

Policy Brief

Workforce Equity in Maternal Health: Tribal and Native Community-Led Solutions

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October 2025

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Executive Summary

This report, jointly authored by the American College of Nurse Midwives (ACNM), the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and the National Association of Certified Professional Midwives (NACPM), outlines urgent priorities and actionable strategies to advance perinatal health workforce equity for American Indian (AI), Alaska Native (AN), and Native Hawaiian (NH) communities.

To honor the cultural, linguistic, and spiritual diversity of Indigenous Peoples in the United States, this report uses the term AI/AN/NH as a collective reference. We recognize that recommendations will resonate differently based on each Tribe's unique context.

Despite long-standing commitments to health equity, AI/AN/NH communities continue to face disproportionately high rates of perinatal and infant morbidity and mortality. In some states, AI/AN/NH individuals are up to 8.5 times more likely to die during pregnancy or within a year postpartum than white counterparts. These disparities are rooted in systemic inequities including underrepresentation in the healthcare workforce, deeply ingrained implicit bias in healthcare systems and chronic underinvestment in community-based systems of care.

Yet, even in the face of these persistent inequities, AI/AN/NH communities continue to demonstrate profound strength, resilience, and leadership. Rooted in millennia of knowledge, Indigenous cultures hold rich traditions of community-based care, kinship support, and land stewardship that have sustained generations. The interconnectedness of family, community, and land forms a foundation for holistic approaches to health and wellbeing. Place and land are not only sources of sustenance but are intimately tied to identity, ceremony, and healing. Supporting perinatal health in these communities requires more than addressing disparities; it calls for honoring Indigenous worldviews, uplifting community-driven solutions, and investing in the restoration and continuation of traditional practices that promote thriving families and futures.

This report centers Tribal sovereignty, Indigenous knowledge, and Native-led solutions as essential to reversing these trends.

Key Findings

- **Severe underrepresentation** of AI/AN/NH professionals in perinatal health.
- **Barriers to education and licensure**, particularly for community-based providers.
- **Workforce retention challenges** due to geographic isolation, safety concerns, lack of infrastructure, and limited long-term incentives.
- **Fragmented care systems** that fail to integrate Tribal, federal, and state health services.
- **Chronic underfunding** of the Indian Health Service (IHS) and Native-led organizations.

Policy Recommendations

- **Invest in culturally grounded education and workforce pathways**, including support for midwifery and community-based care.
- **Expand Medicaid reimbursement** for traditional and Indigenous care providers.
- **Strengthen IHS infrastructure** and align data systems with Indigenous-defined outcomes, including Tribal licensure of healthcare providers.
- **Provide sustained philanthropic and federal funding** to support Tribal governance and long-term sustainability of Native-led care models.
- **Uphold Tribal sovereignty** in licensing and credentialing through recognition by national professional organizations.

This report is both a call to action and a strategic roadmap. It urges Congress, federal and state agencies, philanthropic partners, and health systems to realign policy, funding, and infrastructure with the leadership and expertise of Native communities.

True equity cannot be achieved by simply integrating Native peoples into systems that have historically oppressed them. It requires resourcing the systems of care that uphold Indigenous sovereignty while advancing inclusion, recognition, and respect within broader U.S. health systems.

Community-Based Care & Integration Trends and Challenges

Community-based care refers to systems of health and healing that originate within and are governed by the communities they serve. These models emphasize relational care, cultural congruence, and accountability to local priorities. For AI/AN/NH communities, such systems have existed for generations and reflect longstanding practices of collective responsibility, intergenerational knowledge-sharing, and connection to land and culture.¹

These communities continue to develop and maintain care systems that incorporate both traditional and contemporary approaches to health, including spiritual healing, midwifery, behavioral health, and chronic disease prevention.² Care is often delivered through extended kin networks, community-based organizations, Tribal health departments, and mobile or telehealth services that are responsive to geographic and cultural context.³

Despite this, dominant health care systems and funding mechanisms often marginalize or overlook these models. The lack of sustained investment, regulatory flexibility, and recognition of culturally based care contributes to ongoing disparities in perinatal and overall health outcomes among AI/AN/NH populations.

Strengthening community-based care and promoting effective integration requires aligning policy and funding with Indigenous systems that are already in place, rather than attempting to replace or reshape them through externally, colonial-defined standards.⁴

To advance health equity, it is necessary not only to increase access to dominant models, but to also invest in community-led systems that already exist. This means shifting from extraction to regeneration, from institutional control to community governance, and from short-term service delivery to long-term care ecosystems. Community-based care and integration should not only be about fitting communities into dominant systems, but

¹ Lankester, Ted, and Nathan J. Grills (eds), *Setting up Community Health and Development Programmes in Low and Middle Income Settings*, 4 edn (Oxford, 2019; online edn, Oxford Academic, 1 Mar. 2019), <https://doi.org/10.1093/med/9780198806653.001.0001>

² Hicks, E., Knipper, E., Buchwald, D., & Taylor, V. (2023). “When you hear the noise, you know it’s love”: Family caregiving support among American Indian women’s health. *Frontiers in Public Health*, 11, 1158453. <https://doi.org/10.3389/fpubh.2023.1158453>

³ Hays, T. (2014). The Success of Telehealth Care in the Indian Health Service. *AMA Journal of Ethics*.

⁴ United Nations, *State of the World’s Indigenous Peoples: Indigenous Peoples Access to Health Services* <https://www.niea.org/native-student-data>

rather about resourcing the knowledge systems and opportunities that communities have already built.⁵

This section outlines the key barriers to integrated, community-based care and highlights opportunities to build on the capacity, knowledge, and innovation already present in Indigenous communities. It is grounded in the understanding that equitable health systems must reflect the values and priorities of the people they serve.

Cultural Misalignment in Policy and Regulation Cultural Misunderstanding of Workforce Entry Conditions

A significant barrier to entering the perinatal health workforce in AI/AN/NH communities stems from a lack of understanding by dominant systems of the cultural and economic structures that shape workforce readiness. For example, in many of these communities, more than half of family matriarchs often serve as the primary financial and caregiving anchors, supporting not only their children but extended family networks as well. More than 50% of families rely on matriarchs as their primary source of income and stability. Education and training pathways that require extended time away from home, unpaid internships, or rigid schedules can be nearly impossible to navigate without major disruption to these vital family systems. Without flexible, community-based pathways and financial support mechanisms that acknowledge these realities, many capable and committed individuals are excluded from entering perinatal health professions altogether.⁶

An example of a community-based pathway and financial support mechanism that acknowledge these realities is the use of community reinvestment funds from a non-profit hospital in New Mexico to support 8 AI students in completing their training as a Certified Professional Midwife.

