
Policy Brief

From Barriers to Bridges: Implementing Access Solutions to Improve American Indian, Alaska Native and Native Hawaiian Maternal Health

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Access Solutions to Improve American Indian, Alaska Native and Native Hawaiian Maternal Health

American Indian and Alaska Native (AI/AN) people have unique and structural challenges to accessing the maternity care that is required help keep babies and mothers safe and healthy. This report examines this issue in four parts to address specific issues: 1) accessing care in urban areas, 2) accessing care in rural areas, 3) cultural integrative care models, and 4) the role of traditional medicine in maternal health care.

Part 1: Urban American Indian and Alaska Native Maternal Health Care Services

Authors: Seattle Indian Health Board; Urban Indian Health Institute

Introduction

American Indian and Alaska Native (AI/AN) people have nurtured healthy and thriving families and communities rooted in cultural values for generations. Traditional way of life was interrupted by historical subjugation, and the impact can be measured by the persistent health disparities felt acutely throughout Indian Country, including in urban areas, where 76% of AI/AN individuals now reside.^{i, ii} The AI/AN maternal health crisis is due in large part to the removal of cultural birthing practices that sustained tribal communities as well as lack of access to quality health care services. Despite efforts to address this disparity, the rates of morbidity and mortality continue, and in some tribes are widening.ⁱⁱⁱ In the face of this crisis of epic proportions, there is a pressing need for the federal government to fulfill its treaty and trust obligation to ensure competent physician-led health care to AI/AN people, which was recently upheld in an 8th Circuit Court decision in 2021.^{iv} This obligation extends beyond reservations and village borders and into urban areas where a majority of AI/AN people reside, in the words of the Urban Indian Health Institute, “urban is where we [AI/AN] live, tribal is who we are.”^{2, v} The urban Indian population is served by a network of not-for-profit organizations contracted by the Indian Health Service (IHS) to provide services ranging from resource and referral services to primary health care however, due to the chronic underfunding of IHS, these organizations receive less than 3% of the overall IHS budget.^{vi, vii} As a result of these

ongoing factors, maternal and infant health outcomes for this population are falling short of this federal obligation. The current system fails to meet the needs of rural and urban dwelling AI/AN mothers and their families.

AI/AN mothers face higher rates of maternal morbidity, suffer from disproportionately high maternal mortality rates, and are also more likely to experience mistreatment while accessing care.^{viii} AI/AN people are also nearly three times more likely to receive late or no prenatal care compared to non-Hispanic white mothers.^{ix} The health of mothers translates to the health of infants. The challenges faced by AI/AN mothers impact the outcomes of infants. When compared to the total population, all leading causes of infant mortality occur more frequently among AI/AN infants. AI/AN infants were also 2.4 times more likely to die from both sudden infant death syndrome (SIDS) and congenital malformations

This section discusses several contributing factors to these outcomes, including:

- Historic and ongoing distrust of health care systems
- Chronic underfunding of IHS, including Urban Indian Organizations (UIOs)
- Limited access to care due to maternity care deserts
- Workforce shortages and lower participation of AI/AN people in health care professions
- Jurisdictional fragmentation across federal, state, Tribal, and urban systems.

Access to community-attuned, continuous, and comprehensive maternal care is limited by jurisdictional complexities, under-resourced facilities, and workforce challenges. The Indian Health Service (IHS), the federal agency primarily responsible for providing healthcare to AI/AN people, currently operates only 10 obstetric facilities nationwide. Over 90% of AI/AN births occur outside of IHS facilities, and many AI/AN individuals rely on private insurance and Medicaid for pregnancy, birth, and postpartum care services. The maternity care provided to AI/AN people generally lacks community-attuned care due to lower participation of AI/AN people in healthcare professions. In 2019, only 0.6% of the U.S. healthcare workforce identified as AI/AN.^{xi} Approximately 12,000–15,000 (0.4%) nurses^{xii} and around 4,100 (0.4%) physicians^{xiii} self-identified as AI/AN.

Despite these obstacles, AI/AN communities are leading innovative, community-led solutions. Organizations such as Hummingbird Indigenous Family Services, Native American Community Clinic, Native American Health Center, and Seattle Indian Health Board are providing community attuned maternal health care that incorporates traditional practices of Indigenous communities they serve. These community organizations are designing approaches and strategies that fulfill the desired maternal health care for the people they serve.

Their approaches center engaging and listening to mothers, integrating traditional knowledge with Western medical practices, growing the AI/AN health care workforce, and responding to broad health-related needs illustrating wisdom from practice and the importance of community-defined care to improve maternal and infant health outcomes.

Achieving sustained improvements in maternal health outcomes for AI/AN people require support for these holistic, community-driven approaches that prioritize AI/AN knowledges, address structural gaps, and ensure sustainable funding. The federal government must act with urgency and accountability to fulfill its treaty and trust responsibility to support the health and well-being of AI/AN mothers and infants.

The section will also discuss recent legislative developments, such as the approval of 1115 demonstration waivers for Traditional Indian Medicine in four states and Medicaid doula reimbursement in Washington State. Such efforts must be scaled nationally and supported by sustained federal investment. This urgency was not reflected in the FY26 IHS budget request which included less than \$19 million for maternal health disparities—far below what is needed to address the crisis.

To improve maternal and infant health in Indian Country, Part 1 of this report outlines a comprehensive set of recommendations across key policy areas including:

1. Prevention, Screening, and Diagnosis

- Integrate mental and emotional health screening into every perinatal visit and extend mental health screening through the first year postpartum.
- Integrate cultural protective factors related to breastfeeding, nutrition, and child-rearing.
- Train providers to screen for substance use disorder, suicide ideation, and intimate partner violence during prenatal and perinatal care.

2. Practice and Evidence-Based Interventions and Treatment

- Fund peer-based birthing communities.
- Center traditional healing in all services, alongside physical, mental, emotional, and spiritual health.
- Fund training on traditional perinatal practices for AI/AN individuals.
- Invest in inpatient facilities and culturally based interventions for pregnant and parenting adults.

3. Workforce Development

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- Expand the National Health Service Corps loan repayment to include individuals who are Certified Midwives and Certified Professional Midwives.
 - Increase funding for doula services.
 - Expand HRSA programming, such as the Maternal and Child Health training initiative and the Maternal and Child Health Bureau’s breastfeeding programming.
 - Increase investments to recruit and train AI/AN Breastfeeding Peer Counselors, including outreach efforts.

Background

For generations, American Indian and Alaska Native (AI/AN) families have built thriving communities in cities, and today, 76% of AI/AN people live in urban areas.^{xiv} The Indian Relocation Act of 1956, a federal program that provided incentives to AI/AN people who moved to urban areas, led a significant number of tribal members to relocate to cities in the second half of the 20th century. The promise of jobs and other incentives that were rarely fulfilled and many AI/AN who relocated to urban cities soon fell into poverty, which exacerbated already existing health disparities.² In the present day, AI/AN people continue to come to urban areas for education, employment, and other opportunities and have built thriving intertribal communities across the nation. This growth reflects resilience, adaptability, and the determination to remain connected to culture and tribal values wherever they live. Urban AI/AN people encompass individuals from numerous distinct tribes throughout the United States. In Seattle, where urban Indians are served by an IHS contracted UIO, their service population represents 214 different tribes, all with distinct cultures and traditions.

The United States has a trust responsibility to provide for the well-being of AI/AN people.⁴ In partial fulfillment of these responsibilities, the Indian Health Service (IHS) provides services to AI/AN through the Indian Health Service, Tribal health service, and Urban Indian Organizations (UIOs), or I/T/U, system of care.^{xv} Most clinical and hospital facilities operated by IHS, Tribes, and tribal organizations are in areas inaccessible to urban AI/AN. As a result, urban AI/AN people rely upon UIOs to bridge these gaps in health care access. Even in urban areas, maternal care barriers for AI/AN include lack of access, dissimilar communication styles, and inconsistent continuity of care that honors trust and relationship building with providers.^{xvi} These disparities can be attributed to socioeconomic factors influenced by historical events and perpetuated by structural factors.^{xvii} Due to these factors, urban areas face highly concentrated maternal morbidity rates for AI/AN women at around 80%.^{xviii} AI/AN women and children are at a higher risk of complications throughout pregnancy, birth, and newborn health.^{xix}

Disparities in health care, including maternal health, can be attributed in part to the limited

health care options available in urban and rural settings. Studies have suggested that poor maternal health in AI/AN communities is attributed to socioeconomic status, individual health behaviors, and cultural beliefs; in addition, these pregnant individuals also experience mistreatment while receiving care.^{xx} Barriers in accessing care have led to increased infant and maternal mortalities among AI/AN.^{xxi} Prenatal care is crucial to the overall well-being of both the mother and child, and it can play a significant role in preventing maternal and infant mortality. Yet, in 2022, non-Hispanic AI/AN mothers were nearly three times as likely to receive late or no prenatal care compared to non-Hispanic white mothers.^{xxii}

Poor maternal health is also associated with the social determinants of health such as socioeconomic status, employment, insurance, education, transportation, and a low standard of medical care, resulting in AI/AN infants being 3.2 times more likely to die from sudden infant death syndrome (SIDS).^{xxiii} The I/T/U system of care for AI/AN people plays an essential role in addressing health disparities by offering culturally attuned resources and care that would otherwise be unavailable to AI/AN people. For example, UIOs not only offer primary care and behavioral health services but also social and community services, as well as Traditional Indian Medicine.

Accessing critical maternal care resources should not be difficult; however, access disparities for AI/AN mothers are rooted in historical trauma.^{xxiv} Traditional birthing methods were disrupted for AI/AN communities, resulting in reliance upon Western systems, which are often costly and lack an understanding of the traditional birthing practices of AI/AN communities. Currently, there are only 10 IHS obstetric facilities available nationwide to support infant and maternal health.^{xxv} As a result, over 90% of births to AI/AN people occur outside IHS facilities.^{xxvi} A majority of AI/AN utilize Medicaid to assist in the payment for prenatal, delivery, and perinatal care. When accessible, they utilize the I/T/U system of care however IHS is chronically underfunded and often lacks services crucial to pregnant individuals.

Maternal Mortality

AI/AN women are 2-3 times more likely than Non-Hispanic White (NHW) women to die from pregnancy-related complications.^{3,4} Maternal mortality disparities also widen when examined by age and geography. Pregnancy-related mortality for AI/AN women over the age of 30 was 4 to 5 times higher than for NHW women.² An analysis by the Urban Indian Health Institute (UIHI) also found urban AI/AN women were 4.2 times more likely than NHW women to die from pregnancy-related complications.⁶ Common causes included conditions of mental health, cardiovascular disease (cardiomyopathy), and COVID-19.^{xxvii} AI/AN often face higher rates of stress throughout their pregnancy, contributing to higher rates of maternal deaths.^{xxviii}

Among the maternal AI/AN deaths, 100% were preventable in certain years.^{xxix}

Recent studies highlight the disproportionate impact of maternal mortality on AI/AN women. In 2020, pregnancy-related deaths among AI/AN women were more than two times higher than those of non-Hispanic white women.^{xxx} Common causes included conditions of mental health, cardiovascular disease (cardiomyopathy), and COVID-19.^{xxxi} AI/AN women also face unique risks related to autoimmune diseases and higher vulnerability to postpartum complications. Access to mental health services including treatment for substance use disorder is another factor that has increased maternal mortality rates (Figure 1). Overcoming these disparities requires targeted investments in both preventive care and maternal health services tailored to the overall well-being of AI/AN mothers.

Figure 1. Maternal Mortality and Mental Health

<ul style="list-style-type: none">• Between 2018 and 2022, 51.4% of homicides, 31.8% of suicides, and 34.4% of overdoses occurred during or after pregnancy.^{xxxii}
<ul style="list-style-type: none">• Between 2008 and 2019, 33.3% of pregnancy-associated suicides were linked to substance abuse disorder (SUD).^{xxxiii}
<ul style="list-style-type: none">• In 2020, 50% of pregnancy-related deaths among AI/AN women occurred 7–365 days postpartum, with infection and mental health conditions among the leading causes.^{xxxiv}
<ul style="list-style-type: none">• Native women are 2.5 times more likely to experience sexual violence,^{xxxv} yet still, across the country, too few clinicians are routinely screening for intimate partner violence (IPV).^{xxxvi,xxxvii} IPV and depression screening are effective tools to protect AI/AN.

Health Related Needs

Pregnancy is often accompanied by other major life changes, and for AI/AN women, these challenges are compounded by poverty, housing insecurity, domestic violence, and limited access to consistent health care. Attending prenatal visits can be especially difficult due to extensive travel, childcare, or time away from work. These barriers create risks for both mother and child.^{xxxviii} While the general population faces similar influences, AI/AN communities often encounter unique challenges. For example, research in Wisconsin and North Dakota found that AI/AN women without a high school diploma were more likely to smoke during pregnancy. Nationally, AI/AN women reported a higher prevalence of barriers to care; 66% reported at least one, including lack of transportation.^{xxxix}

Preterm and Low Birthweights

Low birthweight emerged as one of the leading causes of infant mortality in the 1990s. While prenatal care was intended to address this issue, AI/AN communities have faced significant barriers to adequate care. In 2023, non-Hispanic AI/AN mothers were nearly two times as likely to receive late or no prenatal care compared to the general population.^{xi} Studies suggest that initiating prenatal care late or receiving fewer than four prenatal visits significantly increases the risk of infant mortality.^{xii} AI/AN infants whose mothers had delayed or limited prenatal care had 19% higher rates of infant mortality compared to those whose mothers received adequate care.^{xiii}

Infant Mortality

In the U.S., the highest rates of infant mortality are among AI/AN infants. Although infant mortality overall has declined since 1995, the decline among AI/AN populations has been slower compared to non-Hispanic whites (WNH) and the national average. According to the Centers for Disease Control and Prevention (CDC), in 2022, the infant mortality rate for AI/AN infants was twice as high as that of non-Hispanic white infants.^{xliii} In 2023, compared to the general infant population, AI/AN infants were over two times as likely to die from sudden infant death syndrome (SIDS) and 20% more likely to die from congenital malformations.^{xliv} These persistent disparities underscore the urgent need for increased investments in IHS, which plays a critical role in providing essential maternal and infant health services for AI/AN communities.

Discussion

Chronic Underfunding

The health disparities present within AI/AN communities are rooted in policies embedded into the system today.^{xlv} The United States federal government has an obligation to AI/AN for “competent physician-led health care” established under the Snyder Act of 1921 and the Indian Health Care Improvement Act. Due to federal relocation policies and urbanization, the AI/AN urban population has increased. Due to the growing urban AI/AN population, in 1976, the Indian Healthcare Improvement Act established a funding stream for urban Indian health organizations (UIOs) to serve the urban population, creating the IHS I/T/U system of care as we know it today.

The IHS mission: “to raise the physical, mental, social, and spiritual health of American Indians

and Alaska Natives to the highest level.”^{xlvi} However, IHS is chronically underfunded; less than 3% of IHS funding is allocated to urban Indian organizations, which have limited ability to further develop their programs.⁷ Due to this underfunding, UIOs were forced to diversify funding streams in order to serve the needs of the AI/AN people they serve. As a result the types of service provided by UIO’s vary as illustrated by a recent study by IHS (Figure 2) mapped resources across the 41 UIOs and separated them into the following: 1) full ambulatory care, 2) limited ambulatory care, 3) outreach and referral, and 4) residential and outpatient substance abuse disorder treatment.^{xlvii}

Figure 2. UIO Type

<ul style="list-style-type: none"> • Full Ambulatory Care: Outpatient services providing direct medical care to the population served for 40 or more hours per week. • Limited Ambulatory Care: Programs providing direct medical care to the population served for less than 40 hours per week.
<ul style="list-style-type: none"> • Outreach and Referral: Programs providing case management of behavioral health counseling and education services, health promotion/disease prevention education, and immunization counseling, but not direct medical care.
<ul style="list-style-type: none"> • Residential and Outpatient Substance Use Disorder Treatment: Programs providing residential and outpatient substance abuse treatment, recovery, and prevention services.

While many UIOs would like to further expand their services, there is inadequate funding. To meet the UIOs’ future planning, their operating budget would need to reach \$1.37 billion by 2032. If supported by IHS, this would call for a budget increase to Urban Indian health by 1,270%. However, the percentage of operating funds sourced from IHS varies among UIOs, with some reaching 100% while others are as low as 12%.^{xlviii}

Due to persistent gaps in the I/T/U system of care, many AI/AN also rely on Medicaid and private insurance to access external health providers for prenatal and postnatal care. A recent study estimated that 75% of AI/AN people did not have IHS care at the time of delivery.^{xliv} Medicaid plays a critical role in providing prenatal, delivery, and postpartum care for AI/AN populations, though rates of coverage vary by geography. In 2013, Medicaid covered approximately 63% of AI/AN births compared to 42.9% coverage in the overall population.¹ Pregnant AI/AN who rely on Medicaid as their primary insurance are more likely to experience complications and death, though Medicaid expansion has been shown to increase prenatal care utilization among low-income populations at risk of disparities. In 2022, Medicaid remained the primary source of payment for delivery among AI/AN women.

Findings from maternal mortality reviews also have documented instances where bias, stigma, and differential treatment based on racial identity or substance use negatively affected the quality and timeliness of maternal health care. These factors contributed to preventable pregnancy-related deaths.^{li}

Navigating the limitations of IHS coverage and its intersections with other insurance are complex and often restricts access to essential services. Limited capacity within IHS-funded facilities, combined with patient-to-provider ratios, results in long wait times and inconsistent provider availability.^{liii} A recent survey conducted in Los Angeles found that AI/AN women experience higher levels of stress throughout their pregnancy, in part due to the lack of birthing capacity at Indian Health clinics and the resulting delays in referrals. A majority of AI/AN Native births (90%) occur outside of IHS facilities.^{liiii} Despite these challenges, AI/AN individuals seeking culturally attuned care are more likely to utilize IHS as their primary health care provider, illustrating the need and importance of the I/T/U system of care.^{liv}

Limitations on implementing solutions

Pregnant AI/AN individuals are seeking options for birthing that are respectful of their identities and birthing practices. Nationwide, there is a call to action within tribal communities for access to holistic and culturally attuned birthing centers.^{lv} However a lack of appropriate Medicaid reimbursement for these centers continues to stifle this opportunity to provide development and access to such facilities. Addressing Medicaid disparities in reimbursement for birthing centers is essential, and while such reimbursements exist in some states, they do not in others.^{lvi} Certain states also have limits on services that are covered, and reimbursement rates can be significantly lower compared to hospital reimbursement rates, sometimes by as much as 70%.^{lvii} Ensuring national Medicaid coverage and better reimbursement rates for birthing centers may help address this issue and resolve care fragmentation by making it sustainable for Indian health care system providers to add birthing centers to their portfolios.

Health Care Workforce Shortages

Lack of workforce development for AI/AN people has also resulted in a lack of AI/AN representation in the pregnancy and childbirth care workforce for physicians, midwives, nurses, social workers, mental health counselors, addiction counselors, lactation consultants, and doulas.^{lviii} Nineteen percent of AI/AN births in 2020 were attended by midwives; however, only 0.4% of midwives are AI/AN.^{lix} AI/AN individuals represent less than 0.5% of the physician workforce, a gap that is widening. For example, in the 2018-2019 academic year, only 0.2% of accepted medical school students were AI/AN.^{lx}

To put that into perspective, that represented a cohort of only 44 AI/AN students, while, in 2017, hundreds of provider vacancies existed IHS service areas.^{lxi} A representative health care workforce is critical for the provision of culturally attuned services.

Care Fragmentation

Urban Indian organizations were established in 1988 under the Indian Health Improvement Act to address the growing urban Indian population. UIOs are contracted with IHS to provide essential services to urban Indians. Each of these facilities operates with limited services available to provide health care to AI/AN. None of the UIOs have facilities where patients can deliver their babies, while some have partnered with hospitals to credential UIO providers to utilize their birthing facilities; most are forced to refer patients to providers and hospital systems outside of the I/T/U. Mothers engaged in this system will often meet the provider for the first time when they arrive at the hospital to deliver, providers who often will not know or understand their unique needs.

A lack of payment parity within the Indian health care system itself exacerbates fragmentation issues. This is due to the 100% Federal Medical Assistance Percentage (FMAP), which IHS and Tribal facilities benefit from, however Urban Indian Organizations are not eligible. Despite support from tribes for 100% FMAP parity for more than a decade, efforts to pass national legislation have failed. This is an additional barrier to accessing services as it undermines the sustainability of certain programs and facilities.

Chronic Underfunding of IHS

IHS was established to meet the health care needs of AI/AN; however, it is chronically underfunded, resulting in gaps in care and service for AI/AN. For the agency to become fully funded, FY26 funding levels for IHS would need to reach \$63 billion, according to the National Tribal Budget Formulation Workgroup. These levels would need to reach \$73 billion in FY27, representing \$66 billion more than the FY24 enacted levels. This highlights the magnitude of the funding gap for IHS and the effort required to ensure treaty and trust obligations are met. Moving IHS funding to mandatory advance appropriations is a more achievable first step, and would, at a minimum, ensure the delivery of health care services currently funded.

Community-driven initiatives and gaps in wraparound services

UIOs are working to integrate culturally grounded approaches that prioritize holistic, family-centered, and culturally attuned care that work to address health disparities. UIOs are the answer

to addressing AI/AN maternal health disparities, as illuminated in the following case studies.

Case Studies

Seattle Indian Health Board

The Seattle Indian Health Board (SIHB) is a UIO and FQHC based out of Seattle, Washington, which has adopted an agency-wide Indigenous Knowledge Informed System of Care (IndigiKnow) rooted in AI/AN teachings.^{lxii} Their Birthing Sovereignty framework brings together pregnant women due at the same time in group settings that build social connection, trust, and cultural grounding inspired by Centering Pregnancy model.^{lxiii} With the support of a community advisory committee of Indigenous birth workers from Hummingbird Indigenous Family Services, Center for Indigenous Midwifery, and Native American Women’s Dialog on Infant Mortality SIHB created a culturally-tailored curriculum for pregnancy through 1-year postpartum. The curriculum covers information on what to expect at each stage of pregnancy and infant development, while acknowledging the social, emotional, and cultural connections necessary for a healthy pregnancy and birth.

This approach emphasizes integrating Traditional Indian Medicine, providing access to traditional first foods, and embedding traditional perinatal practices directly and through connections with a host of AI/AN partners. Moreover, this model builds upon the traditional wisdom and knowledge that communities hold by encouraging peer learning and sharing across the group care model. To further support the needs of pregnant AI/AN, SIHB plans to open a 92-bed inpatient Thunderbird Treatment Center in 2026, with 15 beds reserved for pregnant women and their young children up to the age of 5 years, so that families are not separated.

Hummingbird Indigenous Family Services

Hummingbird Indigenous Family Services is a 501(c)(3) non-profit organization based out of Seattle, Washington, that provides free culturally responsive, full-spectrum Indigenous doula, family planning support, and perinatal education services to AI/AN pregnant individual. Their services are intended to support AI/AN as they navigate reproductive health care. In urban spaces, birthing parents may have difficulty accessing culturally attuned care. Organizations such as Hummingbird Indigenous Family Services provide access to AI/AN providers offering continuous and unconditional mental, physical, emotional, and spiritual support throughout the perinatal period.^{lxiv}

Birth Justice Collaborative

Birth Justice Collaborative (BJC) is a partnership of six African American and American Indian led community organizations and Hennepin County working to improve birth outcomes among African American and AI/AN communities. Their framework is to implement five priority strategies of acknowledging and addressing the impacts of structural differences affecting certain

groups, advocating for and reforming policy and payment, expanding culturally meaningful workforce pathways, advancing and expanding anti-bias accountability programs, and investing in a network of trusted cultural providers and resources. BJC has conducted a postpartum pilot learning and evaluation program, released a Birth Justice Strategic plan, and is working to implement the plan through piloting cultural parenting programs, establishing billing codes for cultural leaders/healers and resources to allow for reimbursement, building upon the MN Dignity in Pregnancy and Childbirth Act, and providing access to cultural resources through community-endorsed partners.^{lxv}

Policy Solutions

Improving health outcomes for mothers and infants will require a multi-pronged approach: a holistic set of reforms that complement each other and empower communities. Below is a set of recommendations that can lower existing barriers and allow communities to implement changes they know to be effective.

