American Indian/Alaska Native Child Health and Poverty

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Conflict of Interest: The authors have no conflicts of interest to disclose.
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Received for publication November 4, 2020; accepted July 31, 2021.

Abstract

One in three American Indian/Alaska Native (AI/AN) children live in poverty. This rate is higher in some reservation communities. The alarming rates of physical, mental, and social health inequities (eg, poverty) experienced by AI/AN children are symptoms of genocide, a legacy of inhumane Federal Indian policy, and ongoing structural violence. The chronically underfunded Indian Health Service (IHS) is just one example where AI/AN children are not universally guaranteed equitable health care or opportunity to thrive. Poverty is highly predictive of educational achievement, employment opportunities, violence, and ultimately health outcomes. COVID-19 has not only exacerbated physical and mental health inequities experienced by AI/AN communities, but has also intensified the economic consequences of inequity. Thus, it is vital to advocate for programs and policies that are evidence based, incorporate cultural ways of knowing, and dismantle structurally racist policies.

Keywords: American Indian/Alaska Native; child health; poverty

Academic Pediatrics 2021;21:S134−S139

What's New

The first supplement on Poverty by Academic Pediatrics does not include a review on American Indian/Alaska Native (AI/AN) communities. Given the prevalence of poverty in AI/AN communities, this narrative review explores the historical context and future directions, and will serve as an important addition to the existing literature on child poverty.

One in three American Indian/Alaska Native (AI/AN) children live in poverty. This rate is higher in some reservation communities.[1] The alarming rates of physical, mental, and social health inequities (including poverty) experienced by AI/AN children are symptoms of settler colonialism, a legacy of structural racism embodied in Federal Indian policy, and ongoing structural violence. While both biological and social factors lead to differences in health outcomes, we posit the disparities experienced by AI/AN children are a direct extension of systems that have and continue to disrupt once healthy ways of knowing and being. Overcoming adverse health outcomes as a result of poverty must include reclaiming cultural practices, respecting tribal sovereignty, and addressing inequitable policies.

Context

It is widely acknowledged Indigenous peoples have an interdependent relationship with their homelands, and these lands are the very places of creation, medicines, traditional foods, health, and individual and collective power.[2] The systematic dispossession of, and forced removal from, these homelands served to disrupt knowledge systems that maintained a healthy existence since time immemorial. Dispossession of AI/AN land and forced removal was, indeed, the first instance of homelessness in the United States and began a pathway into poverty.

Dispossession is best understood through precedence and legislation spanning centuries. The Doctrine of Discovery gave legal, spiritual, and political justification to seize land from non-Christians in essence denying Indigenous people land and human rights.[3] The Doctrine would later inspire Manifest Destiny, which justified American expansion to the west forcing millions of AI/AN from their homelands. The Reservation Era (1850−1890) created approximately 300 reservations, which were often not the traditional homelands of the Tribes forced to live within those boundaries.[4] The Allotment and Assimilation Era (1880−1940) included passage of the Dawes Act which systematically disassembled reservation land by assigning individual parcels of land, and served to replace a traditional communal economic base with a system of private ownership.[4] Individual ownership disrupted extended families, and ultimately resulted in the loss of 90 million acres. Forced removal of AI/AN children from their families to attend boarding schools was another tool of Assimilation. The Boarding School Era is a major root

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cause of intergenerational trauma and has its own dedicated section under Education. The Termination Era of policymaking in the 1940 to 1960 was meant to abolish Federal supervision over AI/AN Tribes and was another method of land dispossession and assimilation into mainstream culture. Approximately 109 Tribes, villages, and rancherias were stripped of their Federal recognition, and 1.4 million acres of trust land was removed from protected status and sold to non-Natives. At last, the Relocation Era of the 1950s encouraged individuals to leave reservations and gain vocational skills in major cities such as Los Angeles, Chicago, and New York.[4] The promises of relocation oftentimes did not result in the intended outcomes of gainful employment. This push resulted in a demographic shift resulting in over three-quarters of AI/AN living in urban areas today.[5] This history is key to understanding how not only were AI/AN communities forced to make a fundamental shift in their relationship to land (eg, ownership), but the political tools used against Tribes did not provide opportunities for intergenerational passage of wealth let alone economic stability. Instead, what was inherited was a legacy of intergenerational trauma, disruption of traditional parenting practices, cultural loss, and genocide.

