The Health and Development of American Indian and Alaska Native Children In Relationship To Reservation and Rural/Urban Residence

Laurel S. Endfield (White Mountain Apache)

EUROPEANS MOVING into North America and then expanding ever westward was the cause of drastic declines in the American Indian population (Cooper, 1999). Cooper estimated that the American Indian population declined from more than one million people at the beginning of the nineteenth century to fewer than 300,000 in 1879. The causes of this decline were not solely from the battles between the newcomers and the American Indians but more so from the contagious diseases brought to their homelands. Improved health care, increased access to government programs and education, among other developments, have helped American Indian and Alaska Native populations to grow.

According to Snipp (2002), overall, 1.4 million children were identified as Native American or Alaskan Native. However, interpretation of data is difficult because of the census's self-identifying procedures. Respondents were asked to report all races that applied to their ancestry. Comparisons of the 2000 census material was made more difficult than previous censuses because there now requires comparison of two sets of numbers. Out of the 1.4 million reported America Indian/Alaska Native children only 840,000 reported only one racial group. Using the single race definition, American Indian/Alaska Native children (AI/AN) increased by 21%, or by the multiple race definition, by 99%. Approximately 29% of all AI/AN children lived on reservations or in Alaska Native villages. The majority of children living on reservations or villages, 87%, did not report more than one racial ancestry.

According to the U.S. Indian Health Service (2005), "the American Indian and Alaska Native population has grown more rapidly than the nation's population as a whole during the last decade, 17.9% versus 10.7%." However, there are serious threats to American Indian

and Alaska Native health and development that still exist. Diseases and conditions that have a high prevalence rate in AI/AN children include, but are not limited to: diabetes, Fetal Alcohol Syndrome and fetal alcohol effects, nutritional inadequacies, inadequate education, high rates of unemployment, discrimination and cultural differences. Also important to note is that according to Indian Health Service statistics (2005), a safe and adequate water supply and waste disposal facilities are lacking in 12% of AI/AN homes compared to only 1% of homes for the general United States population. On some reservations, for instance the Navajo Nation, some children live in homes that completely lack electricity, water, and indoor plumbing due to the remoteness of their home's location.

Diabetes is a growing disease worldwide; however in AI/AN populations, the disease has reached epidemic proportions (Daychild, n.d.). According to Daychild, "minorities have higher rates than the general population. American Indians and Alaskan Natives (AI/AN) in particular experience type 2 diabetes and its complications 4-6 times more often than the general population." In fact, according to the Indian Health Service (2005), "American Indians and Alaska Natives have the highest prevalence of type 2 diabetes in the world. Diabetes is traditionally a disease of older people but, alarmingly, diabetes is being diagnosed at young ages in Indian communities. Prevention of diabetes has become an urgent priority." Childhood obesity is a leading factor to the development of diabetes and heart disease in children. Over the past 30 years the prevalence of overweight and obese children in American Indian and Alaska Native communities has increased dramatically. Rates of AI/AN children suffering from obesity are three times more likely than national patterns, and overweight children are two times more likely than national patterns (Hammer & Demmert, 2003).

Prenatal exposure to alcohol can result in Fetal Alcohol Syndrome or fetal alcohol effects. According to the American Academy of Pediatrics (2000):

> The term *fetal alcohol syndrome* (FAS) refers to a constellation of

> physical, behavioral, and cognitive abnormalities. In addition to the classic dysmorphic facial features, prenatal and postnatal growth abnormalities, and mental retardation that define the condition, approximately 80% of children with FAS have microcephaly and behavioral abnormalities. As many as 50% of affected children also exhibit poor coordination, hypotonia, attention-deficit hyperactivity disorder, decreased adipose tissue, and identifiable facial anomalies, such as maxillary hypoplasia, cleft palate, and micrognathia. Cardiac defects, hemagiomas, and eye to ear abnormalities are also common.
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> The term *fetal alcohol effects* was developed originally to describe abnormalities observed in animal studies, but it was adopted quickly by clinicians to describe children with a variety of problems, including growth deficiency, behavioral mannerisms, and delays in motor and speech performance, who lacked the full complement of FAS diagnostic criteria.