Prevention, Screening, and Diagnosis

Integrating practices proven to be effective in AI/AN communities is crucial to enhancing maternal and infant health outcomes.

- Preventive mental and emotional health should be integrated into every perinatal visit, just like blood pressure and nutrition. Establishing a baseline for mental health for patients prior to the postpartum period will better equip providers to address issues early or even before they arise. Mental health screening should be continued for at least one year postpartum to ensure optimal outcomes for both parents and their babies.
- Cultural protective factors for prevention must also be integrated, such as cultural practices related to breastfeeding, nutrition intake, and child-rearing practices.
- Federal funding should be distributed throughout the Indian health care system to train providers to screen for substance use disorder, suicide ideation, and intimate partner violence during prenatal and perinatal care. This can support access to other services, when needed, to improve outcomes for mothers and children.

Practice-Based Intervention and Treatment

Western frameworks often ignore practice-based interventions and community practices for AI/AN communities. However, AI/AN communities continue to build on the inherent Indigenous knowledge and practices that protect and strengthen maternal and infant health outcomes.

- Create birthing communities where individuals participate in peer-based cohorts and communities. In a community setting, pregnant women can participate in group

perinatal appointments, educational opportunities, and discussions.

- Center traditional healing in all services to support optimal health outcomes for parents and infants. This should be done in conjunction with, not in place of, physical, mental, emotional, and spiritual health. Education opportunities on traditional healing and how traditional herbs and practices support breast milk production can also support maternal and infant health outcomes.
- Fund training on Indigenous Traditional Perinatal Practices for AI/AN individuals in birthing communities. Training can be co-led by providers, certified nutritionists, traditional practitioners, breastfeeding counselors, WIC program managers, and family residents.
- Fund investments in AI/AN in-patient facilities, as many Tribal and Native communities struggle to identify funding for in-patient facilities. There is only one, and soon to be two, AI/AN in-patient facilities with beds reserved for pregnant and parenting adults.
- Fund training opportunities for delivering culturally based interventions for pregnant and parenting adults. Efforts could mirror Minnesota's SUD system reform from 2018, which included peer recovery coaches and training and certifying AI/AN individuals with lived experience to support harm reduction, outreach, and intervention for pregnant and parenting adults.

Workforce Considerations

- Recognize the Certified Midwives and Certified Professional Midwives with accredited education for loan repayment under the National Health Service Corp to address gaps in the maternal health workforce and increase provider representation from underserved populations.
- Increase funding for community-based doulas. For Native women, doulas support decreasing negative childbirth experiences and support their access to health care providers who understand the unique cultural, social, and economic burden mothers face.
- Expand the HRSA Maternal and Child Health training and workforce development program to reach underserved communities and increase AI/AN representation, leadership development, and professional connections.
- Increase funding for breastfeeding programming through the HRSA – Maternal and Child Health Bureau (MCHB). Increasing breastfeeding resources for community-based organizations through the MCHB would improve health outcomes for AI/AN women and help restore Indigenous breastfeeding practices.
- Invest funding to recruit and train AI/AN Breastfeeding Peer Counselors. Investing in outreach and training for AI/AN breastfeeding peer counselors can positively impact health outcomes. For example, AI/AN infants have a lower rate of breastfeeding initiation than the general population, yet early initiation is associated with a lower risk of neonatal

mortality. Breastfeeding peer counselors are an evidence-based practice that addresses such issues, and the AI/AN workforce should be increased through new opportunities.

Federal and State Legislative Efforts

1115 demonstration waivers for Traditional Indian Medicine

In 2024, the Centers for Medicare and Medicaid Services (CMS) approved 1115 demonstration waivers for Traditional Indian Medicine demonstration projects in 4 states (Arizona, California, New Mexico, and Oregon). In three of these states (California, New Mexico, and Oregon), UIOs are included as eligible providers. Once states have CMS approval, Section 1115 waivers allow states to authorize Medicaid billing for certain demonstration projects. Waivers are submitted on a state-by-state basis and are a pathway for reimbursement for services typically not covered by Medicaid. With waivers in place, managed care organizations in these states can bill Medicaid for Traditional Indian Medicine services received by beneficiaries, allowing Medicaid-eligible AI/AN people to receive TIM services while insurers are made whole. Consultation with UIOs in the process ensured UIOs were included in the final framework.

Medicaid doula reimbursement in Washington State

In 2022, Washington State enacted HB 1881, which established a health profession for doulas in the state. The following year, under the appropriation bill SB 5950, Washington authorized the state Health Care Authority to add doula services as a benefit for Medicaid beneficiaries and to create a doula referral system. Currently, Medicaid beneficiaries in the state are covered for a prenatal intake visit, labor and delivery support, and 20 additional hours of prenatal and postpartum visits.

Funding for UIOs

In July 2025, the House Committee on Appropriations passed a funding bill for Fiscal Year (FY) 2026, which includes \$105.99 million for Urban Indian Health and \$44.43 million for TECs, representing increases of \$15.57 million and \$10.03 million over FY 2025 levels. Meanwhile, the Senate Committee on Appropriations passed a funding bill that includes \$90.42 million for Urban Indian Health, maintaining FY 2025 levels. Both bills include advance appropriations for FY 2027. Final funding amounts may vary once the bills pass the full House and Senate, but this signals UIOs should, at a minimum, not face any funding cuts from the IHS budget in the next fiscal year.

Recommendations

Traditional Indian Medicine

To maximize the benefits of TIM Medicaid reimbursement, Congress should permanently extend 100% Federal Medical Assistance Percentage (FMAP) for UIOs. UIOs received 100% FMAP under a 2-year pilot, which has since expired. Currently, in states with 1115 demonstration waivers for TIM, managed care organizations will receive 100% federal matching for TIM services rendered to Medicaid-eligible AI/AN beneficiaries at IHS or tribal facilities, but not at UIO facilities (where MCOs will receive the regular FMAP rate, and states will need to reimburse the remaining cost). This represents a cost barrier for states seeking 1115 waivers and poses the risk that new 1115s may not include UIOs if states aim to avoid incurring extra costs. If Congress extends 100% FMAP to UIOs, those costs will be shifted to the federal government, thus reducing the financial burden on states submitting waivers for approval. To the extent possible, Congress should also direct CMS to collaborate with states to submit 1115 waivers and direct IHS to develop a credentialing process for TIM practitioners and maintain a record of credentialed practitioners. Under the current framework, individual facilities are responsible for ensuring practitioners are qualified. Shifting this responsibility to IHS would ensure a consistent protocol for verifying practitioner qualifications.

Medicaid doula services coverage

Doulas have been shown to decrease the rates of cesareans and help to prevent other birth complications. For Native women, doulas support decreasing negative childbirth experiences and support their access to health care providers who understand the unique cultural, social, and economic burden mothers face. Congress must enact legislation mirroring efforts such as HB 1881 in Washington state to direct CMS to include doula services as covered services under Medicaid. Additionally, Congress should pass legislation to fund workforce development for doulas, expanding the perinatal workforce and ensuring that sufficient doulas are available to meet community needs.

Funding for UIOs

UIOs are chronically and severely underfunded, despite the federal government's trust and treaty obligations to provide health care services to AI/AN individuals regardless of where they reside. Congress must fully fund IHS, including the urban Indian health line item and the tribal epidemiology center line item. For FY 2026, the National Tribal Budget Formulation Workgroup (NTBFW) has calculated full funding for urban Indian health to be \$770.53 million, \$680.11 million over current funding levels. For FY 2027, the need for urban Indian health is \$1.09 billion, \$998.11 million over current levels, according to the NTBFW. Congress also needs to fund TECs at \$474.47 million

and secure mandatory appropriations for IHS, as it is the only federal health care system not to receive them. In the meantime, advance appropriations must continue to be included in annual funding bills to avoid gaps in care in the event of government shutdowns.

Implement Draft Recommendations from the Native Children’s Commission Implementation Act

Senator Lisa Murkowski, Chair of the U.S. Senate Committee on Indian Affairs, recently released draft legislation focused on improving the health and well-being of AI/AN children. This legislation also calls for the creation of an Inter-Agency Committee, led by the DOJ and the Office of Management and Budget, on Indigenous Data Sovereignty, with a report due to Congress within one year. Quality data on maternal and infant death to be used for data-driven decision making is currently not accessible, and further exacerbates the crisis of AI/AN maternal health.^{lxvi} The establishment of this committee and report on ensuring Indigenous Data Sovereignty could further support efforts to bolster data access for the I/T/U system and, in turn, support additional resources for maternal health.

Other provisions, such as establishing a Tribal Advisory Committee (TAC) within the Bureau of Indian Affairs to support the inter-agency committee, establishing a TAC on Native maternal health within HRSA’s Maternal Health Bureau, establishing a TAC on Early Childhood in the Office of Early Childhood Development at the Administration for Children and Families, and directing the HHS Secretary to conduct a study on maternal mortality and domestic violence would support a further understanding of solution for Native maternal health within executive agencies. Better information within the executive branch would allow federal agencies to be better partners for the I/T/U system as it continues to improve maternal health outcomes.

Women, Infants, and Children (WIC) Nutrition Program

The WIC Breastfeeding Peer Counselor Program should receive increased funding to allow it to reach a broader section of the population, given its high costs effectiveness. Breastfeeding is essential to addressing maternal and infant morbidity and mortality, however, AI/AN women have low breastfeeding rates,^{lxvii} likely related to resource limitations and discrimination. Sustainable outreach could help reverse this trend if given the appropriate resources. Setting aside specific funding for outreach to AI/AN communities could also increase AI/AN representation in the peer counselor workforce and build trust within communities.

Additionally, permanent flexibility waivers should be implemented for WIC, including a physical presence waiver and allowing agencies to issue benefits remotely. This would ease access to the program and ensure continued participation from recipients, and particularly support communities in areas with high food scarcity. Finally, implementing permanent benefits bumps would increase the efficacy of the program. This should include a bump for fresh and frozen fruits and vegetables,^{lxviii} as this has been shown to improve pregnancy and birth outcomes, and should also include bumps for pregnant, postpartum, and breastfeeding women.

Implementation Pathways

Jurisdictional Considerations

Multi-pronged efforts are necessary to address all recommendations. Certain efforts will need to be implemented at the legislative level, while others will require implementation at the administrative level. Ensuring buy-in from stakeholders at both levels will be critical. Congress can, through its oversight of federal agencies, support administrative-level changes. Efforts should be focused on specific committees and subcommittees relevant to the legislative efforts and administrative bodies targeted by these recommendations. These include Appropriations, Indian Affairs, Natural Resources, Energy and Commerce, Finance, and Ways and Means.

Efforts can also be focused within state legislatures and administrative bodies. While unified, national changes are ultimately preferred, state-level changes can fill targeted gaps and demonstrate the effectiveness of certain solutions. State-level changes can serve as pilot programs that federal implementation can be modeled after. An example is the current implementation of doula credentialing and Medicaid reimbursement in Washington state. Once fully implemented and effectiveness has been demonstrated, Congress and the Centers for Medicare and Medicaid Services can follow the state's lead and model in implementing changes to doula services nationwide.

Coordinating for Success

Identifying key opportunities to demonstrate the effectiveness of proposed changes can galvanize support in Congress. Testimony, oral or written, can be a catalyst for change, and advocates should seek opportunities to testify and give success stories. Organizations with similar areas of expertise can coordinate to gather initial support from their respective representatives and build on this additional support. Organizations can also work with their members of Congress to organize briefings and present stories and data to members and staff. Building this base of support is critical to long-term success.

Grant Considerations

The following recommendations should be implemented to address UIO funding issues.

- Refine grant language to include urban Indian organizations. The federal statutory definition of “tribal organizations” does not include urban Indian organizations for federal grant eligibility. Using the language “tribes, tribal organizations, and urban Indian organizations,” as defined by 25 U.S.C. § 1603, mitigates discrepancies between intended eligibility and realized implementation.
- Hire Tribal Coordinators to support grant applications for tribes, tribal organizations, and UIOs. This can support grant access for targeted populations to reach federal resources.
- Reduce administrative challenges by implementing flexible spending, longer time frames for spending, and reducing required reporting.

These will not be sufficient to solve chronic underfunding issues but can be critical in establishing baseline sustainability for Indian health care providers nationwide.

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Part 2: Rural Native Maternal Health Care Access

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Executive Summary

Introduction

Approximately 40% of American Indian and Alaska Native (AI/AN) people in the U.S. live in rural areas – twice the proportion of other populations – and 13% of AI/AN people live on reservations.¹ As a result, many pregnant and postpartum AI/AN individuals experience the additional health and health care access challenges facing rural U.S. communities.² These barriers include limited access to local health care generally (and maternity care, specifically), health care workforce shortages, and transportation constraints.^{3,4} More than half of rural U.S. counties lack hospital-based obstetric services,⁵ and many more are projected to lose obstetric services in the coming years, placing essential maternity care out of reach for many rural families, including a large proportion of AI/AN families.^{2,6}

The Rural Maternity Care Access Crisis

Between 2010-2022, 238 rural U.S. hospitals that offered obstetrics services in 2010 no longer did so in 2022, either because they shuttered their obstetric units or closed entirely.⁴ Hospital and obstetric unit closures are common in states with large AI/AN populations, including Oklahoma, South Dakota, and North Dakota, where well over half of hospitals no longer offer obstetric services.⁵ Research indicates that rural communities that lose local obstetric care may see increases in preterm births, out-of-hospital deliveries, and some maternal and infant complications.⁷ With such a large proportion of AI/AN people living in rural and remote places, these consequences may fall hardest on Indigenous families.

Underlying these closures are the financial, workforce, and resource challenges of sustaining obstetric units that see a low volume of births: high operating costs, workforce shortages, and dependence on Medicaid reimbursements that may not cover fixed costs.^{3,8} For many AI/AN communities, these barriers are compounded by limited transportation options, understaffed Indian Health Service (IHS) and Tribal facilities, and widespread shortages of culturally responsive physicians, midwives, and doulas.^{9,10}

Innovative and Culturally Responsive Solutions

Numerous existing models demonstrate access to high quality care and favorable maternal and

infant health outcomes when programs are designed with and for AI/AN communities. Some examples include:

- **Mobile Maternal Health Units** bring prenatal, postpartum, and mental health services directly to remote areas, often staffed by interdisciplinary teams that include midwives, nurses, and doulas.¹¹ The on the Navajo Nation exemplifies this approach, providing flexible, relationship-based care that integrates Indigenous knowledge and values.¹²
- **Tribal Doula and Birthworker Initiatives**, such as the , reconnect families to traditional practices and improve outcomes by reducing, reconnect families to traditional practices and improve outcomes by reducing cesarean rates, increasing breastfeeding, and strengthening trust in the health care system.¹³ cesarean rates, increasing breastfeeding, and strengthening trust in the health care system.¹³
- **Community Health Aides/Practitioners** in Alaska serve as front-line maternity care workers, using a “hub and spoke” referral pattern to link villages to higher-level facilities when needed and providing continuity of care close to home.¹⁴

Alaska: Unique Challenges and Promising Practices

The state of Alaska – which is highly rural, and where 1 in 5 residents is Alaska Native¹⁵ – illustrates both the challenges and innovative practices in rural Indigenous maternal health. Many communities are off the road system, requiring residents to travel by airplane or ferry to give birth at a hospital-based maternity unit.¹⁶ The state’s Tribal Health System - 28 interlinked Tribal Health Organizations serving 160,000 people - demonstrates a model of regionally integrated, culturally responsive care. Workforce shortages persist, but Alaska’s strong scope of practice for Certified Nurse Midwives and IHS-funded community health aides help stabilize care in rural areas.¹⁶

Policy Gaps and Opportunities for Congressional Action

Despite growing attention to rural maternal health and the challenges faced by rural AI/AN families, major gaps remain in financing, workforce capacity, and representation:

- **Funding Shortfalls:** The IHS remains underfunded by tens of billions annually relative to need.¹⁷ Medicaid is a critical funding source for rural hospitals, and cuts to the program under the “One Big Beautiful Bill Act” may adversely affect access to rural maternity care, potentially leading to additional hospital and obstetric unit closures.

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- **Workforce Shortages:** Almost one third of rural U.S. counties have no practicing obstetric clinicians.¹⁸ Over half of rural hospitals lack access to certified nurse-midwives, and many states still restrict midwives from practicing independently.^{19,20}
 - **Limited Indigenous and Rural Representation:** Rural and AI/AN voices are largely absent from federal and state Maternal Mortality Review Committees and other official bodies, resulting in recommendations that often overlook rural and Indigenous community realities.^{9,21}

Policy Recommendations

The following potential policy considerations may influence maternity care access and outcomes for AI/AN people living in rural areas.

- Options to stabilize Rural Maternity Care Infrastructure:
 - Implement targeted funding strategies, such as volume-based Medicaid payment adjustments and standby capacity payments, to sustain low-volume rural obstetric units.
 - Fund emergency obstetric training and readiness in facilities without delivery units.
 - Increase Medicaid reimbursement for certified nurse-midwives and fund targeted recruitment and retention programs for rural and tribal clinicians.
- Options to support Indigenous-Led and Culturally Grounded Care
 - Expand Medicaid and IHS coverage to include or increase reimbursement for community health aides, tribal doulas, and mobile maternal health programs.
 - Recognize direct-entry midwife credentials and support Indigenous birthworker training initiatives.
- Options to invest in Rural Infrastructure and Broadband
 - Ensure universal broadband access to enable telehealth for prenatal, postpartum, and lactation support and to address broader social determinants of health.
- Options to ensure Representation and Accountability
 - Require Indigenous and rural representation in federal rulemaking, program creation and oversight, Maternal Mortality Review Committees, and support participation costs for rural and Indigenous members.

Conclusion

American Indians and Alaska Native people living in rural US communities face unique, complex, and intersecting challenges related to declining obstetric care services in rural areas, and a general lack of culturally-responsive care and wraparound services preconception, during pregnancy, at the time of childbirth, and postpartum.

Addressing these inequities and improving AI/AN maternal health outcomes will require coordinated policy reforms that strengthen rural health care financing, infrastructure, and representation to meet the unique needs of rural and tribal communities. Tribal-led, community-based, and mobile health care models are among the creative, culturally grounded, and regionally coordinated care solutions that can be invested in and expanded to address the intersecting crises facing rural and AI/AN maternal health. Policy action that combines sustainable funding for the unique financial needs of rural hospitals, investment in rural health care infrastructure and workforce, and Indigenous leadership is essential to reverse current trends and honor the federal trust responsibility to ensure that every Native person can give birth safely.

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Full Report: Rural Native Maternal Health Care Access

Introduction

Approximately 40% of all Indigenous people in the US are rural residents (a substantially higher percentage than other racial/ethnic groups), and 13% of American Indian/Alaska Native people live on reservation lands.¹ Rural and remote areas, including reservation lands, have among the least access to childbirth-related services, including hospital-based obstetric care,²⁻⁶ as well as midwifery care, doula services, childbirth education, lactation support, and mental health care.^{6,7}

Rural residents face heightened risks of severe maternal morbidity and mortality,⁸ and these risks are higher for rural residents who give birth in lower birth volume rural hospitals⁹ as well as those who are lower income and have Medicaid coverage during pregnancy and childbirth.¹⁰ Pregnant Indigenous women living in rural areas are at a substantially elevated risk of maternal death or serious complications in childbirth compared with non-Hispanic white or urban women.^{11,12}

Rural American Indians and Alaska Natives face unique, complex, and intersecting challenges related to the increasing loss of obstetric care services in rural areas,¹³ and a general lack of culturally-responsive care and wraparound services.¹⁴ Addressing American Indian/Alaska Native maternal health care requires particular attention to rural health care delivery.

Rural Maternity Care Access

Rural communities across the U.S. face decreasing access to care for pregnancy and childbirth. Between 2010 and 2022, 238 rural hospitals stopped offering obstetric services, continuing a decades-long decline in access to care.³ Obstetric unit closures affect remote rural communities more frequently¹⁵ and are also more common in communities with higher proportions of Indigenous (and Black and Latinx) residents.¹⁶ As of 2022, three of the five states with the highest share of hospitals lacking obstetric services were also the states with the highest proportions of American Indian/Alaska Native (AI/AN) residents: Oklahoma (14% American Indian/Alaska Native; 63% hospitals lacking obstetrics), South Dakota (8% AI/AN; 60% hospitals lacking obstetrics), and North Dakota (5% AI/AN; 73% hospitals lacking obstetrics).^{17,18}

Research has found that when rural counties lose hospital-based obstetric services, rates of preterm birth as well as births occurring in emergency departments or outside of medical facilities rise.¹⁹ These effects are more pronounced and persistent in rural counties that are

further away from urban centers. Infants born to rural residents and AI/AN people are more likely than those born in urban or non-AI/AN communities to be preterm and to experience severe morbidity and mortality.^{20,21}

Reasons for lack of maternity care services and for closures of obstetric units in rural, remote and AI/AN communities relate to the organization and financing of these health care services.⁴ Contributing factors include the high fixed costs of operating obstetric units, the large share of Medicaid-funded (i.e. lower-reimbursed) births in rural hospitals, and persistent shortages in the rural health care workforce.^{4,22} Family physicians - who historically have been the backbone of rural obstetric care - are providing OB care at a declining rate.²³ Obstetricians are concentrated in urban areas, and certified-nurse midwives are restricted by state regulation from practicing independently.²⁴ These factors likely contribute to the fact that one-third of rural counties have no practicing obstetric clinicians,²³ and over one-half of rural hospitals lack access to certified nurse-midwives.²⁵

Challenges to providing maternity care within IHS and Tribal Clinics

Workforce shortages for maternity care services are widespread in rural communities, but may be particularly challenging at IHS and Tribal clinics due to previously-mentioned financing challenges as well as remote locations and the inadequate resources available to meet patient needs in the IHS system,^{6,13} despite the United States' trust responsibilities to provide health services to tribes.²⁶ Still, IHS plays a critical role in improving access to quality prenatal and postpartum care for rural AI/AN people where available; IHS access is associated with higher care quality among rural AI/AN people, likely due to the geographic concentration of IHS facilities in rural areas.²⁷

Emergency transport challenges and risk factors for rural pregnant women

Loss of hospital-based obstetric care is associated with greater risks of births taking place in hospital emergency rooms,¹⁹ many of which are not fully equipped to care for a maternal-infant dyad.²⁸ Approximately one in four rural hospitals without obstetric units report emergency births in their facilities, delays in urgently-needed patient transport, and nearly one in three report unanticipated adverse birth outcomes.²⁸ Fewer than one in five have the capacity to perform a cesarean birth.²⁸ Research suggests that rural AI/AN pregnant women may travel disproportionately long distances to access maternity care, particularly for complex services.⁶ Increased travel is linked to higher maternal and infant morbidity²⁹ and may exacerbate existing challenges for AI/AN families, including inconsistent care continuity, transportation challenges, provider communication challenges and cultural insensitivity, and discrimination.^{6,13}

Wraparound service limitations and culturally unsafe referrals

High quality care during pregnancy, childbirth, and the postpartum period includes more than just physical access to health care services, but also to educational, informational, and social support services that are evidence-based and culturally-centered. An Indigenous reproductive justice framework includes attention to violence and historical trauma [po];³⁰ when access to the most basic care is lacking, so too is Indigenous reproductive justice and culturally centered care.³¹

Rural counties that lack hospital-based obstetric units - particularly those that have recently experienced closures - face reduced access to evidence-based maternal and infant health services beyond direct obstetric care. These communities have significantly fewer perinatal mental health services, postpartum and breastfeeding support groups, and clinical lactation support.^{7,25,32} AI/AN people, who are more likely to live in remote rural areas, experience limited access to these critical services following childbirth. Freestanding birth centers, which can offer culturally-centered care,³³ are almost non-existent in rural US communities,⁵ as they face financing challenges unique to birth centers,³⁴ as well as the financing challenges faced by all rural-located maternity providers. As a result, many rural AI/AN pregnant women must navigate gaps in essential wraparound services or rely on referrals that may not be culturally safe or accessible.

