

National Indian Health Board



White Paper: Tribal Public Health Infrastructure

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Glossary of Frequently Used Terms

AI/AN	American Indian and Alaska Native
CDC	Centers for Disease Control and Prevention
HHS	US Department of Health and Human Services
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
ISDEAA	Indian Self-Determination Education and Assistance Act
NIHB	National Indian Health Board
PHI	Public health infrastructure
PHICCS	Public Health in Indian Country Capacity Scan
THO	Tribal Health Organization
TPHI	Tribal public health infrastructure

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I. Introduction

Strong Tribal public health infrastructure (TPHI) is essential to achieving health equity for American Indians and Alaska Natives (AI/ANs). Over the last four decades, there has been an increasing understanding of public health infrastructure (PHI) as viewed through the lens of state and local needs. There is no equivalent for Tribes.

Tribes are sovereign nations and the oldest governments in North America, as was recognized in [Article I, Section 8, Clause 3 of the U.S. Constitution](#), which states that the U.S. Congress shall have power “[t]o regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes.” The sovereignty of Tribes within the framework of the U.S. Government was further clarified in [Cherokee Nation v. Georgia, 30 U.S. 1 \(1831\)](#), which states that Tribes occupy a unique area within the American political framework as “domestic dependent nations.” The government-to-government relationship between sovereign tribes and the U.S. federal government reflects the federal trust responsibility, which has its legal and moral foundations in the U.S. Constitution, numerous treaties, statutes, U.S. Supreme Court decisions, and Executive Orders. (National Indian Health Board, 2022c). Each sovereign Tribe has the inherent right and responsibility to decide and implement best practices that promote the well-being and health of its citizens.

Respecting Tribal sovereignty and the government-to-government relationship is fundamental to building strong TPHI. As stated in [Executive Order 13175](#) and reaffirmed by White House memorandum – all executive departments and agencies are charged with “engaging in regular, meaningful, and robust consultation with Tribal officials in the development of Federal policies that have Tribal implications” (Biden, 2021). This recognizes that Tribes are public health subject matter experts in their communities, and Indigenous knowledge has sustained and advanced Tribes and Tribal health for millennia. To that end, Tribes must be at the table, informing federal investment decisions that impact the development and improvement of their public health infrastructure. This ensures practices and policies reflect Tribal interests and priorities and make space for the incorporation of traditional approaches and the inclusion of culture and indigenous knowledge. Tribes have an inherent right to protect their peoples’ health and design systems accordingly. In other words, Tribes have inherent public health authority (National Indian Health Board, 2022c).

The purpose of this paper is to build awareness and increase knowledge of TPHI. Unique characteristics of Tribal public health systems and a general overview of the language, terms, and known resources that support and sustain TPHI efforts in Indian Country will be shared. Tribal and non-Tribal audiences can use this information to support related capacities, frame discussions,

In this report, we prioritize:

a variety of audiences, including Tribal leaders, Tribal public health professionals, federal, state, and local governmental partners, members of Congress, academic institutions, funders, and organizations looking to strengthen and support Tribal nations’ efforts in building public health infrastructure.

and serve as a foundation to develop public health infrastructure-related resources and tools, including frameworks, programs, and policies. The content was informed by Tribal leaders and Tribal health leaders through numerous discussions, listening sessions, committee meetings, national conferences, and a national Tribal public health capacity scan. The paper concludes with seven recommendations for building robust and relevant public health infrastructure for Tribal nations in the context of the overall U.S. public health system.

II. What is *Tribal* Public Health Infrastructure?

Current Tribal public health infrastructure (TPHI) is grounded in pivotal moments in history that have characterized the trajectory of public health systems in Tribal nations.

To date, there are 574 federally recognized, sovereign Tribal Nations in the United States. Each is unique in their culture and experiences that shape the health of their peoples. Historically, Tribes ensured their communities' health by integrating systems of health and overall well-being. As with most, if not all Native peoples, prior to European contact, AI/AN persons had complex traditions, cultural practices, social organizations, economies, forms of government, education systems, and spirituality that interrelatedly worked together to ensure the health and survival of their people. This broad, holistic understanding of interconnectedness and health endures. For example, Cherokee Nation Deputy Principal Chief Bryan Warner, in remarks given at the National Indian Health Board's (NIHB) 2022 National Tribal Public Health Summit:

I feel that public health is central to everything we do. It touches so many things. It touches our languages. It touches our lifeways. It touches our education systems, our career system, our human service system, including all our clinical health. Public health is the protector of all those things we hold sacred and of all our lifeways (personal communication, 2022).¹

In addition to a rich background of culture and tradition, contemporary Tribal public health systems have subsequently been shaped by a history of colonialism, epidemics, government policy, cultural genocide, and a lack of funding (Shelton, 2004; Warne & Frizzell, 2014). As a result, Tribal public health systems have evolved along a separate and inequitable trajectory, are much younger systems, receive drastically less federal funding, and operate differently than their local and state counterparts.

Historical and Legal Context of Contemporary Tribal Public Health

Sovereign Tribal nations, as stated in the introduction, have a unique government-to-government relationship with the U.S. and are entitled to certain federal benefits, services, and protections in recognition of the loss of over two billion acres of homelands whose waters, land, flora, and fauna have sustained Tribal People for millennia. Tribal sovereignty and the government-to-government relationship between Tribal Nations and the federal government have been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders (Rosebud Sioux Tribe v. United States, 2021). Until 1871, the U.S. and various Tribal Nations entered into

¹ *Tribal Health IS Public Health*. National Tribal Public Health Summit 2022 opening plenary address.

treaties on a government-to-government basis. Tribal leaders negotiated to preserve and protect their people as well as their homelands. The U.S. agreed, in recognition of the lost land, again, to date over two billion acres, these treaties (and acts of Congress after 1871) preserved the sovereignty of Tribes and provided for essential services such as healthcare, housing, and education.

The [Indian Health Care Improvement Act \(IHCIA\)](#), along with the [Snyder Act of 1921](#), forms the statutory basis for the delivery of federally funded health care and the direct delivery of care to AI/AN persons. Since its passage in 1976, the IHCIA has provided the programmatic and legal framework for carrying out the federal government’s trust responsibility for Indian Health. In the IHCIA, Congress reiterated that “Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government’s historical and unique legal relationship with, and resulting responsibility to, the American Indian people (25 U. S. Code § 1601 et seq.). As the federal trust responsibility is not restricted only to the [Indian Health Service \(IHS\)](#) and applies to all federal agencies, the nation’s lead public health agency, the [Centers for Disease Control and Prevention \(CDC\)](#) plays a primary role in advancing TPHI.

As the overall American public health system began taking its current shape in the mid-20th century, state and local health departments began receiving increased federal support to develop a public health workforce focused on health promotion and disease prevention (IOM Committee for the Study of the Future of Public Health, 1988). Tribes did not receive equivalent support or funding streams to enable equitable Tribal public health infrastructure development and growth. In fact, Wilkenson and Biggs (1977) re-counted that the mid-20th century was marked by a policy referred to as [Termination](#) when, from 1953-1969, by the hands of the U.S. Congress, 109 Tribal Nations were terminated, millions of acres of trust land were removed from protected status, and close to 12,000 Native Americans lost Tribal affiliation. The authors shared the Tribal perspective as thus, “The management of Indian lands still in trust continued to be a significant question in the termination era. Indians charged that the Bureau of Indian Affairs (BIA) policy was intended to ‘force more of their trust lands onto tax rolls, opening it for sale to whites while Tribal governments stood helplessly by,’” (Wilkinson & Biggs, 1977, p. 161). Indeed, millions of acres of Tribal lands were lost during the termination era.