In addition, the cultural and spiritual importance of remaining land-based, living in ancestral communities, connected to local ecosystems, traditions, and governance, is often in direct conflict with educational programs that require physical relocation or full-

⁵ Geana, M. V., Harrison, L., Williams, M., & Sheats, J. Q. (2012). Improving health promotion to American Indians in the Southwest United States: Differences in access and use of Internet, telephone, and print media. *Health Communication*, 27(5), 478–487. <https://doi.org/10.1080/10410236.2011.606523>

⁶ Glover, R., Downey, M. M., O'Connor, C. E., Johnson-Jennings, M., & others. (2025). Indigenous Motherwork in Crisis: Caregiving, Resistance, and Community Survival During the COVID-19 Pandemic. *Sex Roles*, 91, article 34.

time, in-person residency.⁷ Many midwifery and healthcare training programs are built on models that presume geographic mobility, nuclear family arrangements, and the ability to relocate for months or years at a time. For AI/AN/NH students, this expectation can force a painful choice between achieving professional advancement and preserving cultural connections. Without remote-accessible pathways, decentralized clinical training sites, and education models that respect land-based identity and responsibility, these communities will remain systematically excluded from perinatal health workforce development efforts. **Support for the creation of hybrid educational opportunities in collaboration with Tribes that offer online learning and mobile education units that can travel to Tribal lands is essential.**

Fragmented Systems of Care

Federal, state, Tribal, and local health programs often operate in silos, with limited coordination. This fragmentation results in service gaps, duplicative efforts, and inefficiencies, particularly in rural and remote communities, in which almost all AI/AN/NH communities dwell.⁸ For families navigating perinatal and behavioral health systems, disjointed care pathways often lead to delays in treatment, confusion about eligibility, and lack of care continuity. **To improve perinatal health care delivery to Indigenous communities, it is essential that a mandate is put in place for federal, state, Tribal and local health programs to create a joint Tribal resource map as a part of perinatal quality thereby connecting team members and decreasing frustration related to siloing, ultimately improving workforce experience across programs.**⁹

Structural Underinvestment

“IHS dollars haven’t increased so it is essentially being defunded.” Beata Tsosie Peña, Doula and Lactation Counselor

The Indian Health Service (IHS) remains funded at less than half the per capita rate of

⁷ Walls, M. L., et al. (2012). The intergenerational effects of relocation policies on three generations of American Indians. *American Journal of Public Health, 102*(1), 191–197. <https://doi.org/10.2105/AJPH.2011.300283>

⁸ Sherry, M., et al. (2016). *Bridging the Silos of Service Delivery for High-Need Clients*. National Academy of Medicine, *NAM Perspectives*. Retrieved from PMC.

⁹ Bauer, K. L., Tryon, E. T., Sage, M. E., Reidel, P. S., & Meline, C. M. (2023). Examining characteristics of local public health systems associated with Tribal organization participation. *Frontiers in Public Health*. <https://doi.org/10.3389/fpubh.2023.10833201>

other federal health systems.¹⁰ Many AI/AN/NH serving organizations operate without access to core infrastructure support. Moreover, while the cost of health care, staffing, and infrastructure continues to rise, IHS appropriations often fail to include inflation-adjusted increases. In effect, this amounts to an annual erosion of purchasing power, functionally defunding essential programs and infrastructure even when nominal funding levels remain flat. As a result, community-based programs are forced to operate with chronic under-resourcing, limiting innovation, expansion, and sustainability.

Bureaucratic and Navigational Burdens

Many families must navigate multiple benefit systems (e.g., IHS, Medicaid, CHIP, WIC, TANF) to access basic care. These systems rarely communicate with one another and impose burdensome documentation and renewal requirements. This is particularly challenging for individuals experiencing housing instability, language barriers, substance abuse, or trauma.

Healthcare inequities have significantly contributed to disparities across multiple dimensions of health systems, including cultural misalignment in policy and regulation, misunderstanding of workforce entry conditions, fragmented systems of care, structural underinvestment, and bureaucratic and navigational burdens. Policies and regulations are often developed without adequate engagement from the cultural communities they will most impact, resulting in frameworks that misalign with community values and practices and perpetuate mistrust in health institutions.¹¹ Similarly, regulatory misunderstanding of workforce entry conditions, such as the limited recognition of apprenticeship-based or community-rooted training models disproportionately exclude AI/AN/NH students and providers further constraining the development of AI/AN/NH practitioners.¹² Fragmented systems of care further exacerbate inequities, as patients must navigate disjointed services without culturally competent guidance, which contributes to disparities in outcomes.¹³ Structural underinvestment, particularly evident in the IHS, has created resource gaps that

¹⁰ U.S. Government Accountability Office. (2018). *Indian Health Service: Spending levels and characteristics of IHS and three other federal health care programs (GAO-19-74R)*. <https://www.gao.gov/assets/gao-19-74r.pdf>

¹¹ Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. National Academies Press.

¹² Campbell, K. M., Brownstein, N. C., & Livingston, H. (2018). Improving the pipeline for the midwifery workforce: Overcoming barriers to entry and practice. *Journal of Midwifery & Women's Health*, 63(6), 707–713. <https://doi.org/10.1111/jmwh.12805>

¹³ Chin, M. H., Clarke, A. R., Nocon, R. S., Casey, A. A., & Goddu, A. P. (2012). A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. *Journal of General Internal Medicine*, 27(8), 992–1000. <https://doi.org/10.1007/s11606-012-2082-9>

limit access and quality of care. Additionally, bureaucratic and navigational burdens, including complex eligibility requirements and reimbursement structures, place disproportionate strain on these communities, reinforcing cycles of exclusion and poor health outcomes.¹⁴ Collectively, these inequities demonstrate how systemic failures are embedded not only in access to care but in the very design and operation of health policy and infrastructure.

Trends and Challenges in Workforce Equity

The perinatal healthcare team represents individuals across multiple disciplines including physicians, advanced practice, registered, and licensed practical nurses, credentialed midwives, lactation consultants, doulas, and other birthworkers, with various education and training pathways. There are over 9.8 million AI/AN/NH people who represent approximately 3.4% of the U.S. population^{15,16} and primarily seek healthcare in or around the 324 federally recognized Tribal communities or the 229 federally recognized Tribes in Alaska¹⁷ in the 50 states. However, the supply of qualified healthcare team members does not meet the needs of the population served.^{18,19} In addition, there is an extreme discordance between the race and socioeconomic status of perinatal healthcare team members and the AI/AN/NH communities they serve. There are many factors that contribute to challenges in the perinatal healthcare workforce pathway to meet the needs of this underrepresented population. The following sections will review the current number, growth and population concordance and educational pathways of perinatal

¹⁴ Williams, D. R., Lawrence, J. A., & Davis, B. A. (2019). Racism and health: Evidence and needed research. *Annual Review of Public Health, 40*, 105–125. <https://doi.org/10.1146/annurev-publhealth-040218-043750>

¹⁵ US Department of Health and Human Services Office of Minority Health. (2025) Profile: American Indian /Alaska Native Health <https://minorityhealth.hhs.gov/node/8/visions/8/view>

¹⁶ US Department of Health and Human Services Office of Minority Health.(2025) Profile Native Hawaiian and Pacific Islander Health <https://minorityhealth.hhs.gov/native-hawaiian-and-pacific-islander-health>

¹⁷ Bureau of Indian Affairs. (n.d.). *Alaska Region*. U.S. Department of the Interior. Retrieved October 2, 2025, from <https://www.bia.gov/regional-office/alaska-region>

¹⁸ World Population Review. (2025). Native American Reservations by State, 2025.

<https://worldpopulationreview.com/state-rankings/native-american-reservations-by-state>

¹⁹ US Department of Health and Human Services, Health Resources and Service Administration. (2021). Projections of Supply and Demand for Woman’s Health Service Providers: 2018-2023. <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/projections-supply-demand-2018-2030.pdf>

healthcare providers. When known, successes and challenges are highlighted for each of the perinatal healthcare roles previously mentioned.

Current Number, Growth, and Population Concordance

Advance Practice Registered Nurses (APRN): There are over 500,000 Advanced Practice Registered Nurses (APRNs) in the United States, yet only a fraction identify as American Indian, Alaska Native, or Native Hawaiian (AI/AN/NH). Specifically, just 0.3% of APRNs, 0.58% of Certified Nurse-Midwives (CNMs), and 0.2% of CNMs identify as AI/AN or NH, respectively. This stark underrepresentation limits access to culturally concordant care in Indigenous communities particularly in reproductive and maternal health.

Among the APRN workforce, Nurse Practitioners (NPs) make up 71%, Clinical Nurse Specialists (CNSs) 16.8%, and Certified Registered Nurse Anesthetists (CRNAs) 9.1%. Despite their growing numbers, AI/AN/NH voices remain largely absent from these provider roles.

