



Caring for American Indian and Alaska Native Children and Adolescents

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American Indian and Alaska Native (AI/AN) populations have substantial health inequities, and most of their disease entities begin in childhood. In addition, AI/AN children and adolescents have excessive disease rates compared with the general pediatric population. Because of this, providers of pediatric care are in a unique position not only to attenuate disease incidence during childhood but also to improve the health status of this special population as a whole. This policy statement examines the inequitable disease burden observed in AI/AN youth, with a focus on toxic stress, mental health, and issues related to suicide and substance use disorder, risk of and exposure to injury and violence in childhood, obesity and obesity-related cardiovascular risk factors and disease, foster care, and the intersection of lesbian, gay, bisexual, transgender, queer, and Two-Spirit and AI/AN youth. Opportunities for advocacy in policy making also are presented.

INTRODUCTION

We acknowledge that this policy statement was written together on Coast Salish and Pueblo lands, both diverse, strong, and enduring communities that uphold a sacred legacy of protecting future generations. As American Indian (AI) authors and physicians ourselves, we acknowledge that we intend to represent a diverse and far-reaching group of Indigenous peoples. We humbly submit that not all aspects of caring for our communities could be captured in our article. We ask that this policy statement be used to support and advocate for improved health outcomes and the well-being of children and youth from all tribal and urban AI communities. Many solutions to the problems illustrated below can be found within these very communities.¹

American Indian and Alaska Native (AI/AN) children and adolescents are found throughout the United States, with more now living in urban rather than rural areas.² Many tribal nations have their own languages, and all have rich histories, but most AI/AN people now live in metropolitan areas that may include many different tribal groups. Care for this special

abstract

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population presents a unique and complex clinical opportunity for pediatricians, other providers of pediatric care, and pediatric care organizations because of the high level of documented health inequities within a sociocultural context unfamiliar to most practicing providers of pediatric care. Not only do AI/AN youth face medical access barriers, but they also have a higher prevalence of chronic stress and adverse childhood experiences (ACEs) and exposure to environmental hazards resulting in poorer health outcomes³ when compared with the general population.⁴ In addition, several other significant barriers to care deserve mention. These include conventional barriers for underresourced families, such as lack of transportation, difficulty finding child care, inability to miss work, caring for elders, and other family and work obligations, as well as other socioeconomic challenges. Moreover, less well-recognized issues exist, such as longstanding mistrust of governmental agencies, discrimination in clinical settings attributable to implicit and explicit bias leading to mistrust of health care and of health care-related research, and the cumulative burden of generations of unresolved traumas and racism.⁵⁻⁸ This policy statement explores the roles historical trauma and health inequities have played in shaping the current socioeconomic and health status of AI/AN youth. Disproportionate needs in mental and cardiovascular health and disease processes that are overrepresented in AI/AN youth are discussed to provide a summary of salient issues for pediatric care providers. This statement also provides strategies for culturally sensitive family-centered care to mitigate morbidity and policy recommendations to facilitate institutional and system changes needed for improved health outcomes.

Of note, Native Hawaiians and Pacific Islanders are considered a unique population of Indigenous people who live within the territories discussed but are not considered AI. They have their own distinct cultural identity as well as distinct health outcomes and needs. In addition, they are not considered tribes by the US federal government, so they are not beneficiaries of the Indian Health Service (IHS) or eligible for funding from the Bureau of Indian Affairs. Given these differences and the need for them to be addressed fully, this policy statement does not address this population.

Many of the cited publications in this document compare AI/AN youth to non-Hispanic white youth; the authors would like to note that this phenomenon can lead to white centering. Where possible, we avoided comparing racial groups in this way but were somewhat limited by the available studies.

