2014 NEEDS AND ASSETS REPORT

GILA RIVER INDIAN COMMUNITY REGIONAL PARTNERSHIP COUNCIL

FIRST THINGS FIRST

Ready for School. Set for Life.

Gila River Indian Community Regional Partnership Council

2014

Needs and Assets Report

Prepared by the
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Funded by
First Things First Gila River Indian Community Regional Partnership Council

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February 23, 2015

Message from the Chair:

The 2014 Gila River Indian Community Regional Needs and Assets Report is the forth in a series of assessments conducted every two years for the First Things First Gila River Indian Community Regional Partnership Council. The assessment provides a snapshot of the current status of children and families in the region. It is a collection of useful data and community information that will be used to help determine how best to invest resources to improve the lives of young children and families in the region.

The Gila River Indian Community Regional Partnership Council takes great pride in the progress made over the past six years. Together with our community partners, we are delivering on our promise to build a solid foundation for young children and their families. During the past year, we have provided support to young children and their families through grant awards and activities addressing teen parenting, early education/child care, native language and literacy and home visitation.

The Gila River Indian Community Regional Partnership Council is grateful for the support and guidance received from the Gila River Indian Community Tribal Council. With the on-going support of tribal leadership, The First Things First Gila River Indian Community Regional Partnership Council will continue to advocate and provide opportunities for healthy growth in the first years of life, parent education on child development, and ongoing professional development opportunities for child care providers, teachers, and family caregivers.

Thanks to the dedicated staff, volunteers, and partners, First Things First is making a real difference in the lives of our youngest citizens, not only in the Gila River Indian Community, but throughout the entire State.

Sincerely,

Melissa Madrid, Chair

Chair, Gila River Indian Community Regional Partnership Council

Gila River Indian Community Regional Partnership Council

Introductory Summary and Acknowledgments

The way in which children develop from infancy to well-functioning members of society will always be a critical subject matter. Understanding the processes of early childhood development is crucial to our ability to foster each child's optimal development and is fundamental to all aspects of wellbeing of our communities, society and the State of Arizona.

This Needs and Assets Report for the Gila River Indian Community Geographic Region provides a clear statistical analysis and helps us in understanding the assets, needs, and gaps for young children and points to ways in which children and families can be supported.

The First Things First Gila River Indian Community Regional Partnership Council recognizes the importance of investing in young children and empowering parents, grandparents, and caregivers to advocate for services and programs within the region. A strong focus in the Gila River Indian Community Region in the past year was working with stakeholder's through-out the large region to further develop and refine the strategies required to reach our common goals. Great progress has been made in building the partnerships and relationships necessary to implement programs across the key focus areas of early learning, health and family support to meet the varying needs of young children and families. This report provides data that will aid the Regional Council's ongoing strategic planning and help to build a comprehensive statewide early childhood system.

Acknowledgments:

The First Things First Gila River Indian Community Regional Partnership Council owes special gratitude to the agencies and stakeholders who participated in numerous work sessions and community forums throughout the past four years. The success of First Things First is due, in large measure, to the contributions of numerous individuals who consistently give their time, skill, support, knowledge and expertise.

To the current and past members of the Gila River Indian Community Regional Partnership Council, you are the heart and soul of First Things First. Your dedication, insight, and extreme passion, have guided our effort to make a difference for young children and families within the region. Our continued work together will further aid in building a truly comprehensive early childhood system for the betterment of young children within the region and the entire State.

Our gratitude is also given to the Gila River Indian Community Council, without your support and guidance we could not move the work of understanding and establishing an early childhood system which supports our youngest members. Additionally, the Gila River Health Care, Blackwater, Gila Crossing, and Casa Blanca Community Schools, Sacaton Elementary School, and St. Peter Indian Mission School and their respective boards have all provided vital information and guidance to this report. Also, Arizona Department of Economic Security and,

the Arizona Department of Health Services and the Arizona State Immunization Information System, the Arizona Department of Education, and the Arizona Health Care Cost Containment System for their contribution of data for this report. In addition, our grantees: Gila River Head Start and Early Head Start, Baby Smarts program, VHM and Ira Hayes high schools, Gila River's WIC and Commodities program, and the Early Education Childcare Center are our partners and allies in advancing the early childhood movement in Gila River Indian Community and we are honored to work alongside them. We'd also like to thank all the individuals throughout the region who took the time to talk and meet with us to provide information for the 2014 Needs and Assets Report. This input was invaluable to understanding the needs and assets of young children and their families throughout the Gila River Indian Community.

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Executive Summary

The Gila River Indian Community is located on 372,000 acres of land in south-central Arizona. The Community lies south of the cities of Phoenix, Tempe, and Chandler, and north of Casa Grande. Tribal membership includes the Akimel O'otham (Pima) and Pee Posh (Maricopa) tribes. The Community is divided into seven districts with the central government seat in Sacaton, Arizona. The boundaries of the First Things First Gila River Indian Community Region match those of the reservation boundaries.

In the 2010 US Census, the population of the region was 11,712. Of these, 1,530 were children under the age of six. About three out of every ten households in the region is home to one or more children under six. The majority (58%) of these children were not living with their parents but with some other relatives (such as grandparents or other family members). Many of those who were living with one or both parents also had a grandparent in the home. Multigenerational households are quite common in the Gila River Indian Community Region.

A minority of the residents of the region (14%) report speaking a Native Indian language at home. Several language-preservation projects are active, some of which are supported by First Things First.

The median income for families living in the region ($25,400) is less than half of that for all families in Arizona ($59,600). More than half (53%) of the region's residents—and nearly two-thirds of its young children (64%)—live in poverty. The unemployment rate in the region has decreased in the past years from 34 percent in 2009, to 26 percent in 2013 but continues to be substantially higher than the state rate of 8 percent.

According to American Community Survey data, 11 percent of the region's children live with two parents who are both in the labor force (either employed or actively looking for work). An additional 39 percent live with a single parent who is in the labor force. Adding these two percentages together, 50 percent of the region's children are likely without a stay-at-home parent, and in need of some kind of child care. Most of the remaining children (48%) are living with a single parent who is not in the labor force, who may also require child care to help them re-enter it.

The proportion of Gila River children under six who received SNAP benefits was 57 percent in 2012. About 6 percent received TANF benefits that year. In 2014, three-quarters (75%) of the children under five participated in the WIC program.

Among adults (age 25 and older) living the in the region, about one-third (34%) have a high school diploma or GED, but no college. A slightly greater proportion (36%) have neither a diploma nor GED. Four percent have a bachelor's degree. Over the four years from 2009 to 2012, about half (51%) of the mothers giving birth had less than a high school education. (This

number would include young women who were still in high school, and might earn their diplomas after the child was born).

The Gila River Indian Community Region has several types of early-education programs: child care centers, home-based care, school-based preschools, Family and Child Education (FACE) programs, Head Start and Early Head Start. These programs provide center-based early care and education services to about two-thirds of the preschool-age children in the region. In contrast, about 20 percent of the children birth to three years old received center-based services. This highlights a need for additional child care services for the youngest children in the region.

Comprehensive health care services are available in the region through the tribally-operated Gila River Health Care facilities: Hu Hu Kam Memorial Hospital and Gila Crossing Clinic (now the Komatke Health Center). Health care services are also available to community members through mobile medical units that visit various locations throughout the seven districts on a regular basis. A major asset in the region is the coordinated care provided by the Women's Health Center and the Pediatrics Clinic.

In 2012, the most recent year for which data are available, there were 83 births to women who lived on the Gila River Indian Community. About 80 percent of the mothers started prenatal care during their first trimester, and an estimated 13 percent had fewer than five prenatal visits. Just under ten percent of the births were preterm.

Child welfare services in the region are provided by the Gila River Indian Community Social Services Department. In order to better support families involved with the system, stakeholders in the Gila River Indian Community Region established the Children in Crisis Coalition, which focuses on best practices, coordination and communication, and training. Key informants identified the coordinated efforts of the Coalition as an important asset in the region.

Support for teen parents in the Community is available through the BabySmarts Program that targets students in the two local high schools but is also offered to young parents in the Community at large.

Key informants recognize that the Community offers a wide range of services and programs to families with young children.

A strength of the Gila River Indian Community is the degree to which service providers and others form partnerships and work together collaboratively. The Gila River Indian Community First Things First Regional Partnership Council has been leading an effort around building a strong early childhood system in the region to ensure that young children and their families receive the necessary support to be ready for school.

Who are the families and children living in the Gila River Indian Community Region?

The Gila River Indian Community Region

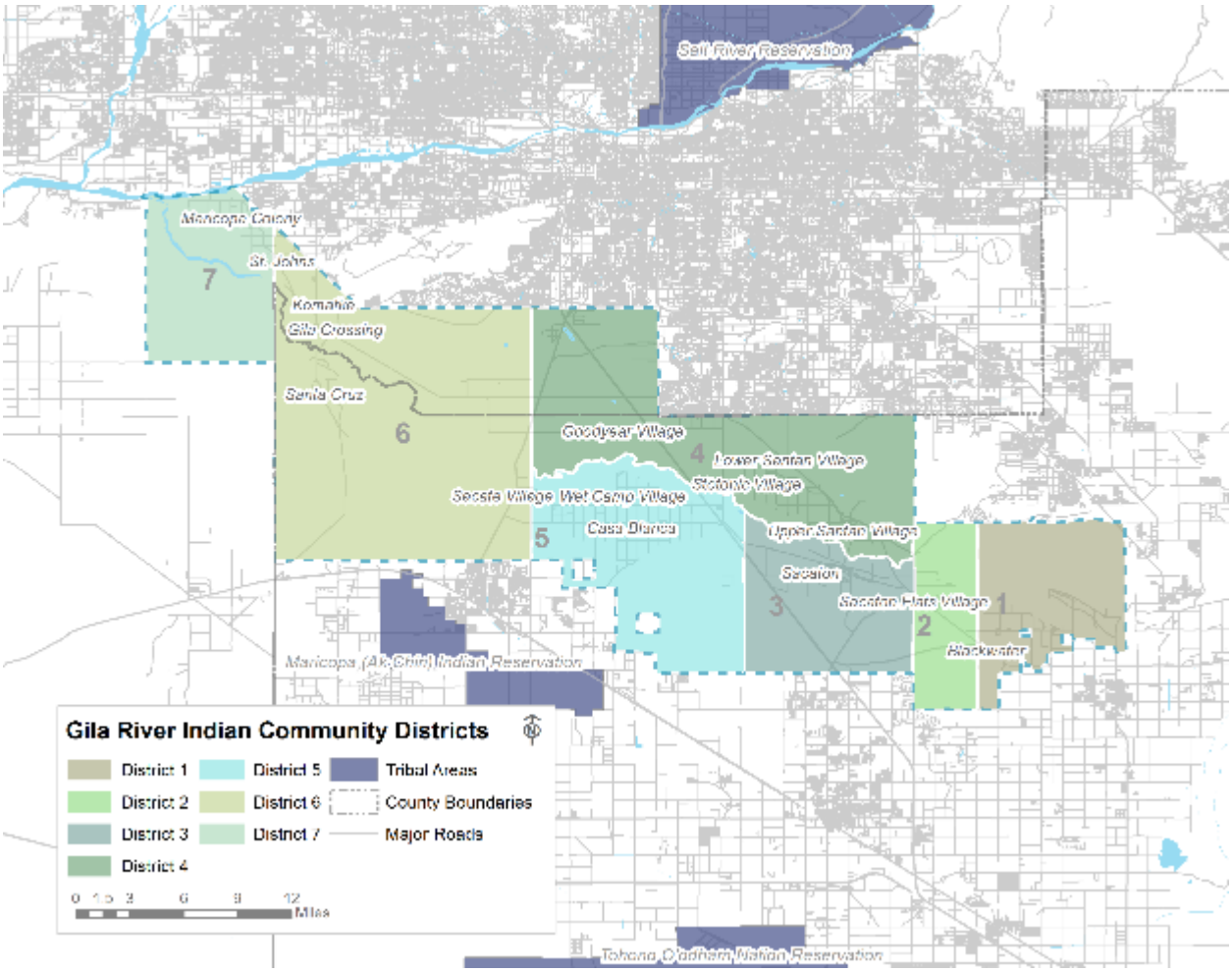
When First Things First was established by the passage of Proposition 203 in November 2006, the government-to-government relationship with federally-recognized tribes was acknowledged. Each Tribe with tribal lands located in Arizona was given the opportunity to participate within a First Things First designated region or elect to be designated as a separate region. The Gila River Indian Community was one of 10 Tribes that chose to be designated as its own region. This decision must be ratified every two years, and the Gila River Indian Community has opted to continue to be designated as its own region.

Regional Boundaries and Report Data

Geographically, the Gila River Indian Community is located on 372,000 acres of land in south-central Arizona. The Community lies south of the cities of Phoenix, Tempe, and Chandler, and north of Casa Grande, and its east to west borders run from Coolidge to Tolleson. The Reservation was established on February 28, 1859 by an Act of Congress. Tribal membership includes the Akimel O'otham (Pima) and Pee Posh (Maricopa) tribes. The Community is divided into seven districts with the central government seat in Sacaton, Arizona. Each district maintains one to four seats on the Tribal Council. The boundaries of the First Things First Gila River Indian Community Region match those of the reservation boundaries.

The map below, Figure 1, shows the geographical area covered by the Gila River Indian Community Region.

Figure 1. The Gila River Indian Community Region



Source: 2010 TIGER/Line Shapefiles prepared by the US Census, 2010

The information contained in this report includes data obtained from state agencies by First Things First, data obtained from other publically available sources and data provided by Gila River Indian Community agencies and departments. It also includes findings from additional qualitative data collection that was conducted specifically for this report through key informant interviews with representatives from tribal agencies and departments in the spring of 2014.

In most of the tables in this report, the top row of data corresponds to the FTF Gila River Indian Community Region. When available, the next rows present the data for the seven districts that comprise the Community. The next three rows show data that are useful for comparison purposes: all Arizona reservations combined, Pinal County, and the state of Arizona.

The level of data (community, zip code, etc.) that is presented in this report is driven by certain guidelines. The UA Norton School is contractually required to follow the First Things First Data Dissemination and Suppression Guidelines:

- "For data related to **social service** and **early education** programming, all counts of **fewer than ten**, excluding counts of zero (i.e., all counts of one through nine) are suppressed. Examples of social service and early education programming include: number of children served in an early education or social service program (such as Quality First, TANF, family literacy, etc.)"
- "For data related to **health or developmental delay**, all counts of **fewer than twenty-five**, excluding counts of zero (i.e., all counts of one through twenty-four) are suppressed. Examples of health or developmental delay include: number of children receiving vision, hearing, or developmental delay screening; number of children who are overweight; etc."

-First Things First—Data Dissemination and Suppression Guidelines for Publications

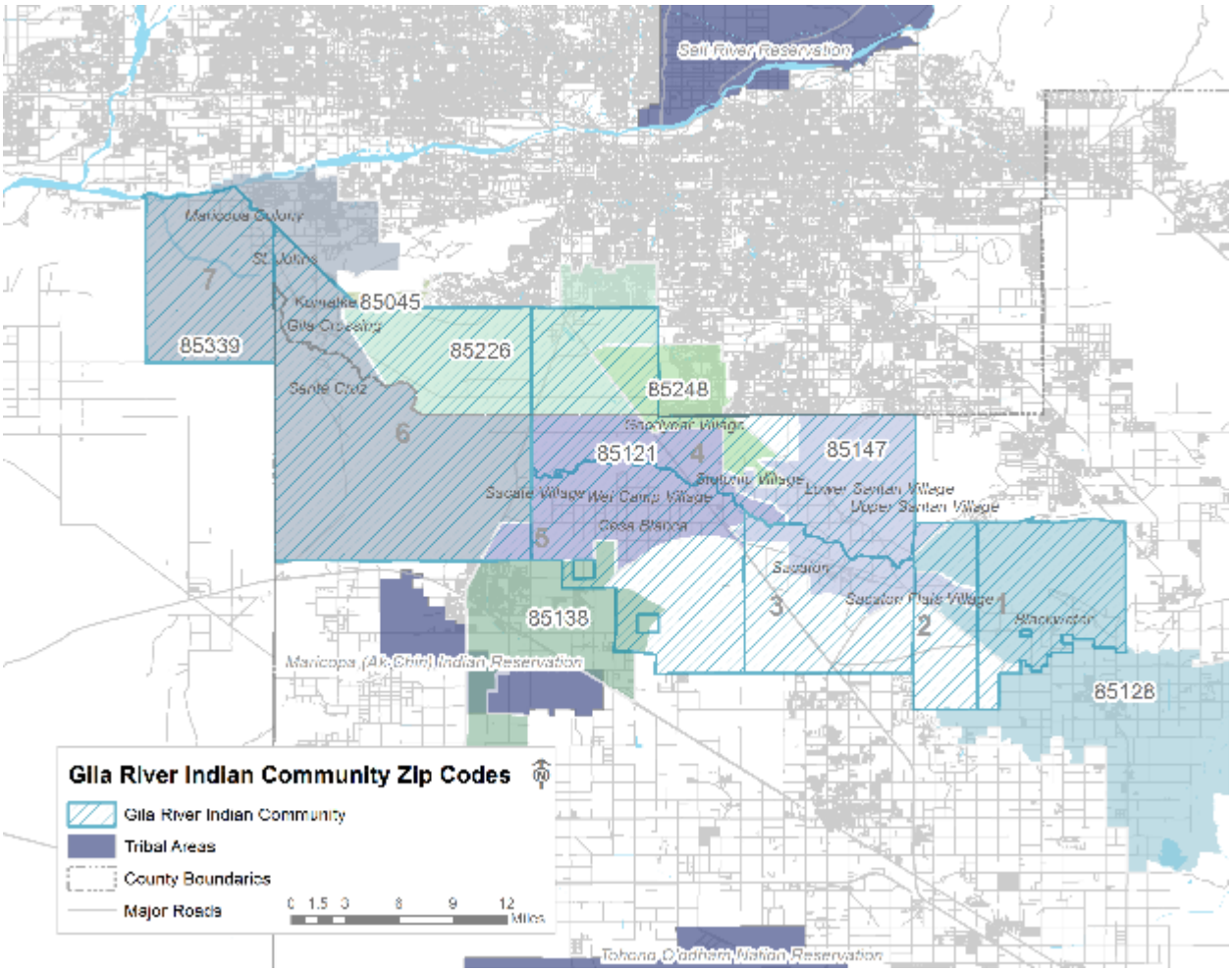
Throughout the report, suppressed counts will appear as either <25 or <10 in data tables, and percentages that could easily be converted to suppressed counts will appear as DS (for "data suppressed").

Please also note that some data, such as that from the American Community Survey, are estimates that may be less precise for smaller areas (see additional information on caveats regarding ACS data in tribal areas, below).

Data for certain tables were provided by FTF through their State Agency Data Request at the zip code level. Because the zip code boundaries do not exactly match those of the region we estimated a share of the numbers to the Gila River Indian Community Region by applying the following formula: we used the percentage of each zip code area's population of children 0-5 which are Gila River Indian Community residents and then applied these percentages the zip code level agency data (e.g. SNAP, TANF) to calculate estimates for the Gila River Indian Community Region.

Figure 2 shows the zip codes included in the region.

Figure 2. The Gila River Indian Community Region, by zip code



Source: 2010 TIGER/Line Shapefiles prepared by the US Census, 2010

In this report we use two main sources of data to describe the demographic and socio-economic characteristics of families and children in the region: US Census 2010 and the American Community Survey. These data sources are important for the unique information they are able to provide about children and families across the United States, but both of them have acknowledged limitations for their use on tribal lands. Although the Census Bureau asserted that the 2010 Census count was quite accurate in general, they estimate that "American Indians and Alaska Natives living on reservations were undercounted by 4.9 percent."[1] In the past, the decennial census was the only accessible source of wide-area demographic information. Starting in 2005, the Census Bureau replaced the "long form"

[1]"Estimates of Undercount and Overcount in the 2010 Census" (May 22, 2012). www.census.gov/newsroom/releases/archives/2010_census/cb12-95.html

questionnaire that was used to gather socio-economic data with the American Community Survey (ACS). The ACS is an ongoing survey that is conducted by distributing questionnaires to a sample of households every month of every year. Annual results from the ACS are available but they are aggregated over five years for smaller communities, to try to correct for the increased chance of sampling errors due to the smaller samples used.

According to the State of Indian Country Arizona Report[2] this has brought up new challenges when using and interpreting ACS data from tribal communities and American Indians in general. There is no major outreach effort to familiarize the population with the survey (as it is the case with the decennial census), and the small sample size of the ACS makes it more likely that the survey may not accurately represent the characteristics of the population on a reservation. The State of Indian Country Arizona Report indicates that at the National level, in 2010 the ACS failed to account for 14% of the American Indian/Alaska Native (alone, not in combination with other races) population that was actually counted in the 2010 decennial census. In Arizona the undercount was smaller (4%), but according to the State of Indian Country Arizona report, ACS may be particularly unreliable for the smaller reservations in the state.

While recognizing that estimates provided by ACS data may not be fully reliable, we have elected to include them in this report because they still are the most comprehensive publically-available data that can help begin to describe the families that First Things First serve. Considering the important planning, funding and policy decisions that are made in tribal communities based on these data, however, the State of Indian Country report recommend a concerted tribal-federal government effort to develop the tribes' capacity to gather relevant information on their populations. This information could be based on the numerous records that tribes currently keep on the services provided to their members (records that various systems must report to the federal agencies providing funding but that are not currently organized in a systematic way) and on data kept by tribal enrollment offices.

A current initiative that aims at addressing some of these challenges has been started by the American Indian Policy Institute, the Center for Population Dynamics and the American Indian Studies Department at Arizona State University. The Tribal Indicators Project[3] begun at the request of tribal leaders interested in the development of tools that can help them gather and utilize meaningful and accurate data for governmental decision-making. An important part of this effort is the analysis of Census and ACS data in collaboration with tribal stakeholders. We

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[2] Inter Tribal Council of Arizona, Inc., ASU Office of the President on American Indian Initiatives, ASU Office of Public Affairs (2013). *The State of Indian Country Arizona. Volume 1.* Retrieved from http://outreach.asu.edu/sites/default/files/SICAZ_report_20130828.pdf

[3] http://aipi.clas.asu.edu/Tribal_Indicators

hope that in the future these more reliable and tribally-relevant data will become available for use in these community assessments.

General Population Trends

According to U.S. Census data the Gila River Indian Community Region had a total population of 11,712 in 2010 (the most recent year for which detailed population data are available), of whom 1,530 were children under the age of six. Table 1, below, lists the total population and number of households for the Gila River Indian Community Region and the state. The proportion of households with children under the age of six (30%) in the region is nearly twice that seen on the state as a whole (16%), and is slightly higher than all Arizona reservations combined (26%).

Table 1. Population and households with children ages 0-5

GEOGRAPHY	TOTAL POPULATION	POPULATION (AGES 0-5)	TOTAL NUMBER OF HOUSEHOLDS	HOUSEHOLDS WITH ONE OR MORE CHILDREN (AGES 0-5)	
Gila River Indian Community	11,712	1,530	2,982	905	30%
District 1 - Blackwater	1,139	146	339	95	28%
District 2 - Hashen Kehk	555	55	163	40	25%
District 3 - Sacaton	2,687	363	634	212	33%
District 4 - Santan	2,378	344	587	197	34%
District 5 - Casa Blanca	1,960	226	504	140	28%
District 6 - Komatke	2,180	301	535	168	31%
District 7 - Maricopa Colony	813	95	220	53	24%
All Arizona Reservations	178,131	20,511	50,140	13,115	26%
Pinal County	375,770	36,181	125,590	24,750	20%
Arizona	6,392,017	546,609	2,380,990	381,492	16%

US Census (2010). Tables P1, P14, P20. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

A comparison between censuses provides information about increases and decreases in population. Table 2 shows changes in population between the 2000 Census and the 2010 Census.

The Gila River Indian Community region experienced an overall population increase as well as an increase in the population of children aged 0-5. However, as shown in Table 2, there was some regional variation in the changes in population between censuses. Although District 4 experienced an important growth in its population of children 0 to 5 years of age, District 5 experienced the opposite trend and a decrease of 20 percent occurred in its population of

young children under the age of six. The Gila River Indian Reservation experienced a 7 percent increase in the number of children aged 0 to 5 across the entire reservation, although Arizona reservations overall experienced a 3 percent decrease.

Table 2. Comparison of U.S. Census 2000 and U.S. Census 2010

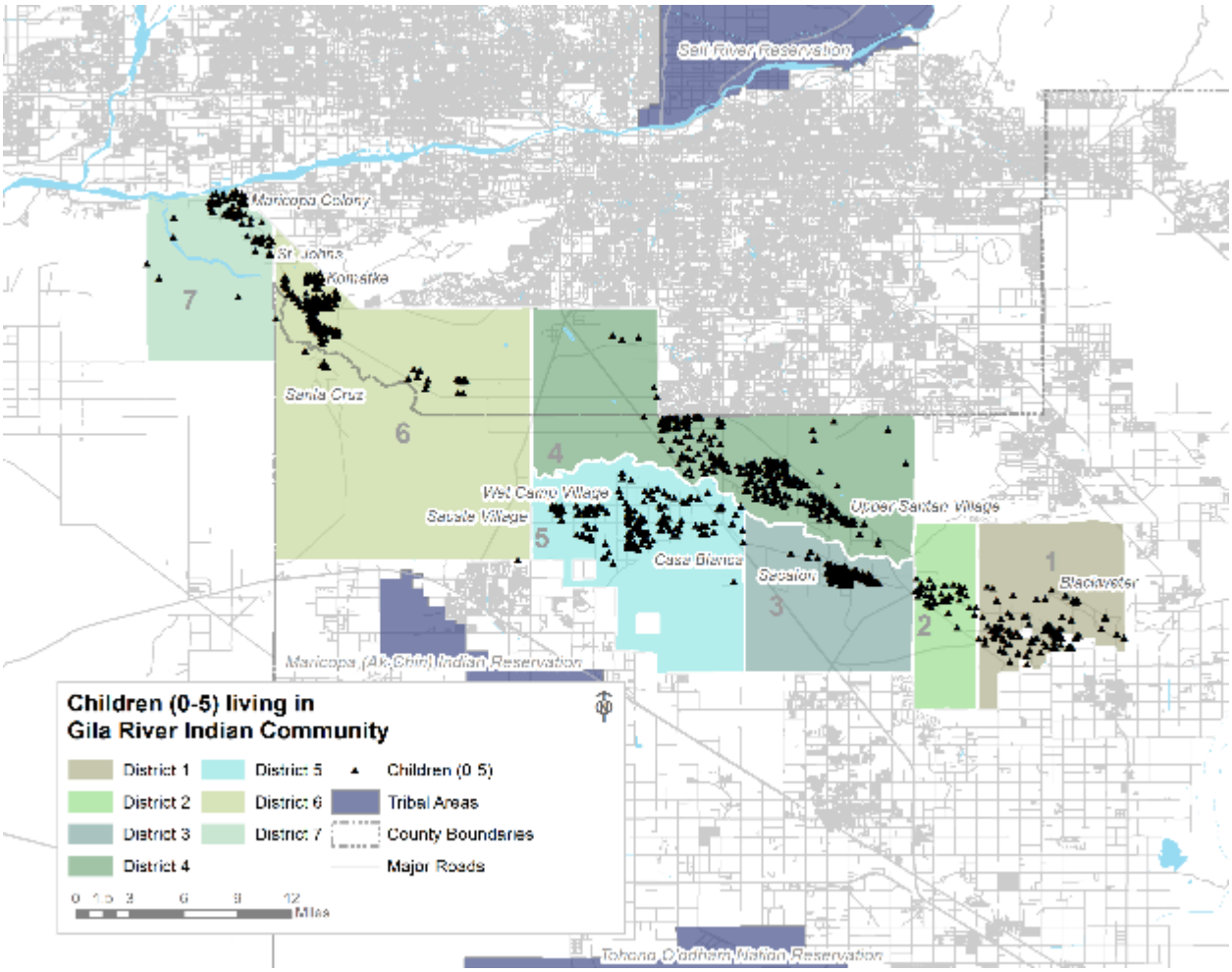
GEOGRAPHY	TOTAL POPULATION			POPULATION OF CHILDREN (0-5)		
	2000 CENSUS	2010 CENSUS	CHANGE	2000 CENSUS	2010 CENSUS	CHANGE
Gila River Indian Community	11,257	11,712	4%	1,429	1,530	7%
District 1	879	1,139	30%	111	146	32%
District 2	368	555	51%	43	55	28%
District 3	3,014	2,687	-11%	337	363	8%
District 4	2,153	2,378	10%	250	344	38%
District 5	2,115	1,960	-7%	281	226	-20%
District 6	1,968	2,180	11%	309	301	-3%
District 7	760	813	7%	98	95	-3%
All Arizona Reservations	179,064	178,131	-1%	21,216	20,511	-3%
Pinal County	179,727	375,770	109%	14,472	36,181	150%
Arizona	5,130,632	6,392,017	25%	459,141	546,609	19%

US Census (2010). Tables P1, P14; US Census (2000) Table QT-P2. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

The "Change from 2010 to 2012" column shows the amount of increase or decrease, using 2010 as the baseline. The percent change between two given years is calculated using the following formula: (Number in Year 2 – Number in Year 1)/Number in Year 1 x 100)

Figure 3 shows the geographical distribution of children under six in the region, according to the 2010 U.S. Census. A triangle on the map represents one child. The dots do not pinpoint each child's location, but are placed generally in each census block in which a young child was living in 2010.

