



National
Urban League

COVID-19

COMMUNITIES OF COLOR NEEDS ASSESSMENT

The Indigenous Wellness Research Institute (IWRI)
In partnership with the Research for Indigenous Social Action and Equity Center (RISE)

American Indians and Alaska Natives

A PARTNERSHIP WITH

The Alliance for National Psychological Associations for Racial and Ethnic Equity



ABOUT THE NATIONAL URBAN LEAGUE

The National Urban League is a historic civil rights and urban advocacy organization. Driven to secure economic self-reliance, parity, power, and civil rights for our nation's marginalized populations, the National Urban League works towards economic empowerment and the elevation of the standard of living in historically underserved urban communities.

Founded in 1910 and headquartered in New York City, the National Urban League has improved the lives of more than two million people annually through direct service programs run by 90 local affiliates in 36 states and the District of Columbia. The National Urban League also conducts public policy research and advocacy work from its Washington, D.C. bureau.

The National Urban League is a BBB-accredited organization and has earned a 4-star rating from Charity Navigator, placing it in the top 10% of all U.S. charities for adhering to good governance, fiscal responsibility, and other best practices.

INDIGENOUS WELLNESS RESEARCH INSTITUTE (IWRI).

In 2005, IWRI (www.iwri.org) was established under the University of Washington's Global Health Initiative with the mandate to nurture, develop, and advance a university-wide interdisciplinary Indigenous research institute for health and health equity research, knowledge sharing, and research capacity building with Indigenous populations. Instituted and directed by an AIAN behavioral scientist, Dr. Karina Walters (Choctaw Nation of Oklahoma) along with AIAN scholar of child welfare, Dr. Tessa Evans-Campbell (Snohomish), IWRI's mission is to marshal community, tribal, academic, and governmental resources toward innovative and collaborative social and behavioral research and education. IWRI values indigenous sovereignty; collaborative community-led partnerships; the resilience and strength of indigenous peoples; and the unique contribution of indigenous knowledge to health research, practices, and wellness. Primarily led and staffed by Indigenous community members, IWRI investigators to date have generated over \$57 million in grant funding, secured over 48 federal grants (37 NIH funded), published over 250 articles and mentored over 400 Native and allied behavioral researchers at all levels.

CONTENTS

- 1** Introduction
- 3** Study Overview
- 24** Summary and Recommendations for Federal Policy
- 32** The IWRI Native American COVID-19 Alliance Research Team
- 33** Appendix
- 34** References

RESEARCH FOR INDIGENOUS SOCIAL ACTION AND EQUITY CENTER (RISE).

Under the Directorship of Dr. Stephanie Fryberg, RISE was created and funded in 2021 to re-imagine and re-create how mainstream U.S. culture engages with narratives about Indigenous Peoples. RISE works toward a society in which all individuals not only learn about Indigenous Peoples but also learn from Indigenous Peoples. Their mission is three-fold: 1) To conduct rigorous multidisciplinary research centering Indigenous Peoples' voices and experiences; 2) To build, support, and sustain a multi-university pipeline of Indigenous scholar-activists; 3) To put research into action by working with artists and activists who use the Center's research to propagate accurate, expansive, and empowering narratives of Indigenous Peoples.

Introduction

The Native American COVID-19 Alliance Needs Assessment (NACA) survey is one of the largest national studies (N=8,549) conducted to date by and for American Indian and Alaska Native Peoples (hereafter referred to as Native American, Native, or AIAN) to identify and give voice to Native American COVID-19 experiences, needs, and resiliencies during the pandemic. The assessment was conducted from January 18, 2021 through March 19, 2021. Our purpose was to ensure that our Native voices are included in any tribal, national, or congressional planning and response efforts to the COVID-19 pandemic. Raising the visibility of Native experiences is critical during this pandemic as Native American communities have been hit exceptionally hard and yet remain largely invisible, undercounted, or misidentified in COVID-19 public health surveillance data. Inadequate systems of reporting, data collection methods, and data analytic approaches have led to significant gaps in understanding the lived experiences and impact of COVID-19 on American Indian and Alaska Native populations, communities, and families.¹

A disturbing picture has emerged in surveillance studies. American Indians and Alaska Natives are dying of COVID-19 at higher rates and at younger ages than other populations.²⁻³ As of February 10, 2021, AIANS have the highest age-adjusted COVID-19 mortality rate of any other population (265/100,000 vs 108-249/100,00 across Asian, White, Black, and Hispanic/Latino populations respectively). Moreover, although COVID-19 mortality rates increased with age among all populations, among AIAN 20-29 years, 30-39 years, and 40-49 years they were 10.5 times, 11.6 times and 8.2 times more likely to die than White persons in the same age group, respectively.²

Chronic and pervasive systemic health and social inequities place AIANS at increased risk of getting sick and dying from COVID-19. Native communities have been plagued by pervasive inequities in access to: quality medical care (i.e., historically underfunded, inaccessible and inadequate care); appropriate housing (substandard, overcrowded); healthful food access (food desert environments); clean and accessible water; electricity; and have endured exposure to damaging environmental hazards, pollutants and toxins,⁵ all of which produce cumulative and chronic adverse health outcomes. These factors drive the disproportionately high chronic disease burden (e.g., diabetes, obesity, heart disease) and corresponding elevated morbidity and mortality rates found in Native communities. AIAN communities living in and with such inequities and corresponding chronic diseases are particularly susceptible to the ravages of COVID-19. The confluence of environmental and socioeconomic inequities and pre-existing chronic disease conditions create a potentially perilous trifecta during infectious disease outbreaks such as COVID-19.⁶ Additionally, there are other potential “invisible” health effects from COVID-19 -such as the impact of public safety strategies (i.e., prohibition of customary burial or funerary rites) that can disrupt mental and spiritual health-including communal abilities to fulfill ceremonial and ancestral obligations.