By 2030, the U.S. is projected to have a surplus of both Women’s Health Nurse Practitioners and Certified Nurse-Midwives. These key roles are capable of delivering reproductive and perinatal care across the lifespan and this surplus presents a unique opportunity to strategically invest in training and supporting Indigenous APRNs to fill persistent care gaps in Tribal and Native Hawaiian communities. This surplus presents as an opportunity for potential improvements when the following action steps are taken:

- Targeted recruitment, scholarships, and mentorship programs for AI/AN/NH students into APRN tracks, particularly Women’s Health NPs and CNMs.
- Strengthened federal funding for culturally grounded APRN education, including support for Tribal colleges, universities, and clinical training sites.
- Workforce policies that prioritize placement and retention of Indigenous APRNs in underserved and Native communities.

Behavioral Health Providers:

The GW Mullan Institute’s *Behavioral Health Workforce Tracker* identifies approximately 1.3 million behavioral health providers in the U.S., broken down as:

- ~700,000 behavioral health specialists (psychiatrists, psychologists, licensed clinical social workers, counselors/therapists, addiction specialists)

- ~435,000 primary care physicians and advanced practice providers who prescribe behavioral-health medications (i.e. who play a behavioral health role)
- ~182,871 other physician specialists who prescribe ≥ 11 behavioral health medications

Credentialed Midwives: There are 14,250 Certified Nurse-Midwives (CNM) and Certified Midwives (CM) in the United States. Only 0.7% self-identify as AI/AN/NH.⁸ They are licensed to practice in all states and territories. There are approximately 3,500 Certified Professional Midwives (CPM), who are licensed to practice in 37 states. There are 5.3% CPMs who self-identified as AI/AN/NH on the 2024 NARM Job Analysis.²⁰

Doulas: There is *no comprehensive registry* of all doulas in the U.S. Some informal estimates include:

- One source (Childbirth Connection data cited in a local article) noted that in 2012, ~6% of surveyed women (n = 2,400) said they used a doula.
- A doula directory (DoulaMatch.net) claims ~5,000 active doulas in its database and uses that as a basis for estimating ~12,000 nationally.
- Certification counts provide a partial signal: for example, DONA International (one of many doula certifying organizations) reports having certified 14,500 doulas (in over 50 countries) as of their recent reporting.

Licensed Practical Nurses: Over 630,000 Licensed Practical/Vocational Nurses are employed in the United States²¹ with similar representation for AI/AN/NH as the other healthcare team members.

Obstetrician-Gynecologist Physicians : There is a declining pool (19,820) of Obstetricians-Gynecologists (OB/GYN)²² across the country and it is anticipated that the demand will outpace the supply by 2030, as a 4% increase in demand is compounded by a 7% reduction in OB/GYN workforce.⁵ Additionally, only 0.3% of medical students

²⁰ Professional Testing Corporation. (2024). *Job task analysis for the Certified Professional Midwife (CPM) certification program: Final report*. North American Registry of Midwives (NARM).

²¹ U.S. Bureau of Labor Statistics. (2024). Occupational Employment and Wages, 2023:29-2061 Licensed Practical and Licensed Vocational Nurses. <https://www.bls.gov/oes/2023/may/oes292061.htm>

²² US Bureau of Labor Statistics. (2023). Occupational Employment and Wage Statistics Obstetrician and Gynecologist. <https://www.bls.gov/oes/2023/may/oes291218.htm>

identify as American Indian, Alaska Native, Native Hawaiian, or Pacific Islander (AI/AN/NH/PI).²³ This shortfall is especially alarming given that only 0.3% of medical students identify as AI/AN/NH/PI forecasting a continued lack of culturally concordant OB/GYN care.

Compounding the issue, there is a notable decline in medical students selecting OB/GYN as their specialty. While many students initially express interest in OB/GYN during their first year of medical school, nearly half change course by graduation, citing factors such as demanding night coverage, work-life balance challenges, and a perceived lack of inclusivity particularly in outpatient settings that do not center community or culturally relevant care.

The distribution of OB/GYN providers is also highly uneven, with the most severe shortages concentrated in rural states, many of which have significant AI/AN/NH populations. In states with large Tribal communities, persistent provider-to-patient disparities remain stark:

- Nebraska (92.9% shortage)
- South Dakota (78.6%)
- Arizona (70.1%)
- Oklahoma (66.1%)
- Utah (65.5%)
- New Mexico (56.8%)

These shortages reflect a broader systemic failure to sustain an OB/GYN workforce that is both geographically and culturally aligned with the needs of AI/AN/NH communities.

Registered Nurses: There are more than 4.7 million registered nurses in the United States, 0.8% who are AI/AN/NH.²⁴

²³ López CL, Wilson MD, Hou MY, Chen MJ. Racial and Ethnic Diversity Among Obstetrics and Gynecology, Surgical, and Nonsurgical Residents in the US From 2014 to 2019. *JAMA Network Open*. 2021 May 3;4(5):e219219. doi: 10.1001/jamanetworkopen.2021.9219. PMID: 34009352; PMCID: PMC8134986.

²⁴ American Association of Colleges of Nursing. (2024). *Nursing Workforce Fact Sheet*. <https://www.aacnnursing.org/news-data/fact-sheets/nursing-workforce-fact-sheet>

Health Workforce Educational Pathways

It is important to understand the varied educational pathways for healthcare providers at all levels as well as the barriers and challenges individuals experience in access to and completion of the required education to be licensed as a healthcare professional.

Advanced Practice Registered Nurses: APRN education requires licensure as an RN, completion of an accredited graduate (Master/Doctorate Nursing Practice [DNP]) nursing program for designated role (Certified Nurse Practitioner, Certified Nurse Midwife, Certified Nurse Anesthesiologist and Clinical Nurse Specialist) and population foci (Adult-Geriatrics, Family, Neonatal, Pediatric, Psychiatric Mental Health, and Woman's Health/gender-related), successful completion of the role-population certification exam and APRN licensure approval. There are several entry pathways for APRN education that include Baccalaureate to Master's (BSN-MSN), Baccalaureate to Doctoral (BSN-DNP), Master's to Doctoral (MS-DNP) and Direct entry (non-nurse) Baccalaureate to Master's (BS-MSN), and Baccalaureate to Doctoral (BS-DNP). Not all APRN-designated roles (CNS) have certification exams for the population foci (women's health), prohibiting licensure in the advanced practice role.¹²⁵

Credentialed Midwives: Education of Certified Nurse-Midwives (CNM) and Certified Midwives (CM) occurs in an accredited graduate program. This is followed by a national certification exam and state licensure. Nurse-midwives have previous degrees in nursing and a current RN nursing license. Certified Midwives have a prior bachelor's degree in other fields, with required science courses. CNMs have licensure in all states; CMs have licensure in 11 states.²⁶ These midwives provide both perinatal and GYN services, as well as care of the neonate in all practice environments including hospitals, birth centers and home.

CPM certification eligibility routes include academic programs accredited and pre-accredited by the Midwifery Education Accreditation Council (MEAC), the American Midwifery Certification Board (AMCB), completion of a Portfolio Evaluation Process either through North American Registry of Midwives (NARM), or a state-sanctioned portfolio pathway, as well as international equivalency. Academic pathways include Competency Based Portfolio programs, Diploma, Associate degree, Baccalaureate degree and Master's Degree. Certified Professional Midwives are licensed in 37 states and the

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²⁶ American Colleges of Nurse-Midwives. About the Certified Midwife Credential. <https://midwife.org/certified-midwife-credential/>

District of Columbia and are recognized without licensure in 2 additional states. Not all eligibility routes are recognized by all state licensure boards.