Figure 3. Geographic distribution of children under six according to the 2010 Census (by census block)



US Census (2010) Table P14, and 2010 TIGER/Line Shapefiles prepared by the US Census. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Additional Population Characteristics

Household Composition

In the Gila River Indian Community Region, fewer than half of the children 0 to 5 years of age (41%) are living with at least one parent according 2010 Census data. This percentage is substantially lower than that of the state as a whole, (81%), and less than the proportion of children living with at least one parent across all Arizona reservations (53%). The majority of children (58%) are living with relatives other than their parents (such as grandparents, uncles, or aunts).

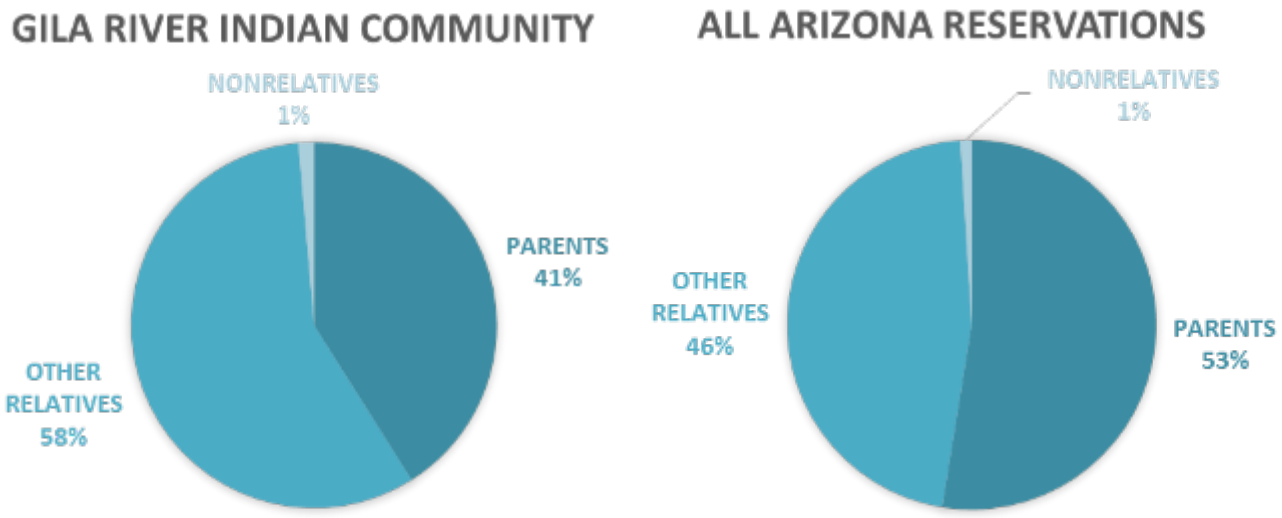
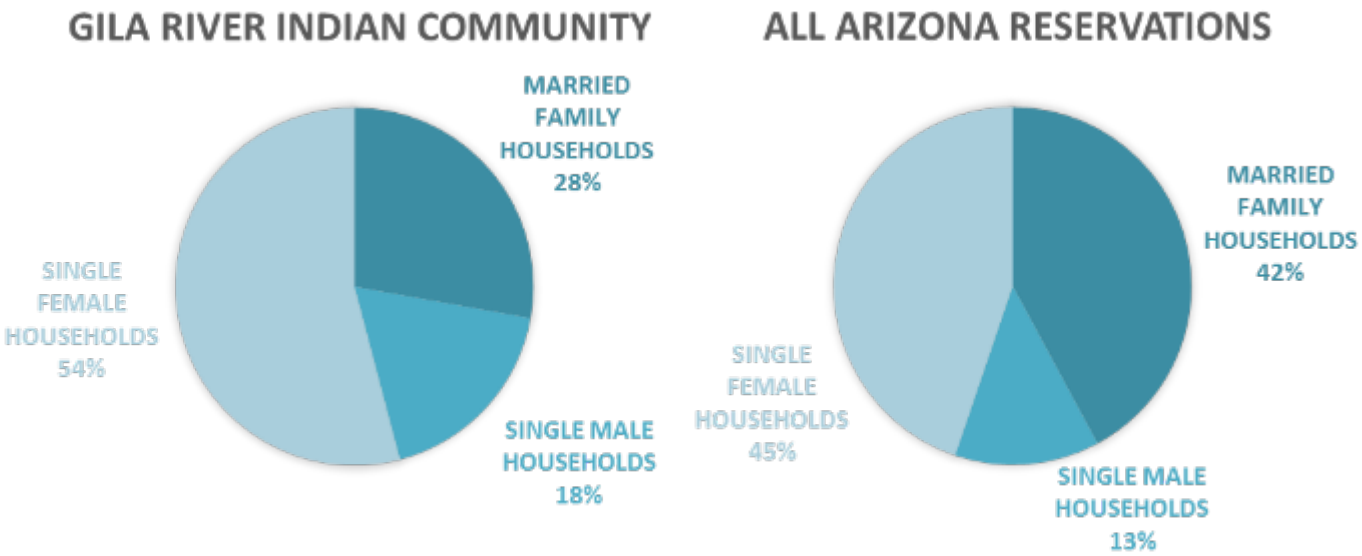


Figure 4. Living arrangements for children

US Census (2010). Table P32. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

More than half of the households with children 0 to 5 years of age in the region (54%) are single female households according to the 2010 Census data (U.S. Census Bureau, Table P20). This proportion is slightly higher than that across all Arizona reservations (45%), and substantially higher than the percentage of single female households in the state as a whole (23%).

Figure 5. Type of household with children (0-5)



US Census (2010). Table P20. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

The percentage of grandparents caring for grandchildren varies across the state. The Arizona Children's Action Alliance reports that in Arizona, approximately 36 percent of grandparents caring for grandchildren under 18 have been doing so for at least five years, and that 21 percent of these grandparents are living in poverty.[4]

In the Gila River Indian Community, 719 children 0-5 (47%) are reported to be living in a grandparent's household. This is a substantially higher percentage than the statewide rate (14%), and is also higher than the rate in Arizona reservations overall (40%). Table 3 below shows detailed data about grandparents caring for grandchildren by district. The proportion of households with three or more generations in the Gila River Indian Community Region (21%) is also higher than both the statewide proportion (5%) and the rate for Arizona reservations overall (16%).

[4] Children's Action Alliance. (2012). *Grandfamilies Fact Sheet.* Phoenix, AZ. Retrieved from http://www.azchildren.org/MyFiles/2012/grandfamilies%20fact%20sheet%20pic%20background.pdf.

Table 3. Number of children living in a grandparent's household

GEOGRAPHY	POPULATION (AGES 0-5)	CHILDREN (0-5) LIVING IN A GRANDPARENT'S HOUSEHOLD		TOTAL HOUSEHOLDS	HOUSEHOLDS WITH 3 OR MORE GENERATIONS	
Gila River Indian Community	1,530	719	47%	2,982	636	21%
District 1	146	63	43%	339	47	14%
District 2	55	19	35%	163	23	14%
District 3	363	146	40%	634	135	21%
District 4	344	181	53%	587	136	23%
District 5	226	125	55%	504	123	24%
District 6	301	144	48%	535	135	25%
District 7	95	41	43%	220	37	17%
All Arizona Reservations	20,511	8,239	40%	50,140	8,104	16%
Pinal County	36,181	4,622	13%	125,590	6,869	5%
Arizona	546,609	74,153	14%	2,380,990	115,549	5%

US Census (2010). Table P41, PCT14. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

It must be noted that extended families that involve multiple generations and relatives along both vertical and horizontal lines are an important characteristic of many American Indian families. The strengths associated with this open family structure -mutual help and respect- can provide members of these families with a network of support which can be very valuable when dealing with socio-economic hardships[5].

Multigenerational households may also have different needs and strengths. For example, they may be more likely to have grandparents provide home-based child care. This may result in families being less connected with outside support services available to them. On the other hand, having grandparents help with child care may create greater employment opportunities for parents. Multigenerational families must find the balance between not paying for child care (which may be subsidized) and needing to distribute low wages across more household members. In other cases, grandparents and parents may both be working which results in higher income for the household but an increased need for child care.

However, there are also considerable challenges that grandparents can face when they become the primary source of care for their grandchildren not because of choice, but because parents become unable to provide care due to the parent's death, physical or mental illness, substance abuse, incarceration, unemployment or underemployment or because of domestic violence or

[5] Hoffman, F. (Ed.). (1981). *The American Indian Family: Strengths and Stresses*. Isleta, NM: American Indian Social Research and Development Associates.

child neglect in the family.[6] Caring for children who have experienced family trauma can pose an even greater challenge to grandparents, who may be in need of specialized assistance and resources to support their grandchildren. In addition, parenting can be a challenge for aging grandparents, whose homes may not be set up for children, who may be unfamiliar with resources for families with young children, and who themselves may be facing health and resource limitations. They also are not likely to have a natural support network for dealing with the issues that arise in raising young children.

There is some positive news for grandparents and great-grandparents raising their grandkids through a Child Protective Services (CPS) placement by the state of Arizona. Starting in February 2014, these families are offered a $75 monthly stipend per child. To qualify, a grandparent or great-grandparent must have an income below 200% of the FPL. They also must not be receiving foster care payments or Temporary Assistance for Needy Families (TANF) cash assistance for the grandchildren in their care.[7] Those grandparents raising grandkids not in the CPS system might also be eligible for this stipend in coming months if Arizona Senate Bill 1346 is passed.[8] This bill, however, will not benefit grandparents whose grandchildren were placed with them by Tribal Child Protective Services departments.[9]

Ethnicity and Race

Table 4 shows the ethnic/racial breakdown for individuals 18 years old and older in the Gila River Indian Community. The vast majority (84%) of the adults living in the region identify themselves as American Indian. Most of the rest (12%) identify as Hispanic. This trend is similar to the racial breakdown of Arizona reservations overall, although the proportion of Hispanic population in the region (12%) is higher than that of all Arizona reservations combined (5%).

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[6] *More U.S. Children Raised by Grandparents*. (2012). Population Reference Bureau. Retrieved from http://www.prb.org/Publications/Articles/2012/US-children-grandparents.aspx

[7] Children's Action Alliance, January 15, 2014 Legislative Update email.

[8] Children's Action Alliance, February 21, 2014 Legislative Update email.

[9] Information provided by staff from the Arizona Department of Child Safety on June 25, 2024 through personal correspondence.

Table 4. Race and ethnicity for adults

GEOGRAPHY	POPULATION (18+)	HISPANIC	NOT HISPANIC				
			WHITE	BLACK	AMERICAN INDIAN	ASIAN or PACIFIC ISLANDER	OTHER
Gila River Indian Community	7,438	12%	2%	0%	84%	0%	1%
District 1	753	20%	3%	1%	74%	0%	3%
District 2	369	9%	1%	0%	88%	0%	1%
District 3	1,718	9%	1%	0%	89%	0%	1%
District 4	1,475	14%	2%	0%	82%	0%	2%
District 5	1,280	12%	1%	0%	86%	0%	0%
District 6	1,308	12%	2%	0%	83%	0%	2%
District 7	535	10%	1%	0%	87%	0%	0%
All Arizona Reservations	117,049	5%	5%	0%	88%	0%	1%
Pinal County	276,070	24%	63%	4%	5%	2%	1%
Arizona	4,763,003	25%	63%	4%	4%	3%	1%

US Census (2010). Table P11. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

The majority (93%) of children ages birth through four living in the region were identified as American Indian and Hispanic (22%). This trend, again, is similar to the breakdown among all Arizona reservations. However, the percentage of Hispanic children in the Gila River Indian Community Region (22%) is more than twice that reported in all Arizona reservations combined (9%).[10]

[10] The Census Bureau reports the race/ethnicity categories differently for the population 0-4 and for the adults. For adults, Table 4 above shows exclusive categories where someone who identifies as Hispanic is only counted once as Hispanic, even if the individual also identifies with another race (e.g. Black). For the population 0-4, Table 5 shows non-exclusive categories and this is the reason why the percentages in the rows do not add up to 100%. This means, for instance, that if a child's ethnicity and race are reported as "Black (Hispanic)" he will be counted twice: once as Black and once as Hispanic.

Table 5. Race and ethnicity for children ages 0-4

GEOGRAPHY	POPULATION (AGES 0-4)	HISPANIC OR LATINO	WHITE (NOT HISPANIC)	AFRICAN AMERICAN	AMERICAN INDIAN	ASIAN OR PACIFIC ISLANDER
Gila River Indian Community	1,280	22%	0%	0%	93%	0%
District 1	118	32%	0%	0%	83%	0%
District 2	47	11%	0%	0%	100%	0%
District 3	296	21%	0%	0%	93%	0%
District 4	283	25%	0%	0%	95%	0%
District 5	199	23%	0%	0%	97%	0%
District 6	252	19%	0%	1%	91%	0%
District 7	85	20%	0%	0%	91%	0%
All Arizona Reservations	17,061	9%	1%	0%	92%	0%
Pinal County	30,182	38%	49%	4%	6%	2%
Arizona	455,715	45%	40%	5%	6%	3%

US Census (2010). Table P12B, P12C, P12D, P12E, P12F, P12G, P12H, P12I. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Note: The number for children ages 0-5 are not readily available from the US Census, but it is likely that the percentage distribution for children 0-4 will be similar to that of children 0-5.

Language Use and Proficiency

Data about language use at home provide additional information about the characteristics of the population in the Gila River Indian Community Region. Of the population 5 and older, a smaller percentage of people in the Gila River Indian Community speak a Native North American language at home (14%) than in Arizona reservations overall (52%) (Table 6). In the Gila River Indian Community, the native languages spoken are Akimel O'otham and Pee Posh. O'otham is a Uto-Aztecan language and Pee Posh is a Yuman language.

Table 6. Home language use for those 5 years and older

GEOGRAPHY	PERSONS (5+) WHO SPEAK ONLY ENGLISH AT HOME	PERSONS (5+) WHO SPEAK SPANISH AT HOME	PERSONS (5+) WHO SPEAK A NATIVE NORTH AMERICAN LANGUAGE AT HOME	PERSON (5+) WHO SPEAK ENGLISH LESS THAN "VERY WELL"
Gila River Indian Community	80%	4%	14%	3%
District 1	92%	0%	8%	3%
District 2	86%	0%	14%	2%
District 3	75%	7%	13%	2%
District 4	79%	6%	15%	6%
District 5	79%	1%	19%	5%
District 6	88%	2%	10%	3%
District 7	75%	5%	19%	7%
All Arizona Reservations	44%	4%	52%	14%
Pinal County	77%	19%	1%	1%
Arizona	73%	21%	2%	2%

US Census (2013). American Community Survey 5-Year Estimates, 2008-2012, Table B16001. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

An estimated 35 percent of the households in the Community report that a language other than English is spoken at home. This proportion is about half that reported for the households in all Arizona reservations (74%). Table 7 below also shows that the percentage of linguistically isolated households in the Gila River Indian Community is lower than that seen in the state as a whole and in Arizona reservations overall. A household is linguistically isolated if all adults (14 and older) speak a language other than English and none speaks English “very well”.

Table 7. Household home language use

GEOGRAPHY	HOUSEHOLDS IN WHICH A LANGUAGE OTHER THAN ENGLISH IS SPOKEN	LINGUISTICALLY ISOLATED HOUSEHOLDS
Gila River Indian Community	35%	2%
District 1	27%	7%
District 2	32%	0%
District 3	27%	0%
District 4	34%	4%
District 5	46%	0%
District 6	30%	5%
District 7	54%	0%
All Arizona Reservations	74%	12%
Pinal County	23%	2%
Arizona	27%	5%

US Census (2013). American Community Survey 5-Year Estimates, 2008-2012, Table B16002. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Note: A "linguistically isolated household" is one in which all adults (14 and older) speak English less than "very well."

Language Revitalization and Preservation Efforts

There are ongoing language and cultural revitalization efforts in the region. The Gila River Indian Community First Things First Regional Partnership Council funds and supports one such effort through the Native Language Enrichment strategy, which aims to connect young children in the Gila River Indian Community to their language and culture. The program provides outreach and materials in order to promote language acquisition and cultural learning among young children and their families. In addition to the First Things First-funded programs, other language and culture revitalization efforts in the community include: the native language early literacy curriculum implemented at FACE and pre-K programs and at the Early Education Child Care Center; and the language and culture class offered to students at the VHM alternative high school. In addition, elders from the Community get together each week at service centers to teach the O'odham and Pima languages. In these classes, students can learn the O'odham /English orthography approved by the Community council.[11]

[11] Juan, K. Elders put forth effort to sustain O'odham language. *Gila River Indian News*. Retrieved from: http://www.gilariver.org/index.php/news/92-august-2009-grin/750-elders-put-forth-effort-to-sustain-oodham-language

Economic Circumstances

Tribal Enterprises

The Gila River Indian Community is steadily increasing and diversifying its industrial, agricultural, retail and recreational economic base. The Community currently operates three industrial parks that are home to several local and national companies. One park, Lone Butte Industrial Park, is nationally acclaimed as one of the most successful Indian industrial parks in the United States.

Agriculture continues to play a prominent economic role in the Gila River Indian Community's economy. The Community's farm grows crops such as cotton, wheat, millet, alfalfa, and barley, among others, on 12,000 acres. In addition, the Gila River Indian Community owns and operates related agricultural activities, such as a chemical fertilizer plant, cotton gin, and grain storage facilities.

Other tribally owned and operated enterprises include Gila River Telecommunications Inc., which provides residential and business phone and internet service to the Community and Gaming Enterprise, which operates three casinos within the Community. Gaming continues to be a positive economic development activity for the Gila River Indian Community. Wild Horse Pass Hotel and Casino, Vee Quiva Casino and Lone Butte Casino are the three gaming facilities in the Community.

Income and Poverty

Income measures of community residents are an important tool for understanding the vitality of the community and the well-being of its residents. The Arizona Directions 2012 report notes that Arizona has the 5th highest child poverty rate in the country.[12] The effects on children of living in poverty can be felt throughout their lives. Living in poverty increases the likelihood that a child will live in chaotic, crowded and substandard housing and that he or she may be exposed to violence, family dysfunction, and separation from family; all of these factors increase the risk of poorer mental health status later in life.[13]

According to the American Community Survey, the percentage of people living in poverty in the Gila River Indian Community (53%) is higher than that of all Arizona Reservations (40%) and more than three times as high (17%) as the state as a whole. Similarly, more than half (64%) of the young children in the Gila River Indian Community are living in poverty. This proportion is

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[12] Arizona Indicators. (Nov. 2011). *Arizona Directions Report 2012: Fostering Data-Driven Dialogue in Public Policy.* Whitsett, A.

[13] Evans, G.W., & Cassells, R.C. (2013). Childhood poverty, cumulative risk exposure, and mental health in emerging adults. Clinical Psychological Science. Published online 1 October 2013. http://cpx.sagepub.com/content/early/2013/09/26/2167702613501496

also higher than that among all Arizona reservations (53%) and the state (27%). The median family income in the Gila River Indian Community is less than half of the median family income across the state.

Table 8. Median family annual income and persons living below the U.S. Census poverty threshold level

GEOGRAPHY	MEDIAN FAMILY ANNUAL INCOME (2010 DOLLARS)	POPULATION IN POVERTY (ALL AGES)	ALL RELATED CHILDREN (0-5) IN POVERTY
Gila River Indian Community	$25,403	53%	64%
District 1	$12,375	66%	-
District 2	$36,071	26%	-
District 3	$28,667	53%	-
District 4	$28,611	51%	-
District 5	$23,722	53%	-
District 6	$18,438	59%	-
District 7	$27,708	41%	-
All Arizona Reservations	-	40%	53%
Pinal County	$55,856	15%	21%
Arizona	$59,563	17%	27%

US Census (2013). American Community Survey 5-Year Estimates, 2008-2012, Table B17001. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
Note: Because of small sample sizes estimates for the districts cannot be reliably calculated

In general, women are more likely to be living in poverty than men for a number of reasons: 1) they are more likely to be out of the workforce, 2) they are more likely to be in low-paying jobs, and 3) they are more likely to be solely responsible for children. In 2012, 79 percent of low-income single-parent households in Arizona were headed by women.[14]

The proposed increase in the federal minimum wage would have an effect on a portion of Arizona families, especially those headed by women. A recent study estimated that 21 percent of the Arizona workforce would be affected by increasing the federal minimum wage to $10.10 by July 2016, and this in turn would impact 18 percent of Arizona children (who have at least

[14] Castelazo, M. (2014). Supporting Arizona Women's Economic Self-Sufficiency. An Analysis of Funding for Programs that Assist Low-income Women in Arizona and Impact of those Programs. Report Produced for the Women's Foundation of Southern Arizona by the Grand Canyon Institute. Retrieved from http://www.womengiving.org/wp-content/uploads/2014/03/WFSA-GCI-Programs-Supporting-Women_FINAL.pdf

one of their parents affected by this change).[15] In many of Arizona's rural counties, wages are low and poverty is high, and an across the board increase in wages could have a marked affect.

Table 9 below shows the median annual income for families with children birth to 17 by type of family.

Table 9. Median family annual income for families with children (0-17)

GEOGRAPHY	MEDIAN FAMILY INCOME			
	ALL FAMILIES	HUSBAND-WIFE FAMILIES	SINGLE MALE FAMILIES	SINGLE FEMALE FAMILIES
Gila River Indian Community	$25,403	$63,850	$28,000	$10,474
District 1	$12,375	-	-	-
District 2	$36,071	-	$41,932	-
District 3	$28,667	$63,000	$30,603	$26,125
District 4	$28,611	$78,031	-	$6,622
District 5	$23,722	$86,500	$10,884	$11,422
District 6	$18,438	$28,571	$25,208	$8,182
District 7	$27,708	$64,750	-	-
All Arizona Reservations	-	-	-	-
Pinal County	$55,856	$65,905	$42,011	$25,719
Arizona	$59,563	$73,166	$36,844	$26,314

US Census (2013). American Community Survey 5-Year Estimates, 2008-2012, Table B19126. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
Note: Because of small sample sizes estimates for some districts cannot be reliably calculated

Unemployment

Parental job loss results in families having fewer resources to meet their regular monthly expenses and support their children's development. This is especially pronounced when the family income was already low before the job loss, the unemployed parent is the only breadwinner in the household or parental unemployment lasts for a long period of time. Family dynamics can also be negatively impacted by job loss as reflected in higher levels of parental stress, family conflict and more punitive parental behaviors. Parental job loss can also impact children's school performance (i.e. lower test scores, poorer attendance, higher risk of grade repetition, suspension or expulsion among children whose parents have lost their jobs).[16]

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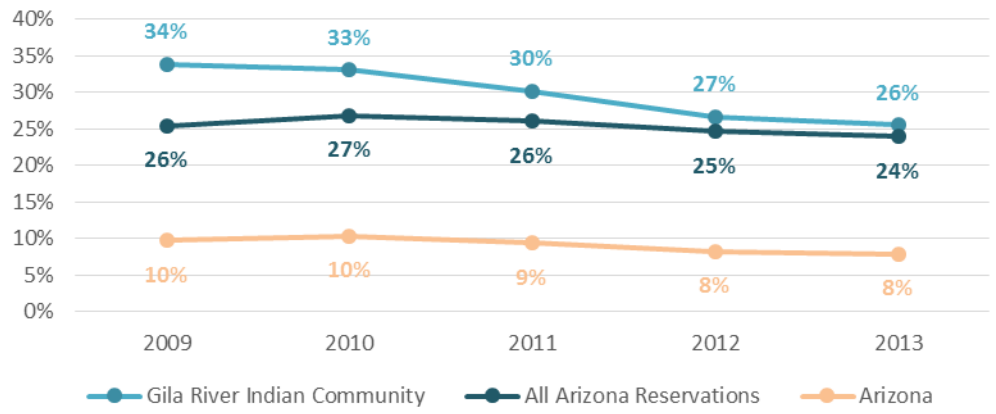
[15] Raising the Federal Minimum Wage to $10.10 Would Lift Wages for Millions and Provide a Modest Economic Boost. Cooper, D. Economic Policy Institute, Briefing Paper #371, December 19, 2013. Retrieved from http://www.epi.org/publication/raising-federal-minimum-wage-to-1010

[16] Isaacs, J. (2013). Unemployment from a child's perspective. Retrieved from: http://www.urban.org/UploadedPDF/1001671-Unemployment-from-a-Childs-Perspective.pdf

Annual unemployment rates, therefore, can be an indicator of family stress, and are also an important indicator of regional economic vitality. As shown in Figure 6 below, the unemployment rate in the state of Arizona and all Arizona reservations decreased only slightly from 2009 to 2013. In the Gila River Indian Community the unemployment rate has decreased more substantially in the same period. Data from the Gila River Indian Community for the year 2013 show an unemployment rate of 26%, similar to that of all Arizona reservations (24%), but still substantially higher than the state rate of 8%.

Figure 6. Annual unemployment rates in the Gila River Indian Community, All Arizona Reservations and the state, 2009-2013



Arizona Department of Administration, Office of Employment and Population Statistics (2014). Special Unemployment Report, 2009-2014. Retrieved from http://www.workforce.az.gov/local-area-unemployment-statistics.aspx

Table 10 below shows the employment status of parents of young children. Almost half of the young children in the region (48%) live with a single parent who is not in the labor force. In all Arizona reservations combined, about a third of the children live with a single parent who is not in the labor force.

Table 10. Employment status of parents of young children

GEOGRAPHY	CHILDREN (0-5) LIVING WITH TWO PARENTS			CHILDREN (0-5) LIVING WITH SINGLE PARENT	
	BOTH PARENTS IN LABOR FORCE	ONE PARENT IN LABOR FORCE	NEITHER PARENT IN LABOR FORCE	PARENT IN LABOR FORCE	PARENT NOT IN LABOR FORCE
Gila River Indian Community	11%	1%	1%	39%	48%
District 1	0%	0%	0%	58%	42%
District 2	-	-	-	-	-
District 3	10%	0%	0%	28%	62%
District 4	18%	0%	0%	35%	48%
District 5	9%	0%	0%	43%	48%
District 6	8%	6%	5%	46%	35%
District 7	61%	10%	0%	0%	29%
All Arizona Reservations	14%	11%	2%	39%	34%
Pinal County	33%	33%	2%	24%	10%
Arizona	32%	29%	1%	28%	10%

US Census (2013). American Community Survey 5-Year Estimates, 2008-2012, Table B23008. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
Note: Because of small sample sizes estimates for District 2 cannot be reliably calculated
Note: "In labor force" includes adults who are employed or looking for employment

The percentage of housing units in the region that have housing problems and severe housing problems is higher than the state rate but similar to the rate of all Arizona reservations combined. The US Department of Housing and Urban Development defines housing units with "housing problems" as housing units lacking complete kitchen facilities or complete plumbing facilities, housing units that are overcrowded (with more than 1 person per room), or housing units for which housing costs exceed 30% of income. Housing units with "severe housing problems" consist of housing units lacking complete kitchen facilities or complete plumbing facilities, housing units that are overcrowded (with more than 1.5 person per room), or housing units for which housing costs exceed 50% of income.[17] Districts 3 and 7 though appear to be the ones most affected by housing problems in the Gila River Indian Community Region.