Pandemics are not new to us. Native populations throughout the Americas have survived major pandemics and are well acquainted with the devastating consequences. As Native people, we know that COVID-19 is exacerbating existing health inequities across the country and the NACA survey revealed just how devastating the pandemic has been and continues to be. However, the data also revealed a story of hope, perseverance and resilience-of families coming together, of communities generating creative ways of connecting- physically distanced but socially, ceremonially, and culturally still close. The vibrancy and motivation to persevere despite pandemic outbreaks, discrimination, and persistent inequities, is a testament to the strength and legacy of our ancestors and our commitment to the health and wellbeing of present and future generations. Through the national Native American COVID-19 Needs Assessment survey, we aimed to elevate our collective voices; to share how the pandemic has impacted families and communities; and to identify what has and what will help us cope, survive, and ultimately thrive through and beyond this pandemic. It is our hope that the data in this report serves as a call to policymakers, congressional and tribal leaders, as well as public health and service sector leaders to wait no longer in providing credible and sustainable solutions to the perilous pre-existing inequities that COVID-19 has exposed and exploited. We also hope that this data will support Native enterprise, generativity and creativity in designing and developing culturally-centered solutions as well as healthful practices and policies to mitigate the impact of COVID-19 on Native communities and to grow Native health and community well-being. Our communities have tremendous resilience and survivance strategies that deserve attention and voice.

Study Overview

The Native American COVID-19 Alliance Needs Assessment (NACA) was directed through the Indigenous Wellness Research Institute (IWRI) at the University of Washington in partnership with the Research for Indigenous Social Action and Equity (RISE) center at the University of Michigan. The study was led by a team of Native researchers known collectively as the Native American COVID-19 Alliance from the University of Washington, University of Michigan, and University of California, Berkeley. The assessment is conducted in partnership with the Center for Native American Youth; IllumiNative; Native Organizers Alliance; Mni Wiconi Clinic and Farm; Department of Native Hawaiian Health; Papa Ola Lokahi; American Indian Cultural Center of San Francisco; Native American Indigenous Studies Program, UC San Diego; Pacific Islander Community Association of Washington; and supported by a Native American COVID-19 Alliance Native Advisory Board Team.



The NACA survey was an online, cross-sectional survey of adults 18 years and older identifying as Native American or American Indian (AI), Alaskan Native (AN), First Nations, Métis, or Inuit (FN), Native Hawaiian (NH), and/or Pacific Islander (PI) conducted between January 18 and March 19, 2021. The online survey link was sent out to all of our partner organizations (at least 20,000 people) including 50+ Native organizations, over 75 tribes, 60 universities (including tribal colleges and Native student organizations) and half a dozen media outlets. This report to the Congressional Caucuses report, is focused on 8,549 respondents who identified as AI, AN, or FN, either alone or in combination with other racial/ethnic groups.

Securing a Geographically and Tribally Diverse Sample


Sampling strategy. We utilized census-based sampling to ensure tribal diversity and approximate representation across the United States and territories. There are 574 federally recognized American Indian and Alaska Native tribes and villages and at least 63 state-recognized tribes across the United States.⁷ Since population distributions derived from the U.S. Census Bureau inform allocation of resources at both the federal and state levels, we based our sampling areas on the four U.S. Census Regions,⁸ which include the: (1) Northeast, (2) Midwest, (3) South, and (4) West (see Table 1 in appendices for more detailed information). To assess the relative distribution of AIAN-identified individuals (i.e., only AIAN and those identifying multiple racial/ethnic groups) across the four Census Regions, we utilized recent estimated AIAN population counts from the 2019 American Community Survey (ACS).⁹ To ascertain adequate demographic representation, recruitment was balanced marginally by gender and rural vs. urban location. With respect to gender, we required a minimum 40% recruitment for female or male gender. We targeted a 22% rural vs. 78% urban split, as defined by the U.S. Census Bureau as off- and on-AIAN areas¹⁰ and a 50% (female) vs. 50% (male) split, across the entire sample. To ensure adequate representation by residential setting, we required a minimum 20% rural and 60% urban recruitment, respectively. Detailed information with respect to research methods and data analyses can be found in the appendices.

Geographic regions represented. The distribution of respondents closely matched the recruitment targets based on ACS data, creating an approximate national representative sample. Our sample mirrored the census region distribution of AIAN populations yielding a highly representative geographic sample:

- 41.3% of respondents lived in the West (AZ, CO, ID, NM, MT, UT, NV, WY; AK, CA, OR, WA, HI respectively; note: 41.7% according to census);
- 33.6% of respondents lived in the South (DE, DC, FL, GA, MD, NC, SC, VA, WV; AL, KY, MS, TN; AR, LA, OK, TX respectively; note: 32.8% according to census);
- 16.1% of respondents lived in the Midwest (IN, IL, MI, OH, WI; IA, KS, MN, MO, NE, ND, SD respectively; note: 16.9% according to the census); and,
- 9% lived in the Northeast (CT, ME, MA, NH, RI, VT; NJ, NY, PA respectively; note: 8.6% according to the census).





Native American COVID-19 Alliance Phase 1 Design & Methods




Research Design

- Cross-sectional online survey




Sampling Methods and N

- Sampling: Targeted by gender & urb/rez/rural
 - National Network Sample (NNS)
 - Qualtrics Panels
- N = 8,549



Sample Size Final

- N: 8,549
- 7,834 NNS
- 715 Qualtrics Panels



Languages Translated

- English only

CENSUS DIVISION AND DISTRIBUTION OF AIAN BY 2019 AMERICAN COMMUNITY SURVEY	AIAN population	%	Final Sample (18+ yrs)	%
Census Region				
1. Northeast	488,347	8.6%	769	9.0%
Div 1. New England: (CT, ME, MA, NH, RI, VT) Div 2. Middle Atlantic: (NJ, NY, PA)				
2. Midwest	956,692	16.9%	1,378	16.1%
Div 3. East North Central (IN, IL, MI, OH, WI) Div 4. West North Central (IA, KS, MN, MO, NE, ND, SD)				
3. South	1,855,980	32.8%	2,875	33.6%
Div 5. South Atlantic: (DE, DC, FL, GA, MD, NC, SC, VA, WV) Div 6. East South Central: (AL, KY, MS, TN) Div 7. West South Central: (AR, LA, OK, TX)				
4. West	2,364,181	41.7%	3,527	41.3%
Div 8. Mountain: (AZ, CO, ID, NM, MT, UT, NV, WY) Div 9. Pacific: (AK, CA, OR, WA, HI)				
TOTAL	5, 665, 200		8,549	
Geographic/Residential Regions				
Reservation/Rural Bordertown		28%	1,635	26.8% (18.0% rez)
Urban/Suburban		72%	3,333	72.1%

Residential patterns. Our sample mirrors AIAN urban-rural residential patterns. Specifically, 26.8% of participants lived on a reservation or in a rural bordertown and 72.1% lived in an urban/suburban setting.