However, during the same time period, the federal government created the IHS under the [U.S. Public Health Service](#); both now reside within the [Department of Health and Human Services \(HHS\)](#). The sole responsibility of IHS is to deliver health care to AI/AN persons. Today, the IHS provides comprehensive healthcare services—using a quality improvement model—to 2.56 million AI/AN people (IHS, 2019); IHS, n.d.). These services are funded and organized through the IHCIA.

The IHS healthcare system consists of three service types: IHS direct healthcare services, Tribally operated healthcare services, and Urban Indian healthcare services and resource centers. The IHS services are administered through a system of 12 Area offices and 170 IHS and Tribally managed service units. While the agency supports limited public health activities, the majority of IHS’s

funding is dedicated to direct patient care and individual health (IHS, 2022b).² This has left the primary impetus and mechanism for the development of public health infrastructure and the delivery of essential public health services falling to the Tribes themselves through self-determination contracts or self-governance compacts, grants, often from other federal agencies, as well as other revenue streams.

Development of PHI, compared to states and local governments, is relatively new for Tribes. In fact, the whole of AI/AN health remained mainly under the management of the IHS until Public Law 93-638 - [Indian Self-Determination Education Assistance Act 1975 \(ISDEAA\)](#) which gave Tribal nations increased autonomy in managing and delivering health services to their citizens. Under the law, each Tribe determines which programs it wants to administer and negotiates with the IHS to enter into contracts and compacts, which may include some or all the health programs managed by IHS. Since ISDEAA and subsequent amendments, the number of health programs managed wholly or in part by Tribes has “seen tremendous growth” since 1993 when the first Tribal Self-Governance Program (TSGP) Demonstration Project agreements were signed (Office of Tribal Self-Governance, n.d.-b). With 369 Tribes participating in the TSGP, 65% of eligible Tribes are entering into agreements with IHS and receiving direct funding to manage their Tribe’s health (Office of Tribal Self-Governance, n.d.-a).

As a consequence of evolving from healthcare service delivery, Tribal public health services are often highly integrated with clinical care. Separating out the infrastructure for the two systems, healthcare vs. public health, as is common for state and local health jurisdictions, can be confusing and complicated. Tribes have fully integrated systems and assert that Tribal health is public health. Today, public health activities for Tribes are often provided by a combination of Tribal, federal, state, local, and non-governmental agencies. Aggregate data from the [Public Health in Indian Country Capacity Scan \(PHICCS\)](#) confirms that Tribes are the main providers of many public health services in their communities (NIHB, 2020a). The [IHS Office of Tribal Self-Governance](#) likewise affirms that the TSGP has a “significant positive impact on the health and well-being of participating Tribal communities (n.d.-b).

Defining Tribal Public Health Infrastructure (TPHI)

Prevailing understandings of PHI have largely been informed through study, research, and analysis of state and local public health systems. Currently, there is no formally adopted definition of PHI, let alone TPHI, and Tribal nations vary in their acceptance and use of existing constructs. Several general frameworks exist to describe the responsibilities of public health including the CDC’s [10 Essential Public Health Services \(10 EPHS\)](#) or the [Public Health Innovation’s](#) Foundational Public Health Services (FPHS) five community-specific services and eight foundational capabilities, including equity (Public Health National Center for Innovation, 2022). Both frameworks are useful to generally understand the functions and capabilities for delivering public health services, however, neither fully captures the underlying characteristics of the infrastructure needed to support the services or develop and sustain the capabilities. Additionally, neither was developed from a Tribal perspective or with Tribal participation.

² Preventive health services represented 4.1% of the total services of the enacted IHS FY2021 budget. Sanitation facilities construction represented 21.4% of total facilities of the enacted IHS FY2021 budget.

Nearing a definition of public health infrastructure, [Healthy People 2030](#) describes “a strong public health infrastructure includes a capable and qualified workforce, up-to-date data and information systems, and agencies that can assess and respond to public health needs” (Office of Disease Prevention and Health Promotion [ODPHP], 2022). This description of a strong public health infrastructure also includes access to resources such as the CDC public health emergency funds. The [Tribal Epidemiology Centers’ \(TECs\) Public Health Infrastructure Program](#) adds “cultural relevance” and “plans for sustainability” (2021) to their PHI description, noting additional characteristics of PHI that are more relevant for Tribal systems.

Given the assorted PHI descriptions, alongside the varied stages of development of Tribal public health systems as well as diversity among Tribal histories and cultures, it is no surprise that Tribal public health leaders have expressed that TPHI is “vast and varied” and is an “ever evolving definition” (V. Bradley, L. Pivec, personal communication, August 4, 2021).³ Developing a standardized definition of TPHI at this point in time may not prove as productive as opening up the discussion to the unique facets of TPHI. There needs to be an understanding of TPHI that reflects the foundational components of Tribal public health systems. This may require a stronger emphasis on commonly accepted components such as public health authority and governance and equity and sustainability in funding. This may also require the inclusion and prioritization of additional components such as language, culture, and relationships.

For the purposes of this discussion, PHI will be loosely organized into five common, interrelated components: public health authority and governance, relationships, workforce, data sharing and information systems, and funding/resources. Health equity and culture will also be discussed as cross-cutting elements binding infrastructure components together. These supports, among others, collectively create an environment where systems, policies, focus areas and resources are leveraged to efficiently address the public health needs of a community. This concept engages professionals and stakeholders across sectors that work both directly and indirectly to shape health outcomes.

Why is addressing infrastructure critical for American Indians and Alaska Natives?

The impact of severe underfunding, omission from the nation’s development of its public health infrastructure and structural racism has resulted in significant disparities across health concerns, including life expectancy, incidence of chronic disease, and prevalence of substance misuse, to name a few. Additionally, as expressed in written testimony submitted to the U.S. Commission on Civil Rights:

As a result of the chronic underfunding, large swaths of Tribal lands lack basic emergency preparedness and response protocols, limited availability of preventive public health services, and underdeveloped capacity to engage in disease surveillance, tracking, and response. And even though Tribal governments and all twelve Tribal Epidemiology Centers (TECs) are designated as public health

³ Comments made during the 22nd Biannual CDC/ASTDR Tribal Advisory Committee meeting, Tribal Public Health Infrastructure: Questions and Discussion.

authorities in statute, they continue to encounter severe barriers in exercising these authorities due to lack of enforcement and education (NIHB, 2020b).

In general, public health infrastructure provides the foundation for program and policy development, resource administration, and workforce capacity necessary to anticipate and respond to a community's health challenges. The ability to address these concerns is critically important as AI/AN communities are often among the most disproportionately impacted by health-related conditions and often shoulder disproportionate burdens related to quality of life and health conditions, access to care, and shorter life expectancies (IHS, 2019; Office of Minority Health, 2022). The COVID-19 pandemic demonstrated this disparity in that AI/ANs have had the highest COVID-19 rates for infections, hospitalizations, and deaths than any other racial/ethnic group (CDC, 2022b).