Promising practices: Mobile maternal health care services, tribal doula programs, cross-state telehealth partnerships

Given the challenges, innovative approaches are essential for ensuring that rural Native communities have access to high-quality maternal health care. Mobile health clinics are a particularly promising strategy, bringing care directly to rural Native communities that often experience significant barriers due to distance, workforce shortages, and facility closures.

Overcoming Barriers: The Promise of Mobile Maternal Health Care

Mobile maternal health units are specially equipped vehicles staffed by interdisciplinary teams, such as nurse practitioners, physician assistants, certified nurse-midwives, community health workers, and doulas, who travel into communities on a consistent schedule.³⁵ These teams offer vital services, including prenatal checkups, screenings for conditions such as gestational diabetes and anemia, vaccinations, postpartum care, mental health assessments and treatment, culturally-tailored health education, and social service referrals.^{35,36} Mobile services can also create an important linkage between communities and the health care system to 1) ensure appropriate and timely primary care and other services for pregnant women and babies not provided on board the mobile units; 2) increase faith in facility-based care; 3) serve as an entry point to hard-to-reach

communities to provide health and social service information and services.³⁶ By consistently meeting patients where they are, and providing services through a lens of cultural humility, mobile health programs can overcome critical transportation and geographic challenges while also building trust, respect, and continuity of care with Native communities. Facilitated in partnership with brick-and-mortar facilities, mobile maternal health solutions may also help close gaps based on clinic data, e.g., no-shows, pregnant people lost-to-follow-up, or late prenatal care initiation.³⁷

Mobile Units in Action: The Fort Defiance Indian Hospital Board Model

On the Navajo Nation, the Fort Defiance Indian Hospital Board (FDIHB) Mobile Health Program provides a leading example of mobile health in action. Operating across 16 chapters and serving a vast, rural, and often remote geographic area, FDIHB’s mobile team delivers primary and preventive care within trusted community spaces, removing physical and logistical access barriers and honoring the importance of place and relationship in Diné culture.³⁸ The program has a proven track record of flexibility, having previously partnered with certified nurse-midwives from the hospital to offer routine women’s health and select maternal health services on the mobile unit. This successful collaboration demonstrates how existing mobile health infrastructure can be leveraged to expand into comprehensive maternal and perinatal care, including postpartum follow-up, mental health support, and newborn care, making the FDIHB model a potential blueprint for rural tribal communities nationwide.³⁷



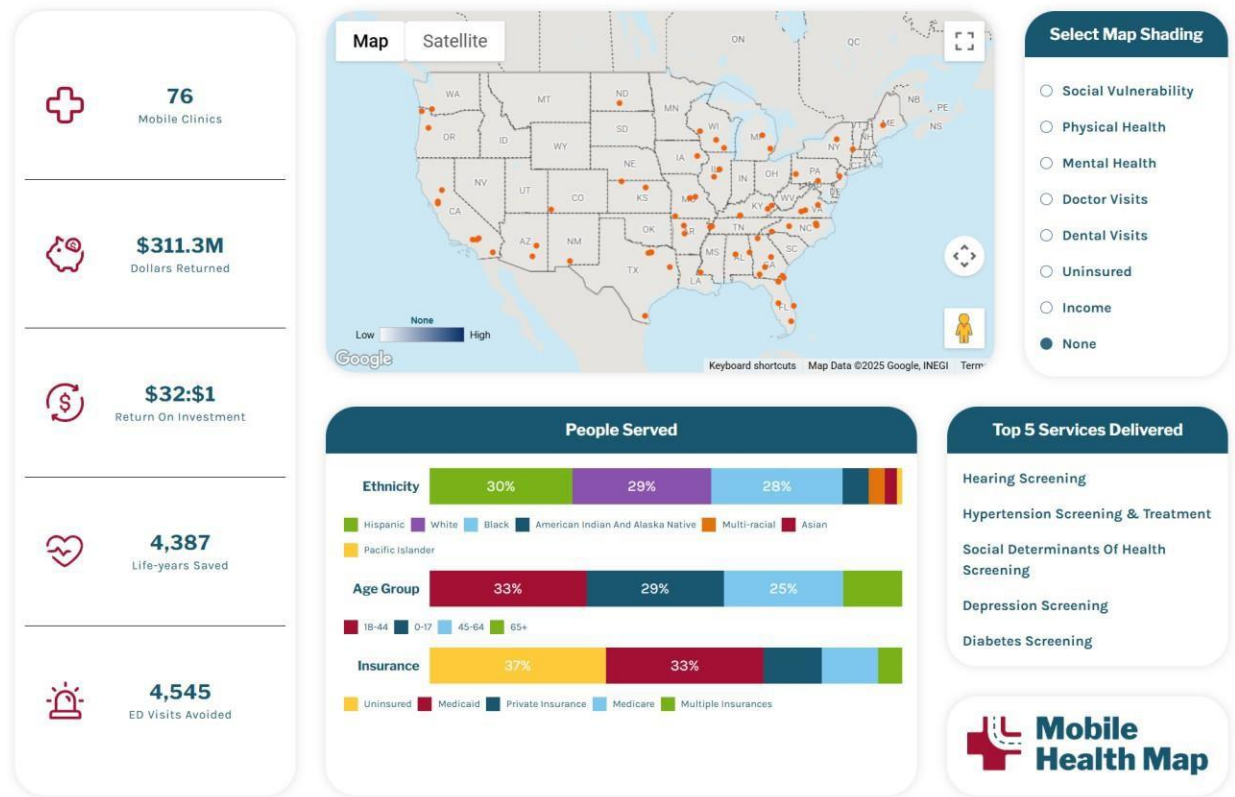


Culturally Grounded Care: Integrating Indigenous Knowledge and Community Voice

Native mobile health programs, such as FDIHB's, are also uniquely positioned to support culturally grounded, community-driven care. When designed in collaboration with tribal leaders, elders, and community members, these programs can effectively integrate clinical expertise and Indigenous knowledge and values, bringing traditional healers onto the mobile unit, hosting parenting circles, and providing culturally and linguistically tailored education. This respectful, collaborative approach addresses not only clinical needs but also the social, cultural, and structural factors that shape maternal and family health, creating more holistic and trusted pathways to stronger health outcomes.

Demonstrable Impact: Outcomes and Return on Investment

Evidence for the effectiveness of mobile health care is substantial. According to self-reported data from Mobile Health Map, a program of Harvard Medical School and the nation's leading expert on research and evaluation in mobile health care, mobile health programs providing maternal care in rural settings achieve a \$32:\$1 return on investment, returning \$311.3 million to the health care system.³⁹ Over the past 5 years, these programs collectively prevented over 4,500 emergency department visits and saved nearly 4,400 life-years.



Scaling What Works: Toward a Blueprint for Tribal Communities

Expanding mobile maternal health care, especially through tribal-led initiatives like FDIHB’s, offers a flexible, culturally adaptable, and sustainable solution to persistent maternal health challenges experienced by rural tribal communities. Consistent, community-based maternal care can not only improve health outcomes for parents and babies, it also builds trust, strengthens relationships with the health care system, and saves lives. With growing evidence supporting the impact of mobile models of care delivery,³⁵ they stand as powerful blueprints for other rural Native communities seeking to advance health equity and ensure that every Native birthing woman and family has access to comprehensive, high-quality care, no matter where they live.

Alaska: Unique Challenges and Innovations

Approximately 1 in 5 Alaska residents are Indigenous, and more than half of Alaskans that live in the state’s rural areas are AI/AN.⁴⁰ Alaska exemplifies both the challenges faced by and potential solutions for rural Indigenous maternal health. The state’s vast geography, lack of road access, expensive transport, and budget constraints create significant logistical hurdles;⁴¹ over 80 percent of communities are not connected by the road system.⁴² Yet, Alaska’s Tribal Health System and other care innovations offer a promising model of regionally integrated, culturally grounded care.

Over one-third of rural hospitals in Alaska do not offer obstetric services,¹⁷ in part due to five Alaska hospitals having closed their obstetric units in the past 20 years.⁴¹ This, combined with the lack of road access, requires many Alaskans to undergo extensive planning and expense to travel via plane or ferry to reach regional hubs with obstetric services. These regional facilities struggle against significant financial pressures, staffing shortages, and safety concerns in order to provide essential maternity care to Alaska families.⁴¹

A critical part of the maternity care network in the state is the Alaska Tribal Health System (ATHS). The ATHS is a network of 28 Tribal Health Organizations (THOs) that deliver and coordinate care for AI/AN people statewide, sometimes incorporating traditional and culturally-responsive practices;⁴³ THOs are often the only health care facilities in their communities.⁴³

Workforce shortages are an ongoing challenge in Alaska, with many communities relying on traveling providers or facing limited local services.⁴¹ A strong scope of practice policy in the state enables Certified Nurse Midwives (CNMs) to help stabilize the maternity care workforce, with over 1 in 4 births attended by CNMs across Alaska.⁴¹ Conversely, service gaps are exacerbated by fewer family physicians being trained in obstetrics, increasing the demand for obstetricians.⁴¹

Promising practices in Alaska:

[Community Health Aides/Practitioners \(CHA/Ps\)](#) in Alaska support prenatal care in villages throughout rural Alaska and connect with higher levels of care when necessary.⁴⁴ These practitioners and their work is administered through the Community Health Aide Program, which was established by Congress and funded by the Indian Health Service.⁴⁵ In isolated areas, CHA/Ps provide essential frontline maternity care, supported remotely by advanced providers and physicians. Although the first prenatal check is done by a higher level provider, subsequent prenatal appointments can be done with CHA/Ps in consultation with a supervisor at a hub facility. CHA/Ps are trained to intervene in emergency situations during pregnancy if higher level care is not available. They are also trained to do post-partum check-ups if necessary. This is a model unique to Alaska but shows promise for adaptability to other regions if funded.

[Manilaaq Health Center](#) in Kotzebue features a unique midwife-led maternity care model. This ensures a stable maternity care team and fosters close patient-provider relationships, creating a safe and supportive environment.⁴⁶ Community preference for midwives over physicians strengthens this model. Certified nurse-midwives travel to Anchorage for training, and a doula training program is available in the region.

[Alaska Native Birthworkers Community \(ANBC\)](#) is a grassroots organization dedicated to providing free, culturally matched care to Native families throughout their reproductive journeys.⁴⁷ ANBC's mission is to serve Native birthing families so that they feel supported, well

cared for, and full of the information they need to make confident choices around reproductive health, birthing, and parenthood. They provide support to Native birthing families wherever they choose, from preconception to postpartum, with most of them birthing at the Alaska Native Medical Center. ANBC also offers free access to capacity building and training for current and aspiring Indigenous birthworkers and builds partnerships at state, national, and international levels for collective impact.

Recent Legislative History

- *IHS maternal health funding trends*

For Fiscal Year (FY) 2025, the President’s budget proposed \$8.2 billion for IHS, including \$8.0 billion in discretionary funding and \$260 million in mandatory funding. Starting in FY 2026, a new funding formula was proposed, aiming to reach \$42 billion by FY 2034 and exempt IHS from federal sequestration rules.⁴⁸ Further, the House Appropriations Committee has approved \$8.41 billion for IHS in FY 2026, including \$6.05 billion in advance appropriations for FY 2027. These increases reflect growing recognition of IHS’s long-standing underfunding, through tribal advocates, however there is still a **shortfall of the estimated \$51 billion needed annually to meet the health service needs.**⁴⁹

In 2024, the Indian Health Service (IHS) Maternal Child Health (MCH) Program funded ten federal sites to improve maternal safety and access to care during pregnancy and the postpartum period.⁵⁰ The initiative focused on strengthening maternal care coordination through telehealth and home visits, and enhancing emergency obstetric readiness, equipment, and supplies. The initiative spans five years and is expected to reach more than 12,000 pregnant and postpartum patients. Participating sites include the Billings Area Office, Chinle Comprehensive Care Facility, Colorado River Service Unit, Crownpoint Service Unit, Gallup Indian Medical Center, Great Plains Area Office, Lawton Indian Hospital, Northern Navajo Medical Center, Red Lake Hospital, and Whiteriver Service Unit.

Recent Legislation Introduced in the 118th and 119th Congress Targeting Rural Maternal Health Care Access

Bill Number	Bill Name	Congress	Key Focus Areas
Increasing Access to Rural Maternity Care			
S.2289	Healthy Moms and Babies Act	118th/119th	Improves maternal health coverage under Medicaid and

			CHIP, modernizes telehealth, coordinates care, and addresses social determinants of health.
S.4773/H.R. 9161	Health Equity and Accountability Act of 2024	118th	Increasing access to health care for underserved populations, potentially including AI/AN and Native Hawaiian communities, through measures like increased FMAP for certain health care services.
H.R. 3305	Black Maternal Health Momnibus Act	118th	Addressing maternal health disparities and improving maternal health outcomes, especially for racial and ethnic minority groups, including AI/AN and Native Hawaiian populations.
H.R. 6004	MOMMIES Act	118th	Improving maternal health outcomes by expanding coverage, establishing maternity care homes, and studying the role of telehealth
H.R. 3304	Maternal Health Pandemic Response Act	118th	Enhancing data collection, public education, and workplace safety related to maternal health during public health emergencies, with a focus on communities of color and rural areas.
H.R. 1996	Mamas and Babies in Underserved Communities Act of 2025	119th	Expanding maternal health care services in underserved communities, including rural areas.
H.R. 238	Health Technology Act of 2025	119th	Establishing conditions for AI/ML technology use in drug prescription, potentially increasing rural telehealth access.
Supporting Rural and Safety Net Providers			

S.2059/H.R. 3942	Keeping Obstetrics Local Act	118th/119th	Enhancing financial support for rural and safety net hospitals providing maternity, labor, and delivery services to vulnerable populations.
S.4079/H.R. 1254	Rural Obstetrics Readiness Act	118th/119th	Improving obstetric emergency preparedness in rural hospitals and clinics through training, grants, and telehealth pilot programs
S.502	Rural Hospital Closure Relief Act of 2025	119th	Updating the Critical Access Hospital 35-mile distance requirements and enabling states to certify a hospital as a “necessary provider” under certain circumstances.
S.2301/H.R. 2493	Improving Care in Rural America Reauthorization Act	119th	Reauthorizing grants that support rural, community-driven initiatives that promote improved access to care, enhance care coordination, and foster sustainable solutions for chronic disease prevention and management in rural areas.
Growing the Rural Health care Workforce			
S.1599	Midwives for MOMS Act	118th/119th	Creates grants for establishing midwifery programs, with special consideration for underrepresented groups or areas with limited access.
S.575/H.R. 1317	Improving Care and Access to Nurses Act	118th/119th	Allows Advanced Practice Registered Nurses (APRNs), including certified nurse-midwives, to practice at the top of their license and broaden the scope of services to meet the needs of rural patients.

S.5456/H.R. 7855	Rural Residency Planning and Development Program	118th	Authorizing the Rural Residency Planning and Development program that awards funding to support start-up costs to establish new rural residency programs, including for maternity and obstetric care.
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- ***Rural maternal health appropriations***

Discretionary Funding Program	Advocate Ask	FY26 LHHS Senate Report Language	FY25 Continuing Resolution
Rural Maternity & Obstetrics Management Strategies Program	\$15M	\$13M	\$12M
Diversify the number of Certified Nurse Midwives (CNMs) through support for education and training in rural and underserved communities, within the Title VIII Advanced Nursing Education Maternity Care Nursing Workforce Expansion (MatCare) Program	\$8M	\$8M	\$8M
Set-aside for midwifery training, within the total funding for the Title VII Scholarships for Disadvantaged Students program	\$5M	\$5M	\$5M
Office of Rural Health within CDC	\$10M	\$5M	\$5M

State-level expansions for midwifery in rural areas

Recent policy attention to maternity workforce shortages in rural areas²³ has included a focus on improving access to midwifery care in rural communities. Midwives play an important role attending births in rural US communities, attending births at 30% of rural hospitals that provide childbirth care.⁵¹ However, access to midwifery care is often limited to rural communities with hospitals that have an obstetrics unit. A recent analysis found that more than half of surveyed rural hospitals reported not having locally available certified nurse-midwife care in their hospitals or communities.²⁵ Additionally, this study showed that local midwifery care was less

common in rural communities with hospitals where at least half of births were Medicaid funded and in counties with majority BIPOC populations.²⁵

State policy environments have substantial effects on access to midwife-attended births,⁵² and the practice and availability of midwifery in rural AI/AN communities.⁵³ Research shows that state policies that allow certified nurse midwives (CNMs) and certified midwives (CMs) to practice independently (without the oversight of a physician) can expand care in rural areas.⁵² As of July 2025, 19 states - including highly rural states with large Indigenous populations like Oklahoma and Texas - still restrict CNM practice, limiting access to midwifery care.²⁴

Issues for Congress

President Trump's One Big Beautiful Bill Act (OBBBA) is significantly impacting American Indians, Native Hawaiians, and Alaska Natives' access to health care, especially in rural areas, through its cuts to Medicaid. Medicaid helps [keep hospital labor and delivery units running](#), including services for high-risk pregnancy management, neonatal intensive care units, and postpartum and lactation support. Impacts of Medicaid cuts on rural hospitals, including those serving Indian Country, are expected to top [\\$137 billion](#) over 10 years, likely leading to rural hospital closures and cuts to maternity services. Tribes are located in 27% of rural areas across the U.S. The OBBBA has created an even greater challenge for policymakers striving to support and improve the rural maternity care system.

Recommendations Summary

- *Invest in rural birth facilities and community infrastructure, including transportation and clinical workforce.*
 - The decline of obstetric services availability in rural areas is directly related to hospital financing challenges, as well as workforce shortages. Policy strategies to address these root causes include:
 - Targeted financing mechanisms aimed at helping low-volume rural hospitals stay financially viable and continue providing childbirth services to their communities.⁵⁴ A 2022 GAO report on rural obstetric care access noted that all 19 of the stakeholders they interviewed believed that increasing Medicaid reimbursement for obstetric services would be beneficial.² Examples of targeted financing include volume-based Medicaid payment adjustments to increase reimbursement for childbirths at low-volume rural hospitals, and standby payments to help cover fixed costs.⁴

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- o Targeted financing mechanisms to support emergency obstetric care training resources for facilities and services that do not have an obstetric care unit but may need to provide emergency care to pregnant, birthing, and postpartum patients and their infants.^{55,56} Such entities needing targeted resources include rural hospital emergency departments, Rural Emergency Hospitals, rural outpatient clinics, emergency medical services, and rural first responders.⁴
 - o Prioritized recruitment and retention of OB/GYNs, certified nurse-midwives (CNMs), doulas, and family physicians with obstetric training to ensure local access to prenatal and delivery care. Increase Medicaid reimbursement rates for CNMs and provide targeted funding for workforce development in rural and tribal communities.

- ***Require rural and Indigenous representation***

To improve rural Indigenous maternal health, the executive branch must ensure rural and Indigenous representation in the establishment of regulations and implementation of programs and policies. In addition to tribal representation that is the foundation of the unique government-to-government relationship, achieving rural representation means that people who live and work in rural areas are included in key decision-making roles and on advisory panels and bodies. This could be implemented by requiring reporting on the demographics of decision-makers, including whether they are residents of rural areas. The presence of rural Indigenous voices is essential to preventing unintended consequences. Seeking rural perspectives during rulemaking and implementation will illuminate relevant issues to inform regulations that support access for Indigenous people who are residents of rural areas, including those who do not live on tribal lands or reservation communities.

- ***Invest in rural infrastructure, including broadband***

Policy action to build rural infrastructure to support community health and wellness, starting at birth, requires broadband Internet access. A thriving community for rural Indigenous people and families contains well-paying jobs, transportation, housing, healthy food, education, health care, and environmental safety. To facilitate this, Indigenous rural residents must be able to connect with one another and participate in broader society, both virtually and physically. An important first step is universal access to broadband Internet, which would expand access to health care via telemedicine, but also address rural/urban inequities in employment and educational opportunities, which are important determinants of health. Expanded telehealth services for prenatal, postpartum, and breastfeeding support can reduce the need for long-distance travel and connect patients with specialists and childbirth education. Streamlining Medicaid eligibility and travel authorization processes would further ensure timely access to early prenatal care.

- ***Reform Medicaid to support flexible, community and tribal-led care models***

Medicaid and tribal health programs should include coverage for labor support people who travel with patients required to give birth away from home. Additionally, the Indian Health Service should recognize direct-entry midwife credentials to expand access to community birth options. Federal and state policymakers should invest in Indigenous-led doula and community health worker programs and ensure Medicaid reimbursement structures are developed with Indigenous birth worker input to reflect cultural and community priorities.

- ***Include rural Indigenous/tribal representation on state Maternal Mortality Review Committees***

Rural and Indigenous perspectives are essential to ensure the effective collection and interpretation of maternal mortality data, and the development of recommendations that are relevant to these communities. “As of December 2018, MMRCs were established in 45 states and the District of Columbia, an increase from 23 in 2010. Legislation was in place in 27 states, up from 6 in 2010. Only three states specifically mentioned rurality in legislation (including one highly rural state), and only two states required rural representation among their MMRC members (neither of which were highly rural states).”⁵⁷ One of the greatest assets of MMRCs is their capacity to make recommendations and identify opportunities for prevention. Examining maternal mortality through a rural Indigenous perspective to identify how needs and resources vary from those in urban settings and among non-Native people would help to inform prevention planning and activities. Rural and Indigenous inclusion and representation on MMRCs would also help to identify quality issues that have an impact on performance on maternal and infant health metrics. MMRCs are an essential tool at the state level to address the issue of maternal mortality, but rural and Indigenous representation in the design and implementation of MMRCs is needed to ensure that the unique needs and constraints of these individuals and their communities areas are taken into account. Policymakers at the state and federal levels should consider ways to provide funding and other resources (e.g., travel and meeting support, facility space) to make rural Indigenous representation possible, especially in resource-constrained rural states and communities.

Community Engagement & Governance

- ***Use of tribal health boards in rural strategy development***

Tribal health boards are important in improving maternal health care in rural and reservation-based communities. In many Native communities, people have to travel long distances just to get basic prenatal care or give birth, which creates serious barriers to safe and healthy

pregnancies.^{6,58} A report from the Centers for Medicare & Medicaid Services found that rural Native women are twice as likely to receive delayed or missed prenatal visits than rural white Native women.⁵⁸

As previously described, Indigenous women living in rural areas face higher risks during pregnancy and childbirth, with potential contributing factors including limited access to local maternity care facilities and clinicians, and a general lack of culturally responsive care.⁵⁹ Tribal health boards are working to reverse these trends by creating strategies rooted in their communities. Efforts include advocating for the reestablishment of tribal birthing centers, better coordination between clinics and social services, and expanded access to midwives, doulas, and traditional healers to support Native families before, during, and after childbirth.