Demographic Characteristics

The majority of health studies and surveillance data either omit AIANs or collapse data into an “other” category, thus erasing our experiences and needs. In this survey, we aimed to ensure unique experiences were represented in order to highlight the diversity of AIAN peoples and communities. AIANs in our survey hailed from hundreds of different tribal affiliations as well as diverse and representative residences (e.g., reservations, small towns, rural communities, and cities). Moreover, our sample reflected the diversity of our populations by gender, sexual orientation, ages, income and education levels.



Over 8,549 Native American peoples representing American Indian federal and state tribes as well as Alaska Native villages took the NACA survey. Urban representation also parallels census data.¹⁰⁻¹³

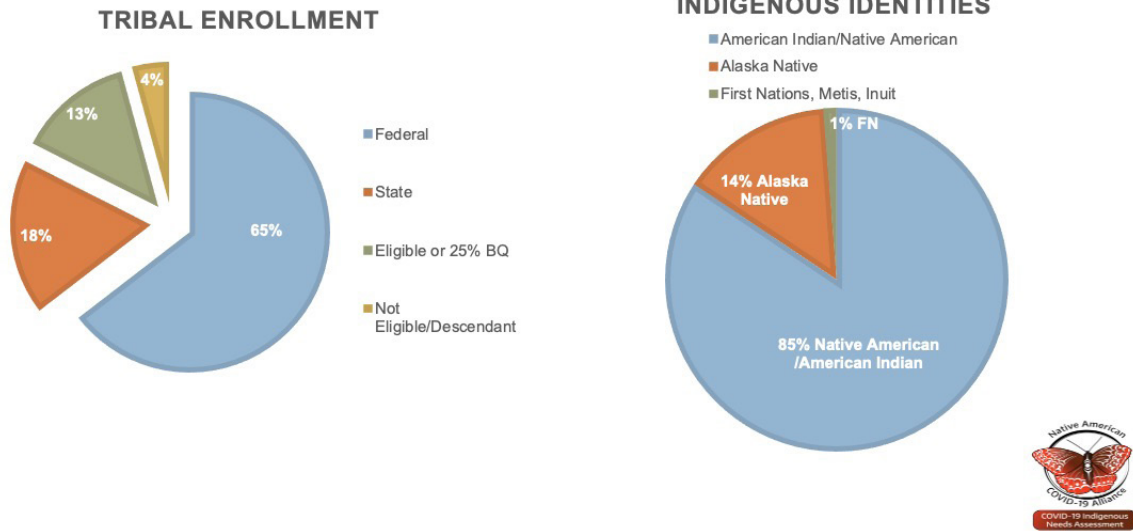
Specifically, the top 10 cities with highest number of respondents for our survey were:

1. New York, NY (n=194)
2. Los Angeles, CA (n=154)
3. Phoenix, AZ (n=117)
4. Chicago, IL (n=100)
5. Seattle, WA (n =92)
6. Anchorage, AK (n=88)
7. San Antonio, TX (n=84)
8. Houston, TX (n=83)
9. Oklahoma City, OK (n=83)
10. San Diego, CA (n=71)

Native American identification. Eighty-five percent of the respondents self-identified as American Indian/Native American alone (74.9%) or in combination with other races (10.2%). Over 14% identified as Alaska Native alone (13.4%) or in combination with other races (1.1%) and 1.2% identified as First Nations, Métis, or Inuit alone (.7%) or in combination with other races (.5%).

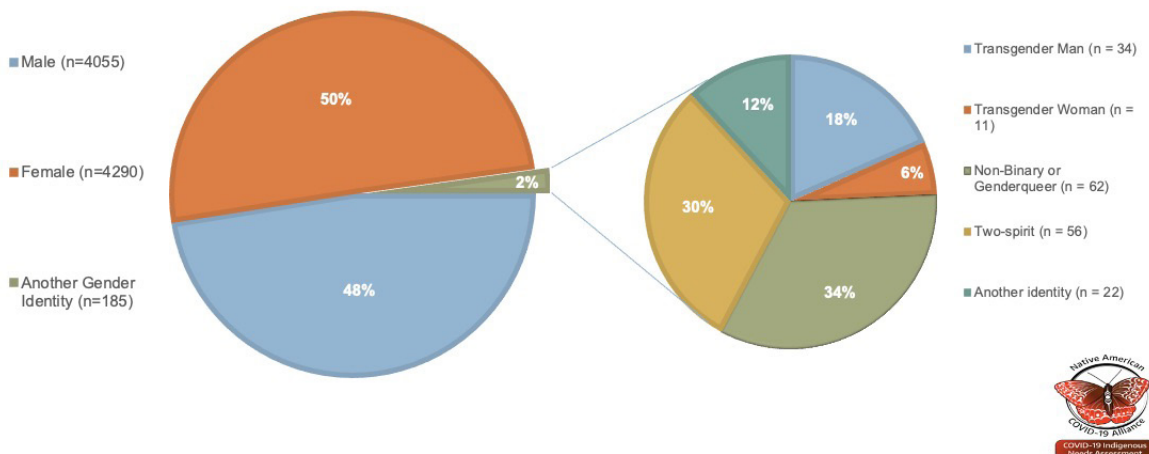
Tribal enrollment. Sixty-five percent of the sample was enrolled in a federally recognized tribe and 18% enrolled in a state recognized tribe. Thirteen percent were not enrolled in a tribe, but were eligible for enrollment and/or were 1/4 or more in total AIAN blood quantum (1/4 is the eligibility standard for some federal services and grants). Four percent of the sample was not eligible for enrollment but had known descendency from a tribe.