Lactation Consultants: There are 20,540 lactation consultants across the United States,²⁷ less than 1% of whom are AN/AI/HN.²⁸

Licensed Practical Nurses: To become a Licensed Practical/Vocational Nurse (LPN/LVN) an individual completes a 12-month certificate program, successfully passes the NCLEX-PN exam and obtains state licensure approval.

Registered Nurses: Registered nurse (RN) educational pathways consist of completion of an accredited program, receiving a Diploma, Associate's degree, or Baccalaureate degree, successfully passing the NCLEX-RN exam, and securing state RN licensure approval. Diploma programs are typically 12-18 months in length (<100), associate degree programs are 2 years in length, and baccalaureate degree programs are 4 years in length. Degree completion programs, where a nurse with a diploma or associate's degree completes coursework to obtain a baccalaureate degree, are 18-24 months long. EMT/Paramedic/Military medic to RN programs vary from 2-5 years. Direct entry Master's programs, for non-nurses changing careers, culminating in a Master's degree in an APRN role, are 3 years long.

Physicians: Physician education typically consists of four years of undergraduate studies, four years of medical school and 3-7 years of residency. Additional years of training are optional after residency, such as those necessary for fellowship-trained specialties like Maternal-Fetal Medicine. Physicians must pass a variety of standardized exams at each stage of training, including the Medical College Admissions Test (MCAT), three separate steps of the United States Medical Licensing Exam (USMLE) or its equivalent, the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). Physicians also sit for specialty-specific board exams. For the field of OB/GYN, this includes both oral and written examinations.

²⁷ International Board of Lactation Examiners, *Current Statistics on Worldwide IBCLCs*, <https://iblce.org/about-iblce/current-statistics-on-worldwide-ibclcs/>

²⁸ Washington Post, Less than 1 percent of America's lactation consultants are Indigenous. For these women, it's a way to empower their communities. <https://www.washingtonpost.com/gender-identity/less-than-1-percent-of-americas-lactation-consultants-are-indigenous-for-these-women-its-a-way-to-empower-their-communities/>

Successes in Education Pathways for Indigenous Students

Alaska: CNA-RN program that contracts with Alaska Native Medical Center providing either free training (CNA) or 12 hours student work weeks with compensation of 36 hours while attending RN school. Preference to AI/AN students.

Alaska: Strengthening Healthcare Access Recruitment Program (SHARP)²⁹ is a loan repayment program for medical, dental, and behavioral health specialties that enter into a 3-way memorandum of understanding between the department of health, employer and healthcare team members that work in rural and underserved areas for 2 years.

Minnesota: In fall of 2023, a historic number of AI/AN DNP students (14) were enrolled at the University of Minnesota School of Nursing.³⁰ A nursing workforce diversity grant by the Health Resources and Services Administration (HRSA) made it possible to profoundly impact the number of doctorate prepared Indigenous nurses, many of whom serve Tribal communities. From 2017-2025, Bemidji State University's Niganawenimaanaanig (Ojibwemowin for 'we take care of them') held the same HRSA grant funding. In eight years, they graduated 43 AI/AN students with a BSN.³¹

New Mexico: In 2023, a non-profit hospital, Presbyterian, directed its community investment fund toward the education of 8 AI CPM students to be trained in their community through the state licensing process.

Oklahoma: OSU-COM at Cherokee Nation, Osteopathic School of Medicine located on the Cherokee Nation reservation, is the first of its kind, where medical students can complete the full four years of education on the Cherokee Nation health campus. Because OSU is a state university, Indian Preference for entry cannot be given. However, it does provide an option for Cherokee students to remain on the reservation to complete their program. The partnership has also implemented a residency program for family medicine and established a same-day style clinic that is staffed by the residents.

South Dakota: South Dakota Oglala Lakota College nursing program offers an Associate Degree Nurse RN program on the Oglala Sioux Tribe reservation. The program graduates

²⁹ State of Alaska, Department of Health, Strengthening Healthcare Access Recruitment Program (SHARP) Incentive <https://health.alaska.gov/en/services/sharp/>

³⁰ University of Minnesota School of Nursing, With a Pathway 16 American Indians Nurses join DNP Program <https://nursing.umn.edu/news-events/pathway-16-american-indian-nurses-join-dnp-program>

³¹ Wilkie, M. (2025). Decolonizing health and restoring balance: Indigenous-led efforts to improve health outcomes among American Indian and Alaska Native populations through doctoral nursing education. *Creative Nursing*, 31(3), 236–242. <https://doi.org/10.1177/10784535251350296>

an average of 10-15 RNs to the workforce each year. . Through a partnership with IHS, students are able to complete all clinicals without leaving the reservation. Admission is not restricted to American Indians, however, tuition for AI students is minimal.

Challenges in Education Pathways for Indigenous Students

Challenges in increasing the workforce of AI/AN/NH persons starts during basic schooling if students are not encouraged to take the math and science courses that are foundational to most health care careers. Disproportionate rates of high school dropouts in AI/AN/NH populations and poor standardized test scores³² results in lower acceptance rates for training. Unlike in other communities, many colleges and universities do not recruit high school students in Tribal communities to attend their institutions.

Once accepted to a program, the length and cost can be a limiting factor. A relative scarcity of mentors and a lack of culturally appropriate educational opportunities and obvious career pathways can make it easier for a discouraged student to leave their programs. In medical education, limits on the amount of loans can deter potential students. Recent federal cuts to university programs and support services for AI/AN/NH students have further compounded these challenges. These programs have historically played a vital role in addressing disparities by providing academic advising, mentorship, and workforce development opportunities tailored to these students. The elimination or reduction of such funding threatens to widen existing inequities. For example, at the University of Alaska, where AN/NH students represent 18.3% of the student body, millions of dollars in federal cuts will directly reduce resources for workforce development initiatives and advising services.³³ This loss undermines efforts to retain these students in higher education and weakens pathways into health professions at a time when AI/AN/NH communities are experiencing urgent shortages in providers. Without sustained federal investment, universities risk eroding the already fragile infrastructure that supports student success and limits the ability of future AI/AN/NH health professionals to complete their training and return to serve their communities.

Aspiring students are challenged by a lack of clinical placements and educational facilities within Tribal communities. Partnership between IHS or Tribal operated hospital

³² National Indian Education Association, Data on Native Students, <https://www.niea.org/native-student-data>

³³ Smith, C. (2025, September 18). Trump administration cuts to University of Alaska programs for Native students are worse than previously announced. *Anchorage Daily News / Alaska Beacon*. <https://www.adn.com/alaska-news/2025/09/18/trump-cuts-to-university-of-alaska-programs-for-native-students-worse-than-previously-announced/>

and academic institutions for clinical rotations is challenging. Limited exposure to these institutions can affect a student's desire to work there in the future. There is frequently a lack of clinical preceptors due to varied training models, such as volunteer-based versus compensation-based services. For clinicians wishing to be clinical preceptors there may be little support from their employers who fear a loss of productivity in the employee who is also a preceptor. IHS currently does not have any specific teaching pathways for its clinicians.

Education that occurs in the local community is challenged by the healthcare faculty shortage that is present nationwide and which is particularly acute in nursing.³⁴ This is amplified by a shortage of culturally congruent faculty and a lack of adequate training on how to provide culturally safe education to non-culturally congruent faculty.

Faculty Shortage

The overall shortage in faculty and resources for health care education is driven by numerous common factors including reliance on unpredictable government funding, a need for highly specialized faculty, lengthy recruitment times, expansion of programs in some specialties leading to a competition for talent, and disparities in salary between clinical practice and a faculty salary.³⁵ In rural states there may be further challenges with attracting healthcare faculty who want the stimulation of a more urban workplace.

