

Policy Brief

Building Systems of Care: Investment in Native Maternal Health Infrastructure

Trends and Opportunities in Indigenous Maternal Health Funding

October 2025

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Acknowledgments

We would like to extend our sincere appreciation to Roanhorse Consulting, who led the authorship of this report. Their culturally grounded expertise, thoughtful analysis, and commitment to uplifting the perspectives of American Indian, Alaska Native, Native Hawaiian, and or Other Pacific Islander communities shaped the foundation of this work. We are grateful for their partnership, and for the opportunity to contribute advisory guidance and editorial support throughout the development process.

Table of Contents

Acknowledgments	2
Executive Summary	6
<i>What Works.....</i>	<i>6</i>
<i>Call to Action.....</i>	<i>6</i>
Introduction.....	8
<i>Goals of the Maternal Health Care Funding Landscape Analysis</i>	<i>9</i>
Data Sovereignty	9
<i>Data</i>	<i>9</i>
<i>Challenges</i>	<i>10</i>
<i>Solutions</i>	<i>10</i>
Workforce Development.....	11
<i>Data</i>	<i>11</i>
<i>Challenges</i>	<i>12</i>
<i>Solutions</i>	<i>12</i>
Access to Educational Degrees.....	13
<i>Data</i>	<i>13</i>
<i>Challenges</i>	<i>13</i>
<i>Solutions</i>	<i>14</i>
Training Outcomes and Quality.....	14
<i>Data</i>	<i>14</i>
<i>Challenges</i>	<i>14</i>
<i>Solutions</i>	<i>15</i>
Policy and Funding.....	15
<i>Data</i>	<i>15</i>
<i>Challenges</i>	<i>15</i>
<i>Solutions</i>	<i>16</i>
Landscape Analysis & Survey Findings.....	17
<i>Executive Summary</i>	<i>17</i>
<i>Methods and Data Sources</i>	<i>18</i>

<i>Evidence</i>	18
Spotlight.....	19
<i>Interpretation</i>	19
Implications and Recommended Actions	19
Case Study Summary: Indigenous-Led Maternal Health Innovations	20
<i>Policy and Governance</i>	22
<i>Funding and Reimbursement Reform</i>	22
<i>Workforce Development and Credentialing</i>	23
<i>Data Sovereignty and Equity</i>	23
<i>Infrastructure and Access</i>	23
<i>Inclusion and Visibility</i>	23
<i>Cultural Revitalization and Narrative Change</i>	23
Conclusion	23
<i>Key Findings</i>	24
<i>Insights and Implications</i>	24
<i>Recommendations</i>	24
Appendix A: Expanded Tables and Data	26
<i>Barriers and Solutions for Tribal Data Sovereignty</i>	26
<i>Barriers and Solutions for Workforce Development</i>	30
<i>Barriers and Solutions for Access to Educational Degrees and Training</i>	35
<i>Barriers and Solutions for Policy and Funding</i>	40
Appendix B: Example of “Next Steps”	44
<i>Immediate (30–90 Days): Laying the Foundation</i>	44
<i>Short Term (3–12 Months): Implementing and Learning</i>	44
<i>Medium Term (12–36 Months): Scaling and Institutionalizing Success</i>	44
Appendix C: Comparable Models	46
Appendix D: Funding Comparison	48
<i>Public (Federal and State)</i>	48
<i>Private (Philanthropy, Corporate, Local donors)</i>	48
<i>Key Funders and Intermediaries in AI/AN MCH Landscape (2020–2025)</i>	49
<i>Key Funders and Intermediaries in Native Hawaiian MCH Landscape (2020–2025)</i>	52

<i>References</i>	53
Appendix E: Case Study Details	55
Appendix F: Innovative Models in Indigenous Maternal Health	56
Appendix G. Maternal Health Legislation Summary (2025–2030)	59
Appendix H. Full List of Solutions & Recommendations	61
<i>Data Sovereignty</i>	61
<i>Workforce</i>	61
<i>Maternal Mortality</i>	62
<i>Access to Education</i>	63
<i>Policy and Funding</i>	63
Appendix I: Leveraging CMS	65
<i>Objective</i>	65
<i>Key Policy Asks</i>	65
<i>Immediate Implementation Steps</i>	65
<i>Metrics and Equity Safeguards</i>	65
<i>Risks and Mitigations</i>	66
References	67

Executive Summary

This report is written to (1) illuminate systemic funding challenges and emerging opportunities within maternal health systems serving Native communities and (2) propose actionable ideas for policymakers, tribal leaders, and funders. This research examines maternal health funding patterns from 2020 to 2025, with a focus on availability, eligibility, allocations, timelines, and scarcity—and how these factors shape opportunities to address maternal mortality in American Indian, Alaska Native (AI/AN), and Native Hawaiian or Other Pacific Islanders (NHOPI) communities; however, despite the expansive nature of these initiatives, many lacked the sustained commitment necessary to support long-term impact within tribal contexts. Notably, this report’s research and development phase occurred shortly after the passage of the One Big Beautiful Bill Act (OBBBA) and during the early phase of the federal government shutdown. The full implications of these events remain to be seen within the maternal health realm.

What Works

Indigenous-governed models integrating midwifery, traditional practices, and cohort-based workforce pipelines show “rapid” uptake. Blending philanthropic seed funding pilots and public reimbursement pilots allows culturally essential services (e.g., elder stipends, ceremony support, apprenticeship stipends) to scale into durable programs when matched by federal streams or Medicaid. Telehealth and mobile services reduce travel burdens where broadband and bill access are available.

To advance equitable maternal health outcomes in Native communities, funders must (1) adopt trust-based, long-term investment strategies; (2) uphold tribal data sovereignty and support culturally sovereign care models; (3) develop evaluation approaches rooted in cultural measures; (4) reform Medicaid and licensure path in ways to reimburse Traditional Practitioners, doulas, and community midwives via state amendments, 1115 waivers, or demonstration pilots.

Call to Action

Native health organizations—including the National Indian Health Board and the National Council of Urban Indian Health—have called for a transformative investment of \$51.4 billion over 10 years to fully fund the Indian Health Service (IHS) (National Indian Health Board, 2025 and National Council of Urban Indian Health, 2025). This includes a mandatory annual baseline of \$9.7 billion, with \$2 billion increases each year to close the persistent gap between need and appropriation (NIHB and NCUIH, 2025). We urge practitioners, policymakers, philanthropic funders, tribal leaders, and organizations to consider the following:

- Chronic underfunding and fragmentation of federal programs:
 - In FY 2025, IHS received approximately \$8.2 billion, translating to an estimated

\$3,154 per capita—a decrease from \$4,078 per capita in 2017 (Warne & Wescott, 2023).

- Inflexible grant structures misaligned with Indigenous values:
 - Health inequities stem from policies and systems that do not fairly distribute or provide access to resources (Ore et al., 2018).
- Lack of visibility and inclusion in national maternal health initiatives:
 - See Appendix G. These programs demonstrate that Indigenous-led maternal health systems are not only visionary—they are already working.
- Workforce development gaps and credentialing barriers:
 - AI/AN individuals make up 0.4% of physicians (U.S.), 0.3% of registered nurses, and <0.1% of mental health professionals.
 - NHOPI representation is similarly low, making up <1% of physicians and nurses, with limited visibility in leadership and academic roles.
- Structural determinants (housing, transportation, food) deeply impact care:
 - Indian Health Service (IHS) is funded at only 49% of its actual need.
 - Many Tribal and NHOPI communities are excluded from Medicaid waivers and managed care pilots that fund SDOH interventions.

Introduction

Native communities face disproportionately high maternal mortality rates, with about 700 deaths per year from pregnancy-related complications (Maykin & Tsai, 2020). While most of the deaths could have been prevented, maternal health overall has declined, where AI/AN people are 2.3 times more likely to die compared to non-White Hispanic people (Maykin & Tsai, 2020). And NHOPI women in Hawaii face similar risks as Black women nationally (Maykin & Tsai, 2020). The Hawaii Maternal Mortality Review Committee found that from 2015–2017, twenty-five maternal deaths occurred, and of those twenty-five, 44% or 11 deaths were from Native Hawaiian or Other Pacific Islander communities (NHOPI) (Maykin & Tsai, 2020). Despite global advancements, the U.S. reports one of the highest maternal mortality ratios among high-income countries—26.4 deaths per 100,000 live births—even as the U.S. invests more per capita in health care than any other nation. It has one of the highest maternal mortality rates among high-income countries (Celaya et al., 2024).

These disparities are rooted in systemic discrimination, historical trauma, and structural barriers such as poverty, lack of health insurance, limited access to culturally responsive care, and geographic isolation (Maykin & Tsai, 2020). Historical injustices—including forced sterilization and child separation—have fostered deep mistrust in health care systems, including the Indian Health Service (Warne). Social determinants of health (SDOH)—limited maternal care centers, language barriers, housing instability, transportation challenges, and exposure to violence—further compound risks. Rural AI/AN women face even greater challenges than their urban counterparts (Celaya et al., 2024).

Non-obstetric causes of maternal death—such as motor vehicle accidents, substance use, homicide, and suicide—are often overlooked in maternal health strategies, despite disproportionately affecting AI/AN and Black, including NHOPI women (Huang et al., 2024). Stressful life events (SLEs), including financial hardship and partner-related conflict, are more prevalent among AI/AN women and are linked to adverse birth outcomes (Rokicki et al., 2023). Emerging research suggests that even modest policy changes, such as increasing the minimum wage, could reduce the burden of SLEs and improve maternal health outcomes (Rokicki et al., 2023)

Despite these urgent concerns, Native communities remain underrepresented in national maternal health initiatives, and culturally grounded interventions are rarely documented in academic literature (James et al. 2021). This report aims to address these gaps by examining the structural, cultural, and policy dimensions of maternal health inequities—and by promoting Indigenous-led models of care centered in sovereignty, resilience, and community-defined wellness.

Goals of the Maternal Health Care Funding Landscape Analysis:

Map the maternal health funding landscape.

- Analyze financial flows across federal, state, and philanthropic sources.
- Assess how funding patterns shape availability, accessibility, and quality of care serving Native communities.

Identify gaps in culturally integrated care.

- Highlight maternity care infrastructure deficits, including reduction of facilities and underrepresentation of culturally integrated services.
- These gaps are compounded by systemic barriers to access and the underrepresentation of Indigenous care models.
- Differentiate between culturally informed and culturally sovereign approaches (e.g., midwifery-led care, doula-focused support, and advocacy-driven strategies).

Define a “gold standard” for Indigenous maternal health systems.

- Promote culturally sovereign, midwifery-integrated, and policy-driven models, supported by scalable and sustainable funding mechanisms.
- Advocate for wraparound services, improved reimbursement processes, and robust workforce development.

These goals aim to clarify systemic barriers, surface effective Indigenous-led practices, and provide a roadmap for shifting maternal health systems toward equity, sustainability, and cultural sovereignty.

Data Sovereignty

Data

- Key facts: Indigenous nations have sovereign authority over the collection, ownership, and use of their health data; Tribal Epidemiology Centers received \$6.8 million (2022–2026) to support 12 IHS areas and Urban Indian Organizations; Center for Disease Control and Prevention committed \$58.9 million (2023–2028) for 34 tribes to strengthen public health systems (CDC, 2025).
- Data gaps: Misclassification affects up to 30% of public records (Urban Indian Health Institute, n.d.); only 3 states had formal data-sharing agreements as of 2022; 0.4% of federal evaluation contracts went to tribes (2012–2022) (NDN Collective & Third Plateau Social Impact Strategies, 2024).
- Funding snapshot: Philanthropic flows to Native communities are tiny (~0.36% of U.S. foundation giving). Federal funding initiatives often lack explicit allocations tied to Indigenous governance.