Fetal Alcohol Syndrome in AI/AN populations is much higher than the rest of the national population. According to the Centers for Disease Control (About, n.d.), "Incidence of Fetal Alcohol Syndrome per 10,000 total births for different ethnic groups were as follows: Asians 0.3, Hispanics 0.8, white 0.9, blacks 6.0, and Native Americans 29.9." Occurrences of Fetal Alcohol Syndrome among AI/AN tribes vary between tribes. Health facilities serving primarily Navajo and Pueblo tribes report prevalence similar to the national statistic, while Southwest Plains Indians reported a much higher prevalence, 1 in every 102 live births (About, n.d.).

In any community, and for any race, there is little that is more important than the health and welfare of its children. The health and development of American Indian and Alaska Native children, including schooling practices, has changed within the last century. Tactics of assimilation are still definitely present in different forms, but can be considered not as severe as in times past. Boarding school practices have made some positive changes that allow children more freedom of expression and reduced the abuse associated with previous board-

ing school practices. However, school programs that provide cultural awareness and language preservation are small in number, even within reservation boundaries. Strides are being made, but there is still a long way to go. Federal laws have been enacted that allow tribes some self-determination, including the right to protection of its children. However, true self-determination is yet to come.

Before 1978, responsibility for American Indian child welfare lay mainly with the Bureau of Indian Affairs (BIA) (Snipp, 2002). Young children were removed from their families and homes and moved to boarding schools where schooling attempts for American Indian children focused on assimilation. The end of the boarding school system began in the early 1930s and more children were allowed to stay at home with their families. The BIA established the Indian Adoption Project in 1958 to oversee the welfare of AI/AN children in possibly abusive homes. The numbers of America Indian children living in off reservation foster or adoptive homes increased swiftly. The majority of placements were in non-Indian households, far from reservations. In 1978 the Indian Child Welfare Act was passed. The law was intended to keep Indian children in environments similar to which they were born. However, time, economic development, acceptance, and technology have changed the parameters of AI/AN children's environments.

Many AI/AN children do not live on Indian reservations or in Alaska Native villages but rather off reservations in both rural and urban settings. The Indian Health Service population trends (2005) shows that in 1990, 56.2% of the Indian population resided in urban areas, with the remaining 43.8% residing in rural areas. Programs for American Indian and Alaska Native children, both on and off the reservation, in both rural and urban areas, are essential to improving their health and development. Accessibility to these programs is dependent upon many factors, including economic status, geographic locations, tribal membership, and transportation, among others.

The major contributor to the improvements in American Indian and Alaska Native health and development, and the primary provider of federal health care, is the Indian Health Service (IHS). IHS is an

agency within the Department of Health and Human Services, and is responsible for providing health services to American Indians and Alaska Natives. The Indian Health Service provides the following information: The provision of health services to federally recognized tribes is a direct result of a special government-to-government relationship between the federal government and Indian tribes. This relationship was established in 1787 and is based upon Article I, Section 8 of the United States Constitution. Numerous treaties, laws, Supreme Court decisions, and Executive orders give this relationship form and substance. Currently, IHS provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 states (Indian Health Service, n.d.). According to the Indian Health Service (2005), approximately 56% of American Indians and Alaska Natives living in the United States rely on the Indian Health Service to provide their primary access to health care services.

In 2003, the AI/AN user population in urban areas was approximately 605,000 (Indian Health Service, 2005). According to IHS (2005), American Indians and Alaska Natives in urban locations experience aggravated health problems because of the lack of family and traditional cultural environments. This same report also identifies American Indian and Alaska Native youth as being at greater risk for serious mental health and substance abuse problems, suicide, increased gang activity, teen pregnancy, abuse, and neglect.

According to IHS (1999) statistics, the service population is increasing at a rate of about "1.8% each year, excluding the impact of new tribes" (p. 35). This yearly increase continues to strain an "already challenged [system] to meet even 60% of the health needs of Indian country". The "user population in FY 1997 was considerably younger than the U.S. All Races population" (p. 28). The total IHS population under age 5 was 10.2%, compared to the U.S. All Races percentage of 7.7. The largest IHS area, Phoenix, which had the highest percentage of population under age 5, had a percentage that was nearly 4% higher than the U.S. All Races percentage. The smallest IHS area, Nashville, which had the lowest percentage of

population under age 5 still had a percentage that was more than 1.1 times the U.S. All Races percentage. The median age of the AI/AN population is 27.8 years, which is considerably younger than the U.S. All Races age of 36 years (Indian Health Service, 2005).

