**

Breast cancer deaths by race (Indiana). Age adjusted rate ber 100,000



Source: CDC Wonder; Graphic by the Polis Center

The variability in mortality rates over this period underscores the need for sustained, equitable healthcare interventions, focused efforts to reduce delays in treatment, and more comprehensive data collection to fully understand and address these disparities, particularly during times of crisis

Sexually Transmitted Infections (STIs)

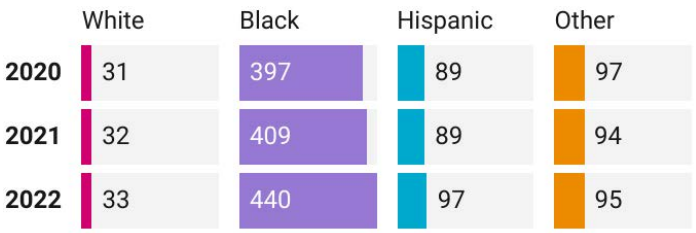
Sexually transmitted infections (STIs) are a major public health concern in the United States, with millions of new cases reported each year. According to the Centers for Disease Control and Prevention, more than 2.5 million cases of chlamydia, gonorrhea, and syphilis were reported in 2022.[21] These infections can lead to serious health complications, including infertility, ectopic pregnancy, and increased risk of HIV transmission, if not diagnosed and treated promptly.

In Indiana, Black women experience a much higher prevalence of HIV (440.2 per 100,000 in 2022) compared to Hispanic women (97.2 per 100,000 in 2022) and White women (32.8 per 100,000 in 2022). In addition, between 2020 and 2022, the HIV rate per 100,000 increased more for Black women (from 396.8 to 440.2) than for Hispanic women (from 88.6 to 97.2) or for White women (from 31.4 to 32.9).[22] Women categorized under "Other" races had relatively stable rates, with 95.3 per 100,000 in 2022.

Research has previously shown strong connections between both income inequality and socioeconomic deprivation with HIV/AIDS, regardless of race/ethnicity or gender, with structural factors contributing significantly to HIV/AIDS rates.[23] Adding race/ethnicity to models consistently show that communities with high levels of racial segregation have higher levels of HIV/AIDS, due to concentrated, generational deprivation & exclusion.[24,25,26,27] One factor driving the multitude of health challenges in Black neighborhoods is that racially segregated areas have difficulty securing consistent healthcare resources, such as providers, educators, facilities, and programs. This is true not only of general healthcare resources, but also for HIV/AIDS-specific needs—these exclusions lead not only to lack of internal resources and decreased social capital to leverage external resources, but

The **HIV rate** per 100,000 **increased more** for **Black women** than for **Hispanic** or **White women**

HIV prevalence rate by race (Indiana)



Source: HIV EPI Profile of Indiana Department of Health, 2020- 2022; Graphic by the Polis Center

Women, all ages

also to decreased community knowledge about HIV/AIDS and prevention/treatment options. Research has also shown higher levels of "medical mistrust" of healthcare providers and institutions among Black, Indigenous, and People of Color (BIPOC) communities, leading to hesitance to talk to providers about sexual behavior, and lack of trust of interventions such as pre-exposure prophylaxis (PreP).[28] While historically, men have faced higher rates of HIV/AIDS, Black women face intersectional issues of race and economic discrimination, compounded with gender-specific issues, such as higher rates of sexual assault, other forms of coerced constraints from partners, and stigma from providers, family, and community about women's sexual autonomy.[29] Along with 'medical mistrust' of providers and institutions, Black women can face isolation leading to lack of access to prevention, treatment, and support.[30]

Mortality

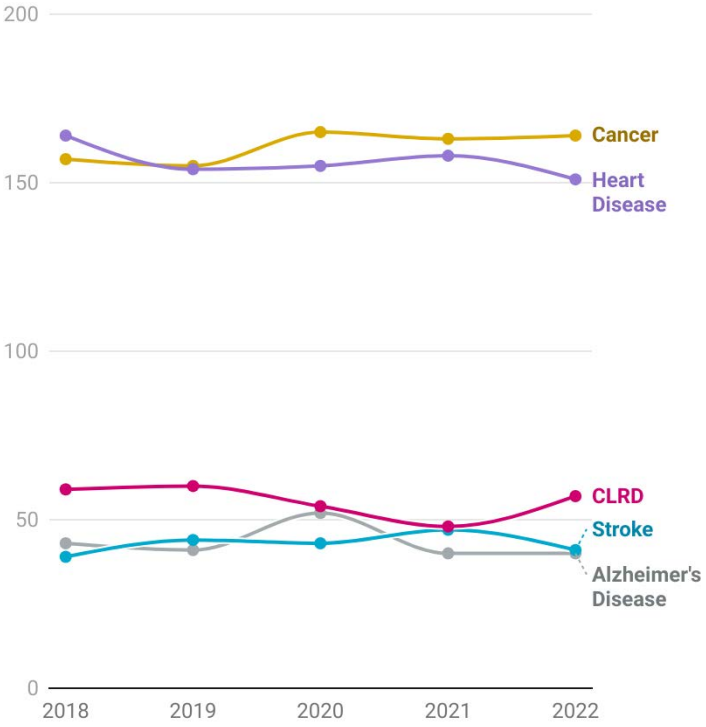
Mortality data reveal the leading causes of death of women in Central Indiana. An examination of these trends helps policymakers and healthcare providers to develop strategies aimed at reducing preventable deaths and improving the life expectancy and quality of life of women across the state.

From 2018 to 2022, heart disease and cancer consistently emerged as the top two causes of death among women in Central Indiana, with crude death rates fluctuating around 150 to 170 per 100,000 population. Deaths related to Alzheimer's disease saw a notable increase in 2020, peaking at 52 per 100,000 women, before declining slightly in the subsequent years. This spike coincides with the COVID-19 pandemic, which could have exacerbated the vulnerabilities of those with pre-existing cognitive impairments.[31] Chronic lower respiratory diseases and stroke also consistently appeared among the top causes of death for women, with relatively stable rates throughout 2018-2022.

Stratifying mortality data by race/ethnicity reveals disparities. Although White women have a higher reported rate of heart attacks, Black women have a higher mortality rate for heart disease (199 per

Top five causes of death for women

Central Indiana's mortality rate from cancer and heart disease is consistently ranked higher between 2018-2022. Deaths related to Alzheimer's disease peaked in 2020 and then slightly went down in recent years.



Source: Polis Center analysis of data from CDC Wonder 2018-2022; Graphic by the Polis Center

*Chronic Lower Respiratory Disease (CLRD) includes Chronic obstructive pulmonary disease (COPD), Chronic bronchitis, Emphysema, and Asthma.

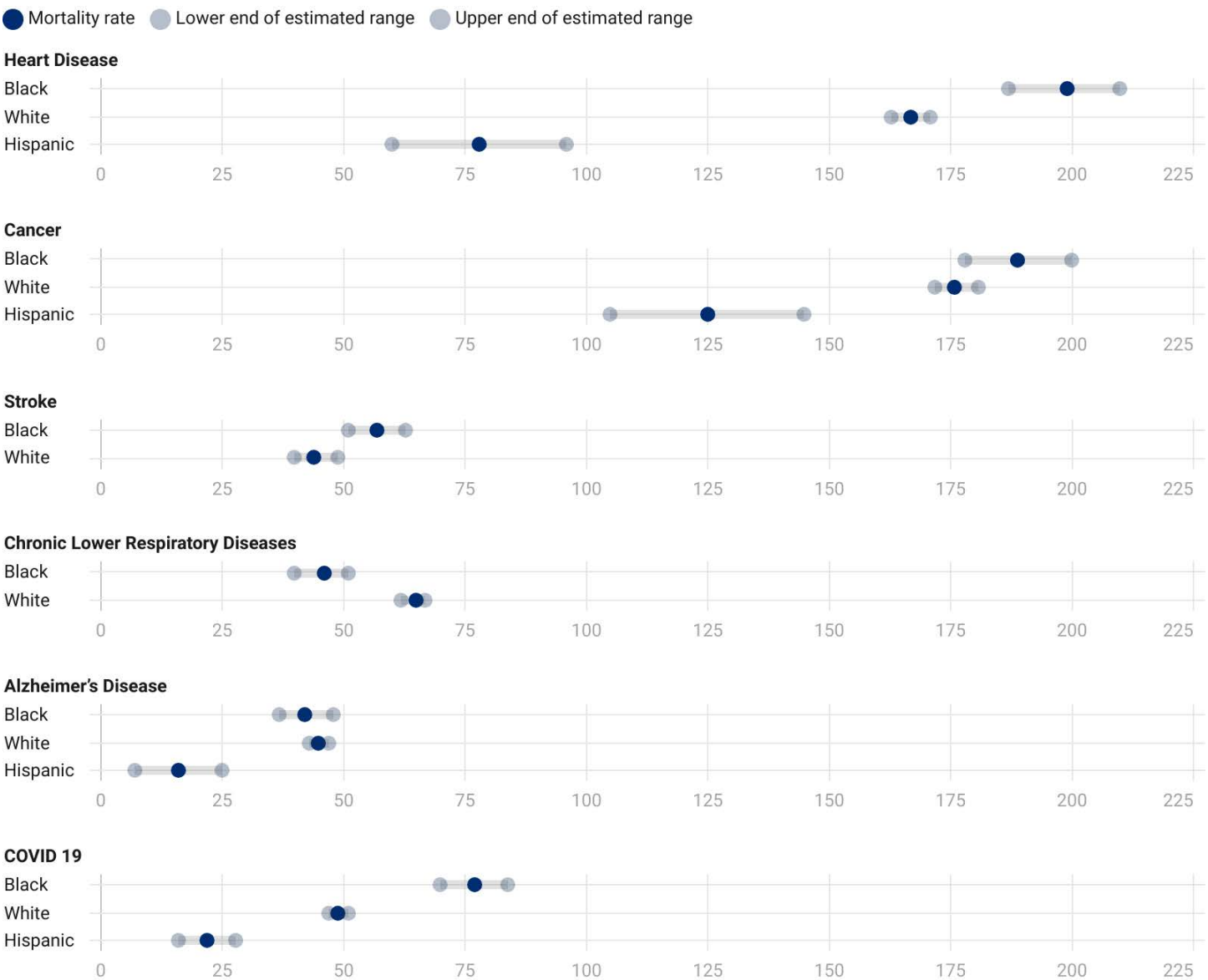
Barriers & Biases

According to the National Library of Medicine, "health care providers hold negative explicit and implicit biases against marginalized groups of people such as racial and ethnic minoritized populations." These biases lead to inequitable outcomes for our communities. It is crucial to address these biases through system-wide interventions.

100,000) compared to White women (167 per 100,000) and Hispanic women (78 per 100,000). Black women also have a higher cancer mortality rate (189 per 100,000) compared to their White (176 per 100,000) and Hispanic (125 per 100,000) counterparts.

Black women in Central Indiana are **more likely** to **die** from **Heart Disease, Cancer,** and **Stroke compared** to **White** and **Hispanic women**

Women major causes of deaths by race (Central Indiana)



Source: Polis Center analysis of data from CDC Wonder 2018-2022 Five Yr Estimates; Graphic by the Polis Center

The blue dot represents the age-adjusted mortality rate. There is a 95% chance the actual value falls within the gray error bars. For Hispanic women, the rate is not available for Stroke and CLRP.

Life Expectancy

Life expectancy is an indicator of overall health and wellbeing in a population, reflecting mortality rates, the quality of healthcare, lifestyle factors, and socioeconomic conditions. In Central Indiana, life expectancy for women varies across counties, with a range from 79.1 years in Marion County to 83.4 years in Hamilton County. The lower life expectancy in Marion County, which overlaps with the state's largest city, Indianapolis, likely may be influenced by urban health challenges such as higher rates of chronic diseases, healthcare access disparities, and socioeconomic factors. On the other end of the Central Indiana life expectancy scale, Hamilton County has the highest life expectancy for women at 83.4 years. Counties like Hendricks (81.2 years) and Hancock (80.4 years) also show higher life expectancies.

Life expectancy in Indiana reached its peak in 2012 and then declined by 0.5 years by 2018. Most counties in Central Indiana show a similar time trend for women, with the notable exception of Hancock County, which peaked in 2018.[32] This decline in life expectancy has been largely attributed to a rise in overdose deaths and substance use disorders among working age adults. Additionally, the COVID-19 pandemic further exacerbated this downward trend.

