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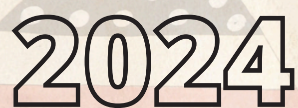


2024 TRIBAL PRENATAL-TO-THREE POLICY AGENDA

Charting a Path to Good Health and Wellbeing for American Indians and Alaska Natives, Prenatal to Age 3

EXECUTIVE **SUMMARY**

PURPOSE

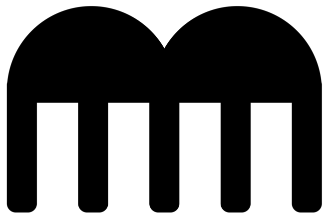
The National Indian Health Board developed the Tribal Prenatal-to-Three Policy Agenda to raise awareness regarding the most impactful and culturally appropriate policy levers and strategies to support American Indian and Alaska Native (AI/AN) health and wellbeing in the earliest years of life, from the prenatal period through age 3. These recommendations chart a path forward to health equity and improved outcomes for AI/AN families, infants, and toddlers.

CONTEXT AND PERSPECTIVE

Several core principles and values guided the development of this policy agenda, including ensuring that the resulting resources and recommendations:

- Honor Tribal sovereignty
- Build on a variety of knowledge sources, including lived experience, Indigenous knowledges, academic literature, and others
- Take a holistic, intergenerational, and strengths-based approach
- Reflect Indigenous perspectives and uses the Indigenous Determinants of Health as a guiding framework

Taking a collaborative approach to policy, NIHB conducted a series of interviews, roundtables, document reviews, and Tribal listening sessions to gather input, recommendations, wisdom, and expertise from Tribes across the country and Tribal subject matter experts in a wide range of critical disciplines. We have made every effort to ensure the following recommendations are truly Tribally led and authentically reflect the priorities, perspectives, and needs of Indian Country. At the same time, we acknowledge that AI/AN communities across the country are diverse and face wide-ranging circumstances, in addition to a continually evolving policy landscape. Therefore, this policy agenda is not the final word on any of these topics, but instead represents a robust starting point for equitable and effective policymaking.



FIVE POLICY GOALS

1. Protect Tribal Sovereignty and Self-Determination

Tribal sovereignty – the inherent right of Tribal nations to self-govern – is the foundation of advancing health equity for American Indians and Alaska Natives. Many of the current issues Tribal communities and families face are rooted in colonization and a history of paternalistic federal policy. Emphasizing Tribal sovereignty and self-determination are essential for healing from this harmful legacy and setting a more equitable, effective path forward.

2. Invest Equitable Resources and Funding.

Tribes have been starved for funding and resources for centuries as federal policy created conditions of scarcity in Tribal communities. For any chance of widespread improvement in outcomes for children prenatal to three, large-scale investment into Tribes must be a top priority.

3. Address Trauma and Strengthen Connection to Culture

Trauma is a root cause of many issues facing Tribal families, communities, parents, and children. At the same time, connection to culture has been found to be a powerful component in building resilience and healing from trauma. To move forward in protecting Native kids in infancy and early childhood, we will need to prevent trauma currently caused or worsened by many systems, support healing from previous trauma (including historical, intergenerational, and individual), and build resilience through the strength of culture.

4. Support Family-Centered Systems

Services and systems Native families must navigate can be complex, stressful, and even traumatic. These barriers can prevent accessing essential care and services young families need. More Tribal control over programs and more flexibility given to Tribes in administering these programs can make these systems easier and more family-friendly to navigate. We can improve health and wellness outcomes for families and young children by designing services, programs, and systems to intentionally prioritize meeting the needs of families, rather than the convenience of funders.

5. Empower Tribal Voice in State and Federal Governance

Federal and state agencies administer programs and make policy choices that have immense impact on Tribes. Tribes must have a voice in these decisions. Improved state-Tribe and federal-Tribe relations can go a long way to supporting the policies and infrastructure needed to support Native families and improve health and wellbeing in early childhood.

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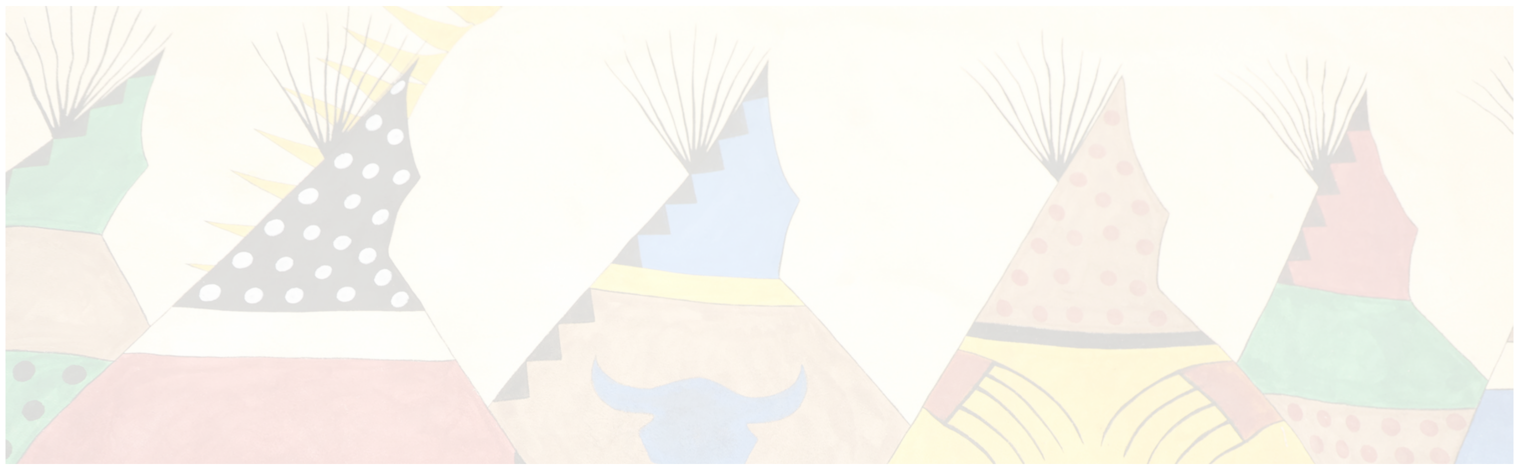


INTRODUCTION **& BACKGROUND**

THE IMPORTANCE OF A HOLISTIC PERSPECTIVE FOR THE PRENATAL TO THREE PERIOD

We have focused on the prenatal to three (PN-3) period because this phase of life has ramifications across the lifespan. The PN-3 period is a critical stage of rapid growth and development that establishes the foundation for a child's subsequent cognitive, social, educational, emotional, and physical health outcomes.[1] When families and parents have the resources and support they need, they can provide nurturing environments to their children. However, inequitable access to resources, health care, social support, and safe and nurturing environments have resulted in staggering health inequities. For example, American Indian and Alaska Native (AI/AN) mothers are 2.3 times more likely to die from pregnancy-related causes compared to non-Hispanic white women;[2] 11.6 percent of non-Hispanic AI/AN infants are born preterm;[3] and non-Hispanic AI/AN infants have 1.8 times the rate of post neonatal infant mortality compared to non-Hispanic white infants.[4] This policy agenda therefore discusses the unique needs of AI/AN children and their caregivers for improving health and well-being when it comes to the PN-3 years.