Without a comprehensive understanding of what exists, what is needed, and the assets in place to achieve public health goals, Tribes may not be able to effectively secure, sustain and coordinate the necessary resources and personnel to respond to existing and emerging public health issues. Defining what and whom public health infrastructure includes can vary among Tribes and the structural organization will rely on attributes and characteristics specific to the culture and needs of the community. This holds true across health organizations, including Tribal Health Organizations (THO). As explained by Chief Health Officer, Sharon Stanphill, DrPH, RD

At Cow Creek and many Northwest Tribes, we don't have public health departments. They are just now being built. COVID caused us to initiate, jumping all in with all Tribal entities, to invest in public health. We have a lot of components; they are just not coordinated. ...When the pandemic hit, we had to transition clinical nurses to public health nurses. We couldn't find people to help with the public health nursing trainings. There are no resources, no funding, no policy for this topic (personal communication, August 4, 2021).⁴

And, as noted in an anonymous response to a NIHB COVID-19 Response Survey,

Our public health infrastructure still isn't adequate to effectively respond to the pandemic; our Tribe lacks communication infrastructure and IT [information technology] resources to adequately respond to or evaluate immediate or future risk within the Tribal jurisdiction (personal communication, 2021).

As a result of the development and advances in PHI, Tribal health organizations (THOs) and communities stand to experience several benefits including, but not limited to,

- improved efficiency and stability of public health services,
- increased accuracy in the identification of gaps and opportunities,
- improved preparedness and response to emerging public health challenges and emergencies,

⁴ Comments made during the 22nd Biannual CDC/ASTDR Tribal Advisory Committee meeting, Tribal Public Health Infrastructure: Questions and Discussion.

- increased credibility and visibility locally and in the broader public health system, and
- improved standing of Tribal governments to manage public health systems and emergency response.

III. Influential Documents and Resources that Shaped TPHI

The following “landmark” resources have all contributed to shaping public health policy and programs in the U.S. for the last 35 years. These documents are important as they reflect the prevailing thoughts, attitudes and desired directions as acclaimed by the dominant public health culture. Resources such as these, from reputable experts and respected organizations, have the power to drive policy, research, and resource allocation. While these documents may have had varying levels of Tribal engagement or consideration, none could remotely be described as *Tribally driven*⁵.

The Future of Public Health and other landmark Institute of Medicine reports

From 1988 to 2012, the Institute of Medicine⁶ (IOM) published several reports documenting the state of the nation’s public health infrastructure and key priorities (2012; 2002; 1988). These reports highlight the many opportunities for advancing public health through the strengthening of governance, enhancing collaborative efforts, and system development. Notably, the 2002 IOM report was one of the first of its kind to acknowledge Tribal governments as part of the broader governmental public health system, albeit inconsistently throughout, alongside federal, state, local, and territorial governments. However, a decade later, the 2012 report highlighting recommendations for measurement of public health, law, and funding as drivers of change are completely void of that recognition. Information from these reports has contributed to the development of public health models and has played a role in informing public health practice and funding across all levels, jurisdiction-s and authorities. They have also contributed to shaping other initiatives such as [Public Health 3.0](#) and Healthy People 2030.

Public Health 3.0

Public Health 3.0 is a framework proposed in 2017 with a focus on strengthening public health infrastructure in the 21st century (Office of the Assistant Secretary of Health, 2017). This framework focuses on two tiers: innovative clinical prevention and total population or community-wide prevention, and specifically emphasizes the importance of building healthy communities IOM reports as well as public health related events that were occurring at the time. Social determinants of health are also featured prominently. The report offers several recommendations to state and local public health departments to promote public health achievement including sustainability of funding, stakeholder engagement, access to data, enhance public health leadership, and enhanced support for accreditation efforts. The lack of acknowledgment of Tribal public health authorities within this document reflects the inconsistencies in understanding the role

⁵ *Tribally driven* is a term used by the National Indian Health Board to describe an approach to policy and program initiatives and solutions that is predominantly authored by Tribal Nations, most notably, Tribal leaders.

⁶ The Institute of Medicine, now known as the National Academy of Medicine, is part of the National Academies of Science, Engineering, and Medicine. For consistency, we refer to these reports under the name of the institution at the time of their original publication.

of Tribal public health systems in the overall U.S. governmental public health system. It is of great concern that this omission is contained in a document published by the federal government. The general sentiment in *Public Health 3.0* and what is reflected in much of the dominant public health infrastructure language situates Tribal nations peripherally as public health “partners” rather than equal and integral public health authorities (Office of the Assistant Secretary of Health, 2017, p. 20).

This peripheralization of Tribes does not only dismiss Tribal sovereignty but short-changes communities overall by ensuring that the health of millions of American citizens – including AI/AN communities – is threatened, vulnerable, and in jeopardy. The COVID-19 pandemic demonstrated in no uncertain terms the benefits of states and local governments embracing and working directly with Tribes. In Alaska, where there are 229 federally recognized Tribes, Dr. Anne Zink, Alaska’s Chief Medical Officer, put it plainly and simply, “Tribal health is public health” while discussing Alaska’s early success in mitigating and controlling the spread of COVID-19 as well as Alaska’s initial success in rolling out the vaccination plan in Alaska (Washington Post Live, 2022). When Tribal governments are ignored or left out, it does not just harm AI/AN people, it harms whole communities.

Healthy People

The *Healthy People* initiative was developed in 1980 by HHS to achieve equity, promote good health through social and physical environments, and promote disease, disability, injury, and premature death prevention across all life stages (ODPHP, 2021). Establishing agendas in 10-year increments, this initiative outlines priority areas for public health improvement across the nation. Widely referenced in the field of public health, this initiative also highlights the need for additional research and inclusion of Tribes to better serve Tribal communities. The objectives specific to Tribal communities tend to be categorized as “developmental,” meaning they are high-priority public health issues but don’t have reliable baseline data (ODPHP, n.d.). Ongoing gaps in data contribute to the continued underrepresentation of AI/AN people, leading to the inability to address disparities that burden AI/AN persons.

10 Essential Public Health Services

The CDC’s *10 Essential Public Health Services* (10 EPHS) define specific activities and serve as a framework to develop public health capacity. Recent revisions in 2020 included the incorporation of equity as a central focus of these services (CDC, 2021a). The 10 EPHS play an essential role in the development of policies, programs, and activities that shape public health. They are an available tool for Tribal health organizations (THOs) as they continue to develop and refine their infrastructure.

Public Health Accreditation and Quality Improvement Efforts

Tribal nations may choose to pursue public health accreditation as one way to systematically assess and strengthen their public health services. The [Public Health Accreditation Board \(PHAB\)](#) oversees accreditation and reaccreditation for Tribal, state, local, and territorial public health entities. They also develop and maintain the associated standards and measures, based on the 10

Essential Public Health Services (EPHS). Five Tribes⁷ have achieved full accreditation status (Public Health Accreditation Board, 2022), and numerous other Tribes are in process of seeking accreditation. Furthermore, there are additional Tribes who use the standards and measures as a tool to guide their own independent public health capacity-building efforts who are not currently seeking accreditation.

Since 2008, the [Tribal Public Health Accreditation Advisory Board \(TPHAAB\)](#), established and coordinated by NIHB, has made important contributions to educate PHAB on Tribal public health, provide input on the standards and measures and raise awareness of Tribal public health improvement efforts. These efforts not only contribute to better understanding among Tribal organizations but also allow for Tribal culture to be infused into the process. The TPHAAB serves as the only existing Tribally specific body devoted as a national sounding board on public health accreditation (NIHB, 2018).