ACES

The call to pediatricians to employ strategies to mitigate toxic stress caused by ACEs is especially critical for AI/AN children.⁹ In a landmark study of more than 13 000 adults, categories of childhood abuse, neglect, and other forms of household dysfunction were linked to adult mortality and morbidity. Risk was quantified by using an ACE score, or the number of categories experienced by an individual before age 18 years.¹⁰ A higher ACE score's association with poor health outcomes is postulated to stem from altered neurodevelopment with subsequent social, emotional, and neurocognitive impairment, which in turn leads to detrimental health behavior and poor health outcomes. For example, compared with those without ACEs, adults with an ACE score of 3 or more are twice as likely to smoke or have cardiovascular disease and 1.5 times more likely to

have severe obesity or diabetes.^{11,12} AI adults and children experience a disparate number of ACEs compared with the general US population. A recent study of 516 AI adults from South Dakota revealed an ACE score of 3 or more in 45.4% of participants as compared with 17.4% of region-matched controls.¹³ Among AI adults from 7 geographically diverse tribes, AI adults were 5 times more likely than non-AI adults to have had 4 or more ACEs.¹⁴ According to the National Survey of Children's Health data collected in 2011 and 2012, 1453 AI children and adolescents aged 0 to 17 years were more likely to have had multiple ACEs compared with non-Hispanic white (NHW) children.¹⁵ In that study, >25% of AI youth had 3 or more ACEs, compared with only 11.5% of NHW children. Regarding the types of ACEs endured, AI populations suffer from a disproportionate prevalence of emotional and physical neglect, substance use disorder, and incarceration among family members, as well as witnessed intimate partner violence, when compared with the general population.¹³⁻¹⁶ The authors of another study of AI adolescents and young adults also found that historical loss-associated symptoms and perceived discrimination are relevant factors in considering ACEs for Indigenous children and youth, suggesting the importance of considering loss of culture and structural racism as contributors to childhood adversity in this population.¹⁶

OBESITY

Obesity prevalence in AI/AN youth is among the highest of all races and ethnicities.¹⁷⁻¹⁹ Obesity onset occurs at a younger age compared with other racial and ethnic groups in the United States; AI children between 2 and 5 years of age have a higher combined prevalence of overweight and obesity (58.8%) than children of all other races or ethnicities (30%).^{17,20,21}

Moreover, AI/AN children experienced an increase in obesity prevalence between 2003 and 2008, whereas the prevalence for other US racial groups declined. Recent data have revealed an alarmingly high prevalence of obesity compared with the general US population but suggest that obesity prevalence (29.7%) in AI/AN children 2 to 19 years of age may have stabilized.^{22,23} Although recent research from 2010–2014 suggests a decline in severe obesity among children 2 to 4 years of age from low-income families, severe obesity remains high for young AI/AN children and is among the highest of all racial and/or ethnic groups receiving benefits through the Special Supplemental Nutrition Program for Women, Infants, and Children.²⁴ It follows that a significant portion of AI children with obesity have significantly abnormal blood lipid levels, higher blood glucose levels, and higher abdominal adiposity compared with children with normal-weight.²⁵

Obesity may largely be determined in infancy, with excess prenatal maternal weight gain, macrosomia, and premature cessation of breastfeeding significantly predicting BMI at 1 year of age in a previous study.²⁶ In the same children, overweight or obesity status at age 1 year persisted to ages 5 to 8 years and was associated with unhealthy levels of low-density lipoprotein. In AI children, once obesity is established, it likely persists into adulthood and increases the risk of chronic disease.^{27,28} The prevalence of disproportionate rates of obesity emerge in early childhood^{17,20,29}; thus, tailored prevention and intervention strategies are needed for young AI/AN children.