Challenges

- Data erasure through aggregation: Misclassification and aggregation that hide AI/AN/NHOPI outcomes.
- Fragmented investment in sovereign data systems: Funding for Indigenous data sovereignty efforts remains fragmented and underreported across federal, state, philanthropic, and tribal sectors (NDN Collective & Third Plateau Social Impact Strategies, 2024).
- Structural barriers to tribal-led evaluation: Low tribal capacity for evaluation because of underfunded infrastructure and few awarded evaluation contracts.
- Under resourced governance in Native-led initiatives: Native-run organizations often rely on a mix of federal grants, tribal resources, and philanthropic support to advance data governance, but these efforts are typically underfunded and project-based.
- Federal oversight gaps for NHOPI visibility: Recognition bias that leaves Native Hawaiians and Pacific Islanders invisible in some federal announcements.

Solutions

- Sustain long-term tribal data infrastructure: Allocate multi-year, unrestricted funding for tribally governed data systems and Indigenous-led evaluation.
- Mandate sovereignty in funding agreements: Require tribal consultation and data-sovereignty clauses in federal and philanthropic awards.
- Build capacity for community-based research: Fund TECs, tribal institutional review boards and community research collaboratives (space, staff, tech, training).
- Design secure, interoperable tribal platforms: Create interoperable, co-designed data platforms with privacy protocols and tribal governance.
- Center cultural indicators in evaluation frameworks: Embed Indigenous-defined metrics (ceremony participation, family involvement, cultural wellbeing) into reporting and dashboards.
- Empower tribal advocacy for data governance: Fund tribal policy staff and coalitions to advocate for data-sharing agreements and governance reforms.

Data sovereignty in maternal care is both a right and a strategic imperative—affirming Indigenous self-determination and strengthening culturally responsive health systems. For AI/AN/NHOPI communities it means the inherent authority of Indigenous nations to govern the collection, ownership, and application of their own health data (First Nations Development Institute, 2023), an authority that stems from their status as sovereign nations and is embedded in federal policy, treaties, and a legacy of advocacy by Tribal and Native leaders (NIHB, 2024).

Sovereign data practices empower communities to define success on their own terms—integrating public health with cultural teachings and addressing social, environmental, and cultural determinants of maternal health rather than focusing on narrowly tracked clinical indicators (First Nations Development Institute, 2023; Rhodes et al., 2024). Institutional

infrastructures often obscure these nuances, pooling complex realities into generalized categories that limit innovation and meaningful analysis.

First Nations Development Institute (2023) identifies that power and paternalistic funding practices are ingrained in funding practices at both a public and private level, which is evident in pre-determined evaluation and reporting requirements, extending program ownership, outcomes, and their respective data. Collaborations must reject research models that do not center Indigenous governance and lead toward long-term, respectful engagement. Investing in Indigenous data capacity through community-led training offers a sustainable, culturally aligned path to maternal health equity and reduces reliance on outside-directed projects (First Nations Development Institute, 2023)

Practical models of self-governance—Tribal IRBs, culturally aligned metrics, and data-sharing agreements—enable metrics that merge clinical indicators with cultural markers such as ceremony participation and family involvement (First Nations Development Institute, 2023). Across the country, Indigenous networks, TECs, and national organizations are tracking integrated maternal outcomes and advocating for increased funding, training, and technical assistance for tribal and Native Hawaiian health systems (NCUIH, 2025). Maternal mortality prevention efforts will continue with the Southern Plains Indian Health Board, Northwest Portland Area Indian Health Board, Chickasaw Nation, and Wabanaki Health and Wellness, to name a few recipients funded by the CDC (Centers for Disease Control and Prevention, 2025).

Workforce Development

Data

- Provider roles referenced: Midwives, doulas, lactation consultants, physicians, nurses, social workers, behavioral health and addiction counselors (Heck et al., 2021; March of Dimes, 2024).
- Workforce projection: By 2037 a projected surplus in some maternal health nurse specialties shortages in family/internal medicine and OB/GYN as the population of women of childbearing age rises by ~3.4 million (HRSA, 2024).
- Program examples of billable integration: States with billable traditional healing or community birthworker models include California, Arizona, New Mexico, and Oregon (National Council of Urban Indian Health, 2023).
- UIO staffing-needs example: Urban Indian Organizations report that 3–5 full-time traditional healing practitioners are needed to meet demand (National Council of Urban Indian Health, 2023).
- Workforce data gaps noted: Limited granular workforce mapping by IHS region or tribal geography as well as the need for data linking workforce shortages to maternal outcomes (National Center for Health Workforce Analysis, 2024).

Challenges

- Supply and distribution: Persistent shortages across the care continuum and geographic maldistribution in rural, tribal, and island communities (Petersen et al., 2019; March of Dimes, 2024).
- Pipeline and accreditation barriers: Narrow degree pathways, accreditation hurdles for tribal colleges and Indigenous midwifery programs that limit clinical placements and reimbursement (Hassanein, 2025; Forrest, 2022).
- Retention and burnout drivers: Housing instability, low pay, lack of ongoing training, and limited infrastructure contribute to turnover and reduced capacity (Heck et al., 2021; National Center for Health Workforce Analysis, 2024).
- Credentialing and reimbursement misalignment: Medicaid and payer rules frequently exclude Traditional Practitioners and community midwives, creating billing obstacles for culturally grounded services (National Council of Urban Indian Health, 2023).
- Regulatory fragmentation: State licensure models and lack of licensure reciprocity impede mobility and recognition of tribal credentialing systems (Jain et al., 2018).
- Funding instability: Short-term grants and project funding prevent multi-year workforce investments and sustainable career pathways (NDN Collective & Third Plateau, 2024).

Solutions

- Invest in culturally grounded training: Fund tribal midwifery schools, cohort-based doula/apprenticeship programs, and intergenerational mentorship (HRSA/tribal compacts).
- Strengthening retention and incentives: Provide multi-year retention stipends, housing support, wellness and self-care packages, and guaranteed stipends for rural placements.
- Align licensure and reimbursement: Advocate for state licensure reciprocity, federal recognition of tribal credentialing, and Medicaid/Centers for Medicare and Medicaid rules that reimburse Traditional Practitioners and community midwives.
- Create clinical placement partnerships: Formalize placement agreements between tribal clinics, birth centers, and academic institutions with funded preceptor salaries.
- Expand scholarships and continuing education: Establish dedicated scholarship funds, salary subsidies, and continuing education unit funding integrating cultural and clinical competencies.
- Leverage third-party incentives: Use CMS waivers, Health Resources and Services Administration rural grants, and private payer incentive programs tied to facility upgrades and community-defined standards.
- Invest in workforce data and planning: Fund tribally governed workforce-mapping and evaluation to target pipeline investments and link staffing to outcomes.
- Fund operating support for UIOs and Traditional Practitioners: Provide flexible, multi-year philanthropic and public operating grants to cover ceremonial materials, land access, and staff capacity (NCUIH, 2023).

Patients and their families depend intensely on the expertise and experience of health care and community workers to ensure they have a safe pregnancy and receive care that honors their

cultural backgrounds. However, workforce shortages persist across the entire continuum of

care—from administrative staff who schedule appointments to highly specialized providers—resulting in a lack of coordinated health care and social services that contribute to pregnancy-related mortality (Petersen et al., 2019).

When appropriate provider-to-patient ratios are met, maternal care can reduce disparities across regions and uplift outcomes for communities most impacted by systemic gaps (March of Dimes, 2024). For tribal nations and Indigenous communities, conducting thorough assessments and establishing clear standards can illuminate why addressing workforce gaps is essential—especially in areas where culturally adapted care models can make the most significant impact (Hect et al., 2021). Understanding and implementing these solutions demands funding at every level, from individual support to broader environmental investments that sustain cultural healing.

Access to Educational Degrees

Data

- Scope and impact: Accreditation barriers and limited degree pathways prevent tribal and community programs from achieving formal recognition, restricting clinical placements and reimbursement needed to sustain local perinatal care (Hassanein, 2025). Native Hawaiian and Pacific Islander prenatal engagement is among the lowest nationally, with disproportionate maternal deaths and documented problems in patient to clinician communication and perceived discrimination (Delafield, 2024; Kozhimannil, 2020).
- Recruitment shortfalls impact AI/AN physicians: Only 0.2% of medical school graduates in recent years identified as AI/AN.
- Licensure portability and reciprocity: Delays in credentialing can take 3–6 months, disproportionately affecting providers in underserved areas (National Council of State Boards of Nursing NCSBN, 2021).

Challenges

- Accreditation and recognition hurdles: Tribal-led curricula and Indigenous midwifery models often fail to meet conventional accreditation frameworks, limiting degree conferral and billing eligibility (Hassanein, 2025).
- Limited mentorship and faculty representation: Few AI/AN mentors and faculty slow pipeline development and perpetuate underrepresentation in clinical education (Forrest, 2022).
- Logistical and financial barriers for students: Living costs, childcare, travel, and broadband constraints hinder enrollment and completion, especially for rural and island students (Coombs et al., 2022).
- Credentialing to reimbursement gap: Even where training exists, states and Medicaid programs may not reimburse Traditional Practitioners or community doulas, undermining employment pathways (National Indian Health Board, 2025).

- Geographic and institutional barriers: Tribal Colleges and Universities (TCUs) and NHOPI-serving institutions are underfunded and often lack accredited health programs (NCSBN, 2021; U.S. DHHS, 2023).

Solutions

- Tribal sovereignty in education: Fast-track recognition of tribal-accredited programs and establish multi-year training hubs on or near tribal lands (National Indian Health Board, 2025).
- Strengthen intergenerational healing: Fund degree pathways and practical training for doulas, midwives, lactation consultants, behavioral health providers, Traditional Practitioners, and physicians with flexible, multi-year mechanisms co-designed with tribes (National Indian Health Board, 2025).
- Improve access to remote learning and telehealth: Expand scholarships, living stipends, and wraparound supports that address housing, childcare, and broadband needs (National Indian Health Board, 2025).
- Traditional healing reimbursement: Align payer policy so CMS/Medicaid reimburse Traditional Practitioners and community labor support via state plan amendments or 1115 waivers (National Indian Health Board, 2025).
- Meet cultural safety training opportunities: Create clinical placement agreements that guarantee culturally safe training sites and supervision (National Indian Health Board, 2025).

Training Outcomes and Quality

Data

- Influence on care quality: Racial and ethnic alignment between patients and clinicians correlates with higher satisfaction, better communication, and greater preventive service use, which are linked to improved maternal outcomes (Forrest, 2022). Programs that pair cultural knowledge with clinical safety (e.g., tribally governed midwifery curricula) show higher community uptake and cultural continuity (Changing Woman Initiative; Appendix E).

Challenges

- Evaluation and sustainability: Short funding cycles and lack of tribally governed evaluation undermine ability to demonstrate long-term outcomes and secure public reimbursement (National Indian Health Board, 2025).
- Credentialing vs. cultural competence tension: Standardized accreditation may undervalue Indigenous epistemologies, creating a tradeoff between formal recognition and cultural fidelity (Hassanein, 2025).

Solutions

- Center cultural indicators in accountability systems: Embed Indigenous-defined metrics (ceremony participation, family involvement, community-defined wellness) into evaluation frameworks and funding requirements (First Nations Development Institute, 2023; Appendix H).
- Stabilize training programs with long-term support: Provide multi-year operating support to training programs to allow time for outcome demonstration and policy translation (NDN Collective & Third Plateau, 2024).
- Advance dual knowledge credentialing pathways: Support tribally governed credentialing pathways that honor traditional knowledge alongside clinical competencies (National Indian Health Board, 2025).