[1]For a more in depth look at the importance of this period for future outcomes, see Prenatal to Three Policy Impact Center's Research Brief: "Why Do We Focus on the Prenatal-to-3 Age Period? Understanding the Importance of the Earliest Years." January 2021.
[2] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007-2016. MMWR Morb Mortal Wkly Rep 2019;68:762-765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3
[3] Osterman M, Hamilton B, Martin JA, Driscoll AK, Valenzuela CP. Births: Final Data for 2020. Natl Vital Stat Rep. 2021; 70 (17): 1-50. Retrieved at https://pubmed.ncbi.nlm.nih.gov/35157571/
[4] Ely DM, Driscoll AK. Infant mortality in the United States, 2021: Data from the period linked birth/infant death file. National Vital Statistics Reports; vol 72 no 11. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: https://dx.doi.org/10.15620/cdc:131356.

Early childhood literature has well established the importance of healthy, stable families to support optimal outcomes for children in this period. This involves strengthening families across multiple domains, including, among others, sufficient household resources; parental health and emotional wellbeing; nurturing and responsive child-parent relationships; nurturing and responsive childcare in safe settings; access to nutritious foods; healthy housing and physical environments; and access to quality healthcare and other needed services.[5]

In many ways, the inclusion of these cross-sector domains in literature about early childhood health, wellbeing, and development demonstrates the growing influence and understanding of social drivers of health (SDOH). This movement towards emphasizing that where a family lives, learns, works, and plays are among the most powerful factors in determining their health outcomes is a promising one. However, this focus on SDOH remains too limited, and the study of the impact and importance of social drivers has largely proceeded without attention to significant drivers specific to Native health. Neglecting Tribal perspectives risks missing the forest for the trees.

A pediatrician we interviewed who recently visited a remote Alaska Native village shared an illuminating story. They described how the community placed great importance on salmon for sustenance, not just for the health benefits but also for the cultural practice of salmon fishing:

> So, the elders would go out and set nets. Youth would go out with them and learn about water safety, cultural tradition, how to catch, how to prepare, how to eat salmon, healthy living, exercise, mental health, all the things needed for health at the personal, spiritual, and social level. And then a few years ago, the number of salmon available in Alaska declined, and salmon fishing was restricted to all but commercial salmon fisheries. These small villages were no longer permitted to fish for salmon. One of the state government food programs suggested a workaround, saying 'We'll fly salmon into the interior, and the village will be able to have the salmon available to them for the nutritional benefits and sustenance.' But boxed salmon can't replace the time that the youth had with the elders and the cultural practices and passing the tradition and exposure to other health-promoting practices. Boxed salmon can't reproduce the resiliency of those cultural protective factors that were lost with loss of access to salmon fishing. Unfortunately, it's historically been one of the strengths that has been removed from so many communities.

Figure 1: Key Domains for PN-3 Health, Development, and Wellbeing

- **Key Domains to Advance PN-3 Health, Development, and Wellbeing**
- Health Care
- Nurturing Child-Caregiver Relationships & Child Welfare
- Parents' Mental/ Emotional Health & Addressing SUD
- Household Economic Stability & Caregiver Ability to Work
- Childcare & Early Childhood Education
- Connection to Community and Culture
- Nutrition & Food
- Physical Environment & Housing

In other words, while an SDOH-approach may focus on questions like, “How can we improve access to healthy foods?”, the more relevant question for many Tribal communities may be: “How can we strengthen our Indigenous food systems and pass on Indigenous food knowledges to younger generations?” In addressing behavioral health issues like depression among new parents, an SDOH-approach may ask, “How can we increase access to mental health treatment services?”, but risks ignoring potential harm caused by treatment that overly relies on Western approaches and focuses on changing an Indigenous person’s way of thinking, perceiving, or behaving, rather than changing the discriminatory and oppressive systems that create the ongoing traumas at the root of the depression. In short, the SDOH framework is insufficient to capture the upstream drivers that influence the health of Native peoples.

INDIGENOUS DETERMINANTS OF HEALTH

To address this gap, Indigenous perspectives of health and equity need to guide the development of policy priorities and strategies for improving PN-3 health and development. One model created from Indigenous perspectives is the Indigenous Determinants of Health (IDH), as adopted by the United Nations Permanent Forum on Indigenous Issues. This model is designed to educate government officials on practical actions to address 33 Indigenous-specific risk and protective factors in a culturally safe way. The IDH Model describes “Indigeneity” as an overarching determinants of health, “an intersectional determinant of health across sectors.” This recognizes that the experiences of Indigenous peoples are substantially distinct from those of other populations around the globe, both in terms of Indigenous peoples’ unique interactions and relationships to social life and environmental elements, and in terms of the widespread patterns of severe, intergenerational harm caused by colonization. Under the umbrella of Indigeneity, the model groups the rest of the protective and risk factors into three categories: Intergenerational, Holistic Healing; Health of Mother Earth; and Re-Indigenizing Culture (Figure 2). Figure 3 provides examples of how these Indigenous-specific drivers of health can inform more appropriate and effective policy priorities to support Native infants and toddlers.

The Indigenous Determinants of Health framework illustrates the bigger picture that provides context to all the issues and priorities that Tribal health advocacy has focused on for decades, including around maternal and infant health. This model is therefore our frame of reference for understanding the underlying challenges creating barriers in each of the key domains, and the policy and strategy recommendations that can present solutions to these challenges.

[5] See, for example, Dagher RK, Linares DE. A Critical Review on the Complex Interplay between Social Determinants of Health and Maternal and Infant Mortality. Children. 2022; 9(3):394 and Burnette CE, Figley CR. Risk and protective factors related to the wellness of American Indian and Alaska Native youth: A systematic review. International Public Health Journal. 2016; 8(2), p137.

Figure 2: Indigenous Determinants of Health Model. Indigeneity is an intersectional, overarching driver of health across sectors. Both negative (outer ring) and positive (middle ring) factors make up the 32 additional drivers of Indigenous health, grouped into three categories.

INDIGENEITY
RE-INDIGENIZING CULTURE
INTERGENERATIONAL HOLISTIC HEALING
HEALTH OF MOTHER EARTH
STRENGTHENING INDIGENOUS IDENTITY
INDIGENIZING & DE-COLONIZING EDUCATIONAL CURRICULA
SOVEREIGNTY OF INDIGENOUS RIGHTS & BELIEF SYSTEMS
GENDER IN INDIGENOUS COMMUNITIES
INDIGENOUS CULTURES & LANGUAGES
LANGUAGE AS INDIGENOUS KNOWLEDGE KEEPER
LAND & SACRED PRACTICES
INDIGENOUS-SPECIFIC SPIRITUALITY
INTER-GENERATIONAL APPROACH
HOLISTIC HEALING
INDIGENOUS TRADITIONAL MEDICINE
ACCESS TO & HEALTH OF TRADITIONAL PLANTS
ACCESS TO WATER SOURCES
INDIGENOUS FOOD SYSTEMS
ECOLOGY, WATER, LAND, & AIR
STRUCTURED, SYSTEMATIC, & PLANNED INVISIBILITY
NORMALIZATION OF ONGOING CULTURAL GENOCIDE
ASYMMETRIC TREATMENT OF INDIGENOUS KNOWLEDGES
SUPPRESSION & OPPRESSION BY SUBSTANCES
INSTITUTIONAL-IZED INDIGENOUS-SPECIFIC RACISM
INSTITUTIONAL PATHOLOGIZING OF INDIGENOUS PEOPLES
INDIGENOUS-SPECIFIC TARGETING STIGMA
ONGOING TRAUMA EXPOSURE
FORCED ASSIMILATION & INDOCTRINATION
EROSION OF TRADITIONAL LIFEWAYS
DISMISSAL OF TRADITIONAL MEDICINE APPROACHES
ENVIRONMENTAL DISPOSSESSION
MIGRATION & URBANIZATION
NON-INDIGENOUS CONCEPTS OF PLANETARY HEALTH
MIS-CONSTRUCTION OF FOOD SECURITY FOR INDIGENOUS COMMUNITIES
MARKETED ULTRA-PROCESSED FOOD REPLACING INDIGENOUS DIETS
LIMITED ACCESS TO INDIGENOUS FOOD SYSTEMS RESOURCES