While each of these resources lends valuable information that can impact the development of TPHI, none of these resources fully reflect Tribes' approaches to delivering public health. There is a need for a Tribal-specific framework that speaks directly to the needs of Tribal communities in a way that is Tribally designed and implemented, and fills gaps that are missing from the initiatives listed above. By identifying components that are important to Tribal nations but often not taken into consideration, strategies that are the best fit to improve TPHI can be developed and implemented.

IV. Select Components of Tribal Public Health Infrastructure

In this section, we discuss *select* public health infrastructure components that may be critical to defining and improving TPHI: public health authority and governance, relationships, workforce, data sharing and information systems, and funding/resources. Health equity and culture are also discussed as cross-cutting elements binding infrastructure components together. The information presented is gathered from both Tribal and non-Tribal general public health infrastructure efforts and existing resources, such as listening sessions, discussions, conference presentations, and Tribal Advisory Committee (TAC) meetings. This list is not exhaustive and is meant to be a starting point as Tribes and federal agencies seek to address TPHI needs and priorities.

Public Health Authority and Governance

As previously stated, Tribal Nations are sovereign entities with inherent public health authority. The structural dynamics and functions of governing bodies will vary by Tribe, and each has the right to determine the makeup of the body that will administer guidance for their Tribe. According to the 2019 PHICCS Report, a majority (58%) of the responding THOs have in place a single governance organization, while 41% report more than one. (NIHB, 2020a). The governing body for public health may lie with a chief or chairperson, a council, a health board, a consortium of Tribes, or a combination. They may be composed of elected or appointed officials, or a

⁷ As of Fall 2021, Cherokee Nation, Yellowhawk Tribal Health Center, Forest County Potawatomi Health and Wellness Center Community Health Department, Oneida Nation of Wisconsin, and the Pascua Yaqui Tribe Health Department have achieved public health accreditation.

combination. Authorities may or may not be specified in a legal document such as a tribal constitution. Tribal codes may or may not contain clearly defined public health provisions, or for those that do exist, they may not be well integrated or comprehensive. (Bryan, Schaefer, DeBruyn, & Stier, 2009). While approximately 59% of THOs who participated in PHICCS report having some type of public health law and/or policy in their Tribal service area, the remaining 41% are either unsure or reported no types of public health law and/or policy in their Tribal service area, as enacted by the Tribe (NIHB, 2020a). For Tribes whose public health systems may not yet be well developed, the need to discover or define internal authorities and decision-making processes could be considered a foundational public health infrastructure priority.

Tribal leaders have called upon the nation's lead public health agency, the CDC, to provide public acknowledgment and technical assistance to Tribes in building TPHI. They have asked CDC to assist in reinforcing and encouraging foundational TPHI efforts as well as sending a message of validity and credibility to state and local authorities. As Chickasaw Nation Legislator Barker stated during the CDC/ASTDR 22nd Biannual Tribal Advisory Committee meeting:

As a Tribal leader, I think something that would help leadership is for CDC to acknowledge that it's a good idea for Tribes to build public health systems. Tribes are efficient and smart at delivering these services – having public support and acknowledgment would be helpful (personal communication, 2021, August 4).

Cherokee Nation Senior Director of Public Health, Lisa Pivec, likewise stated

If CDC acknowledges or talks about Tribal public health and gives examples of what it could look like, then Tribal nations can build public health infrastructure in a way that best fits-their community (2021).

Jill Jim, PhD, MPH, MHA, Navajo Nation Department of Health Director further recommended that

Tribal nations should be recognized as state/local health departments and included at the national level as so (2021).

Relationships

So much of public health work is relationship-building.

(Bryan Warner, Deputy Principle Principal Chief, Cherokee Nation, personal communication, 2022).

THOs often look to partnerships and cross-jurisdictional relationships to deliver essential public health services. They may include other departments within the Tribe, [Area Indian Health Boards \(AIHBs\)](#), TECs, [Urban Indian health programs](#), federal agencies, state and local governments, academic institutions, private or non-profit organizations, or others. These networks are vital components to build infrastructure and expand capacity. They often have shared goals and offer access to resources, including funding, training, and technical assistance.

When considering Tribal to non-Tribal relationships, special emphasis should be placed on the development of agreements and policies that recognize and respect Tribal sovereignty. This may

include special provisions for the collection and use of data, adhering to Tribal review processes, Tribal consultations policies, and allowing flexibility to interact with the unique ways in which Tribes structure their health and public health activities. However, Tribal to non-Tribal relationships go deeper than legal documents such as memorandums of agreement (MOUs) and contracts. Trust and cultural competency are basic to forming and establishing meaningful and lasting relationships and are built slowly over time. NIHB has made several strides to strengthen partnership-building between Tribal organizations and external entities, including through NIHB's [Working with Tribes Training](#) module (2019). This e-course educates state and federal government officials on effective engagement with AI/AN Tribes. The training provides background information on the colonial experience since contact with Europeans, how that experience has impacted the health and well-being of Tribal populations, and best practices for successful engagement with Tribal communities.

It is imperative not to undervalue the power of relationships in Indian Country. It is also imperative to understand that the underlying tenets of good relations, mutual trust, and respect, may be fragile due to historical experiences. Relationships must be nurtured and built slowly over time.

Relationships within the Tribe, between departments and programs and including the broader community are a strength of Tribal health and public health systems. Community engagement provides a sense of common ownership over various public health services and activities. Public engagement can include participation in both internal and external capacities, such as the incorporation of community health representatives to assist with public health activities and healthcare delivery. Tribal health assessments (also referred to as community health assessments) and their partner Tribal health improvement plans (also referred to as community health improvement plans) are two key documents routinely used by Tribal (and non-Tribal public health departments) to describe public health needs, identify goals, and plan for intervention. Community engagement and feedback are cornerstones of these assessments and are just two methods a Tribe may use to assess the insights of those they serve.

Leveraging relationships and pulling together to tackle a problem is a regular and necessary practice among Tribal entities. Acting together for the common good is an enduring Native value. However, due to chronic low funding and limited workforce capacity, pulling from one part of the system may cause stress and potential breakdown in other parts. It is not unusual for services to be interrupted due to competing priorities or even just one staff person's absence. While operating in survival mode may be the norm and Tribes have shown great resiliency in this respect, it should not be an expected characteristic of how Tribal public health should operate on a regular basis. Leveraging internal relationships should add to the overall public health infrastructure strength rather than just shift the focus and risk weakening other parts.

Tribal Public Health Workforce

In the wake of the COVID-19 pandemic, we have seen renewed calls for investments in a strong public health workforce. The public health workforce includes the individuals and groups that carry out public health activities. It can also encompass the skills and expertise across various disciplines needed to perform these functions, including traditional healers. The Tribal public health workforce encompasses a wide range of professions and skills (Table 1). Note that some

workforce cadres may overlap with those necessary for healthcare delivery. For example, public health nurses (PHN) or community health aides (CHA) may provide clinical care to individuals but also engage in population health activities such as mass vaccinations and community health promotion efforts.

Table 1

Public Health Focus Area	Sample Public Health Workforce Positions
Administration	Health directors, public health directors Legal counsel Administrative assistants Finance directors Grants managers Quality improvement coordinators Communications specialists IT staff
Health education and health promotion	Public health physicians, nurses, and physician assistants Health educators Behavioral Health prevention professionals Oral health professionals Nutritionists, Dieticians Community health aides and community health representatives Traditional Healers
Data, Epidemiology, and Surveillance	Epidemiologists Statisticians Data collection, management, and analyst specialists Public health information specialists
Environmental Health	Environmental health workers Sanitarians Inspectors Biologists, chemists, ecologists Data scientists (see above)

In the absence of Tribal-specific competencies, frameworks such as the [Core Competencies for Public Health Professionals](#) (The Council on Linkages Between Academia and Public Health Practice, 2021) have been used to inform the type of knowledge and skillsets that are essential when recruiting and training personnel.