Indigenous Background (n=8549)



Gender. Fifty percent of participants identified as female, 48% as male, and 2% as transgender, non-binary, or as Two Spirit. Of the 2% who identified as transgender, 34% identified as non-binary/genderqueer, 30% identified as Two Spirit, 18% identified as a transgender man, 6% as a transgender woman, and 12% as another gender identity.

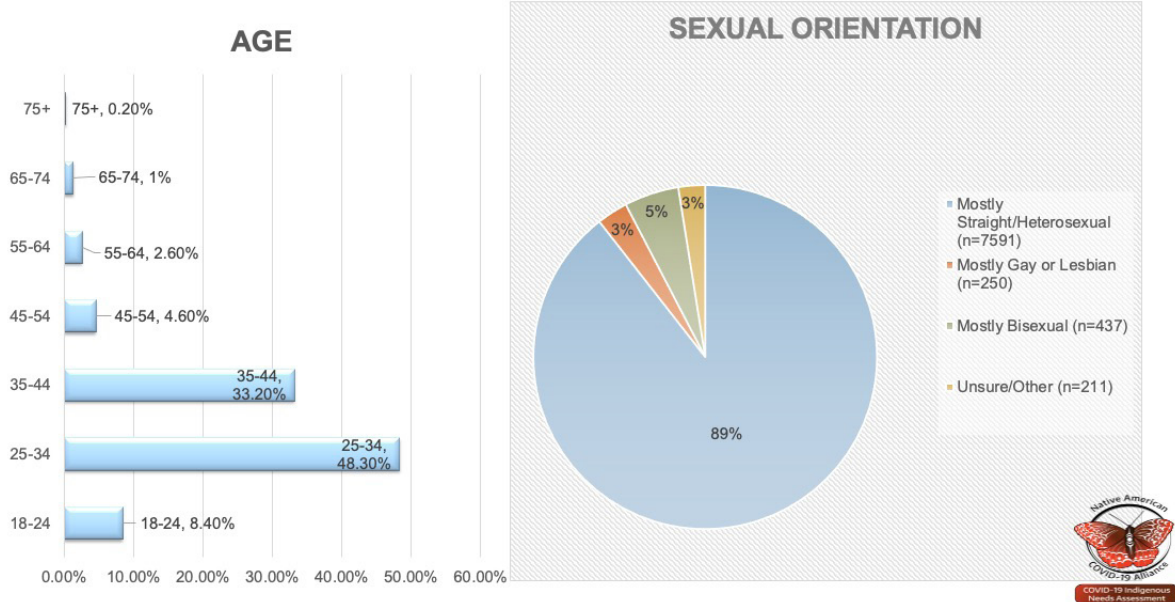
Gender Identity (n = 8,549)



Age. The sample was diverse, with a median age of 33, and ages ranging from 18 to 74 years old. The majority of participants (83%) ranged in age from 25 to 44 years of age. The median age for this sample was slightly older than the median age of AIANs in the Census data (age: 31). Although the number of elder participants were smaller than we had hoped, particularly given the high burden of disease among them; we had a robust sample of participants between 18 to 40 years—an age group that bears considerable disproportional COVID-19 disease mortality than non-Native populations of the same age range.

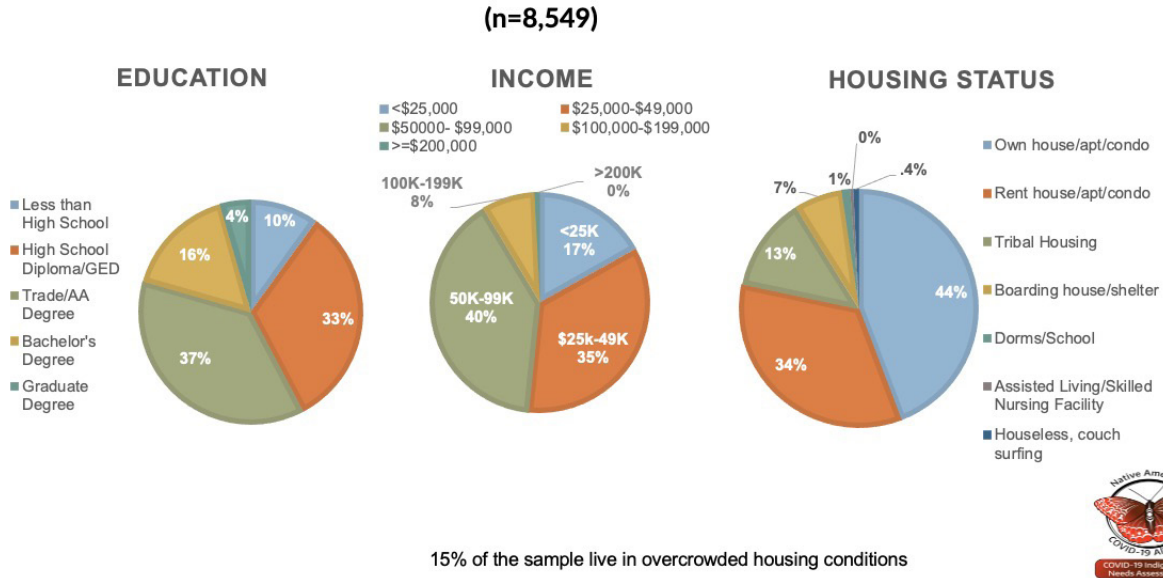
Sexual orientation. Eighty-nine percent of the sample identified as mostly heterosexual or straight and 11% as mostly lesbian/gay (3%), mostly bisexual (5%) or unsure/other (3%).

Demographics (n=8,549)



Education. Although 33% of the participants had a high school diploma or GED equivalent—which is consistent with national AIAN data (31%)—20% of the participants had their bachelor's degree or higher in contrast to 15.3% of AIANs nationally.¹⁴⁻¹⁵ More than half the sample had some college education.

Demographics (cont.)