The mission of IHS is "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level" (Indian Health Service). They strive to reach their goal in assuring that "comprehensive, culturally acceptable personal and public health services are available and accessible". Reports show that solid gains have been made in IHS reaching their goal and improving American Indian and Alaska Native people's health. When IHS was transferred from the Department of the Interior to the Public Health Service in the Department of Health, Education, and Welfare, "the general health of Indian people substantially lagged behind the rest of the U.S. population" (IHS, 1987). This was reflected in the AI/AN mortality rates compared to those of the general population (Rhoades, D'Angelo, & Hurlburt, 1987).

Mortality rates were several times higher for American Indians and Alaska Natives than for other races. As a result of preventative healthcare programs, sanitation improvements, and medical advances, American Indian and Alaska Native health has substantially improved, however, the health of American Indians and Alaska Natives still lags behind the general U.S. population. Life expectancy has increased by 20 years from 1940 to 1980 (Rhoades, D'Angelo, & Hurlburt, 1987). This still leaves American Indian and Alaska Native populations lagging behind the U.S. All Races population by almost 4 years (Indian Health Service, 2005). Significant gains have also been made in reducing infant mortality rates as well as drastic improvements in neonatal mortality rates. Mortality rates in infants dropped from 62.7 deaths per 1,000 in 1955 (Hammer, & Demmert, 2003) to 8.8 in 2001 (Indian Health Service, 2005). The U.S. All Races population infant death rate is 6.9 per 1000 live births. Neonatal mortality rates have reduced by approximately two thirds between the early 1970s and the mid-1990s (Hammer, & Demmert, 2003). It is important to note that these rates are inclusive only for geographical areas serviced

by the Indian Health Service. According to Indian Health Service (2005b), "American Indians and Alaska Natives die at higher rates than other Americans from alcoholism (517%), tuberculosis (533%), motor vehicle crashes (203%), diabetes (210%), unintentional injuries (150%), homicide (87%) and suicide (60%)."

Baldwin et al. (2002) provided more information specific to this study. According to their research, both rural and urban AI/AN mothers were 2 to 3 times more likely than white mothers to receive inadequate prenatal care. Urban AI/AN mothers and infants would more often receive better care than rural AI/AN mothers and infants. Low birth weight rates for AI/AN infants were higher than for Whites, with urban AI/AN rates worse than rural American Indian and Alaska Native rates. Rates for postnatal deaths were very high for both rural and urban AI/AN infants, with rates more than twice the rate for white infants.

Another program that has been successful in improving the overall health and development of AI/AN women, infant and children is WIC, the Supplemental Nutrition Program for Women, Infants, and Children, a federal program operated through state and local agencies. The 33 tribal WIC programs currently on American Indian reservations are administered by Native American organizations and represent nearly 100 of the 557 federally recognized tribes (Cole, 2002). WIC has helped to improve the health and nutrition of AI/AN women, infants, and children by providing nutritious supplemental foods and nutrition education, while also working together with other organizations to improve access to health care (Henchy, Cheung, & Weill, 2000). AI/AN participants make up about 1.7% of the national WIC caseload and have grown from an average of 2,433 clients each month in 1976 (Henchy, Cheung, & Weill, 2000) to serving an average of 121,140 clients each month in 1998 (Cole, 2002). Tribal WIC programs offer culturally appropriate services specific to AI/AN health and nutrition concerns and help to provide continuity of care in geographically isolated tribal lands (Henchy, Cheung, & Weill, 2000). According to Henchy, Cheung, and Weill (pg. 7-8), documented benefits of the WIC program include:

- WIC is successful in improving participants' health and nutritional status, bringing them into the health care setting, and preventing health problems.
- WIC improves the dietary intake of pregnant and postpartum women and improves weight gain in pregnant women.
- Pregnant women participating in WIC receive prenatal care earlier.
- WIC increases the duration of pregnancy and reduces low birth weight rates.
- WIC reduces fetal deaths and infant mortality.
- WIC decreases the incidence of iron deficiency anemia in children.
- WIC significantly improves children's diets.
- WIC improves the growth of at-risk infants and children.
- Children enrolled in WIC are more likely to have a regular source of medical care and are more likely to be immunized.
- WIC helps prepare children for school; children who receive WIC benefits demonstrate superior cognitive development.
- WIC saves money by preventing costly health problems.