Wraparound services are especially important in rural areas, where geographic isolation and limited transportation options can make follow-up care difficult. Tribally-led health systems like the [SouthEast Regional Health Consortium \(SEARHC\)](#) are models of how Indigenous leadership and community collaboration can provide both direct health care services as well and connecting rural AI/AN people to food, housing support, mental health care, and cultural resources.

- ***Inclusion of elders and traditional birth workers, midwives, CHWs and doulas***

The involvement of Elders, traditional birth workers, community health workers (CHWs), and doulas is central to culturally grounded maternity care. These clinicians and community leaders can connect clinical services with local knowledge and traditional practices, helping bridge gaps that are particularly evident in rural and remote areas. Midwifery care and doula support are associated with positive birth outcomes, including lower cesarean rates, higher breastfeeding initiation, and decreased use of pain medication during labor.^{52,60} Critically, doula care is associated with more autonomy and respect reported in the birth process.^{61,62} These reasons likely contribute to a 2021 National Partnership for Women & Families report recommendation that Indigenous birth workers be invested in as key contributors to addressing cultural and structural gaps in the health care system.⁶³

Bringing in traditional and community-based care is not an alternative to clinical care but a return to practices that have supported Indigenous families for generations. Midwives, aunties, and Elders have guided pregnancy, birth, and postpartum care through ceremony, relationship, and teachings centered on the wellbeing of both parent and child within the community. Recent research conducted in Canada found that Indigenous women receiving midwifery care experience improved access to culturally safe care.⁶⁴ These care providers and leaders are particularly vital in rural AI/AN communities, where they may serve as a protective factor against the general lack of culturally grounded care. When fully supported, led by Indigenous

communities, and integrated within rural health systems, inclusion of these individuals may strengthen trust, care continuity, and maternal health outcomes.

Discussion and Conclusion

AI/AN people are twice as likely to be rural residents as non-Indigenous people, with 40% of AI/AN individuals living in rural places and 13% living on reservation lands in rural areas.¹ Consequently, pregnant and postpartum AI/AN individuals and families are uniquely exposed to the health and health care access challenges facing rural U.S. communities. More than half of rural U.S. counties lack hospital-based obstetric services,¹⁵ and many more are projected to lose obstetric services in the coming years, placing essential maternity care out of reach for many rural families, including a large number of AI/AN families.² The challenges of rurality compound the unique challenges faced by AI/AN people during the perinatal period.¹² Combined with a lack of culturally responsive care, these rural gaps in access may contribute to unacceptably high rates of maternal morbidity and mortality among AI/AN people.¹² Addressing these inequities to improve AI/AN maternal health outcomes will require coordinated policy reforms that strengthen financing, infrastructure, and representation to meet the unique needs of rural and tribal communities.^{54,57,59}

The widespread closures of rural obstetric units - driven by low patient volumes, high fixed costs, and limited Medicaid reimbursement - has reduced access to maternity care across rural America.⁴ The consequences extend far beyond inconvenience: when communities lose obstetric services, rates of preterm birth, emergency deliveries and some maternal and infant complications can rise.¹⁹ Targeted policy action is needed to preserve local access to safe childbirth, via hospital care as well as other safe alternatives.⁴

Policy options to address rural maternity care financing challenges include volume-based Medicaid payment adjustments, standby payments to cover fixed costs, and targeted funding for emergency obstetric readiness in facilities without full obstetric units.⁴ These and other strategies have been proposed in federal legislation, including the [Keeping Obstetrics Local Act \(S.2059, 119th Congress\)](#) and the [Rural Obstetrics Readiness Act \(S.380, 119th Congress\)](#). Rural communities also need stronger recruitment and retention pipelines for clinicians trained in obstetrics. Existing and proposed programs such as the [Midwives for MOMS Act \(S.1851, 118th Congress\)](#), [Rural Obstetrics Readiness Act \(S.380, 119th Congress\)](#), and [Rural Residency Planning and Development Program](#) offer frameworks that could be fully funded and implemented with specific incentives for service in tribal and frontier areas. States could also modernize scope-of-practice laws to allow certified nurse-midwives to practice independently, improving access in regions where physician shortages exist.⁵²

Promising innovations such as mobile maternal health units and tribal doula programs demonstrate how flexible, culturally grounded care can overcome geographic and systemic barriers. In particular, Alaska's Tribal Health System and the Alaska Community Health

Aides/Practitioners Program illustrate how tribally-led, regionally-integrated, and culturally-relevant care can succeed when supported by adequate resources.⁴⁴ Federal and state policymakers can scale these models through targeted Medicaid reimbursement for mobile and community-based services, support for tribally-run maternal hubs, and long-term evaluation funding.

Finally, and most importantly, ensuring rural Indigenous and tribal representation in policymaking, program implementation, and Maternal Mortality Review Committees is essential. Inclusion of rural and tribal voices helps identify gaps, prevent unintended consequences, and ensure that data and policy recommendations reflect community realities.^{12,57}

In summary, advancing maternal health equity for rural Indigenous communities will require coordinated policy action across multiple domains: (1) stable financing for ensuring local access to safe maternity care in rural communities; (2) investment in infrastructure and workforce; (3) formal inclusion of tribal and rural perspectives in data-gathering and decision-making; and (4) reimbursement and programmatic support for culturally grounded care models. These steps are needed to prevent further loss of maternal health capacity in rural America and to fulfill the federal trust responsibility to ensure high-quality health care for Indigenous families.

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Part 3: Healing Through Community Integrated Care for AI/AN and Native Hawaiian Peoples: Culturally Competent Integrative Maternal Health Care Models

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Executive Summary

American Indian/Alaska Native (AI/AN) and Native Hawaiian communities experience maternal health inequities driven by systems not designed with or for their unique cultural health worldviews. This has led to persistent maternal health inequities rooted in systemic inequality that drives over medicalized and fragmented care and has led to deep mistrust in the health care delivery system. Despite decades of evidence that culturally competent, community-rooted models deliver safe, cost-effective care and better experiences, these models are significantly underutilized. Existing systems remain misaligned with Indigenous values and world views, despite federal and state programs aimed at improving outcomes. Meanwhile, the evidence consistently shows that midwifery-led community birth and freestanding birth centers demonstrate safety, lower intervention rates, and higher satisfaction when integrated with hospital systems for seamless transfer.

Culturally competent integrative models of care are designed to enhance health care delivery by systematically addressing potential biases, such as implicit and explicit bias, that can affect care. These models strive to build respectful, collaborative relationships with patients by acknowledging their unique experiences. They achieve this by fostering a deep understanding of diverse cultural views on health, illness, and healing practices, with the ultimate goal to adapt health care services and interventions to a patient's specific social, cultural, and linguistic needs, while also actively involving communities and families in the overall design and delivery of care. Indigenous-led models are an excellent example of this, because they integrate ceremony, language, kinship, and land stewardship into relational, community-based maternity care—midwifery, doulas, lactation, nutrition, mental health, and traditional medicine—paired with clear consultation, collaboration, and transfer protocols. They also take into account current barriers to access care like transportation, access to healthy food, access to monetary resources, distance to care, and Indigenous community protocols that are inclusive to ceremonial wellness frameworks.

Culturally competent and integrative models of maternal health care—such as those demonstrated by the Changing Woman Initiative (New Mexico), Pacific Birth Collective (Hawai’i), and Ttáwaxt Birth Justice Center (Washington)—demonstrate how Indigenous-led, community-based approaches can successfully bridge this gap. These models integrate traditional knowledge, ceremony, midwifery, and relational care within modern health systems to achieve respectful maternity care that strengthens self-determination, improved maternal and infant health outcomes, and healthier birth experiences, through the restoration of Indigenous birth sovereignty. Ultimately reclaiming the inherent right for Indigenous communities to control their own health care and birthing practices. These models further strengthen cultural identity, which protect against factors that are negatively impacted by historical trauma and systemic oppression.

The expansion of such models requires a coordinated legislative effort across federal, state, tribal levels to reform Medicaid reimbursement, establish sustainable funding, create long-term evidence base and supporting data, and embed cultural governance within health policy frameworks.

Case Highlights

New Mexico (NM)

- **Need & Disparities.** 55% of births are financed by Medicaid; 27.3% of the state is a maternity care desert; 42.4% of counties have no hospital or birth center offering maternity care. At the time of this report, 2 more birth centers located in Albuquerque and Santa Fe will no longer offer birth services. Indigenous people face higher pregnancy-associated death rates; 83.3% of pregnancy-associated deaths are preventable.
- **Policy Assets.** Birthing Options Program (Medicaid-funded out-of-hospital birth since 2006), 12-month postpartum coverage, Paid Family Medical leave (2024), and a 2025 Doula Credentialing & Access Act enabling Medicaid doula reimbursement statewide. Formal State-Tribal collaboration through Tribal Liaisons.
- **Practice Model.** Changing Woman Initiative (CWI) delivers Indigenous-centered midwifery and wraparound support like access to organic food, traditional medicine, Navajo and Pueblo traditional birth knowledge, and home birth on the Navajo and Pueblo reservations; serves predominantly Indigenous and low-income, under insured families; relies heavily on philanthropy to fill reimbursement gaps. Coordinates care with University of New Mexico, Indian Health Services and tribal 638 clinics/hospitals.

Hawai’i (HI)

- **Need & Disparities.** 42% of residents live in rural areas; core services concentrate on O’ahu, requiring inter-island travel. Native Hawaiian mothers experience elevated morbidity and are least likely to receive adequate prenatal care. Workforce and coverage gaps limit home and community birth access.

- **Policy Shift.** Following litigation (Kaho’ohanohano), **2025 reform of HRS §457J** protects traditional and customary Native Hawaiian birth practices, removes criminal penalties, and expands licensure pathways; Medicaid expansion and 12-month postpartum coverage already in place; Papa Ola Lōkahi coordinates Native Hawaiian health systems, but does not have systems in place to support Native Hawaiian birth practice, despite it being a traditional healing practice.
- **Practice Model.** Pacific Birth Collective provides direct services, “Farm to Mother,” essentials distribution, community-led disaster response and workforce development; sustainability is challenged by short-term grants and inconsistent midwifery coverage.

Washington (WA)

- **Need & Disparities.** 20.5% of counties are maternity care deserts; AI/AN pregnancy-associated death rates far exceed state averages; L&D closures force long-distance diversions. Medicaid covers ~35% of births and ~63% for AI/AN families.
- **Policy Assets.** MMRC with tribal representation (statutory), Birth Equity Project funding community providers, telehealth/satellite OB clinics, and workforce pipelines.
- **Practice Model.** Ttáwaxt Birth Justice Center (Yakama Nation Reservation) delivers culturally grounded support and is building toward a birth center; funded by Medicaid and state streams, with no federal support.

Cross-Cutting System Gaps

- **Payment Inequity.** Birth center facility fees are a fraction of hospital rates (often 15-70%), creating structural deficits and independence on philanthropy; parity and bundled payment options.
- **Coordination Failures.** States underuse 100% FMAP for IHS/Tribal requested services due to missing care coordination agreements; managed care tribal protections and liaison roles vary.
- **Licensure/Accreditation Misfit.** Western-centric standards discount ceremony, apprenticeships, and community governance; Hawai’i’s pre-2025 law exemplified how licensure can exclude and criminalize Native traditional midwifery practice. Birth center accreditation creates near impossible standards that don’t take into account cultural safety, community accountability and governance.
- **Workforce Shortages.** Too few Indigenous midwives; apprenticeships are unpaid and prolonged; NA/AN and NH trainees face housing, childcare, transport, and tuition barriers; burnout is common.
- **Data & Accountability.** Native American, Alaska Native and Native Hawaiian deaths are undercounted; tribally led MMRCs are not resourced; ERASE MM funding expires September 30, 2025; evaluation often omits cultural safety/trust metrics.

Top Legislative Actions

A. Federal – Near-Term (Authorization & Appropriations)

Reauthorize & Expand ERASE MM and MMRC Supports (CDC)

- a. Sustain funding past September 30, 2025; require tribal representation; fund tribally led MMRC pilots and culturally valid metrics with public, community-facing reporting.

Pass the Midwives for MOMS Act (2025)

- b. Scholarships, paid apprenticeships, and clinical sites prioritizing Native American, Alaska Native and Native Hawaiian, rural, and low-income trainees; invest in inclusive curriculum and Native-led training hubs.

Enact the BABIES Act (2025)

- c. Multi-state Medicaid demonstration for freestanding and emerging birth centers; CMS guidance for facility-fee parity and bundled payments; planning grants and national evaluation.

Pass the Tech to SAVE MOMS Act (2025)

Advance MOMNIBUS Elements via Appropriations

- d. Protect/expand funding for community-based organizations, rural maternity services, midwifery training, maternal mental health, and PQCS, and HRSA support for birth center expansion.

B. Federal – Structural (CMS/HHS/Congress)

Set a National Medicaid Floor for Community Birth

- a. Establish **≥ 90 % of hospital delivery rates for the same codes used by birth centers** as the minimum facility fee for birth centers, align professional fees, and enforce timely payment to close the \$7K-\$11K gap.

Standardize Bundled/Value-Based Maternity Payments.

- b. CMS to promulgate a midwifery-led bundle covering prenatal through 12-month postpartum; sharing savings with Native American-led organizations.

Unlock 100% FMAP for Tribal-Requested Services.

- c. Require/monitor state care coordination agreements so IHS/Tribal referrals extend to freestanding birth centers, home birth, CPM/CM care; enforce managed-care tribal protections.

Launch Federal Start-Up & Operating Grants for Native American, Alaska Native & Native Hawaiian-led Centers.

- d. Provide capital (\$1-\$M typical) and multi-year operating support (FQHC-like stability) with AI/AN and Native Hawaiian set-asides.

Redesign Accreditation & Quality Standards.

- e. Recognize culturally inclusive accreditation co-created with AI/AN & Native Hawaiian leaders; tie federal reimbursement with supporting apprenticeship, Indigenous governance and traditional healing/ceremony.

C. State & Tribal Actions

Parity & Coverage

- f. Adopt New Mexico-style Medicaid doula benefits; set birth-center fees at or near hospital levels; establish CPM/CM pathways with clear inclusion in Medicaid.

Protect Cultural Practice in Law

- g. Replicate Hawai'i's 2025 reform: explicit exemptions for traditional practitioners; removal of criminal penalties that limit family/birth-worker support.

Formalize State-Tribal Health Compacts

- h. Strengthen consultation, liaison roles, data-sharing, and disaggregated AI/AN metrics; co-design grant criteria (e.g. WA Birth Equity Project model).

Build Native American, Alaska Native and Native Hawaiian Workforce Pipelines

- i. Fund paid apprenticeships, learner supports (housing, childcare, transport), and Indigenous-led clinical sites; recognize diverse competency frameworks.

Stabilize Access in Maternity Deserts

- j. Deploy telehealth kits, satellite OB clinics, mobile teams; where L & D units closed, substitute with freestanding centers integrated for safe transfer.

Empowering Communities Through Indigenous-Directed Health Data

- k. Create a culturally grounded, Indigenous-directed data infrastructure that is accessible through existing state and federal systems, ensuring community-driven oversight and alignment with broader health initiatives.

Implementation Considerations

- **Financing:** Pair Medicaid parity/bundles with federal start-up and operating grants to reduce reliance on short-term philanthropy and stabilize payroll for NA, AN, and NH clinicians and students.
- **Tribal consultation:** Embed tribal consultation and co-design in all rulemaking, procurement, and managed-care contracts; require disaggregated AI/AN and Native Hawaiian reporting.
- **Scale & Spread:** Document and replicate NM, HI, and WA approaches; fund CMS/HRSA learning collaboratives for AI/AN and Native Hawaiian-led centers and state Medicaid agencies.

Bottom Line

Culturally competent integrative models are essential infrastructure, not “optional” add-ons. With reimbursement parity, Native American governance, and sustained federal-state-tribal coordination, these models can close poor outcome gaps, restore self-determination in birth, and support high-value maternity care across Indian Country and Hawai’i.

Full Report: Healing Through Community Integrated Care for AI/AN and Native Hawaiian Peoples: Culturally Competent Integrative Maternal Health Care Models

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Introduction

Many Indigenous communities in North America rely on modern Western medical institutions to provide pregnancy-related health care. However, these systems were not developed with or for Indigenous communities and often fail to meet the needs of Native American pregnant people.¹⁻⁴

According to the Tribal Maternal Mortality Review (MMRC) Fact sheet published in 2024 by the National Indian Health Board, current federal and state systems are often barriers, not supports for AI/AN families, because they were not built for Indigenous families. Improving maternity services for NA/AN and Native Hawaiian pregnant women need to be built on ideologies that incorporate cultural competence, safety, security, and respect as embedded knowledge, skills, and values that are foundational in transformational practice. Although maternity services in the United States are designed to offer pregnant women the best care, they largely reflect modern western medical values and perceptions of health, risk, and safety.

Like our relatives in Australia, maternity systems have failed to incorporate the evidence provided by Native American, Alaska Native and Native Hawaiian pregnant women on the impact of social risk that includes cultural risk and emotional risk, to birth in facilities that do not reflect indigenous worldview and only considers physical wellbeing, while ignoring the whole community.⁵

Strengthening Indigenous-led community-based care models that emphasize relational culturally congruent care rooted in community accountability offers an opportunity to reshape health care systems. Community driven solutions connected to healing, ceremony, kinship, and land; promotes intergenerational healing and Indigenous frameworks that are integrative and restorative. In this report there are three case studies that demonstrate Indigenous-led community-based models from New Mexico, Washington, and Hawaii.

Birth Centers & Culturally Competent Integrative Models of Maternal Health Care in AI/AN and Native Hawaiian Communities

Interest in the birth center model of care has grown in response to the decrease in maternal health care access as a way to expand access to care. In the United States, birth centers are health care facilities where prenatal, labor and birth, and postpartum care are provided using midwifery and wellness models of care.⁶ A freestanding birth center, means that it is not within or part of a hospital. However, birth centers are integrated into the larger health care system, in which midwives who provide services in this birth setting adhere to standards of consultation, collaboration, and transfer to higher levels of care when appropriate.

With the United States maternity care crisis around poor outcomes, systemic inequality, and inequitable access to care, midwifery-led community birth and birth centers has 30 years of documented safety and efficacy through providing evidence-based practice through continuous labor support, nonintervention in the absence of complications, and support for initiation and maintenance of lactation. Between 2012 and 2016, the Center for Medicare and Medicaid Innovation explored birth centers as an innovative solution to improve quality and decrease costs through an initiative called Strong Start for Mothers and Newborns. The Strong Start evaluation report concluded that the birth center model of care is an appropriate level of care for most Medicaid beneficiaries.⁷ It's important to note that of the 47 birth centers included in the Strong Start for Mothers and Newborns federal study, 21% were in rural locations. According to data from the American Association of Birth Centers, out of the 384 birth centers in the United States, 30% of them are in rural areas and small towns and that this has increased by 97% in the past 10 years.

Birth centers are often interprofessionally staffed with a workforce that includes midwives, obstetricians, nurses, lactation consultants, doulas, and childbirth educators. Integrated and interprofessional maternal health care in birth centers connects clinical, behavioral, and social services, which supports holistic care for families, fostering a continuum of care through collaboration between health care professionals and community. This community centered care respects autonomy and addresses the social determinants of health to improve maternal and infant outcomes.⁸

A recent research study analyzed 90,580 episodes of perinatal care from 84 U.S. birth centers between 2012 and 2020, suggesting that birth center models with diverse staffing models, legal entity status, and call schedules can be implemented with consistently good outcomes.⁹ Further that there were no differences found in transfer rates, cesarean rates and apgar scores between birth centers that were less than 15 minutes to 5 minutes from the hospital of transfer. One study demonstrated no significant difference in neonatal outcomes with transfer distance greater than 30 minutes when community birth is thoroughly integrated with hospital systems for seamless transfer when needed.¹⁰ Transfers from birth centers to hospitals can be made safer with the implementation of programs such as Smooth Transitions, which promotes collaboration and communication between birth centers and hospital facilities.¹¹

This research supports the expansion of birth centers into rural communities, as that birth center model of care has demonstrated durable, stable, and predictable capability to provide high-quality health care. Especially when matching appropriate levels of care while controlling for medical risk factors, rural childbearing families have equal and, in some cases, better outcomes than those living in urban settings. Birth center models of care have also been researched around transfer rates during the antenatal, intrapartum, and postpartum and were found to be stable, regardless of geographic location. This builds on the body of research that supports the role of enhanced birth models to provide risk-appropriate care, as another avenue to strengthen the maternal health infrastructure in the United States.

Addressing maternal health disparities in NA/AN and Native Hawaiian communities requires culturally competent and integrative models of care that respects and centers Indigenous traditions and practices. This integrative care aims to center self-determination and honors birth and motherhood as a sacred ceremony, through the revitalization of native language, use of traditional medicines and birth practices, while rebuilding a relationship to land, food and life way teachings to improve maternal health outcomes. Strengthening NA/AN and Native Hawaiian maternal health approaches birth and motherhood as a sacred ceremony while creating resilient, equitable and effective systems that are inclusive of public health care. Revitalizing Indigenous midwifery and community care as wrap-around services, reinforces culturally safe maternal health care that merges with western medical health systems with Indigenous knowledge ways of knowing. This culturally safe care is often community-led fostering emotional well-being and trust, rather than the standard medical model of care that centers the management of disease processes.

In essence, culturally competent integrative care models aim; 1) to acknowledge and address explicit and implicit bias that may impact care delivery; 2) foster respectful relationships, recognizing that individual experiences of each client and approaching care collaboratively; 3) gain an understanding of various cultural perspectives on health, disease, healing practices, and health-seeking behaviors; 4) adapts services and interventions to align with patient's social, cultural, and linguistic needs; 5) involves communities and families in the design of care delivery.¹²

Globally, countries like Australia's 'Birthing on Country' and Canada's First Nations peoples Indigenous midwifery-led care models are revitalizing traditional maternal health practices to improve preterm birth rates, decrease medical interventions and improve maternal satisfaction, while rebuilding cultural connections between mother and baby. The United States is not far behind, over the last twenty-years Native American, Alaska Native and Native Hawaiians have been developing culturally competent integrative models of care through pure will and determination to fill in the gaps in access to care.

While the principles of culturally competent integrative care provide a framework for addressing inequities in maternal health, their true significance emerges when applied in specific community contexts. New Mexico offers a compelling case study, given its unique demographic composition and the presence of diverse cultural traditions in health, healing, and family care. With American Indian and Alaska Native populations comprising nearly 10% of the state's residents, the integration of culturally safe practices into maternal health services becomes both a necessity and an opportunity. The intersection of Medicaid and Indian Health Services highlights both structural challenges and the opportunities for embedding cultural traditions into maternal health

systems. Hawaii provides a contrasting perspective, where Native Hawaiian approaches emphasize family- and community-centered practices rooted in ancestral knowledge. Washington State adds yet another dimension, as legislative initiatives and health reforms seek to institutionalize cultural competence at the policy level, with intentions of improving care for immigrant, refugee, and Indigenous populations. Together, these three case studies demonstrate the diverse ways culturally competent integrative care can be adapted to address inequities while honoring cultural identity and strengthening community health.