Policy and Funding

Data

- Federal legal context: Snyder Act (1921); Transfer Act (1954); Indian Self-Determination and Education Assistance Act (1975); Indian Health Care Improvement Act (1976, amended 2010) establishes the statutory frame for AI/AN health services and historical centralization of IHS delivery (Warne & Frizzell, 2014).
- Distinct legal statuses: Native Hawaiians and Pacific Islanders face different recognition and eligibility pathways that reduce access to some federal protections and funding (Kauanui, 2008; CMS, 2024; NILC, 2023).
- Funding landscape: Public funds (Title V of the Public Health Service Act, IHS Maternal Child Health HRSA, CDC, SAMHSA) are the largest potential scale but carry clinical/bureaucratic constraints, while philanthropic dollars provide cultural flexibility but are small and time-limited (Native Americans in Philanthropy, 2023; IFIP, 2020).
- Program and budget signals: Recent calls and appropriations activity (e.g., \$274 million request from 19 AI/AN organizations; CDC cooperative agreements) shape near-term funding risk and opportunity (Jomia, 2025; CDC, 2025).

Challenges

- Fragmentation across agencies and payers:
 - Multiple federal agencies fund overlapping maternal health activities without consistent tribal coordination, creating administrative burden and care fragmentation (Jomia, 2025).
 - U.S. insurance churn across Medicaid, ACA marketplaces, employer plans, and IHS disrupts continuity of prenatal/postpartum care (Rosenbaum, 2015).
- Inflexible, short-term funding:
 - Time-limited, project-specific grants hinder workforce stability, cultural program development, and facility upgrades (NDN Collective & Third Plateau, 2024).

- Legal and recognition gaps:
 - Native Hawaiian and Pacific Islander exclusion from some AI/AN-specific exemptions and protections creates inequitable access to program benefits (Kauanui, 2008; NCUIH, 2025).
- Reimbursement, licensure, and billing barriers:
 - Medicaid and CMS rules frequently exclude Traditional Practitioners, community midwives, and birth worker billing pathways, limiting sustainable revenue (Hassanein, 2025; National Council of Urban Indian Health, 2023).
- Data invisibility and governance deficits:
 - Misclassification, lack of tribal data-sharing agreements, and limited tribal-directed evaluation reduce visibility and weaken funding cases (Walter et al., 2023; First Nations Development Institute, 2023).
- Philanthropic scale and restrictions:
 - Philanthropy seeds innovation but is a small share of total giving to Native communities (0.36% of U.S. foundation giving) and often imposes restrictive timelines and eligibility (Native Americans in Philanthropy, 2023).

Solutions

- Policy reforms:
 - Expand Medicaid/CMS reimbursement for Traditional Practitioners, doulas, and community midwives via state plan amendments, 1115 waivers, and explicit CMS guidance (Hassanein, 2025).
 - Require tribal consultation and tribal eligibility in federal maternal health cooperative agreements and surveillance programs (Jomia, 2025).
 - Create statutory recognition pathways or administrative fixes to reduce Native Hawaiian and PI exclusion in relevant maternal health statutes (Kauanui, 2008).
- Funding design:
 - Shift to multi-year, flexible operating grants (3–5+ years) and reduce restrictive reporting requirements (NDN Collective & Third Plateau, 2024).
 - Build blended financing pilots pairing philanthropic anchors with Medicaid/state demonstration billing for doulas, midwives, and telehealth.
 - Establish dedicated HRSA/CDC/NIH funding streams for Indigenous-led MCH research and infrastructure with embedded tribal governance.
- Reimbursement & operational levers:
 - Standardize hospital IHS/Tribal Purchased Referred Care (PRC) playbooks and Care Coordination Agreements to facilitate 100% Federal Medical Assistance Percentage mechanics and received-through models (CMS policy levers).
 - Integrate tribal partners into CMS Transforming Maternal Health Model design and state APMs to include Tribal shared-savings/risk components.
- Data & governance:
 - Fund tribal data infrastructure, TECs, and tribal IRBs. Adopt community-defined metrics and data-sharing agreements as grant conditions (First Nations Development Institute, 2023).

- Prioritize disaggregated AI/AN/NHOPI reporting and fund tribally led evaluation to strengthen evidence for public investment (Walter et al., 2023)
- Philanthropic practice shifts:
 - Encourage trust-based philanthropy with multi-year, unrestricted operating support, simplified applications, and co-designed criteria with tribal leaders (Jomia, 2025).
 - Use philanthropic seed funds as a match for public capital to finance facility upgrades, telehealth infrastructure, and workforce stipends.

Decisions made in federal law and administrative policy have shaped a system that often favors centralized program delivery and short-term project funding over community-controlled, culturally grounded maternal care (Warne & Frizzell, 2014). Different legal and eligibility frameworks for Indigenous groups produce uneven access to federal programs and practical barriers for Native Hawaiian and Pacific Islander communities in particular (Kauanui, 2008; CMS, 2024; NILC, 2023). Multiple agencies and separate funding streams create overlapping initiatives that increase administrative burden for tribal and community organizations and fragment service delivery (Jomia, 2025). Movement across coverage types—Medicaid, marketplace plans, employer insurance, and Indian health programs—causes coverage churn that interrupts prenatal and postpartum continuity of care (Rosenbaum, 2015). Predominant reliance on time-limited, project-specific grants and limited philanthropic scale undermines workforce stability, facility investment, and culturally essential program elements, constraining the ability of Indigenous-led models to scale and sustain impact (NDN Collective & Third Plateau, 2024). Addressing these problems requires harmonized eligibility and reporting, durable flexible funding, and payment reforms that support community-based practitioners and tribal systems so culturally aligned care can be reliably delivered and sustained (Jomia, 2025; Warne & Frizzell, 2014).

Landscape Analysis & Survey Findings

Executive Summary

- Purpose: We reviewed two datasets that analyzed patterns in program design, cultural integration, funding flows, and systemic barriers affecting American Indian, Alaska Native, and Native Hawaiian (AI/AN/NHOPI) maternal health.
- Top takeaways: (1) Cultural sovereignty improves outcomes, (2) workforce investment is the primary leverage point, (3) funding is fragmented and unstable, (4) telehealth is effective but underfunded, and (5) policy and data gaps block scale.

- Action focus: Pair philanthropic seed funding with public reimbursement reforms, invest in paid workforce pipelines, and require co-designed evaluation and tribal data governance.

Methods and Data Sources

- Datasets used: Two primary datasets comprising national and state-level program inventories, funder responses, policy backbones, and detailed program data.
- Analytic scope: Focus on models (e.g., birth centers, midwifery, doulas, telehealth), funding sources (e.g., federal, state, philanthropic), workforce development, data governance, and maternity care deserts.
- Landscape tools: Regional profiles derived from the spreadsheets that revealed reimbursement disparities, access gaps, and cultural integration gradients. States included were selected for higher AI/AN/NHPI population counts and to surface billing pathway gaps needed to secure a sustainable birthworker workforce.

Evidence

- Access gaps and service delivery:
 - Maternity deserts: Access gaps were represented by data designated as “maternity deserts.” These were concentrated in rural and tribal jurisdictions.
 - Service mitigations: Some programs implemented telehealth and patient navigator roles to reduce travel burdens. Broadband limitations and telehealth billing constraints limited impact.
- Funding landscape:
 - Funding comparison: See Appendix A for detailed tables.
 - Stability and fragmentation: Funding is fragmented and unstable. Reliance on short-term philanthropic grants and inconsistent public funding leaves Indigenous maternal health programs vulnerable and unable to scale.
- Workforce and cultural integration:
 - Cultural sovereignty outcomes: Indigenous-governed programs (e.g., birth centers and birthworker collectives) deliver cultural transmission, language use, ceremonies, and community trust alongside clinical services.
 - Workforce leverage point: Cohort-based doula and birthworker training with paid apprenticeships consistently increases local capacity and cultural continuity.
- Telehealth and technology:
 - Effectiveness: Telehealth programs reduced travel and time burdens.
 - Barriers: Telehealth billing rules, inadequate broadband, and reimbursement gaps limited program reach and sustainability.
- Policy and data:
 - Policy barriers: Medicaid exclusions, state licensure models incompatible with community midwifery, and billing complexity prevent pilot-to-scale transitions.
 - Data & evaluation gaps: Lack of disaggregated AI/AN/NHPI data and absent tribal data governance slow evidence-building and hinder policy and funding advocacy.

Spotlight

Cultural sovereignty and workforce investment are primary levers. Indigenous governance produces broader cultural and clinical outcomes, while paid cohort-based training with apprenticeships builds sustainable local capacity.

Interpretation

- Relationship between culture and scale: Programs that center Indigenous governance achieve cultural transmission and community trust while delivering clinical care, indicating that scalability without cultural safeguards undermines outcomes.
- Funding as an enabler and bottleneck: Philanthropic seed funding supports culturally essential start-up costs but cannot substitute for durable public reimbursement mechanisms needed for scale.
- Workforce as system foundation: Reliable, paid pipelines that integrate elder knowledge with clinical training reduce burnout and increase retention. Volunteer-dependent models fail to sustain long-term services.
- Technology as conditional enabler: Telehealth can extend access but depends on parity in billing and reliable broadband to be an effective, scalable solution.
- Data as prerequisite for advocacy: Disaggregated data and tribal-led governance over evaluation are required to build evidence that unlocks larger public investments.

Design Implication:

- Match scalability to cultural fidelity. System integration should require tribal governance and explicit cultural safeguards.

Funding Implication:

- Pair philanthropic seed funding with public mechanisms such as Medicaid and state perinatal bundles to create durable revenue streams.

Workforce Implication:

- Invest in paid training pipelines that honor elder knowledge and clinical prerequisites. Fund apprenticeships and cohort models rather than relying on unpaid volunteer labor.

Policy Implication:

- Prioritize targeted Medicaid policy changes: doula reimbursement; birth center payment models; and telehealth parity to convert pilots into scalable programs.

Evaluation Implication:

- Require co-designed evaluation frameworks and tribal data governance as conditions for funding and policy decisions to ensure ethical evidence-building and to unlock public investments.

Case Study Summary: Indigenous-Led Maternal Health Innovations

Three Indigenous-led initiatives—Changing Woman Initiative (New Mexico), Pacific Birth Collective (Hawaii), and Hummingbird Indigenous Family Services (Seattle)—demonstrate scalable, culturally sovereign models of maternal health care that address systemic gaps in access, trust, and outcomes for Native communities.

Changing Woman Initiative renews traditional Navajo midwifery and birth knowledge to restore community-centered perinatal care. Its services span midwifery, workforce training, cultural revitalization, and healing spaces. By rebuilding local birth worker pipelines and integrating traditional knowledge with clinical safety practices, the initiative improves care-seeking, reduces travel-related risks, and lowers maternal morbidity. Despite strong community demand and culturally sovereign leadership, short-term philanthropic grants and Medicaid reimbursement barriers threaten sustainability. Funders are urged to provide multi-year operating support, fund apprenticeship programs, and invest in policy advocacy to secure reimbursement and credential recognition. Example below:

Measurable outcomes (baseline → targets):

- Clients served: 100+ served (baseline); Target Year 1: +25%; Year 3: +75%.
- Travel/time burden: miles/time to care reduced (ROAM proxy measure); Target Year 1: 20% reduction.
- Workforce: local apprentices trained; baseline: full initial cohort; Target retention at 12 months: 80%.
- Financial sustainability: % budget from public reimbursement; baseline: 0–10%; Target Year 3: 30%.
- Cultural metrics: ceremony participation rate; baseline: program reports; Target Year 1: 60% participation.