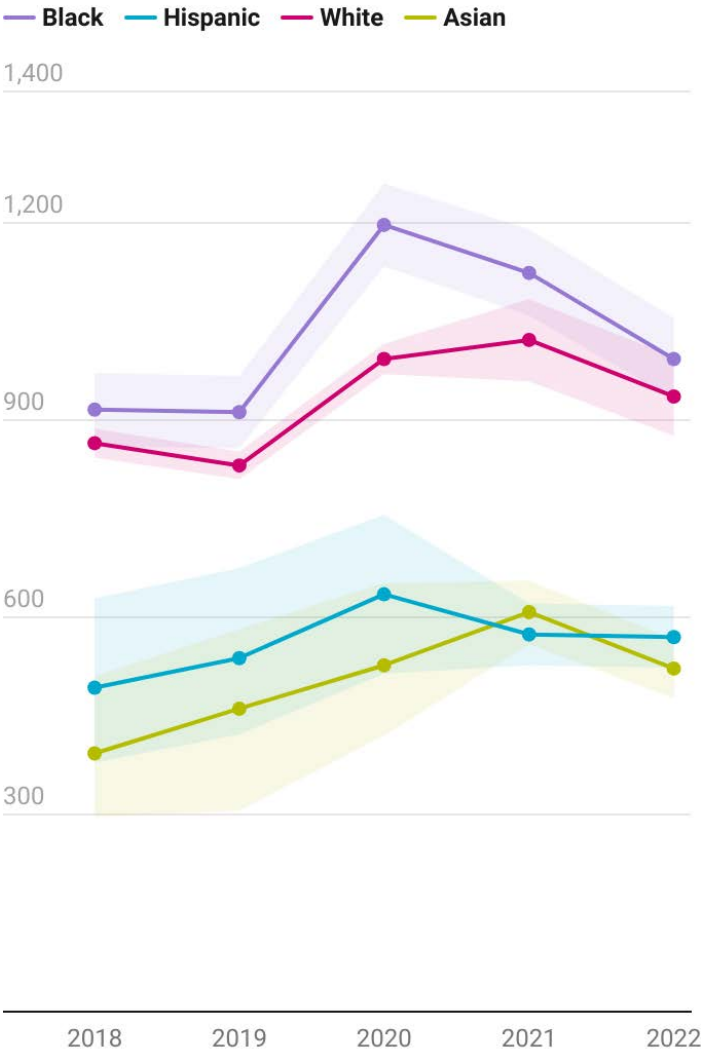
Data Limitations:

Data was sourced from multiple platforms, each with its own constraints and availability. Data stratifications by gender were not available for all desired metrics.

Behavioral Risk Factor Surveillance System (BRFSS) data is only available at the state level, making a county-level breakdown of this data impossible. BRFSS data was collected from three different online sources: the BRFSS dashboard portal, the BRFSS cross-tabulation section on the CDC website, and BRFSS documents provided by the Indiana Department of Health (IDOH) website. Additionally, data was obtained through direct requests from the Indiana Department of Health. Depending on the source, the data may represent combined years from 2018-2022 or data specifically from the years 2022 and 2023.

Black and **White women experience higher overall mortality rates compared** to their **Hispanic** and **Asian** counterparts.

Age-adjusted mortality rates for Central Indiana women



Source: Polis Center analysis of data from CDC Wonder 2018-2022; Graphic by the Polis Center

Barriers & Biases

As we think about life expectancy and growing old, there are disparities in how women and men experience aging. According to the State of Aging Report, "women often enter retirement with lower incomes and fewer assets compared to men. Contributing factors include lower lifetime earnings and a higher likelihood of living alone. In Central Indiana, older women (age 65 and over) on average have less than 60 percent of the personal income of older men."

Mortality-related data was obtained from the CDC Wide-ranging ONline Data for Epidemiologic Research (WONDER) database. This source does not provide age-adjusted rates by county. Where possible, age-adjusted rates were calculated to account for differences in age distribution across populations and provide a more accurate comparison between regions. Age-adjusted rates were computed using the direct method that applies age-specific rates in a population to a standardized age distribution. Age-adjusted rates are relative indexes not actual measures of risk.

Confidence intervals or margins of error calculations were not possible for some data points due to the nature of the data collection methods and variations between sources. This limitation may impact the precision of the estimates provided and should be considered when interpreting the findings.

Hamilton County has the **highest life expectancy** for **women** at **83.4 years**

Central Indiana life expectancy for women as of 2019

Source: Institute for Health Metrics and Evaluation; Graphic by the Polis Center

Strength & Abundance

Women4Change Indiana is an organization that provides civic learning and equip Hoosiers to engage in our democracy to achieve better outcomes in health, economic stability and personal safety for women in Indiana. They were 2023 Women's Fund Grant recipients and are being highlighted for their work around maternal health and reproductive access. These are two major issues for women in Central Indiana right now.

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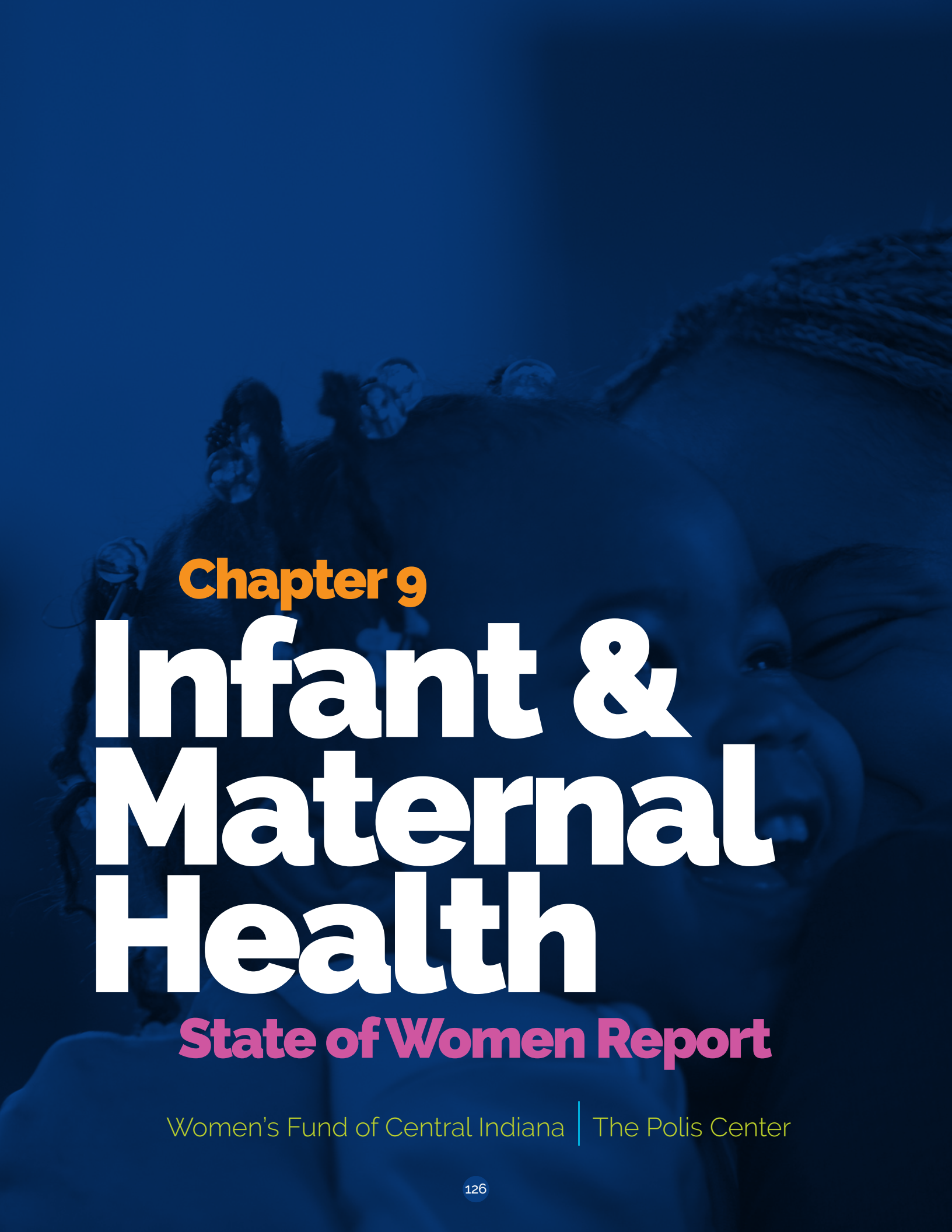


Chapter 9

Infant & Maternal Health

State of Women Report

Women's Fund of Central Indiana | The Polis Center

Infant & Maternal Health

Maternal and infant health are vital indicators of a community's overall wellbeing, as they reflect the quality of healthcare, access to services, and the impact of social and economic conditions on health outcomes. Healthy pregnancies and positive birth outcomes are influenced by medical care and broader societal factors such as education, income, housing, and environmental conditions. Communities that prioritize maternal and infant health typically experience lower rates of chronic diseases, reduced healthcare costs, and improved long-term outcomes for children. In contrast, disparities in these areas often highlight significant gaps in healthcare access and support systems. As a result, maternal and infant health serve as a critical measure of both healthcare effectiveness and social equity.

Key Takeaways:

- In Central Indiana, Black mothers lacking access to first-trimester prenatal care dropped from 46.4% in 2018 to 44.3% in 2022.
- Residents of Morgan County travel an average of 19.5 miles to the nearest birthing hospital, compared to just 4.4 miles in Johnson County.
- Black women in Indiana experienced the highest maternal mortality rates from 2018 to 2021, with 135.6 pregnancy-associated deaths per 100,000 live births.
- Shelby County had the highest smoking rate during pregnancy at 12.1% in 2021, while Hamilton County had the lowest at 0.6%.
- Black infants have the highest rates of low birth weight , peaking at 15.1% in 2020.
- The infant mortality rate for Black infants in Central Indiana was 14.2 deaths per 1,000 live births in 2016, compared to 4.8 for White infants in 2020.

Birth Rate

The birth rate, or crude birth rate, refers to the total number of live births per 1,000 individuals within a population each year, typically calculated around midyear. This rate is a determinant of a nation's population expansion and plays a role in shaping governmental policies related to education, healthcare, and economic strategies.[1]

The birth rate in Indiana experienced a slight decline over the five-year period from 2018 to 2022. In 2018, the birth rate stood at 62.8 per 1,000 people, but by 2022, it had decreased to 59.7 per 1,000.[2] This steady downward trend indicates a modest reduction in population growth across the state during this time frame.

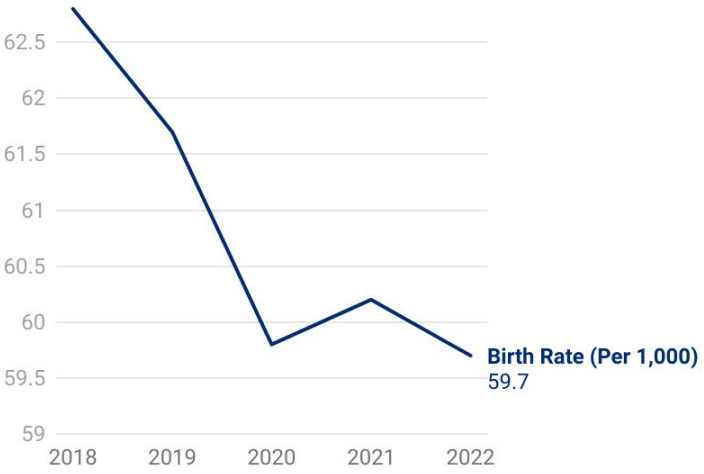
In Central Indiana, birth rates reveal demographic shifts among the Black, Hispanic, and White populations. The Hispanic population's birth rate steadily increased from 81.3 per 1,000 people in 2018 to 100.[3] per 1,000 in 2022, suggesting a rise in population growth.[2] The Black non-Hispanic population, however, saw a slight decrease in birth rates, moving from 74.1 per 1,000 in 2018 to 70.6 per 1,000 in 2022. In contrast, the White non-Hispanic population experienced a consistent decline in birth rates, dropping from 57.8 per 1,000 in 2018 to 53.7 per 1,000 in 2022, reflecting a downward trend in population growth. Meanwhile, the birth rate among all other races initially decreased from 54.9 per 1,000 in 2018 to 45.7 per 1,000 in 2021, but then surged to 63.4 per 1,000 in 2022, showing some variability.