Case Study 1: New Mexico Demographics and Maternal Health

New Mexico (NM) has a total population of about 2.13 million, where American Indian and Alaska Native people make up about 9.5% of the population. There are 23 federally recognized tribes, which include 19 Pueblos, two Apache tribes, two Ute Tribes and the Navajo Nation which extends into Arizona and Utah. 3.79% of New Mexico residents had incomes below 200% of the federal poverty level in 2023 and 9.0% of the total population are uninsured, with 34.3% on Medicaid to access health care.¹³ Approximately 50.7% of Native Americans and Alaska Natives are covered by Medicaid in NM as it plays a crucial role in providing access to health care for NA/AN in New Mexico.¹⁴ Geographically, New Mexico is largely a rural state, of the 33 counties, only 7 contain predominantly urban areas. 23% of the population in New Mexico live in rural areas.¹⁵

When it comes to maternal health, 55% of all births in NM are financed by Medicaid, with 27.3% of the state reported as a maternity care desert, which means that maternity care services are limited or absent, either through lack of services or barriers to care within counties.¹⁶ 12.1% of the counties in NM report low or moderate, not full access to services, which means one or fewer hospitals/birth centers and few obstetric clinicians work there and that less than 10% of women of reproductive age are uninsured. In the entire state of New Mexico 42.4% of counties have no hospital or birth center offering maternity care.¹⁷

According to the NM PRAMS 2000-2011 data, 11% of Native American women in New Mexico received late or no prenatal care. 67% of Native American women who sought prenatal care had health insurance coverage. Babies of mothers who do not get prenatal care are 3 times more likely to have a low birth weight and 5 times less likely to survive, as compared to mothers who get early and routine prenatal care.¹⁸

The New Mexico Maternal Mortality Review committee reviewed 108 pregnancy-associated deaths of New Mexican people occurring between 2015 and 2020. They found that 44 deaths were pregnancy-related, 48% of pregnancy related deaths occurred 42 days postpartum and that 83.3% of all pregnancy associated deaths are preventable. Further that there were significant discrepancies existing between birth rates and pregnancy-associated mortality ratios and that Indigenous (AI/AN) people have an almost one and a half times higher Pregnancy Associated Death Rate than non-Hispanic white people. Leading causes and circumstances surrounding pregnancy-related mortality were mental health conditions, cardiac conditions, and hemorrhage,

with substance use disorders making up half (54.5%) of all pregnancy related deaths. While mental health was a circumstance surrounding death made up (50.0%) of pregnancy related deaths.¹⁹

New Mexico Political Maternal Health Landscape

Maternity Policies

- 55% of New Mexico births are financed by Medicaid
- The Medicaid and CHIP income eligibility level for pregnant women is 255% of the federal poverty level.
- New Mexico adopted the Medicaid 12-month postpartum coverage extension
- For parents to maintain Medicaid eligibility after pregnancy coverage ends in New Mexico, their income must be below 138% of the federal poverty level.
- Paid family leave laws enacted in 2024.

Access to Care

- **Medicaid Expansion:** In 2014, New Mexico adopted Medicaid expansion under the Affordable Care Act, expanded Medicaid to cover women for up to a year after birth.
- **Birthing Options Program:** Established in 2006, offers Medicaid enrolled pregnant individuals out-of-hospital birthing options at home or with licensed birth centers, supported by certified nurse-midwives or licensed midwives. This program has increased access to community midwives and is associated with above-average birth outcomes.
- **Doula Reimbursement:** The new Doula Credentialing and Access Act was signed on March 21, 2025, and came into effect on July 1, 2025, which doulas can enroll as Medicaid providers statewide.
- **Birthing Workforce Retention Fund:** Established in 2008 by the New Mexico Legislature (statute 41-5-26.1), the fund was created to help certified Nurse-Midwives and physicians continue to offer full-scope perinatal and birthing services in New Mexico by offsetting high cost of malpractice insurance premiums. It is administered by the NMDOH Maternal Health Program. Providers that demonstrate that at least 50% of their obstetric practice serves Medicaid-insured indigent patients over two calendar years, maintain current malpractice liability policy covering birthing care, intend to continue full scope obstetric practice in the state during the award period, which is around \$5,000-\$10,000.
- **Title V Perinatal High-Risk Fund:** This fund is administered by the Maternal Health Program to increase access to perinatal services for those lacking insurance coverage.

Focus on Disparities

- **New Mexico Maternal Mortality Review Committee (MMRC):** was formed through New Mexico state legislation in 2022 to review maternal deaths and make recommendations to improve maternal outcomes. The MMRC is represented by various agencies and community programs, its purpose is to review and analyze deaths during pregnancy and childbirth up to one year postpartum. Part of the review is to identify contributing factors, including instances of discrimination,

and develop recommendations for preventing future deaths, according to the New Mexico Department of Health.

- NMDOH works to understand and address the alarmingly high rates of maternal mortality and severe maternal morbidity experienced by Native American women in New Mexico, which exceed national averages.
- **Maternal Health Program:** NM Department of Health operates a Maternal Health Program that supports prenatal care through public health offices, licenses and regulates midwives, and conducts research on pregnancy care.

NM State and Tribal Health Collaboration

The establishment of Tribal Liaisons within cabinet level state agencies in New Mexico is largely attributed to the **State Tribal Collaboration Act (Senate Bill 196)** signed into law in **2003** by Governor Bill Richardson. Public health and health promotion efforts are guided by the STCA and aim to reduce disparities and promote health equity for American Indian populations.

- **Communication and Consultation:** They serve as the primary point of contact between state agencies and tribal governments, facilitating communication, consultations, and information exchange.
- **Policy Implementation:** They ensure that state policies and programs are developed and implemented in a way that respects tribal sovereignty and addresses tribal needs.
- **Resource Navigation:** They help Tribes access state resources, funding opportunities, and technical assistance.
- **Cultural Sensitivity:** They promote cultural awareness and understanding within state agencies, ensuring that state programs are delivered in a culturally appropriate manner.
- **Problem Solving:** They work to resolve misunderstandings and disputes between state agencies and Tribal governments, fostering positive relationships.
- **Training and Education:** They provide training to state employees on working effectively with Tribes and cultural sensitivity.
- **Annual Reporting:** They contribute to the annual State-Tribal Collaboration Act report, detailing the agency's accomplishments in collaborating with tribes.

Collaboration and Partnerships

NMDOH's Office of Tribal Liaison actively engages Tribal partners and leaders to ensure that services and resources are developed and expanded in a manner that respects Tribal sovereignty and self-determination.

NMDOH works with the Health Care Authority (HCA) and Medicaid managed care organizations (MCOs) to guide care for newborns exposed to substances and support their families, including collaborating on delegated care coordination to increase community-driven solutions for health.

The department collaborates with organizations like First Nations Community Healthsource, NM Tribal Health Councils, Navajo AIDS Network, and Santa Fe Mountain Center to deliver culturally specific and tailored HIV prevention interventions to American Indians at risk.

Addressing Social Determinants of Health: NMDOH acknowledges that adverse health outcomes, including high maternal mortality rates among American Indian populations, are

historically rooted in factors like historical trauma, disenfranchisement, and structural inequality. The department strives to integrate western science best practices with indigenous knowledge and Tribal health systems to address health disparities.

In essence, NMDOH's approach to Tribal maternal health involves a multifaceted strategy of improving access to quality care, addressing health disparities, collaborating with Tribal partners, and acknowledging the historical and social factors that influence health outcomes.

NM Maternal Health Challenges and Needs

- **Provider shortage:** Many rural areas lack sufficient providers with advanced training in maternity care
- **Medicaid reimbursement rates:** Low Medicaid reimbursement rates hinder the availability and sustainability of obstetric services in rural areas and hospitals.
- **Mental Health and Substance Abuse:** Mental health conditions and substance use disorders (SUD) are the leading causes of pregnancy-related deaths in NM, accounting for nearly half of maternal mortality cases.
- **Health Care System responsiveness:** There is a need for the health care system to be more responsive to the unique needs of local communities, including addressing disparities in maternal death rates.
- **Increased liability Insurance premiums:** Medical malpractice premiums have increased over 16% in one year, while coverage was cut by more than half. For independent outpatient facilities and hospitals, this is financially burdensome and unsustainable. This exacerbates provider shortages in rural communities and contributes to loss of specialists. Unlike other states that surround, NM has a multi-tiered cap system.

Changing Woman Initiative (NM)

Changing Woman Initiative was founded in 2015 by Nicolle Gonzales (Arthun), Navajo Nurse-Midwife in response to the systemic challenges faced by Native American women within the Western medical systems, in which she witnessed firsthand how these systems failed to support Native American birthing traditions, creating barriers to culturally safe, respectful, and equitable maternal health care. In which, CWI emerged from a deep need to reform health care and return to Native American birth practices, while recognizing the absence of Native American representation in the U.S. Midwifery and maternal health care systems. Through community-led strategic planning, Changing Woman Initiative identified Indigenous-centered and integrated accessible birth options as a priority to restoring Indigenous wellness sovereignty to protect the fundamental human right to reproductive health and dignity.

Through the years CWI scaled up to offer five broad range holistic and culturally rooted programs to address access to immediate, non-barrier reproductive and general health care, food insecurity through traditional nutrition, workforce development through training and supporting Indigenous midwives, strengthening community knowledge and support networks, and advocacy for Indigenous health rights through state, federal and global initiatives.

Problems CWI is Solving

In complex health care system, Changing Woman Initiative is addressing a range of urgent systemic and community-level issues:

- Maternal Health Disparities

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- Health care Deserts
 - Loss of Traditional Knowledge
 - Food Insecurity & Chronic Illness
 - Underrepresentation in Policy and Practice

Who Changing Woman Initiative Serves

CWI's birth services strive to ensure access to Indigenous-centered, accessible health care and traditional childbirth options. CWI intentionally strives to center Indigenous families, hold space for other Black and Brown families, and also offer care to those who could not otherwise access midwifery care. While their midwives focus on community birth, CWI supports families regardless of birthplace. In 2024, CWI served 102 families— 77% Indigenous, 33% Hispanic/Latino, 10% Black and 2% Asian/Pacific Islander reflecting Cochiti, Diné, Indígena de las Américas, Katishtya, Jicarilla-Apache, Kawaika, Katishtya, Keresan, Kewa, Ohkay Owingeh, Po-who-Geh-Owingeh, Shiewhibak, Tewa and Zia communities.

CWI makes midwifery care accessible to those who wouldn't otherwise have the ability to get culturally centered community midwifery care. This care embraces holistic wellness including mental health, emotional support, and frequent meaningful interactions often in their own homes. The challenges our families face include:

- History of Trauma
- Navigating complex health care system
- Not being listened to, dismissed, or silenced
- History of poor hospital experience and mistrust in the medical system
- Limited support system
- Limited resources
- Complex community relationships
- Limited transportation
- Limited access to healthy food

Funding Source and Payer Make up

While many CWI clients are Native American and have access to care through the Indian Health Service, over 80% of clients were low-income, with more than half of those being Medicaid-eligible and 35% not having any insurance coverage. Community birth services are often not covered by private health insurance, though through the innovative state-wide Birthing Options Program, these services are Medicaid-reimbursable. The holistic health services offered by CWI include a functional nutrition program, mental health support, Indigenous doula support, access to traditional medicine and ceremony, and connection to plant medicine— even when able to receive reimbursement from insurance sources, billing only covers approximately one third of the cost of care. Therefore, the vast majority of CWI's funding is from philanthropy, aligned grant-making non-profit organizations, and service contracts.

White Shell Woman Birth Services

- Prenatal care
- Birth services
- Indigenous Doula support
- Nutrition consultation & access to healthy produce with visits
- Lactation assessment, support & education

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- Postpartum care up to 6 weeks for mom and baby
 - Prenatal, birth, and postpartum plant medicine-making bundle
 - Traditional medicine referral, meats, plant medicine, supplements.

Corn Mother Easy Access Clinic

- Well Women's Health Exams – pap smears and breast exams
- STD/STI screening & treatment
- Birth control education & consultation
- Pregnancy testing
- Referral to specialists
- Plant medicine education & consultation
- Traditional Medicine & Healing
- Breastfeeding support

All Our Relatives Community Engagement

CWI's Community Engagement program nurtures relationships with birthing families, community, health partners and family service providers by participating in several community events, health fairs, symposiums, youth events, Indigenous cultural activities, as well as speaking engagements about Indigenous health perspective on maternal and reproductive health in Native American Indian communities.

Rematriating Apprenticeship

Changing Woman Initiative (CWI) is leveraging discussions with local Indigenous midwives and the challenges faced by Indigenous midwifery apprentices to tackle the underrepresentation and harm experienced by BIPOC students in the current midwifery training model. CWI has committed to being a safe, culturally responsive clinical site, providing fertile ground for an alternative apprenticeship model that replaces individualistic and paternalistic approaches with a framework based on rematriation. This work involves both short-term harm reduction strategies for current students, such as developing internal equity-centered practices, student/preceptor contracts, and identifying resources for common barriers like housing, childcare, and tuition costs. The long-term goal is to create robust, sustainable, and BIPOC centered model that provides comprehensive support, mentorship, and academic assistance to serve future students effectively.

- Educational program for in-person delivery of course content as well as culturally-attuned additional knowledge, wisdom, and skills to assist students in learning in a relational system, fine-tuned to individual learning styles, and creating cohesion among a cohort of BIPOC students in NM; monthly academic coursework intensives for the current BIPOC student cohort made up of students apprenticing at Breath of My Heart Birth Place and Changing Woman Initiative
- Create opportunities to open these educational intensives to any BIPOC midwifery student in New Mexico or Navajo Nation, including birth workers who may not be in a formal apprenticeship yet, as a way of creating a pipeline of potential future fellows and midwives.
- Determine replicability and scalability for other regions in the spirit of sharing.

Changing Woman Initiative's unique model includes:

- Getting people into care early
- Integrating traditional birthing practice knowledge through home visiting midwifery-led care
- Connecting birth families to needed resources, including mental health referrals
- Supporting breastfeeding beyond 6 weeks and assisting during the impactful hormonal shift that happens postpartum
- Integrating nutrition and traditional medicine as part of care.

Challenges Changing Woman Initiative Faces to support growth and expansion

Despite New Mexico's respected position nationwide as a model for integrating midwives into maternal care systems, significant challenges remain. After nearly a decade, Changing Woman Initiative (CWI) still navigates strong community misconceptions about the safety of out-of-hospital perinatal care and a generational disconnect from traditional birthing practices. A critical issue is the severe shortage and high burnout rate among BIPOC midwives, who are few and far between. Currently, New Mexico has only a handful of practicing licensed midwives who represent the state's diverse cultural richness, highlighting a major risk to the expansion of services if existing team members are forced to step away from practice.

The current midwifery pathway presents substantial barriers to entry and completion, particularly for BIPOC students. Unlike a busy hospital setting, community midwives maintain a manageable client load but are on call 24/7, attending births in homes often at great distances. The intensive nature of our work means few can take on students. Apprenticeships are almost always unpaid, demanding students be continuously available, which makes holding a side job nearly impossible. Combined with essential out-of-pocket costs for reliable transportation, communication, and flexible childcare, the minimum two-year training period often extends to three to seven years for students facing unique socioeconomic challenges.

CWI's model of care directly addresses these systemic issues through a holistic, trauma-informed, team approach that centers Indigenous wellness. The strategy includes removing barriers, integrating traditional medicine, providing Indigenous food through the Three Sisters Native Farmers Collaboration, and offering extensive educational and emotional support. A core component of their mission is the development of a sustainable apprenticeship model that serves as restorative justice for historical harms. Financially challenged by offering unbillable holistic services and serving a higher-risk client population where hospital transfers minimize their reimbursement, CWI relies heavily on grant funding. As a Native American-led nonprofit, CWI bridges funders to invest in the long-term systems-level work of honoring ancestral knowledge and impacting Native communities with integrity and foresight.

Case Study 2: Hawai'i Demographics & Maternal Health

Hawai'i is the most geographically isolated population center on Earth, located over 2,300 miles from the nearest continental landmass; a state made up of eight main islands. Access to maternal health care is unevenly distributed, with key services centralized on O'ahu, requiring many neighbor island residents to travel interisland to give birth or access specialized care. In a state with a total population of 1.45 million people and 15,000 births a year on average, approximately 42% of Hawai'i's population lives in rural areas, according to the USDA's rural-urban continuum classification. On islands like Moloka'i, Lāna'i, and parts of Maui, Kaua'i, and Hawai'i Island, maternity services may be completely unavailable or limited to basic prenatal care.

Access to maternal care in Hawaii faces several challenges, including geographic barriers such as distance and poor roads, particularly in rural areas.²⁰ Transportation issues and high travel costs are also significant obstacles. Cultural considerations, such as a preference for home births and a lack of female health care providers, can impact facility deliveries. Issues like a lack of privacy and long waiting times at facilities may also negatively affect patient experiences

While Hawai'i's overall maternal mortality rate appears lower than national averages, Native Hawaiian women experience disproportionately higher rates of maternal morbidity, approximately 10-12 women die annually due to pregnancy or pregnancy-related complications, with half of these deaths considered preventable.²¹ Preterm birth rates across the state have remained steady, but Native Hawaiian mothers experience elevated rates of low birth weight and NICU admissions. Additionally Native Hawaiians, compared to other racial groups, are the least likely to receive adequate prenatal care in their pregnancy, and they're most likely to get no prenatal care at all. HRSA data from 2024 indicates that 21.5% of Hawai'i's residents identify as all or part Native Hawaiian.

Approximately 34.3% of births are financed by Medicaid in metro areas and 50% of births in nonmetro areas,¹⁶ with 22.5% of deliveries to Asian mothers and 23.2% of deliveries to Native Hawaiian, American Indian or Alaska Native mothers.²² 2.8% of the state's population is uninsured, which is 38,400 people.²³

Hawai'i Political Maternal Health Landscape

Maternity Policies

- 22.9% of Hawaii residents had incomes below 200% of the Federal Poverty level in 2023, which is smaller than the U.S. share (28.2%).
- Medicaid and CHIP provide health and long-term care coverage to 80 million low-income children, pregnant women, adults, seniors and people with disabilities. Eligibility for Medicaid their income must be below 196% of the federal poverty level for pregnant women.
- Hawaii expanded Medicaid under the Affordable Care Act, to include 12-month postpartum coverage.

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- For parents to maintain Medicaid eligibility after pregnancy coverage ends, their income must be below 138% of the federal poverty level.
 - Hawaii enacted paid family leave or paid sick leave laws as of 2023.

Access to Care

- **Medicaid expansion:** Expanded coverage in 2014 as part of the Affordable Care Act (ACA) to include a broader range of low-income adults.
- **Extending Postpartum Coverage:** Extended Medicaid postpartum coverage from 2 to 12 months, aligning with efforts to address the rising risk of pregnancy-related deaths and severe maternal morbidity in the state.
 - This expansion is a result of state legislative appropriation matched by federal funds, as enabled by the American Rescue Plan Act.²⁴
- **Maternal and Child Health Branch (MCHB):** Administers programs and initiatives focused on women's health, including the Women, Infants, and Children (WIC) program, reproductive health care services, adolescent health services and home visiting programs.
- **Promoting reproductive health and family planning:** The Department of Health Services encourages providers to use evidence-based screening tools like Pregnancy Intention Screening and Contraceptive Coverage OKQ.
- **Hawaii Maternal and Infant Health Collaborative (HMIHC):** Which works to improve maternal and infant deaths to inform prevention strategies.

Focus on Disparities

- **The Hawaii Maternal Mortality Review Committee (HMMRC)** was established in 2016 through the passage of Act 203, where it conducts multidisciplinary reviews of maternal deaths to inform prevention strategies.
- **Pregnancy Risk Assessment Monitoring System (PRAMS):** crucial tool for tracking and measuring progress on improving the health of women and infants. This program is funded federally through the Center for Disease Control and Prevention through a cooperative agreement.²⁵ Hawaii as a state contributes supplemental funding to support the program's activities.
- **Telehealth Services:** Has become a significant part of health care access in Hawaii, since COVID-19, initiatives like Hawaii Maternal and Infant Health Collaborative Pre/Inter-
- **Conception** Workgroup are working to expand access to evidence-based reproductive health counseling and LARC.

Hawaii Maternal Health care Challenges and Needs

- **Limited Access to Prenatal care:** Native Hawaiians are more likely to receive late or no prenatal care due to barriers to care, lack of cultural safety in medical system, communication challenges within health care system and socioeconomic factors
- **Access Barriers:** geographic isolation, some islands are very remote with limited access to health care facilities and providers.
 - **Financial Constraints:** poverty and lack of insurance coverage can prevent women from accessing timely and consistent care.
 - **Transportation Issues:** Difficulties in getting appointments due to lack of transportation or reliable public transportation.
 - **Structural Barriers:** Lack of birthing facilities, shortage of maternity care providers.

- **Cultural and Communication Factors**
 - **Cultural Conflicts:** Native Hawaiian women may experience cultural clashes with health care providers or find health care systems approach to be unsupportive with their cultural beliefs and practices.²⁶
 - **Lack of Culturally Sensitive Care:** some health care settings may not offer culturally appropriate services leading to a lack of trust and reluctance to seek care.
- **Needs:**
 - Increased access to culturally relevant care
 - Expanding access to telehealth
 - Strengthening community-based programs
 - Invest in Research and Data collection
 - Ensuring Affordable and Accessible Health care

HI State and Native Hawaiian Health Collaboration

Papa Ola Lōkahi (POL): was formed as a direct result of the Native Hawaiian Health Care Act of 1988, which was a federal initiative recognizing the unique health challenges faced by Native Hawaiians. The Native Hawaiian Health Care Act of 1988 established a framework for Native Hawaiian health care and specifically empowered Papa Ola Lōkahi to fulfill key functions, such as developing and coordinating a comprehensive health care master plan, training individuals, researching prevalent diseases among Native Hawaiians, and serving as a clearinghouse for information. The Native Hawaiian Care Act of 1988 impacted the state of Hawaii in several ways.



Source: GAO analysis of Health Resources and Services Administration information (information); bonilla1879/stock.adobe.com (map). | GAO-24-106407

- Creation of five Native Hawaiian Health Care Systems that operate within Hawaii, delivering culturally sensitive primary care, mental health, fitness & health education, and nutrition services.
- Papa Ola Lōkahi, as the Native Hawaiian Health Board, acts as a bridge between the federal government and state agencies like the Hawaii State Department of Health (HDOH). They work to coordinate health efforts and ensure the Native Hawaiian community's needs are addressed within the state's health care system. POL is also authorized to enter into agreements with other agencies or organizations to provide resources and services to the Native Hawaiian health care systems.
- Authorizes Papa Ola Lōkahi to receive special project funds for research into the health status and needs of Native Hawaiians. These research findings can inform state-level health policies and programs, leading to targeted interventions and improved health outcomes.
- Integrates traditional Hawaiian values, beliefs, and practices into their services, offering a more holistic approach to health and well-being.
- Includes State oversight and program requirements that work with Papa Ola Lōkahi to ensure program requirements are met through annual reviews, site visits, and monitoring calls²⁷

Pacific Birth Collective(HI)

Founded in 2016 by local birthworkers on the island of Maui, Pacific Birth Collective (PBC) emerged in direct response to critical gaps in Hawai'i's maternal health systems. The founders envisioned an integrative network of maternal health providers - some grounded in clinical best practices, others carrying Indigenous and ancestral knowledge - united by a lived understanding of the systemic barriers facing underserved communities across the state, particularly the long-standing inequities impacting Native Hawaiian families most acutely.

Presently, PBC's work spans direct services, community education, and workforce development, with a focus on serving Native Hawaiian and underserved families across Maui County. Its core programs include:

Community Birth Project – Provides financial assistance for midwifery, doula, lactation, care and pelvic floor therapy, as well as scholarship for local birthworkers beginning or continuing education.

Farm to Mother – Offers fresh, culturally relevant foods and herbal remedies curated to the specific nutritional needs of pregnant and postpartum people.

Donation & Distribution Center – Supplies essentials like diapers, formula, menstrual products, and prenatal vitamins to families in need.

Wellness & Education Events – Hosts support groups and bodywork clinics providing mental, physical, emotional health; social events that strengthen the maternal health provider community across credentials; birth preparation and parenting workshops that integrate Indigenous knowledge and promote informed, empowered birth choices.

Through their multifaceted approach, PBC is creating an integrative maternal health model that addresses the needs of families across diverse geographic, cultural, and emotional contexts while

promoting long-term equity by investing in local birthworkers.