Given the high rates of obesity, AI/AN youth also experience high rates of type 2 diabetes mellitus (T2DM). Testing, as recommended by the American Diabetes Association, for prediabetes and T2DM should be

considered in AI/AN children and adolescents with overweight or obesity.^{30,31} Further information is available in American Academy of Pediatrics technical and clinical reports on management of T2DM for children³² and specifically for AI/AN youth.³³

BREASTFEEDING

The benefits of human milk nutrition for infants are well documented and include wide-ranging effects, such as the reduction of respiratory tract infections, obesity and diabetes incidence, atopic disease, and infant mortality.³⁴ Although the breastfeeding initiation rate for the general US population is 75%, minority populations experience significant disparities in initiating and continuing breastfeeding at 6 and 12 months.³⁵ AI/AN women have the second-lowest prevalence of breastfeeding initiation, duration, and exclusivity compared with all other US racial and ethnic groups. In a previous study, only 59% of AI women initiated breastfeeding, and most of those (76%) stopped breastfeeding within 4 months.²⁶ Encouragingly, those who continued to breastfeed for 6 months tended to continue through infancy.³⁶ Health benefits of breastfeeding have been demonstrated in all populations, including AI/AN populations. For example, in a retrospective cohort study, a lower BMI was reported among AI/AN adolescents breastfed for >6 months.³⁷ Breastfeeding promotion is needed in AI/AN tribal communities and would ideally be coordinated by tribal entities and would involve community members, elders, and health care providers, including paraprofessionals.^{38,39}

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

AI/AN children and youth with special health care needs (CYSHCN) are at particular risk of health

disparities. Although there is no evidence of a higher prevalence of special health care needs among AI/AN children compared with NHW children, AI/AN children are more likely than NHW children to meet criteria for special health care needs on the basis of functional difficulties.⁴⁰ In addition, AI/AN CYSHCN are more likely than NHW CYSHCN to have 3 or more functional difficulties,⁴⁰ which can be interpreted as AI/AN CYSHCN likely having more disability. Although there are no studies on the prevalence of developmental delay, functional difference, or disability among AI/AN children, it is possible that there is a higher prevalence in AI/AN children, compared with the general population, because of a disproportionate burden of injury,⁴¹ inadequate prenatal care,^{42,43} preterm birth,⁴³ environmental stressors,^{42,44} and other social determinants of health and function.

CYSHCN benefit from the accessible, comprehensive, and coordinated care provided by a medical home, but AI/AN CYSHCN are significantly less likely than children without special health care needs to receive care meeting the medical home definition (odds ratio 0.2; 95% confidence interval 0.1–0.4).⁷ In addition to difficulties receiving medical home-based primary care, AI/AN CYSHCN may have challenges accessing subspecialty medical care or pediatric rehabilitation therapies; those who live in rural or remote communities may have to travel many hours to access specialized care. Even among urban AI/AN CYSHCN, there may still be barriers related to transportation,^{45,46} funding, and wait times.⁴⁷ The care used by AI/AN CYSHCN may not be sensitive to the family's values⁷ or address the child's functional needs related to their tribal culture.⁴⁸ Efforts should be made to identify CYSHCN in a timely manner; implement culturally sensitive medical home-based care for AI/AN

TABLE 1 Risk Behaviors and Emotional Distress Reported by Ninth- and 11th-Grade Students in a Minnesota Student Survey Sample

Reported	AI/AN LGBTQ (<i>n</i> = 149 Ninth- and 11th-Graders)	Full MSS Sample (<i>n</i> = 81 885 Ninth- and 11th-Graders)	All LGBTQ (<i>n</i> = 8758 Ninth- and 11th-Graders)
Substance use			
Smoked cigarettes (past 30 d)	32.9	6.1	14.1
Drank alcohol (past 30 d)	25.2	17.2	22.3
Binge drinking (past 30 d)	16.8	8.4	10.7
Smoked marijuana (past 30 d)	33.1	10.8	17.0
Sexual behaviors			
Ever had sex	33.8	22.1	28.8
≥2 partners (past year) ^a	18.3	8.7	14.7
Emotional distress			
Depressive symptoms	51.7	22.3	48.1
Self-harm (past year)	52.1	15.4	43.7
Suicidal ideation (ever)	60.5	21.0	53.6
Suicide attempt (ever)	37.7	7.7	24.4

Minnesota Student Survey (MSS) data were provided by public school students in Minnesota via local public school districts and are managed by the Minnesota Student Survey Interagency Team (M. Eisenberg, ScD, MPH, personal communication, 2018). LGBTQ, lesbian, gay, bisexual, transgender, and queer.