Prenatal Care

Prenatal care is essential for ensuring the health of both mothers and their babies. In Central Indiana, the availability of prenatal care for women distinctly varies across different racial and ethnic groups. In 2022, around half of Hispanic (51.3%) and Black (44.3%) women lacked access to prenatal care, compared to one in six (17.4%) White women.[2] Central Indiana's average rate was 29.5%, close to the entire state average of 29.1%, but significantly worse than the national average of 23% of women who lack access to prenatal care. These rates vary widely across Central Indiana, with Marion County

In **2022,** the **birth rate** had **decreased** to **59.7** per 1,000 from **62.8** per 1,000 in **2018**

Birth rate per 1,000 (Indiana)

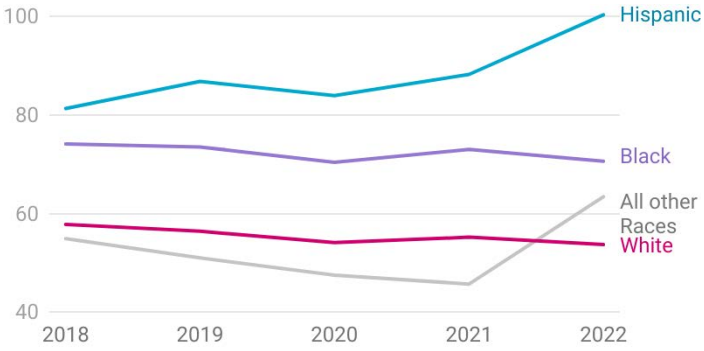


Source: Birth Outcomes and Infant Mortality Dashboard, Indiana Department of Health, 2018 - 2022; Graphic by the Polis Center

All Recorded Births

The **birth rate** among **all other races** initially **decreased** in **2018**, but then **surged** in **2022.**

Birth rate per 1,000 by race (Central Indiana)



Source: Birth Outcomes and Infant Mortality Dashboard, Indiana Department of Health, 2018 - 2022; Graphic by the Polis Center

All Recorded Births

having the highest rates of lacking prenatal access in 2022 (37.9%), and Hancock having the lowest (12.7%).

The frequency of prenatal care visits varies by race in some Central Indiana counties, including Hamilton, Hendricks, Johnson, and Marion. On average, Black and Hispanic women attended fewer prenatal visits, both with an average of 9.4 visits, compared to White women who attended about 11.8 visits and Asian women with 11.4 visits.[3] The overall average for Indiana stood at 11.2 visits, slightly lower than the national average of 12.0 visits. These statistics highlight the disparities in prenatal care access and frequency that can impact maternal and infant health outcomes in the region.

> **"We need culturally responsive services for women of childbearing age."**
>
> ***- Gurinder Kaur,*** *Chief Executive Officer, Immigrant Welcome Center*

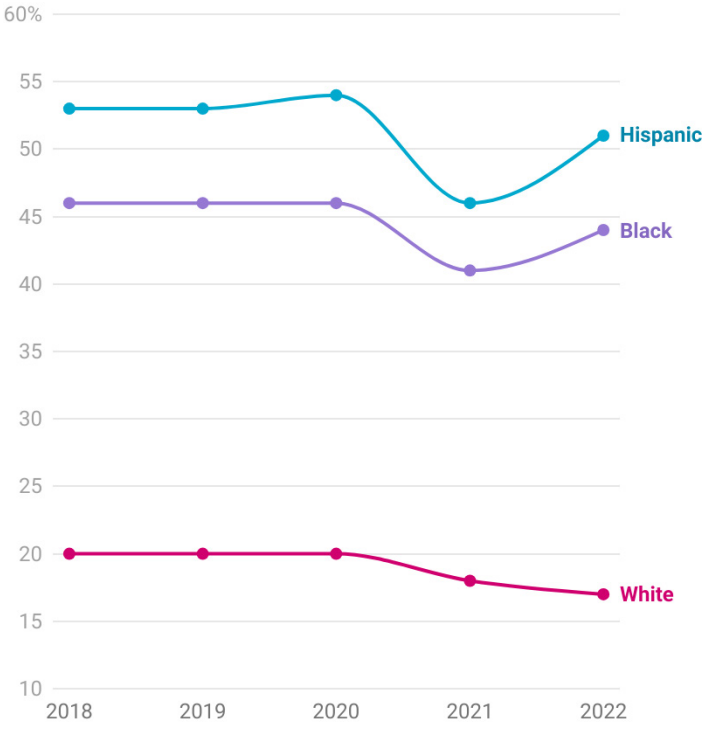
A recent study showed that women in the Midwest were twice as likely to report higher levels of depression and feeling upset from experiences of racism during pregnancy, compared to Northeast & Southern states; both of these are recognized barriers to seeking prenatal care.[4] A related study, which included Indiana, indicated that the top four self-perceived reasons for not getting timely prenatal care were; not being aware of pregnancy status, unavailability of appointments, inability to afford visits and and medical coverage for prenatal care was not prompt.[5] Similarly, another study found Indiana has significantly higher than national rates of maternal vulnerability, even for White Hoosiers. The most common predictors for high maternal vulnerability are deficits in physical environment (such as pollution, transportation access and racial housing segregation), socioeconomic determinants (such as education level, food insecurity, poverty and social capital), and physical/mental health.[6]

Maternity Care Access

The level of maternity care access is based on three key factors: the availability of birthing facilities, the presence of maternity care providers and the percentage of uninsured women. In Indiana,

Around half of Hispanic (51%) and Black (44%) women lacked access to prenatal care, compared to 1 in 6 (17%) White women

Percentage of Women Without Access Prenatal Care by Race (Central Indiana)

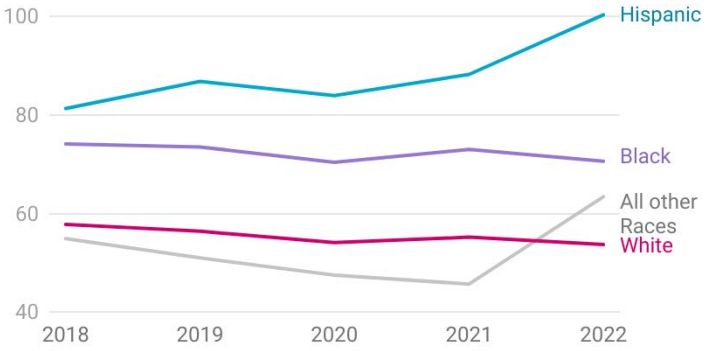


Source: Birth Outcomes and Infant Mortality Dashboard, Indiana Department of Health, 2018 - 2022; Graphic by the Polis Center

Women, all ages

Frequency of Prenatal Care Visits by Race

Hamilton County, Hendricks County, Johnson County, Marion County



Source: CDC Wonder Natality Data, 2022; Graphic by the Polis Center

Women, All Ages by Race/Ethnicity Group

23.9% of counties are classified as maternity care deserts, which means they lack sufficient access to maternity care services. This percentage is lower than the national average, where 32.6% of counties are identified as maternity care deserts. In Central Indiana, all but one County, Morgan, have full access to maternity care.[7] Counties such as Johnson and Shelby offer shorter average travel distances to a birthing hospital at 4.4 and 3.8 miles respectively, facilitating quicker access to care. Marion County residents also have relatively close average access to the nearest birthing hospital about 5.3 miles away. In stark contrast, those living in Morgan County face much longer distances, with the nearest maternity care facility located 19.5 miles away on average.[4] Meanwhile, Boone County experiences a longer average travel distance of seven miles to the nearest birthing hospital. These variations underline the geographical disparities in access to healthcare facilities, which could impact maternal and neonatal health outcomes across different communities.

Deficits in access are a moving target. In its most recent report (2019), the Indiana State Department of Health identified 37 Indiana counties with no inpatient delivery services. Since mid-2023, Parkview Health has closed delivery services in DeKalb, LaGrange and Whitley County hospitals (Northeast Indiana), consolidating birthing services to Warsaw, IN. An *IndyStar* report (Oct 10, 2023), linked this lack of nearby care to the death of a DeKalb County resident from a ruptured ectopic pregnancy. Exacerbating the problem of OB-GYN access in Indiana, Senate Bill 1 (2022) banned most abortions in the state and has impacted the Indiana University School of Medicine's (IUSM) ability to attract OB-GYN residency candidates, and forced IUSM to send candidates to neighboring states to fulfill basic OB-GYN national training requirements.[8] A 2024 March of Dimes report indicated that one in three U.S. counties (35%) has no obstetric clinician or birthing facility, directly impacting 2.3 million women. More than half of U.S. counties have no hospital that provides obstetric care, with one in twenty-five obstetric units closing between 2021-2022.[9]

It should be noted that having available maternity care services does not always ensure that women will utilize or have effective access to these services,

"Our rural access challenges are really distinct because of distance, transportation [barriers], and lack of labor delivery units. These challenges have been mounting since the 1990s, in terms of closures and are an ongoing issue."

- Dr. Tucker Edmonds, *Professor of Obstetrics and Gynecology*

Strength & Abundance

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especially when considering various demographic factors. Barriers like socioeconomic status, transportation challenges, cultural beliefs, language barriers and healthcare costs can impact whether women can access and use available maternity care. Additionally, disparities in insurance coverage and a lack of trust in the healthcare system can further limit the utilization of these services, even in areas where they are theoretically available.

Smoking during Pregnancy

Smoking during pregnancy is a health concern that can lead to adverse outcomes for both the mother and the unborn child. According to medical research, smoking can increase the risk of premature birth, low birth weight, and developmental issues in infants.[10] In Central Indiana, smoking rates among pregnant women vary by county. For example, in 2021, Shelby County reported the highest smoking rate during pregnancy at 12.1%, higher than Hamilton County, which had the lowest rate at just 0.6%.[11] Other counties such as Morgan and Johnson also showed concerning rates at 10.3% and 4.8%, respectively.

A recent study from the Regenstrief Institute explored "preconception health" among Midwestern women, finding a particular risk of smoking among rural Midwesterners. A separate study of three Midwestern states, including Indiana, showed a statistically significant decline in smoking after exposure to a smoking cessation campaign.[12] In contrast, Indiana ranks 39th in the country for lowest state cigarette taxes, incentivizing a recent state legislative push for increased cigarette taxes, which hasn't been increased since 2007.[13] The 2023 Indiana Tobacco Prevention and Cessation report indicated that only 32% of counties are protected by local community smoke-free air laws. Quit Now Indiana, a referral partner for all Women, Infants, and Children (WIC) clinics, served 269 WIC participants in 2023.[14]

Maternal Mortality

Maternal mortality is a public health issue, highlighting disparities in healthcare access and outcomes across different populations. Research shows that maternal deaths can be categorized

Barriers & Biases

Many barriers lead to inequitable outcomes in infant and maternal health, such as: transportation to prenatal and post-pregnancy appointments, differences in cultural knowledge of prenatal and pregnancy care, time and financial ability to prioritize infant and maternal health, and more. IU's Public Policy Institute found that lack of access to services, substance use disorders and discrimination in health care contributed to disparity in maternal mortality rates. These biases and barriers need to be addressed to see more equitable outcomes in infant and maternal health.

as pregnancy-associated, which includes all deaths during pregnancy or within one year of pregnancy, regardless of cause, and pregnancy-related, which directly results from pregnancy or its management.[15] In Indiana from 2018 - 2021, Black, non-Hispanic women experienced the highest rates of both pregnancy-**associated** (135.6 per 100,000 live births) and pregnancy-**related** deaths (28 per 100,000 live births), higher than their White, non-Hispanic counterparts (91.3 and 15.9, respectively) and Hispanic women of any race (55.8 and 14.7, respectively).[16]

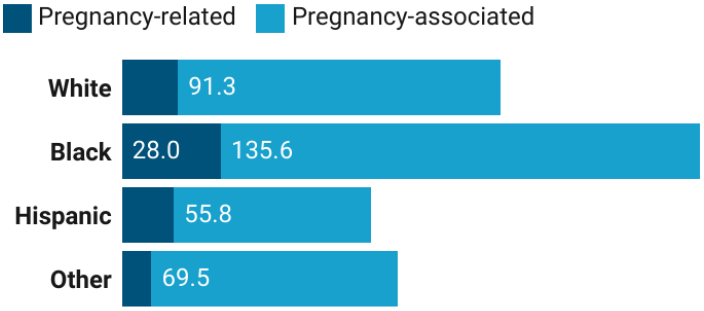
The age of the mother also plays a crucial role in the risk levels associated with pregnancy. Younger mothers aged 15-19 years had a lower rate of pregnancy-associated deaths at 25.1 per 100,000 live births in 2021.[17] However, this rate increased as age progressed, with the highest rate observed in the 35-39 age group at 164.7 per 100,000 live births.

In the United States, Indiana has the third-highest maternal mortality rate among states, with 44 deaths per 100,000 live births in 2022.[18] According to the Organization for Economic Co-operation and Development (OECD), the U.S. has maternal mortality rates (22.3 deaths per 100k live births) significantly higher than any other country. The next highest country, Chile, has 14.3 maternal deaths per 100k live births. The lowest, Norway, has essentially zero maternal deaths per 100k live births.[19] A recent study of Indiana's Maternal Mortality Review Committee (MMRC) 2020 data showed that four of five pregnancy-associated deaths were preventable.[20] According to the 2023 Annual Report, substance abuse and mental health conditions were contributing factors in almost three in four deaths.