Issue: Insufficient and At-Risk Federal Funding for Indigenous Maternal Health Workforce Development

Background:

American Indian, Alaska Native (AI/AN), and Native Hawaiian (NH) communities face some of the highest maternal mortality and morbidity rates in the United States. Addressing these disparities requires a robust, culturally concordant perinatal and reproductive health workforce. However, critical federal funding streams that support

³⁴ American Association of Colleges of Nursing. May 2024. Fact Sheet:Nursing Faculty Shortage. <https://www.aacnursing.org/Portals/0/PDFs/Fact-Sheets/Faculty-Shortage-Factsheet.pdf>

³⁵ Evidence in Motion. 6 Faculty Recruitment Challenges in Healthcare Education. October 2023. <https://eimpartnerships.com/articles/6-faculty-recruitment-challenges-in-health-care-education#:~:text=During%20faculty%20shortages%2C%20existing%20faculty%20members%20may,leading%20to%20increased%20workload%20and%20potential%20burnout.>

Indigenous providers and community-based models of care are either insufficient or under threat.

Key Funding Concerns Affecting AI/AN/NH Communities:

1. Threats to Title VIII Nursing Workforce Programs:
The *Title VIII Nursing Workforce Reauthorization Act* is at risk of being underfunded, threatening programs like the Nurse Faculty Loan Program and the Nursing Workforce Diversity Program. These initiatives are essential for recruiting and training Indigenous nurses and faculty who can serve their own communities.
2. Indian Health Service (IHS) Scholarship and Loan Repayment Programs:
The IHS Scholarship and Loan Repayment Programs are a cornerstone of provider recruitment and retention in Tribal and rural areas. Continued and increased investment is critical to maintaining a stable maternal health workforce in Indian Country.
3. Underfunding of Non-Nurse Midwifery Education:
Under *Title VII*, only \$5 million is allocated to the Scholarships for Disadvantaged Students (SDS) program for non-nurse midwifery education, including Certified Professional Midwives (CPMs) and Certified Midwives (CMs). These culturally and community-aligned midwifery pathways are especially important in AI/AN/NH communities, yet remain severely underfunded.
4. Lack of Dedicated Support for Culturally Concordant Educational Pathways:
Indigenous communities need pathways that support culturally grounded, community-based models of care including doulas, midwives, traditional birth attendants, and Indigenous-led training programs. Current federal funding lacks explicit support for these concordant educational models.
5. Inadequate Loan Forgiveness for Indigenous Perinatal Physicians:
Under the Opportunities for a Better Birth and Beyond Act (OBBBA), the \$200,000 loan cap for perinatal physician training is insufficient. With average medical school debt exceeding \$238,000, this gap creates barriers for AI/AN/NH

students entering maternal health specialties, further limiting access to Indigenous physicians.

Policy Recommendations:

- Fully fund Title VIII and protect diversity-focused nursing programs.
- Expand IHS scholarship and loan repayment allocations to meet maternal health workforce needs.
- Increase Title VII funding for non-nurse midwifery programs serving AI/AN/NH communities.
- Create dedicated funding streams for culturally concordant and community-based education pathways.
- Raise the loan forgiveness cap for perinatal physicians under OBBBA to reflect the true cost of medical education.

Policy Recommendations in Workforce Development

Support Federal funding for health care faculty recruitment/retention and educational program infrastructure such as simulation labs.

Support specific educational funding such as midwifery-specific funding proposed in the Midwives for Maximizing Optimal Maternity Service (MOMS) Act. Support loan forgiveness programs through expanding scholarship opportunities for student midwives enrolled in accredited midwifery education programs, the Midwives for MOMS Act will increase access to evidence-based and culturally congruent maternity care as provided by Certified Nurse-Midwives (CNMs), Certified Midwives (CMs), and Certified Professional Midwives (CPMs).

Opportunities and Needs in Workforce Development

Invest in Existing Community-Based Models

AI/AN/NH-serving groups have established successful models of perinatal and behavioral health that are culturally grounded and community-led. Sustained investment in these models, not just as pilot programs but as core components of the care infrastructure, is essential.

One powerful example is Tewa Women United (TWU) in Northern New Mexico. Founded and led by Indigenous women, TWU provides culturally rooted health, environmental, and reproductive justice services through programs such as the Yiya Vi Kagingdi Community Doula Project. This initiative trains and supports Indigenous doulas who provide wraparound perinatal care grounded in Tewa cultural values, language, and ceremony. TWU integrates advocacy, healing, and direct services, and serves as a model of what is possible when care systems are governed by the communities they serve. Despite its impact, TWU, like many grassroots Indigenous organizations, has faced persistent funding challenges due to the limitations of grant-driven models and the lack of sustained investment in Native-led infrastructure.

Programs like TWU demonstrate that the expertise and innovation needed to address perinatal and behavioral health disparities already exist within AI/AN/NH communities. The priority must now be to fund these efforts with the long-term, flexible resources they require to thrive and scale.

Support Community Health Workers and Traditional Providers

Funding mechanisms should formally recognize and reimburse the role of community-based providers, including Indigenous healers, midwives, birthworkers, and peer support specialists. These providers often serve as the primary point of contact for families and play a critical role in prevention, education, and continuity of care.^{36,37}

Expand Flexible and Place-Based Funding

Federal and state funding streams should allow for flexible use of resources across health, housing, transportation, and broadband infrastructure. This is particularly urgent in rural and island communities where access barriers are shaped by geography as much as by system design.

Prioritize Tribal and Community Governance

Care systems are most effective when governed by the communities they serve. Funding and regulatory frameworks should support Tribal and community authority in the design,

³⁶ National Indian Health Board. (2022). *2022 legislative and policy agenda for Indian health*. National Indian Health Board. <https://www.nihb.org/>

³⁷ Papa Ola Lōkahi. (2024). *Impact report 2022–2024*. Papa Ola Lōkahi.

delivery, and evaluation of integrated care systems, rather than imposing externally defined metrics or structures.

Recommendations for Workforce Development Reform

Philanthropy

- **Fund Community-Governed Care Models**
Increase investment in care systems designed and operated by AI/AN/NH communities. Philanthropic support should prioritize initiatives that integrate traditional and clinical care, expand perinatal and behavioral health access, and operate with cultural governance at their core.
- **Support Indigenous Workforce Infrastructure and Development**
Provide funding for training, mentorship, and retention programs that reflect community-defined standards. This includes traditional knowledge transfer, community-based apprenticeships, and leadership development within AI/AN/NH-serving organizations.
- **Invest in Organizational Stability**
Shift from short-term, project-based grants to multi-year general operating support. Many community-based organizations operate under chronic financial precarity despite delivering high-impact services.

Medicaid

- **Reimburse Culturally Grounded Services**
Approve Section 1115 and 1915 waivers to allow reimbursement of services provided by traditional healers, Indigenous doulas, community health workers, and other non-clinical care providers who are trusted by their communities.
- **Support Tribal and Islander Self-Direction in Care Delivery**
Ensure that Medicaid managed care planning includes Tribal and Native Hawaiian organizational leadership and enables community-directed care coordination models. This includes funding for culturally tailored perinatal and behavioral health programs.
- **Streamline Enrollment and Renewal Processes**
Reduce administrative burdens for families navigating Medicaid and related

programs. Invest in community-based navigation support, language access, and coordinated eligibility systems.

Indian Health Service (IHS)

- **Expand Integrated Care Demonstration Projects**

Fund pilot programs that bring together traditional healing, behavioral health, and perinatal services within IHS- and Tribal-run facilities. Evaluation metrics should emphasize AI/AN/NH data collection design, cultural outcomes, continuity of care, and client-defined success indicators.

- **Modernize Data and Evaluation Systems**

Prioritize data systems that capture holistic and community-based outcomes, including relational care metrics, cultural safety, and non-clinical measures of wellbeing. Ensure community access to data and alignment with Tribal sovereignty protocols.