^a Among sexually active ninth- and 11th-grade students only.

CYSHCN, and facilitate access to services that will help AI/AN CYSHCN achieve their full functional potential and be included in their communities.

SUICIDE AND MENTAL HEALTH

Suicide is the second-leading cause of death for AI/AN and non-AI/AN youth 10 to 24 years of age,^{49,50} but the 2016 age-adjusted suicide mortality rate among AI/AN youth (15.59 per 100 000) is more than 1.5 times higher than that of the general population (9.60 per 100 000).⁵¹ There is significant regional and intertribal variation in AI/AN youth suicide mortality, with some tribes having youth suicide rates 7 times higher than the national AI/AN rate and 12 times higher than the general population rate.^{52,53}

In previous studies, differences in risk and protective factors that may attenuate that risk (such as having a connectedness to family and having the ability to discuss problems with family and friends⁵⁴) explained the higher prevalence of suicidal behaviors among AI/AN students compared with other students.^{55,56} ACEs were also associated with suicide attempts; after controlling for multiple factors, each additional ACE

increased the risk of lifetime suicide attempt by 37% for AI youth.¹⁶ AI/AN individuals of all ages who died by suicide were less likely than NHW individuals to have received mental health diagnoses or treatments and were more likely to have a family member or friend's death precipitate suicide.⁵⁷

Suicide prevention initiatives that are strengths based, community driven, and culturally centered have been used in several AI/AN communities to reduce youth suicide behaviors.^{57,58} For AI/AN youth who do not have access to a community-specific suicide prevention program, efforts should be made to identify youth with an increased burden of suicide risk factors and to strengthen protective factors, particularly cultural protective factors.⁵⁵ If available, school-based health centers may be used for adjunctive mental health care.⁵⁹

INTERSECTIONS OF HEALTH AND IDENTITY

Lesbian, gay, pansexual, bisexual, transgender, gender queer, intersex, and Two-Spirit AI/AN youth experience exponential increases in risk for health disparities.^{60–63} “Two-Spirit” is a unifying term that

encompasses both gender identity and traditional Indigenous understandings of identity and is a widely used term in Indigenous communities across North America. In the 2015 US National Transgender Health Survey, AI/AN transgender respondents reported having experienced harassment (86%), physical assault (51%), and sexual assault (21%). Fifty-seven percent of AI/AN youth identifying as transgender have attempted or contemplated suicide, compared with 4.6% of the general US population and 33.7% of transgender youth as a whole.^{64,65} In this same study, 23% of transgender respondents (all ages) identifying as AI/AN experienced unemployment in the last year.⁶⁶ In another study, youth at the intersection of gender and racial identity had higher rates of risk behaviors and emotional distress (Table 1). Careful attention to gender-affirming care and risk assessments may mitigate these effects.⁶⁷

VIOLENCE

Violence affects AI/AN youth in unique but disproportionate ways. In a study using data from the National Trauma Data Bank, 11.8% of AI/AN children hospitalized for traumatic

injury experienced injury as a result of violent assaults, compared with only 4.2% of NHW children.⁶⁸ Many communities have started to focus on the crisis of missing and murdered Indigenous women and girls. Although limited data exist on rates of missing and murdered Indigenous women and girls and underreporting is extremely likely, a recent study completed by the Urban Indian Health Institute reveals staggering rates of violence toward Indigenous women and girls.⁶⁹ Pediatricians have an opportunity to advocate for better data collection and unbiased media coverage. The Urban Indian Health Institute has created a tool kit (<https://www.uihi.org/resources/mmiwg-we-demand-more-partner-toolkit/>) on how further work in this area can be tailored in a culturally appropriate manner.⁶⁹