The PHICCS scan assessed the workforce levels and needs of 134 THOs between 2018 and 2019 (NIHB, 2020a). Data was collected on the total number of staff, specific occupational classifications, and workforce development needs. Many Tribes have some level of integration of services drawing on clinical health care, public health, and other relevant services. When asked how many public health and full-time equivalents (FTEs) they had for Tribal public health efforts,

respondents cited a median of four staff members and five FTEs. Behavioral health staff are both the highest average number of funded and filled positions, and the most needed positions currently vacant. THOs also commonly cited a need for front-line workers such as community health representatives (CHRs) and PHNs. In many Tribal communities, these professionals play important roles in delivering public health services and addressing the social determinants of health. For example, many CHRs serve as key links between social services, behavioral health, preventative health and education, financial counseling, and more (IHS, 2022a). Epidemiologists, statisticians, and public health informatics specialists were the least frequently funded positions, and the services least frequently provided by THOs or other Tribal divisions. When asked what Tribal public health workforce development needs are, THOs noted that training (both training on technical skills, i.e., data collection and/or analysis, specialized and general training on public health), adequate staffing, and assistance in performance improvement and public health accreditation were common needs.

Recruiting and retaining competent candidates is foundational to advancing TPHI. Many participants reported the need for additional behavioral health practitioners, public health informatics and other data-related positions including biostatisticians and epidemiologists. Being able to recruit and retain competent in these areas is imperative to Tribal data sovereignty.

Tribal leaders have long been advocating for a “grow your own” approach to workforce development. For recruitment, understanding indigenous approaches to career choice and development is crucial to building the TPH workforce. Motivation and inspiration often come from exposure and experiences with one’s family or in the community. The path to a public health career for Native youth may present itself as an unintentional consequence of following a passion to help and serve their community. NIHB hosted a panel discussion, Youth Engagement in Tribal Public Health on May 12, 2022, during the National Tribal Public Health Summit 2022, to hear directly from youth about how they were drawn to pursuing careers in public health and related fields. As expressed by one professional Native youth, Mikah Carlos,

I wasn't planning on going into public health. It wasn't something I ever thought I would do, but as you look at helping your people, having a public health approach is very different, it's very new, but it's also something that is much needed (personal communication).

Other key factors are cultural competency, Native role models, and mentors. As one youth, Rory Wheeler, describes,

Public health is a passion of mine. It's not a job for me. What keeps me doing this work is I think the teachings I get from my family, mother, grandmother when they told me to get an education and come back home and do good work for my people

(Kim Russell, NIHB Public Health Innovation Regional Award Winner, 2022, personal communication, 2022, May 12)

Having Native people [in public health] gives me the inspiration that I can do this too. We need more of our own people who are culturally competent in this field to further advance it. I had people who saw potential in me when I didn't see it myself (personal communication).

He also stresses the importance of continuity from one generation to the next by “always trying to open the door for the person coming after you.”

Workforce programs and initiatives should be designed to build upon and support existing relational and cultural strengths. Assumptions based on Western theories and values, such as individualism need to be examined to adequately identify the factors that enable career development in AI/AN communities (Byars-Winston & Fouad, 2006). Investment in developing AI/AN public health professionals is essential to Tribal public health capacity building.

Data Sharing and Information Systems

Rigorous information systems and data sharing are foundational elements of Western public health approaches. (CDC, 2014). Tribes have long used oral informational systems to communicate indigenous knowledge and customs, which may largely be underrated by Western public health approaches. Tribes understand the importance of observation but have historically relied on oral traditions to pass that data down from one generation to the next. In reference to COVID-19, Dr. Zink acknowledged that due to Alaska Natives' experience with epidemics and pandemics in the past, “oral history played a huge role in the way that we [the state of Alaska] were able to respond to and continue to respond to this pandemic on a regular basis” (Washington Post Live, 2022). Tribes must be afforded the flexibility to develop data systems that best fit with their culture and customs, as well as to have their inherent right to data sovereignty respected.

Data systems allow for the dissemination of vital information between Tribal and non-Tribal partners and stakeholders, to provide timely information, develop the evidence base, and evaluate ongoing programs and activities. Data sharing can include the following activities:

- Collection, analysis, and dissemination of pertinent data and information, and
- Processes to communicate information to members of the community.

These systems may be fully contained within a Tribe or maintained through collaboration between Tribal and non-Tribal partners. For example, IHS as well as state and local health departments may conduct syndromic surveillance and share that data with Tribal Public Health Authorities, who may use the data to plan interventions or outreach activities. However, depending on how and to what extent data are collected, state data may not be representative. As explained by Vickie Bradley, Secretary of Health of the Eastern Band of Cherokee Indians,

The Eastern Band of Cherokee Indians has codified population health measures, but it is hard to find benchmarks in populations similar to ours because most data

are state data. We have to build a data set from the ground up to be able to develop our own outcome measures (personal communication, 2022, August 4).⁸

Implementing data collection efforts to represent Tribal nations is costly and many Tribes do not have the resources for such an endeavor. Furthermore, Tribes assert that it goes against the federal trust responsibility and is inappropriate as well as counter-constructive to force Tribes to work with States when seeking resources and funds intended to build public health capacity in Indian Country. Tribes as sovereign governments argue that they have direct access to these resources. Collaborative efforts (Tribes along with federal agencies) are needed to communicate this to policymakers in order to remove this significant obstruction to Tribes' ability to build public health infrastructure. Tribes should not be expected to carry the burden for the inadequacies of existing data systems. Data modernization efforts, such as those being undertaken by IHS and CDC must solve inequities rather than exacerbate them.

In addition to data being unrepresentative, AI/AN data is often suppressed (i.e. not reported) due to low numbers and data disclosure concerns. This practice contributes to the invisibility of AI/ANs and has repercussions for omissions in policy and programs, hampering health equity efforts and reinforcing structural racism. The PHI implication is that data systems and analysis need to accommodate and value even the smallest numbers, if equity is to be realized.

As Dr. Jill Jim, Executive Director of the Navajo Nation Department of Health explains:

Because we are considered a smaller population, we are not included in some of these important publications [CDC publications on health disparities]. Our small sample size doesn't mean we should be avoided. When we are considered a smaller size, we can't be equally treated [alongside Hispanic and African American populations who also experience disparities]. (personal communication, 2022, March 8).⁹

Tribes may also work closely with the 12 [Tribal Epidemiology Centers](#) (TECs). Authorized by Congress in 1996, TECs provide technical expertise in a wide range of areas, including technical assistance, surveillance, data collection, and support for Tribes to establish data sharing partnerships. These efforts contribute to public health infrastructure by building information and data sharing capacity of Tribes and doing so in a manner that enhances the Tribes' self-governance authority. Implementing the five recommendations put forward by the U.S. Government Accountability Office (GAO) to HHS to address the challenge TECs face in accessing data is a start to improving Tribal public health capacity. Those five recommendations are as follows:

- HHS clarify the data it will make available to TECs as required by federal law
- CDC and IHS develop guidance on how TECs should request data

⁸ Comments made during the 22nd Biannual CDC/ASTDR Tribal Advisory Committee meeting, Tribal Public Health Infrastructure: Questions and Discussion.