Figure 3: Indigenous Determinants of Health Can Inform PN-3 Priorities

3 Categories of Indigenous Determinants of Health	How These Drivers Can Inform PN-3 Policy Priorities
Intergenerational, Holistic Healing.	•Healthy infants and toddlers require healthy, thriving families, communities, and Tribes. To effectively improve PN-3 Native health, taking a holistic view of these issues is essential, as is understanding how they are interconnected. •Intergenerational relationships can greatly strengthen families and communities and support PN-3 health. For Indigenous peoples, effective healing models must address the entire person within the context of past, present, and unborn generations. •Infant and toddler health is supported when all community members and surrounding elements of their environment are healthy and in balance.
Health of Mother Earth	•Indigenous peoples and communities have been in a deep and meaningful relationship with their surroundings for as long as they have existed. They have formed systems of being, including thoughts, behaviors and lifeways that have sustained communities until disruption through the forces of colonization. •To support healthy communities and children, we need to ensure access to clean water, hunting, fishing and gathering grounds with intact ecosystems, thriving Indigeneous food systems and traditional diets, traditional medicine practices, and Indengous ways of being well.
Re-Indigenizing Culture	•Indigenous knowledge systems represent knowledge, practices and ways of being human in relationship with past and future generations, current Indigenous communities, and environments. •Identity of self and connection to community and land are key protective factors for Indigenous peoples. •Promising studies show that Indigenizing and decolonizing curricula can benefit students and future patients. •Applying that to health means remembering, reinvigorating and implementing Indigenous peoples' values, practices, systems and sustainable resource allocation into health systems.

COLONIZATION, TRAUMA, AND CROSS-CUTTING CHALLENGES

When considering factors for health and well-being, the most commonly cited barriers that Native families face can be traced back to deliberate policy choices made by a colonizing government. Therefore, we must identify and address the cross-cutting challenges rooted in the legacy of colonization. Figure 4 illustrates how colonization has led to systemic disparities in health outcomes for American Indian and Alaska Native people.

Among these cross-cutting challenges, one of the most prevalent and powerful is trauma. The common theme of trauma is apparent at multiple levels across all key domains. The taking of lands, lives, children, and culture through colonization continues to impact Tribes and Native families today. The harm of these historical traumas carries down from generation to generation. The Murdered and Missing Indigenous Persons crisis speaks to the widespread violence and trauma all too commonly experienced in Native communities, frequently perpetrated by

> NIHB's sole commitment and focus is to the health of all American Indian and Alaska Native peoples. That work cannot succeed without restoration of language and culture, and healing from colonization. Our very concepts of what it is to be healthy are rooted in our cultures, languages, and in our shared and individual histories. Without standing in the full knowledge and understanding of the impact colonization has defined in all Indigenous experience, we will not know health. We will not heal.
> –William Smith, Valdez Native Tribe, NIHB Chairman of the Board

non-Native people. These experiences and community-level factors contribute to and intersect with domestic violence and interpersonal traumas within families.
All these things function in a cyclical relationship with substance use disorders as well – dependence on substances is frequently a maladaptive coping mechanism for dealing with trauma. In turn, SUD in a household becomes a risk factor for a family's children to experience additional trauma. Child welfare literature speaks to the importance of healthy, stable families for minimizing adverse childhood experiences (ACES) that can be traumatic for young children and potentially lead to lifelong health risks.

Subject matter experts have also observed another kind of trauma unique to the Indigenous experience, remarking that even the most common and routine interactions with essential societal systems (e.g. healthcare, courts, social services, education, etc.) are frequently traumatizing for Native people for the simple fact that these systems were not designed to benefit AI/ANs. Systemic racism remains rampant in many of these institutions,[6] especially when they are not run by the Tribal communities themselves. Trying to navigate these systems can bring its own trauma to families or compound existing trauma, because systems built by the colonizers were never designed to function for the health and wellbeing of Indigenous peoples. In many cases, these systems were intentionally designed for the destruction of Indigenous peoples. Because of this history and ongoing experiences with discrimination, many Tribal communities harbor deep distrust for these institutions.

Moving forward will require understanding these factors and the painful historical context they stem from. It will require acknowledgement of historical trauma and the well-founded mistrust of institutionalized systems that have led Indigenous populations and communities to where they are today. We will need to not only improve access to essential services, but also ensure that the services provided are culturally safe. The safest and most effective systems will be ones created by and for the communities they serve.

[6]See e.g. Taylor J, Novoa C, Hamm K, & Phadke S. Eliminating racial disparities in maternal and infant mortality. A comprehensive blueprint. Center for American Progress. 2019.

Figure 4: Key Drivers of AI/AN Health Inequities

KEY DRIVERS OF HEALTH INEQUITIES

for American Indians and Alaska Natives (AI/AN)

Colonization introduced foreign structures and systems

- Federalism
- Capitalism
- US Government paternalism
- Structural discrimination

Colonialist aims separated AI/AN from community, identity, and culture

- Genocide
- Taking of lands
- Forced relocation
- Forced assimilation policies

As a direct result, Colonization produced:

- Historical and intergenerational trauma
- Erasure of AI/AN from mainstream American society
- Barriers to Tribal self-governance
- Distrust between Tribes and state/federal governments
- Governance structures that limit meaningful Tribal participation
- Generational poverty
- Tension between majority American culture and Native cultures
- Diminished population size of AI/AN

Leading to self-perpetuating problems for AI/AN

- Disparities in opportunities (education, jobs, healthcare)
- Diminished economic and political power for Tribes, and exclusion from decision-making
- Data practices that exclude AI/AN from representation
- Severely underfunded public sector

AI/AN are then further separated from their communities and culture

- Tribes have limited resources to address these systemic problems.
- AI/AN must leave their homes and communities to access resources, meet needs, and pursue opportunities.

The outcome: Severe health inequities for American Indians and Alaska Natives

Because of these systemic injustices, AI/AN face lower life expectancies and higher rates of preventable disease, disability, and death.

The legacy of colonization and impact of ongoing trauma are among the most significant barriers impeding health for pregnant people, infants, and toddlers in Tribal communities. This is critical context to any discussion about health and wellbeing of Native families in the United States. These concepts tie in closely to the core challenges that we found cutting across all domains necessary to healthy, thriving children. These cross-cutting challenges include:

- Trauma (historical, intergenerational, systemic, personal)
- Shortfalls in federal funding promised to Tribes
- Non-equitable and ineffective funding mechanisms
- Federal and state infringement on Tribal sovereignty
- Federal and state unilateral decision-making that impacts Tribes
- Limits on Tribal capacity & self-determination
- Workforce Shortages
- Institutional disregard for Indigenous ways of knowing & cultural values
- Traumatizing and difficult to navigate systems, institutions, and services
- Native families' disconnection from community & culture
- Poverty, lack of household resources

If these core challenges are addressed, outcomes will improve across all domains, leading to healthier, thriving Native families.