AI/AN youth and communities are also vulnerable to sex trafficking.⁷⁰ It is estimated that 30% of AI girls between 11 and 17 years old have a history of sexual abuse, and 11% have reported being raped.^{71,72} Alaska Native women and girls make up 8% of the population in Alaska but represent 33% of sex-trafficking victims.⁷³ In turn, AI/AN girls are 5 times more likely to be incarcerated for prostitution than NHW girls.⁷³ It is important to recognize that men and nonbinary-gendered youth can also experience trafficking, and often times, finding data on these groups proves to be challenging. Identifying, preventing, and addressing trafficking and reducing violence is an integral part of caring for AI/AN communities.⁷⁴

FOSTER CARE

The National Child Abuse and Neglect Data System, the Bureau of Indian Affairs, and the IHS report high rates of child protective services referrals for AI/AN youth.^{75,76} In a previous study, AI/AN youth in foster care

were more likely to have special health care needs compared with others in foster care.⁷⁷ Historically, AI/AN children were systematically removed from their homes in an effort to assimilate them into mainstream culture and to terminate the existence of tribal culture. Rates of ongoing referrals reflect both historical trauma and ongoing social and environmental determinants of inequities at work. The Indian Child Welfare Act was ratified in 1978 after decades of fierce advocacy by tribes for the right to keep their children within families that identify as AI/AN. Often used as a leverage point to threaten the sovereignty of tribal nations, the Indian Child Welfare Act remains an opportune protection for AI/AN children and adolescents.⁷⁸

OTHER HEALTH DISPARITIES

The poor oral health status of AI/AN children is a major public health concern. AI/AN children have the highest rates of tooth decay among any racial and ethnic group in the United States.⁷⁹ The prevalence of tooth decay among AI/AN children between 2 and 4 years of age is 5 times greater than the average US rate.^{79,80} AI/AN children also have limited access to dental services because of ongoing difficulties with recruitment and retention of qualified dentists in the IHS.⁷⁹ More severe early childhood caries frequently requires extensive treatment under general anesthesia, creating an additional health care access barrier for AI/AN children. More information is available in the joint American Academy of Pediatrics and Canadian Paediatric Society policy statement on early childhood caries and its impact on Indigenous communities.⁸¹ In addition to oral health conditions, chronic otitis media and many other conditions disproportionately and inequitably affect AI/AN children and adolescents.^{82,83} The authors have chosen some of the most prominent

to focus on but do not consider this an exhaustive list.

GOVERNMENTAL AND POLITICAL INFLUENCES

The delivery of health care to AI/AN children is influenced by governmental policy at the federal, state, and tribal level. Treaties between the federal government and sovereign tribal nations established a trust relationship for health care. Although these treaties are unique agreements between tribal nations and the US government, failure of the government to honor them has also shaped mistrust among many AI/AN people and communities. Today, that treaty-based health care system is organized through the IHS, an agency within the US Department of Health and Human Services. Many health care settings serving AI/AN people receive funding through the IHS, including IHS federally operated clinics and hospitals, tribally operated clinics and hospitals, and urban AI clinics run by urban AI health organizations in metropolitan areas. Yet many AI/AN children receive health care services at clinics that are not associated with the IHS, including private clinics and federally qualified health centers.

Not all people who identify as AI/AN are members of tribes that have been federally recognized. Tribes that are not federally recognized are not eligible for federal funding from the IHS or the Bureau of Indian Affairs.

The IHS is chronically underfunded, with the budget determined by annual federal appropriations. By way of comparison, in 2017 the IHS was funded at \$4078 per person, whereas the US government spent \$10 692 per person in the Veterans Affairs system.⁸⁰ An underfunded IHS results in workforce instability and reduced ability to effectively deliver a full spectrum of necessary health

care. Chronic underfunding leads to infrastructure issues as well. Many facilities are overdue for updates, many locations have trouble providing housing for staff and providers, and much of the equipment is outdated. Furthermore, funding shortages lead to challenges in providing specialty care through contract health services.