⁹ Comments made during the March 8, 2022, Department of Health and Human Services Secretary's Tribal Advisory Committee meeting.

- CDC should develop and document agency procedures on reviewing TEC requests for and making data available to TECs
- IHS should develop written guidance for TECs on how to request data
- IHS should develop and document agency procedures on reviewing TEC requests for and making data available to TECs

(U.S. Government Accountability Office, 2022)

Respect of Tribal public health authority and sovereignty must guide any public health information systems and related partnerships. Practically, this may look like establishing comprehensive data sharing agreements, and ensuring Tribes have access to systems and data relevant to their communities. Without the capacity to operate information systems efficiently, Tribes may experience extended lag time to get feedback and analysis. Without Tribal-specific information activities, the information gathered may not be specific enough to serve the needs of Tribal communities.

Funding/Resources

Nearly 100 years ago, the federal government began the practice of setting public health standards and funding state and local health departments that met those standards; there was no equivalent funding to Tribes (IOM (US) Committee for the Study of the Future of Public Health, 1988). At the that time, the federal policy toward Native Americans was one of assimilation. For perspective, Native Americans were not granted citizenship and the right to vote until 1924, and not allowed to establish modern Tribal governments until 1934 (United States Department of the Interior, 2022).

The 2019 PHICCS report highlighted that funding is a common need among Tribal public health organizations (NIHB, 2020a). Funding is imperative to not only establish public health programing but is key to build sustainable, durable programs. Investments should be made to support the entire public health system and allow flexibility to enable Tribes to utilize funds based on Tribally determined priorities. One such method of funding includes Tribal set asides. These are specific amounts or specific percentages of federal dollars reserved explicitly for Tribal governments. Tribal set asides, when appropriately deployed,¹⁰ are flexible and allow for Tribes to determine how funds can best be used to meet public health needs and make it easy for Tribes to designate funding towards areas that have been identified as concerns.

Other funding options are block grants, such as the [Preventative Health and Health Services \(PHHS\) Block Grant](#) distributed by the CDC. These non-competitive grants allow broad flexibility to recipients to improve their public health infrastructure, including key components such as surveillance capacity strengthening, workforce development, and evaluation. However, as of March 2021, only two Tribes received \$46,193 each, of the total yearly \$145 million PHSS Block Grant funding distributed to all 50 states, 8 U.S. Territories and the District of Columbia (CDC, 2021b). The amount of funding represents just .06 percent of the total funding even though AI/ANs make up 2.9 percent of the total U.S. population (United States Census Bureau, 2021). As part of

¹⁰ Funding is often appropriated in conjunction with technical assistance, training, and support from the funding agency(ies). At a minimum, funders should ensure that these resources are available to all grantees, regardless of funding agency or distribution mechanism.

the federal trust responsibility, it is critical that Tribes be provided equitable access to non-competitive funding streams to build their public health capacity, and that allows maximum flexibility and sustainability.

Health Equity

A definition of health equity offered by the Robert Wood Johnson Foundation is, “Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care” (Braverman, Arkin, Orleans, Proctor, & Plough, 2017). It is unconscionable that many Tribal communities do not have these basic needs. Indeed, many do not have access to safe water and sanitation systems nor any type of public safety/law enforcement, nor mission-critical services such as access to high-speed internet. That is, basic infrastructural needs to support public health are completely absent in many Tribal communities.

It is important to understand that the social determinants of health unique to AI/AN persons are not often included in national discussions of health equity. NIHB is working towards defining Native determinants of health, which will include factors unique to the history and experience of Native peoples, such as access to culture, language, political status as Tribal citizens and federal Indian policies. While it is not known how widely the term “health equity” is used in Indian Country, the underlying tenets of inclusion, fairness and justice are enduring values. Tribes have consistently and disgracefully suffered the greatest levels of inequities in the U.S. Tribes must be designated a priority in HHS’s and CDC’s health equity work. Meaningful and measurable investment in Tribes, Tribal Epicenters, and Tribal organizations is necessary to build parity and break the history of inequities suffered by Tribes. Reprogram funding to demonstrate commitment to investing in Tribal Nations. Tribes are their best subject matter experts in identifying priorities and asset-based approaches that are innately culturally appropriate, capable, and competent to build public health for and with Tribal Peoples.

Improved public health infrastructure across the United States requires equitable inclusion and representation of the public health authority of Tribal Nations as well as resources to achieve parity with other U.S. populations. Health equity is promoted through efforts and interventions put in place to ensure every individual and community can achieve optimal health. At a community level, examples may include removing language barriers or improving access to care across the spectrum of individuals receiving care at IHS/Tribal/Urban Indian health facilities. At a broader level, it can mean using methods that respect Tribal sovereignty and indigenous ways of knowing in research that impact AI/AN communities (Jernigan, et al., 2015).

Equity also must be reflected in the larger structures and standards used to gauge public health capacity. For example, NIHB has worked with Tribal partners and national public health organizations, including PHAB and the [Council on Linkages between Academia and Public Health Practice](#), to revise national public health accreditation standards and measures and the [Core Competencies for Public Health Professionals](#). Ongoing discussions and advocacy are necessary to ensure that Tribal voices are elevated and that revised standards of accreditation fairly and accurately reflect Tribal public health needs and priorities. However, it is important to avoid a

trickle-down approach to resource development and expecting a seamless adaptation and swift uptake by Tribal systems. A trickle-down approach means supporting non-Tribal agencies to create resources, largely for non-Tribal systems, and then adapting those to Tribal communities.

Culture and TPHI

Native American culture shattering practices – *Colonialism* - has resulted in lasting negative impacts for Tribal communities. The loss of traditional practices as well as sacred spaces and knowledge, which contribute to the well-being of Tribal society and community, have been a detriment to indigenous health. Speaking about how Tribal public health is grounded in culture, traditional knowledge, and wisdom of Tribal communities, Winnebago Public Health Administrator, Mona Zuffante explains:

*We have embodied public health for centuries. We have provided that foundational work for protecting one another, being there for one another and helping one another. Our ancestors have already created that framework for us to work from. It is always important that the answers we are seeking are within our communities (personal communication, 2022, May 12).*¹¹

It is essential that Tribes have the choice and resources to build systems that embrace their values through implementation of culturally appropriate policies and programs and self-determined needs and solutions. Embracing culture as something woven throughout PHI includes recognizing the need for culturally competent staff, meaningful and respectful partnerships, flexibility in program development, and the inclusion of data sharing agreements that reflect Tribes' right to control how their data is used and shared. Each of these factors will differ by Tribe but are equally important when building infrastructure and honoring Tribal culture and sovereignty.

V. Tribal-specific Resources

Below, we highlight several Tribal-specific resources to support TPHI development:

Public Health in Indian Country Capacity Scan (PHICCS)

PHICCS is the only national scan that assesses the capacity of Tribal health and Tribal public health organizations for delivering public health services. It is to be conducted every three years by NIHB. It is important to understand the capacity or the range of public health activities, workforce characteristics, governance structures and systems improvement activities across the nation. This knowledge informs the allocation of resources, as well as policy development and advocacy to improve population health among American Indians and Alaska Natives.

The first capacity assessment was conducted in 2009 and resulted in the [2010 Tribal Public Health Profile: Exploring Public Health Capacity in Indian Country](#). The second iteration, called the PHICCS I, was conducted from November 2018 - August 2019 and resulted in the [2019 PHICCS report](#).