Most report recommendations were aimed at system-level interventions, such as publicly funded childcare (beginning in infancy), universal access to contraception, increased Medicaid coverage (including for mental health and substance abuse disorder), increased funding for social services, and better access to public transportation.[20] A related national study of policy impacts on maternal health showed that states which had implemented legislation to restrict access to abortions from 2007-2015 had increased maternal mortality rates of 38%,

Black, non-Hispanic women experienced the **highest rates** of both **pregnancy-associated** and **pregnancy-related deaths**

Average Four-Year Rate of Pregnancy-Associated and Pregnancy-Related Deaths by Race and Ethnicity (per 100,000 Live Births) in Indiana

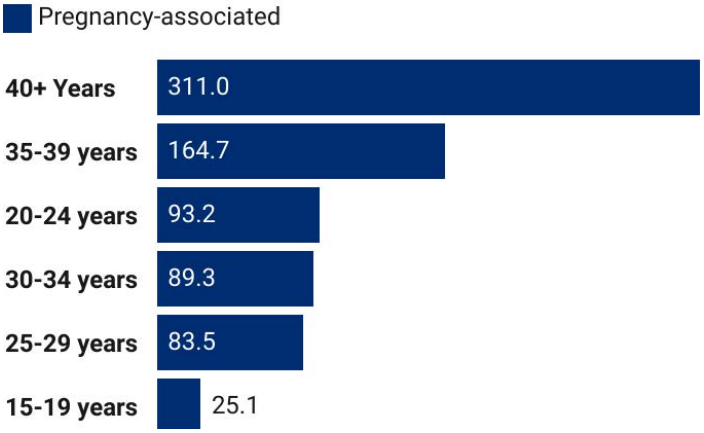


Source: Indiana Maternal Mortality Review Committee 2023 Annual Report, 2018 - 2021; Graphic by the Polis Center

All Pregnancy Related and Pregnancy Associated Deaths, N = 295, by Race/Ethnicity Group

Risk of death increases dramatically for **mothers over 35**

Rate of Pregnancy-Associated Deaths by Age of the Mother at Death (per 100,000 Live Births) (Indiana)



Source: Indiana Maternal Mortality Review Committee 2023 Annual Report, 2021; Graphic by the Polis Center

All Pregnancy Associated Deaths, N = 80

of particular concern given Senate Bill B1 here in Indiana.[21]

Abortion

Abortion is the removal of pregnancy tissue, products of conception or the fetus and placenta (afterbirth) from the uterus. In general, the terms 'fetus' and 'placenta' are used after eight weeks of pregnancy.[22] According to the Indiana State definition, the term "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus. This is a reportable event in the state of Indiana.[23]

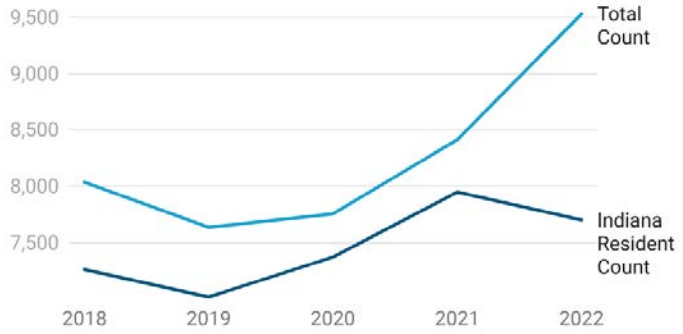
In Indiana, the trends in abortions show fluctuations over recent years. In 2018, there were a total of 8,037 terminated pregnancies, of which 7,263 were among Indiana residents. This number slightly decreased in 2019, followed by a small increase in 2020, and a more substantial rise in 2021 with 8,414 terminations.[17] By 2022, the total count increased to 9,529, although the number among Indiana residents decreased to 7,702.

The age distribution of terminations among women in Indiana illustrates that the majority of procedures occur among younger women, with those aged 20-24 and 25-29 accounting for the highest percentages at 30.5% and 28.1% respectively.[17] This is followed by the 30-34 age group at 19.4%. Women under 16 years old represent a small fraction of the total at 0.6%. Women aged 40-44 and those over age 45 have much lower rates of terminations at 3.3% and 0.3%, respectively, reflecting decreased fertility and possibly more settled decisions about childbearing.

The distribution of abortions by weeks of gestation in Indiana shows a clear preference for early-stage procedures. A substantial majority of abortions (67.1%) occur at or before eight weeks of gestation, suggesting that individuals are likely to make decisions early in the pregnancy.[17] This trend continues into the first trimester, with 31.7% of abortions happening between nine and 13 weeks. Together, these early abortions account for almost 99% of all cases, aligning with medical guidance that earlier procedures are generally associated with fewer health risks. The number of abortions

By **2022,** the **total count increased** to **9,529,** although the number among **Indiana residents decreased** to **7,702**

Trends in abortion in Indiana



Source: Terminated Pregnancy Report 2022, Indiana Department of Health, 2018 - 2022; Graphic by the Polis Center

Women, all ages

The **majority** of **procedures** occur among **younger women,** with those **aged 20-24** and **25-29** accounting for the **highest percentages**

Abortions by age (Indiana)

Age	Count of Abortions	Percentage of Abortions (%)
< 16	59	1
16-17	171	2
18-19	633	7
20-24	2,910	31
25-29	2,675	28
30-34	1,849	19
35-39	893	9
40-44	314	3
≥ 45	25	0

Age Distribution of Terminations Among Women

Source: Terminated Pregnancy Report 2022, Indiana Department of Health, 2022; Graphic by the Polis Center

Women, all ages

decreases as pregnancy progresses, with only 0.8% occurring between 14 and 20 weeks and 0.3% at or beyond 21 weeks.

Infant Health

Low Birth Weight

The percentage of low birth weight (LBW) infants —those weighing less than 2,500 grams at birth— varies by race and has implications for public health strategies targeting neonatal care. In Central Indiana, data from 2018 to 2022 highlights racial disparities in LBW rates.

In 2018, the LBW rate for Black infants was notably higher at 12.8% compared to Hispanic infants and White infants, who had rates of 6.1% and 6.8%, respectively. The rate for all other races stood at 8.8%.[2] Over the following years, Black infants consistently experienced the highest LBW rates, peaking at 15.1% in 2020. While the rates for Hispanic and White infants also fluctuated, the changes were less pronounced. By 2022, LBW rates among Black infants increased again to 14.7%. Hispanic rates slightly decreased to 8.0%, and White rates rose to 7.3%, with the rate for all other races at 9.0%.

> **"Our maternal and infant health is not something to be proud of."**
>
> ***- Gurinder Kaur,*** *Chief Executive Officer, Immigrant Welcome Center*

Preterm Birth

The percentage of preterm births, defined as births occurring before 37 weeks of gestation, varies by race, reflecting broader disparities in maternal and infant health outcomes. In Central Indiana, Black infants consistently exhibit the highest rates, peaking at 15.0% in 2022, up from 13.5% in 2018.[2] This rate is significantly higher compared to other racial groups over years 2018 to 2022. White infants saw a gradual increase in preterm birth rates, starting at 9.4% in 2018 and slightly rising to 10.2% by 2022. Hispanic infants' rates varied slightly, beginning at 10.4% in 2018 and peaking at 11.0% in 2021 before settling at 10.6% in 2022. The rate for infants of all other races started at 9.2% in 2018 and reached 9.7% in 2022, showing less fluctuation compared to other groups.

Abortions by **weeks** of **gestation**

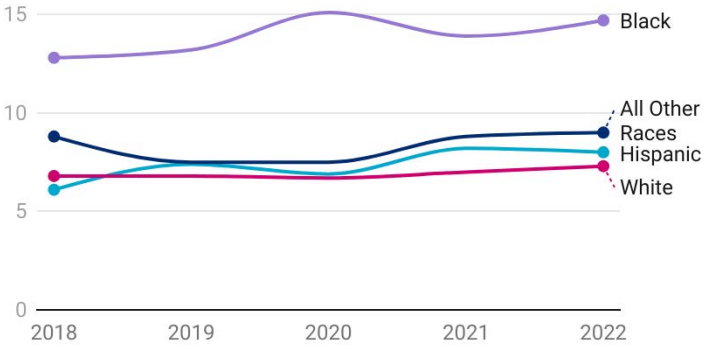
Weeks of Gestation	Count	Percentage (%)
≤8 weeks	6,401	67
9-13 weeks	3,024	32
14-20 weeks	75	1
≥21 weeks	29	0

Source: Terminated Pregnancy Report 2022, Indiana Department of Health, 2022; Graphic by the Polis Center

Women, all ages

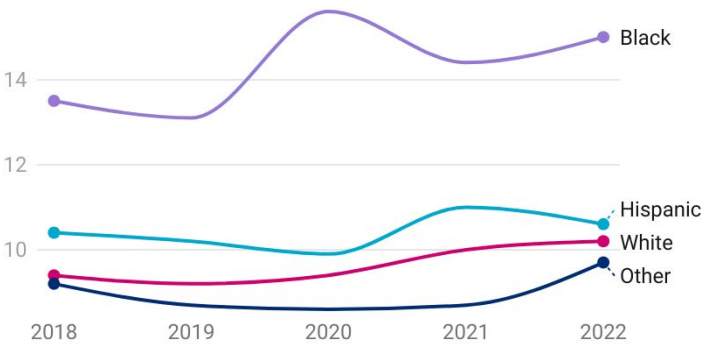
In **2018,** the **LBW rate** for **Black infants** was **notably higher** at **12.8%** compared to **Hispanic** and **White infants**

Percentage of low birth weight by race (Central Indiana)



In **Central Indiana, Black infants consistently** exhibit the **highest rates** of **preterm birth**

Percentage of Preterm Births by Race (Central Indiana)



Source: Birth Outcomes and Infant Mortality Dashboard, Indiana Department of Health, 2018 - 2022; Graphic by the Polis Center

All Recorded Births

Infant Breastfeeding

Infant breastfeeding helps the optimal growth and development of infants and the health of mothers.[24] In Central Indiana, the percentage of infants not engaging in breastfeeding across different counties highlights regional variations. Boone County reports a lower non-breastfeeding rate of nine percent. Conversely, Shelby County records the highest percentage at 19.8%. This is followed by Morgan and Marion counties with rates of 16.0% and 14.0%.[24,25]

Strength & Abundance

The Milk Bank's mission is to promote community health by expanding the safe use of human milk for all babies, especially premature and ill infants. They were a 2023 Women's Fund Grant recipient to educate employers about the recent passing of the PUMP Act and their responsibilities to support breastfeeding employees.

Infant Mortality

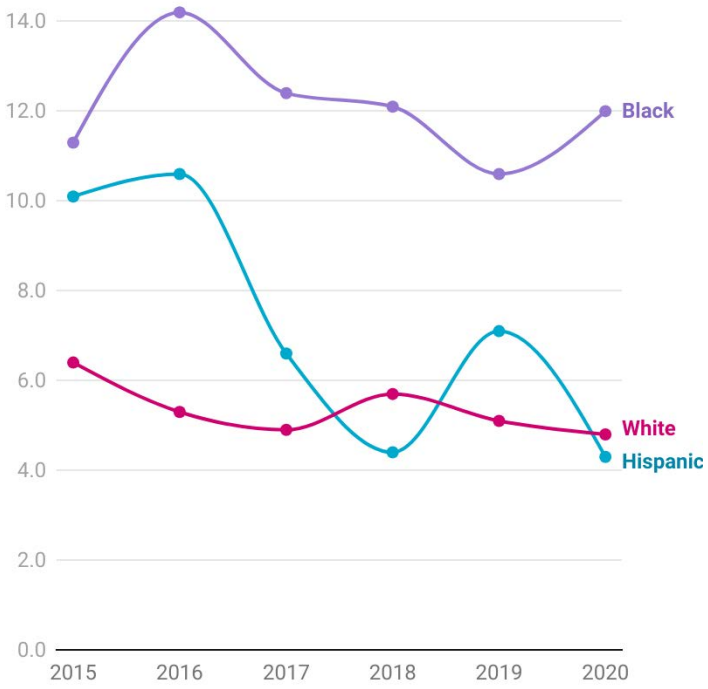
Infant mortality measures the number of infants who die before their first birthday per 1,000 live births. These variations underscore the impact of socioeconomic, environmental, and healthcare factors on infant survival rates. Between 2015 and 2020, the infant mortality rate per 1,000 births for the Black population consistently remained the highest in Central Indiana, starting at 11.3 deaths per 1,000 births in 2015, peaking at 14.2 in 2016, and ending with 12.0 in 2020. The Hispanic population saw a significant decline, beginning at 10.1 deaths in 2015, dropping to a low of 4.3 by 2020. The White population's rates were the most stable but still showed some variability, starting at 6.4 deaths, then dropping to 4.8 by 2020. In 2022 Indiana's statewide infant mortality rate stood at 6.7 per 1000 live births above the national average of 5.4.[26]

> **"Black infant mortality and Black maternal mortality rates are unacceptable and a real threat to our overall well-being as a society."**
>
> ***- Dr. Tucker Edmonds,*** *Professor of Obstetrics and Gynecology*

Similar to maternal mortality, infant mortality statistics in the U.S. are among the worst of OECD countries, ranking 33 of 38,[27] and Indiana ranking near the bottom of the U.S., falling to 7th worst in 2022.[28] Many factors contribute to this, but as reported above, the race/ethnic disparities are a large driver of this problem. Two recent national studies of social factors associated with high infant mortality indicate that Indiana is in a cluster of states with lower than average employment and income for women, fewer reproductive rights,

The **Hispanic** population saw a **significant decline** in **infant mortality**

Infant Mortality Rate (per 1,000 Births) by Race (Central Indiana)



Source: Birth Outcomes and Infant Mortality Dashboard, Indiana Department of Health, 2015 - 2020; Graphic by the Polis Center

All Recorded Births by Race/Ethnicity Group

higher rates of preventable disease, and lower than average women in elected office (and thus, decreased representation at the legislative table for women's issues), specifically pointing out that Indiana had the lowest rating in the country for "work and family" social factors, such as paid leave and childcare policies/funding, unemployment insurance, and gender gap in parents' labor force participation.[29,30] Further, one might assume high maternal & infant mortality rates are limited to families in the lowest socioeconomic categories, but a Journal of the American Medical Association (JAMA) study comparing the highest income and "Whitest" counties in the U.S. to other high-income countries (primarily OECD) shows worse than expected outcomes even for this group, pointing to broader structural factors within our country that put all women and infants at risk.[31]

Data Limitations

Data used for this report were limited to publicly available datasets, it is important to note that the timeliness of publicly available data may impact its relevance, especially in rapidly changing areas of public health.