Medicaid payment rates are directly tied to the likelihood of a practice accepting Medicaid patients, which is subsequently correlated with access to health care for children with Medicaid.^{84,85} It follows, therefore, that increasing Medicaid payment rates and access to Medicaid coverage would potentially improve health care access for AI/AN youth. With more than 300 000 AI/AN children covered by Medicaid, there is an obvious need for continued and improved access to health services.^{86,87} Continuing to expand access to Medicaid coverage for AI/AN children is essential for ensuring access to needed services.

Another complicating factor for many AI/AN communities is the inconsistent and overenforcement of punitive drug laws targeting pregnant women. Punitive drug screening practices for pregnant women lead to a decrease in prenatal visits, which, in turn, increases the risk of preterm birth.^{88,89} Often, tribal laws differ from state and local laws, and in some instances, tribal jurisdictional boundaries may cross multiple states. Federally operated IHS facilities are bound by federal laws and policies. This overlap of governing bodies often results in confusing policies and a lack of standard and universal screening of pregnant AI/AN women, leading to late or inadequate detection of infants with a history of in utero substance exposure, including infants with neonatal opioid withdrawal syndrome.

RECOMMENDATIONS

Opportunities for Pediatric Care Providers in Practice

Pediatric care providers, because of their early interaction with AI/AN youth and their families, have a distinct opportunity to promote resilience and improve the health of these children, which will have far-reaching benefits as they age and raise their own children. Pediatricians and other pediatric care providers can implement systems in their practice that can help all patients and families, including AI/AN families, feel that they are welcome and will be treated respectfully and that high-quality family- and patient-centered care will be delivered regardless of social class, personal history, or cultural, spiritual, gender, racial, or ethnic identity. These strategies include providing trauma-informed care,⁹⁰⁻⁹² screening for substance use⁹³ and social determinants of health,⁹⁴⁻⁹⁶ connecting to substance use prevention and treatment programs,⁹³ home visiting,⁹⁷ literacy programs,^{98,99} and leveraging school-based health centers if available.⁵⁹ Addressing social determinants of health also includes addressing housing insecurity¹⁰⁰ and food insecurity.¹⁰¹ The inclusion of the AI/AN perspective and disaggregated data in early childhood initiatives should be sought to improve outcomes within broader systems-based efforts. When implementing these strategies, pediatricians are encouraged to seek programs and interventions that incorporate AI/AN culture, tradition, and practices.¹⁰² The following recommendations reflect the issues raised above and provide opportunities for pediatricians and others who provide care to AI/AN pediatric patients:

- Partner with local tribes and communities to set health priorities, understand historical experiences, and combine efforts

already underway, such as cultural enrichment and preservation programs.

- Provide opportunities for adequate training of clinical and office staff in culturally sensitive care practices. Advocate for local and regional models that incorporate culturally and linguistically appropriate services tailored for local tribes.
- Provide evidence-based supports for parents and young children by promoting the use of home visiting models, high-quality child care, and early childhood programs, such as Early Head Start, Head Start, and Nurse-Family Partnership (<https://www.nursefamilypartnership.org>).¹⁰³
- Start a Reach Out and Read program in AI/AN clinics and any clinic serving these families. Include books representing AI/AN and Indigenous children and families.
- Assess patients for ACEs and social determinants of health (eg, poverty, food insecurity, homelessness, lack of neighborhood safety, incarceration of parents or other family members, mental health conditions of parents or other household family members, housing inequity, access to schools, academic achievement, intimate partner violence, child abuse and neglect, and involvement with the juvenile legal system) to help families identify and implement practical solutions.
- Identify strengths and screen youth and families for protective factors to promote positive youth development.
- Create efforts to promote and strengthen protective factors for youth, focusing on cultural preservation-based efforts.
- Consider testing for prediabetes and T2DM in AI/AN children and adolescents with overweight or

obesity, as recommended by the American Diabetes Association.