EXPANDING THE PN-3 POLICY LANDSCAPE

This policy agenda builds on previous policy work and recommendations developed by Vanderbilt University's Prenatal-to-3 Policy Impact Center and the Alyce Spotted Bear & Walter Soboleff Commission on Native Children, as well as other partner organizations.

2024 PRENATAL-TO-3 STATE POLICY ROADMAP

Initially launched with support from the Pritzker Children's Initiative, the Prenatal-to-3 Policy Impact Center has developed and annually updated a Prenatal-to-3 State Policy Roadmap to provide evidence-based policy recommendations to states. As described by the PN-3 Impact Center, "Grounded in the science of the developing child and based on the most rigorous evidence available, the Roadmap details the state actions that foster the nurturing environments infants and toddlers need, and that reduce longstanding racial, ethnic, and socioeconomic disparities in access and outcomes." The Roadmap includes four specific policy recommendations and another eight evidence-based state-level strategies to meaningfully improve outcomes for American families with young children.

NIHB, also supported by the Pritzker Children's Initiative, learned from and built on this foundational work as we developed this Tribal Prenatal-to-Three Policy Agenda, which is uniquely focused on Tribal perspectives of health, determinants of health, and policy priorities. In addition, this Tribal Policy Agenda includes some state-level recommendations but is significantly more focused on federal policy changes.

SPOTTED BEAR AND SOBOLEFF COMMISSION REPORT

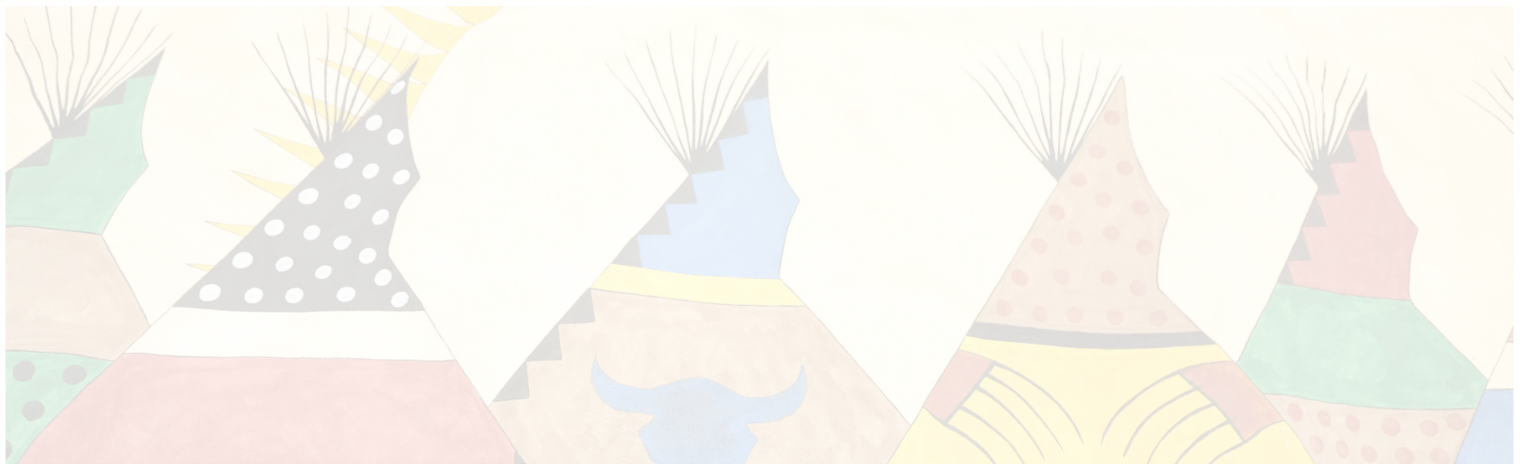
In 2016, Congress appointed and funded the Alyce Spotted Bear and Walter Soboleff Commission on Native Children to conduct a comprehensive study of the federal funding and programs intended to support Native youth and to make recommendations for improving those efforts and helping Native children thrive. Using a holistic approach, the commission thoroughly studied programs, policies, and outcomes across

many of the key domains and sectors that influence the health and wellbeing of Native children. The final findings and recommendations of the commission were published in February 2024 in "The Way Forward: Report of the Commission on Native Children." Like this Tribal PN-3 policy agenda, the Commission used "an expansive approach, to bring into view the connections and crossover issues and solutions among the various disciplines that address endemic and historic issues facing Native children and youth."

The key themes identified in this thorough report further support the policy recommendations and strategy approaches recommended in this agenda. Key themes identified by the Commission included these integral concepts:

- "Cultural engagement and language learning are critical components of healing and resilience for Native children and youth."
- "Community control and community-level decision-making yield the best results for Native children and youth and for their families and communities."
- Many of these key themes and the subsequent "Flexible funding approaches support innovation and responsiveness."
- "Trauma—the emotional response to a terrible event or circumstances—is a root cause of many of the issues with which Native children, youth, and families wrestle today."

rMany of the ecommendations found in the Way Forward Report are echoed in this policy agenda. This repetition is not incidental. As the authors commented in the report: "The Commission notes that few of its recommendations are truly new. Much has been known—and for quite some time—about how to improve the wellbeing of Native children and youth. A tendency toward top-down decision-making, inadequate funding, and a limited understanding (or lack of appreciation) of the cultural factors that can enhance wellbeing have combined to forestall the implementation of strategies and approaches that would turn the wheel."



FIVE POLICY **GOALS**

Taking a collaborative and Tribally-led approach to policy, NIHB conducted a series of interviews, roundtables, document reviews, and Tribal listening sessions to gather input, recommendations, wisdom, and expertise from Tribes across the country and Tribal subject matter experts in a wide range of critical disciplines. (See Appendix A for more details on our methods for developing policy recommendations). From these diverse Tribal perspectives, we honed our understanding of the most critical issues, identified the cross-cutting challenges and barriers for Native families and communities, and gathered recommendations for policy solutions.

The following five cross-cutting policy goals will address the cross-cutting challenges and improve outcomes for Native families in each of the key domains:

1. Protect Tribal sovereignty and self-determination
2. Invest equitable resources and funding
3. Address trauma and strengthen connection to culture
4. Support family-centered systems
5. Empower Tribal voice in state and federal governance

The following sections explain these goals in more depth and the recommended policies and strategies under each to break down the barriers Native families face in each of the key domains. We have made every effort to ensure the included recommendations are truly Tribally led and authentically reflect the priorities, perspectives, and needs of Indian Country. At the same time, we acknowledge that AI/AN communities across the country are diverse and face wide-ranging circumstances, in addition to a continually evolving policy landscape. Therefore, this policy agenda is not the final word on any of these topics, but instead represents a robust starting point for equitable and effective policymaking.

POLICY GOAL 1

PROTECT TRIBAL SOVEREIGNTY AND SELF-DETERMINATION

Tribal sovereignty – the inherent right of Tribal nations to self-govern – is the foundation of advancing health equity for American Indians and Alaska Natives. Many of the current issues Tribal communities and families face are rooted in colonization and a history of paternalistic federal policy. Emphasizing Tribal sovereignty and self-determination are essential for healing from this harmful legacy.