Confidence intervals or margins of error calculations were not possible for some data points due to the nature of the data collection methods and variations between sources. This limitation may impact the precision of the estimates provided and should be considered when interpreting the findings.

The data for abortions includes data from the Terminated Pregnancy Report Indiana, however the term "terminated pregnancy" was not used as it is not clinically appropriate in many situations. For this reason, "abortion" was utilized instead.

Birthing hospitals include healthcare facilities that provide maternal and newborn care, including labor and delivery services, postnatal care, and neonatal care. These hospitals have the necessary staff and equipment to assist with childbirth and manage potential complications for both the mother and infant.

Strength & Abundance

The Indiana Community Action Association works to strengthen the capacity of Indiana's Community Action Agencies to address community needs and poverty. They were a 2023 Women's Fund Grant recipient for Know Your (New) Rights: Pregnant and Postpartum Workers. We are highlighting them in this report to underscore how significantly a role reproductive rights play in the lives of women in Central Indiana.

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Chapter 10
Mental Health
State of Women Report

Women's Fund of Central Indiana | The Polis Center

Mental Health

Mental health is a critical aspect of overall wellbeing, affecting how individuals think, feel, and interact with the world around them. However, mental health is not a one-size-fits-all issue; it is deeply influenced by gender, with women often experiencing mental health challenges that are both distinct and more nuanced compared to men. Biological, social, and cultural factors all intersect to shape the mental health experiences of women, leading to unique patterns in the prevalence, manifestation, and treatment of mental disorders.

Women's mental health in Central Indiana has emerged as a critical concern, with alarming trends in depression, frequent mental distress and substance use disorders. Recent data highlights the urgency of addressing these issues, particularly among younger women and women who are Black, Indigenous, and People of Color (BIPOC), who face the compounding effects of chronic stress and socioeconomic disadvantages that exacerbate mental health disparities over time.

Key Takeaways:

- According to most recent data, 29.7% of women in Central Indiana report experiencing depression, with the highest rates among women aged 18-34.
- Frequent mental distress affect 20.3% of women, particularly those aged 18-24.
- The drug overdose mortality rate among Black women in Central Indiana rose to 47.2 per 100,000 in 2022, surpassing the rate among White women (42.4 per 100,000).
- Women in Central Indiana consistently have higher rates of emergency interventions for mental health crises compared to men.

Depression

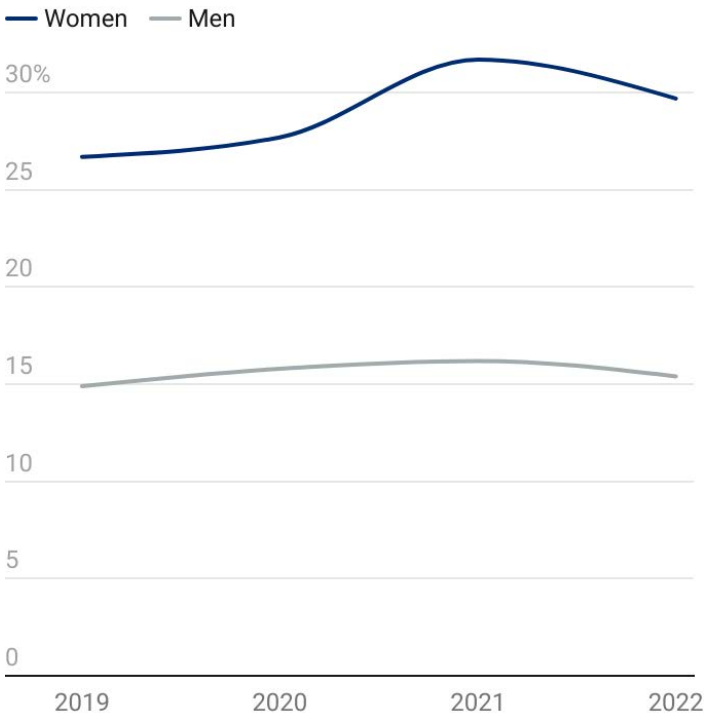
Depressive illnesses, including depression, major depression, dysthymia and minor depression, are severe medical conditions that profoundly affect the lives of millions. In the United States, one in five adults lives with a mental illness, and approximately one in 25 adults have a serious mental illness such as schizophrenia, bipolar disorder, or major depression.[1] Alarmingly, women are twice as likely as men to experience depression, a treatable condition that can affect any woman, regardless of age, race, or income.

In Indiana, the disparity is even more pronounced. Recent data reveals that one in every three women aged 18 and older suffers from depressive disorders, compared to one in eight men in the same age group. The highest depression rates are found among women aged 18-34, with a staggering 40% reporting depressive symptoms. The high prevalence of depression among young women (18-34 years) in Indiana mirrors national trends, where younger adults are more vulnerable to mental health issues. Factors contributing to this include heightened societal pressures, economic instability, challenges in establishing careers, and the pervasive influence of social media, which can exacerbate feelings of inadequacy and loneliness. Additionally, the COVID-19 pandemic has intensified these stressors, particularly for young adults, leading to an increased incidence of depression nationwide.

> **"Around the time of COVID, folks started talking about the allostatic load, which is the cumulative stress that the public was experiencing around the pandemic. That's how I see women in Central Indiana, even before the pandemic, and then carrying our communities or kids or families through the pandemic, the assaults on reproductive justice, all of those things. It's that cumulative factor, and the intersectionality of all of these spaces where women have to show up and they don't get to set the balls down."**
>
> *- Anonymous*

For residents **18** or **older, 1** in every **3 women** suffers from **depressive disorders, compared** to **1** in **8 men**

Depression by gender in Indiana

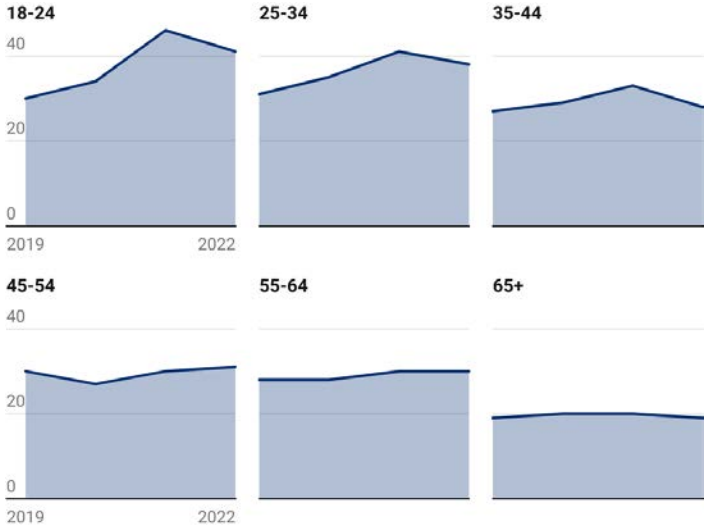


Source: BRFSS, 2019-2022; Graphic by the Polis Center

Age Group (18 and older)

The **highest depression rates** are found among **women aged 18-34**

Depression in women in Indiana by age (18 and older)



Source: BRFSS, 2019-2022; Graphic by the Polis Center

Age Group (18 and older)

Furthermore, women who identify as multiracial exhibit the highest prevalence of depression, with 42% affected. These findings can be attributed to the intersectionality of their identities, which often leads to unique stressors and challenges.[2] Research suggests that multiracial individuals may experience a heightened sense of marginalization and identity conflict, which can contribute to mental health issues. This demographic may also face discrimination and social isolation from both within and outside their racial groups, further exacerbating feelings of depression.[3] The mental health challenges faced by these women do not exist in isolation; they have profound effects on physical health. Chronic stress and depression can contribute to conditions such as hypertension, cardiovascular disease, and weakened immune function, making these individuals more susceptible to physical illnesses.[4] The combination of mental and physical health struggles further contributes to the overall allostatic load, creating a cycle where psychological stressors manifest physically, intensifying health disparities within these communities.

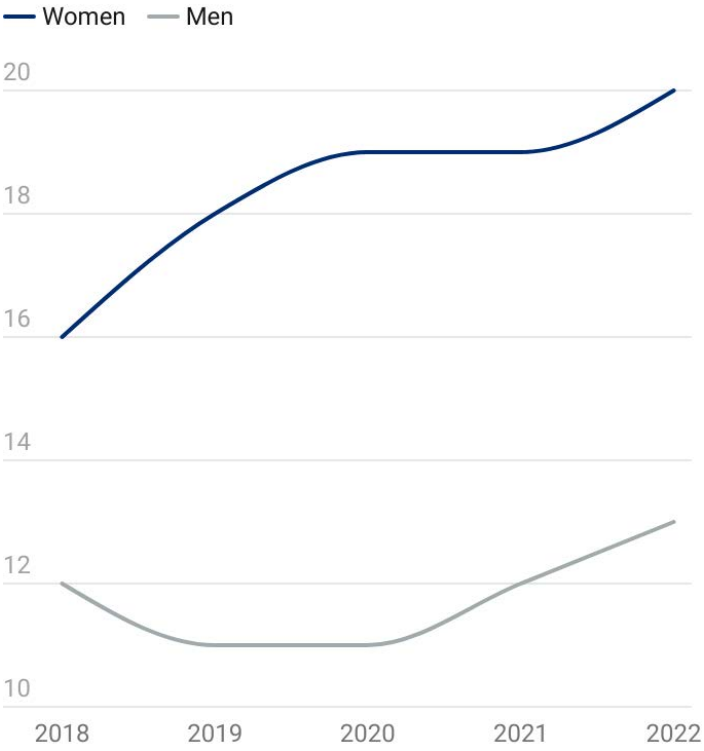
Frequent Mental Distress .

Frequent mental distress (FMD) is defined as experiencing 14 or more days of poor mental health in a month,[5] is a significant concern, particularly among women in Indiana. In 2022, one in five women in the state reported suffering from FMD, compared to one in eight men. This disturbing disparity highlights the critical need for mental health interventions that are tailored to the unique challenges faced by women.

Certain groups of women are especially vulnerable to FMD, mirroring trends observed in depressive disorders. Young women in Indiana aged 18-24 and 25-34 are disproportionately affected, with the highest rates of FMD reported in this age group (35% and 28%, respectively). Societal pressures, academic and career-related stress, and the complexities of navigating emerging adulthood contribute to their heightened levels of mental distress. Additionally, the demands of balancing multiple roles—such as work, childcare, and caregiving—further exacerbate these challenges.