Replication guidance (priority 3 steps):

1. Launch paid apprenticeship with elder mentorship and clinical preceptorship (seed philanthropy for stipends).
2. Secure Medicaid demonstration/billing pilot with state Medicaid (assign Billing & Policy Navigator).
3. Create tribal-governed credentialing pathway and data governance agreement.

Pacific Birth Collective offers island-wide, Indigenous-led birth and postpartum care through mobile units, subsidized services, and emergency response support. It fills urgent access gaps in disaster-affected and geographically isolated areas, while advocating for birth sovereignty and midwifery rights. The collective’s direct-service subsidy model and volunteer practitioner

network reduce barriers to culturally congruent care. However, legislative restrictions and limited public reimbursement mechanisms pose challenges. Funders can strengthen impact by supporting mobile infrastructure, paid practitioner pools, and policy campaigns to decriminalize traditional midwifery and expand Medicaid reimbursement. Example below:

Measurable outcomes (baseline → targets):

- Mobile clinic appointments: baseline appointments recorded; Target Year 1: +20 appointment
- Postpartum follow-up: baseline follow-up rate; Target Year 1: increase by 25%.
- Emergency response time: baseline; Target Year 1: reduce median response time by 15%.
- Financial sustainability: percent revenue from public reimbursement; baseline low; Target Year 3: achieve 25%.
- Cultural metrics: client-reported cultural safety score; Target Year 1: +15% improvement.

Replication guidance (priority 3 steps):

1. Capital grant for mobile unit + telehealth kit deployment.
2. State Medicaid waiver or 1115 demonstration to enable reimbursement for mobile and island outreach.
3. Formalize partnerships with local hospitals for emergency transfers and teleconsultation.

Hummingbird Indigenous Family Services provides full-spectrum doula care, guaranteed basic income (GBI), home visiting, and mental health support for Native families in the Seattle area. Its evidence-based, culturally specific programs address social determinants and perinatal mental health—key drivers of maternal mortality. Multi-year philanthropic partnerships have enabled scale, but long-term sustainability requires public reimbursement mechanisms and technical assistance for grassroots partners. Funders should pair operating grants with community-led evaluation and advocacy funding to translate outcomes into Medicaid and state financing. Example below:

Measurable outcomes (baseline → targets):

- Doula cohort size and retention: baseline cohorts; Target retention at 12 months: 85%.
- Postpartum contact/completion of visits: baseline; Target Year 1: +30% completion.
- Maternal mental health indicators: baseline screening positive rate; Target Year 1: decrease in unmet needs by 20%.
- Financial sustainability: % operating budget from Medicaid reimbursement after Year 3: target 35%.
- Cultural metrics: community-defined wellness index improvements (storytelling + survey).

Replication guidance (priority 3 steps):

1. Secure multi-year operating support to fund GBI and cohort stipends.
2. Pilot Medicaid doula reimbursement with state Medicaid and a demonstration site.
3. Embed community-led evaluation with cultural metrics and tribal data governance.

These models combine culturally grounded leadership, rapid community uptake, and innovative service delivery, but face short funding cycles, credentialing barriers, and limited public reimbursement—priority levers are multi-year operating support, Medicaid parity for Indigenous birthworkers, and blended public to philanthropic funding.

Strategic Opportunities & Policy Recommendations

Native communities face a maternal health crisis shaped by systemic underfunding, fragmented programs, and exclusion from national strategies. To advance equity, funders and policymakers must align resources with Indigenous leadership and community-defined wellness.

Policy and Governance

- Support federal legislation: Advance bills like Tech to Save Moms Act and Advancing Birth Centers Act, which include Tribal and Urban Indian organizations. See Appendix G for additional bills.
- Elevate tribal governance: Center Indigenous leadership in maternal health policy through support for tribal IRBs, data-sharing agreements, and culturally aligned evaluation frameworks.
- Create multi-year appropriations and trust authorities: Attach funding to Interior, Health, and Commerce trust authorities to ensure long-term stability.
- Establish interagency data equity trust fund: Pool resources from Health and Human Services, Department of Interior, Indian Health Services, and U.S. Department of Housing and Urban Development, Education, and Census into tribe-directed grants.
- Set statutory set-asides for tribal capacity building: Prioritize rural, small, and culturally distinct tribes and regional, tribe-governed consortia.

Funding and Reimbursement Reform

- Expand Medicaid and CMS reimbursement: Include Traditional Practitioners and community midwives. Pilot billing agreements with tribal health systems.
- Reform federal and philanthropic funding: Shift from short-term grants to multi-year, flexible, trust-based investments.
- Finance culturally sovereign care models: Invest in Indigenous-led maternal health infrastructure and wraparound services.
- Align maternal health funds with structural drivers: Adopt a ‘fundamental causes’ approach to maternal health funding, as proposed by Fleming et al. (2020), by aligning investments with structural determinants—housing, education, justice reform—and embedding Indigenous governance across funding mechanisms.

Workforce Development and Credentialing

- Invest in Indigenous workforce pathways: Fund training for Indigenous doulas, midwives, lactation consultants, and traditional healers.
- Reform credentialing systems: Recognize culturally sovereign models and embed training programs on or near tribal lands.

Data Sovereignty and Equity

- Advance Indigenous data sovereignty: Support tribally governed systems integrating clinical and cultural indicators.
- Require culturally tailored disaggregation: Fund oversampling, multilingual instruments, and community-driven survey design.
- Support NHOPI-led data infrastructure: Fund Native Hawaiian and Pacific Islander data hubs with legal frameworks for consent and reuse.
- Ensure NHOPI representation in data governance: Include NHOPI voices on the Tribal-Federal Data Equity Advisory Board or create a parallel body.

Infrastructure and Access

- Target infrastructure funding: Invest in housing, transportation, and broadband to reduce access barriers and support telehealth.

Inclusion and Visibility

- Increase visibility in national strategies: Explicitly include Native Hawaiian communities through disaggregated data.
- Expand eligibility for funding and programs: Include Native Hawaiian organizations, Pacific Islander groups, and inter-island consortia.

Cultural Revitalization and Narrative Change

- Support healing justice and narrative change: Fund Indigenous-led storytelling, ceremony integration, and cultural revitalization to reclaim birth traditions.

Conclusion

To advance maternal health equity for American Indian, Alaska Native, and Native Hawaiian communities, policy and funding structures must shift toward sustained, culturally sovereign investment. Tribal communities have consistently demonstrated their ability to build impactful programs, resilient workforces, and culturally grounded care systems. Yet chronic underfunding—both public and philanthropic—continues to ration essential services and deepen disparities. Maternal health should not be subject to fragmented coverage or short-term grants that undermine prevention, care coordination, and cultural integration. Federal

programs remain siloed and insufficient, while private funders often impose restrictive pathways that fail to meet the urgency of the crisis.

Key Findings

- Federal maternal health funding and programs are fragmented across IHS, HRSA, CDC, and SAMHSA, producing misaligned timelines, reporting, and eligibility that drive administrative burden and coverage churn.
- Short-term, restrictive funding—both federal and philanthropic—limits tribal capacity to plan, build infrastructure, and retain workforce, perpetuating crisis-driven responses rather than prevention.
- Tribal leadership and sovereignty are insufficiently centered in current funding and governance structures, creating jurisdictional confusion and underinvestment in culturally integrated models of care.
- Lack of long-term, unrestricted capital constrains scale-up of accredited birth centers, workforce pipelines, and community-defined supports that reduce maternal morbidity and emergency care costs.

Insights and Implications

- Coordinating funding and policy across IHS, HRSA, CDC, and SAMHSA while formally centering tribal co-governance will reduce duplication, simplify reporting, and enable aligned, outcome-focused investments.
- Adopting 12-month continuous Medicaid postpartum eligibility and integrated enrollment pathways is a high-impact policy lever that stabilizes coverage, supports continuity of care, and lowers downstream crisis expenditures.
- Shifting philanthropic practice to trust-based, multi-year, unrestricted support co-designed with tribal leaders unlocks sustained planning, culturally integrated service models, and workforce retention.
- Federal matching and seed funding for tribal-led public to private partnerships eliminates the risk of private investment, accelerates infrastructure build-out, and scales community-governed care models.

Together, these shifts move systems from short-term crisis response toward durable, sovereignty-aligned maternal health systems that improve outcomes and reduce system-wide costs.

Recommendations

1. Establish an interagency maternal health coordination mechanism with mandated tribal co-governance to harmonize funding rules, timelines, and shared performance metrics across IHS, HRSA, CDC, and SAMHSA.
2. Implement 12-month continuous Medicaid postpartum coverage nationally and build integrated, cross-agency enrollment and renewal pathways to eliminate coverage churn.

3. Require and incentivize trust-based philanthropic practice: prioritize multi-year, unrestricted grants co-designed with tribal leaders and align reporting to tribal capacities.
4. Create federal matching and dedicated seed funds to scale tribal-led public–private partnerships focused on accredited birth centers, facility upgrades, and workforce pipelines.
5. Prioritize long-term, flexible capital investments for tribal infrastructure and operations rather than time-limited pilots to sustain culturally integrated care models.
6. Standardize core outcome metrics and simplify reporting. Delegate evaluation leadership to tribal partners where appropriate to reduce administrative burden and honor tribal priorities.

Policy must serve as a tool for repair, not repetition of historical neglect. Without these shifts, the promise of health equity remains unfulfilled.

Appendix A: Expanded Tables and Data

Barriers and Solutions for Tribal Data Sovereignty

Impact	Root causes	Proposed solution	Responsible partners	Resource needs	Success indicators
Barrier: Fragmented and underreported funding					
Uneven, short-term projects; inability to sustain tribal data systems	Siloed funders; lack of transparent tracking; short funding cycles	Create multi-year pooled funding streams with transparent reporting and tribal governance requirements	Tribal governments, federal agencies, and philanthropic intermediaries	Pooled fund; grant managers; M&E framework	Number of multi-year awards; percent of flexible funds to tribes
Barrier: Demographic misclassification					
Underestimates AI/AN/NHOPI health needs; flawed metrics	Inconsistent race/ethnicity collection; registry mismatches; provider training gaps	Standardize collection protocols; implement tribal data linkages and routine validation; fund training for registrars	TECs; state health departments; hospitals; tribes	IT for linkages, training budget, and data analysts	Reduction in misclassification rate; improved completeness of AI/AN/NHOPI fields
Barrier: Absence of tribal co-design and governance in federal programs					
Programs misaligned with tribal priorities; weakened sovereignty	Top-down program design; no mandated tribal governance clauses	Require co-design and tribal decision-making clauses in federal grants; fund tribal review and governance costs	Federal funders; tribal leaders; NCUIH/TEC networks	Policy language, tribal consultation funds, and legal support	Percent of grants with co-design clauses; tribal satisfaction scores
Barrier: Limited tribal IRBs and governance instruments					
Delayed approvals; inadequate	Few funded tribal IRBs; unclear	Fund establishment and staffing of	Tribes; regional TECs;	Legal counsel; training for IRB members;	Number of functioning tribal IRBs;

protection of cultural data; inconsistent adherence to data standards	templates; lack of legal support	tribal IRBs; create template DSAs that reflect IDS principles	legal nonprofits	admin support	DSAs aligned with IDS principles
Impact	Root causes	Proposed solution	Responsible partners	Resource needs	Success indicators
Barrier: Data infrastructure and workforce capacity gaps					
Inability to collect, store, analyze culturally relevant metrics	Outdated systems; scarce trained data staff; high turnover	Invest in interoperable, tribe-owned data systems and sustained workforce pipelines with training and mentorship	Tribal health departments; CDC/HRSA; universities	Hardware; software; training curricula; scholarships	Increase in tribal data staff; systems implemented and maintained by tribes
Barrier: Prescriptive reporting and evaluation requirements					
Extractive evaluation practices; loss of tribal control over outcomes	Funder-mandated indicators; rigid timelines; external evaluator dominance	Shift to flexible reporting that includes tribal-defined indicators and tiered reporting options	Funders; evaluators; tribal evaluation teams	Revised reporting templates; evaluator training; flexible funding	Share of evaluations using tribal indicators; number of co-led evaluations
Barrier: Exclusion of state-recognized tribes, Urban Indian Orgs, and NH/PI					
Gaps in coverage; unequal access to resources and recognition	Narrow eligibility criteria; recognition bias	Expand eligibility criteria; create dedicated program tracks for state-recognized, urban, and NH/PI communities	Federal agencies; state health departments; philanthropic funders	Policy revision; outreach budget; application assistance	Number of inclusive awards; representation in funded cohorts
Barrier: Weak accountability for inconsistent adherence to data standards principles in evaluations					