¹¹ Comments made during Building the Future of Tribal Public Health [panel discussion], National Tribal Public Health Summit 2022.

NIHB is currently undertaking the next iteration of PHICCS. As of August 2022, NIHB is in Phase 2, which is the data collection phase. The next report is expected to be released by the end of July 2023.

Tribal Public Health Accreditation Advisory Board (TPHAAB)

[TPHAAB](#) serves as the only existing Tribally specific body devoted as a national sounding board on public health accreditation. Therefore, the Board serves many purposes, including:

- Advising NIHB on internal accreditation-related activities, technical assistance, materials development, and helping to guide NIHB’s strategic approach to supporting Tribal public health accreditation.
- Providing guidance to PHAB on how best to support Tribal health departments that are seeking public health accreditation.
- Serving as a work group to help develop and deliver materials and messaging around public health accreditation to Indian Country (NIHB, 2018).

Strengthening Tribal Public Health Systems

In partnership with the CDC, NIHB supports Tribes interested in strengthening their public health capacity through the [Strong Systems Strong Communities](#) grant initiative. This opportunity provides funding, training, technical assistance, and support to Tribal sub-awardees as they complete projects that improve their performance, advance their progress toward national public health accreditation standards, and promotes interconnection across public health systems to improve population health. Examples of activities conducted through this grant opportunity include Tribal health assessments and improvement plans, strategic planning, workforce development, and asset mapping. Since 2015, these NIHB initiatives have provided funding and direct technical assistance to 29 Tribal nations, including four of the five Tribes that have since achieved public health accreditation.

Area Indian Health Boards (AIHBs) and Regional Tribal Organizations (RTOs)

AIHBs and RTOs are tribal governmental and/or non-profit organizations governed by and accountable to the Tribal governments of their membership in 12 geographical regions of the country, closely aligned with the 12 IHS service areas. AIHBs and RTOs vary in their scope and mission, but all are integral to the regional TPhi. They plan and implement public health programs, analyze, and advocate on policy issues and provide technical assistance to area Tribes. They often house the TECs, enhancing public health capacity in their region. They also serve as the member organizations of NIHB, each seating a representative on the NIHB board of directors.

Tribal Epidemiology Centers (TEC) and the TEC Public Health Infrastructure Program (TECPHI)

The first four [TECS](#) were established in 1996 by the IHCIA. According to the TEC website, “Tribal Epidemiology Centers are Indian Health Service, division funded organizations who serve American Indian/Alaska Native Tribal and urban communities by managing public health information systems, investigating diseases of concern, managing disease prevention and control programs, responding to public health emergencies, and coordinating these activities with other public health authorities” (2022). The [TECPHI program](#) refers to a five-year cooperative

agreement between the CDC and the TECs to increase the capacity of the TECs to deliver public health services to and with the Tribes, Tribal organizations and Urban Indian organizations.¹²

External Partners and Resources

NIHB has also partnered with several national organizations and institutes to expand the visibility and reach of Tribal public health infrastructure. NIHB works alongside organizations including the [CDC](#), the [National Association of City & County Health Officials](#), the [Public Health Foundation](#), the [Association of State and Tribal Health Officials](#), the [National Network of Public Health Institutes](#), [PHAB](#) and the [Public Health National Center for Innovation](#).

Many Tribes have benefited from relationships with colleges and universities, for example, [Seven Directions](#), an indigenous public health institute housed at the University of Washington, regional centers such as the [American Indian Public Health Resource Center](#) at North Dakota State University, other non-profit organizations and consultants. These partnerships foster environments that allow for sharing of tools and resources and delivery of technical assistance related to TPHI.

Tribal Advisory Committees (TACs)

TACs are established by federal agencies to enhance the government-to-government relationship, honor Federal trust responsibilities and obligations to Tribes and AI/AN people and increase understanding between federally recognized Tribes and federal agencies (NIHB, 2022). The Federal Advisory Committee Act governs the establishment, operation and termination of advisory committees, and serve as a primary mechanism for obtaining public input on federal policies and issues (HHS, 2019). Tribal leaders comprise the TACs and bring forth concerns and priorities to federal officials. The [CDC/Agency for Toxic Substances and Disease Registry TAC](#) has been the prominent vehicle for TPHI discussions between Tribal leaders and the CDC. While the need for increased TPHI has been voiced by Tribal leaders for many years, TPHI first appeared as an agenda item for the 22nd Biannual CDC/ASTDR Tribal Advisory Committee (TAC) meeting on in August 4, 2021 (CDC, 2022a). The CDC/ASTDR, as well as other TACs, do not supplement the need for consultation with Tribal governments but they are excellent forums to convey TPHI needs and priorities.

VI. Call to Action/Next Steps

Tribal nations are at a pivotal moment for public health infrastructure development. The COVID-19 pandemic and response has highlighted not only the strengths but the ongoing and persistent need for comprehensive and capable Tribal public health systems. Over the past 50 years, as many Tribes have slowly been building PHI and capacity, the COVID-19 pandemic has jump-started TPHI initiatives for many. The Biden-Harris Administration has declared a special focus on health equity, issued renewed calls for investments in Tribal infrastructure and has re-affirmed their commitment to the government-to-government relationship. Improvements that can be made today stand to alleviate the risks for AI/ANs in ongoing and future threats to public health.

¹² The funding opportunity for a new 5-year (2022-2027) closed on May 11, 2022.

The following recommendations capture TPHI priorities vocalized by Tribal nations through various testimonies, listening sessions, Tribal advisory committee meetings, and national discussion sessions since 2019.

Critical actions necessary for addressing the searing TPHI inequities include:

1. **INVEST** in and develop a comprehensive, yet flexible Tribal public health infrastructure framework that encompasses an indigenous worldview and includes language, culture, traditional healing, and elements that are informed by and resonate with Tribal nations.
2. **COLLECT AND CREATE** a body of Tribal-specific public health infrastructure building resources including examples, case studies, models, tools, and templates.
3. **INCREASE VISIBILITY AND EDUCATION** of Tribal public health authority and governance with Tribal, and non-Tribal federal, state, and local entities.
4. **INVEST** in and develop and improve Tribal public health career pipelines that emulate indigenous strengths and values.
5. **ENSURE** data and information systems representing AI/AN persons, are accessible to Tribal public health authorities and that data sovereignty is respected.
6. **INVEST** in infrastructure necessary to achieve equity among Tribal, state, local and territorial governments in the development and dissemination of all public health capacity-building resources, including funding.
7. **IMPROVE OPPORTUNITIES** for indigenous, practice-based evidence and knowledge grounded in culture to foster public health innovation in Tribal communities.

Moving forward, next steps should include a commitment by federal agencies to implement actionable and measurable steps to prioritize TPHI according to the needs and directions of Tribal nations. Government-to-government convenings should continue to integrate TPHI and continually identify and act upon Tribal priorities and recommendations. Convenings of Tribal public health practitioners, researchers, subject matter experts, and other partners should likewise gather continuous feedback on the practicalities of building TPHI. It is imperative that communication and accountability be built into the process. Non-federal partners can share resources with Tribes and partner in system improvement initiatives that seek to strengthen TPHI on par with non-Tribal systems. Tribal nations themselves can assess and communicate their public health capacity and capabilities, develop, and share innovative strategies that work, and continue to advocate for needed resources.