[17] US Department of Housing and Urban Development (2011). CHAS Background. Retrieved from http://www.huduser.org/portal/datasets/cp/CHAS/bg_chas.html

Table 11. Percent of housing units with housing problems

GEOGRAPHY	TOTAL HOUSING UNITS	HOUSING PROBLEMS	SEVERE HOUSING PROBLEMS
Gila River Indian Community	3,083	43%	36%
District 1	294	46%	23%
District 2	228	24%	24%
District 3	600	56%	50%
District 4	591	37%	30%
District 5	554	46%	42%
District 6	474	31%	26%
District 7	105	57%	50%
All Arizona Reservations	45,911	45%	38%
Pinal County	118,883	37%	18%
Arizona	2,326,354	38%	20%

US Department of Housing and Urban Development (2011). CHAS 2008-2010 ACS 3-year average data by place. Retrieved from http://www.huduser.org/portal/datasets/cp/CHAS/data_download_chas.html

Public Assistance Programs

Participation in public assistance programs is an additional indicator of the economic circumstances in the region. Public assistance programs commonly used by families with young children in Arizona include Nutrition Assistance (SNAP, Supplemental Nutrition Assistance Program, formerly known as "food stamps"), Temporary Assistance for Needy Families (TANF, which replaced previous welfare programs), and Women, Infants, and Children (WIC, food and nutrition services).

Supplemental Nutrition Assistance Program (SNAP)

Nutritional Assistance, or SNAP, helps to provide low income families in Arizona with food through retailers authorized to participate in the program. According to the U.S. Department of Agriculture Economic Research Service, in 2010, about 20 percent of Arizonans lived in food deserts, defined as living more than a half-mile from a grocery in urban areas and more than 10 miles in rural areas.[18] Families living in food deserts often use convenience stores in place of grocery stores. New legislation in 2014 could have an effect on what's available in these stores, as they will have to begin stocking "staple foods" (such as bread or cereals, vegetables or fruits, dairy products, and meat, poultry or fish) to continue accepting SNAP.[19] The estimated proportion of young children in the region receiving SNAP has increased substantially over the

[18] http://www.ers.usda.gov/data-products/food-access-research-atlas/about-the-atlas.aspx#.UxitQ4VRKwt

[19] http://cronkitenewsonline.com/2014/02/new-food-stamp-requirements-could-affect-arizona-convenience-stores/

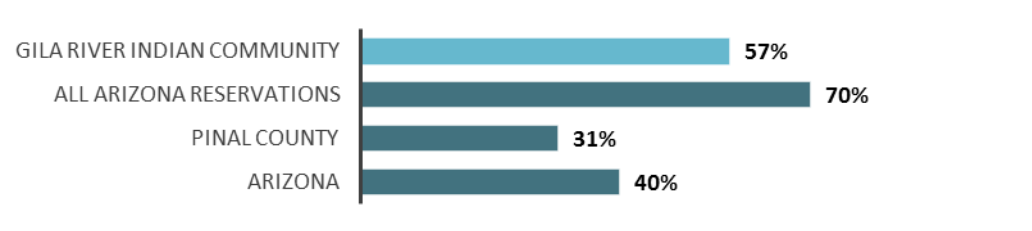
last several years (Table 12). However, as Figure 7 shows, the most recent estimate for the region (January 2012, 57%) is still lower than the estimate for all Arizona reservations (70%).

Table 12. Monthly snapshots of children ages 0-5 receiving SNAP (Supplemental Nutritional Assistance Program)[20]

GEOGRAPHY	2010 CENSUS POPULATION (AGES 0-5)	JANUARY 2010	JANUARY 2011	JANUARY 2012	CHANGE 2010-2012
Gila River Indian Community	1,530	25%	46%	57%	+128%
All Arizona Reservations	20,511	66%	68%	70%	+7%
Pinal County	36,181	27%	28%	31%	+12%
Arizona	546,609	39%	37%	40%	+2%

Arizona Department of Economic Security (2014). [SNAP data set]. Unpublished raw data received from the First Things First State Agency Data Request
US Census (2010). Table P14. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
Note: The "Change from 2010 to 2012" column shows the amount of increase or decrease, using 2010 as the baseline. The percent change between two given years is calculated using the following formula: (Number in Year 2 – Number in Year 1)/Number in Year 1 x 100

Figure 7. Monthly snapshot of children ages 0-5 receiving SNAP in January 2012



Arizona Department of Economic Security (2014). [SNAP data set]. Unpublished raw data received from the First Things First State Agency Data Request

Twenty five percent of children enrolled in the Gila River Indian Community Head Start program received SNAP benefits in the 2012-2013. In the same year, 14 percent of children in the Gila River Early Head Start Program participated in the SNAP program.[21]

[20] Data for this table were provided by FTF through their State Agency Data Request at the zip code level. We applied the following formula to estimate a share of the numbers to the Gila River Indian Community Region: we used the percentage of each zip code area's population of children 0-5 which are Gila River Indian Community residents and then applied these percentages SNAP data to calculate estimates of SNAP recipients for the Gila River Indian Community Region.

[21] Office of Head Start (2013). 2013 Performance Indicator Report Data Extract. Retrieved from https://hses.ohs.acf.hhs.gov/pir/

Temporary Assistance for Needy Families (TANF)

At the state level, the number of children receiving TANF has decreased over the last several years. This is likely due to new eligibility rules and state budget cuts to the program, which have been enacted annually by state lawmakers. In addition, a 2011 rule which takes grandparent income into account has led to a decline in child-only TANF cases, and fiscal year 2012 budget cuts limited the amount of time that families can receive TANF to two years.[22] Over the last decade federal TANF funds have also been increasingly re-directed from cash assistance, jobs programs and child care assistance to Child Protective Services. Federal cuts to funding to support TANF, including supplemental grants to high growth states, have also been enacted. It is estimated that there will be a deficit in Arizona TANF funds between 10 and 29 million dollars in fiscal year 2014, with a projected to increase to 20-39 million dollars in fiscal year 2015.[23] This decreasing trend in the number of TANF recipients can be seen across all Arizona reservations combined and the state as a whole. In the Gila River Indian Community, however, the estimated percent of young children receiving TANF benefits has increased somewhat, as shown in Table 13.

Table 13. Monthly snapshots of children ages 0-5 receiving TANF (Temporary Assistance for Needy Families)

GEOGRAPHY	POPULATION (AGES 0-5)	JANUARY 2010	JANUARY 2011	JANUARY 2012	CHANGE 2010-2012
Gila River Indian Community	1,530	5%	5%	6%	+29%
All Arizona Reservations	20,511	9%	5%	4%	-53%
Pinal County	36,181	3%	2%	1%	-49%
Arizona	546,609	4%	2%	2%	-48%

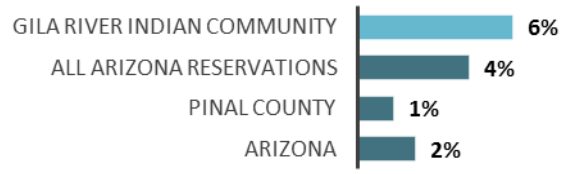
Arizona Department of Economic Security (2014). [TANF data set]. Unpublished raw data received from the First Things First State Agency Data Request

Note: The "Change from 2010 to 2012" column shows the amount of increase or decrease, using 2010 as the baseline. The percent change between two given years is calculated using the following formula: (Number in Year 2 – Number in Year 1)/Number in Year 1 x 100

[22] Reinhart, M. K. (2011). *Arizona budget crisis: Axing aid to poor may hurt in long run.* The Arizona Republic: Phoenix, AZ. Retrieved from http://www.azcentral.com/news/election/azelections/articles/2011/04/17/20110417arizona-budget-cuts-poor-families.html

[23] The Arizona Children's Action Alliance. *Growing up Poor in Arizona: State Policy at a Crossroads.* May 2013. http://azchildren.org/wp-content/uploads/2013/06/TANF_report_2013_ForWeb.pdf

Figure 8. Monthly snapshot of children ages 0-5 receiving TANF in January 2012



Arizona Department of Economic Security (2014). [TANF data set]. Unpublished raw data received from the First Things First State Agency Data Request

Similar rates of TANF participation can be seen among children enrolled in the Gila River Indian Community Head Start (5%) and Early Head Start Program (3%).[24]

Gila River Indian Community Women, Infants and Children (WIC) Program

WIC is a federally-funded nutrition program which services economically disadvantaged pregnant, postpartum, and breastfeeding women, as well as infants and children under the age of five. More than half of the pregnant and postpartum women, infants, and children under age five are estimated to be eligible for WIC in Arizona, and in 2011, Arizona WIC served approximately 62 percent of the eligible population.[25] A primary goal of the WIC program is obesity prevention through the promotion of breastfeeding, nutritious diet, and physical activity. Changes to WIC in 2009 may in fact be impacting childhood obesity. In that year, WIC added vouchers for produce and also healthier items such as low-fat milk. Studies following the change have shown increases in purchases of whole-grain bread and brown rice,[26] and of reduced-fat milk,[27] and fewer purchases of white bread, whole milk, cheese and juice.[28]

In many Arizona tribal communities the WIC program was initially funded through the state of Arizona. Over time, however, several tribes advocated for services that were directed by the tribes themselves and that met the needs of tribal members. As part of this effort, in 1986 the

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[24] *Office of Head Start (2013). 2013 Performance Indicator Report Data Extract. Retrieved from https://hses.ohs.acf.hhs.gov/pir/*

[25] Arizona Department of Health Services, Bureau of Nutrition and Physical Activity. (2013). WIC needs assessment. Retrieved from http://www.azdhs.gov/azwic/documents/local_agencies/reports/wic-needs-assessment-02-22-13.pdf

[26] Andreyeva, T. & Luedicke, J. Federal Food Package Revisions Effects on Purchases of Whole-Grain Products. (2013). American Journal of Preventive Medicine, 45(4):422–429

[27] Andreyeva, T., Luedicke, J., Henderson, K. E., & Schwartz, M. B. (2013). The Positive Effects of the Revised Milk and Cheese Allowances in the Special Supplemental Nutrition Program for Women, Infants, and Children. Journal of the academy of nutrition and dietetics, Article in Press. http://www.yaleruddcenter.org/resources/upload/docs/what/economics/WIC_Milk_and_Cheese_Allowances_JAND_11.13.pdf

[28] Andreyeva, T., Luedicke, J., Tripp, A. S., & Henderson, K. E. (2013). Effects of Reduced Juice Allowances in Food Packages for the Women, Infants, and Children Program. Pediatrics, 131(5), 919-927.

Inter Tribal Council of Arizona (ITCA), led by the by Colorado River Indian Tribes, Gila River Indian Community, Salt River Pima-Maricopa Indian Community and the Tohono O'odham Nation, applied for and received approval to become a WIC state agency through the USDA, initially funding seven Tribes. Currently, the ITCA WIC program provides services to 13 reservation communities and the Indian urban populations in the Phoenix and Tucson area.[29] The Gila River Indian Community WIC is one of the tribally operated programs under the ITCA WIC umbrella. As of May 1, 2014, the program's funded caseload is 1,175 (the previous year it had been 1,150).

The Gila River Indian Community WIC program provides services to Community members and also to residents of the surrounding communities of Casa Grande, Chandler and Coolidge. The table below shows the number of WIC clients (women, infant and children) participating in the program, which has increased overall since 2012. In January of 2014, the number of children 0-4 served by the Gila River Indian Community WIC Program was the equivalent of three-quarters of the total population of children in that age range in the Community. WIC Programs also keep data regarding their no-show rates, which are defined as the percent of clients who are enrolled in the program but do not show up for their scheduled appointment and are therefore considered 'not-participating.' No-show rates for the Gila River Indian Community WIC Program have remained at less than 20 percent in the past three years (see Table 14).

Table 14. Gila River Indian Community WIC Program participation, 2012-2014

MONTH	WOMEN	INFANTS	CHILDREN (1-4)	TOTAL	% INFANTS AND CHILDREN 0-4	NO-SHOW RATE
January 2012	258	298	588	1,144	69%	19%
January 2013	263	319	571	1,153	70%	19%
January 2014	276	329	626	1,231	75%	16%

Gila River Indian Community WIC Program. (2014). January 2014, January 2013 and January 2012 Caseload Management Reports. Unpublished data provided by the Gila River Indian Community WIC Program.
US Census (2010). Table P14. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
The percent of infants and children 0-4 is calculated using the Census 2010 population of children in that age range.

According to program staff, families who live off the reservation boundaries but receive prenatal care at Gila River Health Care facilities also choose to access WIC services from the Community's program. This may help explain the high enrollment rate.

[29] http://itcaonline.com/wp-content/uploads/2012/01/2010-Annual-Report.pdf

The Gila River Indian Community Head Start and Early Head Start Program Information Reports show that 55 percent of children enrolled in Early Head Start and 58 percent of children enrolled in Head Start receive WIC benefits.[30]

Free and Reduced Lunch

Free and Reduced Lunch is a federal assistance program providing free or reduced price meals at school for students whose families meet income criteria. These income criteria are 130 percent of the Federal Poverty Level (FPL) for free lunch, and 185 percent of the FPL for reduced price lunch. The income criteria for the 2014-2015 school year are shown below.

Table 15: Free and reduced lunch eligibility requirements for 2014-2015 school year

FEDERAL INCOME CHART: 2014-2015 SCHOOL YEAR						
	FREE MEALS – 130%			REDUCED PRICE MEALS – 185%		
Household Size	Yearly Income	Monthly Income	Weekly Income	Yearly Income	Monthly Income	Weekly Income
1	$15,171	$1,265	$292	$21,590	$1,800	$416
2	$20,449	$1,705	$394	$29,101	$2,426	$560
3	$25,727	$2,144	$495	$36,612	$3,051	$705
4	$31,005	$2,584	$597	$44,123	$3,677	$849
5	$36,283	$3,024	$698	$51,634	$4,303	$993
6	$41,561	$3,464	$800	$59,145	$4,929	$1,138
7	$46,839	$3,904	$901	$66,656	$5,555	$1,282
8	$52,117	$4,344	$1,003	$74,167	$6,181	$1,427
Each Additional Person	$5,278	$440	$102	$7,511	$626	$145

http://www.fns.usda.gov/sites/default/files/2014-04788.pdf

As Table 16 shows, a large proportion of the students in the school districts that serve children from the Community (except for the Kyrene Elementary District) are eligible for free or reduced

[30] Office of Head Start (2013). *2013 Performance Indicator Report Data Extract.* Retrieved from https://hses.ohs.acf.hhs.gov/pir/

lunch (for a map showing the school districts and how they overlap with the Community boundaries see Figure 9 below).

Table 16. Free and reduced lunch eligibility by school district

SCHOOL DISTRICT NAME	PERCENT ELIGIBLE FOR FREE OR REDUCED LUNCH
Coolidge Unified District	66%
Kyrene Elementary District	29%
Sacaton Elementary District	82%
Union Elementary District	85%

Arizona Department of Education (2014). Percentage of children approved for free or reduced-price lunches, October 2013. Retrieved from http://www.azed.gov/health-nutrition/frpercentages/

Educational Indicators

A national report released in 2012 by the Annie E. Casey Foundation ranked Arizona among the ten states with the lowest score for children's educational attainment.[31] More recent reports have illustrated similar concerns: *Quality Counts*, an annual publication of the Education Week Research Center, gave Arizona an overall K-12 education rank of 43 in 2013.[32] A 2013 Census Bureau report indicates that Arizona schools receive less in state funding than most states. In 2011, Arizona schools received about 37 percent of their funding from the state, compared to a national average of about 44 percent. The report also found that Arizona has one of the lowest per-pupil expenditures nationally. Arizona spent $7,666 per pupil in 2011, below the national average of $10,560 for that year. Arizona also spent the lowest amount nationally on school administration in 2011.[33]

The educational system in the Gila River Indian Community includes schools operated by the Arizona Department of Education (ADE), Bureau of Indian Education (BIE) schools, and schools chartered under the Community.

The Sacaton School District, which includes Sacaton Elementary School and Sacaton Middle School, is the only ADE district that lies fully within the reservation boundaries.

Figure 9 below shows the school districts on and around the reservation boundaries.

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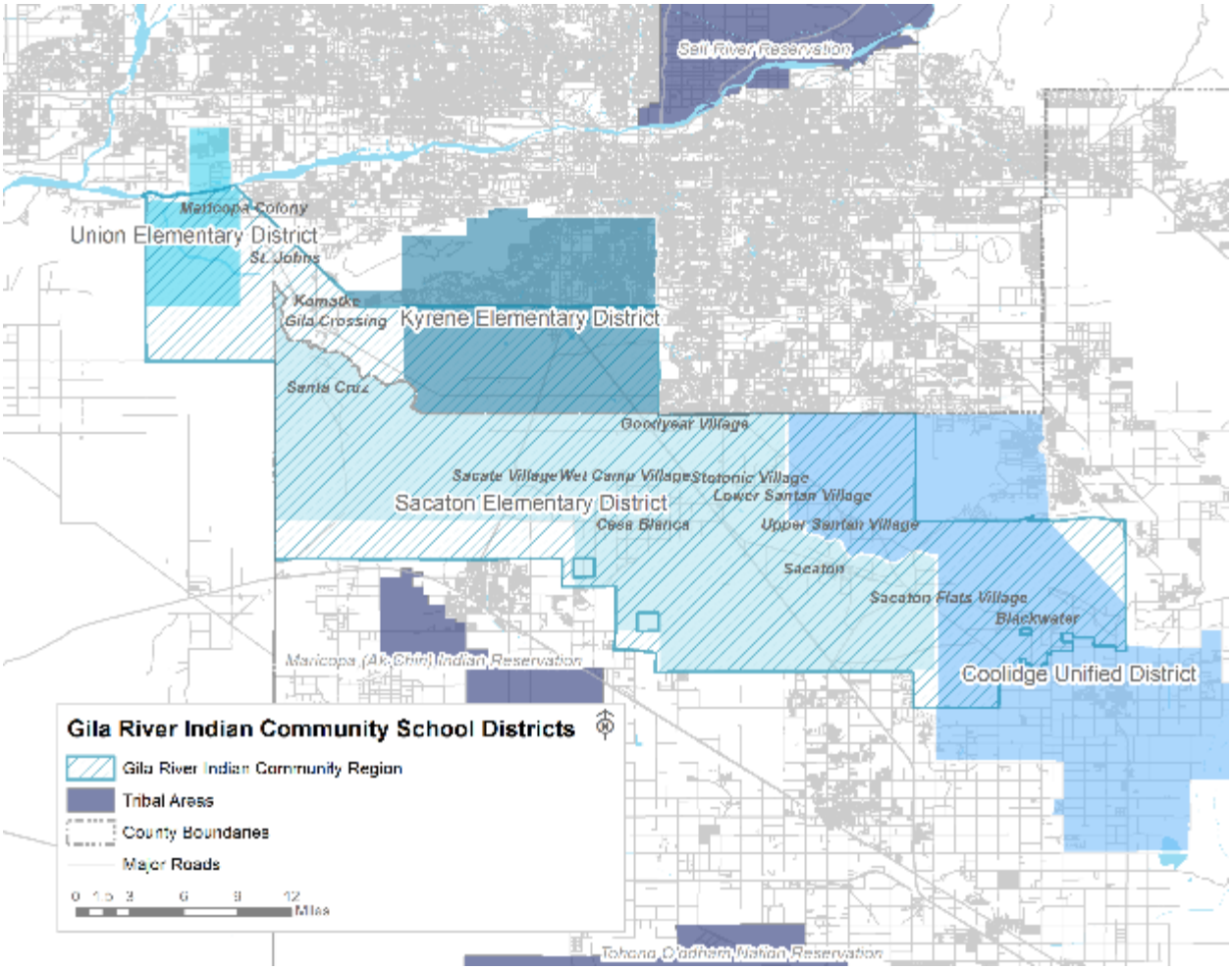
[31] Annie E. Casey Foundation. (2012). *Analyzing State Differences in Child Well-being*. O'Hare, W., Mather, M., & Dupuis, G.

[32] Education Week. (2014). *Quality Counts 2013 Highlights*. Retrieved from http://www.edweek.org/media/QualityCounts2013_Release.pdf

[33] Dixon, M. (2013). *Public Education Finances: 2011, Government Division Reports*. Retrieved from http://www2.census.gov/govs/school/11f33pub.pdf.

Figure 9. School districts serving the Gila River Indian Community Region



Source: 2010 TIGER/Line Shapefiles prepared by the US Census, 2010

Blackwater Community School, Casa Blanca Community School and Gila Crossing Community Schools are all BIE grant schools.

Akimel O'Otham Pee Posh Charter School and Blackwater Community School operate as one school under a unique partnership between federal, state and tribal governments; according to the school's website, the charter school is located on federal trust land operated under the Bureau of Indian Affairs, Bureau of Indian Education (BIE). The school was established as a K-2 day school (currently Blackwater Community School, serving preschool to second grade). In order to expand to higher grades, the school board and administration requested permission from BIE for the school to apply as a state charter school for grades 3 – 5. This was granted and in 2000 the State Board of Charters approved the application.

In the fall of 2012, the principal of Blackwater Community School, Jacqueline Power, was named as one of the 2012 National Distinguished Principals. She was the first principal of a Native American School to receive this recognition.[34]

Casa Blanca Community School is a single-school district serving children from kindergarten to 4th grade. The school describes itself as a safe and drug-free educational environment in which cultural identity and respect for the history and language of the Gila River Indian Community are combined with knowledge of the present. The school prides itself on offering a student to teacher ratio of 18:1.[35]

Gila Crossing Community School located on the northwest corner of the Gila River Indian Community, serves pre-K to eighth grade students with a current enrollment of about 500 students. Gila Crossing was formerly a Bureau of Indian Affairs School and in 1995 it became a grant school chartered under the Gila River Indian Community. It is the largest Bureau-funded school in the Community. In January of 2002 the school took over a neighborhood school formerly known as Estrella Mountain Accommodation School. The new location became Gila Crossing Community School North Campus, currently called Middle School.[36]

New legislation at the federal and state levels have the objective of improving education in Arizona and nationwide. These initiatives are described in the following sections.

Common Core/Early Learning Standards

The Common Core State Standards Initiative is a nationwide initiative which aims to establish consistent education standards across the United States in order to better prepare students for college and the workforce. The initiative is sponsored by the Council of Chief State School Officers (CCSO) and the National Governors Association (NGA). Common Core has two domains of focus: English Language Arts/Literacy (which includes reading, writing, speaking and listening, language, media and technology), and Mathematics (which includes mathematical practice and mathematical content). The initiative provides grade-by-grade standards for grades K-8, and high school student standards (grades 9-12) are aggregated into grade bands of 9-10 and 11-12.

To date, 44 states and the District of Columbia have adopted the Common Core State Standards. Arizona adopted the standards in June of 2010 with the creation of Arizona's College and Career Ready Standards (AZCCRS). A new summative assessment system which reflects

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[34] National Center for Family Literacy. (January 2013). *Blackwater Community School FACE Site Visit Report*. Unpublished report provided by Blackwater Community School.

[35] More information about the school's mission and vision can be found at: http://www.cbcschools.com/index.cfm?pID=5995

[36] http://www.gccseagles.org/

AZCCRS will be implemented in the 2014-2015 school year. This assessment will replace the AIMS test. More information about the Common Core State Standards Initiative can be found at www.corestandards.org, and additional information about AZCCRS can be found at http://www.azed.gov/azccrs.

Move on When Ready

The Arizona Move on When Ready Initiative is a state law (A.R.S. Title 15, Chapter 7, Article 6) and is part of the National Center on Education and the Economy's *Excellence For All* pilot effort. Move on When Ready is a voluntary performance-based high school education model that aims to prepare all high school students for college and the workforce.

Key components of the Move on When Ready model include offering students individualized education pathways; moving away from a "one-size-fits-all" educational approach; and a new performance-based diploma called the Grand Canyon Diploma that can be awarded voluntarily to students. Grand Canyon Diplomas have been available since the 2012-2013 academic year. They can be awarded to high school students who have met the subject area requirements specified by the statute and who also meet college and career qualification scores on a series of exams. After a student earns a Grand Canyon Diploma, he or she can opt to remain in high school, enroll in a full-time career and technical education program, or graduate from high school with the Grand Canyon Diploma and attend a community college.

Schools may participate in Move on When Ready on a voluntary basis. As of April 2014, the Center for the Future of Arizona reported that 38 schools were participating in Move on When Ready. None of the school districts in the region are currently participating in this initiative.

Educational Attainment

Several socioeconomic factors are known to impact student achievement, including income disparities, health disparities, and adult educational attainment.[37] Some studies have indicated that the level of education a parent has attained when a child is in elementary school can predict educational and career success for that child forty years later.[38]

Adults in the Gila River Indian Community show lower levels of education than the state of Arizona overall and all Arizona reservations combined with 36 percent of adults in the region

[37] Annie E. Casey Foundation. (2013). *The First Eight Years: Giving kids a foundation for lifetime success*. Retrieved from http://www.aecf.org/~/media/Pubs/Initiatives/KIDS%20COUNT/F/FirstEightYears/AECFTheFirstEightYears2013.pdf

[38] Merrill, P. Q. (2010). Long-term effects of parents' education on children's educational and occupational success: Mediation by family interactions, child aggression, and teenage aspirations. *NIH Public Manuscript*, Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2853053/

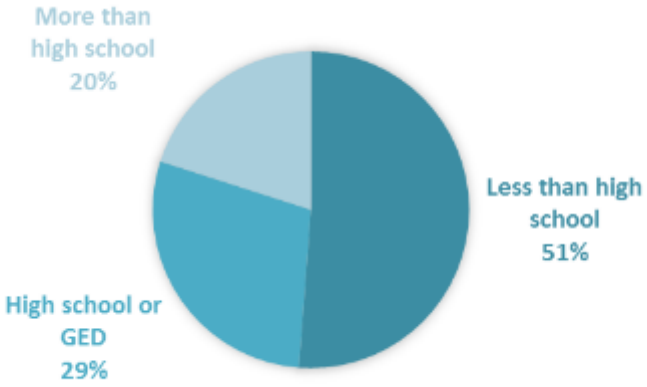
without a high school diploma or GED (see Table 17). In addition, more than half of births in the region are to women without a high school diploma (see Figure 10).

Table 17. Educational achievement of adults

GEOGRAPHY	Adults (ages 25+) without a high school diploma or GED	Adults (ages 25+) with a high school diploma or GED	Adults (ages 25+) with some college or professional training	Adults (ages 25+) with a bachelor's degree or more
Gila River Indian Community	36%	34%	26%	4%
District 1	46%	38%	17%	0%
District 2	31%	17%	46%	6%
District 3	33%	32%	32%	3%
District 4	39%	39%	18%	3%
District 5	29%	34%	31%	6%
District 6	45%	37%	13%	4%
District 7	36%	27%	33%	4%
All Arizona Reservations	30%	33%	29%	7%
Pinal County	16%	29%	37%	18%
Arizona	15%	24%	34%	27%

US Census (2013). American Community Survey 5-Year Estimates, 2008-2012, Table B15002. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml

Figure 10. Births by mother's educational achievement on the Gila River Indian Reservation Region (2009-2012)



Arizona Department of Health Services (2014). [Vital Statistics data set]. Unpublished raw data received from the First Things First State Agency Data Request

Youth in the Gila River Indian Community attend high schools at two local alternative charter schools (Ira H. Hayes High School and Vechij Himdag MashchamakuD), off-reservation boarding schools, and off-reservation public high schools in the surrounding communities. In the 2013-

2014 school year, there were 66 students enrolled at Ira H. Hayes High School and 74 students enrolled at Vechij Himdag MashchamakuD.[39]

Vechij Himdag MashchamakuD high school (VHM) constitutes a major asset in the community, providing at-risk youth with opportunities to continue with their education and receive job training so they can graduate and go to college with work experience and technical training. After going through a major restructuring process that reorganized the academic program and curriculum in the summer of 2009, VHM high school currently offers a combination of online and traditional classes; for their online work, each student has access to a laptop computer and tutors are available on-site to provide any needed assistances. According to school staff, partnering with the community was a crucial element of the restructuring process and the consequent success the school has experienced in the years after. VHM high school emphasizes the need to set a high level of academic rigor while removing, to the extent possible, the barriers that at-risk youth face when trying to stay in school and graduate.

VHM works closely with a wide range of community partners and tribal agencies and departments. Establishing these close partnerships was an important aspect of the restructuring process; it has helped the school successfully place its students in training opportunities and connect enrolled youth to services available to them.