“Community-based primary health education will support communities to create their own research, ethics guidelines, and data collection policies within an Indigenous context, and to promote self-determination and Indigenous-led governance. Indigenous collected and owned data has the potential to provide crucial insights regarding race and gender to support Indigenous health workforce planning and other targeted interventions to improve Indigenous health outcomes. Indigenous primary care providers working with Indigenous peoples understand the community context and convey it to their colleagues across the health system. Indigenous people receiving care feel safer and can more easily build trust as there is a shared understanding of social realities of the community and sensitivity to local perceptions of the health system and its colonial legacy. Local Indigenous health professionals are role models for future generations by improving awareness of racism, challenging assumptions, and changing the way healthcare is delivered, ultimately creating a more culturally safe healthcare system.”

—National Aboriginal Council of Midwives (NACM), 2024

- **Increase Support for Workforce Sustainability**

Invest in the long-term recruitment, training, and retention of AI/AN/NH health providers through expanded HRSA-IHS partnerships, career pathway development, and comprehensive support programs. This includes not only clinical and degree-based tracks, but also community-centered, non-degree

pathways such as doulas, lactation consultants, home visitors, traditional healers, and peer support workers.

These roles are often the most trusted and accessible forms of care in their communities, yet remain chronically underfunded and excluded from workforce development programs. Federal and state investment should include scholarships, paid apprenticeships, and tuition support for culturally rooted training programs. Equitable workforce sustainability also requires recognizing the legitimacy of non-institutional education models, many of which are led by AI/AN/NH organizations, and ensuring these providers are eligible for Medicaid reimbursement, professional credentialing, and inclusion in interdisciplinary care teams.

Federal Policy

- **Advance Tribal and Community Sovereignty in Health Governance**
Federal agencies should defer to Tribal and Native Hawaiian organizations in the design, implementation, and evaluation of community-based care systems. This includes recognizing local governance bodies as primary decision-makers.
- **Coordinate Cross-Agency Investments in Infrastructure for Care**
Align health funding with federal investments in housing, water access, broadband, and transportation. Community-based care systems cannot operate effectively without the infrastructure that supports access, safety, and continuity.
- **Improve Grant Access for Small and Rural Organizations**
Simplify application and reporting requirements to ensure smaller AI/AN/NH-serving organizations can access federal funding. Provide technical assistance and adjust criteria to reflect the realities of rural and island-based work.

Just and effective community-based care cannot be achieved by repairing legacy systems that were not built for these communities in the first place. It must be led by those most impacted, resourced with long-term investment, and governed by frameworks that reflect the interdependence of health, land, culture, and community. Community-based care and integration are essential strategies to advance health equity and strengthen outcomes for AI/AN/NH communities. These approaches are already active, effective, and deeply rooted in local culture, governance, and knowledge systems. However, they remain underfunded, underrecognized, and constrained by systems that were not designed to support them.

Policy and investment must shift toward aligning with the leadership, expertise, and capacity that AI/AN/NH communities have long demonstrated. Integration must reflect not only technical coordination, but respect for sovereignty, cultural relevance and reverence, and the interconnected conditions that support wellbeing. With adequate support and flexible, sustained funding, community-based systems can serve as national models for effective, equitable, and culturally anchored care.

AI/AN/NH communities already hold the knowledge, infrastructure, and leadership needed to transform perinatal and behavioral health. Federal and philanthropic policy must now catch up realigning funding, credentialing, and regulation to support the health ecosystems these communities have long sustained. Equity will not come from integration into systems of harm, but from amplifying the systems of care that are already whole.

This section draws on frameworks developed by frontline communities and movement leaders working toward more regenerative, just, and adaptive health systems. We recognize and uplift their leadership in shaping the path forward.

Workforce Recruitment and Retention

The U.S. government's obligation to protect the welfare and safety of American Indian communities is rooted in historical treaties, federal statutes, and long-standing trust responsibilities. These legal and ethical commitments have driven efforts to shape and reform policies that promote equity, including within the health care workforce. Persistent underfunding and insufficient federal investment have undermined these commitments. The Indian Health Service (IHS), a primary provider of care for many AI/AN/NH communities, remains chronically underfunded. This limits its capacity to recruit and retain qualified health professionals, fully fund contract obligations to Tribes, and hampers long-term strategic planning to strengthen AI/AN/NH representation in the health workforce.

The failure to uphold treaty obligations and fulfill contractual responsibilities with sovereign Tribal governments has contributed to the underdevelopment of critical infrastructure. Many Tribal communities continue to face barriers to basic services such as safety, housing, reliable transportation, nutritious food, quality education, and accessible health care. These systemic gaps not only exacerbate health disparities but also make it difficult to attract and retain providers willing to commit to long-term service in Tribal health systems.

Barriers to Recruitment

Economic and social disparities contribute significantly to health inequalities. Healthcare providers plausibly face the same significant barriers that American Indian communities face when living on reservations. This can include geographic isolation, underdeveloped infrastructure, lack of access to high quality food, education, housing, and high rates of crime. Some reservations have unemployment rates of 80-90% contributing to widespread poverty where over 50% of residents are living below the national poverty line. These extremes of unemployment and poverty are indicative of an absence of economic opportunities on the reservation. Consequently, the presence of these factors can be associated with increased crime and heightened personal safety concerns among potential healthcare worker recruits.

Personal safety, such as the risk of theft or assault, becomes a crucial consideration for professionals weighing job opportunities. Many reservations face higher-than-average crime rates, including issues related to drug use and violence. However, law enforcement on reservations is often underfunded and understaffed. Recruitment efforts are hindered by these very circumstances, forcing healthcare facilities to rely on temporary staff, which can disrupt continuity of care and negatively affect patient relationships. Even when healthcare professionals accept positions on reservations, these safety concerns inevitably lead to high turnover rates.

This inability to recruit AI/AN/NH providers and to provide culturally relevant care leads to mistrust, miscommunication, and causes inadequate treatment. Socioeconomic challenges, geographic isolation, and historical trauma further intensify these health disparities. A shortage of invested, high-quality healthcare workers has resulted in higher perinatal morbidity and mortality for American Indian women.

Barriers to Retention

The Indian Health Service Student Loan Repayment Program is an effective tool for recruiting healthcare professionals to work in underserved areas, such as reservations. However, while it addresses recruitment, it doesn't ensure retention once obligations are fulfilled. Once the obligation period (typically two years) is completed, there's no further financial incentive tied to loan forgiveness to keep professionals from seeking other opportunities in more resourced and developed areas. Healthcare workers often move to higher-paying jobs or locations that offer better living conditions or professional development opportunities once their loan forgiveness period has ended. Without additional incentives, such as competitive salaries, housing benefits, or continued

professional development opportunities, healthcare workers might not see enough reason to stay beyond the loan repayment period. The cycle of frequent departures leads to a constant influx of new, less experienced staff. This can create gaps in continuity of care, affecting patient outcomes and community trust in the health care system. Experienced professionals who have built relationships with patients and understand the unique needs of the community are harder to retain, leading to a potential decline in the quality of care. Furthermore, Tribal members who are providing healthcare on reservations in unlicensed jobs such as community workers, often have intractable obstacles to gaining professional certifications, as reviewed in the *Education and Pathways* section of this brief.