The Pacific Birth Collective Serves

PBC serves a broad cross-section of Hawai‘i’s population, with a focus on families in rural, under-resourced, and wildfire-impacted areas. This includes Native Hawaiian, Pacific Islander, immigrant, and low-income communities. Because Native Hawaiians are overrepresented in nearly every category of maternal and child health disparity in Hawai‘i, PBC’s services design all programs to support Native Hawaiian families, while supporting system-wide equity.

Funding Source and Payer Make Up

PBC’s funding model combines public and private grants, government contracts, individual contributions, membership fees, fee-for-service, and in-kind donations to ensure sustainability and flexibility in serving families across Hawai‘i. In 2024, 59% of PBC’s income came from private grants, securing their first County of Maui and State of Hawaii funding in 2025. To date, PBC has received no federal funding.

Challenges Pacific Birth Collective Faces

The Pacific Birth Collective (PBC) has become a trusted resource for Hawai‘i families over the last decade but faces ongoing challenges with capacity, sustainability, and funding stability. A primary concern is the reliance on short-term, time-limited private foundation grants. While these funds support essential programs, their project-based nature makes long-term planning and program continuity difficult, potentially causing disruption when cycles end. Additionally, restricted grants limit flexibility in responding to evolving community needs. Maintaining a balance between restricted and unrestricted funding is a critical strategic challenge for PBC’s long-term sustainability.

Workforce limitations are closely linked to funding constraints, Hawai‘i faces a shortage of maternal health providers, particularly in rural and outer island communities. This is compounded by the fact that there are a few local OB-GYNs, even fewer of Native Hawaiian descent, and currently not a single licensed Native Hawaiian midwife practicing due to the historical suppression of traditional practices. An additional barrier is the difficulty in obtaining insurance coverage for Licensed Midwives (CPMs and CMs), as many plans only recognized Certified Nurse Midwives (CNMs) for reimbursement. This disparity increases out-of-pocket costs for families seeking community-based care, compelling them to rely more heavily on PBC’s programs.

Geographic barriers further complicate PBC’s work in serving rural and outer island communities, demanding significant logistical coordination, transportation costs, and staffing challenges. To overcome these hurdles, PBC utilizes strong community partnerships, mobile programs, and innovative solutions like virtual wellness programming. The organization maintains a resilient, solutions-oriented approach, leveraging local leadership and a holistic service model, integrating perinatal support, nutrition, and education, while providing culturally competent and trauma-informed care. These challenges, while significant, are seen as opportunities for innovation and collaboration to strengthen PBC’s capacity to serve families across Hawai‘i.

Supporting Native Hawaiian Midwives

In 2019, Hawai‘i passed a midwifery licensure law that threatened Native Hawaiian birth traditions and the cultural practitioners that facilitate them. The law, codified at Hawai‘i Revised Statutes (HRS) § 457J, required nearly anyone providing information, advice, or care during pregnancy, birth, or postpartum to have a midwifery license. The licensure eligibility requirements were narrow, excluded many skilled midwives, and imposed significant barriers on local residents. Anyone without a proper license was subject to imprisonment, fines, and other penalties, putting Native Hawaiian traditional midwives, doulas, lactation counselors, childbirth educators, and even family members at risk.¹ And although the law included references to Native Hawaiian traditional and customary practices, these purported protections were later found to be inadequate.

In February 2024, the Center for Reproductive Rights, Native Hawaiian Legal Corporation, and Perkins Coie filed a lawsuit on behalf of nine women, including a Native Hawaiian midwife, midwifery student, and pregnant mother whose traditions and reproductive choices were threatened or disrupted by the law.² The lawsuit, *Kaho‘ohanohano v. State*, argued that HRS § 457J violates constitutional rights, including rights to Native Hawaiian traditional and customary practices under Haw. Const. art. XII.³ The lawsuit highlighted barriers to maternal health care in Hawai‘i, the adverse outcomes and disrespectful or discriminatory health care that Native Hawaiian women endure, and the personal and cultural significance of decisions surrounding pregnancy and childbirth. The lawsuit also demonstrated that Native Hawaiian midwives are critical to meeting community needs for care and cultural connection and that § 457J interrupted the practice and teaching of those traditions.⁴

On July 23, 2024, the Court issued an order preliminarily prohibiting the state from enforcing, threatening to enforce, or otherwise applying any penalties against individuals who practice, teach, and learn “traditional [Native Hawaiian] healing practices of prenatal, maternal, and child care.”⁵ The Court found that although HRS § 457J-6(b) addresses Native Hawaiian practices and ostensibly creates a path to protect them, there is no means *in practice* to attempt to apply for an exemption for the specific customary rights at issue. As a result, Native Hawaiian maternal health practitioners are left without an *actual* and *meaningful* pathway to exercise their traditional and customary rights.⁶ In finding this system unconstitutional in practice, the Court noted that there is a very real threat that certain pregnancy-related customary practices will be impermissibly regulated out of existence.

In 2025, the Hawai‘i legislature passed a bill to replace HRS § 457J, addressing several concerns raised in *Kaho‘ohanohano v. Hawai‘i*. The newly enacted law is less likely to discourage support from family members and birth workers, expands pathways to licensure for local midwifery students, rejects criminal penalties, and clearly exempts Native Hawaiian cultural practitioners engaged in traditional and customary practices.

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2 [About the Plaintiffs: Kaho‘ohanohano v. State of Hawai‘i - Center for Reproductive Rights](#)

3 *Kaho‘ohanohano v. State*, 1CCV-24-0000269 (Haw. Cir. Ct. filed Feb. 27, 2024)

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Case Study 3: Washington

Demographics and Maternal Health

Washington State's population in 2024 was 8,035,700 with American Indian and Alaska Native population making up 1.8% of the population, which is about 145,066. Washington is home to 29 federally recognized tribes, who are located on reservations throughout the state, from the Pacific Coast to the eastern border.²⁸ According to the March of Dimes, 20.5% of counties in Washington are defined as maternity care deserts with 61.5% of women in rural areas living over 30 minutes from a birthing hospital, as compared to 15.3% in urban areas. While Washington's maternal mortality rate is lower than the national average there are significant disparities by race and ethnicity, with American Indian and Alaska Native (AI/AN) people experiencing significantly higher rates. The rate of pregnancy-associated death for non-Hispanic AI/AN people is 8.5 times greater than non-Hispanic white people. The 2023 Washington maternal mortality report found that from 2014-2020, American Indian and Alaska Natives had a rate of approximately 263 deaths per 100,000 births, compared to the overall state rate of 37 deaths per 100,000 births.²⁹ Specific recommendations to address this disparity, highlighted in the report, stressed the importance of tribally developed and implemented solutions, in partnership with state funding and collaboration, while attributing this disparity to 500+ years of trauma and discrimination.³⁰ A University of Washington study found a 71.2% increase in the state's maternal mortality for AI/AN population from 1999-2019, as compared to the increase in white people's maternal mortality to be 52.9%.³¹

In 2023, Medicaid financed approximately 35% of all births in Washington State, which is 35 out of 100 mothers giving birth in Washington were covered by Medicaid. For American Indian and Alaska Native (AI/AN) individuals, Medicaid covered approximately 63.3% of all births. The higher reliance on Medicaid among AI/AN populations reflects underlying socioeconomic disparities and systemic inequities within the health care system.

Consistent disparities exist for American Indian and Alaska Natives in Washington state around 60% of pregnancy-related deaths being preventable, that AI/AN mothers are three times more likely to receive late or no prenatal care, that they have lowest rate of returning to care for postpartum visits, and are twice as likely to experience severe maternal morbidity. AI/AN mothers have higher rates of preeclampsia and gestational diabetes and the highest percentage of c-sections as compared to other racial groups.³²

AI/AN infants have a higher rate of premature births and low birth weights. They are 50% more likely to die from complications related to low birthweight. The Neonatal intensive care unit admits more AI/AN newborns than any other race and ethnic group in Washington.

Contributing factors to these maternal and infant outcomes include lack of health insurance, food insecurity, poor living conditions, lack of transportation, systemic discrimination, geographic isolation with inadequate health care infrastructure, and insufficient insurance coverage, underfunding of tribal health care systems, lack of culturally competent care, and lack of support for mental health challenges and substance use.

Washington Political Maternal Health Landscape

Maternity Policies

- 10.3% of Washington’s population live below the poverty line. With five counties reporting the highest rates including: Okanogan, Yakima, Grant, and Franklin Counties.
- In 2023, Medicaid financed 35.9% of all births.
- Medicaid coverage for AI/AN births in 2023 shows that Medicaid coverage at the time of birth was 63.6% and 28.9% for Native Hawaiian from 2021 data.
- Washington extended postpartum coverage and implemented After-Pregnancy Coverage (APC), extending Medicaid coverage for pregnant individuals up to 12-months postpartum, regardless of income changes or pregnancy outcome.
- Paid Family and Medical Leave (PFML) provides partial wage replacement for eligible employees, including new parents. However tribes often do not opt into this leave creating hardship for families.

Access to Care

- **Medicaid Expansion:** Washington State was an early adopter of the Affordable Care Act (ACA) and expanded eligibility to pregnant women with incomes up to 198% of poverty and continues coverage for 12 months after the baby is born.
- **Pregnant Women Assistance (PWA) Program:** This state funded program provides cash assistance and referrals for low-income pregnant women not eligible for other programs
- **Birth Equity Project:** Led by Washington State DOH, aimed at tackling racial and ethnic disparities in birth outcomes through community partnerships, listening sessions, funding community-based organizations up to \$200,000 per fiscal year for 2.5 years to support their culturally responsive services.
- **Workforce Pathways Program:** This program provides paid public health internships and professional opportunities to promote equitable access to public health careers for those serving communities across Washington State.³³
- **Telehealth Expansion:** Washington expanded telehealth coverage and reimbursement.
- **Satellite OB Clinics:** Established in rural areas and are housed in community health centers and staffed by medical assistants or nurse practitioners who perform in-person prenatal and postpartum checkups, followed by video conferences with OB providers in the nearest labor-and-delivery hospital.
- **Telehealth Kits:** For high risk pregnancies, OBs can prescribe telehealth kits, including a tablet with embedded devices for at-home monitoring of vital signs and fetal heart rates.³⁴

Focus on Disparities

- **Maternal Mortality Review Panel (MMRP):** was formed in the late 2000’s and in 2016 through legislative mandate, the panel was officially established within the Department of Health through Senate bill 6534. This multidisciplinary panel reviews maternal deaths, identifying contributing factors, and recommends systemic improvements.

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- In 2019, Senate Bill 5425 permanently established the MMRP and its review process. It also expanded the Panels authority, requiring tribal representation, broadening the types of providers and organizations represented, allowing for data sharing.³⁵

Washington State and Tribal Health Collaboration

Washington State and its Tribal governments have a long-standing history of collaboration in health care, rooted in the recognition of Tribal sovereignty. Key elements of this collaboration include³⁶

- Formal Agreements: The 1989 Centennial Accord established a government-to-government relationship, and this relationship is implemented through structures like the [Health Care Authority's](#) (HCA) guidelines for Tribal relations.
- The American Indian Health Commission (AIHC): Formed in 1994, the AIHC comprises 29 federally recognized Tribes and two urban Indian health organizations. It acts as an advocate and convenor for these entities to collaborate with the state government on health initiatives.
- Dedicated Structures: Washington has regional Tribal liaisons, established Tribal workgroups, and hosts statewide Tribal conferences to foster communication and collaboration.
- Focus on Sovereignty: The collaboration emphasizes centering the experience and perspective of Tribal governments.
- Missing and Murdered Indigenous People State Committee

Ttáwax̣t Birth Justice Center (WA)

Ttáwax̣t Birth Justice Center (TBJC) began as a coalition in 2013, made up of concerned providers and community members. It was led by Jessica Whitehawk, a co-founder and the first executive director of the organization. The coalition transitioned to a 501c3 organization in 2019 and is currently located on the Yakama Nation Reservation in Wapato, Washington. The Yakama Nation Reservation is the largest reservation in Washington State, with 1.13 million acres, in eastern Washington.

TBJC is working to protect and revitalize Indigenous wisdom in everyday life and for broader systemic change. TBJC was developed and implemented as a community-based Indigenous birth justice model, which is grounded in Native American values and approaches to supporting the Indigenous birthing community on their journey of family and parenthood. The staff is led by all Indigenous women from the community who hold community knowledge and understand the systemic issues faced by the families they serve. TBJC currently provides pregnancy, birth, and postnatal supportive care to birthing families living on or near the Yakama Nation Reservation and those migrating for fishing. Services provided include: supportive care through cultural practices, support groups, breastfeeding consultations, childbirth education, and prenatal and women's health care access clinics in partnership with local health care providers. They also partner with Nurse Family Partnership to provide collaborative services and referrals.

Problems TBJC Is Solving

The Ttawaxt Birth Justice Center (TBJC) is working to combat severe health disparities in Yakima County, where Native American infant mortality rates (8.72 per 1,000) are significantly higher than those for non-Hispanic white infants (5.75 per 1,000), and Native women face maternal-related death rates of 8.5 times higher than white women in Washington State. TBJC aims to address this maternity desert by improving access to care, reducing these mortality rates, enhancing maternal mental health, and integrating the cultural values of Indigenous people into all aspects of the care to revitalize traditional birthing culture for families.

The organization is actively developing sustainable, culturally centered model of care to address systemic challenges that contribute to dismal health outcomes. This includes building a competent workforce of medical and community health birth workers in a county that currently has fewer than five non-Indigenous midwives. The need for a birth center is critical, especially after the Astria Toppenish Community Hospital on the reservation abruptly closed its labor and delivery services in 2022, leaving only two hospitals in the county that frequently divert patients due to capacity issues. The TBJC works with limited resources, infrastructure, and funding to build these vital systems, striving to provide safe, accessible birthing options for the community they serve.

Who TBJC Serves

TBJC has served hundreds of families in its tenure. Currently, Ttáwaxt Birth Justice Center serves 100% self-identified Native American women and their families. Many of their clients are from different tribal backgrounds, but primarily Yakama Nation enrolled members or descendants. Through services offered in our space, we average about 100 families per year, or about 700 encounters or interactions with our relatives.

In addition, TBJC is working towards expanding their services to reach teens who are pregnant, young mothers, or prior to becoming a pregnant to assist in body education, connecting to

ceremony, and building community through monthly ceremonies and intimate cross generational teachings.

They build partnerships locally, statewide, and nationally to influence policy, advocacy, and systemic changes. Their experience of building and implementing a community-designed and driven health and supportive system for birthing families on a rural reservation has contributed to innovative approaches to addressing maternal deserts on a reservation.

Funding Source and Payer Make Up

- 100% of Ttawaxt Birth Justice Center OB/GYN clients are on Medicaid.
- About 50% of FY 2025 budget is funded by private philanthropy, and the other half is funded by various Washington state funds.
- Three full-time FTEs are funded by community health worker wages provided by the State of Washington.
- Zero dollars are funded by the federal government.

Challenges Ttwaxt Birth Justice Center Faces

The Ttwaxt Birth Justice (TBJC) is working to address severe disparities in maternal health care on the Yakama Nation Reservation, where access to essential services has been dramatically reduced. All local OBYGN services were eliminated, and the only labor and delivery unit, available for 70 years, closed in 2022. This forces residents to travel significant distances, often 150-200 miles to Seattle for high-risk care. The nearest local hospital frequently diverts patients due to capacity and staffing issues, sending them even further away and creating significant hardship for families who already face a one-in-three poverty rate on the reservation. The high death rates among AI/AN populations, largely due to stress and economic hardship, further compound the challenges for birthing families.

In response, TBJC is focused on revitalizing nearly lost traditional midwifery practices and rebuilding the local midwifery workforce, which currently has very few practicing midwives with hospital access. The organization faces financial challenges, as implementing its holistic, community-focused model is hindered by a lack of local tax base and low reimbursement rates for birth center facility fees in Washington State compared to hospitals. TBJC is advocating for equitable reimbursement policies, similar to those in New Mexico, to ensure the sustainability and viability of essential birth center services and improve health outcomes for the Yakama Nation community.

Innovative Work Happening in Washington to Address NA/AN Maternal Health

- Integration of traditional protocols and western maternal care
- How these centers operate, funding structures, workforce models
- The role of birth centers in advancing Indigenous birth sovereignty
- Policy barriers to sustainability and Medicaid reimbursement

Recent Federal and State Legislative History

Federal Maternal Health Policies and Programs

Beyond the Indian Health Services, a complex web of federal laws, policies, and programs shape the U.S. health care infrastructure that many American Indian, Alaska Native, and Native Hawaiian individuals rely on—before, during, and after pregnancy. These include health insurance programs such as Medicaid and subsidies related to the Affordable Care Act, health services delivered through the Veteran’s Administration, Title IV funding for state maternal and child health programs, federally funded research and data collection, workforce development, and support for health facilities in rural and medically underserved communities.

Additionally, as challenges and inequities in U.S. maternal health outcomes became more widely recognized over the last decade, numerous federal initiatives developed or were modified to better, and more specifically, target maternal health concerns. However, like so many other instances of U.S. policy making, the design and implementation of these health care resources has failed to adequately consider or address Native people’s needs.

At the same time, recent changes at the federal level—including legislation passed by Congress, administrative actions, and decisions made by the U.S. Supreme Court—threaten the modest progress made and further undermine the U.S. government’s capacity to fulfill its federal trust obligations to provide health care to American Indians, Alaska Natives, and Native Hawaiians.

Maternal Health Data Collection

Maternal health data is an important driver of maternal health policy decisions and a critical policy issue in its own right. The United States collects data on maternal health in a variety of ways.

One important indicator of maternal health is a nation’s maternal mortality ratio, calculated as the number of maternal deaths per 100,000 live births. The World Health Organization defines a maternal death as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.” (Using this definition enables international comparisons and benchmarking, but may not capture all pregnancy related deaths). To collect this data, the **National Center for Health Statistics (NHCS)**, **National Vital Statistics System (NVSS)** relies on state-issued death certificates and ICD-10 codes.³⁷ Changes made to these forms as well as incorrect inputs have undermined the quality of this data, leading to both undercounting and overcounting.³⁸ Due to concerns about data quality, NVSS suspended publication of maternal mortality statistics in 2007. In 2020, it began publishing these statistics again with the release of 2018 data, using updated methods.³⁹ However, NVSS maternal mortality data is only available for the four race/ethnicity categories “for which statistically reliable rates can be calculated” and provide a limited view into maternal health causes and disparities. NVSS maternal mortality rates are published for Asian, Black, White, and Hispanic populations, but not for Native Americans, Alaska Natives, or Native Hawaiians.⁴⁰

The **CDC’s Pregnancy Mortality Surveillance System (PMSS)** conducts national surveillance on pregnancy-related deaths, which are defined more broadly to include the year after a pregnancy ends. This extended timeframe is significant because more than a quarter of pregnancy-related deaths in the U.S. occur between 42 and 365 days after the pregnancy ends.⁴¹ The PMSS also relies on vital records, which are analyzed by medical epidemiologists. PMSS published data indicates a rise in pregnancy-related deaths since the 1980s, and includes information about primary causes, urban/rural location, age, and some race/ethnicity data.⁴² Like the NVSS, deaths among Indigenous women are typically suppressed.⁴² However, an analysis of PMSS data from 2011-2015 published in 2019 indicates that American Indian and Alaska Native women have a pregnancy-related mortality ratio 2.5 times higher than white women.⁴³

Recognizing that more detailed information was needed to understand and prevent maternal deaths, Congress passed the **Preventing Maternal Deaths Act in 2018**.⁴⁴ This legislation authorized the CDC to support state and tribal maternal mortality review committees and provided funding necessary for implementation. In 2019, the CDC established the **Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM)** program. ERASE MM has since supported 46 states and 6 U.S. territories and freely associated states in establishing and improving **Maternal Mortality Review Committees (MMRCs)**. Maternal

Mortality Review Committees are multi-disciplinary committees whose members collectively review the circumstances of each suspected pregnancy-related death that has occurred in their jurisdiction. Among other things, the committee assesses whether the death was indeed pregnancy-related, whether it was preventable, and if so, what interventions might save lives in the future. ERASE MM has distributed \$90 million in funding over the past 5 years,⁴⁵ but also provides technical assistance, as well as standardized forms and a central data system called Maternal Mortality Review Information Application (MMRIA). These resources facilitate data quality, analysis, and dissemination of MMRC best practices.⁴⁶

As a result of this nationwide effort, the infrastructure for learning about maternal deaths has rapidly improved in a relatively short period of time, with many states establishing an MMRC for the first time in the last decade. All states except Texas and the District of Columbia currently participate in the program.⁴⁶ Native representation varies across committees. A few states include requirements for committee membership and diversity, such as tribal representation, in their state-level MMRC authorizing legislation.

Although no tribal MMRCs have yet been established, options for improving review of Indigenous pregnancy-related deaths have been explored. For instance, in “to learn about tribally led maternal health improvement work from tribal leaders, American Indian and Alaska Native tribal members, Urban Indian Organizations, tribal health care providers, tribal serving organizations, and others working in tribal maternal health, to inform a sustainable funding initiative for tribes and tribal serving organizations.”⁴⁷ In September 2020, the National Indian Health Board hosted a webinar examining the experience of Native individuals serving on state MMRC’s and exploring the possibility of creating tribally-led MMRCs. In 2023 and 2025, NIHB and the CDC co-hosted convenings on maternal mortality and the development of Tribal MMRCs.⁴⁸

With MMRCs now functioning at the state and local levels, inequities in Native maternal health that were long suspected but underreported are officially coming to light. In 2022, the CDC published data based on analysis of 36 MMRCs indicating that American Indian and Alaska Native people were twice as likely than white people to suffer a pregnancy-related death. It also reported that in more than 90% of these cases, the MMRC determined that the death was preventable.⁴⁹ In 2024, the CDC reported that data from 39 state MMRCs revealed 12 maternal deaths among AI/AN women in 2020, while also acknowledging that number is likely an undercount.⁵⁰ In 2023, the CDC posted data showing that Native Hawaiian and Other Pacific Islanders have the highest rates of pregnancy-related deaths among all racial and ethnic groups (4.5 times that of white people).⁵¹ This data was removed from the CDC website in 2025.

In addition to contributing to higher quality, more standardized maternal death data, MMRCs are generating evidence-based policy recommendations tailored to the needs of their jurisdiction. Despite these achievements, the future of MMRCs is uncertain as **ERASE MM’s funding expires on September 30, 2025.**⁴⁵

Medicaid

Medicaid provides public health insurance to more than 80 million people in the U.S., including millions of Native Hawaiian, American Indian, and Alaska Native individuals.^{52,53} For AI/AN

individuals, Medicaid coverage can help fill gaps in care or services available through IHS. It also provides a critical source of revenue for many hospitals, helping to sustain the health care infrastructure that whole communities depend on.