Income and housing status. Seventeen percent of the sample lived below the poverty threshold (income below 25,000) this past year, with 35% at or near the poverty threshold. The average household income was between \$35,000 and \$49,000 dollars. Forty-four percent owned homes or condos and 34% rented a house, apartment or a condominium. Thirteen percent lived in tribal housing. Seven percent of the participants lived in a boarding house or a shelter.

Unemployment and disability status. Nearly 14% of the participants had been unemployed in the prior week; among unemployed participants, 1 out of 10 reported it was due to health or disability related reasons.

Essential worker status. Over one-third of the participants (36.5%) reported being essential workers (i.e., must report to work as a health care worker, law enforcement, bus driver, custodial staff, building maintenance, store worker, delivery worker, etc.).

Overview of Preliminary Findings

Findings from the NACA survey revealed that Native Americans are experiencing serious and significant adverse negative COVID-19 impacts with respect to: COVID-19 related illness, mortality, and other physical health impacts; significant loss of jobs and finances; isolation from social networks and significant COVID-related losses and social network deaths; and significant mental health distress. Despite such difficulties, participants also revealed healthful behavioral strategies to cope with the impact of COVID-19, including activating cultural and spiritual practices and engaging family in cultural and land-based healthful activities. Moreover, participants expressed positive attitudes about vaccine uptake and interest. Yet, 4 out of 10 still were unlikely to or were unsure about getting the vaccine. Findings from this study amplified clear needs and identified emergent policy priorities.



Overview of Preliminary Findings

- Native Peoples are experiencing **significant adverse negative COVID impacts** with respect to:
 - COVID-related illness or other Physical Health needs
 - Loss of Jobs and Income
 - Isolation and COVID-related loss within Social Networks
 - Mental Health & Stress
- Healthful behavioral, **spiritual and cultural coping strategies utilized**
- Hopeful with regards to progress vaccinating in Indian Country; but **concerned that 4 in 10 Natives report being unlikely to get or unsure about getting the vaccine**
- Very clear needs and policy priorities emerge

Physical Health and Healthcare/Medicine Access

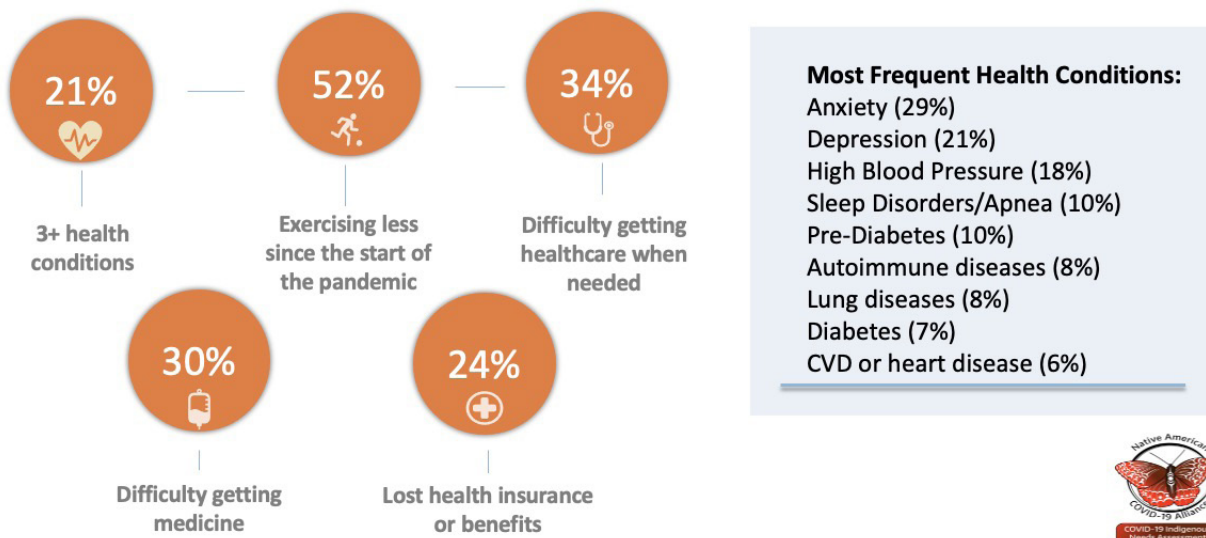
Pre-existing health conditions and COVID-19. Many participants reported living with multiple health conditions (e.g., chronic lung diseases, diabetes, heart conditions, overweight and obesity) that may make them more susceptible to severe COVID-19 illness (i.e., hospitalization, intensive care, ventilator to help breathe), longer hospital stays or even death. In response to the question: *Has a doctor, nurse, or medical provider ever told you that you have the following health conditions* (list provided), nearly 1 out of 10 participants reported that they have pre-diabetes (10%) or diabetes (7%); autoimmune disease and lung diseases (8%); and/or cardiovascular or heart disease (6%). Moreover, over 21% of the participants reported living with at least 3 or more serious health conditions. Pre-existing chronic lung, pulmonary hypertension among other diseases lead to more severe COVID-19 illness, increasing vulnerability to longer hospital stays, and poorer COVID-19 related health outcomes and recovery challenges (e.g., long hauler symptoms). Moreover, pre-existing mental health concerns at some point in their lifetime may also become re-activated or exacerbated during the pandemic contributing to physical health distress. Nearly one out of three reported had been told by a health provider that they currently have or have had anxiety (29%) or depression (21%) in the past.

Physical activity levels. Physical inactivity is associated with a higher risk for severe COVID-19 related outcomes. Specifically, studies have demonstrated that patients with COVID-19 who were consistently inactive had a greater risk of hospitalization, admission to the ICU and death due to COVID-19 than COVID-19 patients who were consistently physically active.¹⁶ Over half of the participants reported that their physical activity levels have declined since the pandemic outbreak. Specifically, 52% report that they were exercising less since the pandemic.