Several challenges have been identified in the recruitment and retention of qualified healthcare workforce that include:

- Lack of awareness regarding AI/AN/NH health and training opportunities within dominant education institutions
- Propensity of healthcare workers in Indigenous families that are temporarily contracted versus permanently employed
- Decreased salary, compensation and benefits in Tribally operated hospitals versus IHS operated hospitals
- Social conditions and lack of safety on some reservations
- Geography limiting Tribal members from leaving their communities for education in outside dominant systems
- Systemic inequality and underfunding of infrastructure which has led to less opportunity
- Lack of Indigenous knowledge in dominant education and healthcare systems
- Lack of funding support for education and licensure including loan forgiveness or incentive programs
- Indian Health Service (IHS) offers loan repayment of \$25,000 per year for a 2 year commitment to practice in health facilities serving AI/AN communities. The Health Resource Service Administration's (HRSA's) National Health Service Corps (NHSC) Loan Repayment offers up to \$75,000 in loan repayment in

exchange for 2 years of service at a NHSC approved site (which includes many IHS sites).³⁸ HRSA's Nurse Corps Loan Repayment Program offers up to 85% of Nursing Education debt for RNs, APRNs and nursing faculty for working in an eligible health care facility with a critical shortage of nurses or an eligible nursing school as a nurse faculty.³⁹ While these entice individuals to come to reservations for loan reimbursement, they offer no incentive to stay.

- Lack of visibility of job opportunities on Tribal reservations. Federal jobs are posted on usajobs.gov, Tribally operated hospitals advertise jobs on internal Tribal websites.
- Significant licensure and credential barriers for traditional and community-based providers
- Loan cancellation commitments result in repetitive turnover
- Lack of Medicaid reimbursement (only half of the 50 states)
- Lack of full practice authority in all 50 states
- Not federally recognized as mandatory reimbursed providers for SSA, TRICARE, or IHS. (Many roles, CPM, Doulas, RN, and APRN)

Successes with Recruitment and Retention

Four Corner Region (NM, UT, AZ, CO): Navajo Birth Collective serves Diné families with compassionate unbiased and accessible care to all birthing families and infant health⁴⁰. They offer several services via in-person or virtually.

Minnesota: Ninde Doula Program at the Division of Indian Work in Minnesota, offers doula services, traditional parenting classes, home visiting programs, lactation services

³⁸ Health Resources & Services Administration. (n.d.). *NHSC Loan Repayment Program*.

<https://nhsc.hrsa.gov/loan-repayment/nhsc-loan-repayment-program>

³⁹ Health Resources & Services Administration, Bureau of Health Workforce. (n.d.). *Apply to the Nurse Corps Loan Repayment Program*. <https://bhw.hrsa.gov/funding/apply-loan-repayment/nurse-corps>

⁴⁰ Navajo Birth Collective Facebook @NavajoBirthCollective

and wrap around services for at risk families and families involved with child protective services⁴¹.

Navajo Nation: Indigenous Women Rising serves the Navajo Nation and surrounding states. They are committed to honoring AI/AN/NH people through equitable and culturally safe health options⁴². They also offer access to health education, resources and advocacy.

New Mexico: Changing Woman Initiative's mission is to empower diverse Indigenous communities to protect cultural birth resiliency and the fundamental Indigenous human right to reproductive health, dignity, and justice⁴³.

New Mexico: Tewa Women United nurtures and celebrates the collective power of belonged families, communities, and *Nung Ochuu Quiyo* (Earth Mother)⁴⁴. Their programs embody courageous spaces that center Indigenous women and girls to connect with ancestral knowingness, healing strengths and lifeways for the wellbeing of all.

Washington: Hummingbird Indigenous Family Services, a team of five Indigenous doulas, have provided culture-specific care for many Native pregnant women and their babies in the first thousand days of their baby's life. They have reduced the perinatal and infant mortality rate from the state's rate that Native mothers die eight and half times more often than white mothers during pregnancy or within a year after to zero⁴⁵.

Sustainability Recommendations

- Midwives for Service Members would expand TRICARE reimbursement to include CPMs and CMs and be a victory toward federally mandated reimbursement inclusion for these credentialed midwives.
- BABIES Act helps create additional birth centers that serve as clinical sites for training midwives.

⁴¹ Native American Community Development Institute Ninde Doula Program at Division of Indian Work <https://nacdi.org/directory/item/ninde-doula-program-at-division-of-indian-work/>

⁴² Indigenous Women Rising <https://www.iwrising.org/>

⁴³ Changing Woman Initiative <https://cwi-health.org/>

⁴⁴ Tewa Women United <https://tewawomenunited.org/>

⁴⁵ Kunze, J. & Lazaro Moss, J. Native News Online, The Rise of Indigenous Doula <https://pulitzercenter.org/stories/rise-indigenous-doulas>

Workforce Recruitment and Retention Recommendations

Achieving perinatal workforce equity for American Indians means ensuring that Native mothers have access to culturally responsive, high-quality perinatal health services. Efforts to strengthen workforce equity, particularly by increasing the number of healthcare professionals who are AI/AN/HN or deeply committed to serving Native communities, are critical to improving both access and quality of care. Health professionals must be supported in education and in practice to increase their representation on both Tribal lands and in urban settings. This support must include assurance of safety, access to quality food, transportation, housing, and embedding diverse knowledge systems and cultural practices into educational and practice systems, all of which currently act as barriers. This type of transformation will involve multiple sectors and, likely, significant time to achieve. Yet, workforce equity and retention of quality healthcare providers is foundational to addressing perinatal disparities within AI/AN/HN communities. One way to approach immediate need is by Tribes recognizing and formalizing relationships with invested, respected individuals who already serve in unlicensed healthcare roles by providing pathways to licensure and reimbursement run by the Tribes themselves. This type of Tribal licensing is something that is currently happening on a small number of reservations. This is one solution to creating a healthcare workforce that is representative and responsive to the unique needs of American Indian communities during pregnancy, childbirth, and beyond.

Perinatal professional organizations such as ACOG, ACNM, AWHONN and NACPM should recognize, uphold, support, and endorse the development of provider licensing by and for Tribes. Reimbursement for such providers can be via multiple sources including IHS funding with 638 federal self determination contracts. This asserts Tribal authority to issue the licenses and also remediates the questions of who will pay for such services. This solution helps by removing the current issues to licensing and reimbursement experienced by traditional and trusted providers who are sometimes trained in non-dominant healthcare ways. Further, it amplifies the sovereignty of the Tribe and allows for centering on the trusted relationships of providers who are already embedded and invested in the community. This Tribally led licensing can be expanded with the assistance of the National Indian Health Board (NIHB) supporting Tribes with developing their own licensing and reimbursement infrastructures. In time, consortiums of Tribes could offer cross-recognition of licensure to expand provider coverage over multiple reservations.

Legislative & Policy Recommendations

CMS should encourage and play an active role in facilitating state plan development and approve pending Section 1115 demonstration waivers to extend postpartum coverage permanently.

To ensure the new state plan option created by the American Rescue Plan Act has its intended impact on perinatal health, CMS should issue timely and comprehensive guidance for states detailing the opportunity to take advantage of the new state plan flexibility.

CMS should require the timely collection and ethical use of data by race/ethnicity for Medicaid financed births. Data should be disaggregated within major broad racial and ethnic categories (e.g. AAPI) to respond more effectively to specific communities' issues and conditions.

CMS should encourage states to continue eligibility (without redeterminations) (via state plan amendments) for women following a Medicaid financed birth, for one year after delivery. Their infants are already automatically and continuously eligible for one year under federal law. This will allow for access to care for women in the interconception period to focus on chronic disease management and behavioral health services.

Expand the availability and capacity of licensed and accredited free-standing birth centers.

Expand the availability and capacity of all nationally certified midwifery credentials and ensure they are able to practice and provide full-scope midwifery care under IHS.

Remove the requirement that CNMs be supervised by a physician under IHS.

Provide community-based prenatal, postpartum, and newborn care using a care team approach. This includes the use of doulas and other community-based perinatal health workers to provide education and support during pregnancy, labor, delivery, and recovery.