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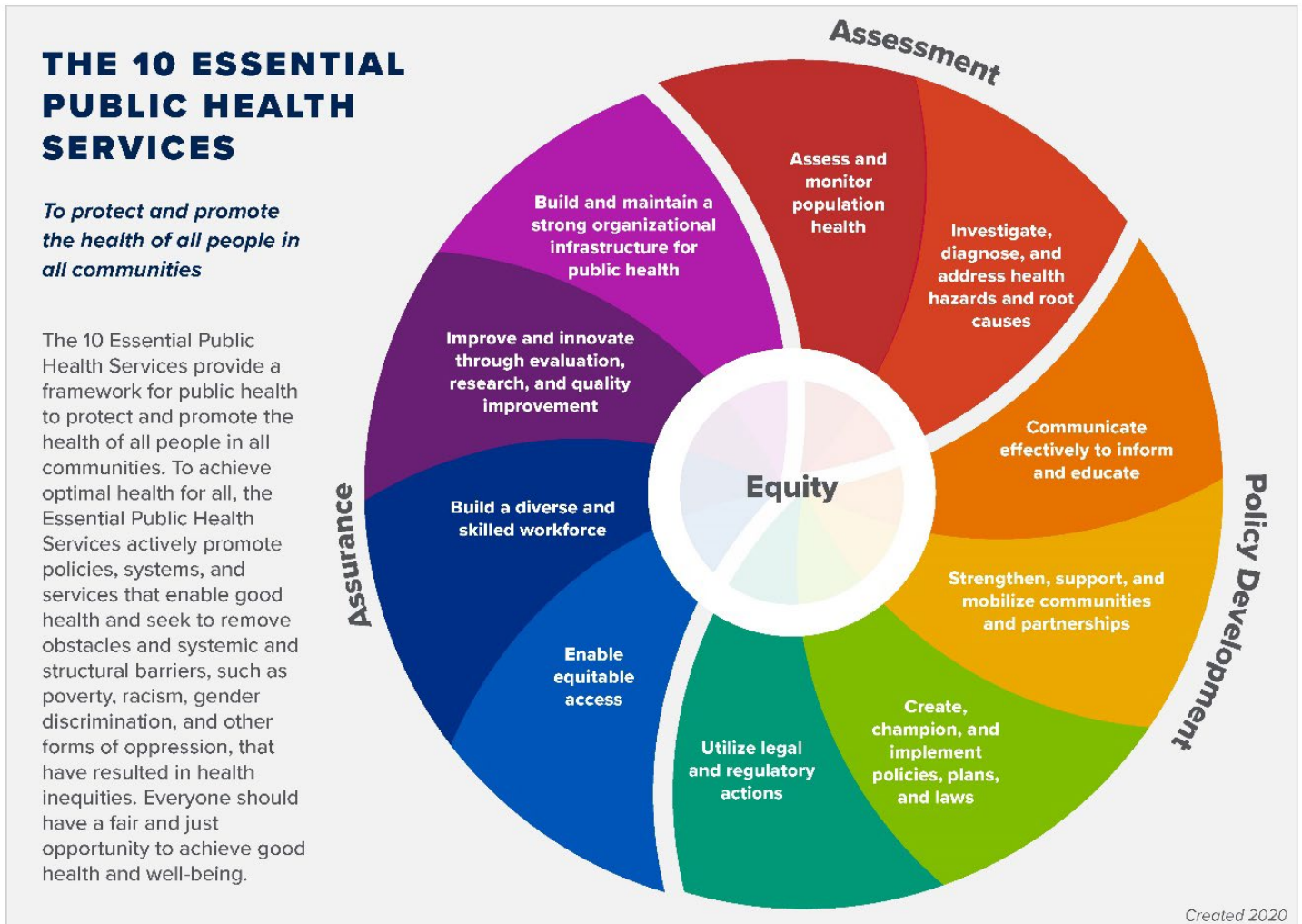
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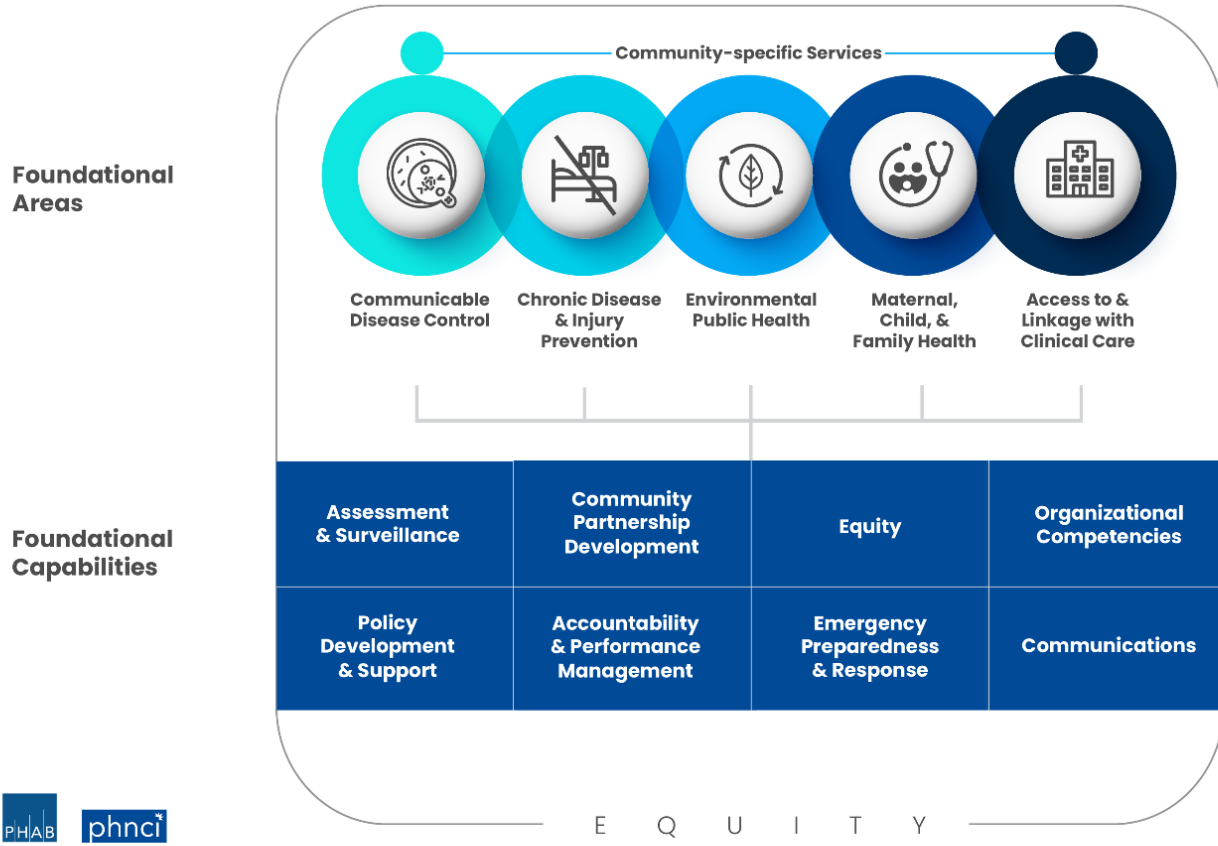
VIII. Appendices

Appendix A: The Ten Essential Public Health Services



Appendix B: Foundational Public Health Services

Foundational Public Health Services



February 2022