Fundamental to poverty is settler colonialism and racism. Systemic and institutional racism are the tools that uphold and perpetuate poverty. It is therefore critical to address racism when addressing poverty. In this review, we will focus on the unique forms of racism faced by AI/AN children and communities, explore the many factors that influence poverty, and outline pertinent recommendations to uplift the health of AI/AN children.

Health Impact of Poverty and Structural Racism

The compounding impact of poverty and structural racism on the lives of AI/AN communities is perhaps best measured in years of life expectancy. AI/AN life expectancy is 5.5 years shorter compared to all races in the US (73.0 years to 78.5 years, respectively).[6] Many of the causes of mortality begin in childhood. Poverty impacts the physical health, social and emotional well-being, mental health, and developmental trajectory of children and youth. AI/AN children have some of the highest rates of chronic diseases compared to the general population, including obesity, cardiovascular disease, Type 2 diabetes mellitus, dental caries, depression/anxiety, and suicide.[7] Living in impoverished conditions causes significant chronic toxic stress, and it is not surprising Adverse Childhood Experiences (ACEs) disproportionally affect AI/AN children compared to other races.[8] Emotional, behavioral, and developmental difficulties were 10 times higher among AI/AN children with 2 or more ACEs compared to AI/AN children with fewer ACEs.[9] This adversity portends worse outcomes for children as they enter adulthood. Compounding these poor outcomes is the lack of access to health care. Health insurance and access to medical care lie at the intersection of poverty and structural racism, and magnify poor health outcomes.

Healthcare

AI/AN are one of the few groups entitled to health care, education, and housing in exchange for land, natural resources, culture, lives, and languages lost. These obligations are codified in the most significant legal principle known as the federal trust responsibility. The Indian Health Service (IHS) is the agency entrusted to administer the trust obligation of the United States to provide health care for AI/AN. IHS provides healthcare to approximately 2.6 million AI/AN people who belong to 574 federally recognized Tribes. Based on inequitable budgeting and numerous reports, it is clear the United States is not fulfilling this trust obligation. The IHS is funded at 60% of need and about one-third of the per capita spending of the Veterans Affairs Health System, a comparable agency. Despite more than 75% of AI/AN residing in urban areas, less than 1% of the IHS budget is allocated to urban Indian health care.[10] Chronic underfunding has led to rationing of needed services and a crumbling infrastructure, exacerbated by significant turnover in key leadership positions.

In 2017, 14.9% of AI/ANs had no health insurance coverage.[11] Nearly one-third (28.8%) of those who reported being AI/AN and were under 65 years old were uninsured,[12] despite additional protections afforded under the Affordable Care Act. Although children may have better access to publicly insured programs, one study found that less than half of AI/AN children had a medical home, and that IHS utilization was not associated with a medical home among AI/AN children who were uninsured or publicly insured.[13]

Education

Institutional education has had detrimental effects on AI/AN communities and the long-term health of Indigenous children.[14] The first Indian boarding school in the United States was established in 1879 to assimilate AI/AN children and youth into mainstream society. These schools served to strip them of their culture, language and identity, and break down traditional family and community structures.[15] It is well documented these children often suffered physical, sexual, emotional abuse, and death. At the height of the boarding school era, over 367 boarding schools existed with 64 still in operation today.[15] In 1975, the Indian Self Determination and Education Assistance Act was passed, allowing Tribes to operate schools with an emphasis on culturally relevant rigorous academic preparation, but the transition was not immediate and the long-term health effects have been lasting.[16,17]

AI/AN children today are largely educated through the public schools (both rural and urban operated at the state and local level) with about 93% of all AI/AN attending public schools. Most recent data estimate AI/AN make up approximately 1.1% of all students in public schools but

have profound educational disparities including access to educational opportunity, lower graduation rates, higher rates of suspension/expulsion, and the highest drop-out rate compared to other races and ethnicities.[18]

In a large study, The New Teacher Project (TNTP) set out to understand why students of color are more or less likely to achieve their academic goals.[19] They reviewed instruction and surveyed students and families from schools across America (public, charter, and private). TNTP found educational disparities are due to the quality of education as evidenced by the lack of access to four key resources: grade-appropriate assignments, effective instruction, deep engagement, and teachers who hold high expectations. This lack of access is not random and has much to do with the funding of school systems discussed in detail below. Though TNTP looked at Black and Latinx children, one can extrapolate their findings to AI/AN children.