In **2022**, **1** in **5 women** in the state reported suffering from **frequent mental distress**, **compared** to **1** in **8 men**

Frequent mental distress gender disparities

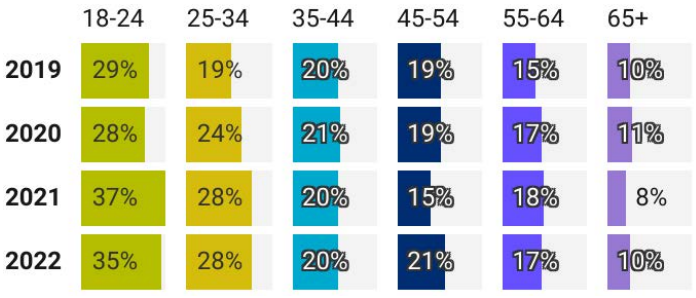


Source: BRFSS, 2019-2022; Graphic by the Polis Center

18 and older

Young women in Indiana **aged 18-24** and **25-34** are **disproportionately affected** with **frequent mental distress**

Frequent Mental Distress in Women by Age in Indiana (18 and Older)



Source: BRFSS, 2019-2022; Graphic by the Polis Center

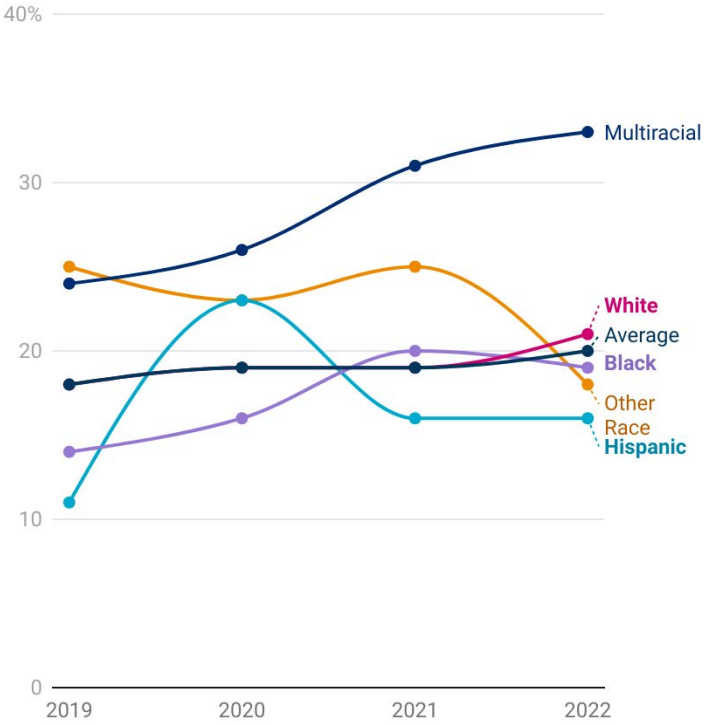
18 and older

Multiracial women in Indiana also experience significantly higher rates of FMD (32%), consistent with the elevated prevalence of depressive disorders in this demographic. The unique stressors associated with managing multiple racial identities, alongside experiences of marginalization and discrimination, contribute to their increased mental distress. This group often faces distinctive challenges that can lead to heightened feelings of isolation and mental health struggles.

Socioeconomic factors play a critical role in the prevalence of FMD among Indiana women. Those from lower-income backgrounds (annual income less than $25,000) are at even greater risk, with financial instability, unstable employment and housing insecurity contributing to chronic stress and anxiety. These socioeconomic challenges disproportionately impact young and multiracial women, compounding their vulnerability to FMD.

Multiracial women in Indiana experience **significantly higher rates** of **frequent mental distress**

Frequent Mental Distress in Women by Race in Indiana

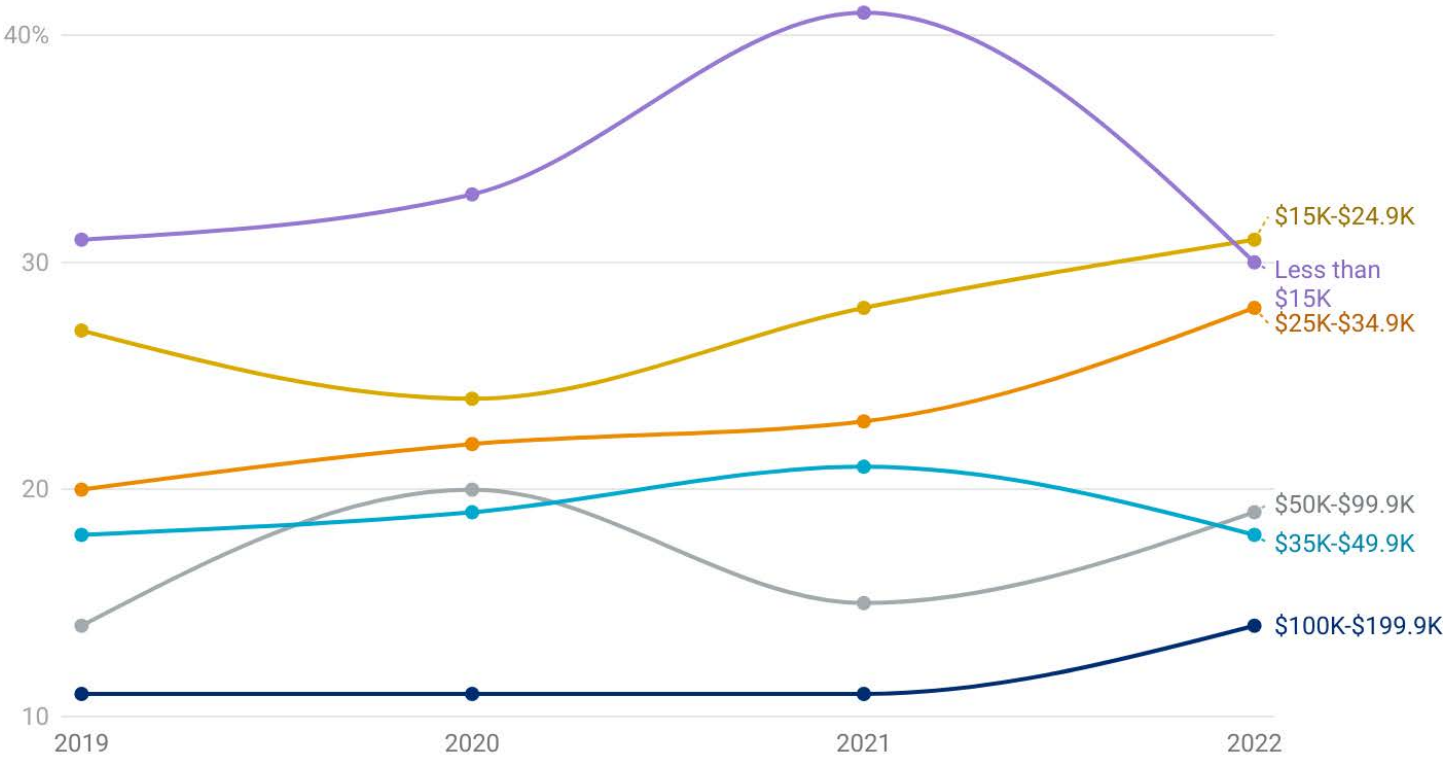


Source: BRFSS, 2019-2022; Graphic by the Polis Center

18 and older

Those from **lower-income backgrounds** (annual income less than $25,000) are at **even greater risk** of **frequent mental distress**

Frequent Mental Distress in Women by Income level Indiana



Source: BRFSS, 2019-2022; Graphic by the Polis Center

18 and older

Acute Mental Distress

In Central Indiana, recent data reveals that women consistently experience higher rates of mental health-related incidents requiring Emergency Medical Services (EMS) and Emergency Department (ED) intervention compared to men. Although the difference may appear marginal, it is significant in highlighting the unique and persistent mental health challenges that women face in the region.

This trend is not isolated; it reflects broader national patterns where women are more likely to seek emergency care for mental health crises.[6] However, this tendency to seek care does not always translate to better outcomes. Women, particularly those in underserved areas, may face barriers to accessing consistent mental health care, leading to more frequent crises and emergency interventions.

Substance Use Disorder

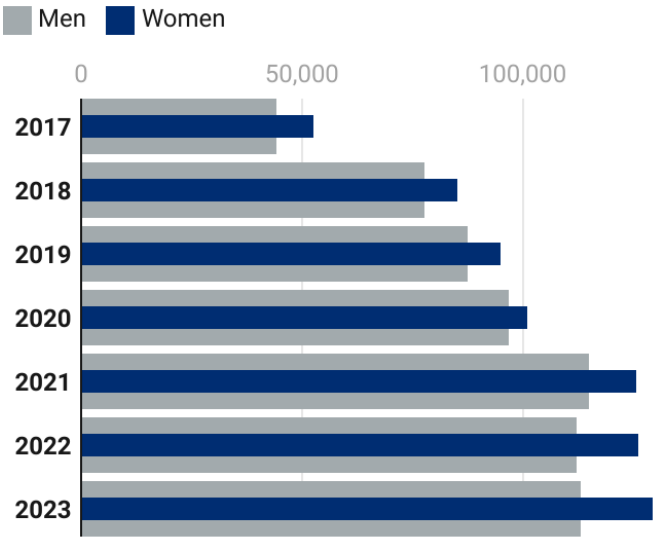
Substance Use Disorder (SUD) is a growing public health crisis in Central Indiana, particularly among women. Data from the CDC WONDER database reveals a troubling trend: drug overdose mortality rates among women in Central Indiana are not only higher than the state average but are also increasing at a disconcerting pace. While men continue to experience higher overdose mortality rates, with rates nearly twice those of women, the gap is narrowing as women's mortality rates rise consistently year after year.

The intersection of mental health and Substance Use Disorder (SUD) in women in Central Indiana significantly impacts certain age groups and racial demographics, with clear evidence showing these issues disproportionately affect these populations.

Race plays a critical role in understanding the dynamics of SUD and drug overdose mortality among women in Central Indiana. Historically, from 2018 to 2020, Black women had lower drug overdose mortality rates compared to White women. However, there was an upward trend in the rates among Black women during this period. By 2021, the mortality rates between Black and White women equalized, signaling a significant shift. Data from 2022 highlights this concerning trend, with the crude mortality rate due to drug overdose at 47.2

Women experience higher rates of mental health-related incidents requiring Emergency Medical Services

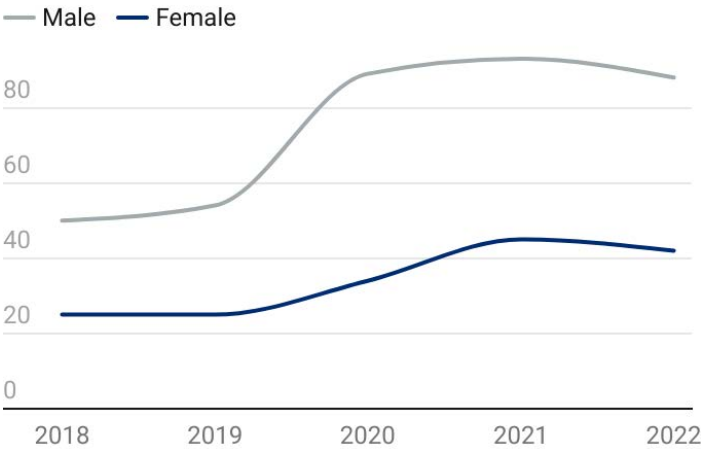
Acute Mental Health Events by Gender Central Indiana (All Ages 0-85+)



Source: https://www.in.gov/mph/projects/mental-health-related-events-dashboard/; Graphic by the Polis Center

While men continue to experience higher overdose mortality rates, the gap is narrowing as women's mortality rates rise consistently each year

Crude Mortality Rate per 100,000 for Overdose Deaths, Central Indiana Men vs Women



Source: CDC WONDER Drug overdose deaths are identified using ICD–10 underlying cause-of-death codes: X40–X44, X60–X64, X85, and Y10–Y14.7; Graphic by the Polis Center

Crude Mortality Rates Used Age Adjustment is impossible due to data suppression for 5-year age groups

per 100,000 for Black women and 42.4 per 100,000 for White women.

This increase in overdose mortality rates among Black women suggests that the factors driving SUD may be changing or that existing disparities in access to prevention, treatment, and recovery services are worsening. The equalization and subsequent overtaking of mortality rates among Black women reflect broader social determinants of health, including economic instability, systemic racism and limited access to culturally competent healthcare services.

The age groups most affected by this rising mortality trend are women aged 35-54, followed by those aged 20-34. Among Black women, the impact of SUD is particularly severe in these age groups, potentially due to a combination of economic stressors, chronic health conditions, and limited access to quality healthcare and support services. These factors may also contribute to the higher rates of substance use as a coping mechanism, further exacerbating the mortality rates.