<p>Low adherence to sovereignty standards; limited tribal consultation</p>	<p>No enforcement or monitoring mechanisms; minimal IDS literacy among contractors</p>	<p>Require IDS compliance plans in contracts and fund independent audits; provide IDS training for contractors</p>	<p>Funders; contracting agencies; tribal sovereign entities</p>	<p>Compliance unit; audit budget; training modules</p>	<p>Percent of contracts with IDS plans; audit results showing compliance</p>
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Barriers and Solutions for Workforce Development

Impact	Root causes	Proposed solution	Responsible partners	Resource needs	Success indicators
Barrier: Supply and geographic maldistribution					
Reduced access to timely prenatal, birth, postpartum care in rural, tribal, island areas; worse maternal outcomes	Persistent shortages across continuum; rural/tribal isolation; limited recruitment pipelines	Targeted rural/tribal recruitment with funded rural placements & housing supports; telehealth + hub-and-spoke clinical networks	Tribal health programs; state rural health offices; HRSA; health systems	Rural placement stipends; housing supports; telehealth infrastructure ; recruiting funds	Increased provider-to-patient ratios in target areas; reduced travel distances for care
Barrier: Pipeline and accreditation barriers					
Limited number of locally trained clinicians; blocked clinical placements; fewer Indigenous-led programs	Narrow degree pathways; accreditation hurdles for tribal colleges and Indigenous midwifery programs; limited clinical sites	Fund and accredit tribal midwifery schools; cohort-based apprenticeship/doula programs; formal placement agreements with funded preceptors	Tribal colleges; accrediting bodies; academic medical centers; birth centers	Accreditation technical assistance; program seed funding; preceptor salary support	New accredited tribal programs; # local graduates; increased local clinical placement capacity
Barrier: Retention, burnout, and workforce instability					
High turnover; loss of institutional knowledge; reduced continuity of care	Low pay; housing instability; lack of ongoing training; limited infrastructure	Multi-year retention stipends; guaranteed rural stipends; wellness programs; continuing education and	Tribal HR; state workforce offices; funders; employers	Multi-year salary supplements; housing vouchers; CE funds; mentorship program	Reduced annual turnover rates; staff retention at 1–3 years; improved staff well-being

		career ladders		budgets	scores
Impact	Root causes	Proposed solution	Responsible partners	Resource needs	Success indicators
Barrier: Credentialing and reimbursement misalignment					
Culturally grounded providers excluded from billing streams; unsustainable service models	Medicaid and payer rules often exclude Traditional Practitioners and community midwives; billing obstacles	Advocate Medicaid/CMS policy changes to reimburse Traditional Practitioners and community midwives; create billing codes for cultural services	State Medicaid agencies; CMS; tribal leaders; NCUIH; payers	Policy advocacy funds; billing implementation technical assistance; payer contracting support	New payer policies/codes ; % of Traditional Practitioners billing; increased reimbursed visits
Barrier: Regulatory fragmentation and mobility barriers					
Inability to deploy providers across jurisdictions; slowed emergency response; limited recognition of tribal credentials	State licensure variability; lack of licensure reciprocity; no federal recognition of tribal credentialing	Develop interstate/tribal reciprocity compacts; federal guidance recognizing tribal credentialing pathways	State licensing boards; tribal governments; federal HHS; professional associations	Legal/regulatory technical assistance; convening funds; compact implementation resources	Signed compacts/MOUs; increased cross-jurisdictional placements; reduced credentialing time
Barrier: Funding instability and short-term grants					
Programs cannot scale or retain staff; frequent	Reliance on short-term grants; lack of multi-year	Shift to blended financing: multi-year	State budget offices; Medicaid; philanthropy;	Transition bridge funding; grant-to-	% programs with ≥3-year funding; fewer service

service interruptions	operating funds	public budgets, Medicaid waivers, philanthropic multi-year operating grants	tribal finance offices	sustainability planning; Medicaid waiver application support	interruptions; stable staffing levels
Impact	Root causes	Proposed solution	Responsible partners	Resource needs	Success indicators
Barrier: Workforce data gaps					
Poorly targeted investments; inability to link staffing to maternal outcomes	Limited granular mapping by IHS region/tribal geography; no workforce–outcome linkage	Fund tribally governed workforce mapping & interoperable dashboards; standardize indicators linking staffing to outcomes	Tribal epidemiology centers; IHS; public health depts; HIEs	IT investment; data governance agreements; analytic capacity building	Tribal dashboards, data-sharing metrics, and workforce–outcome analyses
Barrier: Under-resourced cultural/traditional workforce					
Inadequate culturally grounded services; unmet community demand; lower engagement	Payers exclude traditional healing; limited billing pathways; insufficient operating support for ceremonial needs	Create billable pathways for traditional healing; operating grants for UIOs; reimburse community birthworker models	State Medicaid; NCUIH; UIOs; tribal finance; private payers	Policy change resources; operating grants covering ceremonial materials and land access; billing infrastructure	States with reimbursable traditional models; UIOs funded to hire 3–5 FTEs; increased service utilization
Barrier: Insufficient clinical training sites and preceptors					
Training bottlenecks	Few accredited	Strengthen clinical	Birth centers; tribal clinics;	Site development	Expand accredited

reduce workforce pipeline throughput	birth centers in tribal/rural areas; preceptor burnout; lack of compensation for teaching	training: formalize placements, fund preceptors, and accredit local birth centers.	academic partners; funders	grants; preceptor stipends; liability coverage; simulation resources	sites, boost local placements, cut waitlists
Barrier: Limited local pipeline and youth engagement					
Workforce not reflective of community; long-term shortages persist	Lack of exposure to health careers; cost barriers to education	Implement school-to-career pathways, internships, & Indigenous youth scholarships	Tribal education depts; schools; community colleges; funders	Outreach funding; scholarship pools; paid internship wages	No. of local youth enrolled in health pathways; scholarship uptake; interns transitioning to training programs

Barriers and Solutions for Access to Educational Degrees and Training

Impact	Root causes	Proposed solution	Responsible partners	Resource needs	Success indicators
Barrier: Accreditation and recognition hurdles for tribal-led curricula					
Tribal programs unable to confer recognized degrees; limited clinical placements; reduced reimbursement and sustainability	Conventional accreditation frameworks that exclude Indigenous epistemologies; lack of technical assistance for TCUs and tribal programs	Fast-track recognition pathways; create tribal-accreditation reciprocity; fund multi-year training hubs on/near tribal lands co-designed with tribes	Tribal colleges; National Indian Health Board; accrediting bodies; state higher ed agencies; tribal governments	Accreditation technical assistance; convening funds; seed operating grants for training hubs; legal/regulatory support	Number of tribal programs with formal recognition; increase in accredited clinical placements; sustained program budgets ≥3 years
Barrier: Limited mentorship and underrepresentation among faculty					
Slower pipeline development; fewer AI/AN graduates; reduced cultural concordance in care	Low representation of AI/AN clinicians in academia; limited faculty development pipelines; hiring biases	Fund AI/AN faculty fellowships and mentorship programs; tuition forgiveness for graduates who return as faculty; paid mentorship stipends	TCUs; medical/nursing schools; tribal health orgs; funders	Fellowship funds; salary support for mentor roles; recruitment and retention incentives	Increase in AI/AN faculty hires; mentorship pairings completed; higher retention of program graduates in academic roles
Barrier: Logistical and financial barriers for students (housing, childcare, travel, broadband)					
Lower enrollment and completion, especially from rural/island	High living costs; inadequate student supports; digital divide; transportation	Expand scholarships, living stipends, childcare funds, travel grants, and	State education agencies; TCUs; philanthropic funders; tribal education	Scholarship pools; living stipend budgets; childcare subsidies; broadband	Enrollment and completion rates among tribal/NHOPI students; reduced

communities; delayed workforce entry	barriers	broadband subsidies; offer hybrid and cohort scheduling	departments	grants; transportation assistance	course dropouts; % students with stable housing/childcare are during training
Impact	Root causes	Proposed solution	Responsible partners	Resource needs	Success indicators
Barrier: Credentialing-to-reimbursement gap (Traditional Practitioners, community doulas)					
Trained providers cannot obtain sustainable employment; programs collapse despite training completion	Medicaid/payer exclusion of Traditional Practitioners and community birthworkers; lack of billing codes	Enable reimbursement for Traditional Practitioners via state plans, waivers, or CMS guidance; create cultural service billing codes	State Medicaid; CMS; NCUIH; tribal leaders; payers	Policy advocacy funding; technical assistance for billing implementation; payer contracting support	New or amended Medicaid policies; % of Traditional Practitioners/doulas able to bill; reimbursed service volumes
Barrier: Geographic and institutional underfunding of TCUs and NHOPI-serving institutions					
Few accredited health programs locally; loss of potential local trainees; continued dependence on external pipelines	Historic underfunding of TCUs/NHOPI institutions; limited infrastructure and faculty capacity	Invest in TCUs/NHOPI institutions and fund academic partnerships for shared accreditation	Federal/state education funders; tribal education offices; philanthropic partners; academic partners	Multi-year operating grants; capital for facilities and labs; faculty development funds; partnership MOUs	# of newly accredited programs at TCUs/NHOPI institutions; local graduate counts; sustained program funding beyond pilot years
Barrier: Insufficient clinical placement agreements and preceptor capacity					

Training bottlenecks; students denied local supervised practice; reduced throughput into workforce	Lack of funded placement agreements; preceptor burnout; liability and site accreditation barriers	Create guaranteed clinical placement agreements with funded preceptor compensation and protected teaching time; develop local birth center accreditation support	Birth centers; tribal clinics; academic institutions; funders	Preceptor stipends; liability/insurance support; site development grants; protected teaching time funding	Increase in local clinical placements; reduced placement waitlists; number of funded preceptors engaged
Impact	Root causes	Proposed solution	Responsible partners	Resource needs	Success indicators
Barrier: Evaluation, sustainability, and outcomes linkage gaps					
Programs cannot demonstrate long-term outcomes; difficulty securing public reimbursement or scaling culturally defined metrics	Short funding cycles; lack of tribally governed evaluation frameworks; limited data linking workforce to maternal outcomes	Fund tribal-led evaluation, integrate Indigenous-defined metrics, and sustain multi-year reporting	Tribal epidemiology centers; funders; program leaders; public health departments	Evaluation grants; data infrastructure; training in culturally grounded metrics; multi-year operating funds	Integrate Indigenous metrics, finalize long-term evaluations, and increase outcome-based reimbursement.
Barrier: Under-resourced cultural/traditional workforce					