TNTP findings parallel the research of John Hattie.[20] Hattie found the most important factor in whether students in the classroom succeed is the teacher's belief they can positively impact educational outcomes. The teacher's estimation that a student can succeed is another important factor. Roughly 80% of educators in the US are white. Lowered expectations held by these educators become self-fulfilling prophecies for students of color in the classroom. In 2017-2018, only 0.5% of public-school teachers were AI/AN despite growing evidence having diverse teachers positively impacts academic success.[21]

Compounding this issue, school funding systems are often directly dependent upon property taxes. This policy creates a system where under-resourced communities have underfunded school systems, thereby perpetuating the cycle of poverty.[22] It is through the Termination Era and Relocation Era of the 1950s that American Indians were often relocated to the poorest neighborhoods in urban areas. This was further exacerbated by the Federal redlining policies that effectively segregated families of color by denying mortgages and preventing them from buying a home in certain neighborhoods in major cities. Social and economic opportunities are profoundly impacted by the disparities in educational attainment experienced by AI/AN youth. The scars of redlining still exist today and make it impossible for many families to break the cycle of poverty.

Employment and Housing

It is oversimplifying to say employment is linked to poverty. Participation in the labor market, access to employment and employment-associated benefits, inclusion in unions and wage parity by race and gender have historically been contingent on one's racial or ethnic identity, nationality, and gender. As a result, AI/AN populations face barriers to meaningful employment, employer-based benefits like health insurance, pensions, or retirement plans, opportunities for collective bargaining, and living wages. These barriers include forms of structural racism excluding AI/AN from certain jobs. People of color are less likely to be in management positions or in the highest paying professional fields.[23] These factors contribute to the impoverishment of AI/AN families and communities rooted in dispossession. What is not obvious is the challenge many people face when trying to find safe employment that pays a living wage. The current and future impacts of COVID-19 serve as an example.[24] While unemployment skyrocketed, many aid programs are expected to end in the coming months, and the effects of these lost jobs will reverberate for generations. Who will be rehired, who can afford to work from home, what sorts of jobs are conducive to phasing back in and then perhaps back out with COVID-19? While for many, education directly correlates to improved employment circumstances, these opportunities are not fairly distributed. Even with higher education, we see lower wages for AI/AN workers than for many peers entering the job market with similar levels of training/education.[23]

Employment is directly tied to housing. Policies like redlining, predatory loans, and forced removal from traditional land were enacted with the express purpose of keeping people of color from owning homes. Today most families of color do not own their own homes.[25] The quality of housing impacts health through exposure to lead, lack of clean water, and safety hazards. The day-to-day stress that housing insecurity causes in parents and guardians is difficult to measure but must be considered in any analysis of health outcomes affected by poverty.[26]

Violence, Trauma, and Loss

There have been many calls to recognize the violence directed toward AI/AN communities. This violence is evident in many ways, including overt racism, structural and institutional racism, human trafficking, Missing and Murdered Indigenous People (MMIP), separation of children and parents via the foster care system, police violence, imprisonment, interpersonal and intimate partner violence, and many others. AI/AN are disproportionately impacted by this violence, rooted in white supremacy. White supremacy reinforces forms of violence (physical, structural, interpersonal) and deprivation (dispossession, impoverishment, scarcity). The result is that racism not only leads to poverty, but also a life filled with greater risk of violence, precarity, and chronic illness. This impact is intergenerational and cyclical. Thus, poverty is inextricably linked to safety. Crime and violence are driven by the pressures to survive in the conditions that poverty causes. Safety is in turn inextricably linked to health.[27]

Despite massive undercounting, murder is the 3rd leading cause of death in AI/AN women. Approximately 30% of AI/AN girls between the ages of 11 and 17 years old have a history of sexual abuse and 11% have reported being raped.[28,29] Alaska Native women and girls make up 8% of the population in Alaska and represent 33% of sex trafficking victims.[30] These experiences of violence are ACEs, which have been well-documented drivers of poor

long-term health outcomes such as heart disease, diabetes, and obesity.[31]