Early Education and School Readiness

The positive impacts of quality early education have been well-documented. Previous research indicates that children who attend high-quality preschools have fewer behavior problems in school later on, are less likely to repeat a grade, are more likely to graduate high school, and have higher test scores.[40] Enrollment in preschool provides children with social, emotional and academic experiences that optimally prepare them for entry into kindergarten. In 2012 in Arizona, two-thirds of children aged three and four were not enrolled in preschool (compared to half of children this age nationally). In 2013, Arizona was ranked 3rd to last nationally in the number of preschool aged children enrolled in preschool.[41] In the Gila River Indian Community Region, the estimated proportion of children ages 3 and 4 who are enrolled in early education settings (39%) is about the same as that of all Arizona reservations (41%). Both of these estimates are higher than the percent of children estimated to be enrolled in early education

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[39] *Arizona Department of Education (2014). October 1 Enrollment 2013-2014. Retrieved from http://www.azed.gov/research-evaluation/arizona-enrollment-figures/*

[40] Annie E. Casey Foundation. (2013). *The First Eight Years: Giving kids a foundation for lifetime success*. Retrieved from http://www.aecf.org/~/media/Pubs/Initiatives/KIDS%20COUNT/F/FirstEightYears/AECFTheFirstEightYears2013.pdf

[41] Children's Action Alliance. Retrieved from http://azchildren.org/wp-content/uploads/2014/01/2013-NAEP-Fact-Sheet-one-sided-version.pdf

settings at the state level, suggesting that children living in tribal communities may be more likely to access early childhood opportunities than children who live in non-tribal areas.

Table 18. Children (3-4) enrolled in nursery school, preschool, or kindergarten

GEOGRAPHY	2010 CENSUS PRESCHOOL-AGE CHILDREN (AGES 3-4)	ESTIMATED PERCENT OF CHILDREN (AGES 3-4) ENROLLED IN NURSERY SCHOOL, PRESCHOOL, OR KINDERGARTEN
Gila River Indian Community	546	39%
District 1	53	-
District 2	20	-
District 3	119	52%
District 4	115	32%
District 5	89	17%
District 6	106	36%
District 7	44	-
All Arizona Reservations	6,881	41%
Pinal County	12,348	28%
Arizona	185,196	34%

US Census (2010). Table P14. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml; US Census (2013). American Community Survey 5-Year Estimates, 2008-2012, Table B14003. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
Note: Because of small sample sizes, estimates for some districts cannot be reliably calculated

Arizona reduced funding for kindergarten from full-day to half-day in 2010, and eliminated funds for pre-K programs in 2011. First Things First funds a limited number of preschool scholarships across the state, including $13.7 million for Pre-K Scholarships and $39 million for Quality First Scholarships in FY 2013.[42] More information about how these scholarships are used in the Gila River Indian Community Region can be found in the *Early Childhood System* section of this report**.**

First Things First has developed Arizona School Readiness Indicators, which aim to measure and guide progress in building an early education system that prepares Arizona's youngest citizens to succeed in kindergarten and beyond. The Arizona School Readiness Indicators are: children's health (well-child visits, healthy weight, and dental health); family support and literacy (confident families); and child development and early learning (school readiness, quality early education, quality early education for children with special needs, affordability of quality early

[42] The Build Initiative. Arizona State Profile. Retrieved from http://www.buildinitiative.org/Portals/0/Uploads/Documents/ArizonaProfileFinal.pdf

education, developmental delays identified in kindergarten, and transition from preschool special education to kindergarten).[43]

Standardized Test Scores

The primary in-school performance of current students in the public elementary schools in the state is measured by Arizona's Instrument to Measure Standards (AIMS).[44] AIMS is required by both state and federal law, and is used to track how well students are performing compared to state standards. Performance on AIMS directly impacts students' future progress in school. As of the 2013-2014 school year, Arizona's revised statute[45] (also known as *Move on When Reading*) states that a student shall not be promoted from the third grade "if the pupil obtains a score on the reading portion of the Arizona's Instrument to Measure Standards (AIMS) test…that demonstrates that the pupil's reading falls far below the third-grade level." Exceptions exist for students with learning disabilities, English language learners, and those with reading deficiencies.

The tables below show the math and reading AIMS test scores for schools on the reservation (Sacaton Elementary District and Akimel O'Otham Pee Posh Charter School) as well as other districts whose boundaries overlap with those of the region. Overall, the Sacaton Elementary third graders performed similarly to students statewide in math, but showed a slightly lower level of achievement in reading when compared to Arizona third graders. These rates, however, are an improvement from those reported on the 2012 Needs and Assets Report, where 12 percent of Sacaton Elementary students who took the test scored "far below standard" in math and the math passing rate (indicated by a combination of the percentages for "approaches" and "falls far below") was 62 percent. Similarly, the 2012 report shows 10 percent of students scoring "far below standard" in reading (compared to 0% in the table below) and 64 percent passing the reading component.

Test scores for the students in the Akimel O'Otham Pee Posh School in the reading portion of the test were similar to those of the Sacaton Elementary Children. However, the rate of students passing the math component was substantially lower than both the Sacaton Elementary and the statewide rates.

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[43] First Things First. *Arizona School Readiness Indicators.* Retrieved from: http://www.azftf.gov/Documents/Arizona_School_Readiness_Indicators.pdf

[44] For more information on the AIMS test, see the Arizona Department of Education's Website: http://www.ade.az.gov/AIMS/students.asp

[45] Arizona Revised Statute §15-701

Table 19. Math 3rd grade AIMS results, 2013

Local Education Agency (LEA)	Math Percent Falls Far Below	Math Percent Approaches	Math Percent Meets	Math Percent Exceeds	Math Percent Passing
Sacaton Elementary District	4%	27%	57%	13%	70%
Akimel O'Otham Pee Posh Charter School, Inc.	13%	50%	27%	10%	38%
Coolidge Unified District	21%	32%	35%	12%	47%
Kyrene Elementary District	4%	15%	40%	41%	81%
Union Elementary District	15%	35%	38%	12%	50%
Arizona (All charter and district schools)	9%	23%	43%	26%	68%

Arizona Department of Education (2013). AIMS and AIMSA 2013. Retrieved from http://www.azed.gov/research-evaluation/aims-assessment-results/

Table 20. Reading 3rd grade AIMS results, 2013

Local Education Agency (LEA)	Reading Percent Falls Far Below	Reading Percent Approaches	Reading Percent Meets	Reading Percent Exceeds	Reading Percent Passing
Sacaton Elementary District	0%	30%	63%	7%	70%
Akimel O'Otham Pee Posh Charter School, Inc.	2%	29%	65%	4%	69%
Coolidge Unified District	11%	37%	50%	2%	52%
Kyrene Elementary District	2%	12%	64%	22%	87%
Union Elementary District	4%	42%	53%	2%	54%
Arizona (All charter and district schools)	4%	21%	62%	13%	75%

Arizona Department of Education (2013). AIMS and AIMSA 2013. Retrieved from http://www.azed.gov/research-evaluation/aims-assessment-results/

Data about academic achievement in school year is available for BIE schools in the region.[46] Of the schools in the region, detailed data about academic achievement is available only for Casa Blanca Community School and Gila Crossing Community School. No data are available from the Akimel O' Otham Pee Posh/Blackwater Community School because they tested fewer than 10 children.

The attendance rate in Casa Blanca Community School was high, with 92 percent of students attending each day. In the 2012-2013 school year, 49 percent tested as proficient or advanced in reading, and 21 percent scored as proficient or advanced in math.[47]

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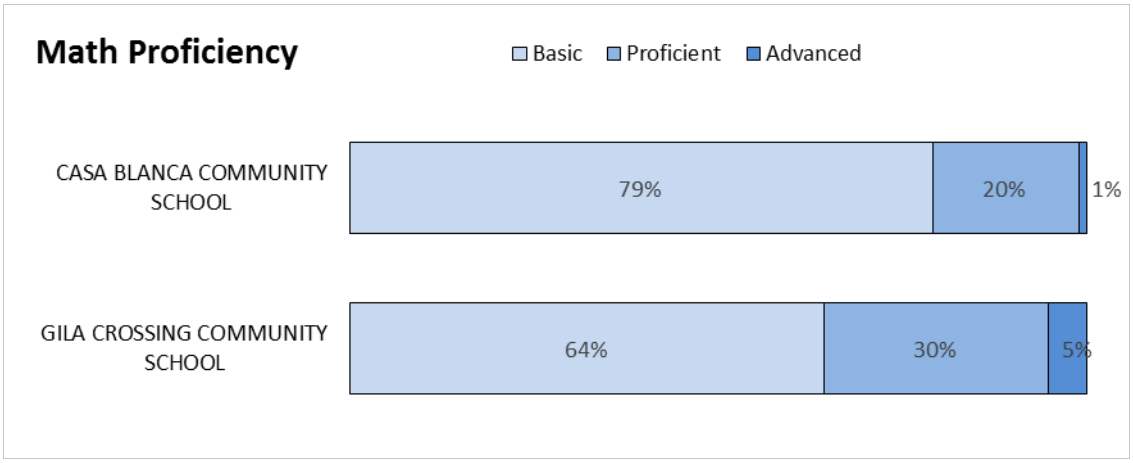
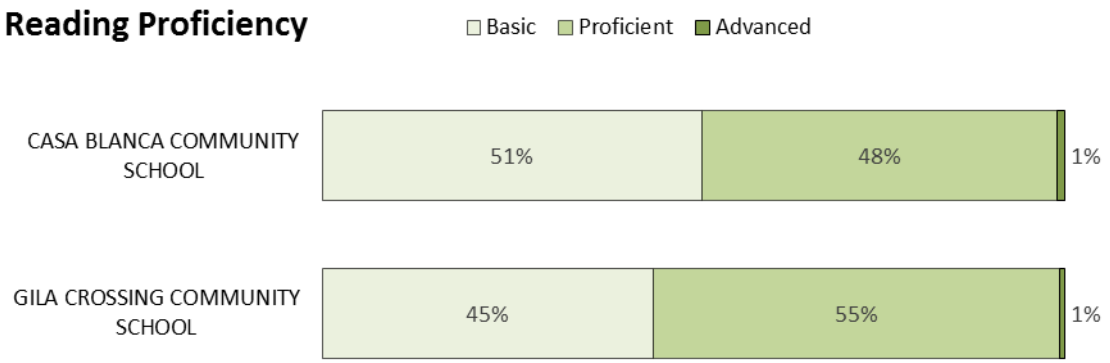
[46] Data were obtained from the BIE School Report Cards available at http://www.bie.edu/HowAreWeDoing/Scorecards/index.htm. Note that statewide comparison for all BIE schools in Arizona was not available from the School Report Cards website.

[47] http://www.bie.edu/cs/groups/xbie/documents/text/idc1-026221.pdf

In the Gila Crossing Community School the attendance rate was also high at 92 percent. Data from the 2011-2013 school year show that 55 percent of students tested as proficient or advanced in reading and 36 percent scored as proficient or advanced in math.[48]

Figure 11. Math and Reading achievement testing data, Casa Blanca Community School and Gila Crossing Community School, 2012-2013





U.S. Bureau of Indian Education Division of Performance and Accountability. (2013). School Report Card 2012-2013. Retrieved from http://www.bie.edu/HowAreWeDoing/Scorecards/index.htm

A sample of students in grades 4, 8, and 12 also takes the National Assessment of Educational Progress (NAEP), which is a nationally administered measure of academic achievement that allows for comparison to national benchmarks. A 2014 report by the Annie E Casey Foundation highlighted early reading proficiency across the nation using the National Assessment of Educational Progress data. In Arizona, the percentage of fourth graders reading at or above

[48] http://www.bie.edu/cs/groups/xbie/documents/text/idc1-026340.pdf

proficient levels increased from 23 percent in 2003 to 28 percent in 2013, compared to a national average of 34 percent in 2013.[49]

Strong disparities exist based on income. Eighty-five percent of low-income fourth graders in Arizona were reading below proficiency, compared to 57 percent of fourth graders from high income households.

Other research shows that five year-olds with lower-income, less-educated parents score more than two years behind on standardized language development tests by the time they enter kindergarten. Further, new research posits that this gap in language development begins as early as 18 months of age.[50]

This data reflects not only the need to enhance language development among Arizona's children, but also the need for increased early intervention among the state's poorest children. However, Arizona has decreased or eliminated funding for a number of child-focused programs including full-day kindergarten, Healthy Families, family literacy and the Early Childhood Block Grant. Between 2009 and 2014, Arizona's financial investment in early education is estimated to have fallen from more than $450 million to less than $150 million.[51] The need for strengthening the early childhood system at the state level is clear. The following section will highlight local efforts in this area taking place in the region.

[49] Annie E. Casey Foundation. (2014). Early Reading Proficiency in the United States. January 2014. Retrieved from http://www.aecf.org/~/media/Pubs/Initiatives/KIDS%20COUNT/E/EarlyReadingProficiency/EarlyReadingProficiency2014.pdf

[50] Carey, B. (2013). Language gap between rich and poor children begins in infancy, Stanford psychologists find. Retrieved from Stanford News http://news.stanford.edu/news/2013/september/toddler-language-gap-091213.html

[51] Children's Action Alliance. Arizona's Investment in Early Education has Fallen Substantially. Retrieved from http://azchildren.org/wp-content/uploads/2014/01/chart-for-NAEP-enews-story.pdf

The Early Childhood System: Detailed Descriptions of Assets and Needs

Quality and Access

Early Care and Education

Children who take part in high-quality early education programs have better success in school, are less likely to enter the criminal justice system,[52] and have better long-term outcomes into adulthood as seen through higher high school graduation rates, increased employment opportunities and earnings, and lower rates of depression and drug use.[53] Studies of the cost-effectiveness of investing in early education (pre-kindergarten) programs show a substantial return on investment in the long term through increases in economic productivity and decreases in expenses to the criminal justice system.[54]

Early care and education options available to parents of young children in the Gila River Indian Community include child care centers, home-based care, school-based preschools, Family and Child Education (FACE) programs, Head Start/Early Head Start Programs and off-reservation child care services. Despite the variety of options, early care for children in the Community is limited: All of these programs combined provide about 500 early childhood care and education slots available to children under six in the region. This means that about two thirds of the children ages 0 to 5 have little to no access to formal early care settings.

Center and home-based Care

School-based preschool programs - School-based preschool programs in the Gila River Indian Community Region currently include the Blackwater Community School pre-K program and the Sacaton Elementary School preschool program.

The Gila River Indian Community First Things First (FTF) Regional Partnership Council provides funding to the Blackwater Community School for a 20-student preschool program. This program is modeled after the Bureau of Indian Affairs Family and Child Education program -FACE (for more information on the FACE programs see p. 53 below). Other program components include the Houghton Mifflin Preschool Curriculum, Every Day Counts Calendar Math™, Stages of

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[52] Lynch, R. (2007). Enriching Children, Enriching the Nation (Executive Summary). Washington, DC: Economic Policy Institute. Retrieved from http://www.epi.org/content.cfm/book_enriching

[53] The Annie E Casey Foundation. *The first eight years; giving kids a foundation for lifetime success*. (2013). Retrieved from http://www.aecf.org/~/media/Pubs/Initiatives/KIDS%20COUNT/F/FirstEightYears/AECFTheFirstEightYears2013.pdf

[54] Castelazo, M. (2014). Supporting Arizona Women's Economic Self-Sufficiency. An Analysis of Funding for Programs that Assist Low-income Women in Arizona and Impact of those Programs. Report Produced for the Women's Foundation of Southern Arizona by the Grand Canyon Institute. Retrieved from http://www.womengiving.org/wp-content/uploads/2014/03/WFSA-GCI-Programs-Supporting-Women_FINAL.pdf

Writing Development Measurements, Arizona Literacy Plan (birth to five section), cultural development with O'Odham culture and language, and nutrition education through the school lunch program and GENESIS Diabetes Prevention Program.[55]

The FTF Blackwater preschool program collaborates closely with other programs in the region providing services to young children such as the Early Childhood Special Services Program providing services in the areas of speech and language development, occupational and physical therapy, counseling and behavior modification to children with special needs enrolled in the program. In addition, the Gila River Health Care school nurse is available to provide services to children in the preschool program. The Genesis Program provides health and fitness education with a cultural component to enrolled children. The preschool program also collaborates with the Blackwater FACE Program (se FACE Programs section below) on planning of lessons and activities for the children.

In addition to the FTF-funded program, Blackwater Community School was able to secure funding from the 21st Century Community Learning Centers program for another 20-student preschool program, which began in 2012-2013. Funding for this program will be available through 2015.

In school year 2012-2013 Gila Crossing Community school also received funding from the FTF Gila River Indian Community Regional Partnership Council and the Gila River Indian Community Tribal Council for two preschool classrooms that enrolled a total of 12 and 13 children each. This program was in place for only one year as funding from the Tribal Council could not be secured for the following year.

An important addition to the early childhood education system in the Community is on the way, as St. Peter Indian Mission School is currently in the process of adding two pre-K classrooms to the school. St. Peter's school staff has been working in close collaboration with the FTF Regional Director and Regional Partnership Council, as well as with staff from the Early Education Childhood Center in the planning and design of their pre-K classrooms.

Local Education Agency (LEA) Preschools

Under the No Child Left Behind Act (NCLB), Title I provides preschool, elementary, and secondary schools with financial assistance in order to assist all children, including educationally disadvantaged children, in meeting the state's academic standards. Title I funding is intended to assist schools in administering supplementary programs, such as those designed to increase parent involvement, additional instructional services, and school wide reform efforts. The U.S.

[55] Southwest Interdisciplinary Research Center. (August 2013). *Blackwater Community School Preschool Evaluation Report August 2012-June 2013*. Unpublished report provided by the Blackwater Community School

Department of Education encourages the use of these funds to support early childhood education, recognizing that this is an area that often has not had sufficient resources. Sacaton Elementary School is the LEA in the region that offers a preschool program. This program, however, exclusively serves children with special needs in the Community. The program operates two days a week from 8:00 am to 3:00 pm. By the end of the 2013-2014 school year this program enrolled a total of 23 children. As of September of 2014, there were 13 children enrolled in the program for the 2014-2015 school year, although key informants indicated that enrollment tends to increase as the school year progresses.

Table 21 below shows the LEA preschools in school districts on or around the Gila River Indian Community reservation boundaries (only the Sacaton Elementary School District lies fully within the Community's boundaries).

Table 21. Local Education Agency Preschools

LOCAL EDUCATION AGENCY (LEA)	NUMBER OF PRESCHOOL PROGRAMS	PRESCHOOL STUDENTS ENROLLED
Sacaton Elementary District*	1	23
Coolidge Unified District	2	59
Kyrene Elementary District	10	406
All Pinal County Districts	4	144
All Arizona Districts	220	10,063

Arizona Department of Education (2014). October 1 Enrollment 2013-2014. Retrieved from http://www.azed.gov/research-evaluation/arizona-enrollment-figures/

**Information provided through personal communication with staff at Sacaton Elementary School. The number of children enrolled shown in the table reflects end-of-year enrollment.*

Early Education Child Care Center (EECC) – The EECC is a tribally owned and operated program. The EECC Center receives federal funding from the Child Care Development Fund. The EECC center is tribally licensed through GRIC Department of Public Health Environmental Health Services. The EECC is a one of the child care services options provided by the Child Care and Development Services Department to families in the Community who meet income guidelines and who are in need of child-care services because they are either: employed or looking for employment, in training, attending school or training. Child care services through this Department are also available to children involved with CPS or in foster care.[56] The EECC also serves GRIC employees who are either qualified for the Child Care and Development funding or

[56] Gila River Indian Community Employees who are enrolled with another tribe may be eligible for child care assistance if they meet the following criteria: proof of enrollment in a federally recognized tribe; proof of tribal enrollment for children; meet income guidelines and provide any necessary documentation for application process. http://mygilariver.com/gricted/earlyeducation/childcare/childcare.htm

full-pay parents. In addition to Child Care Development Fund subsidies, EECC also provides 25 child care scholarships through Valley of the Sun United Way.

The EECC is located in District 3 (Sacaton) and has a capacity to serve a total of 122 children from as early as six weeks old. As of June of 2014, EECC enrollment was 100 (43 children ages birth to three and 57 children three to five years old).The Center rarely has any 0 to 3 slots available because those get filled as soon as they become vacant. Recently, there was a substantial increase in the number of children on the EECC waiting list, from 58 in 2012 to 92 in June of 2014. Key informants indicated that a possible cause of this increase, which has doubled the number of children waiting for an EECC spot, may be the number of families who have recently moved into the Community after a substantial number of new homes had been built on the reservation. This could suggest a possible increase in the demand of other services for families with young children in the region. Another possible reason may be that Community members are becoming more aware of the child care subsidy program, which, as of last year's funding plan, is only available to Community members.

Although EEEC rates for full-time child care are low relative to the rates charged by full-time regulated child care centers in surrounding counties and in the state overall, the rates are still very challenging for many families in the Gila River Indian Community to meet. The table below shows the cost of child care in the EECC center by percent of median income for parents who do not qualify for CCDF assistance.

Table 22. Cost of full-time child care by percent of median income (parents who do not qualify for CCDF assistance)

CHILD CARE PROVIDER	MEDIAN FAMILY INCOME	CHILDREN UNDER 1	CHILDREN 1-2 YEARS OLD	CHILDREN 3-5 YEARS OLD
Gila River Indian Community	$25,403.00	25%	23%	21%
Maricopa County	$64,841.00	16%	14%	13%
Pinal County	$55,856.00	17%	16%	13%
Arizona	$59,563.00	17%	15%	13%

US Census (2013). American Community Survey 5-year estimates, 2008-2012. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml; Arizona Department of Economic Security (2012). Child Care Market Rate Survey 2012. Retrieved from https://www.azdes.gov/InternetFiles/Reports/pdf/MarketRateSurvey2012.pdf; Gila River Indian Community (2014). Gila River Indian Community Early Education/Child Care Centers Rates. Retrieved from http://www.mygilariver.com/gricted/child_care/rate_sheet.pdf

The Gila River Indian Community Child Care and Development Services Department, which oversees the EECC, also has funds available for home-based child care providers. However,

currently there are no providers available in the region. Key informants noted that recruiting home-based providers is often difficult. One of the challenges may be the low reimbursement for home-based providers. Going through the process of backgrounds checks required of home-based providers may be another challenge. The process takes a long time and past offenses may prevent potential providers from clearing background checks.

However, key informants emphasized that home-based child care is an important option for families in the Community, and there is a constant effort to recruit additional providers at community events and health fairs.

The Gila River Indian Community Child Care and Development Services Department also provides support for families with children birth to 13 years old who are in need of off-reservation child care services. According to key informants, this support is mostly used for early care and after-school programs during the school year, and for summer camps during the summer months. This benefit is utilized mostly by families with school-age children. As of June 2014 there were 30 families representing a total 43 children receiving this type of financial support.

FACE Programs

Family and Child Education (FACE) is an early childhood and parental involvement program for American Indian families in schools sponsored by the Office of Indian Education Programs, Bureau of Indian Affairs. The goals of the FACE program include increasing family literacy; strengthening family-school-community connections; promoting the early identification and provision of services to children with special needs; and promoting the preservation of the unique cultural and linguistic diversity of the communities served by the program. FACE services and activities are currently taking place in 46 Bureau of Indian Education schools, 12 of which are located in the state of Arizona.

FACE has both a center-based and a home-based component. The home-based component includes personal visits and screenings by parent educators and is aimed at families with children from birth to age three. The center-based component includes an early childhood education program for children aged three to five, adult education for the children's parents, and parent/child time. Through FACE children are also screened for developmental delays and health concerns, including yearly vision and hearing tests. If learning or health special needs are identified, parents and caregivers are then connected to the appropriate programs or agencies in the "Resource Network" so that services can be provided to the child.

In the Gila River Indian Community Region FACE programs operate at Blackwater, Casa Blanca and Gila Crossing Community Schools. However, each program is independent and must apply for funding individually.

The Blackwater FACE program has been in place for 20 years. In 2008 the program earned accreditation by the National Association for the Education of Young Children (NAEYC) and was reaccredited again in 2012. According to the FACE Site Visit Report of January 2013, the FACE team at Blackwater are experienced and work well together, with participation rates of over 80 percent. All children enrolled in the program receive Imagination Library books. The program has strong administrative, community and school support and is considered a vital part of the Blackwater Community School. Recently, the Blackwater FACE program secured funding to obtain e-readers (Kindle Fires) that are used to promote literacy among both adults and children during Parent And Child Time (PACT), as well as during adult classroom time. Other agencies and departments within the region work closely with the FACE program at Blackwater Community school including: the Genesis Program, Tribal Recreation Department for District I and the Drug and Alcohol Program. School staff supports the program by serving as mentors and substitutes and making sure that families in the FACE program receive appropriate transportation and food services. FACE staff members are included in all professional development and staff meetings at Blackwater Community School.[57] In school year 2012-2013 there were 15 children participating in the center-based component of the Blackwater FACE program.

The Casa Blanca Community School FACE Program had 15 children enrolled in center-based services and 24 in the home-based program in school year 2012-2013.

The Gila Crossing Community School FACE program enrolled a total of 11 children in the center-based component during school year 2012-2013.

Head Start/Early Head Start

The Gila River Indian Community operates federally regulated Tribal Head Start and Early Head Start programs. Head Start is an early education program that promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services to enrolled children and families. Eligibility requirements for the Head Start program include: the child must be three or four years old by September 1st, parents must meet income eligibility guidelines, and priority is given to four year old children with special needs.[58] The Gila River Indian Community Head Start

[57] National Center for Family Literacy. (January 2013). *Blackwater Community School FACE Site Visit Report*. Unpublished report provided by Blackwater Community School.

[58] As of March 2012, eligibility criteria for the Head Start program include: being a resident of Arizona; being a parent or primary caregiver for a child who is too young for public school; having a pre-tax household income of $10,830 for a one-person household, of $18,310 for a two-person household, $22,050 for four-person household, of $25,790 for a five-person household, of $29,530 for a six-person household, of $33,270 for a seven-person household, of $37,010 for an eight-person household, and

is a half-day program funded to enroll a total of 203 children in four centers throughout the Community: Sacaton Head Start Center, with three classrooms serving 60 children and families; Santan Head Start Center, with two classrooms serving 43 children and families; Vah-Ki Head Start Center, with three classrooms serving 60 children and families; and the District Six Head Start Center, serving 40 children and families in morning and afternoon groups.[59] As of September of 2014, there were a total of 160 children in the Head Start/Early Head Start waiting list.

Table 23. Gila River Indian Community Head Start and Early Head Start waiting lists by district

PROGRAM	DISTRICT 3	DISTRICT 4	DISTRICT 5	DISTRICT 6	TOTAL
Early Head Start	29	25	11	18	83
Head Start	5	28	20	24	77

Gila River Indian Community Head Start/Early Head Start Program. Waiting list as of September 2014. Unpublished data provided by the Gila River Indian Community Head Start/Early Head Start Program

In early 2014 a new Head Start/Early Head Start facility was opened in Sacaton. The new 40,000-square-facility has eight classrooms, four of them serving infants and toddlers in the Early Head Start Program, and another four dedicated to preschool-age children in the Head Start Program.[60]

As it has been described in this section, there are a number of early childhood care and education programs available to families in the region. Table 24 summarizes the enrollment of preschool age children in the various center-based programs.

of $40,750 for a household larger than eight person. $3,740 may be added for each additional person in the home for larger households. Arizona residents not meeting these criteria may still be eligible for Head Start if: their income status is low or very low, they are under-employed, unemployed, or about to become unemployed, facing pregnancy, or under 19 years of age. Retrieved from http://www.benefits.gov/benefits/benefit-details/1897.