According to the United States Department of Agriculture: Food and Nutrition Service (as cited in Cole, 2002), the 63% of AI/AN WIC enrollees located on or near reservations differ considerably from WIC enrollees living off reservations:

WIC enrollees located on or near reservations are concentrated in the West (61%) and Mountain Plains (20%), while those off the reservation are most concentrated in the Southwest (44%). Those located off the reservation are more likely to reside in metropolitan areas (45.7% versus 33.4%). Compared to Native American WIC enrollees off reservations, those on or near reservations have larger average family size (4.4 versus 4.0) and are more likely to be in families of six or more persons (23.8% versus 14.0%). Those on or near reservations also have greater participation in public assistance programs (24.6% versus 15.2% receive TANF; 39.4% versus 29.5%

receive food assistance) and more severe poverty (41.4% versus 34.9% are below 50% of the federal poverty level) (Cole, N. 2002).

The Bureau of Indian Affairs (1997) reported that 30% of the employed American Indians in Indian country still live below the poverty line. The United States unemployment rate is approximately 4%, while many American Indian tribes suffer unemployment rates of 50%, with some even higher (Fryer, 1999). The consequence of such poor economic circumstances is that 43.1% of AI/AN children under the age of 5 are living in poverty compared to 20.1% of the U.S. All Races (Indian Health Service, 1998).

According to Cole (2002), AI/AN infants have greater recorded prevalence, compared with all WIC infants, in the major risk categories. Infants living on reservations or in Alaska Native villages, compared to those off reservations, have higher clinical risks (22.2% versus 12.5%) and dietary risks (19.2% versus 12.3%), while infants off reservations are slightly higher in anthropometric rates of risk (28.9% versus 27.5%). AI/AN children also show greater prevalence to risk categories except in biological risks. Their patterns of risk replicate those of infants on and off reservations. Additionally, AI/AN children have higher rates of obesity as compared to all WIC children: prevalence is 20% for children on or near reservations, 16% for children off reservations, and 13% for all WIC children.

Traditional AI/AN education was conducted at home amongst the people within family units and villages. Children were educated for tribal life by their elders, family members, and peers. Storytelling, working with adults, participation in ceremonies and puberty rites were essential to cultural education. Education also came from the customs of the different clans (Spring, 2001). With the introduction of European cultures into North America, AI/AN children were introduced to cultures very different from their own. Fortunately, AI/AN cultures and languages have experienced some revitalization, as well as renewed acceptance and respect so that children are receiving some culturally and developmentally appropriate educational services from different federally, grant, and tribally supported programs.

Although there has been a revitalization of Native languages, indigenous languages continue to be lost at an alarming rate. There is an ongoing struggle to promote language and preserve it in written form. Many linguists predict that half of the world's 6000 languages will be dead or dying by the year 2050. Languages are becoming extinct at twice the rate of endangered mammals and four times the rate of endangered birds. Linguists predict that if this trend continues, a dozen or fewer languages could dominate the world (Ostler, 2000).

The leading federal program that provides AI/AN children with developmental and educational services is Head Start. Head Start programs, including Early Head Start, are comprehensive child development programs, which serve pregnant women, children from birth to age 5, and their families. These child-focused programs strive to reach an overall goal of increasing school readiness of young children from low-income families (U.S. Administration for Children & Families, 2003).

Head Start began in 1965 as an 8-week summer program by the Office of Economic Opportunity, and was designed to help break the cycle of poverty (Administration for Children & Families, 2003). The preschool program, serving children from ages 3 to 5, was a comprehensive program designed to meet the emotional, social, health, nutritional, and psychological needs of the low-income children served. Head Start provides a range of individualized services in the areas of education and early development including: medical, dental, and mental health services; nutrition; and parent involvement. Head Start also ensures that all services provided are responsive and appropriate to individual child and family development, ethnicity, culture, and linguistic heritage and experiences (Administration for Children & Families, 2002). Head Start has had a strong impact on children, families, communities, and early childhood programs across the country. Head Start serves both rural and urban children and their families in all 50 states, the District of Columbia, Puerto Rico, and the U.S. territories, including many American Indian and Alaska Native children (U.S. Administration for Children & Families, 2002).

According to the Head Start Bureau's fiscal year 2004 Head Start

program fact sheet, the actual 2004 fiscal year budget for Native American and migrant programs was $451,325,000.00 (U.S. Administration for Children & Families, 2005). The fiscal year 2005 appropriation is $456,003,000.00. There are 2,729 Head Start grantees and delegate agencies. Excluding family childcare homes, there are 20,049 Head Start and Early Head Start centers. Of these grantees and delegate agencies, 6% are through tribal governments or consortium agreements. The Head Start enrollment for 2004 was 905,851. Of these children, 3.1% were AI/AN (U.S. Administration for Children & Families, 2005). These numbers represent about 50% of the pregnant women, infants, and preschool-age children eligible to receive Head Start services (National Head Start Association, n. d.).