- Promote breastfeeding in AI/AN tribal communities, ideally coordinated by tribal entities and involving community members, elders, and health care providers, including paraprofessionals.
- Include early childhood oral health as part of overall childhood health and well-being. Perform oral health screening during early childhood health assessments and provide referrals as needed to dental health providers. Be knowledgeable of fluoride levels in the drinking water for local tribal communities in your area.⁸¹
- Create a medical home that acknowledges and is sensitive to discrimination in clinical settings and generations of unresolved traumas and racism that AI/AN children and families experience. Work with local community hospitals and pediatric emergency departments, which may serve as a referral source, to become a medical home for AI/AN children whose families use emergency departments rather than seek primary care.
- Create a medical home model that facilitates access to services that will help AI/AN CYSHCN achieve their functional potential. Identify AI/AN CYSHCN, engaging staff, including care coordinators, in cultural competency training and partnering with the community.
- Assess patients for mental health conditions, including signs of posttraumatic stress, anxiety, grief, depressive symptoms, and suicidality, as well as their mothers for perinatal depression¹⁰⁴ using validated screening tools and a trauma-informed approach. Participate in strengths-based, community-driven, and culturally centered suicide prevention programs.⁵⁸

- Screen AI/AN youth for substance use, and if identified, conduct a brief intervention and then refer for ongoing treatment.^{105–107}
- Work with local schools to identify AI/AN students in need of mental health and educational services.
- Offer gender-affirming care in line with the previously published American Academy of Pediatrics policy statement.⁶⁷
- Work to prevent, identify, and address sex trafficking in AI/AN youth.

Opportunities for Public Policy Advocacy

Pediatricians also have an opportunity to advocate for systems change that addresses health inequities and other systemic factors that contribute to ongoing health disparities experienced by AI/AN children and youth. The following recommendations are intended to support the policies and systems needed to promote and protect the health of AI/AN children and youth:

- Advocate for community initiatives and develop partnerships to address health disparities, such as altering practices of frequent consumption of sugar-sweetened beverages through education and improving the selection of foods locally available, to address healthy weight and oral health.
- Share information with the US Congress, state legislatures, foundations, and other appropriate advocacy groups about the inequities and tremendous health disparities that exist between AI/AN populations and the general US population.
- Invest in new research and clinical pathways to create culturally relevant screening and interventions for ACEs.

- Advocate for federal, state, and local policy to end AI/AN homelessness through consultation and engagement with tribal leaders, AI/AN communities, and AI/AN young people with lived experience of homelessness. Advocate for the investment in improved data collection on homelessness among both rural and urban AI/AN youth and culturally responsive interventions to address homelessness among diverse tribal nations.
- Work with local tribes and communities to address the need for research and advocacy around missing and murdered Indigenous women and girls.⁶⁹
- Advocate for the protection and enforcement of the Indian Child Welfare Act.
- Advocate for increased Medicaid coverage for children and families as well as increased payment for services.
- Advocate for improved IHS budget and funding, which is chronically underfunded. IHS expenditures are among the lowest per capita compared with other federal health care expenditures, such as Medicare and the Veterans Health Administration. This disparity contributes significantly to the ongoing health inequities experienced by AI/AN people. Advocate for policies such as advanced appropriations or mandatory funding to provide the IHS with predictable and continuous funding.
- Work with local government and tribal communities to understand and mitigate the negative effects of punitive drug laws for pregnant women.

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ABBREVIATIONS

ACE: adverse childhood experience
AI: American Indian
AI/AN: American Indian and Alaska Native
CYSHCN: children and youth with special health care needs
IHS: Indian Health Service
NHW: non-Hispanic white
T2DM: type 2 diabetes mellitus

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