Even before pregnancy, Medicaid serves as an important preconception health resource by providing access to contraception and care for conditions that may later complicate pregnancy, enabling covered individuals to enter pregnancy in better health and at a time that is right for them. Under the **Affordable Care Act**, Medicaid eligibility was extended to cover low-income adults without children, including many women of reproductive age who would otherwise be uninsured. Some states expanded Medicaid eligibility up to 138% of the Federal Poverty Level for this population, while others did not. States that rejected Medicaid expansion have maternal mortality rates 35% higher than those chose expansion.⁵⁴

Medicaid covers pregnant women with incomes at 138% or below the federal poverty level. All states have chosen to extend eligibility to pregnant women with incomes higher than that, though at varying levels. States with more inclusive eligibility criteria for pregnant people have more rural hospitals with obstetric services than states with restrictive criteria.⁵⁵ The Medicaid program covers more than 40% of births in the U.S. and even more in certain states and rural areas.⁵⁵

Medicaid coverage during pregnancy includes prenatal care and birth services, and as of recently, a full year of postpartum care. Previously, Medicaid coverage ended after 6 weeks postpartum. But as MMRCs began to reveal how many maternal deaths occur after that point, many recommended that their state extend pregnancy-related Medicaid coverage beyond that cutoff. Beginning in 2020, states began to increase postpartum coverage using state funds or section 1115 waivers. The **American Rescue Plan Act** (2021) eased this process by enabling states to extend Medicaid postpartum coverage to 12 months via a State Plan Amendment. Currently, there are only two states that have not done so.⁵⁶

States have also taken steps to expand benefits, including Medicaid coverage for doula services. Doulas provide non-clinical physical, emotional, and informational support during the perinatal period and have been shown to improve maternal health outcomes and experiences.⁵⁷ Nearly all states have taken some action to initiate the process of providing Medicaid coverage for doula care, with 23 states and DC actively reimbursing these services.⁵⁸

On July 4, 2025 President Trump signed the **One Big Beautiful Bill Act** (OBBA) into law. This law has significant implications for the U.S. health care system and will inevitably and adversely impact maternal health. Among the changes are sweeping cuts to Medicaid. The Congressional Budget Office estimates that the OBBA will reduce federal Medicaid spending by \$911 billion over ten years.⁵⁹ Rural areas are expected to lose \$137 billion in Medicaid funds during that time, an amount that far exceeds the \$50 billion that the OBBA allocates to a rural health fund.⁵⁹ For many communities, these cuts accelerate an access crisis already underway. For years, hospitals in both rural and urban settings have been closing or reducing services at an alarming rate, diminishing access to labor and delivery units and other critical pregnancy-related care.⁶⁰ Currently, more than 300 rural hospitals across the U.S. are already facing an “immediate risk of closure.”⁶¹ And at least 144 rural hospitals with labor and delivery units are at risk of closure or severe service reductions as a result of the OBBA.⁶²

As states grapple with drastic funding cuts, they will have to make difficult choices about benefits and eligibility. Recent maternal health coverage gains such as doula care and extended postpartum coverage, as well as access to some licensed midwives (and the home births they help support) could be reconsidered.⁶² Inclusive income eligibility criteria for pregnant people could also be at risk. Native Hawaiians who are not pregnant will be subject to the OBBA’s new Medicaid work requirements and redetermination eligibility requirements. And even though AI/AN individuals and pregnant people will be exempted from Medicaid work requirements, the anticipated documentation burdens, service cuts, and facility closures caused by OBBA will impact everyone.

Key Maternal Health Legislation and Recent Funding Appropriations

The **MOMNIBUS Act** is a package of 13 bills that aim to dramatically improve U.S. maternal health by addressing a wide range of factors that influence outcomes.⁶³ Introduced and championed in the U.S. Congress by members of the Black Maternal Health Caucus, the legislation has a strong focus on health equity and eliminating racial disparities. Because it explicitly names health equity as a goal and directs new resources towards communities experiencing disproportionately adverse outcomes, the MOMNIBUS Act is likely to have a significant impact on Native maternal health.

The MOMNIBUS Act includes investments in the social determinants of health (nutrition, housing, transportation), the perinatal workforce, and community-based organizations that support maternal health. It seeks to improve maternal mental health, care for veterans and incarcerated moms, maternal health data and quality measures, and access to maternal vaccinations. It also promotes innovation in payment models and digital tools, and seeks to mitigate maternal health risks associated with climate change and public health emergencies.⁶³

The MOMNIBUS Act was first introduced in the U.S. Congress in 2020 and evolved with reintroduction.⁶⁴ Only one of the bills has been enacted (Protecting Moms Who Served Act, 2021). However, since 2023, members of the Black Maternal Health Caucus have incorporated ideas from the MOMNIBUS into the federal appropriations process, securing \$200 million in new maternal health funding.⁶⁵ This includes:

- **NIH** funding for research on maternal mortality, morbidity, and interventions to promote equity
- **HRSA** funding for research grants to study maternal health disparities, state maternal health innovation grants, state maternal and child health block grants, midwifery training and education, growing the maternal health workforce in shortage areas, expanding maternity services in rural areas, screening and treatment for perinatal mental health disorders, a maternal mental health hotline, and a plan for HRSA to assist in the expansion of birth centers
- **HHS Office of Minority Health** funding to support community-based organizations working in areas with high rates of adverse maternal health outcomes
- **Centers for Disease Control and Prevention (CDC)** funding for Safe Motherhood programs, which include support for Maternal Mortality Review Committees and Perinatal Quality Collaboratives, and surveillance of “emerging threats to mothers and babies”
- **Substance Abuse and Mental Health Services Administration (SAMHSA)** funding

for substance use disorder treatment for pregnant and postpartum individuals

***Many of these are now threatened or reversed due to new administrations priorities, attacks on DEI, etc. but was the most comprehensive MH equity leg introduced thus far.

Federal

Midwives for MOMS Act 2025

The bipartisan **Midwives for Maximizing Optimal Maternity Services (Midwives for MOMS) Act** would increase the number of midwives in the United States, a key step to improving maternal and infant health. Introduced by Senators Ben Ray Luján (D-NM) and Lisa Murkowski (R-AK), Midwives for MOMS would establish new federal funding streams to support midwifery education, address the maternity care workforce shortage, and strengthen and diversify the workforce by ensuring that the workforce better reflects the population by prioritizing students from rural and economically disadvantaged communities. These measures would help improve outcomes and experiences of care for communities of color and underserved communities by expanding access to culturally competent, evidence-based midwifery care.

BABIES ACT 2025

The **Birth Access Benefitting Improved Essential Facility Services (BABIES) Act** would create a federally funded Birth and Women’s Health Center demonstration program to advance the learnings from the CMMI Strong Start Program and other studies finding that birth center care can improve health outcomes for mothers and babies and results in greater satisfaction with care, while reducing costs. The BABIES ACT would establish a Medicaid demonstration program in six states to expand access to freestanding birth center services by creating uniform standards for participation in the program, publishing guidance on effective, innovative Medicaid payment models to support the financial feasibility of birth center models, and awarding planning grants for states to develop program proposals. The project would also conduct a detailed evaluation of the birth center outcomes and cost savings.

Tech to Save MOMS Act 2025

The **Tech to Save MOMS Act** is a bipartisan bill to deploy technology to address barriers and bridge gaps preventing moms and families in maternity care deserts and other underserved communities from getting the maternity care they need. Tech to Save Moms was introduced by Senators Ben Ray Luján (D-NM) and Dan Sullivan (R-AK) to support greater integration of telehealth in maternal health care. The Tech to Save Moms Act would fund technology-enabled collaborative learning and capacity building models to promote digital tools and deliver instruction and training for maternity care providers in rural and underserved populations and areas with high rates of maternal deaths and severe complications, including Tribal organizations and Urban Indian organizations. The bill would also support a study of the use of technology to reduce maternal deaths, complications, and disparities.

Issues for Congress

1. Inclusion of Birth Centers in Federal Reimbursement Structures

- a. **Medicaid Coverage Gaps:** Medicaid must cover freestanding, licensed birth centers, reimbursement is inadequate and inconsistent across states. Many centers report low payment rates, delayed reimbursements, or exclusion from value-based care initiatives.
 - i. Birth Centers operating under state Medicaid programs typically receive only 15% to 70% of what hospitals are paid for comparable services. Which means, reimbursement is significantly below service costs, which jeopardizes financial viability.
 - ii. Inconsistent State Reimbursement Policies across select states, where reimbursement rates for birth center facility fees vary dramatically from state to state.
 - iii. **Insurance Disparities**-private insurers frequently exclude or underfund birth centers, leaving families-especially Indigenous and low-income-without equitable access, as that the additional cost of care falls on AI/AN families, further it forces AI/AN women toward hospital-only care, where racial bias contributes to mistreatment and poor outcomes.

2. Gaps in Tribal-State-Federal Coordination for Indigenous Birthing Services

- a. **100% FMAP for Tribal IHS Services:** Medicaid statute establishes a 100% federal match (FMAP) for services provided “through” Indian Health Services (IHS) or Tribal facilities, intended to preserve tribal sovereignty and relieve state budget burdens. This only applies when states have operational care coordination agreements that document services requested through IHS/tribal facilities.
 - i. To access full federal reimbursement, states must:
 1. Maintain written care coordination agreements
 2. Ensure services are requested by IHS/Tribal practitioners, even when delivered by non-tribal providers
 3. Avoid duplicate billing
 - ii. ***Many states lack these structured mechanisms, leading to confusion and underutilization of available funds.⁶⁶
 - iii. IHS technically covers services referred to outside providers, but without clear care coordination agreements, coverage doesn’t include free standing birth centers, home birth services, or care with certified professional midwives.

b. Managed Care Gaps & Tribal Protections

- i. In Medicaid managed care contexts, protections exist- tribes are entitled to **Through Tribal Consultation** and rights like having Tribal Liaison roles within managed care organizations. These tools can help resolve conflicts but are unevenly implemented across states.⁶⁷

3. Funding for AI/AN and Native Hawaiian-Led Birth Centers

- a. Start-up and Capital Barriers
 - i. **High upfront costs:** Launching a freestanding, AI/AN and Native Hawaiian-led birth center requires significant investments in facilities, equipment, licensing, and accreditation. These costs easily exceed \$1-2 million- a major barrier for Tribal communities and grassroots organizations without access to capital.

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- ii. **Limited access to financing:** Traditional financing streams (private loans, hospitals, philanthropic grants) are often inaccessible or misaligned with NA/AN and Native Hawaiian values and governance structures.
 - iii. **Federal precedent is limited:** While hospitals and Federally Qualified Health Centers (FQHCs) receive ongoing federal support, birth centers must largely self-finance start-up costs.

4. Innovation and Integration

- a. Native American, Alaska Native and Native Hawaiian culturally integrative maternal health care services are uniquely positioned to integrate cultural practices, community governance, and health equity models that are trauma informed and reproductive justice based. Despite their proven cost-effectiveness and outcomes, they are largely excluded from federal innovation pilots.

Recommendation Summary

1. Standardize and Raise Medicaid Reimbursement

- a. Set minimum Medicaid facility and professional reimbursement rates that align with hospital-level reimbursement or no less than 90% of hospital reimbursement rates to support financial viability and equitable access.

2. Medicaid Parity Between Payers

- a. Address the \$7K-\$11K delivery payment gap by aligning Medicaid payment structures more closely with commercial insurance benchmarks.

3. Streamline IHS Coordination Agreements

- a. Requires states to establish and maintain care coordination agreements with Tribal entities to enable consistent access to 100% FMAP. This legal infrastructure must be supported and enforced.

4. Mandate Effective Tribal Managed Care Protections

- a. Enforce requirements in managed care contracts for designed Tribal Liaisons, for robust Tribal Consultation and disaggregation of AI/AN data.

5. Scale Effective State-Tribal Medicaid Models

- a. Document and replicate successful partnerships that center Tribal governance and flexible program design.

6. Expand Medicaid Funding to Community-Based Settings

- a. Support State Plan Amendments (SPAs) are formal changes that a state makes to its Medicaid program, which must be approved by the Centers for Medicare & Medicaid Services (CMS).
- b. This Matters for IHS and Tribal Providers, because many health needs occur in community-based settings (homes, schools, community centers, mobile units, birth centers)
- c. Expanding this would allow for IHS and Tribal providers outside of the clinic walls to bill for Medicaid, which is essential for access in rural or remote tribal areas.
- d. Expanding reimbursement locations enables culturally responsive, flexible care models in spaces where patients feel comfortable.

7. Expand Bundled and Value-Based Models

- a. Introduce bundled Medicaid payment structures covering prenatal, birth and postpartum services under midwifery-led models, with financial incentives aligned with cost savings.

8. Federal Start-up grant programs

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- a. Create federal start-up grant programs modeled on the BABIES Act or Transforming Maternal Health (TMaH) grants, specifically earmarked for Native American, Alaska Native and Native Hawaiian-led centers.

9. Federal Operating Grants

- a. Establish dedicated federal operating grants for Native American, Alaska Native and Native Hawaiian-led birth centers, parallel to the support FQHCs receive, to ensure stable recurring funding.

10. CMS Demonstration Projects

- a. Expand CMS demonstration projects to explicitly include NA/AN and Native Hawaiian-led culturally integrative maternal health care services and centers.
- b. Fund evaluation and research through HRSA and NIH to document outcomes and scale best practices nationally.

Community Engagement & Governance

Culturally competent integrative models of care developed by American Indian, Alaska Native and Native Hawaiian communities demonstrate that maternal health services are most effective when they are guided by cultural values, community voice, and Indigenous governance. These models emphasize not only clinical safety but also the importance of ceremony, family networks, and ancestral knowledge as a central to the birthing experience. From Native Hawaiian approaches that prioritize ‘ohana (family) and community well-being, to AI/AN models that integrate traditional midwifery language, and healing practices, these frameworks show that cultural safety is inseparable from quality care. Building on these examples, strong community engagement and governance structures are essential for culturally competent integrative models of care, ensuring that decisions about care, design, and accountability remain in the hands of the people they serve.

Recommendations

1. Mandate Community-Majority Advisory Boards

- a. Require that NA/AN and Native Hawaiian-led birth centers receive federal funding to establish governance boards with at least 51% community or client representation modeled after FQHCs.
- b. Boards should reflect the diversity of NA/AN and Native Hawaiian populations—including representation from multiple tribal nations, urban Native families, youth, and maternal health advocates.
- c. Provide technical assistance and funding for tribes to establish and maintain these boards, ensuring they have meaningful decision-making authority (not just advisory status).

2. Embed Culturally Safe Governance Process

- a. Federal and state agencies should require tribal consultation and co-design before implementing policies that affect NA/AN and Native Hawaiian maternal health.
- b. Encourage consensus-based decision-making, circle processes, and restorative practices as accepted governance models for NA/AN and Native Hawaiian-led health centers.
- c. Integrate cultural safety accountability metrics into federal quality programs (MMRCs, POCs, Health Start), ensuring NA/AN and Native Hawaiian perspectives drive evaluation criteria.

3. Support Family and Community-Centered Care

- a. Expand Medicaid and federal funding to cover birth support teams that include doulas, kinship caregivers, and cultural practitioners alongside clinical providers.
- b. Fund infrastructure that allows birth centers to create ceremonial and family spaces, where ritual, songs, and Native languages can be incorporated into maternal care.
- c. Develop mentorship programs to engage Native youth in maternal health, connecting intergenerational knowledge with future workforce pipelines.

4. Redesign Accreditation Standards and Quality Standards Reform to include Native American, Alaska Native and Native Hawaiian Birth Centers

- a. **Reform AAB Accreditation:** That American Association of Birth Centers (AABC) currently sets accreditation standards that are heavily biomedical and Western-centric, often misaligned with Indigenous practices such as ceremony, midwifery apprenticeships, or community-based governance.
- b. **Culturally Inclusive Standards:** Congress and CMS should require accreditation pathways that recognize Indigenous knowledge, traditional midwifery, and culturally safe practices as valid components of high-quality care.
- c. **Alternative Accreditation Models:** Develop as American Indian, Native Alaskan, and Native Hawaiian-led accreditation body or require AABC to collaborate with AI/AN and Native Hawaiian leaders to redesign criteria so that AI/AN and Native Hawaiian-led centers are not forced to conform to non-Indigenous models that challenge their self-determination.
- d. **Federal Recognition:** HHS should formally recognize AI/AN and Native Hawaiian-led accreditation frameworks, similar to how tribal accreditation is recognized in other health and education contexts, ensuring these centers are eligible for federal reimbursement and funding.
- e. **Accountability:** Accreditation redesign should mandate the inclusion of tribal consultation, traditional knowledge keepers, and Native governance representatives in oversight and evaluation process.

5. Accountability and Transparency Mechanisms

- a. Require NA/AN and Native Hawaiian-led health, birth centers, and services receiving federal support to conduct annual community listening sessions and publish community-facing reports on outcomes and decision-making.
- b. Encourage co-created evaluation tools that measure cultural safety, community trust, and equity outcomes- not just clinical metrics
- c. Create federal grant conditions that tie funding to documented community engagement in governance and design.

Summary

Culturally competent integrative models of care emphasize humility, equity, and responsiveness, ensuring that health services respect the diverse traditions, languages, and values of the communities they serve. For American Indian, Alaska Native and Native Hawaiian families, these models go beyond clinical outcomes-they restore trust, strengthen sovereignty, and affirm the sacredness of birth. Yet persistent challenges remain. Inadequate Medicaid reimbursement, fragmented tribal-state-federal coordination, restrictive licensure, and accreditation systems that exclude Native American worldviews continue to limit access to safe and culturally aligned care.

The path forward requires more than financial investment; it demands structural change. Congress must act to fund culturally competent integrative models of care like AI/AN and Native Hawaiian-led birth and health centers, sustain midwifery pipelines, and redesign accreditation standards to reflect Indigenous knowledge as evidence-based care alongside biomedical practice. Community governance must be prioritized through advisory boards, traditional knowledge keepers, and consensus-based decision-making processes. Implementation pathways-including federal start-up grants, tribal state reimbursement agreements, telehealth expansion, and integration into maternal health collaboratives- can ensure that these models are sustainable and scalable.

Culturally competent integrative care is not an optional supplement to the health system; it is essential to close disparities and building a maternal health framework rooted in justice and sovereignty. By embedding AI/AN and Native Hawaiian leadership, cultural safety, and community authority at every level, policymakers have the opportunity to transform maternal health care into a system that is not only clinically effective but also culturally healing, equitable, and resilient for future generations.

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Part 4: The Value and Role of Traditional Medicine in AI/AN and Native Hawaiian Maternal Health

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Executive Summary

Traditional medicine and indigenous midwifery have long anchored maternal health among American Indian/Alaska Native (AI/AN) and Native Hawaiian communities, centering birth as a sacred ceremony that integrates spiritual, emotional, mental, and physical wellbeing. 20th-century medicalization displaced indigenous midwives and traditional medicinal practices—eroding self-determination, trust, and vital intergenerational knowledge—contributing to today’s disparities. Reclaiming ceremony, plant medicine knowledge, traditional midwifery, and relationship-based care alongside mainstream medical services is both a cultural imperative and a public-health strategy to reduce maternal mortality and restore trust.

AI/AN and Native Hawaiian women have long faced severe maternal health inequities, including a 2021 maternal mortality rate of 118.7 per 100,000 live births—4.9x that of non-Hispanic white women. Consistently, MMRCs find that more than 80% of pregnancy-related deaths are preventable and a 2021 MMRC report identified that 100% of AI/AN maternal deaths were preventable.¹ Historic harms like forced assimilation, coercive sterilization, suppression of ceremony through the Religious Crimes Code of 1883, and contemporary barriers like licensure and institutional policies, marginalize traditional practitioners, even criminalization, perpetuate distrust and limit access to culturally respectful maternal health care. Evidence from Native-led programs across the country show that integrating ceremony, elders, traditional midwives, and plant-based healing with clinical care strengthens mother-child-community bonds and supports trauma healing, language transmission, and identity—key determinants of maternal wellness.

Landscape

There are multiple communities working to expand culturally congruent services like Alaska’s Traditional Healing Clinic and Native Hawaiian efforts to integrate practices like *lā‘au lapa‘au*, *lomilomi*, *ho‘oponopono*, and placenta protocols in partnership with hospitals to restore ‘Ōiwi birthing practices. As well as, on the Navajo Nation, where traditional Navajo (Diné) healers and cultural practices are integrated into hospital childbirth in Chinle AZ, which reflect an ongoing

partnership between traditional medicine and modern health care.² At the same time, persistent structural tensions slow integration as a result of mainstream narrow ideology around “evidence” rooted in western frameworks over community and ceremonial knowledge. It is important to understand that indigenous knowledge systems and knowledge translation practices are rooted in a very different linguistic, cultural, social, political and historical context. Indigenous knowledge systems have a distinctly different epistemology from those of academic health sciences.³ Whereas health sciences knowledge is characterized by specialization and academic silos where knowledge is translated from researcher to health care provider. Despite these differences, the most effective and comprehensive approach to improving AI/AN and Native Hawaiian maternal health involves respectful integration of traditional medicine in Western medical practices, as this approach leverages the strengths of both systems to provide the best possible care.⁴

While there are many reasons AI/AN and Native Hawaiian women may not feel comfortable or safe in western medicalized spaces, State rules and provider licensure regulations often criminalize traditional birth keepers, Indigenous midwives, who carry the knowledge of traditional birth ceremony and plant medicine knowledge for practicing medicine without a license. A recent case in Hawaii affirmed the right to self-determination over birth through accessing traditional midwives.⁵ Which further strengthens the right to reclaim Indigenous birth traditions, protecting future generations.

“We finally have a way forward to protect and pass down our sacred practices”

Ki‘inaniokalani Kaho‘ohanohano
Native Hawaiian Traditional Midwife

The litigation and legislative outcomes achieved protection of cultural birthing practices and ensured that Native Hawaiian birthing practitioners can continue to serve their communities-free from the threat of criminalization.⁵ This was possible due to Hawai‘i’s State Constitution, which protects the rights of Native Hawaiians to practice their traditional and customary ways of life.

In similar ways the American Indian Religious Freedom Act of 1978 protects the rights of AI/AN and Native Hawaiian peoples to practice, protect, and preserve traditional practices, including ceremonial rites and access to sacred sites. As it lays the foundation for federal-level policy that would protect cultural birthing as an expression of religious and spiritual belief, it has not been effective in protecting traditional birthing practice. The federal government continued to promote assimilation policies beyond 1978 that targeted AI/AN and Native Hawaiian reproductive and family practices. In 2010 the ACLU launched a lawsuit against the Indian Health Service,⁶ to gain access to information on American Indian women being pressured to induce labor and denied the freedom to make decisions over their birth. These cases address failures in medical consent and the right to raise children within one’s culture and to birth with traditional Indigenous midwives.

AI/AN and Native Hawaiian Traditional Healing Practices

The World Health Organization describes AI/AN traditional healing practices “[The] sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.”⁷ Examples of traditional healing include gathering and the use of medicines and herbs to treat ailments or for wellness, sweatlodge, ceremonial dances and prayers for protection, gathering and ingestion of traditional foods within the community. It also includes the application of plant and animal salves to promote wound healing and recovery. In pregnancy, birth and postpartum—traditional healing includes the use of a traditional midwife, elder or medicine person to guide labor and birth. The use of sacred items, songs, drums used during labor. After birth it includes saving the placenta for sacred burial, naming ceremony for the baby, herbal baths, postpartum confinement period, traditional foods to support breastfeeding and nutrition, and beliefs around hot and cold.

The misconceptions about AI/AN and Native Hawaiian traditional healing are that it is a form of naturopathy and neuropathic medicine. And that there is no “evidence” that these practices are effective in peer reviewed literature. In 1849, one of the state medical societies called for all “irregular-bred pretenders,” like “Indian Doctors,” to be considered illegal practitioners. Though this is a state society policy and not an AMA policy, the AMA publicly acknowledged the organization’s racist past and made Embedding Racial Justice and Advancing Health Equity as a priority in its 2021-2023 strategic plan.⁸ In 2022, the White House Office of Science and Technology Policy (OSTP) and the Council on Environmental Quality (CEQ) released guidance for federal agencies to recognize and include Indigenous knowledge alongside Western methods in research, policy and decision-making. The White House formally recognized Indigenous Knowledge as one of the many important bodies of knowledge that contributes to the scientific, technical, social, and economic advancements of the United States.