The National Head Start Association (n. d.) provides that:

- Substantial research finds that Head Start and Early Head Start programs provide positive educational benefits.
- Head Start children performed better on cognitive, language, and health measures than their comparison group counterparts did.
- Head Start programs improve the well-being of the children and families they serve, providing health and dental services to children and families who might otherwise not have them.
- Parents who participate in Head Start are found to have greater quality of life satisfaction; increased confidence in coping skills; and decreased feelings of anxiety, depression, and sickness.
- Head Start children are at least eight percentage points more likely to have had their immunizations than those children who did not attend preschool.

According to Taylor (1996), during the 1994 Reauthorization of Head Start, Early Head Start was established as an outreaching arm of the Head Start program. Early Head Start is a federally funded, comprehensive early childhood program serving low-income prenatal to age three children, pregnant women, and their families. Research has shown that the years from conception to age 3 are critical in human development. This called for the Head Start program to embark

on an extensive planning process that would ensure that children and families would receive high quality services that would enhance growth and development, making a difference in outcomes for young children (Taylor, 1996). The National Head Start Association (2005) provides documentation of the following benefits of the Early Head Start program:

- Early Head Start children on average had a higher cognitive development score than their control group had.
- Early Head Start children demonstrated a higher level of social-emotional development than their control group in a number of areas. Compared with their control group, they showed less aggressive behavior and were more attuned as they played.
- When their children were 3 years old, Early Head Start parents reported significantly less depression than parents in the control group did.
- Early Head Start children had a higher immunization rate than children in a control group.
- Early Head Start children at age 3 had larger vocabularies than the control children had.

Head Start has made huge impacts in the health and development of AI/AN children. Children are receiving services both on and off American Indian reservations. As a parent who has had children in both settings, I recognized that a major benefit of reservation, or tribal programs, is the promotion of culture in the classroom. American Indian programs are respectful, knowledgeable, and appreciative of the culture of the children they serve. According to Strand and Peacock (2002), feeling good about one's tribal culture; participation in tribal and cultural activities; positive feelings of belonging within a community and a family; appreciation of the influences of elders, parents, and grandparents; and participation in a school setting where the curriculum included culture provided for three positive characteristics in AI/AN children: good self-concept, a strong sense of direction, and tenacity. All three of these are very important attributes

for children to have to succeed in the world.

Head Start is only one of the early childhood programs available for American Indian and Alaska Native children both on and off the reservation and in both rural and urban settings. Many individual tribes provide grant-funded childcare, such as those funded by the Child Care and Development Fund, for parents of young children that ensure that the children are receiving care that is monitored by the tribe. Children off the reservation, in both rural and urban settings, may qualify for state and/or grant-funded programs that monitor childcare to ensure the health and safety of the children.

Although programs are offered both on and off the reservation and in both rural and urban settings, a disparity that exists between rural and urban settings, as well as on or off the reservation, is the availability of programs. Children in urban areas are going to have greater access to programs that will contribute to their health and development than those living in rural areas. Similarly, children living off the reservation are going to have access to more and different programs, including state-funded programs. It is important to note that continuing budget cuts in not only Head Start, but also in child care and educational programs in general, are making it more difficult for AI/AN children and families to receive quality child care. Unless education and childcare become a priority to the government, cutbacks and decreases will continue to have negative impacts on AI/AN children nationwide.

Historically, AI/AN populations represent the most economically disadvantaged and underserved groups in America. They have the lowest income and educational levels as well as the lowest standard of living (O'Connell, 1985). Fortunately, for American Indians and Alaska Natives, the best of both worlds have combined after centuries of frustration, confusion, misunderstanding, repression, and perseverance. American Indians and Alaskan Natives have remained determined throughout years of attempted assimilation to keep their native traditions and tongues alive. Formal Native American education spans from reservation preschools to universities far from the reservation lands of the native peoples. It can and should encompass

tribal traditions, cultural beliefs, academics, and technology in a middle ground between two distinct cultures with each providing the other with the opportunities to teach, learn, and grow. However, too often educational endeavors remain unable to break completely away from assimilation tactics and embrace cultural values. Regardless, Native American and Alaska Native populations have emerged victorious as students, educators, and leaders determined to leave their mark on American history and to carve their place in the future.

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