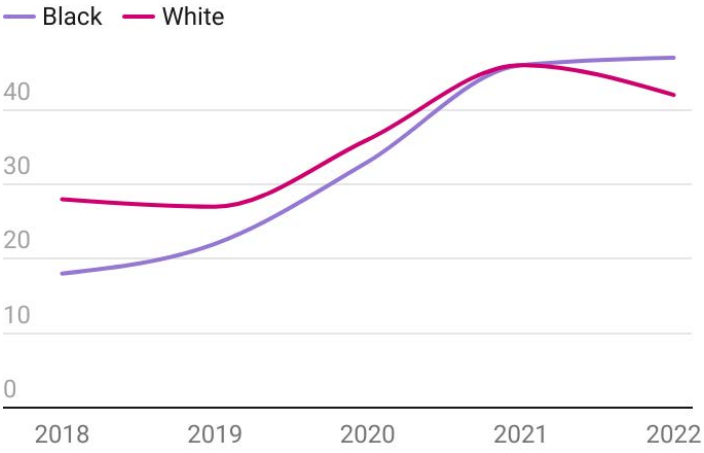
For women of childbearing age, the increasing prevalence of SUD, particularly Opioid Use Disorder (OUD), has far-reaching implications. The rise in drug overdose mortality rates among younger women, especially Black women, poses significant risks to maternal and child health. The increasing number of newborns affected by Neonatal Abstinence Syndrome (NAS) is a direct consequence of this trend, placing additional strain on healthcare systems and contributing to long-term health disparities in these communities.

Suicide

Data on suicide mortality in Central Indiana reveals a complex pattern, with the region consistently exhibiting a slightly higher suicide mortality rate compared to the state average, except for the year 2021. The rates, measured per 100,000 population, show fluctuations over the years without a clear trend of increase or decrease. This variability highlights the importance of regional analysis in public health, suggesting that Central Indiana may require targeted interventions to address the specific needs of its population.

By **2021,** the **mortality rates** between **Black** and **White women equalized,** signaling a **significant shift**

Crude Mortality Rate per 100,000 for Drug Overdose Deaths by Race in Central Indiana

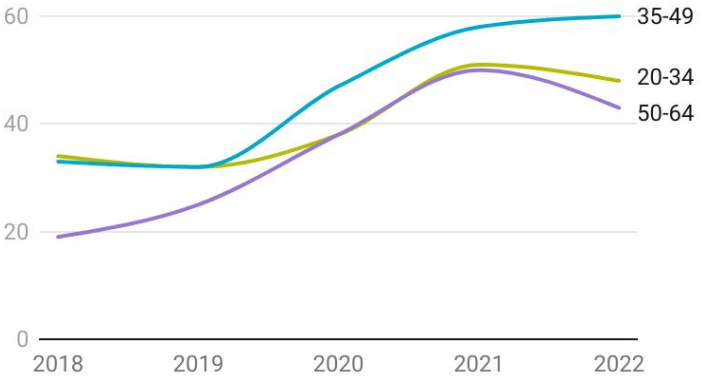


Source: CDC WONDER Drug overdose deaths are identified using ICD–10 underlying cause-of-death codes: X40–X44, X60–X64, X85, and Y10–Y14.[7]; Graphic by the Polis Center

Crude Mortality Rates Used Age Adjustment is impossible due to data suppression for 5-year age groups

The **age groups most affected** by this **rising mortality trend** are **women aged 35-54**

Crude Mortality Rate per 100,000 for Drug Overdose Deaths Central Indiana Women by Age Groups



Source: CDC WONDER Drug overdose deaths are identified using ICD–10 underlying cause-of-death codes: X40–X44, X60–X64, X85, and Y10–Y14.[7]; Graphic by the Polis Center

Data for 65 and older not available due to suppression

Crude Mortality Rates Used Age Adjustment is impossible due to data suppression for 5-year age groups

When examining the gender disparities in suicide mortality rates, the data from Central Indiana aligns with national trends. Throughout the period analyzed, the suicide mortality rate for men remains significantly higher than that for women. In 2018, the suicide rate for men in Central Indiana started just below 35 per 100,000 population and remained relatively stable, ending slightly higher in 2022. In contrast, the suicide rate for women started just above 10 per 100,000 population in 2018 and displayed similar stability, ending somewhat lower in 2022.

Nationally, men are approximately 3.7 times more likely to die by suicide than women, a trend that is reflected in Central Indiana.[8] However, it is essential to note that while men have higher mortality rates, women are known to have higher rates of suicide attempts. Research indicates that women are 1.5 times more likely to attempt suicide than men, though their methods are often less lethal, contributing to the lower mortality rate.[9]

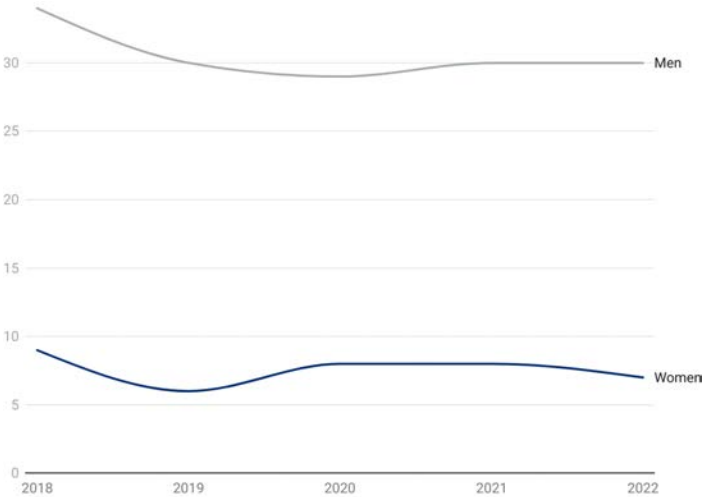
In Central Indiana, poor mental health and substance abuse are significant risk factors for suicide. Statewide data reveals that 46% of those who die by suicide had a known mental health condition, and the co-occurrence of substance use further increases the risk of suicidal behavior.[10] Additionally, Central Indiana is one of three regions in the state that has seen an increase in the number of suicide prevention lifeline calls between 2016 and 2019, underscoring the growing awareness and need for mental health support in the region.[10]

Social Isolation and Supports

The COVID-19 pandemic had a tremendous effect on the connectedness of communities, causing increased feelings of social isolation. We explored what this effect looked like for the women of Central Indiana. Most of our interviewees felt that there was more isolation overall, and that isolation can have effects on women in particular.

The **suicide mortality rate** for **men** remains **significantly higher** than that for **women**

Crude Mortality Rate per 100,000 for Men vs Women Central Indiana (Age 20+)



Source: CDC WONDER, 2018-2022; Graphic by the Polis Center

Crude Mortality Rates used as data for 5-year age groups were suppressed

> **"[There is] less fellowship within communities. There used to be more active groups and clubs prior to COVID. A lot of those communities are shifting online and not providing the same supports."**
>
> *- Anonymous*

A sense of community is important for one's wellbeing and a lack of connection or social inclusion can have negative effects on one's mental health. Kelly McBride, the Executive Director of the Domestic Violence Prevention Network, speaks to this: "If you do not have a community, you are more likely to get depressed and it's a downward cycle." Social isolation and community connectedness are just a few factors to consider regarding the mental health of women.

Luckily, Central Indiana has many resources and communities available for women to find their place. Jenny Menalas, MBA, from the City of Indianapolis, speaks to the power of community: "I feel like in every aspect women find and make their own communities, and when they do that, they are so effective and powerful."

Our interviewees highlighted an important distinction among immigrant and refugee women in regard to social isolation. Immigrant women may have even fewer connections and are more likely to be socially isolated. One of our interviewees speaks to this experience:

> **"Immigrating to a new country can be traumatic, and often, takes an emotional toll on women. They have had to leave all they know behind, their family, their friends, and in some ways their heart. To address that trauma and emotional toll, it is important that there are support services available for these newcomers, so that they can establish a solid and productive foundation in their new home."**
>
> ***- Marlene Dotson,*** *President and CEO of the Indiana Latino Institute*

It is crucial to consider the variety of lived experiences that the women of Central Indiana have daily. While there are many similar experiences, it

Strength & **Abundance**

A strength uplifted by our interviewees was the prevalence of women supporting women. There was a collective understanding of the power of the women you keep close to you. According to our interviewees, it seems this has been a shift over the years from a more competitive feeling amongst women to more of a sisterhood mentality. "Women are changemakers. When women come together, they can make a difference," said Wendy Noe, CEO of Dove Recovery House.

is important that we uplift, listen to and understand those who experience our community differently.

Conclusion

The mental health of women in Central Indiana is at a critical juncture, with rising rates of depression, frequent mental distress, and substance use disorders requiring immediate attention. To better support the mental wellbeing of women in the region leaders must consider gender-responsive policies that expand access to care, address socioeconomic disparities, and enhance crisis response. By prioritizing such actions, Central Indiana can improve the mental health outcomes for women and ensuring a healthier future for all.

> **"Mental health emerges as a critical concern, given the myriad of responsibilities women shoulder in their families, careers, and communities. Isolation, exacerbated by a tense political environment, further complicates matters."**
>
> ***- Mackenzie Pickerrell,*** *Executive Director of Girl Coalition of Indiana*

Data Limitations:

Data in this analysis is derived from various sources, each with specific limitations that may impact the findings. Behavioral Risk Factor Surveillance System (BRFSS) data was obtained from the Indiana Department of Health (IDOH) website, specifically from BRFSS Statistical Analysis System (SAS) output documents. The data points used reflect the prevalence of mental health conditions among women respondents. Additionally, some data was gathered from relevant dashboards, capturing the status as of the date of data retrieval. It is crucial to note that the timeliness of this data may affect its relevance, especially in rapidly evolving areas of public health.

Mortality-related data, including data on Substance Use Disorder (SUD) and suicide deaths, was sourced from the CDC WONDER database. A limitation of this source is that it does not provide age-adjusted rates by county. Where feasible, age-adjusted rates were calculated by the Polis Center team. Age-

Barriers & Biases

While resiliency is admirable, our Black women interviewees emphasized the effects that involuntary resiliency has had over time. Involuntary resiliency is a condition where one achieves a state of resiliency without consent and often by way of an intersection of structural and domestic oppression. It's important to understand that the compounding factors of sexism and racism have very real effects on women who are Black, Indigenous, and People of Color (BIPOC), particularly Black women. "As Black women continue to exhibit remarkable resilience and grit to ensure their families and community are well, this bears a great weight on their emotional and physical wellbeing. We want to ensure that Black women have spaces and opportunities to be vulnerable and safe." - Rhonda L. Bayless, Executive Director, Centers of Wellness for Urban Women (CWUW)

Defining Crude Mortality Rate

A measure of the number of deaths in a given population during a specific time period, without adjusting for age differences. It is calculated as the total number of deaths divided by the total population, often expressed per 100,000 individuals. Crude rates are useful for understanding the overall burden of mortality but can be influenced by the age structure of the population.

Defining Weathering

A hypothesis that suggests chronic exposure to social, economic, and environmental stressors contributes to the early health deterioration and accelerated aging of marginalized groups, particularly those experiencing systemic racism. The concept of weathering emphasizes how cumulative adversity affects the physical and mental health of individuals over time.

Defining Allostatic Load

A measure of the cumulative burden of chronic stress and life events on the body's systems. It represents the "wear and tear" that occurs when an individual is exposed to repeated or prolonged stressors, leading to physiological changes that can increase the risk of health issues such as cardiovascular disease, diabetes, and mental health conditions.

adjusted rates help standardize mortality rates to account for differences in age distribution across populations, offering a more accurate comparison between regions. However, for SUD and suicide-related deaths, crude mortality rates are used as age adjustment was not possible due to data suppression.

These limitations and definitions should be considered when interpreting the results, as they may affect the precision and generalizability of the findings related to mental health outcomes.

Strength & **Abundance**

An important strength highlighted by our interviews was the perseverance and resiliency shown by Black women, due to the systems they must navigate on a daily basis. The experience of Black women is an important distinction from the entire population of women that must be made. Dr. Tucker Edmonds, Professor of Obstetrics and Gynecology, speaks to this: "Anything that is a challenge for White women is compounded by and made exponentially more challenging for Black women because of structural racism that operates with the intersectional impact among Black women."