As The Way Forward Report explains, “the overarching request in the Commission’s report to the President and Congress is to fulfill the Federal trust responsibility as articulated in treaties, statutes, and policies—a responsibility that in the modern era includes providing an appropriate level of Federal support for self-determination and self-governance so that Tribes, Tribal organizations, and other Native entities can implement and manage programs and services in their communities. Doing so will chart a bold, new path toward intergenerational wellbeing.”

Respecting Tribal sovereignty means, in large part, deferring to Tribal control by supporting Tribal nations to make decisions for themselves on the best way to run programs. Empowered to make their own choices and run their own programs for their people, Tribes are able to be more innovative and more effective in meeting their people’s needs. Tribes should control the resources, plans, policies, and goals intended to improve the health and wellness of their citizens. Tribes know their people, communities, social and historical context, needs, and strengths best.

The federal government is most effective in working toward improving PN-3 health when it puts its resources behind supporting the leadership of Tribal communities. To be clear, this does not mean providing a patchwork of resources through competitive grants. These programs more often serve the needs of the federal government or funding agency, and not the Tribal nation and its citizens. Funding should be non-competitive, broad-based, and with limited reporting/ administrative requirements.

If you want to talk about protective health factors, this is what you can do: really looking outside of health care policy, but also at state government, trade, financial, housing, all the things that can affect a Tribe's autonomy and decision-making. Tribes know inherently what is good for their well-being, but that is continually being taken.

\- Interview Participant

Programs run by Tribes are able to help families circumvent potential barriers that would otherwise cut off access to essential services. For example, Tribes can make social services offices physically more accessible, make paperwork and proof of eligibility more flexible and clear, and work with Tribal members to address individual circumstances. Given authority over eligibility criteria, Tribes can also make sure the programs reach the families who need them most. Programs commonly run by Tribes, like the Temporary Assistance for Needy Families Program (TANF) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), have demonstrated this success. Tribally-run programs are trusted within their communities, can ensure cultural safety and cultural appropriateness, and can more effectively use resources to holistically meet multiple needs at once.

Ensuring sufficient flexibility and support for Tribes to design their own solutions and priorities for health equity is both more effective and more respectful of Tribal sovereignty. For example, Alaska has assumed management of Medicaid travel for Tribal beneficiaries within the Tribal health care system, which was more effective and cost-saving in a region with many unique travel challenges. Similarly, expanding self-governance processes into more systems and programs could address many of the barriers families face across sectors and key domains.

Protecting and enhancing Tribal sovereignty and self-determination is the necessary foundation on which all other policy and strategy choices can be built. Without it, no program or strategy, no matter how well-studied or "evidence-based", will ever result in the paradigm shift needed to fully support Native families and improve outcomes for children prenatal to three.

RECOMMENDED POLICIES & STRATEGIES

To ensure protect Tribal sovereignty and self-determination and improve prenatal to three outcomes for AI/ANs, policymakers should prioritize the following goals and actions:

- Fully implement Executive Order 14112, "Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination"
- In multi-jurisdictional situations, defer to Tribal sovereignty
- Enhance flexibility in funding and program design to support Indigenous knowledge and traditional ways of knowing, including Indigenous evaluation methodologies
- Expand Tribal Self-Governance across all programs under the U.S. Department of Health and Human Services
- Remove program standards created by outside entities (like state or federal agencies), and instead defer to Tribal-set standards
- Boost the capacity of Tribal social services and Tribal courts
- Support policies that advance Tribal food sovereignty, including recognizing Tribal sovereignty in deciding SNAP and WIC eligibility and program policies
- Honor Tribal data sovereignty and enforce federal mechanisms that allow Tribal data to be accessed by Tribal nations

POLICY GOAL 2

INVEST EQUITABLE RESOURCES AND FUNDING

Tribes have been starved for funding and resources for centuries as federal policy created conditions of scarcity in Tribal communities. For any chance of widespread improvement in outcomes for children prenatal to three, large-scale investment into Tribes must be a top priority.

The United States owes a legal and moral obligation to provide sufficient resources to ensure good health for American Indians and Alaska Natives. This obligation, known in federal Indian law as the federal trust responsibility, is integral to the unique legal and political relationship the U.S. maintains with Tribal governments, which has been established through and confirmed by the U.S. Constitution, treaties, federal statutes, executive orders, and judicial decisions. The federal trust responsibility has its roots in the treaties the U.S. signed with Tribal nations promising certain rights and services, including health care, in exchange for land.

While Congress has clearly acknowledged in the Indian Health Care Improvement Act and elsewhere 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," government reports over the course of the past century clearly demonstrate that this obligation has never been fulfilled.[11]

To this day, the Indian Health Service and other essential programs supporting Tribes remain chronically and detrimentally underfunded.

This chronic underfunding cripples the systems that Tribes rely on to protect and strengthen families and keep children healthy. Huge swaths of Indian Country are maternity care deserts; when pregnant people must travel for several hours to reach an appropriate provider, prenatal and postpartum care may be impossible and delivery can be exceptionally dangerous. Similarly, critical treatments for substance use disorders are frequently unavailable in Tribal communities, compounding challenges families face.

Some essential programs, like the Tribal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, recently saw meaningful (though still insufficient) funding increases. However, issues remain regarding many of the funding mechanisms commonly used by the federal government, which do not work for Tribes and result in inequitable outcomes. For example, a great deal of federal funding, including MIECHV, is distributed through competitive grants to Tribes. At the same time, all states receive MIECHV funding without being subjected to a competitive process. This systemic inequity in funding contributes to inequities in outcomes for AI/AN.

[11] *See e.g.* Meriam Report: The Problem of Indian Administration (1928); Indian Policy Review Commission Report (1978); A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country (2003); Broken Promises: Evaluating the Native American Health Care System (2004); and Broken Promises: Continuing Federal Funding Shortfall for Native Americans (2018).

I think also pointing out treaty rights and obligations… that's an important piece of background for this report. And, again, the federal government itself recognizes in its own reports, the ways that federal treaty obligations have fallen woefully short.

– Interview Participant

Another example is the Title V Maternal and Child Health (MCH) Services Block Grant [12] administered by the Health Resources and Services Administration (HRSA). This block grant aims to improve public health for mothers and families. However, the grant flows through states, leaving Tribal governments out of this critical funding stream, despite American Indian and Alaska Native women having some of the poorest outcomes for maternal and child health.

Additionally, many grants require burdensome application and reporting requirements that disadvantage small Tribes with limited staff capacity and technical grant expertise. Burdensome administrative requirements ultimately waste resources that could have gone into program implementation. Many grants are also restrictive in how the funds may be used, frequently demonstrating disregard for Indigenous ways of knowing, traditional practices, and Tribal cultural values, and instead privileging only Western methodologies and practices as "valid." As a result, the most culturally relevant programs are sometimes the least likely to be funded.

The federal trust responsibility is owed to all of Indian Country; forcing Tribes to compete against each other means that only a few are winners and the rest are left behind. This system of winners and losers does not fulfill the federal trust responsibility to Tribal nations. Competitive grants do a lot to serve the federal government, but little to ensure meaningful impact for Tribal communities.