[59] http://mygilariver.com/gricted/earlyeducation/headstart/centers.htm

[60] http://www.gilariver.org/index.php/news/4318-new-head-start-facility-opens-in-sacaton

Table 24. Center-based enrollment (children 3 to 5 years old) in early childhood education programs

PROGRAM	ENROLLMENT (3-5)
Early Education Childcare Center (EECC)	57
Blackwater Preschool Program	40
Blackwater FACE Program	15
Casa Blanca FACE Program	15
Gila Crossing Community School Preschool Program*	25
Gila Crossing Community School FACE Program	11
Head Start	203
Sacaton Elementary School preschool**	23
TOTAL	366

Data provided by each of the programs listed are for year 2013-2014 with three exceptions: the EECC number reflects data as of June 2014; the Sacaton Elementary School preschool program enrollment is as of September 2014; and the Gila Crossing School preschool program data, which reflects enrollment from 2012-2013, the only in which this program was in place before it was suspended due to funding cuts.
*** This program is only available to children with special needs and it operates two days a week.*

Although the table above shows the enrollment of children three to five years old, it can be assumed that the majority of these children are in the 3-4 years old age range since children can transition into kindergarten by age five. According to Census 2010 data, there are 546 children ages three and four years old in the region. This means that an estimated 67 percent of the preschool-age children in the region received some type of center-based early care and education services. In contrast, a total of 131 children birth to three years of age received center-based services from the EECC or Early Head Start Programs.[61] This represents a much lower proportion (about 18 percent) of children in this age range participating in center-based early care and education programs. Altogether, 497 children birth to five years old were enrolled in center-based programs, representing an estimated 32 percent of the young children in the region.

In order to support unregulated, home-based child care providers as well as those providing kith and kin care for young children in the region the First Things First Gila River Indian Community Regional Partnership Council funds the Family, Friends and Neighbors strategy. In the Gila River Indian Community this program is provided through a contract with the

[61] Note: center-based enrollment for Early Head Start includes children only (no pregnant women). Total funded enrollment is 92, with 4 pregnant women included.

Association for Supportive Child Care. Funding is available to provide training and financial incentives to 30 home-based providers in the region.

Quality First

Quality First, a signature program of First Things First, is a statewide continuous quality improvement and rating system for child care and preschool providers, with a goal to help parents identify quality care settings for their children.

Quality First provides financial and technical support for child care providers to help them raise the quality of care they provide young children. Program components of Quality First include: assessments, TEACH scholarships, child care health consultation, child care scholarships, and financial incentives to assist in making improvements. The Quality First Rating Scale incorporates measures of evidence-based predictors of positive child outcomes. Based on these, a center is given a star rating that ranges from 1-star – where the provider demonstrates a commitment to examine practices and improve the quality of care beyond regulatory requirements – to 5-star, where providers offer lower ratios and group size, higher staff qualifications, a curriculum aligned with state standards, and nurturing relationships between adults and children.[62] Quality First providers with higher star ratings receive higher financial incentives and less coaching while those with lower ratings receive more coaching and lower financial incentives.[63] Table 25 describes the rating scale as defined by First Things First.

[62] First Things First (2011). *Measuring Quality in Early Childhood Education*. Retrieved from http://www.azftf.gov/WhoWeAre/Board/Documents/Policy_Brief_Q2.pdf (April 2012)

[63] The BUILD Initiative. Arizona State Profile. Retrieved from http://www.buildinitiative.org/Portals/0/Uploads/Documents/ArizonaProfileFinal.pdf

Table 25: Quality First Rating Scale

1 Star (Rising Star)	2 Star (Progressing Star)	3 Star (Quality)	4 Star (Quality Plus)	5 Star (Highest Quality)
Demonstrates a commitment to examine practices and improve the quality of care beyond regulatory requirements.	Demonstrates a commitment to provide environments that are progressing in the ability to foster the health, safety and development of young children.	Demonstrates a level of quality that provides an environment that is healthy and safe with access to developmentally appropriate materials. Curriculum is aligned with state standards. Interactions between adults and children are enhanced. Staff qualifications exceed state regulatory requirements.	Demonstrates a level of quality that provides an environment of developmentally appropriate, culturally sensitive learning experiences. Curriculum is aligned with state standards. Relationships between adults and children are nurturing and promote language development and reasoning skills.	Demonstrates a level of quality that provides an environment of lower ratios/group size and higher staff qualifications that supports significant positive outcomes for young children in preparation for school. Curriculum is aligned with state standards and child assessment. Relationships between adults and children are nurturing and promote emotional, social, and academic development.

In the Gila River Indian Community Region there are currently three Quality First sites: the Early Education Child Care Center and the preschool programs at Blackwater Community School and Sacaton Elementary School.

Professional Development

Formal educational attainment of Early Childhood Education (ECE) staff is linked with improved quality of care in early care and education settings. According to the 2012 Early Care and Education Workforce Survey, the number of assistant teachers obtaining a credential or degree increased from 21 percent in 2007 to 29 percent in 2012, and the percentage of all teachers holding a college degree rose from 47 to 50 percent over the same time period. During that same period however, the wages of assistant teachers, teachers and administrative directors working in licensed early care and education settings across the state decreased when adjusted for inflation. Those working in early care and education settings in Arizona, only make about half the annual income of kindergarten and elementary school teachers across the state.[64] It is likely that these issues impact retention and turnover of early care and education professionals across the state. The table below shows the educational attainment of teachers and teaching assistants at the various early childhood education centers in the region.

[64] Arizona Early childhood Development and Health Board (First Things First). (2013). Arizona's Unknown Education Issue: Early Learning Workforce Trends. Retrieved from http://www.azftf.gov/WhoWeAre/Board/Documents/FTF-CCReport.pdf

Table 26. Credentials of early childhood education professionals in the Gila River Indian Community Region

Professionals	Total	ECE [65]	CDA[66]	AA[67]	BA[68]	MA[69]
Blackwater Community School						
Teachers	3	0	0	0	0	3 (100%)
Teacher Assistants	4	0	0	2 (50%)	2 (50%)	0
Head Start						
Teachers	16	0	0	8 (50%)	3 (19%)	0
Teacher Assistants	19	0	1 (5%)	1 (5%)	0	0
Early Head Start						
Teachers	12	1 (8%)	1 (8%)	5 (42%)	5 (42%)	0
Teacher Assistants	11	0	0	1 (9%)	0	0
Gila Crossing Community School						
Teachers*	2	0	0	0	1 (50%)	1 (50%)
Teacher Assistants*	2	0	1 (50%)	1 (50%)	0	0
Casa Blanca Community School, Inc.						
Teachers	1	0	0	0	0	1 (100%)

[65] Early Childhood Education

[66] Child Development Associate's Degree

[67] Associate's Degree

[68] Bachelor's Degree

[69] Master's Degree

Teacher Assistants	1	0	0	0	1 (100%)	0
Early Education Child Care Centers						
Teachers*	12	4 (33%)	3 (25%)	4 (33%)	1 (8%)	0
Teacher Assistants*	12	3 (25%)	0	0	0	0

Scholarships

First Things First offers Teacher Education and Compensation Helps (TEACH) Scholarships to support child care providers in their pursuit of their CDA certification or Associate of Arts (AA) certificate/degree. Through participation in TEACH, child care providers (center or home based), directors, assistant directors, teachers, and assistant teachers working in licensed or regulated private, public and Tribal programs are able to participate in 9-15 college credits of college coursework leading to their CDA (Child Development Associates) credential or AA degree. A Bachelor's Degree model of the TEACH program is also currently being piloted in one FTF Region. According to the region's 2015 funding plan, as of fiscal year 2014, there were 4 child care professionals in the Gila River Indian Community Region who had received TEACH scholarships to take coursework leading to an early childhood credential or degree.[70]

Opportunities for Professional Development

Other early childhood education professional development opportunities are available in the region. One is the Arizona Department of Economic Security Child Care Administration (DES/CCA) Child Care Professional Training (CCPT) offered through Yavapai College to residents of Pinal County and through the Association for Supportive Child Care to residents of Maricopa County. This training is a no-cost, two week (60-hour) course covering the basics of child development, nutrition, early reading and math activities and child-care licensing to prepare participants to enter the early care and education workforce. The training is aimed at individuals with minimal or no work-experience in child care and early education. The grant provides up to 15, 60-hour workshops in 11 counties in Arizona each year. Each CCPT session includes rolling of fingerprints for individuals in need of a finger print card for employment. Upon completion, students can earn either 60 training hours or 3 college credits.[71]

[70] Gila River Indian Community FTF Regional Partnership Council. (2014). SFY 2015 Regional Funding Plan. Retrieved from http://azftf.gov/RPCCouncilPublicationsCenter/Funding%20Plan%20-%20GRIC%20SFY15.pdf

[71] Child Care Resource and Referral. (April-June 2014). Early Childhood Quarterly. Retrieved from http://www.arizonachildcare.org/pdf/quarterly.pdf

A number of professional development and credentialing opportunities are available to child care professionals in the Gila River Indian Community Region through colleges proximal to the region. Table 27 below shows information about programs and degrees available.

Table 27. Degrees and Professional Development Opportunities Proximal to the Gila River Indian Community Region

School	Degree or Certificate
Central Arizona Community College	Early Care and Education (Transfer Pathway) AAS in Early Childhood Education CDA in Early Care and Education
	A.A.S. Early Childhood Education
	Certificate in Early Childhood Education
Mesa Community College	AAS in Early Care and Education AA in Transfer Partnership: Early Childhood Teacher Ed AAS in Early Learning and Development
Arizona State University - Tempe	B.A.E. Early Childhood Special Education*
Northern Arizona University (Online Programs)	B.A.S. in Early Childhood Education
	M.Ed. in Early Childhood Education

Health

Access to Care

As a result of the Indian Self-Determination and Education Assistance Act (PL-93-638) (ISDEAA), federally recognized tribes have the option to receive the funds that the Indian Health Service (IHS) would have used to provide health care services to tribal members. The tribes can then utilize these funds to directly provide services to tribal members (they can also opt to take the funds from IHS and provide the services through another entity). This process is commonly known as utilizing “638 contracts”.

This means that tribes have three options regarding the overall management of their health services: 1) Having IHS fully manage all services; 2) Having IHS manage some services and taking over responsibility for other services (a 638 contract); or 3) Taking over control of *all* services from IHS and have them be fully managed by the tribe (known as 638 compact). Most tribes in Arizona currently have their health services managed through options 1 or 2. The two exceptions are the Gila River Indian Community and the Ak-Chin Indian Community, whose health services are fully tribally managed. Through contracts and compacts, ISDEAA enables tribes more control over the federal funds that are allotted to the IHS for health care enabling tribes to self-determine how funding will be distributed based on the tribe’s own identified needs and priorities.

In 1995, the Gila River Indian Community assumed responsibility from IHS for the operation and management of health care facilities in the region: Hu Hu Kam Memorial Hospital and Gila Crossing Clinic (now the Komatke Health Center). The Gila River Indian Community formed a 501c(3) Tribal Health Corporation. This quasi-private sector model allows a more autonomous and independent relationship with the Tribe, as the Corporation is not dependent on Tribal Procurement and personnel practices. Gila River Health Care employs 700 people and their budget is supported by the IHS, grants and third-party revenues (such as Medicare, private pay, Blue Cross, and Medicaid).

The Gila River Health Care is a major asset in the Community. It provides general medical and surgical care for inpatient, outpatient, and emergency services which are available 24 hours a day, seven days a week.

The wide array of services provided by Gila River Health Care include: primary care, medical imaging, pharmacy, dental, infection control, optometry services, podiatry, behavioral health, dialysis, dietetic services, laboratory, physical therapy, life center - diabetes education, school

health services, public health nursing, family planning, emergency transportation services, medical transportation services and cancer support services.[72]

Health care facilities operated by Gila River Health Care include the Hu Hu Kam Memorial, a 10-bed hospital located in Sacaton which also offers services to the Ak-Chin Indian Reservation. Gila Crossing Health Center (now the Komatke Health Center), a freestanding clinic located in District 6 in the Village of Gila Crossing.

According to key informants, prenatal and pediatric care services are easily accessible to families in the region and it is easy for families to make an appointment. However, transportation to the health care facilities in the region is a challenge for parents of young children. In addition to providing transportation services, Gila River Health Care Public Health has other services in place to help families cope with the challenge posed by lack of transportation: the Public Health Nurses, for instance, are able to fill prescriptions and make medication available to families through their home visitation services. In addition, mobile health care units are available to serve families in various parts of the reservation. These include the Public Health Nurses and the Family Planning mobile units.

Key informants indicated that while many health services are available to families in the region, many Community residents may still not know about their existence. Continued coordination among the different systems that work with young children and their families (e.g. health care facilities, schools) can help make sure families get connected to the services they need.

The Arizona Department of Health Primary Care Area Program designates Primary Care Areas (PCAs) as geographically based areas in which most residents seek primary medical care within the same places.[73] The labels for the Primary Care Areas are drawn from the major population centers for those areas. The Gila River Indian Community Region is a PCA.

Medically Underserved Areas and Populations (MUAs and MUPs) are federally designated areas or populations that have a need for medical services based on: too few primary care providers; high infant mortality; high poverty; and/or high elderly population. Groups designated as an MUP include those with economic barriers such as being largely low-income or Medicaid-eligible populations, or those with culture and/or linguistic access barriers to primary care

[72] http://www.grhc.org/getpage.php?name=index

[73] Definition based on Arizona Department of Health Services, Division of Public Health Services Data Documentation for Primary Care Area and Special Area Statistical profiles. Bureau of Health Systems Development.

services. With 36 MUAs and 10 MUPs in Arizona, each of Arizona's 15 counties has some areas designated as medically underserved areas or population.[74]

The Arizona Department of Health Primary Care Area Program designates Arizona Medically Underserved Areas (AzMUAs) in order to identify portions of the state that may have inadequate access to health care. Each PCA is given a score based on 14 weighted items including points given for: ambulatory sensitive conditions; population ratio; transportation score; percentage of population below poverty; percentage of uninsured births; low birth weight births; prenatal care; percentage of death before the U.S. birth life expectancy; infant mortality rate; and percent minorities, elderly, and unemployed. Based on its scores on these indicators, the Gila River Indian Community Primary Care Area is designated as Medically Underserved.

A new priority for the State Title V priorities for 2011-2016 for Arizona's maternal and child health population is to improve access to and quality of preventive health services for children. According to a 2013 report, Arizona may have increasing capacity to provide preventive health services for children ages birth though five years through funding from First Things First, and through potential funding for home visiting programs through the Affordable Care Act.[75]

Pregnancies and Births

Pregnant women in the Gila River Indian Community have access to on-reservation prenatal care provided at the Gila River Health Care Women's Health Center (previously known as the Purple Clinic), a facility that is part of the Gila River Health Care Corporation. This clinic moved to a new building in early 2014. In addition to Community members, the Women's Health Center also serves women from surrounding communities in the Phoenix Valley area such as Glendale, Tempe and Mesa. Medical staff with the Women's Health Center also provide ob/gyn services at the Komatke Health Center. Deliveries do not take place at this facility but in the various hospitals in the Phoenix Valley area.

Soon after their initial appointment confirming they are pregnant, patients at the Women's Health Center schedule a one-on-one prenatal education appointment with a nurse educator (staff with the clinic indicated they found individual educational sessions to be more successful that group classes).

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[74] Arizona State Health Assessment, December 2013. Arizona Department of Health Services. http://www.azdhs.gov/diro/excellence/documents/az-state-health-assessment.pdf

[75] Maternal and Child Health Services Title V Block Grant, State Narrative for Arizona, Application for 2013, Annual Report for 2011. http://www.azdhs.gov/phs/owch/pdf/mch/title-v-block-grant-narratives-2013.pdf

The Women's Health Clinic has set up a good follow-up system for patients who do not show up for their appointments. In the past, they had found that limited follow-up resulted in higher no-show rates –patients' frequent change of address and telephone numbers was one of the challenges that they encountered. The clinic involves a care coordinator in the follow up process who reaches out to the patient both by phone and mail. A safety check can be initiated for no-show patients living on the reservation though the Public Health Program. This safety check allows the clinic to find out if the patient's absence is due to at-risk situations such as domestic violence and substance abuse; or to help arrange transportation for the patient, if this is the reason for her missed appointment. Patients who reside off-reservation limits are followed up by mail or phone. Although this system has helped improve the clinic's no-show rates, staff pointed out that other barriers still exist. Lack of transportation is one of the main problems patients face; in addition, a common belief that pregnancy is 'something natural' that does not require frequent medical monitoring or intervention can also become an obstacle to adequate prenatal care. This can be problematic considering that staff with the clinic estimates that about 80 percent of their patients have high-risk pregnancies related to factors such as diabetes, teen pregnancy, chronic hypertension, elevated BMI and substance abuse. For these high-risk pregnancies the Women's Health Center uses the services of contracted perinatologists that serve as consultants and co-manage care for these patients. The clinic has an obstetrics high-risk task force that meets weekly. A consultant perinatologist joins the task force when available to go over patients' files and provide advice and education to clinic staff.

The care coordinator at the Women's Health Center also conducts follow-up for the clinic's patients after delivery. The clinic is alerted about admissions in the hospitals throughout the valley to obtain a discharge summary. The patient is also contacted by phone to ensure that a six-week follow up appointment is in place. The continuum of care for the newborn is ensured through good coordination with the pediatrics department. The care coordinator with the Women's Health Center notifies the case manager in the pediatrics department of babies that are born and of any potential high-risk health issues they may face.

Similar to the role of the care coordinate at the Women's Health Center, pediatric case managers with Gila River Health Care's Pediatrics clinic play a crucial role in making sure that newborns and children receive adequate care after women give birth in the Phoenix Valley area hospitals or after children are hospitalized and return to the Community.

After newborns are discharged, pediatric case managers reach out to the families to make sure they get connected to services available to them in the Community such as the Public Health Nurses, BabySmarts, Car Seat, and the Women, Infants and Children (WIC) programs. They can also connect families with Gila River Health Care's benefits coordinators who can assist families with their Arizona Health Care Cost Containment (AHCCCS) applications; according to key informants, benefits coordinators can assist families in their own homes.

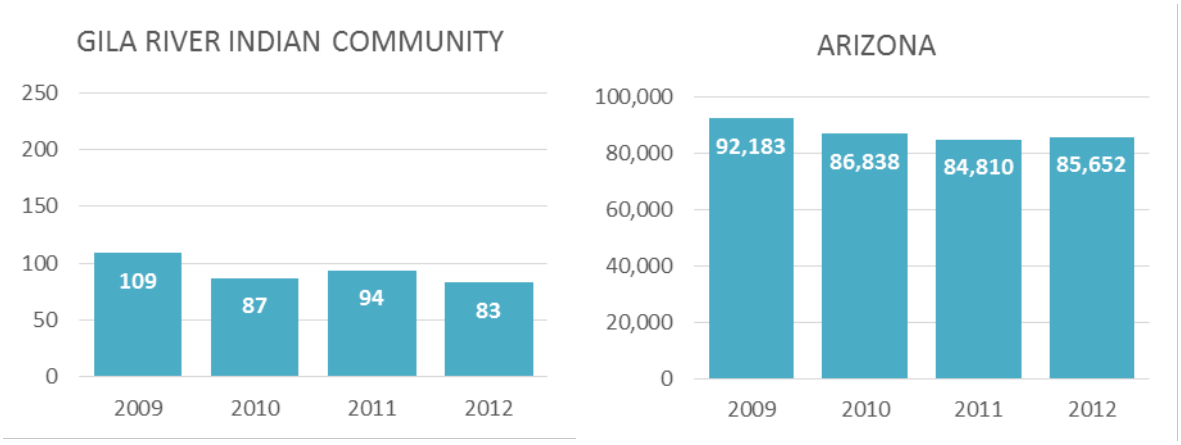
Pediatric case managers interact with the various hospitals facilitating access and communication between families from the Community and their health care providers. They also make sure that health care providers at Gila River Health Care's Pediatrics Clinic have access to the child's health records: pediatric case managers have the ability to remotely access electronic health records for patients receiving care at Gila River Health Care who were born or hospitalized in the Phoenix Valley area hospitals. According to key informants, pediatric care coordinators put a strong emphasis on building relationships with nearby hospitals, many of which recognize the value of these connections which may result in fewer hospital re-admissions. Pediatric care coordinators work closely with parent liaisons (some of whom are Native American) who can visit hospitalized patients and make sure families are receiving the care they need. Parent liaisons can reach out to families in person if there are any particular concerns about hospitalized patients. They can deliver materials to the parents about resources or services available to them and even serve as an additional resource to the hospital, providing one-on-one support to Community families.

As with any others services provided at Gila River Health Care, pediatric case management is provided to families with children living on and off-reservation as patients at Gila River Health Care come from different communities. According to key informants, many Native families that belong to other tribes may seek services at Gila River Health Care because they feel more comfortable with the Native staff and programs available there.

This level of coordinated care is a major asset in the region. Coordination between the Women's Health Center and the Pediatrics Clinic facilitates an important continuum of care (i.e. prenatal care- labor and delivery - pediatric care) that is particularly relevant as women must go outside of the region to give birth.

From the 1950's until the economic downturn in 2008, the number of babies born in Arizona had increased each year. Since 2008, the number of babies born each year has been less than the number born the year before. This decreasing trend may be over, as the number of babies born in 2012 (85,652) was greater than the number born in 2011 (84,810). A decreasing trend can be seen in the Gila River Indian Community Region between 2009 and 2012, too, with 83 babies born to mothers residing in the region in 2012 compared to 109 in 2009.

Figure 12. Total number of births in the Gila River Indian Community and the state (2009-2012)



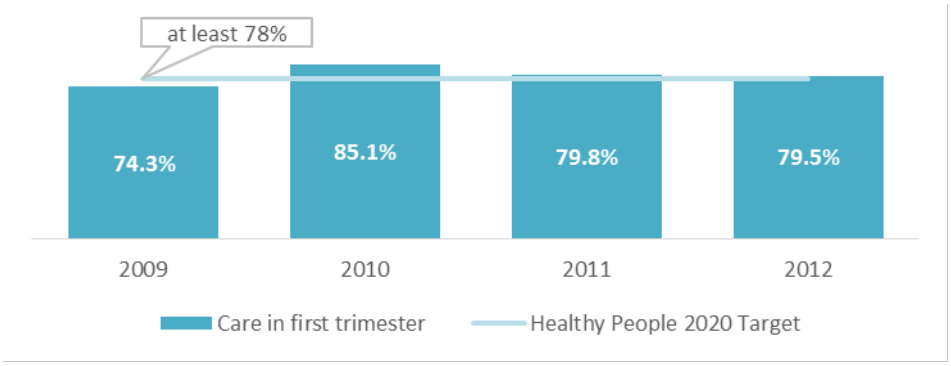
Arizona Department of Health Services (2014). [Vital Statistics data set]. Unpublished raw data received from the First Things First State Agency Data Request

Many of the risk factors for poor birth and neonatal outcomes can be mitigated by good prenatal care, which is most effective if delivered early and throughout pregnancy to provide risk assessment, treatment for medical conditions or risk reduction, and education. Research has suggested that the benefits of prenatal care are most pronounced for socioeconomically disadvantaged women, and that prenatal care decreases the risk of neonatal mortality, infant mortality, premature births, and low-birth-weight births.[76] Care should ideally begin in the first trimester.

Healthy People is a science-based government initiative which provides 10-year national objectives for improving the health of Americans. Healthy People 2020 targets are developed with the use of current health data, baseline measures, and areas for specific improvement. The Healthy People 2020 target for receiving prenatal care in the first trimester is 78 percent or more. In Arizona as a whole, seventy-nine percent of births meet this standard. From 2010 until 2012 (the last year for which data are available) the Gila River Indian Community Region has exceeded the Healthy People 2020 of assuring that at least 78 percent of pregnant women receive prenatal care in the first trimester.

[76] Kiely, J.L. & Kogan, M.D. *Prenatal Care.* From Data to Action: CDC's Public Health Surveillance for Women, Infants, and Children. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/reproductivehealth/ProductsPubs/DatatoAction/pdf/rhow8.pdf

Figure 13. Percent of births with prenatal care begun first trimester (2009-2012)

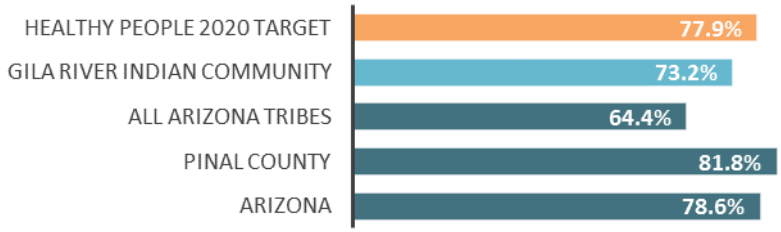


Arizona Department of Health Services (2014). [Vital Statistics data set]. Unpublished raw data received from the First Things First State Agency Data Request

Because the Gila River Indian Community Region is relatively sparsely populated, data from any one year for rare occurrences (such as births) tend to vary from one year to the next. The Gila River Indian Community Primary Care Area Statistical (PCA) Profile provides data on a number of maternal and child health indicators averaged over a ten-year span (2002-2011). PCA data are also available for Pinal County, all Arizona tribes combined, and the state as a whole. Where available, in this report we will present both the yearly trend data provided to First Things First by the Arizona Department of Health Services (as shown in Figure 13) and the PCA data that allows for comparisons to the county, all Arizona reservations, and the state (Figure 14).

The graph below shows that women in the Gila River Indian Community receive early prenatal care at a higher rate than women in all Arizona reservations combined.

Figure 14. Average percent of births with prenatal care begun first trimester (2002-2011)

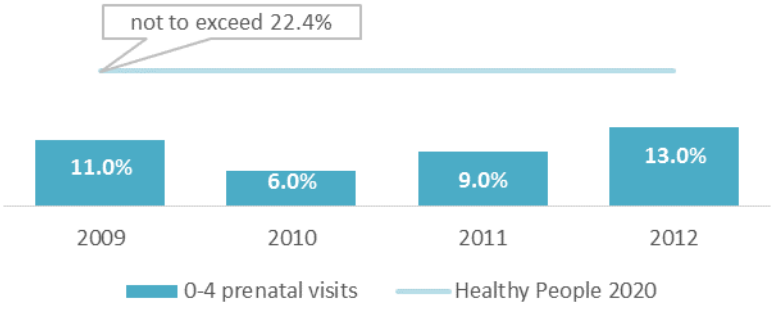


Arizona Department of Health Services (2013). Primary Care Area Statistical Profiles 2012. Retrieved from http://www.azdhs.gov/hsd/data/profiles/primary-care/

In addition to early care, it is important that women receive adequate prenatal care throughout their pregnancy, in order to monitor their health and provide them with information for a healthy pregnancy and post-natal period. The American College of Obstetrics and Gynecology (ACOG) recommends at least 13 prenatal visits for a full-term pregnancy; seven visits or fewer

prenatal care visits are considered an inadequate number.[77] The Healthy People 2020 target for receiving fewer than five prenatal care visits is 22.4 percent or less. The Gila River Indian Community Region has consistently met this target since 2009.

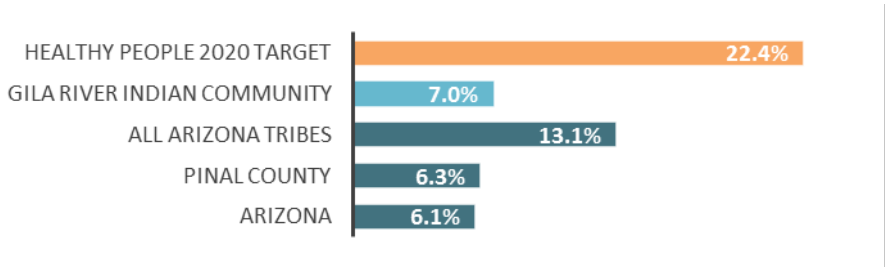
Figure 15. Percent of births with fewer than five prenatal care visits (2009-2012)



Arizona Department of Health Services (2014). [Vital Statistics data set]. Unpublished raw data received from the First Things First State Agency Data Request

When looked at from 2002-2011 the rate of inadequate care was about half the rate (7%) than all Arizona reservations combined (13%) and similar to the county rate (see Figure 16).