Another form of violence is the separation of AI/AN children into foster care. Substance use disorder is a tangible example of the criminalization of poverty that can lead to separation of AI/AN children. The likelihood of testing a mother for drugs is driven primarily by race, ethnicity, and income. Subsequently, the likelihood of separation of a child from said mother is directly linked to a state's laws, its availability of treatment for substance use disorder, and once again race and ethnicity. All of this results in a greater likelihood of AI/AN children being separated from their parents after birth into foster care. If they are not placed within kinship care or another AI/AN family, they risk losing cultural knowledge and connections (which, in turn, is exponentially linked to poorer mental health outcomes).[32,33] The Indian Child Welfare Act (ICWA), ratified in 1978, was created to prevent disproportionate placement of AI/AN children out of their community. It gives rights to Tribes, allowing the children's community to decide who is best to raise them. This act is more than just a protection for individual children, this is also a protection of the sovereignty of Tribes. Protecting this groundbreaking legislation from innumerable and constant attacks is an active stand against structural racism, and ensures the healthy existence of future generations.

The Environment, Land Rights, and Climate Change

AI/AN have a unique relationship to their lands, both ancestral lands and their newly adopted reservation lands that continue to be threatened through political battles. The Dakota Access Pipeline is an example of a decision made by the US government, specifically the US Army of Engineers, threatening the health of AI/AN communities for economic gain. The Dakota Access Pipeline threatens health by potential contamination of drinking water, and desecration of a sacred site for the Standing Rock Sioux tribe.[34] Fortunately, through protests, international attention and ultimately litigation, the pipeline was ordered to be shut down. Indigenous populations were the original caretakers of the land and Tribes carry Indigenous ecologic knowledge. Climate change threatens the food sources and traditional ways of life of many tribal communities, leading to food insecurity, water safety issues, and continued cultural genocide.[35]

Evidence for the Interventions or Strategies

Despite deeply entrenched racist systems and policies, there are many examples of tribal policies and programs upending the cycle of poverty through self-determination. We explore examples below.

The home-visiting Family Spirit program is an example of an evidence-based, culturally-centered program created in collaboration with tribal communities.[36] Family Spirit uses paraprofessionals from the community to conduct home visits with young families focused on building upon their strengths and culture to promote family resilience. It was developed, implemented, and evaluated by the John Hopkins Center for American Indian Health in collaboration with the Navajo, White Mountain Apache and San Carlos Tribes using community-based participatory research beginning in 1995. Since then, Family Spirit has spread to over 100 tribal communities. Through multiple randomized controlled trials, Family Spirit has shown to increase parental knowledge and involvement and home safety, and decrease maternal depression and behavioral problems in mothers and children.[37,38]

Tribal colleges and universities are tribally chartered, culturally-based educational institutions often located in rural communities. They provide high quality education to those within the community, reducing barriers to higher education based on geography. Funding for these schools comes primarily from federal sources but is operated by the Tribes. Continuing to support these schools allows Tribes to exercise their tribal sovereignty and create educational opportunities with the funding guaranteed by treaties.

With approximately three quarters of AI/AN living off reservations it is also important to recognize the programs and policies addressing poverty in urban areas. The Indian Health Center of Santa Clara Valley, an urban Indian clinic, offers a program to AI/AN youth called Instilling Wellness through Workforce Development.[39] Using a needs assessment, it was found community members living in an area with an extremely high cost of living were challenged by low wages. This program addresses this by helping youth build their employability through career exploration, resume building, interview skills, and financial literacy.

At the federal level, it is important to support legislation allowing each tribal nation to implement policies that work for their unique cultures and communities. The Violence Against Women Act, originally authorized in 1994 and reauthorized by President Obama in 2013 allows tribal judicial systems to prosecute Native and non-Native perpetrators in their communities, thereby strengthening public safety and infrastructure while recognizing tribal sovereignty.[40]

Recommendations for Systems and Institutions

The history of poverty in AI/AN communities and the solutions to ending poverty are complex. Although the authors are AI/AN, we do not represent all AI/AN Tribes and communities, nor will all the recommendations apply to every AI/AN community. In any solution, it is vital to respect and honor tribal sovereignty and the treaties negotiated by our ancestors.