Tension between standardized credentialing and cultural fidelity	Risk that programs lose Indigenous knowledge when pursuing formal recognition; lower community trust and uptake	Accreditation standards that prioritize biomedical models over Indigenous knowledge; binary credentialing systems	Fund tribal credentialing models that honor tradition and clinical rigor; align cultural certification with degree programs	National Indian Health Board; accrediting agencies; tribal credentialing bodies; professional associations	Development funds for dual credential frameworks; convening/negotiation resources; pilot credentialing programs
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Barriers and Solutions for Policy and Funding

Impact	Root causes	Proposed solution	Responsible partners	Resource needs	Success indicators
Barrier: Fragmentation across agencies and payers					
Confusing funding streams; duplicated admin work; stalled program accreditation and degree development	Multiple federal programs with inconsistent tribal coordination and reporting requirements	Create an interagency tribal maternal health coordination unit to harmonize grant criteria and reporting	HHS agencies (HRSA, CDC, CMS); IHS; tribal authorities; OST; funders	Convening funds; staffing for coordination unit; shared reporting platform	Single coordinated funding portal; fewer duplicate reports; % grants aligned to unified criteria
Barrier: Inflexible, short-term funding					
Training programs cannot scale; high turnover; inability to sustain degree programs	Project-specific grants; short philanthropic cycles; restrictive reporting	Shift to multi-year (3–5+ year) flexible operating grants and blended financing pilots pairing public funds with philanthropic anchors	Federal funders; philanthropies; tribal finance offices; state agencies	Multi-year grant pools; bridge funding; matching funds for pilots	% programs with ≥3-year funding; reduced staff turnover; sustained program operations
Barrier: Legal and recognition gaps for Native Hawaiian and PI students/institutions					
Exclusion from some federal protections; reduced access to degree funding and accreditation support	Distinct legal statuses and eligibility pathways; ambiguous administrative rules	Create administrative fixes or statutory recognition pathways to extend eligibility and parity for NH/PI institutions	HHS; DOJ; DOI; Congress; tribal/NHOPI leaders	Legal/legislative drafting resources; advocacy funding; policy convenings	Policy changes enacted; increased NH/PI access to federal program funds

Barrier: Reimbursement, licensure, and billing barriers					
Trained Traditional Practitioners and community birthworkers cannot secure paid roles post-training	Medicaid/CMS rules exclude Traditional Practitioners and community midwives; lack of billing codes	Advance payer alignment to fund culturally grounded care via state and CMS pathways	State Medicaid agencies; CMS; tribal leaders; NCUIH; payers	Policy advocacy funds; billing implementation TA; code development resources	New reimbursement pathways; % trained providers billing; sustainable job placements
Impact	Root causes	Proposed solution	Responsible partners	Resource needs	Success indicators
Barrier: Data invisibility and governance deficits					
Lack of evidence linking training to outcomes; weaker funding cases for degree programs	Misclassification of AI/AN/NHOPI data; absence of tribal data-sharing agreements; limited tribal IRBs	Fund tribally governed data systems, TECs, and tribal IRBs; require disaggregated AI/AN/NHOPI reporting in grants	Tribal epidemiology centers; IHS; CDC; funders; TECs	IT infrastructure; data governance agreements; training for tribal analysts	Functional co-governed datasets; number of grants requiring disaggregated reporting; published workforce–outcome analyses
Barrier: Accreditation and recognition hurdles for TCUs and tribal programs					
Inability to confer degrees; restricted clinical placements; loss of reimbursement eligibility	Accreditation frameworks not accommodating Indigenous epistemologies; limited TA for TCUs	Fast-track recognition pathways; accreditation technical assistance; support for tribally governed credential stacks	Accrediting bodies; TCUs; National Indian Health Board; state higher ed agencies	TA funding; legal/regulatory support; seed operating grants for accreditation processes	# of TCUs with accredited programs; increased local degree conferrals; more clinical placements

Barrier: Philanthropic scale and restrictions					
Limited catalytic capital for multi-year degree programs; restrictive timelines hamper program maturation	Small share of philanthropic funding to Native communities; short timelines and narrow eligibility	Promote trust-based philanthropy: multi-year unrestricted grants and match public capital to scale training hubs	Philanthropic foundations; Native funders; public funders; tribal leaders	Pledged multi-year philanthropic funds; match-funding commitments; simplified application processes	Increase in multi-year philanthropic commitments; higher match rates to public funds; growth in accredited training hubs

Appendix B: Example of “Next Steps”

Immediate (30–90 Days): Laying the Foundation

Build early momentum through pilot testing, partnership coordination, and initial investment commitments that demonstrate feasibility and urgency.

- Launch a funder-convened pilot proposal that pairs a philanthropic anchor (3-year commitment) with a Medicaid telehealth/doula billing pilot; secure seed commitment (\$500k) to start cohort training and hire a Billing & Policy Navigator.
- Draft State Medicaid policy brief and cost-offset case using ROAM travel/time savings as evidence.
- Co-create a draft evaluation + tribal data governance template and circulate to 2–3 NM community partners for revision.

Short Term (3–12 Months): Implementing and Learning

Activate pilots into practice, funding the first Indigenous birthworker cohort, and generating early data to inform scaling and policy alignment.

- Implement first paid cohort (8–12 trainees) with stipends, elder mentorship, and clinical preceptorship; collect baseline metrics.
- Execute Medicaid pilot agreements with one health system and NM Medicaid for demonstration billing.
- Secure infrastructure grants for telehealth kits and participant tech stipends in targeted maternity care deserts.

Medium Term (12–36 Months): Scaling and Institutionalizing Success

Transform pilots into sustainable policy and funding mechanisms by aligning federal, state, and philanthropic systems around proven Indigenous-led models.

- Aggregate pilot results into a policy package for statewide Medicaid adoption and federal advocacy (Title V/HRSA alignment).
- Scale successful cohort and billing models to neighboring tribal jurisdictions with a replicable cultural customization playbook.
- Institutionalize a tribal data governance clearinghouse for maternal programs to support multi-site evaluation while protecting sovereignty.

Appendix C: Comparable Models

Model	Model type	Key measurable results (baseline → targets)	Top 3 replication steps	Federal lever
Changing Woman Initiative	Navajo midwifery revival / birth center	Clients served 100+; travel/time ↓ 20% Year1; retention 80% @12mo	Apprenticeship + elder mentorship; Medicaid billing pilot; tribal credentialing	HRSA tribal training grants; Medicaid demonstration
Pacific Birth Collective	Mobile/postpartum services	Mobile missions +20 Year1; postpartum follow-up ↑25%; response time ↓15%	Capital mobile unit; Medicaid waiver for mobile services; hospital partnerships	CMS 1115 waiver; state Medicaid reimbursement
Hummingbird Indigenous Family Services	Doula + GBI + home visiting	Doula retention 85% @12mo; postpartum visits ↑30%; MH unmet needs ↓20%	Multi-year ops support; Medicaid doula pilot; co-designed evaluation	Medicaid doula reimbursement pilot; HRSA workforce grants
ROAM (New Mexico)	Telehealth maternal access	Miles saved 10,000+; patient time saved 190 hours	Broadband + telehealth kits; telehealth billing codes; local staff training	HRSA telehealth grants; Medicaid telehealth parity
Alaska Full-Spectrum Doula Training	Cohort training pipeline	27 trained; local capacity ↑	Seed stipends; formal clinical placements; CEU pathways	HRSA training grants; Title V alignment

Sources: Case details and program descriptions in Appendix B and Appendix C of attached draft.

Appendix D: Funding Comparison

Public (Federal and State)

Public funding, including Title V, IHS MCH, HRSA, SAMHSA, state MCO reinvestments, and state pilot funds, provides the largest pools of money and the core infrastructure needed to scale maternal health programs. These federal and state sources are positioned to underwrite large investments such as facility upgrades, telehealth capital, and statewide workforce development initiatives that individual philanthropic grants cannot sustain alone.

However, public funding carries significant constraints. Administrative eligibility requirements and a clinical, hospital-centered orientation often misalign with traditional midwifery and community doula models. Billing rules and licensure frameworks frequently exclude or complicate compensation for Indigenous birth workers, and per-tribe allocations are commonly insufficient to meet local needs.

When policy barriers are addressed, public funding is best suited to support infrastructure and scale. With adjustments to Medicaid reimbursement, licensure flexibility, and explicit allowances for community-governed models, these funds can finance telehealth networks, sustained workforce pipelines, and ongoing service delivery across maternity care deserts.

Private (Philanthropy, Corporate, Local donors)

Over the past five years, philanthropic funding for American Indian and Alaska Native (AI/AN) communities has grown significantly, but it remains disproportionately small relative to need. Between 2018 and 2022, U.S. foundation giving to Native communities nearly doubled, reaching approximately \$793 million in 2022. Yet this represented only 0.36% of all U.S. philanthropic grantmaking, despite persistent health disparities, including maternal and child health outcomes (Native Americans in Philanthropy, 2023). The surge in giving in 2020, prompted by COVID-19 and racial justice movements, highlighted both the vulnerabilities and resilience of Native communities, with intermediaries such as NDN Collective and the Decolonizing Wealth Project playing a critical role in moving resources quickly to address urgent family needs (Native Americans in Philanthropy, 2023; NDN Collective, 2022).

Health-specific and MCH-adjacent investments were most visible through Indigenous-led institutions and re-granting entities. The Alaska Native Tribal Health Consortium (ANTHC), for example, received significant philanthropic support and redistributed millions to regional organizations providing direct services, including maternal, infant, and family health programs (International Funders for Indigenous Peoples, 2020). Large-scale gifts from high-net-worth donors and donor-advised funds (DAFs), such as MacKenzie Scott's Yield Giving and vehicles like Fidelity Charitable and the National Philanthropic Trust, provided unrestricted support that grantees often used to stabilize family, perinatal, and childcare services (Native Americans in Philanthropy, 2023). Several national funders also emerged as important actors, including the

W.K. Kellogg Foundation, known for its long-standing early childhood portfolio, and the Novo Foundation, with a focus on women and girls.