Figure 16. Average percent of births with fewer than five prenatal care visits (2002-2011)



Arizona Department of Health Services (2013). Primary Care Area Statistical Profiles 2012. Retrieved from http://www.azdhs.gov/hsd/data/profiles/primary-care/

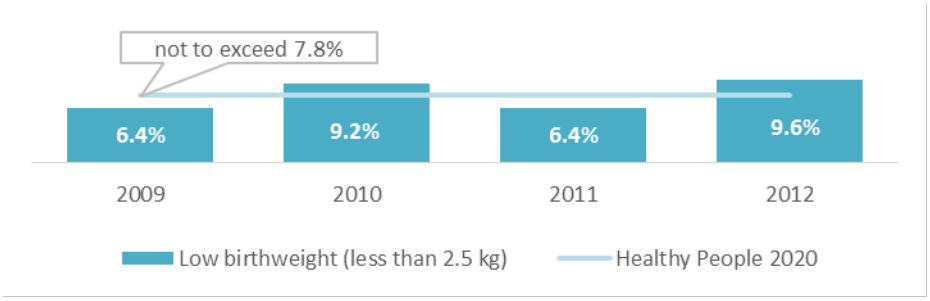
Low birth weight is the risk factor most closely associated with neonatal death; thus, improvements in infant birth weight can contribute substantially to reductions in the infant mortality rate. Low birth weight is associated with a number of factors including maternal smoking or alcohol use, inadequate maternal weight gain, maternal age younger than 15 or older than 35 years, infections involving the uterus or in the fetus, placental problems, and birth defects,[78] as well as air pollution.[79] The Healthy People 2020 target is 7.8 percent or fewer

[77] American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 5th ed. Elk Grove Village, Ill.: American Academy of Pediatrics, and Washington, D.C.: American College of Obstetricians and Gynecologists, 2002

[78] Arizona Department of Health Services. Preterm Birth and Low Birth Weight in Arizona, 2010. Retrieved from: http://www.azdhs.gov/phs/owch/pdf/issues/Preterm-LowBirthWeightIssueBrief2010.pdf

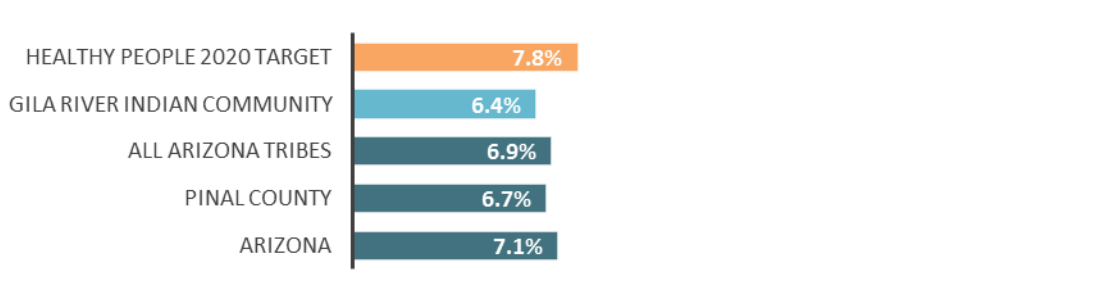
births where babies are a low birth weight. Figure 17 shows that in 2012 the region exceeded this target. However, the rate presented in Figure 18 shows that the region's 10-year averaged low birth weight rate (6.4%) does meet the Healthy People 2020 target and is also lower than the state and all Arizona tribes rates.

Figure 17. Percent of births with low birth weight (5 lbs., 8oz. or less) (2009-2012)



Arizona Department of Health Services (2014). [Vital Statistics data set]. Unpublished raw data received from the First Things First State Agency Data Request

Figure 18. Average percent of low birth weight (5 lbs., 8oz. or less) births (2002-2011)



Arizona Department of Health Services (2013). Primary Care Area Statistical Profiles 2012. Retrieved from http://www.azdhs.gov/hsd/data/profiles/primary-care/

Teenage parenthood, particularly when teenage mothers are under 18 years of age, is associated with a number of health concerns for infants, including neonatal death, sudden infant death syndrome, and child abuse and neglect.[80] In addition, the children of teenage mothers are more likely to have lower school achievement and drop out of high school, be incarcerated at some time during adolescence, give birth as a teenager, and face unemployment as a young adult. Teenaged mothers themselves are less likely to complete high

[79] Pedersen, M., et al. (2013). Ambient air pollution and low birth weight: A European cohort study (ESCAPE). The Lancet Respiratory Medicine. Advance online publication. Doi: 10.1016/S2213-2600(13)70192-9

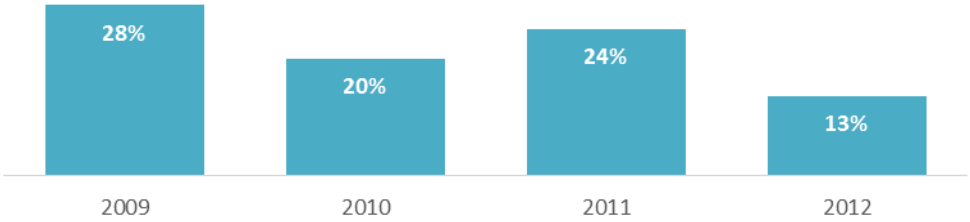
[80] Office of Population Affairs, Department of Health and Human Services, (2010). Focus area 9: Family Planning, Healthy People 2010. Retrieved from: http://www.healthypeople.gov/Document/HTML/Volume1/09Family.htmgov/Document/HTML/Volume1/09Family.htm

school or college, and more likely to require public assistance and to live in poverty than their peers who are not mothers.[81]

The teen birth rate in Arizona in 2012 was 18.7/1000 for females aged 15-17, and 66.1/1000 for females aged 18-19. Although the number of teen births in Arizona has dramatically decreased in recent years, Arizona still has the 11th highest teen birth rate nationally.[82] Because young teen parenthood (10-17) can have far-reaching consequences for mother and baby alike, and older teen parenthood (18-19) can continue to impact educational attainment, these rates indicate that teen parenthood services for teen parents may be important strategies to consider in order to improve the well-being of young children in these areas.

In 2012, 13 percent of all births in the region were to mothers aged 19 or younger, compared to nine percent in Arizona as a whole. The 2012 teen birth rate in the region is substantially lower than in previous years (Figure 19).

Figure 19. Percent of births to mothers ages 19 and younger (2009-2012)



Arizona Department of Health Services (2014). [Vital Statistics data set]. Unpublished raw data received from the First Things First State Agency Data Request

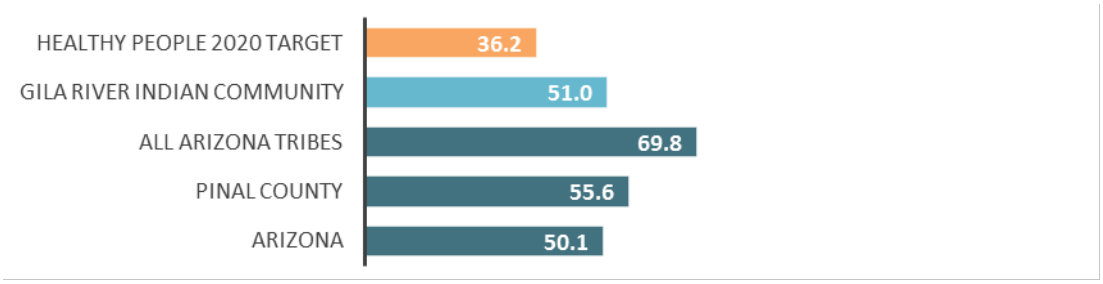
PCA data averaged over ten years show that the rate of teen births per 1,000 females in the region has been, and similar to the state rate and somewhat lower than the combined all Arizona tribes rate. Reducing the rate of teen pregnancy among youth less than 19 years of age is one of the ten State Title V priorities for 2011-2016 for Arizona's maternal and child health population.[83]

[81] Centers for Disease control and Prevention. Teen Pregnancy. About Teen Pregnancy. Retrieved from: http://www.cdc.gov/teenpregnancy/aboutteenpreg.htm

[82] The National Campaign to Prevent Teen and Unplanned Pregnancy. Teen Birth Rate Comparison, 2012. http://thenationalcampaign.org/data/compare/1701

[83] Maternal and Child Health Services Title V Block Grant, State Narrative for Arizona, Application for 2014, Annual Report for 2012. http://www.azdhs.gov/phs/owch/pdf/mch/title-v-block-grant-narratives-2014.pdf

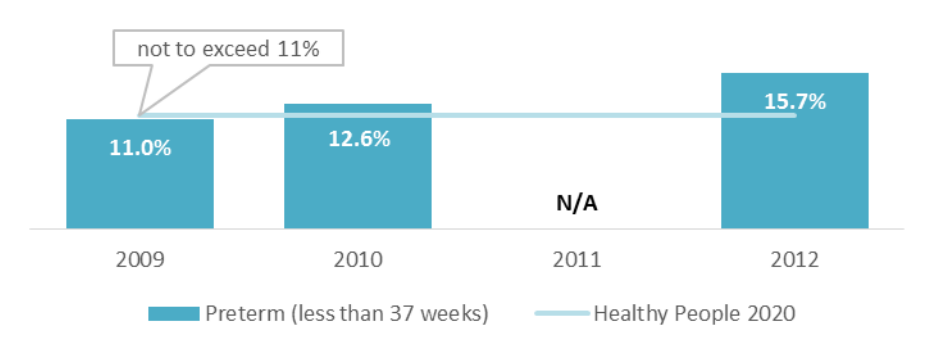
Figure 20. Rate of teen births (ages 19 and younger) per 1,000 females ages 14 to 19 (2002-2011)



Arizona Department of Health Services (2013). Primary Care Area Statistical Profiles 2012. Retrieved from http://www.azdhs.gov/hsd/data/profiles/primary-care/

Two of the consequences that has been linked to high teen birth rates are preterm births and high infant mortality. In 2012, the percent of preterm births in the region (16%) exceeded the Healthy 2020 target of 11 percent or fewer (Figure 21).

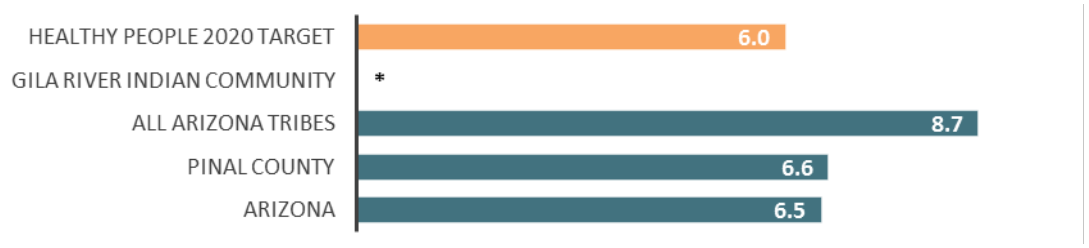
Figure 21. Percent of births that are preterm (less than 37 weeks) (2009-2012)



Arizona Department of Health Services (2014). [Vital Statistics data set]. Unpublished raw data received from the First Things First State Agency Data Request

The Healthy People 2020 target for all infant deaths is 6.0 infant deaths or fewer per 1,000 live births. The Primary Care Area Statistical Profiles include data about the average infant mortality rate. However, there were insufficient data to report this rate for the Gila River Indian Community Region in the 2012 Profile. In the same year, the rate across all Arizona reservations (which includes the Gila River Indian Community) was 8.7 per 1,000 live births, which is higher than the state rate of 6.5 per 1,000 live births. Both of these rates exceed the Healthy People 2020 target of 6.0 per 1,000 live births or less.

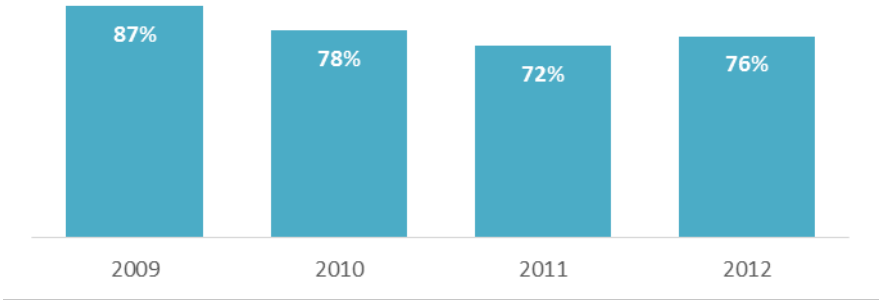
Figure 22. Average infant mortality rate per 1,000 live births (2002-2011)



Arizona Department of Health Services (2013). Primary Care Area Statistical Profiles 2012. Retrieved from http://www.azdhs.gov/hsd/data/profiles/primary-care/

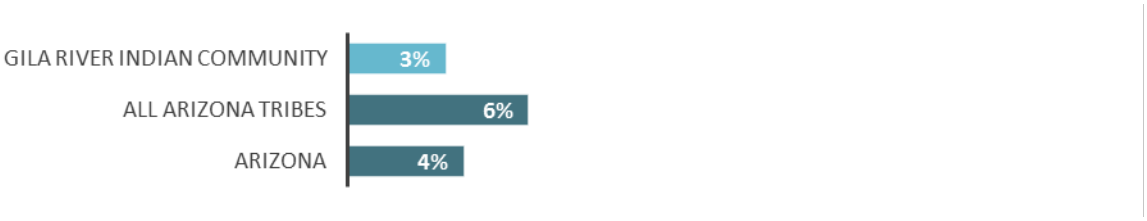
The percent of births to that were covered by the Arizona Health Care Cost Containment System (AHCCCS, Arizona's Medicaid) or the Indian Health Service (IHS) has decreased since 2009 (Figure 23). In 2012, 76 percent of the births in the region were covered by AHCCCS or IHS, a proportion that is considerably higher than the statewide rate of 55 percent. The average percent of uninsured births (defined as self-pay or 'unknown' payee in the Vital Statistics birth record) in the region over ten years (3%) is similar to the Arizona rate (4%), and half of the proportion of all Arizona reservations births covered by public payee (6%, see Figure 24).

Figure 23. Births covered by AHCCCS or IHS by year (2009-2012)



Arizona Department of Health Services (2014). [Vital Statistics data set]. Unpublished raw data received from the First Things First State Agency Data Request

Figure 24. Average percent of uninsured births (2002-2011)



Arizona Department of Health Services (2013). Primary Care Area Statistical Profiles 2012. Retrieved from http://www.azdhs.gov/hsd/data/profiles/primary-care/

According to key informants, a wide array of maternal and child health services are currently available to families in the region. Nevertheless, additional support may be needed in the areas

of postpartum depression, families with premature babies (to foster bonding) and helping parents cope with a diagnosis of developmental disabilities for their young children.

Gila River Indian Community WIC Program Maternal and Child Health Indicators

As mentioned above, the Gila River Indian Community WIC Program operates under the Inter Tribal Council of Arizona (ITCA) WIC Program umbrella. ITCA regularly produces a *WIC Program Maternal and Child Health Profile* for each of the participating tribal programs. The tables below show a selection of the maternal and child health indicators contained in the 2012 and 2014 Profiles (please note that the actual data in the reports are for years 2011 and 2012, respectively). Data from the ITCA WIC program as a whole are included in the tables below for comparison.[84]

In 2012, about nine percent of the newborns enrolled in the Gila River WIC Program had a low birth weight (defined as weighing less than 2.5 kilograms, or 5.5 pints). This rate is over the Health People 2020 target of 7.8 percent. About nine percent[85] of Gila River WIC babies were premature (defined as a gestation of less than 37 weeks). This rate meets the Healthy People 2020 target of 11.4 percent or fewer.

The Gila River WIC breastfeeding rate of 69.2 percent is much lower than the Healthy People 2020 target of 81.9 percent but is consistent with the rate reported by all ITCA WIC programs combined (67.5%).

[84] The "ITCA WIC" rates include aggregated data from all the tribal and urban Indian programs under the ITCA umbrella which include: Colorado River Indian Tribes WIC, Gila River Indian Community WIC, Havasupai Tribe WIC, Hopi Tribe WIC, Hualapai Tribe WIC, Native Health WIC, Pascua Yaqui Tribe WIC, Salt River Pima Maricopa WIC, San Carlos Apache Tribe WIC, Tohono O'odham Nation WIC, White Mountain Apache Tribe WIC and Yavapai Apache Nation WIC.

[85] Please note that this rate corresponds to 2011. Data for 2012 were not available for this indicator.

Table 28. Infant and child health indicators from Gila River Indian Community WIC clients

	GILA RIVER INDIAN COMMUNITY WIC		ITCA WIC		HEALTHY PEOPLE 2020 TARGET
	2011	2012	2011	2012	
AGES OF INFANTS AND CHILDREN DURING 2012					
0	27%	30%	24%	25%	-
1	23%	24%	22%	21%	-
2	17%	17%	18%	18%	-
3 to 4	33%	30%	36%	36%	-
BIRTH WEIGHT					
High birth weight (4 kg or more)	9.2%	8.8%	7.4%	7.8%	-
Normal birth weight	70.8%	74.1%	73.5%	73.3%	-
Low birth weight (2.5 kg or less)	10%	8.6%	9.5%	9.4%	7.8%
PRETERM BIRTHS					
Less than 37 weeks	8.7%	NA	6.8%	NA	11.4%
INFANT BREASTFEEDING					
Ever breastfed	69.5%	69.2%	64.8%	67.5%	81.9%
OVERWEIGHT AND OBESITY IN CHILDREN (2-4 YEARS OLD)					
Overweight (85th to 95 percentile)	19.8%	22.9%	20.9%	20.9%	-
Obese (95th percentile or greater)	31.1%	27.6%	25.5%	25.5%	9.6%

Inter Tribal Council of Arizona, Inc. (December 2012).Gila River Indian Community WIC Program Maternal and Child Health Profile. Unpublished report provided by the Gila River Indian Community WIC Program
Inter Tribal Council of Arizona, Inc. (February 2014).Gila River Indian Community WIC Program Maternal and Child Health Profile. Unpublished report provided by the Gila River Indian Community WIC Program

The rate of obesity in the older children (2 to 4 years old) in the Gila River WIC program (27.6%) is substantially higher than the Healthy People 2020 target (9.6%). However, there has been a slight decrease in this rate since 2010, when the proportion of Gila River WIC children who were obese was 33 percent.[86]

Of the mothers enrolled in the Gila River Indian Community WIC program in 2012, 6.5 percent were under the age of 18. This is a slightly higher rate than the one for all ITCA WIC programs combined. (see Table 29).

High overweight and obesity rates are also a concern among women of childbearing age in the Community. At the beginning of pregnancy, 60.5 percent of the Gila River WIC mothers were obese. The rate of obesity is substantially higher than the ITCA average (43.8%).

[86] First Things First Gila River Indian Community Regional Partnership Council. (2012). Needs and Assets Report. Retrieved from: https://www.azftf.gov/RPCCouncilPublicationsCenter/Gila_River_Indian_Community_Needs_and_Assets_Report_2012.pdf

Table 29. Maternal health indicators from the Gila River Indian Community WIC program clients

	GILA RIVER INDIAN COMMUNITY WIC		ITCA WIC		HEALTHY PEOPLE 2020 TARGET
	2011	2012	2011	2012	
MATERNAL AGE					
17 or younger	19.8%	6.5%	16.4%	5.1%	-
18 to 19	16.4%	12.9%	16.7%	11.9%	-
20 to 29	55.6%	60.6%	56.0%	59.6%	-
30 to 39	8.2%	17.8%	10.9%	22.1%	-
40 or older	0.0%	2.2%	0.1%	1.2%	-
PRE-PREGNANCY BODY MASS INDEX (BMI)					
Normal weight (or Underweight)	15.0%	17.6%	27.0%	28.2%	53.4%
Overweight (BMI 25 to 30)	20.1%	21.9%	27.5%	28.1%	-
Obese (BMI over 30)	64.9%	60.5%	45.5%	43.8%	-
PRE-PREGNANCY OVERWEIGHT OR OBESE					
2006	70.7%		61.7%		-
2007	67.0%		60.1%		-
2010	84.7%		72.9%		-
2011	85%		73%		-
PRENATAL CARE					
Begun during first trimester	79.7%	76.3%	81.1%	82.4%	77.9%
ALCOHOL AND TOBACCO					
Mother smokes at initial WIC visit	2.1%	6.5%	9.3%	2.9%	1.4%
Smoker present in the household	8.9%	11.3%	8.5%	8.0%	-
Alcohol consumption in last trimester	0.3%	0.9%	0.2%	0.3%	1.7%

Inter Tribal Council of Arizona, Inc. (December 2012).Gila River Indian Community WIC Program Maternal and Child Health Profile. Unpublished report provided by the Gila River Indian Community WIC Program

Inter Tribal Council of Arizona, Inc. (February 2014).Gila River Indian Community WIC Program Maternal and Child Health Profile. Unpublished report provided by the Gila River Indian Community WIC Program

More than three-quarters of Gila River WIC mothers reported beginning prenatal care during the first trimester of pregnancy. This rate matches the Healthy People 2020 target (77.9%).

About seven percent of Gila River mothers reported smoking at the time of enrollment in the WIC program.

Reported alcohol consumption (less than 1%) during the third trimester meets the Healthy People 2020 target (1.7%).

An important resource to families in the Community is the Family Planning/HIV Program, which provides innovative outreach medical services directly to the Community using a Medical Mobile Unit (MMU) that features professional medical staff and state-of-the-art medical equipment. The goal of the program is to bring comprehensive, culturally sensitive reproduction health services directly to the Community with an emphasis on the prevention of unintended pregnancies, sexually transmitted infections (STI), and HIV (Human Immunodeficiency Virus). Services include well-woman examinations, a wide variety of birth

control options, pregnancy testing, post-partum care, emergency contraception, and reproductive health education for men and women. The Mobile Medical Unit (MMU) and staff travel to and provide services in all seven districts of the Gila River Indian Community, and to the Ak-Chin Indian Community. The program provides services to both high schools in the community, and to the juvenile and adult correction facilities. Both Native and non-Native men and women are able to access care, and no patient will be denied services due to the inability to pay a fee.

Insurance Coverage

Affordable Care Act and Medicaid Expansion

In 2012, Arizona had the third highest rate of uninsured children in the country, with 13 percent of the state's children (those under 18 years of age) uninsured.[87]

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010. The ACA aims to expand access to health care coverage, requires insurers to cover preventative and screening services such as vaccinations, and ensures coverage for those with pre-existing conditions. In 2013, states could choose to expand Medicaid, with the federal government covering the entire cost for three years and 90 percent thereafter, which Arizona chose to do. Arizonans who earn less than 133 percent of the federal poverty level (approximately $14,000 for an individual and $29,000 for a family of four) are eligible to enroll in Medicaid (AHCCCS), while those with an income between 100 percent and 400 percent of the federal poverty level who are not eligible for other affordable coverage may receive tax credits to help offset the cost of insurance premiums.[88] These individuals can purchase health insurance thru health insurance exchanges. The ACA requires most Americans to obtain insurance coverage.

In addition to immunizations, the ACA requires insurance plans to cover of a number of "essential" services relevant to children. These include routine eye exams and eye glasses for children once per year, and dental check-ups for children every six months.[89] However, in Arizona, offered health plans are not required to include these pediatric vision and oral services, as long as supplemental, stand-alone pediatric dental and vision plans are available to

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[87] Mancini, T. & Alker, J. (2013). Children's Health Coverage on the Eve of the Affordable Care Act. Georgetown University Health Policy Institute, Center for Children and Families. http://ccf.georgetown.edu/wp-content/uploads/2013/11/Children%E2%80%99s-Health-Coverage-on-the-Eve-of-the-Affordable-Care-Act.pdf

[88] The Affordable Care Act Resource Kit. National Partnership for Action to End Health Disparities. http://health.utah.gov/disparities/data/ACAResourceKit.pdf

[89] Arizona EHB Benchmark Plan. Centers for Medicare & Medicaid services. http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/arizona-ehb-benchmark-plan.pdf

consumers.[90] A potential barrier to this method is that a separate, additional premium for this supplemental plan is required,[91] and subsidies will not be available for these separately purchased plans.[92] Both these factors may make these supplemental pediatric dental and vision plans unaffordable for some families. In addition, when these "essential" services are offered in a stand-alone plan, families are not required to purchase them to avoid penalties. These factors may limit the uptake of pediatric dental and vision coverage in Arizona.

Affordable Care Act and American Indians and Alaska Natives

As mentioned, the ACA aims to improve the health of all Americans by increasing health care coverage and health care services. The ACA also permanently reauthorizes the Indian Health Care Improvement Act, which legalizes the provisions of healthcare to be provided to American Indians and Alaska Natives (AIANs). Under the ACA, all Indian Health Service providers and functions will continue to operate as before; and AIANs who acquire health care coverage through the Market Place are still eligible to receive services from Indian Health Service and tribal and urban health clinics/programs. In addition, the ACA contains several mandates concerning American Indians and Alaska Natives (AIANs), tribal health delivery systems, and tribal employers that are important to take note of.

American Indians who are members of federally recognized tribes (and Alaska Natives who are members of ANCSA Corporations) have special privileges under the ACA that other Americans do not have. One such privilege is the ability to enroll in a health insurance plan at any time during the year, regardless of open enrollment time frames. AIANs are also able to change their health insurance plans as often as once a month. Qualified AIANs are also eligible for special insurance plan rates. Those who make below 300 percent of the federal poverty level (approximately $34,500 for an individual and $70,700 for a family of four) are eligible to enroll in Zero Cost Sharing plans which require no out-of-pocket costs to enrollees. Additionally, qualified AIANs who make above 300 percent of the federal poverty level, are eligible to enroll in Limited Cost Sharing plans. AIANs are also eligible to apply for exemption from the fee (Shared Responsibility Fee) that applies to Americans who can afford to buy health insurance, but choose not to buy it. Those who are not members of a federally recognized tribe but are still eligible to receive Indian health care services, can also benefit from special cost eligibility requirements for both Medicaid and the Children's Health Insurance Program (CHIP).

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[90] Essential Health Benefits. Arizona Department of Insurance. June 1, 2012. http://www.azgovernor.gov/hix/documents/Grants/EHBReport.pdf

[91] Can I get dental coverage in the Marketplace? https://www.healthcare.gov/can-i-get-dental-coverage-in-the-marketplace/

[92] Kids' Dental Coverage Uncertain under ACA. Stateline, The Daily News of the Pew Charitable Trusts. http://www.pewstates.org/projects/stateline/headlines/kids-dental-coverage-uncertain-under-aca-85899519226

Enrolling in Medicaid, CHIP, and private insurance plans offers both individual health benefits and benefits for entire tribal communities and all AIAN people. Individuals who enroll in a health insurance plan gain increased access to health care services by being able to visit their insurance plan providers and Indian Health Services, Tribes and Tribal Organizations, and Urban Indian Organizations (I/T/Us). Entire AIAN communities benefit because when an outside insurer is billed for medical services there is a savings in Contract Health Service. The money saved through outside billing (3rd party billing) can then be used in other ways to benefit all tribal citizens.

Another mandate of the ACA is that many employers must offer health care insurance coverage to their employees. Tribes are unique in this sense because many tribes also function as employers, therefore, this mandate will apply. However, this mandate will effect tribes and tribal employers differently, depending on the number of full-time and full-time equivalent employees the tribe/tribal enterprise has. As a basic rule of thumb, employers who employ 50 or more full-time or full-time equivalent employees are classified as a 'Large Employer' and required to offer health insurance to their employees or pay a fine. More information regarding employer health insurance mandates and an interactive questionnaire for employers can use to find out what their business is classified as and what their health insurance responsibilities are can be found at http://tribalhealthcare.org/tribal-employers/.

The estimated proportion of uninsured young children in the region (30%) is slightly lower than the rate for the population overall (34%), and both of these rates are higher than the proportion of young children and total population who are uninsured across all Arizona reservation. The uninsured rates vary by district, with D1 having the highest estimated rate of uninsured population in the Community among all ages (52%) and young children.

Table 30. Percent of population uninsured[93]

GEOGRAPHY	CENSUS 2010 POPULATION (ALL AGES)	ESTIMATED PERCENT OF POPULATION UNINSURED (ALL AGES)	CENSUS 2010 POPULATION (0-5)	ESTIMATED PERCENT OF POPULATION UNINSURED (0-5)
Gila River Indian Community	11,712	34%	1,530	30%
District 1	1,139	52%	146	78%
District 2	555	53%	55	-
District 3	2,687	36%	363	24%
District 4	2,378	27%	344	0%
District 5	1,960	19%	226	12%
District 6	2,180	41%	301	50%
District 7	813	40%	95	0%
Arizona	6,392,017	17%	546,609	11%
All Arizona Reservations	178,131	29%	20,511	23%
Pinal County	375,770	15%	36,181	10%
Arizona	6,392,017	17%	546,609	11%

US Census (2010). Tables P1 and P14. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
US Census (2013). American Community Survey 5-Year Estimates, 2008-2012, B27001. Retrieved from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
Note: Because of the small sample size, the estimate for District 2 cannot be reliably calculated

Medicaid (AHCCCS) Coverage

Children in Arizona are covered by the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid, through both the Title XIX program (Traditional Medicaid and the Proposition 204 expansion of this coverage of up to 100 percent of the Federal Poverty Level or FPL) and the Title XXI program (Arizona's Children's Health Insurance Program known as KidsCare). KidsCare operates as part of the AHCCCS program and provides coverage for children in households with incomes between 100 percent -200 percent of the FPL. However, due to budget cuts at the state level, enrollment in the KidsCare Program was frozen on January 1, 2010, and eligible new applicants were referred to the KidsCare Office to be added to a waiting list.