Expand the use of certified nurse-midwives and/or certified midwives and allow them to practice to the full extent of their certification in all states and in all facilities.

Expand and sustain access to telehealth via reliable broadband internet service for prenatal, early labor triage, and early and continuous postpartum and newborn care, including physicians, certified nurse-midwives and certified midwives, home visitors,

home health workers, and doulas as a care team. This should be done in the context of a comprehensive healthcare system dedicated to assuring the best possible health outcomes for the communities that it serves.

Support broad financing (including Medicaid) for telehealth for the full range of perinatal care services provided.

Expand the use of federal financing for home visiting (including virtual visits) and indicated device monitoring (e.g. blood pressure monitors) for pregnant women, infants, and postpartum women for one year following delivery.

Mandate and fund fetal and infant mortality review committees in every state.

Establish, expand, and sustain the public health workforce. Given that the ARPA provides \$7.66 billion for community workforce development, the Secretary should dedicate some of these dollars for personnel (community health workers, midwives, home visitors, nurses, doulas, navigators, etc.) who care and are trained for serving MCH populations, particularly vulnerable pregnant women and infants.

Invest in strengthened research methods and data protocols to measure the impact of implicit bias, unequal treatment, and structural inequality on health care access, quality, delivery, and outcomes for women of reproductive age, pregnant and breastfeeding women, and their infants.

Expand access to doula services.

Establish a grant program to support doula training to increase the available doula workforce to support pregnant AI/AN/NH women.

Reimbursement for Doula care should be increased to sustain a doula workforce.

Other recommendations that have been discussed and/or included in legislative proposals:

1. Enhance Child Tax Credits
2. Evaluate the impact of a child allowance.
3. Expand Earned Income Tax Credit (EITC)
4. Enhance Child and dependent care tax credit

5. Provide emergency assistance for basic needs: Income, food, child care, housing, and more
6. Implement universal paid family leave
7. Increase Income support (TANF)
8. Enhance Housing assistance (rental assistance, LIHEAP, homeowner counseling),
9. Expand the public health workforce, funding 100,000 public health workers to nearly triple community health workers
10. Increase funds for National Health Service Corps, Nurse Corps, mental health, and other workforce programs
11. Enhance funding for Community Health Centers/FQHCs
12. Expand and sustain health center work force
13. Restore and increase funding for family planning
14. Expand support home visiting through MIECHV

Advancing Tribal-Led Health Workforce Equity for AI/AN/NH Communities

AI/AN/NH communities face severe and persistent health disparities, including some of the highest rates of maternal mortality, mental health crisis, and chronic under-resourcing of care systems. These disparities are directly tied to a lack of sustained investment in community-led, culturally grounded care models and a critical shortage of Indigenous health professionals.

We urge Congress to advance legislation that supports Tribal sovereignty, sustainable health workforce development, and culturally responsive care by authorizing and funding the following:

Establish a National Tribal Health Workforce Development Program

- Provide dedicated funding for Tribal governments and Native-serving organizations to create and expand education and training pathways in perinatal,

behavioral, and community health.

- Include scholarships, stipends, loan repayment, and wraparound services to recruit and retain AI/AN/NH students in clinical and non-clinical roles.
- Prioritize partnerships with Tribal Colleges and Universities (TCUs) and Native-led training institutions.

Fund Community-Led Models of Care as Permanent Infrastructure

- Provide sustained, not pilot-based, funding for AI/AN/NH-led perinatal and behavioral health programs.
- Expand Medicaid and IHS reimbursement to include doulas, midwives, traditional healers, and community health workers credentialed by Tribes.
- Support the development of Tribal licensure and credentialing systems recognized across federal and state health programs.

Build and Strengthen Tribal-Academic Clinical Partnerships

- Fund infrastructure and capacity building for clinical education sites in Tribal and rural communities, including housing for students and faculty.
- Support clinical preceptor training, compensation, and protected time for IHS and Tribal facility clinicians who serve as educators.
- Incentivize academic institutions to form equitable, long-term partnerships with Tribal health systems for student placements and research.

Affirm and Uphold Tribal Sovereignty in Health Workforce Policy

- Require federal agencies to consult with Tribes in the design and implementation of all workforce development and healthcare delivery initiatives affecting AI/AN/NH people.

- Recognize and resource Tribal self-determination in setting licensure, scope of practice, and reimbursement policies for providers serving AI/AN/NH communities.

This legislation would strengthen the Indigenous health workforce pathways, reduce maternal and behavioral health disparities, and support Tribal governments in delivering culturally rooted care. Equity cannot be achieved by folding Native communities into systems that have historically excluded them, it must be built by resourcing the systems Indigenous communities are already leading.

Authorization and appropriation of \$200 million over five years to support these initiatives, with direct-to-Tribe funding mechanisms and strong accountability to Tribal priorities would accomplish these goals.

Appendices

Maternal & Perinatal Health Policy Recommendations Chart

Policy Area	Recommendation	Responsible Entity
Medicaid & CMS Policy	Encourage and approve state plan development and Section 1115 waivers to extend postpartum coverage permanently.	CMS
	Issue guidance for states to utilize new postpartum coverage options under ARPA.	CMS
	Require timely, disaggregated race/ethnicity data collection for Medicaid births.	CMS
	Encourage 12-month postpartum eligibility continuation via state plan amendments.	CMS
Midwifery & Birth Centers	Expand licensed and accredited free-standing birth centers.	HHS, States
	Expand midwifery credential availability and full-scope practice, including IHS.	HHS, IHS
	Remove physician supervision requirement for CNMs under IHS.	IHS
Community-Based Care Models	Provide team-based prenatal, postpartum, and newborn care including doulas and perinatal health workers.	HHS, States

	Expand full-scope practice for CNMs/CMS across all states and facilities.	States, CMS
Telehealth	Expand telehealth access via broadband for perinatal and newborn care.	FCC, HHS
	Support Medicaid financing of telehealth for full perinatal care.	CMS
Home Visiting & Monitoring	Expand federal financing for home visiting, including virtual and device monitoring.	HHS, CMS
Mortality Review & Public Health Infrastructure	Mandate and fund fetal and infant mortality review committees in every state.	Congress, HHS
	Invest in public health workforce serving maternal and child health (MCH).	HHS, Congress
Structural Inequality & Implicit Bias	Fund research on bias, inequality, and health inequities in maternal health.	NIH, HHS
Doula Workforce & Services	Expand access to doula services.	States, CMS
	Create a grant program to train doulas for AI/AN/NH women.	HHS, Congress
	Increase reimbursement for doula care.	CMS, States
Social Determinants & Economic Supports	Enhance Child Tax Credit, EITC, and child/dependent care credits.	Congress

	Evaluate child allowance impact.	Congress, Treasury
	Provide emergency support for food, housing, income, child care.	Congress, HHS
	Implement universal paid family leave.	Congress
	Increase TANF and housing assistance.	HHS, HUD
	Fund 100,000 public health workers.	Congress
	Increase funds for NHSC, Nurse Corps, and other workforce programs.	HRSA
	Enhance funding for Community Health Centers.	Congress
	Restore funding for family planning programs.	HHS
	Expand home visiting support via MIECHV.	Congress
Tribal-Led Health Equity & Workforce Development	Establish National Tribal Health Workforce Development Program.	Congress, Tribal Orgs
	Fund community-led care as permanent infrastructure.	Congress, CMS, IHS

Build Tribal-academic clinical partnerships. Congress,
HRSA

Affirm Tribal sovereignty in licensure,
policy, and funding. Congress,
HHS

Appropriation Request: \$200M over 5
years, direct-to-Tribe funding. Congress

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Acknowledgements

This report was generated at the request of Sen. Ben Ray Lujan and Nicolle Arthun, CNM.

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