Key Funders and Intermediaries in AI/AN MCH Landscape (2020–2025)

Type	Indigenous Focus	Example Recipients / Channels	Geography	Relevance to MCH	Notes (2020–2025)
Alaska Native Tribal Health Consortium (ANTHC)					
Nonprofit tribal health system & re-grantor	Direct services & regranting to tribal health orgs	Southcentral Foundation, regional tribal health orgs, Susan G. Komen (breast health)	Alaska	Provides maternal, infant, and family health services	Received \$34M+ historically; redistributed millions to Alaska Native health orgs (IFIP, 2020)
NDN Collective					
Indigenous-led intermediary	Broad Native movement & resilience funding	Over \$177.5M raised (2018–22)	National (Plains, Upper Midwest)	Re-grants support family wellbeing, childcare, community care	Critical during COVID-19, including family health and resilience (NAP, 2023; NDN, 2022)
Decolonizing Wealth Project / Liberated Capital					
Indigenous-led intermediary	Equity and wealth redistribution	Emergency COVID-19 funds to Native-led orgs	National	Flexible support for urgent family health needs	Key in rapid pandemic response (NAP, 2023)
MacKenzie Scott / Yield Giving					

High-net-worth philanthropy	Large unrestricted gifts to Native orgs	≥\$205.2M to Native orgs (2020–22)	National	Stabilized community orgs, enabling perinatal & childcare supports	Major flexible infusion (NAP, 2023)
Type	Indigenous Focus	Example Recipients / Channels	Geography	Relevance to MCH	Notes (2020–2025)
Fidelity Charitable, National Philanthropic Trust					
Donor-advised funds (DAFs)	Pass-through to Native-led orgs	Varies by donor	National	Flexible source often covering maternal/child care gaps	Among top 10 funders to Native causes (NAP, 2023)
W.K. Kellogg Foundation					
Institutional foundation	Early childhood & family health	Native-serving orgs (unspecified)	National	Strong early childhood alignment	Top funder to Native communities (NAP, 2023)
Novo Foundation					
Institutional foundation	Women, girls, bodily autonomy	Native-serving orgs (unspecified)	National	Relevant to perinatal & maternal wellbeing	Top 10 funder to Native communities (NAP, 2023)
Ford Foundation, Bush Foundation					
Institutional foundations	Equity & self-determination	Native intermediaries and community orgs	National, Upper Midwest	Broader equity portfolios with family/health relevance	Among top funders overall (NAP, 2023)

New Venture Fund					
Fiscal sponsor & pooled funder	Supports emerging initiatives	Native-serving pooled projects	National	Provides backbone for new health/child/family initiatives	Seen in Native funding flows (NAP, 2023)

While the philanthropic landscape for Native Hawaiian (NH) communities has been less systematically documented, several recent initiatives reveal important patterns. The Hawai'i Community Foundation (HCF) has been a leading actor, with its Promising Minds initiative (2019–2024) investing in infant and early childhood behavioral health systems, and its Health & Wellness (CHANGE) and Maui Strong Fund grants providing flexible, culturally grounded support for family health and trauma recovery. The Lili'uokalani Trust and Kamehameha Schools also represent major Native Hawaiian–governed institutions funding early childhood, youth development, and family well-being programs, demonstrating a strong place-based philanthropic infrastructure.

In addition, national philanthropy has begun to engage directly in Native Hawaiian maternal health. Notably, the Robert Wood Johnson Foundation's Evidence for Action program awarded funding for "Weaving Indigenous and Western Perinatal Care," a Native Hawaiian–led project to reduce maternal and infant morbidity by integrating cultural practices into perinatal care systems. Smaller grassroots funders, such as the Hawai'i People's Fund, also play an important role through urgent action and wellness grants that address keiki and 'ohana needs. Collectively, these efforts show that while Native Hawaiian MCH philanthropy is less visible in national datasets, it is anchored by strong local institutions and increasingly recognized by national funders.

Key Funders and Intermediaries in Native Hawaiian MCH Landscape (2020–2025)

Type	Focus & Why It Matters for MCH	Recent Signals / Examples
Funder / Program: Hawai'i Community Foundation — Promising Minds		
Place-based foundation initiative	Infant & early childhood behavioral health; trauma-informed systems	System and workforce investments for keiki/families (2019–2024)
Funder / Program: Hawai'i Community Foundation — Health & Wellness (CHANGE)		
Foundation grants	Flexible community-led health equity, including perinatal & family supports	\$620K+ in grants awarded in 2023
Funder / Program: Hawai'i Community Foundation — Maui Strong Fund		
Disaster philanthropy (pooled)	Mental health and family stability post-wildfire; culturally relevant care	\$2M+ to mental health/family support (2023–24)
Funder / Program: RWJF / Evidence for Action — Weaving Indigenous & Western Perinatal Care		
National philanthropy	Culturally responsive perinatal care for Native Hawaiian birthing people	Launched 2024
Funder / Program: Lili'uokalani Trust		
Native Hawaiian private trust	Early childhood, family strengthening, trauma-informed programs	Ongoing multi-year initiatives
Funder / Program: Kamehameha Schools — Kaiāulu		
Private educational trust	Large-scale early learning & family support with cultural grounding	Multi-million grants to partners (2024)

Funder / Program: Kamehameha Schools — Kaiāulu		
Private educational trust	Large-scale early learning & family support with cultural grounding	Multi-million grants to partners (2024)

Philanthropic and private funding offers flexibility and cultural fit that public funds often lack. Foundations, corporate gifts, and local donors frequently cover culturally specific activities such as elder stipends, ceremonies, cohort-based training, and community-driven program design. These sources are effective at seeding innovation and supporting elements of care essential to cultural sovereignty.

Philanthropic dollars also have limits. Aggregate philanthropic funding is smaller than public budgets, grants are often time-limited to one to three years, and eligibility rules such as nonprofit status or minimum organizational maturity can exclude grassroots tribal efforts. These constraints make philanthropy an unstable sole source for long-term program operations.

The complementary dynamic is clear: philanthropy seeds culturally aligned innovation while public dollars provide the scale needed for sustainability. To convert pilots into enduring services requires policy alignment that enables Medicaid inclusion, licensing exceptions for community midwives, and telehealth parity so public funds can reliably support culturally grounded models. The following findings synthesize key themes across federal, state, and philanthropic funding mechanisms.

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Appendix E: Case Study Details

Changing Woman Initiative renews traditional Navajo midwifery and birth knowledge to restore community-centered perinatal care. Its services span midwifery, workforce training, cultural revitalization, and healing spaces. By rebuilding local birth worker pipelines and integrating traditional knowledge with clinical safety practices, the initiative improves care-seeking, reduces travel-related risks, and lowers maternal morbidity. Despite strong community demand and culturally sovereign leadership, short-term philanthropic grants and Medicaid reimbursement barriers threaten sustainability. Funders are urged to provide multi-year operating support, fund apprenticeship programs, and invest in policy advocacy to secure reimbursement and credential recognition (Changing Woman Initiative.,n.d.).

Pacific Birth Collective offers island-wide, Indigenous-led birth and postpartum care through mobile units, subsidized services, and emergency response support. It fills urgent access gaps in disaster-affected and geographically isolated areas, while advocating for birth sovereignty and midwifery rights. The collective's direct-service subsidy model and volunteer practitioner network reduce barriers to culturally congruent care. However, legislative restrictions and limited public reimbursement mechanisms pose challenges. Funders can strengthen impact by supporting mobile infrastructure, paid practitioner pools, and policy campaigns to decriminalize traditional midwifery and expand Medicaid reimbursement (Pacific Birth Collective, n.d.).

Hummingbird Indigenous Family Services provides full-spectrum doula care, guaranteed basic income (GBI), home visiting, and mental health support for Native families in the Seattle area. Its evidence-based, culturally specific programs address social determinants and perinatal mental health—key drivers of maternal mortality. Multi-year philanthropic partnerships have enabled scale, but long-term sustainability requires public reimbursement mechanisms and technical assistance for grassroots partners. Funders should pair operating grants with community-led evaluation and advocacy funding to translate outcomes into Medicaid and state financing. (Hummingbird Indigenous Family Services, n.d.)

Appendix F: Innovative Models in Indigenous Maternal Health

This Table highlights a diverse portfolio of Indigenous-led and culturally responsive maternal health initiatives across the U.S., illustrating scalable strategies for workforce development, telehealth expansion, credentialing reform, and culturally grounded care delivery. Each model demonstrates the potential of blended funding approaches—public, private, and philanthropic—to address systemic barriers and improve outcomes in maternity care deserts.

Model	Potential Approaches using blended funding methods
<p>Expanding Telehealth Infrastructure</p> <p>Reference: New Mexico Department of Health. (n.d.). <i>Rural OB Access & Maternal Services (ROAM) Program</i>. Retrieved October 13, 2025, from https://www.nmhealth.org/</p>	<p>ROAM – Rural OB Access & Maternal Services (New Mexico)</p> <p>Funding Type: Public/Private-Philanthropic</p> <p>Impact: Saved over 10,000 miles of travel and 190 hours of patient time through telehealth</p> <p>Barriers: Telehealth billing uncertainty, tech requirements, limited provider reimbursement</p> <p>Opportunity: Funding broadband and telehealth kits can replicate this success in other maternity care deserts.</p>
<p>Workforce Pipeline: Paid Training Cohorts & Mentorship</p> <p>Reference: Hummingbird Indigenous Family Services. (n.d.). <i>Indigenous-led perinatal support and guaranteed income programs</i>. Retrieved October 13, 2025, from https://www.hummingbird-ifs.org/</p>	<p>Hummingbird Indigenous Family Services (Washington)</p> <p>Focus: Traditional midwifery & doula services</p> <p>Funding type: Public-Private</p> <p>Scalability: High</p>
<p>Community-based mentorship and training for Indigenous birthworkers</p> <p>Reference: Alaska Native Birthworkers Community. (n.d.). <i>Full Spectrum Indigenous Doula Training</i>. Retrieved October 13, 2025, from https://www.indigenousbirthak.org/</p>	<p>Full Spectrum Indigenous Doula Training (Alaska)</p> <p>Lead: Alaska Native Birthworkers Community</p> <p>Funding type: Private-Philanthropic</p>

	Impact: 27 participants trained, cultural revitalization, grassroots expansion
<p>Credentialing Reform: Tribally Governed Licensure</p> <p>Reference: Changing Woman Initiative. (n.d.). <i>Indigenous-led reproductive health and midwifery care</i>. Retrieved October 13, 2025, from https://www.changingwomaninitiative.com/</p>	<p>Changing Woman Initiative (New Mexico)</p> <p>Lead: Navajo-led CWI</p> <p>Funding: WKKF and others</p> <p>Impact: Revived traditional births for 100+ clients</p> <p>Barrier: Licensing and Medicaid exclusion</p> <p>Opportunity: Reform accreditation to honor tribal knowledge and remove systemic barriers</p>
<p>Medicaid Demonstration Projects</p> <p>Reference: Montana Department of Public Health and Human Services. (n.d.). <i>MOMS Program Overview</i>. Retrieved October 13, 2025, from https://dphhs.mt.gov/</p>	<p>Montana Tribal Maternal Health Mini Grants</p> <p>Lead: Dept. of PH and HS MOMS Program</p> <p>Funding: Public</p> <p>Impact: Culturally safe education, community-healthcare connections</p> <p>Opportunity: Pilot Medicaid billing agreements with tribal systems to reimburse culturally sovereign care</p>
<p>Philanthropic Investment in Cultural Innovation</p> <p>Reference: Indigenous Women Rising. (n.d.). <i>Cultural innovation and reproductive justice initiatives</i>. Retrieved October 13, 2025, from https://www.iwrising.org/</p>	<p>Rain, Emergence, MoodPie Funds (New Mexico)</p> <p>Lead: Indigenous Women Rising</p> <p>Funding: Private, Donations</p> <p>Focus: Ceremony integration, herbal medicine, menopause and contraception support</p> <p>Scalability: High</p>

	<p>Opportunity: Philanthropy can fund elder stipends, ceremony-based care, and culturally specific program design</p>
<p>Program Evaluation with Cultural Metrics</p> <p>Reference: Cihuapactli Collective. (n.d.). <i>Sacred Community Birthworker Training</i>. Retrieved October 13, 2025, from https://www.cihuapactli.org/</p>	<p>Sacred Community Birthworker Training (Arizona)</p> <p>Lead: Cihuapactli Collective</p> <p>Focus: Comprehensive support across birthworker roles</p> <p>Opportunity: Embed metrics like ceremony participation, family involvement, and community-defined wellness</p>
<p>Scaling with Public Dollars</p> <p>Reference: University of New Mexico Health Sciences Center. (n.d.). <i>Improving Perinatal Health ECHO Program</i>. Retrieved October 13, 2025, from https://hsc.unm.edu/echo/</p>	<p>Improving Perinatal Health (IPH) ECHO Program (New Mexico)</p> <p>Lead: UNM</p> <p>Funding: Public-Private</p> <p>Impact: 274 providers trained across 18 counties</p> <p>Barriers: Broadband access, workforce shortages, limited infrastructure</p> <p>Opportunity: Adjust Medicaid and Title V to fund facility upgrades and workforce expansion</p>