The lack of resources infused into our communities is a continuation of genocide. Hundreds of years of federal Indian policy has had a direct horrific effect on our health and well-being. We are taught to have a scarcity mindset and that there are never enough resources. In reality, we live a country of extreme wealth, and the hoarding of this wealth is both unethical and immoral when our people are literally dying.

– Interview Participant

[12] See HRSA Maternal & Child Health: Title V Maternal and Child Health (MCH) Services Block Grant. Updated December 2023. https://mchb.hrsa.gov/programs-impact/title-v-maternal-child-health-mch-services-block-grant

RECOMMENDED POLICIES & STRATEGIES

To invest equitable resources and funding to improve prenatal to three outcomes for AI/ANs, policymakers should prioritize the following goals and actions:

- Congress should honor the federal trust responsibility for health toward Tribal nations by providing full and equitable funding for the Indian Health Service and 10% set-aside for Tribal nations across all other HHS programs
- Tribal set-asides should be distributed as noncompetitive formula funds directly to Tribes, and not through state or local governments.
- Reform federal block grant funding to create direct access for Tribal nations, especially for the Title V Maternal and Child Health (MCH) Services Block Grant. These funds should include a 10% Tribal set-aside and should be available to be received through self-governance compacts and contracts.
- Streamline the grant process for Tribes by providing additional outreach and support to Tribal applicants. Eliminate burdensome and excessive application and reporting requirements.
- Congress should appropriate funds and expand innovative and effective workforce development initiatives [14] (including training programs, loan repayment, residency, increased salaries, provision of housing, etc.) to improve maternal and child health outcomes. These programs should focus not only on additional physicians but training for Tribal members to fill other critical roles, like midwives, doulas, lactation consultants, community health representatives, and behavioral health providers. Investment is also needed to expand the Native workforce for childcare services, early childhood education, and other essential services for families with infants and toddlers.
- Provide Medicaid reimbursement for community health representatives, traditional healers, Native doulas[14], midwives, and other birth workers.

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[14] These recommendations align with the 2024 Prenatal-to-3 State Policy Roadmap strategy "Community-Based Doulas," which include the key policy levers "Provide financial support for doula training and workforce development" and "Cover and reimburse community-based doula services under Medicaid." For more information and evidence of effectiveness about community-based doulas, as well as a 50-state scan of current Medicaid coverage for doulas, see https://pn3policy.org/pn-3-state-policy-roadmap-2024/us/community-based-doulas/.

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POLICY GOAL 3

ADDRESS TRAUMA AND STRENGTHEN CONNECTION TO CULTURE

Trauma is a root cause of many issues facing Tribal families, communities, parents, and children. Colonization and the worldviews, values, and systems introduced by the colonizers have led to the devastating health inequities Tribal communities are experiencing, both historically and currently through many institutions of daily life. For example, many Native women seeking maternal health care feel unheard and unsafe in non-Tribal healthcare facilities, where experiences of macro- and micro- aggressions are common. These experiences of racism and discrimination can lead to increased anxiety and poor health outcomes. We must continue dismantling racism in every form while building new approaches to healthcare that center culture. Incorporating traditional practices and cultural teachings into healthcare can significantly improve the comfort and trust of Native patients.

Leaning into traditional values and cultural practices opens paths to move forward in a good way. Connection to culture and community has been found to be a powerful component in building resilience and healing from trauma and can be an effective intervention to support many positive health outcomes. For example, some Tribes have seen significant success in improving safe sleep practices for infants by incorporating traditional teachings around cradleboards in parenting education. Another example raised by interviewees was the power of being able to include elders, speakers of Native languages, and Indigenous knowledge bearers into preschool and early Pre-K classrooms. However, they cited numerous barriers to doing so, including inflexible credentialing requirements for early childhood educators. With increased resources and flexibility, Tribes can offer culturally tailored programs to more effectively support the health and development of Native children prenatal to three.

As described in The Way Forward Report, “Personal, intergenerational, and historical trauma give rise to layered and cyclical effects in

We are experiencing high rates of suicide and depression in our maternal communities and not having access to a mental health care provider. But understanding the trauma that Native women have experienced and continuing to experience is partially because of having to navigate a complex system; not being able to practice our traditional ways of life; having our families fragmented so our support systems are not there.

- Interview Participant

Native families; adverse childhood experiences are both a cause and an effect of such trauma. By contrast, benevolent childhood experiences are an important counterbalance and healing force in the lives of Native children and youth throughout the life course. Appropriate Federal, state, local, and Tribal policy can support benevolent experiences and lay practical groundwork for them."

Recent progress shows promising steps forward on a path to healing. The Centers for Medicare and Medicaid Services (CMS) recently approved, for the first time, a way to provide Medicaid reimbursement for traditional healing practices in several states. The door is open to strengthen access to traditional healing and further incorporate traditional practices and culture in day-to-day healthcare practice. Even more momentous, President Biden this year offered the first formal apology from the United States to Native peoples for the Federal Indian Boarding Schools and the centuries of tragedies and trauma they inflicted on Native kids, families, and communities. Documenting, acknowledging, and apologizing for the great harms done to Native peoples are powerful steps, as President Biden said, "to right a wrong, to chart a new path toward a better future for us all."

To move forward in protecting Native kids in infancy and early childhood, we will need to support healing from previous trauma (including historical, intergenerational, and individual), prevent the trauma that is currently caused or worsened by many systems and institutions, and build resilience through the strength of culture as an intervention.

When we talk about trauma currently, the onus is on the individual versus the environment that was created – which, for American Indian people, is still happening, right? There's still these systems that are creating harm in our communities, and in this country—in other countries, like, Canada, they have Truth to Reconciliation that's happening. The government has acknowledged the harm that it's caused… but in the United States, we're the only a colonial state who refuses to acknowledge [the harm].
– Interview Participant

POLICY GOAL 3

RECOMMENDED POLICIES & STRATEGIES

To address trauma and strengthen connection to culture and improve prenatal to three outcomes for AI/ANs, policymakers should prioritize the following goals and actions:

- Invest in community-based programs that provide education, support, and resources for Native mothers during pregnancy and beyond (e.g. doulas, lactation support, midwifery, and wraparound supportive services)
- Ensure Tribal home visiting and other family support programs have resources and flexibility to be culturally tailored
- Change standards of federally funded programs to allow for “practice-based evidence" alongside “evidence-based practice”
- Allow cultural practitioners/ elders to be integrated into programming in early childhood education
- Create flexibilities in prenatal care and birthing, including offering services in more culturally friendly locations and options for group prenatal care [15]
- IHS and other healthcare providers should prioritize trauma-informed care, cultural safety, and cultural competency (including through additional provider training) and address bias against Indigenous ways of knowing
- Incorporate culture into health care and social services workforce training and education
- Provide resources, personnel, trainings, and support to address secondary trauma impacting healthcare providers, social workers, and others who work with people experiencing trauma
- Develop multigenerational nutrition programs for Native children, youth, and families; support access to nutritious and culturally appropriate foods
- Ensure federal and state child welfare policy supports culturally appropriate services for Native children and families and provides Tribal nations equitable access to federal resources
- Reorient child welfare policy to focus on family stability, not child removal
- Support restorative justice models based on cultural values
- Treat substance use disorders (SUD) as predominantly a public health matter, rather than relying solely criminal justice approaches. Remove penalties and disincentives for seeking prenatal care and SUD treatment.