Beginning May 1, 2012 a temporary new program called KidsCare II became available through January 31, 2014, for a limited number of eligible children. KidsCare II had the same benefits and premium requirements as KidsCare, but with a lower income limit for eligibility; it was only open to children in households with incomes from 100 percent to 175 percent of the FPL, based

[93] Please note that if an individual indicated that his only coverage for health care services is through the Indian Health Service (IHS), the ACS considers this person to be "uninsured."

on family size. Monthly premium payments, however, were lower for KidsCare II than for KidsCare.[94]

Currently, enrollment for the original KidsCare remains frozen in 2014. Children enrolled in KidsCare with families making between 133 percent and 200 percent of the FPL will remain in KidsCare as long as they continue to meet eligibility requirements, and continue paying the monthly premium. Children enrolled in KidsCare whose families make between 100 percent and 133 percent of the FPL will be moved to Medicaid (AHCCCS). New applicants to KidsCare with incomes below 133 percent of the FPL will be eligible for Medicaid (AHCCCS). Applicants with incomes above 133 percent of the FPL will be referred to the ACA health insurance exchanges to purchase (potentially subsidized) health insurance.[95]

Data on AHCCCS or KidsCare enrollment at the regional level were not available to be included in this report.

Developmental Screenings and Services for Children with Special Developmental and Health Care Needs

The National Survey of Children with Special Health Care Needs estimated that 7.6 percent of children from birth to 5 (and about 17% of school-aged children) in Arizona have special health care needs, defined broadly as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." [96] The survey also estimates that nearly one in three Arizona children with special health care needs has an unmet need for health care services (compared to about one in four nationally).

In addition, although all newborns in Arizona are screened for hearing loss at birth, approximately one third of those who fail this initial screening don't receive appropriate follow up services to address this auditory need.[97]

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[94] Monthly premiums vary depending on family income but for KidsCare they are not more than $50 for one child and no more than $70 for more than one child. For KidsCare II premiums are no more than $40 for one child and no more than $60 for more than one. Note that per federal law, Native Americans enrolled with a federally recognized tribe and certain Alaskan Natives do not have to pay a premium. Proof of tribal enrollment must be submitted with the application. http://www.azahcccs.gov/applicants/categories/KidsCare.aspx and http://www.azahcccs.gov/applicants/KidsCareII.aspx

[95] Arizona State Health Assessment, December 2013. Arizona Department of Health Services. http://www.azdhs.gov/diro/excellence/documents/az-state-health-assessment.pdf

[96] "Arizona Report from the 2009/10 National Survey of Children with Special Health Care Needs." NS-CSHCN 2009/10. Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [08/06/12] from www.childhealthdata.org.

[97] Maternal and Child Health Services Title V Block Grant, State Narrative for Arizona, Application for 2013, Annual Report for 2011. http://www.azdhs.gov/phs/owch/pdf/mch/title-v-block-grant-narratives-2013.pdf

The Arizona Child Find program is a component of the Individuals with Disabilities Education Act (IDEA) that requires states to identify and evaluate all children with disabilities (birth through age 21) to attempt to ensure that they receive the supports and services they need. Children are identified through physicians, parent referrals, school districts and screenings at community events. Each Arizona school district is mandated to participate in Child Find and to provide preschool services to children with special needs either though their own schools or through agreements with other programs such as Head Start.

Table 31 shows the services provided to children with special needs enrolled in the Head Start Program.

Table 31. Head Start services for children with special developmental and health care needs

PROGRAM NAME	% CHILDREN WITH IEP OR ISFP	RECEIVING SERVICES FOR SPEECH IMPAIRMENT	RECEIVING SERVICES FOR HEARING IMPAIRMENT	RECEIVING SERVICES FOR DEVELOPMENTAL DELAY
Early Head Start	5%	-	-	-
Head Start	14%	4%	0%	11%

Office of Head Start (2013). 2013 Performance Indicator Report Data Extract. Retrieved from https://hses.ohs.acf.hhs.gov/pir/

Screening and therapy services are provided by the Gila River Early Childhood Special Services (ECSS). ECSS is a Community program for families with children birth to five who may have disabilities and developmental delays. Early Childhood Special Services provides support to families through educating and providing developmental services to their children to help them reach their full potential. Services for children can include: Hearing and vision checks, physical, occupational, and speech and language therapy, activities geared to help develop learning skills, activities to help social and emotional development, continuing services at age three as the child moves on to school, supportive child care providers or preschool teachers of enrolled children. Family services can include: Parent trainings, access to support groups, and family services, coordination of district wide agencies that provide social and health services, in home and community settings.

AzEIP Referrals and Services

Screening and evaluation for children from birth to three are provided by the Arizona Early Intervention Program (AzEIP), which also provides services or makes referrals to other appropriate agencies (e.g. for Department of Developmental Disabilities case management). Children eligible for AzEIP services are those who have not reached 50% of the developmental milestones for his or her age in one or more of the following areas: physical, cognitive, communication/language, social/emotional or adaptive self-help. Children who are at high risk for developmental delay because of an established condition (e.g., prematurity, cerebral palsy, spina bifida, among others) are also eligible. Families who have a child who is determined to be eligible for services work with the service provider to develop an individualized Family Service

Plan that identifies family priorities, child and family outcomes desired, and the services needed to support attainment of those outcomes.

AzEIP providers can offer, where available, an array of services to eligible children and their families, including assistive technology, audiology, family training, counseling and in-home visits, health services, medical services for diagnostic evaluation purposes, nursing services, nutrition, occupational therapy, physical therapy, psychological services, service coordination, social work, special instruction, speech-language therapy, vision services, and transportation (to enable the child and family to participate in early intervention services).

AzEIP moved to a team based model for delivery of early intervention services in 2013. In this model, a team lead is the primary partner with the family in the provision of services. The team lead's focus is on collaborative coaching of families as the primary intervention strategy. The lead is supported by other team members, through regular team meetings and joint visits with the family.[98] The move to this team model required that contracted agencies be able to provide multiple therapeutic services (such as OT, PT, speech therapy, etc.) which lead to specialized and smaller agencies being excluded from participation, and resulted in more contracts with larger agencies in urban settings who either sub-contracted services out to more rural communities, or had to travel to the areas to provide services.

Private insurance often does not cover the therapies needed for children with special needs. The 2009-2010 National Survey of Children with Special Health Care Needs found that 22 percent of families with a child with special health care needs pay $1000 or more in out of pocket medical expenses (U. S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, 2013). The cost of care has become an even more substantial issue as state budget shortfalls led AzEIP to institute a system of fees for certain services (called "Family Cost Participation"). Although no fees are associated with determining eligibility or developing an Individualized Family Service Plan, some services that were previously offered free of charge, such as speech, occupational and physical therapy, now have fees. The families of AHCCCS-enrolled children are not required to pay the fees. The cost of services is based on location and how difficult an area is to serve; urban areas are considered "base" and have lower rates per hour compared to rural areas. According to the AzEIP website, the agency is in the process of updating their Early Invention Policies and Procedures. The proposed revisions would eliminate the Family Cost Participation, and public comment on the new policy was received through June 16, 2014.[99]

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[98] https://www.azdes.gov/AzEIP/KeyPrinciples/

[99] https://www.azdes.gov/main.aspx?menu=98&id=13684

Regional AzEIP data were unavailable for the current report, however some state-level summaries were provided. Data provided include AzEIP statewide data for the total unduplicated number of children served for 2012 (note: these numbers include children served in AzEIP only, DDD and ASDB (AZ Schools for the Deaf and Blind)). During the month of February 2013, there were 5,451 AzEIP eligible children with an Individualized Family Service Plan. In addition, the total number of children served in Arizona in 2012 based on an October 1st count was 5,100. Of those, 667 were one year old or younger, 1,561 were between the ages of one and two and 2,872 were between two and three years of age. The total number of infants and toddlers receiving early intervention services from July 1, 2011, through June 30, 2012 was 9,738 (this includes all AzEIP eligible children including AzEIP only, DDD and ASDB).[100]

The region's AzEIP service provider is the Easter Seals Blake Foundation and RISE Early Intervention Services, depending on where Community residents live.

Preschool and elementary school children enrolled in special education

Another indicator of the needs for developmental services and services for children with special needs is the number of children enrolled in special education within schools. As can be seen in Table 32, the percentage of preschool and elementary school students enrolled in special education in the Sacaton Elementary District is twice the rate as among all Arizona Public and Charter schools.

Table 32. Percent of preschool and elementary school children enrolled in special education

LOCAL EDUCATION AGENCY (LEA)	NUMBER OF SCHOOLS	NUMBER OF STUDENTS	STUDENTS ENROLLED IN SPECIAL EDUCATION	
Coolidge Unified District	10	1,919	252	13%
Kyrene Elementary District	52	13,641	1,103	8%
Sacaton Elementary District	4	373	91	24%
Union Elementary District	4	1,386	155	11%
All Arizona Public and Charter Schools	2,846	610,079	72,287	12%

Arizona Department of Education (2014). [Preschool and Elementary Needs data set]. Unpublished raw data received from the First Things First State Agency Data Request

According to key informants, good services are available to help parents and caregivers of children with special needs in the region. Sometimes, however, finding vendors that are qualified and licensed to serve children in the region may be a challenge because the region lies on both Pinal and Maricopa Counties and vendors may be able to provide services in one county but not the other. Key informants pointed out that the provision of services being

[100] Arizona Department of Economic Security. (2014). [AzEIP data set]. Unpublished raw data received through the First Things First State Agency Data Request.

divided by county lines is confusing for parents and other health providers in the region, and may result in families not accessing the services available to them.

In addition, lack of local providers often means that families have to drive more than one hour to receive services (for physical therapy services at Cardon Children's Medical Center in Mesa, for instance).

Immunizations

Recommended immunizations for children birth through age six are designed to protect infants and children when they are most vulnerable, and before they are exposed to these potentially life-threatening diseases.[101] Personal belief exemptions, parents/guardians opting out of required immunizations for their children for personal reasons rather than medical ones, have risen in Arizona kindergartens in recent years from 1.6% in 2003 to 3.9% for the 2012-2013 school year.[102] More than a third of kindergartens (35%), and 29 percent of child care facilities in the state have personal belief exemption rates greater than five percent. Personal belief exemptions are most often done for convenience (it may be easier than obtaining vaccination records) or due to fears about the negative health consequences of the vaccine itself. Those obtaining personal belief exemptions in kindergarten settings are more likely to be from white, higher income families, with higher rates also found in charter schools compared to public schools.[103] This is particularly interesting when considered along with the fact that Arizona has the highest number of charter schools in the country. Geographic clustering of high personal belief exemption rates also exists in the state, which is of particular concern when considering the likelihood of vaccine-preventable disease outbreaks, e.g., pertussis. In sum, parental refusal to vaccinate is contributing to levels of under-vaccination across the state.

In response to these concerns, the Arizona Department of Health Services has developed an Action Plan to Address Increasing Vaccine Exemptions.[104] This plan includes strategies aimed at schools, child care centers, physicians' offices and parents consisting of revisions to exemptions

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[101] Centers for Disease Control and Prevention. Immunization Schedules. Retrieved from http://www.cdc.gov/vaccines/schedules/easy-to-read/child.html

[102] Birnbaum, M. S., Jacobs, E. T., Ralston-King, J. & Ernst, K. C. (2013). Correlates of high vaccination exemption rates among kindergartens. Retrieved from http://www.azdhs.gov/phs/immunization/documents/statistics-reports/personal-beliefs-exemption-study/correlates-of-high-vaccination-exemption-rates-among-kindergartens.pdf

[103] Birnbaum, M. S., Jacobs, E. T., Ralston-King, J. & Ernst, K. C. (2013). Correlates of high vaccination exemption rates among kindergartens. Retrieved from http://www.azdhs.gov/phs/immunization/documents/statistics-reports/personal-beliefs-exemption-study/correlates-of-high-vaccination-exemption-rates-among-kindergartens.pdf

[104] Arizona Department of Health Services. *Action Plan to Address Increasing Vaccine Exemptions*. 10/1/2013. Retrieved from http://azdhs.gov/phs/immunization/documents/statistics-reports/action-plan-address-vaccine-exemptions.pdf

forms, education and training, streamlined immunization reporting and better resources covering immunization requirements. Implementation of these strategies have begun and rates of exemptions will be tracked over time to judge the success of these strategies.

The table below shows the proportion of children in the Head Start and Early Head Start programs that were up-to-date with on their immunizations at the end of the 2012-2013 year.

Table 33. Percent of Head Start children up-to-date on immunizations

PROGRAM	CHILDREN ENROLLED	PERCENT UP-TO-DATE ON IMMUNIZATIONS AT END OF YEAR
Early Head Start	111	77%
Head Start	222	100%

Office of Head Start (2013). 2013 Performance Indicator Report Data Extract. Retrieved from https://hses.ohs.acf.hhs.gov/pir/

Behavioral Health

Researchers and early childhood practitioners have come to recognize the importance of healthy social and emotional development in infants and young children.[105] Infant and toddler mental health is the young child's developing capacity to "experience, regulate and express emotions; form close interpersonal relationships; and explore the environment and learn."[106] When young children experience stress and trauma they have limited responses available to react to those experience. Mental health disorders in small children might be exhibited in physical symptoms, delayed development, uncontrollable crying, sleep problems, or in older toddlers, aggression or impulsive behavior.[107] A number of interacting factors influence the young child's healthy development, including biological factors (which can be affected by prenatal and postnatal experiences), environmental factors, and relationship factors.[108]

A continuum of services to address infant and toddler mental health promotion, prevention and intervention has been proposed by a number of national organizations. Recommendations to

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[105] *Research Synthesis: Infant Mental health and Early Care and Education Providers*. Center on the Social and Emotional Foundations for Early Learning. Accessed online, May 2012: http://csefel.vanderbilt.edu/documents/rs_infant_mental_health.pdf

[106] Zero to Three Infant Mental Health Task force Steering Committee, 2001

[107] Zero to Three Policy Center. Infant and Childhood Mental Health: Promoting Health Social and Emotional Development. (2004). Retrieved from http://main.zerotothree.org/site/DocServer/Promoting_Social_and_Emotional_Development.pdf?docID=2081&AddInterest=1144

[108] Zenah P, Stafford B., Nagle G., Rice T. *Addressing Social-Emotional Development and Infant Mental Health in Early Childhood Systems.* Los Angeles, CA: National Center for Infant and Early Childhood Health Policy; January 2005. Building State Early Childhood Comprehensive Systems Series, No. 12

achieve a comprehensive system of infant and toddler mental health services would include 1) the integration of infant and toddler mental health into all child-related services and systems, 2) ensuring earlier identification of and intervention for mental health disorders in infants, toddlers and their parents by providing child and family practitioners with screening and assessment tools, 3) enhancing system capacity through professional development and training for all types of providers, 4) providing comprehensive mental health services for infants and young children in foster care, and 5) engaging child care programs by providing access to mental health consultation and support.[109] Table 34 shows information about the mental health services to children in the Gila River Indian Community Head Start Program.

Table 34. Child Mental Health Services through Head Start

PROGRAM	MENTAL HEALTH PROFESSIONAL ON-SITE (AVERAGE)	% CHILDREN WITH INDIVIDUAL MENTAL HEALTH ASSESSMENTS	% CHILDREN REFERRED FOR OUTSIDE MENTAL HEALTH SERVICES	% CHILDREN REFERRED FOR MENTAL HEALTH SERVICES THAT RECEIVED SERVICES
Early Head Start	20 hours/month	0%	0%	-
Head Start	20 hours/month	5%	3%	100%

Office of Head Start (2013). 2013 Performance Indicator Report Data Extract. Retrieved from https://hses.ohs.acf.hhs.gov/pir/

The Arizona Department of Health Services/Division of Behavioral Health Services is the permanent authority for publicly-funded behavioral health services in the state. The Division contracts with Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) to deliver integrated managed care services through six geographic service areas throughout the state. In 2012, over 213,000 Arizonans were enrolled in the public behavioral health system. According to Arizona Department of Health data, 68,743 (32.2%) of enrollees were children or adolescents, up from 21.3 percent in 2011; children aged 0-5 comprised 4.6 percent of all enrollees[110] in 2012, compared to 3.8 percent in 2011.[111] With about 546,609 children aged birth to 5 in Arizona, this means that almost two percent of young children statewide are receiving care in the public behavioral health system.

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[109] Zero to Three Policy Center. Infant and Childhood Mental Health: Promoting Health Social and Emotional Development. (2004). Retrieved from http://main.zerotothree.org/site/DocServer/Promoting_Social_and_Emotional_Development.pdf?docID=2081&AddInterest=1144

[110] Division of Behavioral Health Services, Arizona Department of Health Services. (2013). *An Introduction to Arizona's Public Behavioral Health System*. Phoenix, Arizona. Retrieved from http://www.azdhs.gov/bhs/documents/news/az-behavioral-health-system-intro-2013.pdf

[111] Division of Behavioral Health Services, Arizona Department of Health Services. (2012). *An Introduction to Arizona's Public Behavioral Health System*. Phoenix, Arizona.

It is likely that there are a much higher proportion of young children in need of these types of services than are receiving them. The lack of highly trained mental health professionals with expertise in early childhood, particularly in more rural areas, has been noted as a barrier to meeting the full continuum of service needs for young children. Better equipping healthcare and other service providers to meet infant mental health needs and to serve as effective sources of referral has been proposed as one strategy to help with this barrier to access to this level of care.[112]

The Gila River Regional Behavioral Health Authority is the contracted agency providing services in the region.

The Behavioral Health Services Department of Gila River Health Care serves all tribal members, AHCCCS enrollees and the uninsured. Services available through this department include: outpatient mental health counseling program (individual and family counseling); child and adult psychiatric services; crisis intervention; medical social work services and prevention. Case management is provided by a clinical liaison in several offices throughout the community, although most clients receive services in Sacaton.

The Behavioral Health Services Department also has a 90-day substance abuse treatment component. A residential program for adults is available within the Community and clients can bring in their children 12 and under.

Counselors with the Department conduct mental health observations of the children in the Gila River Indian Community Head Start program at least twice a year (within the first 60-90 days of school). Depending on the results of these observations counselors might have more frequent visits. If any behavioral health issues arise as part of the observations a meeting with the parents is set up and a referral to psychological or psychiatric services is made when appropriate. Counselors are also available to do in-services for the Head Start staff. A Maricopa county fellowship program for child psychologists allows fellows to provide services once a week at the Gila River Behavioral Health Services Department on a rotation basis. Fellows conduct observations with clients and can also offer training for the Department's staff; they are also able to attend meetings set up with parents to provide education to reduce the stigma surrounding behavioral health services.

According to key informants, a recent development in the Gila River Behavioral Health Services Department has been a closer relationship with the hospital-based behavioral health services, in an effort to integrate both areas. The department has also been collaborating more closely

[112] U.S. Department of Health and Human Services. (2000). Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Author.

with other programs under Gila River Health Care such as the Pediatrics Department and the Life Center (diabetes prevention). These programs have been working together in gathering information about how diabetes education is being delivered by different programs in the Community (e.g. Early Head Start, WIC, Early Childhood Special Services) so they can develop a consistent message.

Another project that the Behavioral Health Services Department's Prevention Program has recently been involved with is a suicide registry. Starting in January of 2013, this registry tracks information about cases of suicide attempts or completion from the Emergency Medical Services (EMS) first responders. The goal is to be able to identify areas in the Community with higher rates and do targeted prevention programming. This work has been possible through a grant from the Indian Health Service (IHS).

Oral Health

Oral health is an essential component of a young child's overall health and well-being, as dental disease is strongly correlated with both socio-psychological and physical health problems, including impaired speech development, poor social relationships, decreased school performance, diabetes, and cardiovascular problems. Although pediatricians and dentists recommend that children should have their first dental visit by age one, half of Arizona children 0-4 have never seen a dentist. In a statewide survey conducted by the ADHS Office of Oral Health, parents most frequently cited difficulties in finding a provider who will see very young children (34%), and the belief that the young child does not need to see a dentist (46%) as primary reasons for not taking their child to the dentist.[113] Among Arizona third-grade children screened in 2009-2010, American Indian children showed higher rates of decay experience (treated and untreated) than did non-Native children (93 percent compared with 76 percent), with 62 percent showing signs of untreated decay (compared to 41 percent among non-American Indian children). American Indian children were also less likely to have seen a dentist during the year prior to their screening (59 percent, compared to 73 percent for non-American Indian children).[114]

Dental services for children 6 months of age to 5 years of age are available through Gila River Health Care.

In 2009 IHS launched a national initiative called Early Childhood Caries (ECC) Collaborative with the overall goal of the program being to draw attention to, and prevent Early Childhood Caries,

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[113] Office of Oral Health, Arizona Department of Health Services. (2009). *Arizona Oral Health Survey of Preschool Children.*

[114] *Arizona American Indian Oral Health Summit, Final Report* (2011). Retrieved from http://www.azdhs.gov/diro/tribal/pdf/reports/OralHealthSummit2011.pdf

which affects more than half of American Indian children nationwide. Early Childhood Caries (ECC, also known as early childhood tooth decay) is an infectious disease that can start as early as when an infant's teeth erupt having lasting detrimental impact on a child's health and well-being.

The ECC Collaborative is a multi-faceted program designed to enhance knowledge about early childhood caries prevention and early intervention among dental providers, healthcare providers in general, other programs working with young children (such as WIC and Head Start) and the community at large. The IHS Division of Oral Health provides funding for this Collaborative for printed materials, training for conducting dental health surveillance in participating communities utilizing the Basic Screening Survey (BSS), travel costs for presentations to engage community partners at many levels, and the conduction of the actual BSS. One finding of the 2010 BSS survey of particular importance was that nationwide, by the age of two years old, 44 percent of children already had some form of dental carries, leading the IHS ECC Collaborative Committee to make the statement that "two is too late" for children to be receiving their first oral exam by a dentist.

The ECC Collaborative has collected oral health data from IHS Service Areas 6 months prior to, and 6 months after the ECC was launched around their four objectives of: 1) Increasing access to care, 2) Increasing number of sealants applied, 3) Increasing the number of fluoride varnish applications, and 4) Increasing the number of ITRs applications for American Indian/Alaska Native children 0 to 5 years of age. Currently, the IHS ECC Collaborative is in its 5th and final year of operation, final data collection will take place in the fall of 2014. After final data is collected, the IHS ECC Collaborative will then evaluate various interventions that have been on-going since the initiative began, and identify which interventions were most the most effective in reducing the prevalence of ECC in American Indian Children. [115]

Data from the 2010 and 2011 ECC Basis Screening Survey (BSS) for the Phoenix Area (which includes the Gila River Indian Community) show that more than half (57%) of the 571 children 0 to 5 who participated in the survey had tooth decay. Over one third (36%) of the children participating had untreated tooth decay and the mean number of teeth with decay among them was 3.69. In the IHS Phoenix Area overall, more than half of the young children surveyed (52%) had caries by age two. By five years of age, 75 percent of the children had caries.[116]

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[115] Indian Health Service Early Childhood Caries Collaborative (2014). The IHS ECC Collaborative: Beginning the 5th and Final Year. *The IHS Dental Explorer*, 1-14.

[116] Huber, D. (2013, June). *Arizona Basic Screening Survey Results 2010, 2011*. Presentation delivered at the 2013 Intertribal Circle of Caring and Sharing Training Conference, Prescott, Arizona.

Table 35. Tooth decay among young children

GEOGRAPHY	% CHILDREN (0-5) WITH TOOTH DECAY	% CHILDREN (0-5) WITH UNTREATED TOOTH DECAY	MEAN NUMBER OF TEETH WITH DECAY	NUMBER OF PARTICIPATING CHILDREN
Phoenix Area IHS	57%	36%	3.69	571
All IHS	54%	39%	3.5	NA

Huber, D. (2013, June). Arizona Basic Screening Survey Results 2010, 2011. Presentation delivered at the 2013 Intertribal Circle of Caring and Sharing Training Conference, Prescott, Arizona.

The IHS ECC encourages collaboration between dental providers and key partners such as Head Start programs. In 2012-2013 the majority of children enrolled in the Gila River Indian Community Head Start program received an oral health exam (87%) and more than a third received (39%) preventative services. Fifty two percent of the children examined were found to need dental treatment, and of those, 79 percent were reported to have received treatment.[117]

Table 36. Child Oral Health Services for children enrolled in Head Start

PROGRAM	% CHILDREN WITH CONTINUOUS ACCESSIBLE DENTAL CARE	% CHILDREN WITH DENTAL PREVENTATIVE CARE	% CHILDREN WITH ORAL HEALTH EXAM	% CHILDREN DIAGNOSED NEEDING DENTAL TREATMENT	% CHILDREN RECEIVING DENTAL TREATMENT
Head Start	41%	39%	87%	52%	79%

Office of Head Start (2013). 2013 Performance Indicator Report Data Extract. Retrieved from https://hses.ohs.acf.hhs.gov/pir/

In additional to the IHS ECC Collaborative going on at the national level, there are other local initiatives at the state level promoting awareness on the importance of early childhood oral health among Native children in Arizona. In April of 2011 the first Arizona American Indian Oral Health Summit was held at the Fort McDowell Yavapai Nation. One of the recommendations that originated from this gathering was the creation of an Arizona American Indian Oral Health Coalition with the goal of improving oral health literacy, prevent oral health disease, increase the quality of treatment, and increase the number of Native oral health professionals in the state. The Arizona American Indian Oral Health Coalition was awarded a grant from the DentaQuest Foundation to conduct a series of Tribal Leaders' Roundtables with representatives from all Arizona tribes. These gatherings provided recommendations for the structure and future goals of the Coalition, whose overall goal is to advocate for improved oral health among American Indians living in Arizona.

[117] Office of Head Start (2013). *2013 Performance Indicator Report Data Extract*. Retrieved from https://hses.ohs.acf.hhs.gov/pir/

Overweight and Obesity

Overweight children are at increased risk for becoming obese. Childhood obesity is associated with a number of health and psycho-social problems, including high blood pressure, high cholesterol, Type 2 diabetes and asthma. Childhood obesity is also strong predictor of adult obesity, with its related health risks. Of particular concern for younger children is research that shows a child who enters kindergarten overweight is more likely to become obese between the ages of five and 14, than a child who is not overweight before kindergarten.[118]

A major new report revealed promising news however: a 43 percent decline in the obesity rate among children aged two to five years-old in the United States over the past decade, from about 14 percent to about 8 percent.[119] While the cause for the decline is not known, possible reasons include reduced consumption of overall calories and sugary drinks by young children, increased breastfeeding and/or state, local or federal policies aimed at reducing obesity. While this decline is indeed promising, the disproportionate rates of obesity in minority and low-income children remain. Nationally among two to five year olds in 2012, about four percent of White children were obese, compared to 11 percent of Black children and 17 percent of Hispanic children. This is in spite of fairly similar obesity rates for children under two years old. And while 18 other states have shown a decrease in obesity among low-income preschoolers between 2008 and 2011, Arizona was not one of those states[120].

As mentioned above, the obesity rate of children ages 2 to 4 who participated in the Gila River Indian Community WIC program in 2012 was 27.5 percent.

One of the efforts in the region aimed at addressing the high rates of obesity and diabetes is the Genesis program. This program aims to promote awareness of the health benefits of breastfeeding, healthy food choices, and family fitness activities in order to improve the health and longevity of Gila River Indian Community children and families. The program offers breastfeeding information and support, and awareness education about nutrition, physical activity, and diabetes. Three categories of nutrition classes are offered: Nutrition Education for Infants, Nutrition Education for Toddlers and Young Children (ages 1-5), and Nutrition Education for Families. Nutrition education and physical activation classes are offered in a location selected by each client, including the client's home, school, clinic, or the Genesis office.

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[118] Cunningham, S. A., Kramer, M. R., & Venkat Narayan, K. M. (2014). Incidence of Childhood Obesity in the United States. The New England Journal of Medicine. 370 (5); 403-411.