Healthcare and prescription medication access. Physical health vulnerabilities coupled with lack of access to health care and medicines when in need, places Native communities at particular risk for increased worsening physical health, psychological distress, and a greater likelihood of developing severe illness from COVID-19. Thirty-four percent had difficulty getting healthcare during the pandemic for their family when they needed it and 30% had difficulty getting medicine. Moreover, 1 out of 4 AIAN participants lost their health insurance or benefits during the outbreak.

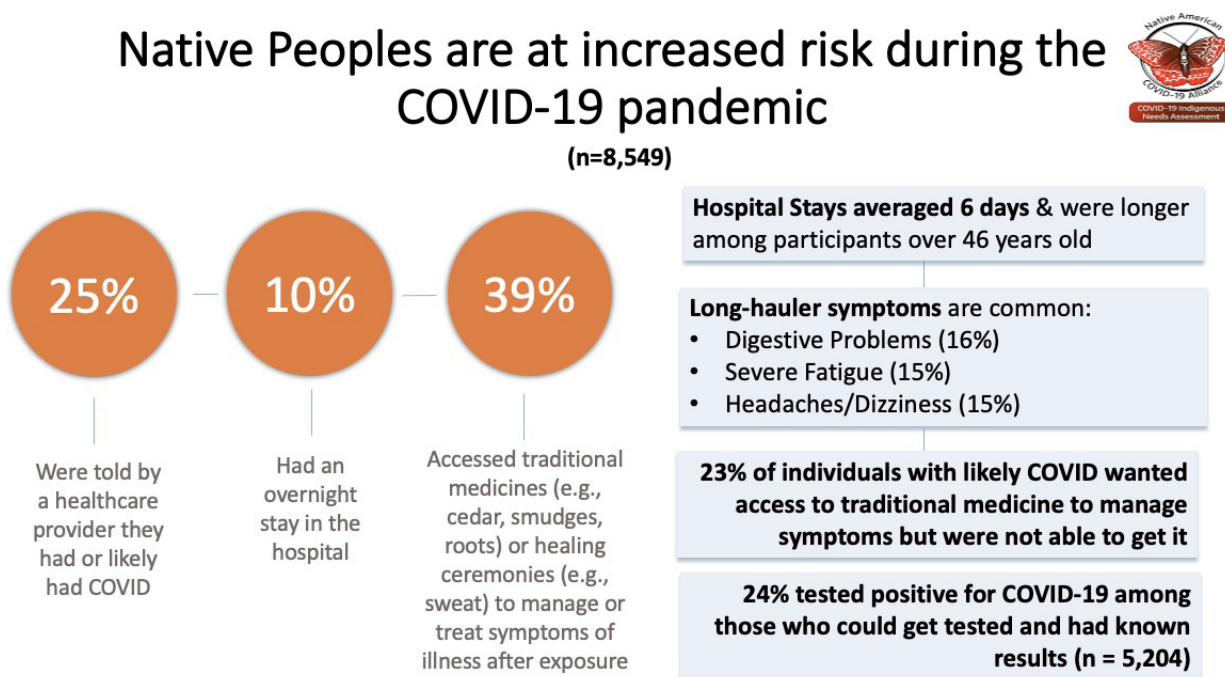
Physical Health Needs: Native Peoples are at increased risk during the COVID-19 pandemic

(n=8,549)



COVID-19 Exposure and Hospitalization

COVID-19 prevalence. Twenty-five percent of participants were told by a healthcare provider that they had or likely had COVID-19. Similarly, the prevalence of diagnosed COVID-19 by a health professional was one in four, in our nationally representative sample of AI/AN participants who had access to testing with a known result (n=5,204). In a recent MMWR report 20, the CDC notes that “Historical trauma and persisting racial inequity have contributed to disparities in health and socioeconomic factors between AI/AN and white populations that have adversely affected AI/AN communities; these factors likely contribute to the observed elevated incidence of COVID-19 among the AI/AN population.”



COVID-19 hospitalization. Ten percent of the sample reported staying overnight in a hospital, lasting on average nearly one week (6 days of hospital stay on average) and even longer among participants older than 46 years old. Many participants who had COVID-19 reported persistent COVID-19 symptoms one month post diagnosis; 16% reported persistent digestive problems and 15% reported severe fatigue as well as headaches/dizziness.

Traditional medicine access for COVID-19 illness and recovery. Nearly one out of four AIAN participants who likely had COVID-19 wanted access to traditional medicines (Native medicines such as roots, teas, smudges, etc.) to manage their symptoms but were not able to access them. Nearly 40% however, did access traditional medicines to manage or treat symptoms of COVID-19 or to help them with their post-recovery.

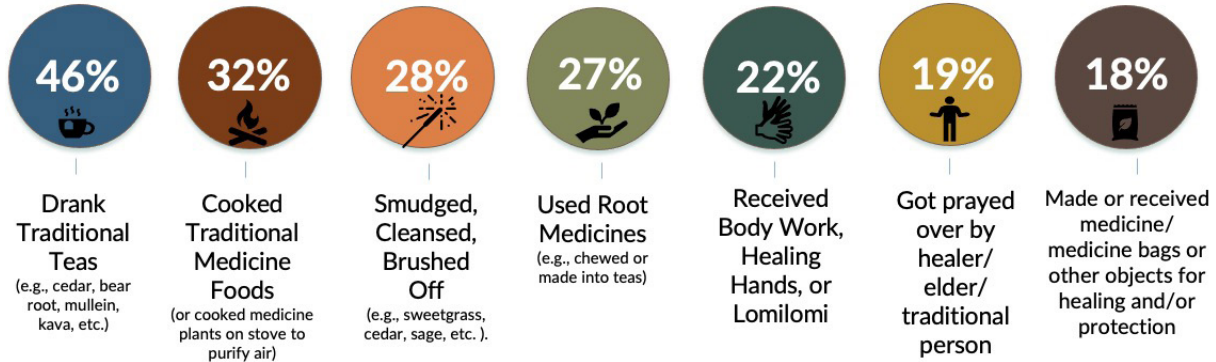
Traditional health practices to manage COVID-19 illness and recovery. The majority of AIAN participants exposed to COVID-19 (n=1,502) utilized traditional health practices to manage, mitigate, treat, and recover from their COVID-19 illness. Nearly half (46%) of those who had COVID-19 exposure drank traditional teas (e.g., cedar, bear root, mullein, etc.) to treat their symptoms. One-third cooked traditional plants or foods to purify the air, to eat, or to create salves and other medicines. Twenty-eight percent smudged, cleansed, or brushed off with smoke or plants (e.g., sweetgrass, cedar, sage, etc.) and 27% used root medicines to chew or make into teas. Nearly one out of four received some type of body work (e.g., healing hands, lomilomi). About one out of five got prayed over by a healer, elder, or traditional person and 18% made or received medicine bags/ bundles or other objects for healing and/or protection. Five to ten percent got cleaned/brushed off by someone, put goods/offerings (i.e. prayer ties/tobacco) out for their healing, cleaned and aired out their homes, and gathered/harvested traditional plant medicines and food for their healing and recovery.