Endnotes

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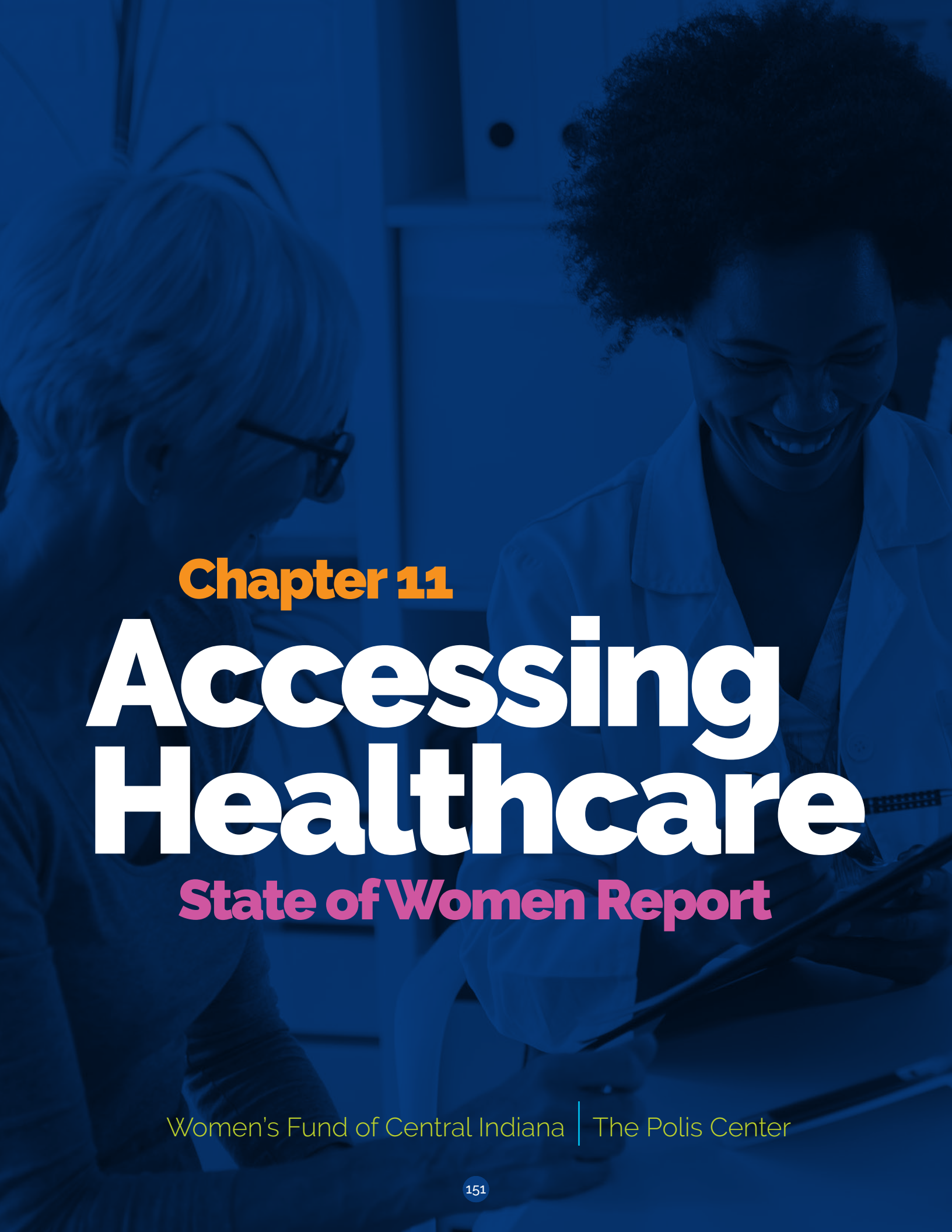


Chapter 11

Accessing Healthcare

State of Women Report

Women's Fund of Central Indiana | The Polis Center

Accessing Healthcare

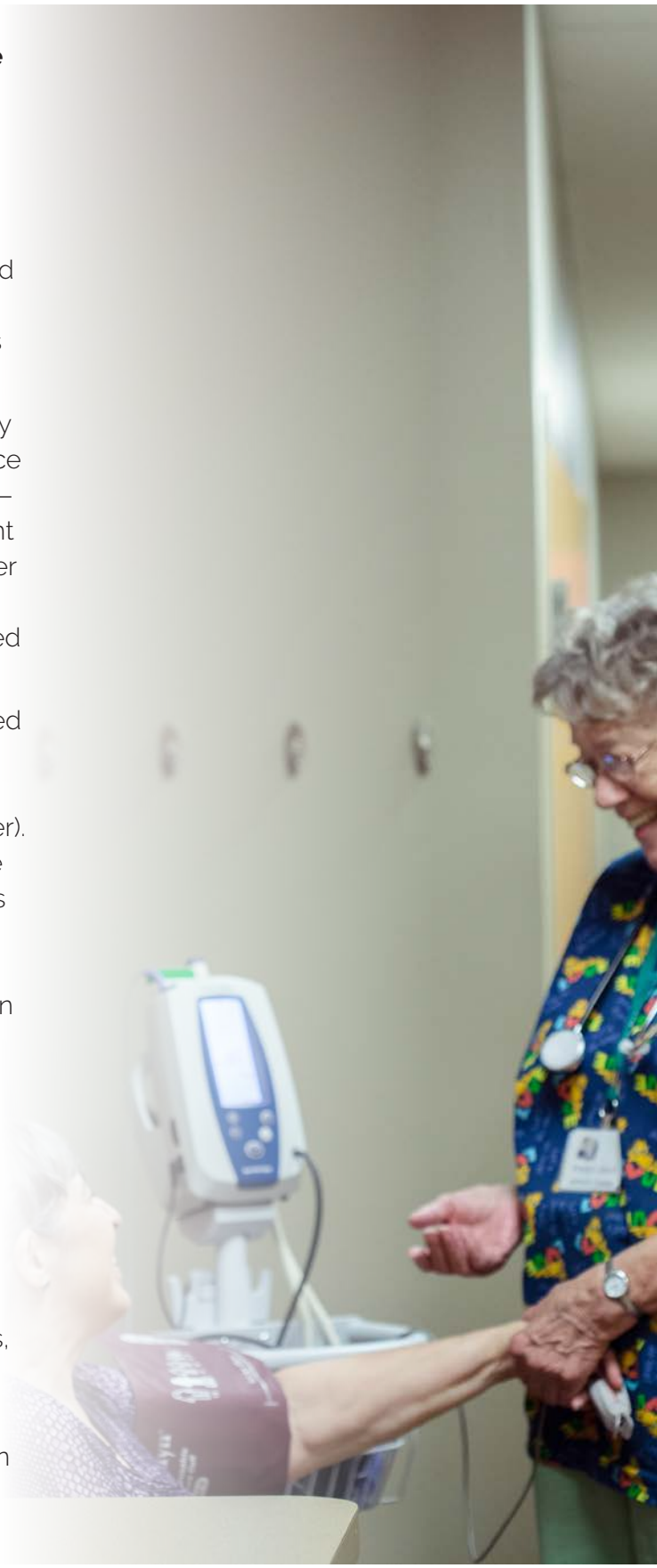
Access to healthcare in the United States remains a critical issue, influenced by a variety of policies that shape socioeconomic factors, leading to widespread disparities. Policies that have historically enforced racial residential segregation and disinvestment in communities of Black, Indigenous, and People of Color (BIPOC) have created enduring barriers to healthcare access by contributing to economic instability, inadequate transportation, underfunded education, substandard housing and poor infrastructure. These structural conditions, in turn, impact health outcomes across populations.[1,2]

Research shows that the lack of investment in predominantly Black and minority communities—often a direct consequence of discriminatory housing and lending policies like redlining—has led to disparities in economic stability. This disinvestment leaves these communities with fewer job opportunities, lower wages, and limited resources for healthcare services. As a result, individuals in these neighborhoods are often uninsured or underinsured, further limiting their ability to access care.

Additionally, inadequate transportation systems in disinvested areas, such as limited public transit options and poor infrastructure, make it difficult for residents to travel to healthcare facilities (Learn more in the Transportation chapter). Many neighborhoods in these areas lack basic infrastructure like sidewalks and safe walking spaces, making it dangerous or impossible to walk to nearby clinics or hospitals. This geographic isolation worsens the healthcare access gap, particularly for those who cannot afford private transportation or live in healthcare deserts (areas with few or no healthcare providers).

Substandard housing conditions, such as overcrowding, exposure to environmental toxins, and unsafe living environments, exacerbate health issues like asthma, hypertension and mental health disorders. These factors, combined with limited access to healthy food options—commonly known as food deserts—result in higher rates of chronic diseases like diabetes and cardiovascular conditions, which require consistent medical attention.

However, due to the economic and geographic barriers shaped by policies, residents of these communities are often unable to receive the necessary preventive care, leading to higher rates of acute health episodes.



Research shows that disparities in healthcare access, driven by these socioeconomic and policy-driven factors, lead to varied health outcomes across different populations.[3] Health insurance, when available, enhances access to primary and preventive healthcare, which is essential for managing chronic conditions and reducing acute health episodes[4,5]. However, until policies address the systemic disinvestment in communities of BIPOC and the resulting socioeconomic inequities, access to healthcare will remain deeply unequal, perpetuating health disparities.

> **"Accessing quality healthcare is an issue for women, especially Black women. Providers and healthcare systems although publicly acknowledged racial and gendered issues are a concern, there still aren't enough systems changes to address the poor service many women receive due to bias and bigotry."**
>
> ***- Rhonda L. Bayless,*** *Executive Director, Centers of Wellness for Urban Women (CWUW)*

Key Takeaways:

- In Indiana, women are less likely to be uninsured (6.9%) than men (8.7%), while younger women are more likely than men to be on Medicaid (public health insurance for low-income individuals)
- Hispanic women have a significantly higher rate (20.8%) of avoiding access to care due to cost compared to White women (8.5%).
- The lack of a regular health care provider is notably higher among Hispanic women (26.2%) compared to White women (8.2%).

Barriers & Biases

There are many barriers to accessing healthcare, such as: access to insurance, access to *quality* insurance, transportation to appointments, getting an appointment scheduled instead of joining a waitlist, and many more. While there are several organizations that help to address these barriers in the community, more work is needed. Equitable access to quality healthcare is crucial to allowing every woman in Central Indiana the ability to thrive.

Health Insurance Coverage

Uninsured rates in the U.S., Indiana, and Central Indiana decreased between 2015 and 2022, showcasing gradual improvements in overall health insurance coverage due to the Affordable Care Act.[6] Within the population that remained uninsured, there are gender disparities, with men more likely to be uninsured than women. In the U.S., 9.7% of men are uninsured compared to 7.7% of women. In Indiana, 8.7% of men are uninsured, compared to 6.9% of women.[7]

For those under the age of 65 with health insurance coverage, women are more likely than men to have Medicaid insurance, which is public health insurance designed for people with limited income and resources.

Among women, young adults aged 19-34 have the highest uninsured rate.[8] Younger women face higher uninsured rates than older women due to lower wages, part-time employment, and life transitions like finishing school or starting families. Older women (aged 65 and older) also benefit from eligibility for Medicare.

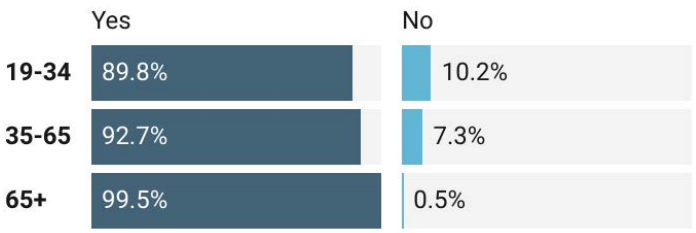
Impact of Financial Barriers on Healthcare Utilization

Economic constraints influence healthcare utilization. Over ten percent (10.2%) of all women in Indiana report deferring medical care due to cost constraints.[2] In Indiana, Hispanic women have the highest rate of deferring care due to cost (over 20%), which is notably higher than the rate for White women (8.2%), but not statistically different than the rate for Black women (12.4%).[2] This statistic was not available for Central Indiana.

Hispanic women also are significantly more likely to lack a regular provider (26.2%) compared to White women (8.2%). The rate for Black women lacking a regular provider is 12.4%. Immigrant status can impact Hispanic women's access to healthcare. Language barriers, cultural differences[9], economic challenges[10], fear of legal repercussions[11], and limited resources in predominantly Hispanic communities all contribute to this disparity.

Among **women,** young adults **aged 19-34** have the **highest uninsured rate**

Health Insurance Coverage Status of Women Across Different Age Groups (Central Indiana)

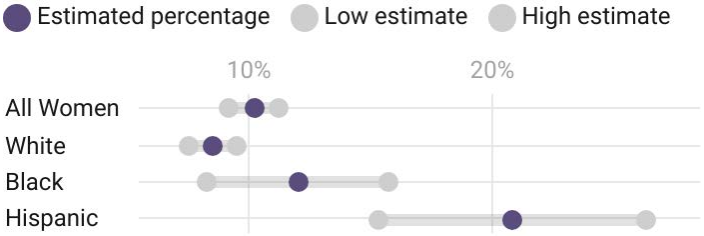


Source: ACS 5-Year Estimates, 2018 - 2022; Graphic by the Polis Center

Women aged 19 and older

Over ten percent (10.2%) of **all women** in Indiana report **deferring medical care due** to **cost** constraints

Percentage of Women Who Avoided Care Due to Cost in the Past 12 Months by Race (Indiana)



Source: Behavioral Risk Factor Surveillance System (BRFSS), 2022; Graphic by the Polis Center

Women aged 18 and older

Strength & **Abundance**

Centers of Wellness for Urban Women (CWUW) "provides a supportive setting and support system to assist the participant in understanding the various ways she can approach successful healing and have a better understanding of why preventive health is important." While this is one of many organizations that supports the community and their health, CWUW focuses solely on women and helping them learn to navigate the healthcare system. This work is crucial to addressing the barriers and biases in the healthcare system.

Endnotes

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