Appendix G. Maternal Health Legislation Summary (2025–2030)

Bill Name	Focus Areas	AI/AN & Native Hawaiian Inclusion	Potential Impact	Funding (FY 2025–2030)
Tech to Save Moms Act (2025)	Telehealth, remote monitoring, provider training	Explicitly includes Tribal and Urban Indian organizations	Expands access to tech-enabled care in underserved areas	<i>Undisclosed</i>
Midwives for MOMS Act (2025)	Midwifery education, workforce diversity	Prioritizes minority and disadvantaged students	Increases culturally competent care in underserved areas	<i>\$35 million over 5 years</i>
Advancing Maternal Health Equity Under Medicaid Act	Medicaid expansion, doula/community health worker support	Includes Indigenous women in equity focus	Reduces racial disparities in maternal outcomes	<i>90% FMAP (Federal Matching Rate)</i>
Preventing Maternal Deaths Reauthorization Act (2025)	Maternal Mortality Review Committees (MMRCs), data collection	Not explicit, but MMRCs can include Tribal data	Improves understanding of causes of maternal death	<i>Undisclosed</i>
Veterans Nutrition and Wellness Act of 2025	Maternal health for veterans, nutrition services	Not explicit, but may benefit AI/AN veterans	Supports maternal wellness for veteran populations	<i>Undisclosed</i>

Rural Obstetrics Readiness Act	Emergency obstetric training, rural hospital support	Not explicit, but relevant to rural Native communities	Improves readiness in maternity care deserts	<i>\$5 million authorized</i>
BABIES Act	Birth center access, Medicaid demonstration projects	Includes Native Americans and vulnerable populations	Promotes midwifery-led care in underserved areas	<i>\$5 million over 5 years</i>
Healthy Moms and Babies Act	Medicaid payment reform, prenatal care access	Not explicit, but supports early care access	Enhances care coordination and data tracking	<i>Undisclosed</i>
Connected MOM Act	Remote monitoring, Medicaid coverage barriers	Not explicit, but supports rural/Tribal access	Improves access to digital maternal health tools	<i>Undisclosed</i>
Maternal Health Awareness Day (Jan 23, 2025)	National awareness and education	Symbolic, not programmatic	Opportunity for advocacy and visibility	<i>No funding attached</i>

Appendix H. Full List of Solutions & Recommendations

Data Sovereignty

1. Invest in tribal data systems and Indigenous-led evaluation efforts by allocating multi-year funding through federal grants and philanthropic partnerships to tribal governments and Indigenous organizations to build and sustain culturally grounded evaluation frameworks.
2. Build core infrastructure for community-led research collaboratives by supporting the development of tribally governed research centers by funding physical spaces, technology, and staffing; prioritize capacity-building grants that include training in data sovereignty and research ethics.
3. Fund tribal policy staff and coalitions to strengthen advocacy capacity by creating dedicated budget lines in maternal health programs for tribal policy positions; offer technical assistance and flexible funding to support coalition convenings and cross-jurisdictional policy alignment.
4. Develop co-funded data systems through public-private partnerships by facilitating agreements between tribal entities, state agencies, and philanthropic funders to co-design interoperable data platforms that respect tribal governance and privacy protocols.
5. Support community-controlled data hubs and storytelling metrics by investing in digital infrastructure and training for Indigenous communities to manage their own data repositories; fund participatory research that centers oral histories, visual storytelling, and culturally relevant indicators of maternal health.
6. Ensure Indigenous communities can define, measure, and advocate for maternal health outcomes on their own terms by embedding Indigenous-defined metrics into federal reporting requirements and maternal health dashboards; fund advocacy campaigns that elevate community-led narratives and policy demands.

Workforce

1. Invest in workforce training, retention, and licensure alignment by directing federal and philanthropic funding to tribal health departments and Indigenous-led organizations to design culturally grounded training programs, retention strategies, and licensure pathways.
2. Fund tribal midwifery schools and mentorship programs by establishing grant programs through HRSA and tribal health compacts to support curriculum development, faculty recruitment, and intergenerational mentorship rooted in Indigenous birthing knowledge.
3. Provide retention stipends and long-term incentives for Indigenous birth workers by offering multi-year stipends, housing support, and wellness packages for Indigenous midwives and doulas, especially those serving in rural or high-need areas.
4. Expand scholarships, salary support, and continuing education funds by creating dedicated scholarship funds for Indigenous students pursuing maternal health careers;

subsidize salaries through tribal-state-federal agreements; fund CEUs that integrate cultural and clinical competencies.

5. Establish clinical placement partnerships with tribal and community-based facilities by formalizing agreements between tribal clinics, birth centers, and academic institutions to ensure placements are culturally aligned and logistically supported.
6. Align licensure policies with tribal authority to remove barriers to practice and reimbursement by Advocating for state-level licensure reciprocity and federal recognition of tribal credentialing systems; amend Medicaid and private payer policies to reimburse care provided under tribal governance.
7. Utilize third-party incentives and reimbursement to increase rural provider access by Leveraging CMS waivers, HRSA rural health grants, and private payer incentives to attract culturally competent providers to tribal and rural regions; tie reimbursement to facility upgrades and community-defined standards of care.

Maternal Mortality

1. Establish multi-year block grants for tribal maternal health programs that prioritize cultural alignment, Traditional Practitioners, and tribally governed data systems.
2. Expand Medicaid waivers to cover Traditional Practitioners without requiring Western credentialing, modeled after existing state innovations.
3. Create a dedicated funding stream within HRSA, CDC, and NIH for Indigenous-led maternal health research and infrastructure, with tribal consultation embedded in program design.
4. Mandate tribal eligibility in all maternal health-related cooperative agreements, including Urban Indian and state-recognized tribes.
5. Tie federal maternal health funding to tribal data sovereignty principles, requiring tribal consultation, culturally defined metrics, and community governance.
6. Launch state maternal equity funds that include set-asides for tribal and Native Hawaiian communities, with flexible use for workforce, infrastructure, and culturally congruent care.
7. Authorize Medicaid reimbursement for Traditional Practitioners through state plan amendments or 1115 waivers, removing credentialing barriers.
8. Fund tribal-university partnerships to build local maternal health pipelines, including scholarships, mentorships, and retention stipends for Indigenous students.
9. Support regional tribal maternal health collaboratives to address geographic disparities and coordinate care across IHS regions.
10. Shift from project-based grants to core operating support for Indigenous maternal health organizations, enabling long-term planning and cultural continuity.
11. Invest in tribal workforce development through multi-year fellowships, leadership training, and community-based research apprenticeships.
12. Fund tribal data infrastructure to support culturally defined maternal outcomes and protect ceremonial knowledge.
13. Create pooled funding initiatives with tribal governance boards to guide maternal health investments across regions and sectors.

14. Support policy advocacy and technical assistance for tribal governments navigating Medicaid expansion, federal grant applications, and maternal health legislation.

Access to Education

1. Expand Indigenous-focused educational initiatives that center tribal governance, embed traditional knowledge into curricula, and place training on or near tribal lands so communities can lead and sustain their own workforces.
2. Fund degree pathways and practical training for midwives, doulas, lactation consultants, behavioral health providers, Traditional Practitioners, and physicians. with multi-year, flexible, nonrestrictive mechanisms designed with tribal leaders and community members.
3. Align federal and philanthropic levers—HRSA to include tribal-led training grants, CMS to reimburse and integrate Traditional Practitioners, and increased foundation investment—to resource tribally governed credentialing and culturally sovereign licensure models that remove accreditation barriers and address social determinants that enable completion and community return.
4. Expand telehealth and support community-based birthworkers and home visiting programs to extend services beyond clinical settings; note: the Tribal MIECHV initiative supported 53 grantees across 110 communities and completed 94% of scheduled home visits.
5. Scale reimbursement for doula services through state plans as an additional pathway to increase access to culturally competent traditional birth support.

Policy and Funding

1. Create blended funding pilots: Pair multi-year philanthropic anchors (3–5 years) with an explicit Medicaid/state pilot for billing doulas, community midwives, and telehealth perinatal services.
2. Fund paid cohort-based workforce waterways: Support apprenticeship stipends, elder stipends, clinical preceptor salaries, and credentialing costs to build durable Indigenous midwifery and doula workforces.
3. Advance Medicaid policy reforms: Advocate for (a) Medicaid doula reimbursement and parity, (b) licensing flexibility for community midwives, and (c) telehealth reimbursement with dedicated codes for perinatal services.
4. Invest in infrastructure for maternity deserts: Prioritize broadband, telehealth kits, travel vouchers, and mobile clinics through combined state and philanthropic capital grants.
5. Adopt a standardized culturally aligned evaluation + data sovereignty template: Funders should accept community-approved metrics and tribal governance clauses to accelerate evidence use and protect data rights.
6. Encourage multi-year, flexible philanthropic commitments: Funders should reduce onerous eligibility requirements and support grassroots tribal organizations with multi-

year operating grants that include unrestricted overhead and cultural line items.

Appendix I: Leveraging CMS

CMS should issue model patient relationship categories and codes, care coordination arrangement for AI/AN patients by clarifying clinical responsibility, data-sharing, and billing mechanics for hospital services furnished “received-through” IHS/Tribal facilities; require transforming maternal health state models and TMaH pre-implementation so partnerships are mature by APM go-live.

Objective

- Standardize hospital–Tribal referral and reimbursement mechanics so hospital-delivered obstetric, perinatal mental health, and specialty services for American Indian and Alaska Native (AI/AN) patients flow through IHS/Tribal hubs and qualify for 100% FMAP, while funding Tribal care coordination and preserving Tribal data sovereignty.

Key Policy Asks

- Issue a CMS Hospital–Purchased Referred Care (PRC) and Care Coordination Agreement (CCA) playbook with templates for CCAs, data-use agreements, clinical responsibility tables, and billing/claim examples.
- Require Transforming Maternal Health (TMaH) state APMs to incorporate hospital–Tribal shared-savings or risk arrangements and documented postpartum continuity plans with IHS/Tribal primary care.
- Promote and operationalize the 100% FMAP “received-through” pathway by publishing technical guidance, exemplar CCAs, and checklists for FMAP claims.

Immediate Implementation Steps

- Publish a one-stop CMS toolkit with ready-to-use CCA, data-sharing, privileging, and billing templates.
- Pilot hospital–Tribal CCAs and shared-savings APM language in TMaH pre-implementation states and scale proven models in the implementation phase.
- Fund Tribal care coordination positions through grants or Medicaid flexibilities to operationalize referrals, teleconsult workflows, and navigation.
- Convene a CMS learning collaborative for hospital and Tribal clinical, billing, and legal teams to troubleshoot FMAP claims and share best practices.

Metrics and Equity Safeguards

- Track process metrics: number of executed CCAs; hospital OB teleconsults routed through IHS/Tribal hubs; claims billed at 100% FMAP.
- Track outcome metrics: postpartum visit continuity at 30 and 90 days with IHS/Tribal

primary care; maternal morbidity and readmission rates for AI/AN patients; patient-reported experience.

- Require Tribal opt-in, co-governance language, and explicit data-sovereignty protections in all CCAs and APMs.

Risks and Mitigations

- Billing denials: include exemplar claim attachments and CMS pre-approval templates in the toolkit.
- Unclear clinical responsibility: include a standardized clinical responsibility matrix in CCAs that assigns roles, signature authority, and transfer thresholds.
- Tribal sovereignty concerns: require Tribal legal review, Tribal-led governance clauses, and direct funding flows to Tribal care coordination.

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