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[15]This recommendation aligns with the 2024 Prenatal-to-3 State Policy Roadmap strategy “Group Prenatal Care.” For more information and evidence of effectiveness about group prenatal care, see https://pn3policy.org/pn-3-state-policy-roadmap-2024/us/group-prenatal-care/.

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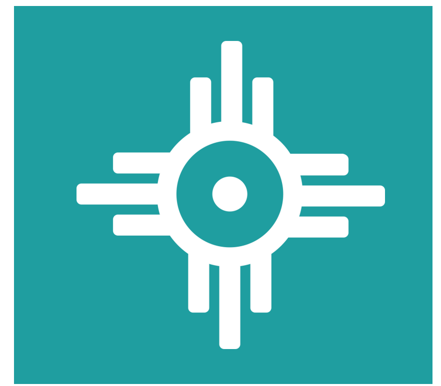
POLICY GOAL 4

SUPPORT FAMILY-CENTERED SYSTEMS



Services and systems Native families must navigate can be complex, stressful, and even traumatic. These barriers can prevent accessing essential care and services young families need. More Tribal control over programs and more flexibility given to Tribes in administering these programs can make these systems easier and more family-friendly to navigate. We can improve health and wellness outcomes for families and young children by designing services, programs, and systems to intentionally prioritize meeting the needs of families, rather than the convenience of funders.

For many Native birth-givers, after delivering the baby and returning home, weeks may pass without any contact from a health care provider or other support. Information may not be readily available to them about resources, services, or where to go for help. Even when new parents are aware of potential support programs, paperwork and application requirements may present hurdles not easily overcome during this high stress period. Without sufficient support, significant health and family problems can develop during this time, with sometimes lasting and devastating consequences.

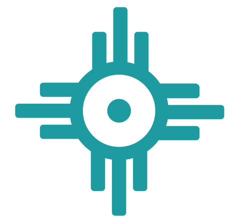
Outcomes can improve when healthcare and family support is provided in a way that centers the needs of the family. A model of a wraparound services can substantially improve access and outcomes by bringing together all the community resources in alignment, as well as supporting infusion of language, culture, and traditional healing. Native doulas, traditional birth workers, home visitors, and community health representatives can also provide a consistent touchpoint to families to support them through the pregnancy and the first few critical months postpartum. Ongoing support from a trusted person can provide reliable information to navigate every step of the process and connect families to any additional support or care they need.

When it comes to child welfare concerns related to parental use of substances, programs that prioritize SUD treatment and strengthening families have shown significant success and can avert the trauma of removing a child from their home. When designed around traditional ways of knowing – emphasizing supporting and nurturing caregivers, even when they are struggling with substance use disorder – child welfare systems can be more about healing than about trauma.

Across many types of family programs, when flexibility exists to coordinate and accommodate the needs of families, Tribes have been able to achieve significant successes. For example, in instances where a Healthy Start program and a Head Start program have a memorandum of understanding, a pregnant woman can apply with one and know that she and her child will be automatically enrolled in both services, providing the family consistent support. With un-siloed funding and coordination, transitions can become seamless for families and programs can operate more efficiently.

Some of the biggest barriers to supporting families are really system-level inequities that are perpetuated by federal funding streams that don't allow that integration across systems.

– Interview Participant



RECOMMENDED POLICIES & STRATEGIES

To support family-centered systems and improve prenatal to three outcomes for AI/ANs, policymakers should prioritize the following goals and actions:

- Reduce barriers to advanced training and degree programs, including more flexibilities and short term or phased certification programs.
- Explore options for delivering health care as close to families as possible, e.g. through expansions of midwifery workforce, models like Community Health Aides/Practitioners (CHAP) and Behavioral Health Aides, and more home- and school-based care.
- Leverage telehealth services, including for behavioral health services
- CMS should continue the regulatory waiver allowing for virtual clinical supervision
- In all states, expand Medicaid[16] and adopt the option for 12-month postpartum Medicaid coverage
- Better coordinate all levels of health care and facilitate smooth referrals/transfers between levels, when needed
- Support wrap-around services models and comprehensive screening and connection programs[17]
- Provide more supports for grandparents and other non-parent relatives who are primary caregivers
- Expand Tribal access to the Maternal, Infant, and Early Childhood Home Visiting Program[18]
- Reduce barriers to health care access including transportation, childcare, and concerns related to risk of incarceration/child protective services involvement.
- Integrate behavioral health care into prenatal, postnatal, and primary care
- Support for pregnant people throughout pregnancy and post-partum to navigate systems and services
- Increase post-SUD treatment ongoing recovery support
- Follow local community standards for Native foster and kinship placements
- Provide for paid family leave[19] and universal childcare [20]
- Promote family dependency treatment courts
- Reduce barriers to accessing needed services (e.g. expanding eligibility, instituting automatic determinations, providing service navigators, etc.)[21]
- Waive bar rules to allow community justice workers limited practice in civil legal needs (e.g. appeal food stamp denials; write letters to challenge eviction notices; file domestic protective orders; etc.)

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[16] Many recommendations in this section align with the 2024 Prenatal-to-3 State Policy Roadmap, e.g. the strategy "Expanded Income Eligibility For Health Insurance." For more information and evidence of effectiveness about Medicaid expansion, see https://pn3policy.org/pn-3-state-policy-roadmap-2024/us/health-insurance/.
[17] Aligns with PN3 Roadmap strategy "Comprehensive Screening And Connection Programs."
[18]Aligns with PN3 Roadmap strategy "Evidence-Based Home Visiting Programs."
[19] Aligns with PN3 Roadmap strategy "Paid Family and Medical Leave"
[19]Aligns with PN3 Roadmap strategy "Group Prenatal Care."
[20] Short of instituting universal child care, child care subsidies are an effective strategy for supporting families with young children and improving health outcomes. This strategy is recommended by the PN3 Roadmap; learn more here
[21] Aligns with PN3 Roadmap strategy "Reduced administrative burden for snap"

POLICY GOAL 5

EMPOWER TRIBAL VOICE IN STATE AND FEDERAL GOVERNANCE

Federal and state agencies administer programs and make policy choices that have immense impact on Tribes. Tribes must have a voice in these decisions. Improved state-Tribe and federal-Tribe relations can go a long way to supporting the policies and infrastructure needed to support Native families and improve health and wellbeing in early childhood. In addition, the federal trust responsibility and the nation-to-nation relationship are core components of advancing health equity and improving the stability and wellbeing of communities and families.

Where there is insufficient cooperation, coordination, and deference to Tribal sovereignty, conflicts can result that impede effective service delivery for Native families. For example, a policy in one state requires that a municipality seeking water and sewer funding must first meet state-set standards for "best practices," demonstrating that the local government meets the state's interpretation of a good city government. But remote Tribal communities that are most in need of resources to support running water and sewer availability may not fit the box of what the state thinks is a good city government. Although the funding comes from the U.S. Environmental Protection Agency, the funding mechanism allows the state to restrict Tribal access to this vital resource. Policies like these contribute to ongoing inequities in resources, leading to inequities in health outcomes for AI/ANs. The nation-to-nation relationship is between Tribal nations and the U.S. government—not the states; no federal policies, initiatives, or funding should subject Tribes to the oversight of a state.