[119] Ogden, C. L., Carroll, M. D., Kit, B. K., & Flegal, K. M. (2014). Prevalence of Childhood and Adult Obesity in the United States, 2011-2012. JAMA, 2014; 311(8):806-814. http://jama.jamanetwork.com/article.aspx?articleid=1832542

[120] CDC. Vital Signs: Obesity among Low-Income, Preschool-Aged Children — United States, 2008–2011. MMWR, August 9, 2013 / 62(31);629-634

The program also offers breastfeeding classes for pregnant women and mothers. Class topics include breastfeeding and common problems, prenatal nutrition, developing a support system, and returning to work or school. Transportation to classes is provided for registrants who live within the Gila River Indian Community boundary. Breast pumps and other supplies are additionally provided to Gila River Indian Community members by Genesis.

Family Support

Family well-being has been identified as an important factor in child success.[121] Warm, nurturing, responsive, and consistent interactions can be protective factors for young children and help buffer them from adversities. Young children who experience exposure to abuse, neglect or trauma, however, are more likely to show abnormal patterns of development.[122] Providing resources, education, and supports to families can reduce childhood stresses and help young children reach their fullest potential in school and in life.

Key informants indicated that living in a small community, where most members know each other and care about their children is one of the main positive aspects of raising children in the region. Key informants also highlighted the fact that family is very important to Community members, and that there is a strong expectation of 'being there' for family members when they are in need. A diversity of programs and services available locally to families with young children was also reported to be a strength of the Community.

In terms of the most challenging aspects of raising children in the region, key informants pointed out that navigating some of the existing systems (e.g. child welfare; support for children with special needs) can be overwhelming for parents, who often are unsure of where to start in terms of accessing services. Another need identified by key informants was resources that target young parents (teenaged but also in their twenties) to provide them with parenting skills.

Other challenges reported by key informants were those related to the high rate of families living in poverty, and to the impact of historical trauma and alcoholism.

This section describes programs that are available to support families in the region.

[121] Martinez, Mehesy, & Seeley, 2003

[122] Scheeringa, M. S., & Zeanah, C. H. (1995). Symptom expression and trauma variables in children under 48 months of age. Infant Mental Health Journal, 16(4), 259–270.

Parental Involvement

Parental involvement has been identified as a key factor in the positive growth and development of children,[123] and educating parents about the importance of engaging in activities with their children that contribute to development has become an increasing focus.

Parent Education

Parenting education supports and services can help parents better understand the impact that a child's early years have on their development and later readiness for school and life success. Early Head Start and Head Start are important sources of parent education in the Community.

Table 37. Family Education Services through Head Start

PROGRAM	% FAMILIES RECEIVING AT LEAST ONE FAMILY SERVICE	% RECEIVING HEALTH EDUCATION	% RECEIVING PARENTING EDUCATION	% RECEIVING ADULT EDUCATION	% RECEIVING JOB TRAINING
Early Head Start	36%	36%	29%	4%	33%
Head Start	12%	7%	12%	2%	5%

Office of Head Start (2013). 2013 Performance Indicator Report Data Extract. Retrieved from https://hses.ohs.acf.hhs.gov/pir/

Teen Parenting

A key component of the VHM high school is the Teen Parenting Program, which provides crucial on-site support to teen parents to help them continue with their education. Youth who are expecting a child or are already parents have priority in enrollment. An important component that distinguishes the Teen Parenting program at VHM from similar programs is the fact that VHM is not limited to teen mothers but it is also geared towards the fathers. The school estimates over 80 percent placement of its students in some post-secondary endeavor (college or employment). As part of the Teen Parenting program, in 2010 VHM partnered with Early Head Start to bring a small child care center to the school campus. However, in early 2014 the Early Head start component that had been housed at VHM was moved to the new Head Start/Early Head Start facility that opened in Sacaton, located less than a mile away from VHM. While the new Early Head start location is still within easy access from the VHM campus (a 15-20 minute walk), key informants expressed some concerns about how even this relatively short distance might affect teen mothers' ability and willingness to breastfeed because of not having their babies as close to them as it used to be. Key informants, however, also pointed out that the new facility provides for a more adequate and ample space for the children.

[123] Bruner, C. & Tirmizi, S. N. (2010). *The Healthy Development of Arizona's Youngest Children.* Phoenix, AZ: St. Luke's Health Initiatives and First Things First.

Support for teen parents at VHM is also available from the Baby Smarts Program, funded by the Gila River Indian Community FTF Regional Partnership Council. Baby Smarts has two components: teen parent education and home visitation. The teen parent education component is provided to teen parents at both of the high schools in the Community (VHM and Ira H. Hayes). The teen parent education program puts a strong emphasis on preventing second pregnancies and on supporting teen parents so they can graduate from high school.

Home Visitation Programs

As mentioned in the previous section, the Gila River Indian Community Regional Partnership Council is currently funding a home visitation component as part of the Baby Smarts Program. The home visitation component provides in-home services for families, and focuses on education about topics such as parenting skills, child development, early literacy, and health using the Parents as Teachers (PAT) curriculum. According to the Region's SFY15 Funding Plan the target number of families to be served by this program is 40. There are two home visitors employed by the program and they work closely with the teen parent education coordinator but putting a stronger emphasis on the parent-child relationship.

Home visitation services are also available from the Gila River Health Care Public Nurses. According to key informants, this program is currently moving into the direction of aligning with the FTF-funded Baby Smarts one by also utilizing the PAT curriculum.

Child Welfare

Child abuse and neglect can have serious adverse developmental impacts, and infants and toddlers are at the greatest risk for negative outcomes. Infants and toddlers who have been abused or neglected are six times more likely than other children to suffer from developmental delays. Later in life, it is not uncommon for maltreated children to experience school failure, engage in criminal behavior, or struggle with mental and/or physical illness. However, research has demonstrated that although infants and toddlers are the most vulnerable to maltreatment, they are also most positively impacted by intervention, which has been shown to be particularly effective with this age group. This research underscores the importance of early identification of and intervention for child maltreatment, as it cannot only change the outlook for young children, but also ultimately save state and federal agencies money in the usage of other services.[124]

Indian Child Welfare Act (ICWA) - Special federal guidelines are currently in place to regulate how Native children and their families interact with the state's child welfare system. In 1978,

[124] Zero to Three: National Center for Infants, Toddlers, and Families. (2010). *Changing the Odds for Babies: Court Teams for Maltreated Infants and Toddlers.* Washington, DC: Hudson, Lucy.

Congress passed the Indian Child Welfare Act (ICWA) after investigations found that a disproportionately high number of Native (American Indian and Alaska Native) children were being placed in foster care and adoptive care with non-Native families and that those children who were being placed in non-Native families were experiencing problems adjusting to life away from their Native families and communities. Directly prior to the passing of the ICWA, under the Indian Adoption Project between 1961 and 1976, approximately 12,500 Native children had been removed from their reservation homes and placed with non-Natives parents through adoption procedures. Investigations conducted in 1969 and 1974 by the Association of American Indian Affairs found that at the time, between 25 percent and 35 percent of Native children were living in homes or institutions away from their families and communities. These findings, coupled by past policies and the practice of forcibly removing Native children from their homes into boarding schools, led Congress to passing the Indian Child Welfare Act. Representative Morris Udall of Arizona, a strong supporter of the ICWA, stated "there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children." ICWA established federal guidelines that are to be followed when an Indian child enters the welfare system in all state custody proceedings.[125]

Under ICWA, an Indian child's family and tribe are able and encouraged to be actively involved in the decision-making that takes place regarding the child, and may petition for tribal jurisdiction over the custody case. ICWA also mandates that states make every effort to preserve Indian family units by providing family services before an Indian child is removed from his or her family, and after an Indian child is removed through family reunification efforts. If an Indian child is removed by state Child Protective Services, ICWA requires preference for the child's placement to be first, with the child's relatives; second, with fellow tribal members; third, with another Indian person. Under IWCA, only in extreme cases can a tribal child be placed somewhere other than the preferences that have been established by the law.[126]

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[125] ICWA defines an "Indian child" as any unmarried person, below the age of 18 who is either a member of a federally recognized tribe, or eligible to become a member and is the biological child of a recognized tribal member.

[126] Frichner, T.G. (2010). The Indian Child Welfare Act: A National Law Controlling the Welfare of Indigenous Children. American Indian Law Alliance.

National Congress of American Indians. Child Welfare & TANF. National Congress of American Indians. Retrieved from http://www.ncai.org/policy-issues/education-health-human-services/child-welfare-and-tanf

National Indian Child Welfare Association. Frequently Asked Questions About ICWA. Retrieved from http://www.nicwa.org/indian_child_welfare_act/faq/#active_efforts

Palmiste, C. (2011). From the Indian Adoption Project to the Indian Child Welfare Act: the resistance of Native American communities. Indigenous Policy Journal 22(1), 1-10.

Child welfare services in the Gila River Indian Community are provided by the Gila River Indian Community Social Services Department.

In order to better support the families in the child welfare system, stakeholders in the Gila River Indian Community Region have worked to create a Children in Crisis Coalition. This group was established in 2009 when it became a model court system that involved the tribal Social Services Department, attorneys, prosecutors, tribal behavioral health services and the youth home. The Coalition started to focus on protocols and best practices, and also on trauma-informed care. In the fall of 2013 Coalition members made a decision to concentrate their efforts on young children (birth to five). Since then, the Coalition holds monthly meetings and has increased its list of stakeholders and agencies invited to participate. This expanding list now includes departments that had traditionally not been part the work children in crisis team such as pediatric care coordinators, the Gila River Indian Community WIC program and the Police Department.

In addition to bringing key stakeholders together to share information and build a better system to support families in crisis, the Coalition also provides training opportunities for staff from the departments directly involved with the children (e.g. tribal Child Protective Services foster parents, tribal Social Services Department).

One of the current projects of the Coalition is a “Judges’ Checklist” that will help make sure all the different pieces of information about a child are available to them (e.g. medical records, any known developmental delays, upcoming appointments and immunization records). The Children in Crisis Coalition is currently focusing this work on young children who are wards of the court with the goal of expanding its efforts to older children and children who are not wards of the court. The goal is to start implementing the use of the Judges’ Checklist by January 2015.

Another project that the Coalition is working on is the Parent Port: a notebook that “travels” with children in out-of-home placements that includes important information about the child such as medical records, information from previous foster homes or Individualized Education Program (IEP), if one is in place for the child.

According to key informants the work of the Coalition has been very much welcomed in the Community and stakeholders are interested in participating. One of the challenges to the Coalition’s work (and to the region’s child welfare system in general), however, is a high

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Senate Report 104-288. 104th Congress. Retrieved from http://www.gpo.gov/fdsys/pkg/CRPT-104srpt288/html/CRPT-104srpt288.htm

turnover rate in some key areas, particularly in the Prosecutor's Office and the Social Services Department.

In addition to the Children in Crisis Coalition, other assets in the region's child welfare system identified by key informants include: a comprehensive Ordinance in place that establishes with detail how cases must be handled; and staff in the various agencies involved who really care about the safety of the children.

Key informant also identified some of the current challenges to the child welfare system in the region as well as some of the unmet needs which include:

- Assistance for parents to help them navigate the system, which can be very overwhelming. In particular, key informants noted that parents could use additional support to help them understand how visitations should happen and what is expected of them.
- Support for children who age out of the child welfare system without family to rely on
- Assistance for grandparents who are caring for their grandchildren with very limited financial support.
- Recruiting more foster homes within the Community and providing additional support for current foster families (e.g. working with a benefit coordinator to make sure they access all the services that the children may qualify for).

Key informants also advocated for a preventative approach to supporting at-risk families, providing parents with the skills and support needed in order to prevent child abuse.

Incarcerated Parents

A 2011 report from the Arizona Criminal Justice Commission estimates that in Arizona, about three percent of youth under 18 have one or more incarcerated parent. This statistic includes an estimated 6,194 incarcerated mothers and an estimated 46,873 incarcerated fathers, suggesting that in Arizona, there are over 650 times more incarcerated fathers than incarcerated mothers.[127] More recent data from the Arizona Youth Survey corroborate this estimation. The Arizona Youth Survey is administered to 8th, 10th, and 12th graders in all 15 counties across Arizona every other year. In 2012, three percent of youth indicated that they currently have a parent in prison. Fifteen percent of youth indicated that one of their parents has previously been to prison. This suggests that approximately one in seven adolescents in Arizona have had an incarcerated parent at some point during their youth.

[127] Arizona Criminal Justice Commission. Statistical Analysis Center. (2011). *Children of Incarcerated Parents: Measuring the Scope of the Problem.* USA. Phoenix: Statistical Analysis Center Publication.

This represents a population of Arizona youth who are at great risk for negative developmental outcomes. Previous research on the impact parental incarceration has on families demonstrates that parental incarceration dramatically increases the likelihood of marital hardship, troubling family relationships, and financial instability. Moreover, children who have incarcerated parents commonly struggle with stigmatization, shame and social challenges, and are far more likely to be reported for school behavior and performance problems than children who do not have incarcerated parents.[128] In recent studies, even when caregivers have indicated that children were coping well with a parent's incarceration, the youth expressed extensive and often secretive feelings of anger, sadness, and resentment. Children who witness their parents arrest also undergo significant trauma from experiencing that event and often develop negative attitudes regarding law enforcement.[129]

The emotional risk to very young children (0-5) is particularly high. Losing a parent or primary caregiver to incarceration is a traumatic experience, and young children with incarcerated parents may exhibit symptoms of attachment disorder, post-traumatic stress disorder, and attention deficit disorder.[130] Studies show that children who visit their incarcerated parent(s) have better outcomes than those who are not permitted to do so[131] and the Arizona Department of Corrections states that it endeavors to support interactions between parents and incarcerated children, as long as interactions are safe.[132] Research suggests that strong relationships with other adults is the best protection for youth against risk factors associated with having an incarcerated parent. This person can be, but does not necessarily need to be, the caregiver of the child. Youth also benefit from developing supportive relationships with

[128] Arizona Criminal Justice Commission. Statistical Analysis Center. (2011). *Children of Incarcerated Parents: Measuring the Scope of the Problem.* USA. Phoenix: Statistical Analysis Center Publication.

[129] Children of incarcerated parents (CIP). Unintended victims: a project for children of incarcerated parents and their caregivers. http://nau.edu/SBS/CCJ/Children-Incarcerated-Parents/

[130] Adalist-Estrin, A., & Mustin, J. (2003). *Children of Prisoners Library: About Prisoners and Their Children.* Retrieved from http://www.fcnetwork.org/cpl/CPL301-ImpactofIncarceration.html.

[131] Adalist-Estrin, A. (1989). *Children of Prisoners Library: Visiting Mom and Dad.* Retrieved from http://www.fcnetwork.org/cpl/CPL105-VisitingMom.html.

[132] Arizona Criminal Justice Commission. Statistical Analysis Center. (2011). *Children of Incarcerated Parents: Measuring the Scope of the Problem.* USA. Phoenix: Statistical Analysis Center Publication.

other adults in their community.[133] Other studies have suggested that empathy is a strong protective factor in children with incarcerated parents.[134]

According to the US Department of Justice,[135] the number of inmates confined in Indian Country jails increased between 2011 and 2012 by 5.6%. Of the 14 facilities in Indian Country that held the majority of inmates, six were in Arizona. About 43 percent of all inmates in custody in Indian Country were held in Arizona. This increases the likelihood that there may need to be supports for children of incarcerated parents.

The Gila River Department of Rehabilitation and Supervision (DRS) is the largest correctional facility in Indian county. The 277-bed adult facility is co-ed and operated by tribal and federal funding. On average, this facility houses 200-225 inmates. This facility offers a wide variety of programs and services to inmates with the ultimate goal of reducing recidivism. These include education and vocational training, life-skills, healthy relationships, and child-development classes. Self-directed GED computer resources are available to inmates working towards their certificate. GED testing fees are paid for by DRS and staff from Central Arizona College routinely comes onsite to conduct the testing. Staff from various tribal departments come to the facility on a weekly basis to provide services such as sexual health education, screening and testing. The Gila River Tribal Social Services Department offers parenting classes, and numerous volunteer organizations regularly visit inmates. On-site counseling and medication management are also available to inmates from the Community's Behavioral Health Clinic.[136]

The DRS Juvenile facility has the capacity to hold up to 106 inmates. Key informants pointed out that re-entry into school programs is one of the main challenges for adjudicated youth due to credit transfer and curriculum differences. The disconnect between the educational opportunities they are able to pursue inside correctional facilities and regular educational settings outside of detention results in an very high dropout rate among this population.

An important and unique collaboration has been established between the DRS Juvenile facility's Education Department and Vechij Himdag Alternative School (VHM) that allows adjudicated youth to more easily re-enter into their school programs after being released. A shared web-

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[133] La Vigne, N. G., Davies, E. & Brazzell, D. (2008). *Broken bonds: Understanding and addressing the needs of children with incarcerated parents*. Washington, DC: The Urban Institute Justice Policy Center.

[134] Dallaire, D. H. & Zeman, J. L. (2013). Empathy as a protective factor for children with incarcerated parents. *Monographs of the Society for Research in Child Development, 78*(3), 7-25.

[135] Minton, T. (2013). *Jails in Indian Country, 2012*. Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice.

[136] http://www.gilariver.org/index.php/departments-cols5-colw1190-colw2190-col3w190col4w190-col5w190-right0-tribal-departments/80-department-of-rehabilitation-and-supervision-adult-division

based curriculum has been available to students at both VHM and the DRS Juvenile detention center since 2009. This means that a student at VHM who is adjudicated can continue his education while in detention using the same curriculum that he had been working on at school. And when leaving the facility, this same student can go back to the school and resume his work just where he left it at during his time in the detention facility. This can make a big difference in terms of whether students (who are often teen parents themselves) continue enrolled in school or drop out. Key informants indicated that this agreement requires a good amount of coordination, but it has allowed both entities (VHM and the Juvenile detention center) to address one the main challenges that adjudicated youth face in terms of continuing their education.

Other programs, such working in a garden that grows traditional crops, are also available to youth at the DRS Juvenile facility.

Domestic Violence

Domestic violence includes both child abuse and intimate partner abuse. When parents (primarily women) are exposed to physical, psychological, sexual or stalking abuse by their partners, children can get caught up in a variety of ways, thereby becoming direct or indirect targets of abuse, potentially jeopardizing the their physical and emotional safety.[137] Physically abused children are at an increased risk for gang membership, criminal behavior, and violent relationships. Child witnesses of domestic violence are more likely to be involved in violent relationships.[138]

Promoting a safe home environment is key to providing a healthy start for young children. Once violence has occurred, trauma-focused interventions are recommended.[139] In order for interventions to be effective they must take the age of the child into consideration since children's developmental stage will affect how they respond to trauma. While trauma-specific services are important (those that treat the symptoms of trauma), it is vital that all the providers a child interacts with provide services in a trauma-informed manner (with knowledge

[137] Davies, Corrie A.; Evans, Sarah E.; and DiLillo, David K., "Exposure to Domestic Violence: A Meta-Analysis of Child and Adolescent Outcomes" (2008).Faculty Publications, Department of Psychology. Paper 321. http://digitalcommons.unl.edu/psychfacpub/321

[138] United States Department of Justice, National Task Force on Children Exposed to Violence. (2012). Report of the Attorney General's National Task Force on Children Exposed to Violence. Retrieved from http://www.justice.gov/defendingchildhood/cev-rpt-full.pdf

[139] United States Department of Justice, National Advisory Committee on Violence against Women. (2012). Final report. Retrieved from http://www.ovw.usdoj.gov/docs/nac-rpt.pdf

of the effects of trauma to avoid re-traumatizing the child). Children exposed to violence need ongoing access to safe, reliable adults who can help them regain their sense of control.

According to the US Department of Justice, over one-third of Indian women and one-eighth of Indian men in the United States will experience domestic violence.[140] By midyear of 2012, 38 percent of the total inmate population at the Gila River Department of Rehabilitation and Supervision Adult facility was in custody because of domestic violence-related offenses compared to 13 percent among all detention centers in Indian Country.[141]

On June 1, 2012 the Gila River Indian Community opened "On Eagle's Wings," the Community's first domestic violence shelter, located in Sacaton. Other programs in the Community such as Family Planning have started conversations with the shelter about collaboration. The Gila River Behavioral Health Department has begun to provide training for the shelter staff, teaching the workers what to look for and how to make referrals to their services

Public Information and Awareness and System Coordination

Key informants agreed that continuing to promote parents' and caregivers' awareness of early childhood is important in the region, especially among young parents who may benefit from additional support in their parenting skills.

Key informants also noted that an increasingly connected system is in place in the region to make sure that this and other services are easily accessible and utilized by parents and caregivers in the region. They pointed out that overall, there is good coordination and communication among the different programs and agencies in the region providing services to families with young children. Some key informants, however, pointed out that these coordinated efforts could be improved by helping individual programs 'see the big picture.' And they also highlighted that current efforts are in place that aim at addressing this need. Collaborative undertakings such as the Children in Crisis Coalition are bringing together diverse groups of providers to enhance communication and coordination among them. Informants indicated that these efforts are key to ensure families are receiving the support they need

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[140]Department of Justice, Office of Justice Programs, *Extent, Nature, and Consequences of Intimate Partner Violence*, NCJ 181867 (Washington, D.C.: 2000). Justice uses the term Indian in this study to refer to persons who self-identify as American Indian or Alaska Native and does not limit the term to those enrolled in state- or federally recognized tribes.

[141] Minton, T. (2013). *Jails in Indian Country, 2012*. Bureau of Justice Statistics, Office of Justice Programs, US Department of Justice. Note that without more context, it is difficult to interpret these numbers. A lower rate of prosecutions for domestic violence can be attributed to increased awareness and prevention of domestic violence incidents, or to a decrease in a willingness of victims to prosecute.

without being 'inundated' with information about services that may not even be the most relevant for them.

In addition, in the past year the Gila River Indian Community Regional Partnership Council has been leading an effort around building the early childhood system in the region. This initiative is an ongoing process that will continue through 2015.

Summary and Conclusion

This Needs and Assets Report is the fourth biennial assessment of early education and health services in the Gila River Indian Community Region.

Through both quantitative data assembled, and through interviews with regional service providers, it is clear that the region has substantial strengths. The early childhood education system in the region offers a variety of programs and provides services to a large proportion of preschool-age children. Community members are able to access comprehensive health care services delivered locally in a culturally-appropriate manner through tribally-operated facilities. A number of health care services are also easily accessible to Community members who may lack transportation through mobile medical units that visit all the Community districts on a regular basis. A table containing a full summary of identified regional assets can be found in Appendix A.

However, there continue to be challenges to fully serving the needs of families with young children throughout the region. A table containing a full summary of identified regional challenges can be found in Appendix B**.** Many of these have been recognized as ongoing issues by the Gila River Regional Partnership Council and are being addressed by current FTF-supported strategies in the region. Some of these needs, and the strategies proposed to address them, are highlighted below. A table of Gila River Indian Community Regional Partnership Council Planned Strategies for fiscal year 2013 is provided in Appendix C**.**

- **A need for additional quality childcare services** – Although the early childhood education system in the region offers a variety of programs to families, most of them operate at capacity. Lack of quality child care can have an impact not only on the well-being of the child, but on a family's employment situation. Having reliable child care makes it easier for parents to avoid missing work or being late. The Regional Partnership Council has recognized this need and supported Pre-K program expansion initiatives at Gila Crossing Community School and Blackwater Community School. In addition, a number of strategies are in place to improve the quality of existing programs through Quality First, and to support access to those programs through scholarships. The Family, Friend and Neighbor Strategy addresses the reality of many families who only have access to, or deliberately chose to have their children cared for, by kith and kin. Professional development scholarships aim to assure a trained early childhood workforce.
- **A need to support teen and young parents** – Key informants note that teen and young parents in the Community require additional support in their parenting skills. Current strategies attempt to address this through home visitation and community-based parent education programs.

This report also highlighted some additional needs that could be considered as targets by stakeholders in the region.

- **Children living with grandparents** —The majority of young children in the region are living with relatives other than their parents, many of those with grandparents. Grandparents have identified a number of supports that would be helpful to them in facing the unique physical, emotional, legal and financial challenges of raising their young grandchildren. Among these are: financial assistance similar to that provided to foster parents; support groups of other grandparents that include child care; respite support that provides safe child care; and a resource guide targeted specifically at the needs of elders taking care of grandchildren.
- **Lack of transportation** – A lack of transportation among families has been identified as one of the primary local barriers in the region to accessing child care, health, social and employment services. Highlighting this issue among collaborating service agencies may help identify additional services that could be referred to or developed to meet these needs of families without access to reliable transportation.
- **Additional support for foster families**– Key informants noted that a challenge to the child welfare system is the recruitment of foster families as well as making sure that participating foster parents are well connected to services available to them. Additional support, such as that of a benefit coordinator, could help parents access services that they or their children may qualify for.

Successfully addressing the needs outlined in this report will require the continued concentrated effort of collaboration among the Gila River Indian Community Regional Partnership Council and staff; Tribal leadership; First Things First and other state agencies; local providers; and other community stakeholders in the region. Doing so will help continue to support families and young children in this Community where members are known for “being there” for one another.

Appendix A. Table of Regional Assets

First Things First Gila River Indian Community Regional Assets
Small community where most people know each other and care about the wellbeing of children
Early childhood care and education system that includes a large selection of programs, which enroll a large proportion of preschool-age children in the region
High quality public schools - Akimel O'otham Pee Posh/Blackwater School – nationally recognized
Gila River Health Care – comprehensive health care services operated by the Gila River Indian Community itself available locally in the Community, including provision of services through mobile medical units
High quality prenatal care that is reflected in rate of first-trimester prenatal care meeting Healthy People 2020 target
Coordination of care among providers of prenatal care services and pediatric care services to make sure pregnant women and newborns receive timely and appropriate services
Supportive leadership – Tribal Council supportive of early childhood initiatives and programs
A wide variety of programs and services available locally for families with young children
Parent education sessions at both local high schools including innovative Teen Parenting Programming
Children in Crisis Coalition that brings together stakeholders relevant to the child welfare system to better support families in need

Appendix B. Table of Regional Challenges

First Things First Gila River Indian Community Regional Challenges
Need for expanding the capacity of current child care and early education programs, especially for children birth to 3 years old
Lack of transportation
Need for increasing parent awareness of the importance of early childhood health and development
Need for supporting foster families
High rates of childhood obesity
Substance abuse
High unemployment rate
Need for supporting grandparents caring for their grandchildren

Appendix C. Table of Regional Funded Strategies, Fiscal Year 2015

Gila River Indian Community Regional Partnership Council First Things First Planned Strategies for Fiscal Year 2015		
Goal Area	**Strategy**	**Strategy Description**
	Quality First	Supports provided to early care and education centers and homes to improve the quality of programs, including: on-site coaching; program assessment; financial resources; teacher education scholarships; and consultants specializing in health and safety practices.
Quality and Access	Quality First Child Care Scholarships	Provides scholarships to children to attend quality early care and education programs. Helps low-income families afford a better educational beginning for their children.
	Child Care Health Consultation	Addresses the region's limited access to high quality, affordable early care and education programs for children living within the region.
	Pre-Kindergarten Scholarships	Provides scholarships to quality preschool programs in a variety of settings to allow programs serve more children.
Professional Development	Scholarships TEACH	Provides scholarships for higher education and credentialing to early care and education teachers. Improves the professional skills of those providing care and education to children 5 and younger.
	Conference Scholarships	Increase knowledge and awareness about early childhood development and health issues by providing increased access to seminars and conferences within and across the region.
Family Support	Parent Education Community-Based Training	Provides classes on parenting, child development and problem-solving skills.
	Home Visitation	Provides voluntary in-home services for infants, children and their families, focusing on parenting

		skills, early physical and social development, literacy, health and nutrition.
	Native Language Enrichment	Provides materials, awareness and outreach to promote native language and cultural acquisition for the young children of Tribal families.
	Family, Friends and Neighbors	Supports provided to family, friend and neighbor caregivers include training and financial resources.
	Summer Transition to Kindergarten	Provides first time classroom experiences for children who are about to begin kindergarten, and information to their parents.
Evaluation	Statewide Evaluation	Statewide evaluation includes the studies and evaluation work which inform the FTF Board and the 31 Regional Partnership Councils, examples are baseline Needs and Assets reports, specific focused studies, and statewide research and evaluation on the developing early childhood system.
Community Awareness	Media	Increases public awareness of the importance of early childhood development and health via a media campaign that draws viewers/listeners to the ReadyAZKids.com web site.
	Community Awareness	Uses a variety of community-based activities and materials to increase public awareness of the critical importance of early childhood development and health so that all Arizonans are actively engaged in supporting young kids in their communities.

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