“Indigenous Knowledge is a body of observations, oral, and written knowledge, innovations, practices, and beliefs developed by Tribes and Indigenous Peoples through interaction and experience with the environment”⁹

Despite federal support barriers still exist around administrative and billing complexities, inadequate funding for implementation, ambiguous regulations and changing priorities, and cultural differences in measuring outcomes. There are also barriers around geographical isolation, workforce and infrastructure gaps, and chronic underfunding of Indian Health Services.

Policy Momentum: Section 1115 Waivers

Under the Biden-Harris administration, CMS approved Section 1115 demonstration in Arizona, New Mexico, Oregon, and California to reimburse traditional services for AI/AN beneficiaries,

California currently limited to SUD-related care. Arizona additionally committed \$100,000 in state funds to unlock ~\$222M in federal match for cultural traditional healing. Washington State’s American Indian Health Commission requested a similar waiver in January—signals of a growing-federal pathway to scale. Early implementation is promising but requires evaluation specific to maternal health.

Congressional Recommendations

1. **Create federal definitions & reimbursement** for traditional maternal services for ceremony, traditional midwifery, herbal supports, postpartum home and community care across Medicaid, CHIP, Medicare, IHS, and TRICARE; enable enhanced FMAP and streamlined billing codes.
2. **Affirm tribal authority & credentialing** so tribal governments can recognize practitioners and scopes of practice; support portability across IHS and state partners.
3. **Invest in facility integration** ceremony-friendly birth rooms, community birth centers, healing gardens, tied to cultural-safety standards.
4. **Funding workforce pipelines** paid apprenticeships, elder stipends, community-led training and allow for federal scholarship/loan repayment for traditional practitioners.
5. **Community-led research & knowledge protection**, accepting community evidence and safeguarding sacred knowledge/benefit sharing.
6. **Enforce civil-rights & cultural-safety requirements** so hospitals accommodate ceremony, traditional attendants, and kinship support.
7. **Cover travel, doulas, and home-based supports** with parity.
8. **Integrate maternal mental health & SUD care** with traditional modalities and warm handoffs.
9. **Mandate measurement & oversight** of cultural safety, trust, language transmission, and community-defined wellbeing in federal dashboards.
10. **Protect ceremony in emergencies** continuity of access to sacred sites and medicines.
11. **Prioritize Native-led procurement & ownership** for grants/contracts and perinatal supply chains.

Implementation Pathways

- Use Section 1115 and aligned IHS/Medicaid coding to pay for traditional services across the perinatal continuum.
- Co-design standard operating procedures for ceremonies, herbal supports, kinship-based care, and cross-referrals; grant privileges for traditional practitioners.
- Resource regional networks of traditional midwives/healers; fund apprenticeships to secure knowledge transfer.
- Build ceremony-friendly spaces and community infrastructure like healing clinics, women’s circles and herbal gardens.

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- Create a perinatal registry with context-specific metrics like maternal/neonatal indicators, social determinants, cultural safety, trust, and language transmission and report back to communities.

Bottom Line

Traditional maternal health and Indigenous midwifery practices are core components of high-quality care for AI/AN and Native Hawaiian families. Federal recognition, financing, and protection—designed and governed with elders, midwives, and knowledge keepers—can close equity gaps, rebuild trust and uphold Indigenous self-determination while improving perinatal outcomes. Congress has actionable levers to support ceremony and cultural safety across the maternal health system.

Full Report: The Value and Role of Traditional Medicine in AI/AN and Native Hawaiian Maternal Health

Introduction

For American Indian, Native Alaskan, and Native Hawaiian communities, birth has long been understood as a deeply spiritual cultural passage. Not simply a biological event. Traditionally, childbirth was attended at home by traditional midwives. These were medicine women who relied upon centuries old ceremonial practices, herbal medicines, and relationship-based care to provide holistic care during the birthing process. In fact, historical evidence exists acknowledging the presence of midwifery dating back to c.2000 BC and earlier in ancient Mesopotamian and Egyptian cultures. In the origin stories of American Indians, Native Alaskans, and Native Hawaiians, birth is described as a ceremony connecting mother, child, and spirit. The ceremony of birth is a transformative experience that strengthens familial bonds and communal ties across generations. While ceremony can have different meanings to different people(s), birth as a cultural right of passage shares a multi-faceted view, encompassing a deep respect and reverence for life and the dynamic relationship between the physical, emotional, mental, and spiritual. Patrisia Gonzales, traditional midwife, speaks to the birthing matrix that is reflected in many Indigenous cultures today; by calling in the community, it is recognized that, at a symbolic level, all will help to catch the baby. That birth was a communal celebration, in which female forces of the mother and midwife were recognized.¹⁰ Further, these ceremonies evolved as ways of asking for or transferring knowledge.¹¹ This holistic approach reflected a worldview in which maternal health was inseparable from community wellbeing, land-based knowledge, and ancestral continuity.

The groundwork for disrupting the transmission of traditional indigenous knowledge was laid through federal assimilation policies like the Religious Crimes of 1883, implemented by the Bureau of Indian Affairs, criminalized Indigenous spiritual and healing practices, forcing traditional healers and medicine people to go underground, severing the intergenerational transmission of traditional birth knowledge.¹² Additional policies like the Civilization Fund Act

of 1819, worked to dismantle traditional Indigenous health practices as an effort to bring childbirth under federal control and halting the transfer of herbal medicine knowledge through the physical separation of American Indian children from their communities to be placed in boarding schools.¹³

Beginning in the early twentieth century, the creation and expansion of Indian Health Services, pushed for the rapid medicalization of childbirth. Native American women were forced to abandon traditional home births with traditional midwives for physician attended births in government hospitals, leading to cultural, social, and geographic disconnection.¹⁴ Home births that once accounted for nearly all deliveries in 1900 declined to about half by 1930, and by the 1960s more than 95 percent of births occurred in hospitals. State-level regulation of midwifery, such as licensure and regulation such as Hawai'i's 1931 licensing law,¹⁵ accelerated this transition for AI/AN and Native Hawaiian people. Among the Navajo, for example, fewer than 10 percent of women delivered in hospitals before 1940, but by 1970 hospital births were nearly universal. Similarly, Native Hawaiian birth attendants (*kahu hānau*) were marginalized as Western medicine took precedence, even as Queen Kapi'olani's maternity home of 1890 reflected both Native leadership and the growing institutionalization of birth.¹⁶

While the shift to hospital births was often framed as a move toward safety and modernization, it also entailed the suppression of family and native health practices, cultural knowledge and the erosion of Indigenous sovereignty. The consequences continue to impact maternal and infant health disparities today. Yet, in the face of these disruptions, Native communities have consistently sought to protect and revitalize traditional medicine as an essential dimension of maternal health.

In 1975 the U.S. enacted the Indian Self-Determination and Educational Assistance Act, formally ending the tribal "Termination Era" and affirming that AI/AN right to self-determination and self-governance.¹⁷ During the 2007 general assembly the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), resolution was adopted. It asserted to protect the rights of Indigenous peoples to their traditional medicines and health practices, including midwifery. Article 24 directly addresses Indigenous health rights, including the right to traditional medicines, maintenance of health practices, conservation of vital medicinal resources, and access to health services without discrimination.¹⁸ The UNDRIP's provisions on health and cultural practices like Article 11, which affirms the right to practice and revitalize cultural traditions and customs, provides a framework for incorporating Indigenous childbirth practices into health care settings,¹⁹ while addressing the historical suppression of Indigenous traditional midwifery. In 2021, the International Confederation of Midwives released a position statement on "Partnership Between Indigenous and Non-Indigenous Midwives" recognizing the role of Indigenous midwives as stewards of knowledge regarding traditions and rites within their communities, which support intergenerational health.²⁰

From birthing programs like Changing Woman Initiative, that integrate traditional medicine alongside evidence-based maternal health care, to contemporary efforts by Native Hawaiian midwives to reclaim their rightful practice, traditional medicine persists as both a health resource and act of cultural survival.

This legacy underscores the value of Indigenous maternal health knowledge-not only as a repository of clinical skill and resilience, but also as a vital expression of sovereignty, identity, and community healing. Understanding the historical medical and political shift from home to hospital birth, requires equal attention to the ways Native peoples are reclaiming traditional medicine to restore balance in maternal and child health today. Contemporary Traditional Medicine in Maternal Health

Contemporary strategies increasingly emphasize the value and need for culturally congruent care, integrating traditional practices-such as ceremonies, plant medicines, relationship-based rituals, and traditional midwives- with Western health care to improve health outcomes. This is in response to the severe maternal health disparities AI/AN and Native Hawaiian women face with maternal mortality reaching 118.7 per 100,000 live births in 2021 - 4.9 times the rate of non-Hispanic whites.²¹ This is further compounded by distrust of clinical systems due to historic trauma around forced sterilization, infant separation, and systemic inequality through the medical model of care. Through a resurgence of Indigenous midwifery and community-led services, modern practitioners are blending ancestral knowledge with clinical support to address trauma and systemic biases within prenatal and birthing care.¹³

With traditional healing being reintegrated into health care systems to enhance cultural safety, places like Southcentral Foundation in Alaska offer a Traditional Healing Clinic staffed by tribal doctors, healing councils, and women's talking circles in addition to a traditional garden for medicinal plants.²² On the Navajo Nation, the Chinle Comprehensive Health Care Facility employs traditional Navajo healers, *hataalii* or "singers," to support laboring patients on labor and delivery, who work alongside medical staff to provide care and are available to patients. Their services are used to support both physical and mental health wellness. They also oversee ceremonies. These services reflect a holistic approach-blending spiritual, emotional, and physical wellness-within health care.

In Hawaii, traditional Hawaiian medicine in maternal health care integrates ancient practices like *lā'au lapa'au* (herbal remedies), *lomilomi* (massage), and *ho'oponopono* (reconciliation) with modern health care to address health disparities faced by Native Hawaiian families. Despite historical and current restrictions that limited access to traditional midwives, today's practitioners work to incorporate culturally sensitive practices and community-based support, such as the sacred *kanu 'iewe* (placenta ceremony) and the revival of ancestral birthing traditions.

Recent research on the value of returning 'Ōiwi (Native Hawaiian) birthing practices to Hawai'i hospitals exemplifies contemporary traditional medicine by merging ancient healing wisdom with modern health care.²³ This approach focuses on holistic family and community wellness to address health inequities that surround maternal health through focusing on spiritual connection to the land practices like *kanu 'iewe* (planting the placenta), and the use of traditional healing methods. Therefore, implementing these practices in hospitals requires a comprehensive approach through collaboration with Native Hawaiian communities to carefully collaborate on education and policy reform for greater patient empowerment.

The Role of Elders, Midwives, and Plant-Based Medicines in Maternal Health

Maternal health for AI/AN and Native Hawaiian's has always been rooted in relationships between, family, community, the spirit and natural world. Elders, midwives, and plant-based medicines play central roles in safeguarding pregnancy, birth, and postpartum well-being, offering guidance that extends beyond the physical to encompass spiritual, emotional, and cultural dimensions of care. Elders serve as knowledge keepers, bridging generational traditional beliefs and lived experiences to the next generation. Midwives embody both spiritual and practical skills to ensure that birth remains a culturally safe and sacred passage. Plant-based medicines, used with prayer and reciprocity, are used for wellness support during pregnancy and in everyday life outside of pregnancy. Together, these interconnected systems provide a foundation for healing that supports maternal and infant health through community care, that affirms sovereignty, resilience, and cultural continuity in the face of ongoing health inequities.

Culturally, these relationships have sustained generations of Indigenous communities through an interconnected web of safety for moms, babies, and communities. What Native American communities have known for centuries is that traditional ceremonies heal trauma, revitalizing culture, and are a vital part of the health matrix that supports AI/AN and Native Hawaiians.²⁴ Reclaiming ancestral birth teachings can also help contemporary people reconnect with their natural cycles, especially for those whose traditional practices were suppressed or lost through historic colonization. Reclaiming ancestral birth teachings represent a powerful form of cultural healing. All of which connect with reviving traditional foods that support pregnancy and lactation, learning native language that supports the passage of traditional knowledge, and strengthening a sense of identity through relationships built through this reclamation process.

Birth and motherhood are powerful thresholds in which the use of sacred birth practices can break cycles of trauma and interrupt the transmission of historical intergenerational trauma within AI/AN and Native Hawaiian communities. When Native families engage in this process of reclaiming traditional birthing practice through ceremony, language, kinship networks, use of plant medicines, and language, they are actively countering the medicalized, often traumatizing model of care that has been imposed through traditional health care systems. Healing the Mother-Child-Community triangle is dependent on strong mother-child bonds, which in turn require community support. When new parents can sing traditional lullabies, offer prayers in ancestral languages, and teach their children cultural concepts from birth, it creates positive feedback loops that strengthen all three points of this relationship. Children grow up with strong cultural foundations and a sense of identity connected to their ancestors.

Tensions With Medical Systems and Protection of Traditional Knowledge

Up until the 1978 American Indian Religious Freedom Act, which allowed Natives to practice their healing and religious ceremonies without repercussions, traditional practices were banned from the community. Additionally Indian policies of forced assimilation practices, such as federal funded boarding schools, continued to disrupt the mother-child bond by forcibly removing children from their homes and families. This further disrupted the transfer of generational knowledge around Indigenous parenting which has led to cycles of dysfunction in families and the loss of sacred birthing and healing practices.

In the 1960s and 1970s, many American Indian women were coercively sterilized by the Indian Health Services (IHS), the federal agency responsible for Native health care.^{25,26} All of which have led to an erosion of trust in the medical system. Through the years, as the medical model of care has been forcibly imposed on American Indians across the United States, advancements in medicine have left Native people behind and have intentionally challenged the legitimacy that traditional medicine plays in health and wellness. While other acts of religious freedom have been supported through policy and advocacy, the right to seek care from a traditional midwife and to integrate traditional birthing practices into care has not been supported. For example, the Ethical and Religious Directives (ERD) prohibit certain procedures by Catholic hospitals, including sterilizations and, in some cases, specific aspects of maternity care, based on religious doctrines;^{27,28} lawsuits have been filed under the Religious Freedom Restoration Act (RFRA 1993) stating that lack of access to reproductive rights such as abortion, is a violation of religious freedoms.²⁹ Amish & Mennonite Communities often choose home births or midwife-assisted births outside hospitals for religious and cultural reasons and states such as Pennsylvania and Ohio have historically accommodated these practices, even when home birth regulations were stricter for others. Additionally, the American Indian Religious Freedom Act (AIRFA, 1978) protects the religious practices of Native peoples, including ceremonies connecting to fertility, reproduction, and birth, however, it is not explicitly stated that care from a traditional midwife is also an act protected under religious freedom.

Native Hawaiians face parallel struggles. Traditional healing systems such as *lā'au lapa'au* (plant-based medicine), *lomilomi* massage, and *ho'oponopono* were long suppressed by medical policies and remain undervalued within biomedical systems today. The recent restriction of traditional midwifery through Hawai'i state law, which requires costly and mainland-based licensure, has been described as a form of "medical colonialism" that effectively criminalizes Native Hawaiian midwives and threatens generational knowledge transfer.³⁰

Today, these historical harms continue to manifest as structural tensions between Native communities and mainstream health care systems. Medical centric ideologies often center scientific and evidence-based validation to guide practice over Indigenous knowledge through Western frameworks, dismissing the spiritual and holistic foundations in traditional healing. Intellectual property concerns further complicate this relationship, as NA/AN and Native Hawaiian communities seek to safeguard ancestral knowledge from exploitation by biomedical research and pharmaceutical interests. At the same time, traditional birth keepers, healers, and traditional midwives face systemic barriers to recognition, licensure, and reimbursement, which limits their ability to serve their communities despite evidence of cultural safety and improved

health outcomes when traditional and Western practices are integrated. This tension demonstrates a broader struggle over the right to self-determination over health practices.

While localized initiatives demonstrate progress, ongoing structural inequities create a pressing need for federal action. Protecting traditional knowledge and resourcing traditional practitioners is not only a matter of cultural survival but a critical public health strategy to reduce maternal mortality, restore trust, and uphold Indigenous sovereignty. To advance meaningful change, Congress can address these structural tensions between biomedical systems and traditional medicine and ensure that Indigenous voices lead the design and governance of maternal health policies for our communities.

Recent Legislation

Social Security Act's Section 1115 Demonstration Waiver

- Use of the Social Security Act's Section 1115 Demonstration Waiver Authority to Increase Access to Traditional Medicine: Under the Biden-Harris administration, the Centers for Medicaid and Medicare Services (CMS) approved four section 1115 demonstration waivers for Arizona, California, New Mexico, and Oregon that explicitly expanded access and coverage through Medicaid and CHIP for traditional care for AI/AN communities.³¹
- In Arizona, New Mexico, and Oregon, the waivers allow anyone whose care is covered by Medicaid and CHIP and who are eligible to receive care through the Indian Health Service to receive traditional health care services. California's waiver currently only applies to IHS-eligible beneficiaries seeking care for substance use disorder (SUD) treatments. While this is far more limited than the other three states, this may still be an extremely beneficial alternative for pregnant AI/AN individual's seeking care for SUDs.
 - o Arizona: In July 2025 Gov. Katie Hobbs allocated \$100,000 in state funds in order to receive more than \$222 million in matching federal funds to support culturally traditional healing practices in the state for Native American communities.³² Many practitioners and beneficiaries in the state are hopeful for this opportunity to provide and receive care that is reimbursed.³³ They also see this as a way to ensure these practices continue to be passed on to the next generation. The scope of Arizona's waiver is broad and should encompass maternal health care.³⁴ Since this is relatively new development, analysis of the impacts and benefits to American Indian communities in AZ is ongoing.
 - o New Mexico and Oregon have also requested and received federal funding to implement this program. More research and evidence will be needed to understand how implementation is benefiting AI/AN practitioners and individuals.³⁵
 - o In January, Washington state's American Indian Health Commission requested that the state submit a similar waiver to allow Medicaid to cover traditional health care services for AI/AN individuals.³¹ This may be a hopeful indication that more states will consider coverage of traditional medicine for AI/AN populations.

Issues for Congress

1. Federal Recognition & Reimbursement Pathways

Create clear federal definitions for NA/AN and Native Hawaiian traditional maternal health services and practitioner types so CMS can authorize reimbursement across Medicaid/CHIP, Medicare, IHS, and TRICARE. Encourage state plan options and demonstrations to cover ceremony, traditional midwifery, herbal supports, and postpartum home- and community-based care with enhanced FMAP and streamlined billing codes.

2. Tribal Authority & Credentialing

Affirm tribal sovereignty to recognize and credential traditional practitioners and set scopes of practice for those who want to do this, without requiring alignment to exclusively medical licensure. Encourage portability of tribal credentials across Indian Health systems and state partners through creating a tribal compact.

3. Facility Integration & Investment

Fund ceremony-friendly spaces in hospitals and clinics, culturally safe birth rooms, community birthing centers, and healing gardens. Tie HRSA, IHS, USDA, and SAMHSA capital programs to cultural safety standards and operational manuals that accommodate ceremony and traditional supports created by NA/AN and Native Hawaiian communities.

4. Workforce, Education & Apprenticeships

Resource paid apprenticeships, elder/knowledge keeper stipends, and pipeline programs. Allow Title VII/VIII health workforce authorities and scholarship/loan repayment to include traditional practitioners, with community validation pathways in lieu of medicalized-only accreditation.

5. Research, Evidence & Knowledge Protection

Fund community-led research on NA/AN and Native Hawaiian maternal outcomes of traditional care with informed consent. Require federal research programs to accept community evidence and qualitative outcomes. Establish protections against misappropriation of sacred knowledge and ensure benefit-sharing when research involves ancestral practices.

6. Civil Rights, Cultural Safety & Non-Discrimination

Enforce and strengthen federal nondiscrimination standards, Section 1557, to include cultural safety in maternity settings. Require hospitals receiving federal funds to accommodate ceremony, traditional attendants, and kinship support.

7. Coverage of Travel, Doulas & Home-Based supports

Encourage parity for community-based care delivered outside facilities, to also include postpartum home visiting by traditional practitioners.

8. Maternal Mental Health & Substance Use Integration

Ensure maternal mental health and SUD programs through grants and coverage, explicitly fund traditional healing modalities, peer circles, and land-based therapies, with warm handoffs between medical and cultural care.

9. Create a federal task force

Between agencies and inclusive to community cultural health experts to align funding and evaluation. Require annual reporting to Congress on access, outcomes, and cultural safety metrics for traditional maternal health care.

10. Measurement, Reporting & Oversight

Mandate inclusion of cultural safety, trust, language transmission, and community-defined wellbeing in federal maternal health dashboards. Commission studies on reimbursement barriers, and OIG guidance to prevent program integrity actions from legitimate traditional practice.

11. Emergency Preparedness & Continuity of Ceremony

Ensure federal emergency and public health preparedness programs protect access to ceremony, sacred sites, and essential materials (including traditional medicines) during disasters, with procurement and logistics plans developed alongside communities.

12. Procurement & Community Ownership

Prioritize grants and contracts to tribal governments, Native-led and community-based organizations for traditional maternal health programs. Encourage cooperative ownership models and local supply chains for perinatal herbal supports and foods.

Summary Recommendations

- Traditional maternal health practices should be resourced, protected, and recognized as core components of the perinatal continuum. This means creating sustainable funding streams like grants, contracts, and reimbursement pathways that compensate traditional healers, midwives, and cultural practitioners for prenatal, birth, and postpartum care, as well as for ceremonies and protocols that maintain maternal and infant wellbeing.
- Policy definitions and clinical standards should explicitly name ceremony, cultural protocols, and community-based supports (ex: placenta protocols, herbal medicine, massage and bodywork traditions, and conflict-resolution protocols) as covered, quality care - not as “extras.”

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- Remove regulatory barriers that criminalize or marginalize Native American, Alaska Native and Native Hawaiian traditional midwives; create licensure/recognition paths that are community-governed and culturally grounded.
 - In parallel, health systems should invest in community infrastructure that rebuilds trust-healing clinics, women's circles, community gardens, apprenticeships, and intergenerational teaching spaces, so knowledge is transmitted and families can access care close to home.

Community Engagement & Governance

- Authentic governance starts with elders, midwives, and knowledge keepers leading-formally and continuously
 - Establish Native American, Alaska Native and Native Hawaiian standing councils that co-design programs, set priorities, and oversee implementation in clinics, hospitals, and community settings.
 - Their guidance should shape the layout of ceremony-friendly spaces that support prenatal visits and postpartum rituals.
- Implement a clear, community-led consent process for any use of ceremonial knowledge, practices, or data.
- Knowledge Protection Protocols: Adopt policies on intellectual property, data sovereignty, and non-disclosure to prevent exploitation of ancestral medicine and birth teachings.
- Create MOUs with tribal and community authorities to enable ceremony-friendly spaces, birth protocols, and on-call traditional practitioners.
- Require community review of outcomes, complaints, and quality metrics; tie funding to adherence with cultural safety standards.

Implementation Pathways

- Map, resources, and coordinate regional networks of traditional midwives/healers; fund apprenticeships to ensure knowledge transfer.
- Use Section 1115 authority to pay for traditional services across the perinatal continuum; align IHS/tribal facilities and state Medicaid billing codes.
- Develop standard operating procedures for ceremonies, herbal supports, and kinship-based care in clinics and hospitals; train staff in cultural safety and trauma-informed practice.
- Embed cultural care access in maternal health coverage
- Support dual-competency training for traditional and biomedical cross-referrals, and clinical privileges for traditional practitioners.
- Co-create evaluation with communities on maternal/infant outcomes, cultural safety, trust, language/cultural transmission, report back to the community through forums.
- Pursue state/federal recognition of traditional midwifery; reduce licensing burdens that require mainland pathways; protect NA/AN and Native Hawaiian cultural practice rights

in maternity care.

- Create a perinatal data registry that uses validated, context-specific metrics to capture maternal and neonatal health indicators, social determinants of health, and culturally relevant variables.

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