Federal agencies must pay special attention to the unique complexities at the intersection of jurisdictions. As a joint federal-state program administered through the states, Medicaid is another case in which Tribes may not be getting the full resources, reimbursement, and voice they should. States receive 100% of the Federal Medical Assistance Percentage (FMAP) for services provided at IHS and Tribal health programs. Nonetheless, Tribal health programs and IHS facilities are still subject to the rules that state governments prescribe under Medicaid. Tribes in many states find it frustrating that Tribes must work with states with regard to Medicaid programs. This is especially problematic in that states may have vastly different priorities

I think Tribal communities are moving towards leveraging their sovereignty and investing in their communities, but it's still within this colonial state that we don't have any control over.

– Interview Participant

and goals in running their Medicaid programs than Tribes do, since Tribes are trying to ensure access to all necessary services for AI/ANs to achieve their optimum health, while many states are primarily trying to reduce costs. These kinds of state goals do not prioritize or effectively advance health equity. For example, not all states have expanded Medicaid or adopted the optional 12-month postpartum continuous eligibility option, but these policy changes would substantially improve access, options, and health outcomes for many Native families in the prenatal to three period.

One of the essential forms of Tribal inclusion in governance is Tribal consultation. Because Tribes are sovereign nations, any time a state or federal government agency contemplates a policy change that will impact a Tribe or its citizens, that agency has an obligation and responsibility to pursue timely, meaningful, robust Tribal consultation. Meaningful consultation requires two-way communication and collaboration, not just informing Tribes about decisions that have already been made. Tribal consultation must be held at the policy-development stage for regulations as well as sub-regulatory and nonregulatory guidance, like billing manuals, fee schedules, and strategic plans. In addition to Tribal consultation, other formalized mechanisms like Tribal liaisons, Tribal advisory committees, and Indian health advisory boards all provide important avenues for Tribal participation in policy development at the state and federal levels. Fostering collaboration, communication, relationships, and transparency between states and Tribes can make a meaningful difference in supporting healthy communities and families.

RECOMMENDED POLICIES & STRATEGIES

To empower Tribal voice in state and federal governance and improve prenatal to three outcomes for AI/ANs, policymakers should prioritize the following goals and actions:

- Create more avenues for Tribal input into budget development and legislative processes at state and federal levels
- Prioritize intergovernmental relationships based on trust, respect, commitment, and financial resources to support programs for Native people
- Require state reporting on key Indian Child Welfare Act (ICWA) requirements in cases involving Native children and families, including expanded technical assistance for states and Tribes working to improve ICWA compliance
- More meaningful and accountable Tribal consultation, including meaningful follow-up
- Improve collaboration among federal agencies serving the same populations – siloed federal programs impede effective implementation of programs at the Tribal level by requiring additional reporting and meetings amongst the agencies
- Require environmental impact health assessments to reduce risks to Native children and youth
- Improve data practices to ensure AI/AN are not rendered invisible, e.g. by always reporting “AI/AN alone or in combination,” rather than just using “Other” or “AI/AN alone” for race/ethnicity statistics

APPENDIX A

DEVELOPMENT OF THE POLICY RECOMMENDATIONS

LANDSCAPE REVIEW

Agenda development began with a landscape review of the published literature to identify key factors that impact AI/AN prenatal to health, development and wellbeing, as well as relevant policies, research, programs, gaps and asset-based approaches that may be prioritized, replicated, or addressed.

INTERVIEWS & ROUNDTABLES

After drafting some potential key policy goals based on the literature, we conducted semi-structured interviews and roundtables with 23 subject matter experts from across Indian Country. These included a wide representation of areas of expertise, geography, and Tribal membership. Interviewees included experts in pediatrics, maternal and child health policy, Medicaid policy, Native doulas and birth worker professions, child welfare in Indian Country (including the Indian Child Welfare Act), early childhood education, home visiting programs, OB/GYNs and family physicians, maternal behavioral health, Head Start, TANF, and early childhood services. These interviews/roundtables asked open ended questions about the greatest barriers to healthy, thriving Native kids prenatal to three; greatest protective factors or sources of resilience; and priorities for policy change. Interviewees then reviewed the list of draft policy goals and provided feedback and commentary. These thoughtful discussions improved our insight into the important issues affecting AI/AN PN-3 outcomes and key policy strategies that could potentially have the greatest benefit.

DOCUMENT REVIEW

We supplemented what we learned about key themes, findings, and policy recommendations from the interviews and roundtables with document reviews of reports and policy agendas developed by Tribal organizations or federal bodies on relevant topics.

SYNTHESIS

After analyzing and synthesizing all of this information, we identified the cross-cutting challenges relevant to multiple key domains impacting health and wellbeing for Native PN-3. This allowed us to narrow down to seven impactful policy goals that would address those cross-cutting challenges and improve outcomes for families across multiple key sectors.

VETTING & LISTENING SESSIONS

During the 2024 National Tribal Health Conference, we presented an early draft of the policy agenda to a workshop of Tribal (and a handful of federal and state) stakeholders and experts in Tribal maternal and child health. During this workshop, attendees had robust discussion on impactful policy levers to support Native families and improve PN-3 health and wellbeing and provided specific input on the policy agenda. Using all gathered information and feedback, we further narrowed the key policy goals to the most impactful 5, with a list of policies and strategies relevant to achieving each goal. We then vetted and further refined the draft Tribal Prenatal-to-Three Policy Agenda through a series of three Tribal listening sessions, as well as further expert review.

The final version of the Tribal Prenatal-to-Three Policy Agenda therefore contains collective wisdom and expertise from Tribes across the country and Tribal subject matter experts in a wide range of critical disciplines. NIHB will continue to update and revise the Tribal Prenatal-to-Three Policy Agenda as needed in future years as needs and context continue to change.

APPENDIX B

CROSS-WALK OF CHALLENGES TO KEY DOMAINS

The following table shows how some of the most common challenges and barriers to emerge from the roundtables and interviews cut across all key domains important to the health and wellbeing of Native infants and toddlers and their families. To address these challenges, we propose 5 cross-cutting policy goals: Protect Tribal Sovereignty & Self-Determination; Invest Equitable Resources and Funding; Address Trauma and Strengthen Connection to Culture; Support Family-Centered Systems; and Empower Tribal Voice in State and Federal Governance.

Cross-cutting challenges: What's preventing Tribes/families from achieving these goals?	Key Domains for PN3 & Family Wellness							
	Health Care	Nurturing and Responsive Child-Caregiver Relationships/ Child Welfare	Parents' Mental & Emotional Health/ Addressing SUD	Household Economic Stability/ Caregiver ability to work	Childcare and Early Childhood Education	Connection to Community and Culture	Nutrition & Food	Physical Environment & Housing
Trauma (historical, intergenerational, continuous, personal)	x	x	x	x	x	x	x	x
Workforce Shortages	x	x	x		x			x
Government funding shortfalls	x	x	x	x	x	x	x	x
Issues with funding mechanisms (e.g. grant based, or Tribes locked out of block grants)	x	x	x	x	x	x	x	x
Disregard for Indigenous ways of knowing/cultural values	x	x	x	x	x	x	x	x
Disconnection from community, culture	x	x	x	x	x	x	x	x
Infringement on sovereignty/ Need boosted Tribal capacity & self-determination	x	x	x	x	x	x	x	x
Services/systems are difficult to navigate, create barriers & add trauma; need for flexibility	x	x	x	x	x		x	x
Conflicts with state/Tribal governance	x	x	x	x		x		
Poverty, lack of household resources	x	x	x	x	x	x	x	x