The Medicine Wheel (Fig. 1), which is widely adopted and accepted among AI/AN Tribes, is borne from spiritual traditions, and is applicable to many facets of life and medicine. Broadly it signifies balance and interconnectedness. In the context of medicine, it is a reminder that

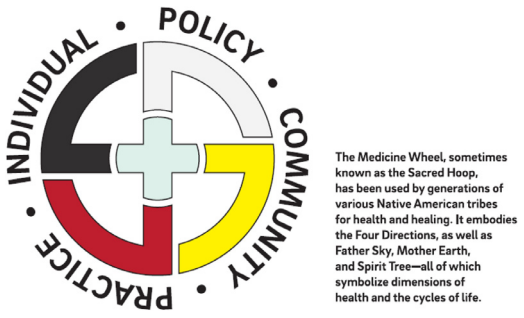

Figure 1. *The Medicine Wheel.*

health and wellbeing include not just the physical, but also social, emotional, and spiritual health. As such, solutions and recommendations are often approached holistically. Despite that outlook, and approaching this work with a holistic lens, our recommendations are notably "out of balance" (eg, more than half of the recommendations had policy implications). This is no surprise given the current and historical realities, and the fact many AI/AN health outcomes can be tied to the consequences of a legacy of racist federal Indian policymaking, a system rooted in white supremacist and colonial ideology. Even more striking is the suppression and attempted obliteration of traditional systems of knowledge that fostered good health and wellbeing for millennia. Thus, it is no surprise that the counterbalance to the policy recommendations is those that advocate for the centering and reclamation of traditional knowledge, and systems honoring tribal sovereignty in order to restore balance.

Current federal policies and programs have fallen painfully short in fulfilling the Federal Indian Trust Responsibility which calls for the protection of tribal sovereignty, and the provision of basic rights including social, medical, and education services for AI/AN. One clear and longstanding recommendation is for Congress to enact a just and appropriate level of funding for the IHS. IHS funding should be made an entitlement rather than an appropriation in order to reflect the very charge of its existence, to fulfill a federal trust responsibility. Enacting a Medicare for All policy would ensure coverage for AI/AN who are ineligible for IHS services. Additionally, to protect children and youth ICWA must continue to be upheld despite repeated attacks. Federal policies to address climate change will improve health for all but most importantly protect children most at risk from the effects. We recommend relying on the ecological knowledge of Indigenous communities to lead these efforts with compensation for their expertise.

To support educational equality, policies to allow equitable funding to schools to address the scars of redlining are vital. This should also include policies and programs to help diversify the teacher workforce and the implementation of trauma-informed education. However, employment opportunities and equitable pay must also be addressed. We should strive to protect tribal sovereignty with a less paternalistic approach and by investing in Native-owned and Native-managed businesses and entities to allow for economic opportunities.

The American Academy of Pediatrics policy statement on "Caring for American Indian and Alaska Native Children and Youth" highlights what individual providers, practices, and communities can do to care for this unique population with recommendations for implementation.[8] While addressing many of these policies, practices and programs are a step in the right direction toward the US fulfilling its federal trust responsibility, it does not erase over 400 years of genocide, racist policies, and historical trauma. Until racism is directly addressed, AI/AN and communities of color will be disproportionately impacted by poverty. Acknowledging that colonization and racism are ongoing, and dismantling the systems that uphold them is requisite in liberating future generations of AI/AN children from poverty and ensuring holistic health and wellness.

ACKNOWLEDGMENTS

We acknowledge and thank the original caretakers of the land that OHSU occupies and is built upon: the Multnomah, Kathlamet, Clackamas, Tumwater, Watlala bands of the Chinook, the Tualatin, Kalapuya, Molalla, Wasco, and the many Indigenous nations of the Willamette Valley and the Columbia River Plateau.

We acknowledge and thank the original caretakers of the land that the Los Angeles County Department of Mental Health occupies and is built upon: the Tongva, Tataviam, and Chumash people.

We acknowledge that the University of Washington's Department of Pediatrics is on Coast Salish land, which is diverse, strong, and enduring communities that uphold a sacred legacy of protecting future generations.

Financial disclosure: This article is published as part of a supplement sponsored by the Robert Wood Johnson Foundation.

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