Traditional health practices were engaged to manage or treat illness symptoms after COVID-19 exposure



Top 7 Traditional Health Practices To Treat Illness After COVID-19 Exposure

(n=1,502)

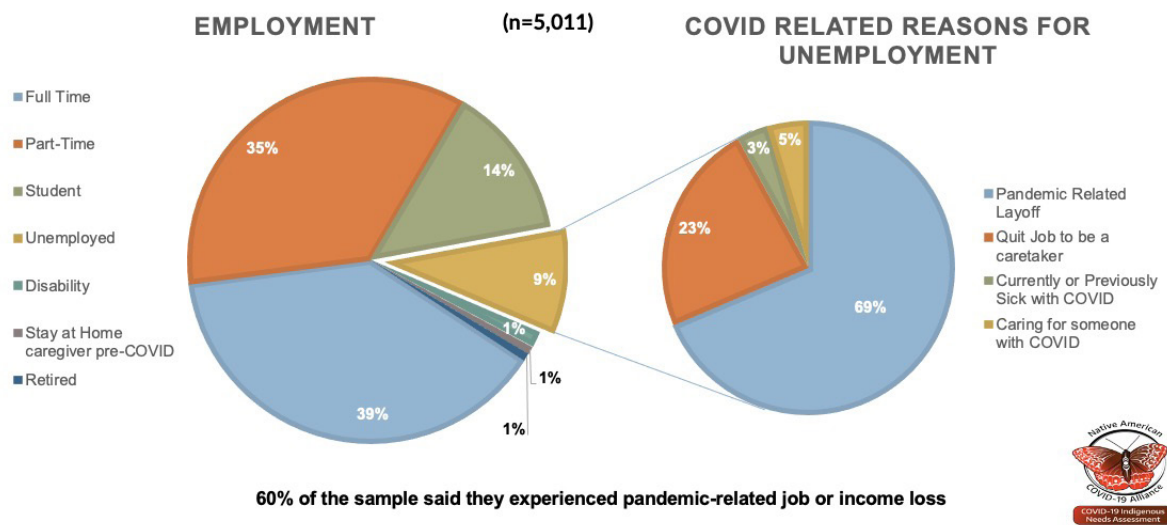


5-10%: got cleaned off/cleansing from someone, put goods/offerings (prayer ties/tobacco) for healing, cleaned/aired out house, gathered traditional plant medicines & food

Economic Impact

Employment and pandemic job loss. AIAN participants have been hit hard economically during this pandemic. Specifically, 60% said they experienced pandemic-related job or income loss. Thirty-nine percent were employed, 35% had part-time employment; 14% were full-time students, and 1% reported were stay-at-home caregivers or retired. Nine percent reported that they were unemployed. Among those unemployed, 69% said their unemployment was the result of a pandemic-related layoff; 23% said they had to quit their job to become a full-time caretaker; 5% said they had to quit their job to care for someone with COVID-19 in their family/social network; and 3% said they became unemployed due to being ill (currently or previously) from COVID-19.

The pandemic has resulted in job & income loss

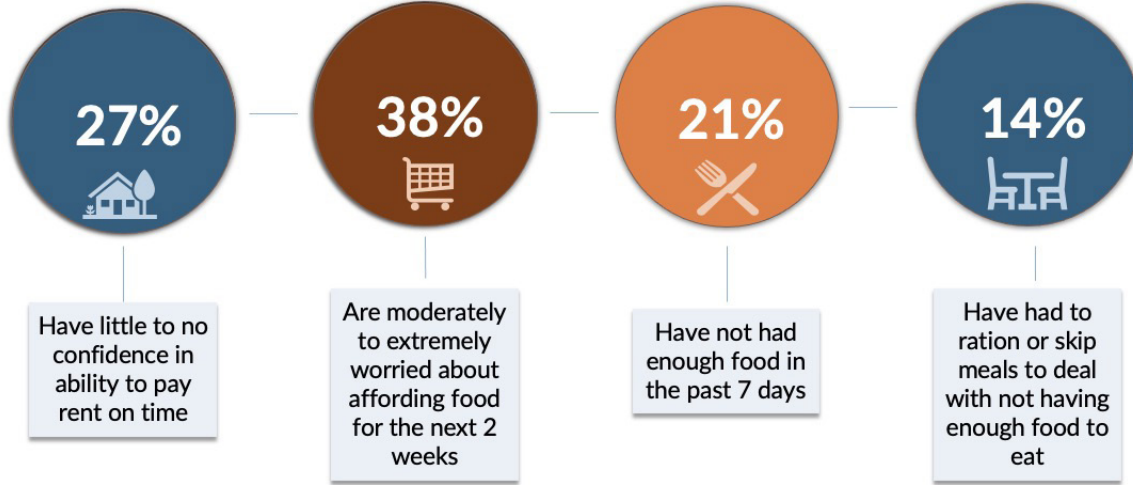


Food and housing insecurity. Loss of jobs and finances has severely impacted AIAN ability to meet basic needs. The impact becomes particularly palpable with high rates of COVID-19 related food insecurity. Over one in three (38%) reported that they are moderately to extremely worried about affording food for the next two weeks. Moreover, 21% said that they have not had enough food for the past 7 days and 14% said they have rationed or skipped meals to deal with not having enough food to eat. Moreover, over one in four of the participants reported little to no confidence in their ability to pay rent on time. The confluence of high levels of job loss (60%), food insecurity (38%) and housing insecurity (27%) has severely impacted AIAN participants' ability to meet basic needs during the pandemic.

Loss of jobs and finances has impacted ability to meet basic needs



(n=8,549)



Pandemic impact on children: Educational and socio-emotional development

Thirty-eight percent of participants said that access to financial support for emergency childcare was highly needed in their tribal or urban native community. Moreover, one in five participants reported that the impact of the COVID-19 pandemic on their family was a primary source of stress, including the developmental and social impact of COVID-19 on their children’s well-being. Nearly three-quarters of participants had school-age children and among Native parents, 21% reported concern about the social and emotional impact on their children being separated from friends and not attending school in person. Finally, 12% of parents also expressed worry about the COVID-19 pandemic’s impact on their children’s behaviors (e.g., staying up late at night, sneaking out).

COVID-19 Impact on Family Members and Social Networks

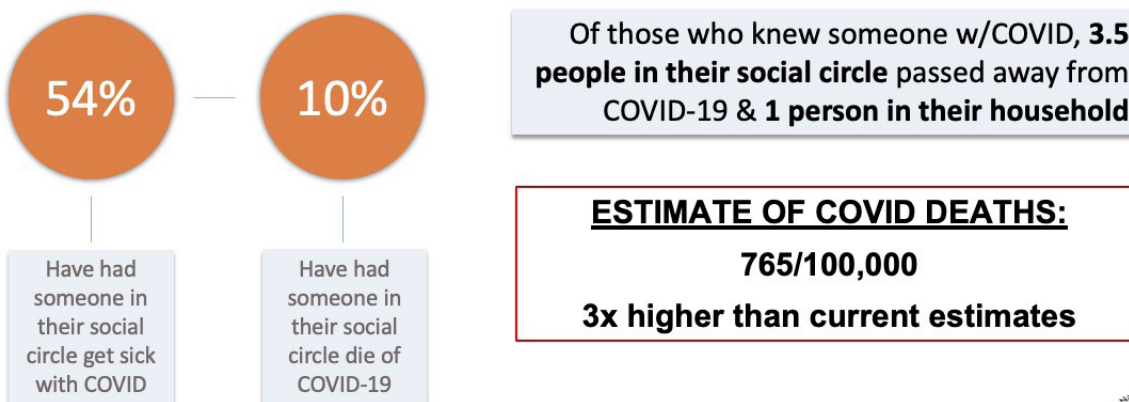
Research has shown that being socially connected and having strong familial networks are strong predictors of resilience during natural disasters and serves as critical psychological, social, cultural, and spiritual sources of support in times of collective crises.¹⁷ The pandemic has disrupted how people go about their daily lives and connect with significant familial and cultural system due to physical distancing policies aimed at reducing the spread of COVID-19. Moreover, the pandemic has created ruptures in support systems and families when they experience high levels of COVID-19 morbidity and mortality.

Over half (54%) of the participants in this study had someone in their family or social circle get sick with COVID-19. Moreover one out of ten people had someone in their social circle die of COVID-19.

COVID-19 social/familial mortality. Of those who knew someone with COVID-19, on average, 3.5 people in their social circle died from COVID-19 and at least one person died from their household. In tight, close-knit Native communities the impact of particularly high rates of COVID-19 death among family and social networks can produce prolonged grief reactions.¹⁹

Native Peoples are at increased risk during the COVID-19 pandemic

(n=8,549)

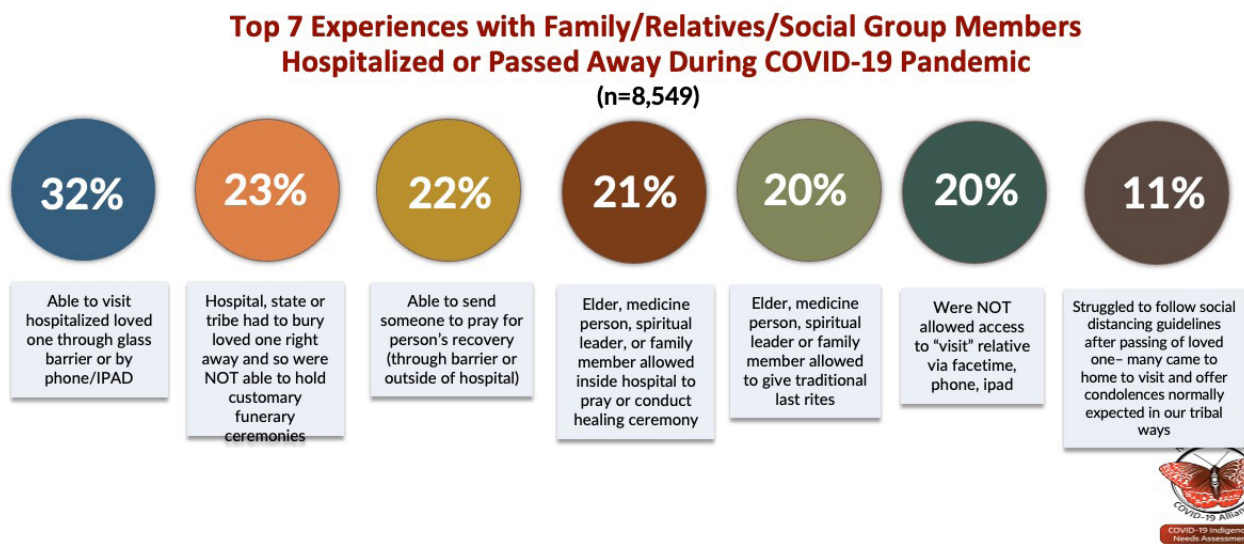


COVID-19 AIAN mortality estimate. The crude estimate of COVID-19 AIAN deaths is 765/100,000 which is three times that of estimates for the time period in which the study was conducted.

COVID-19 Cultural loss worries. Twenty-four percent of participants worried about the impact of COVID-19 on their communities if they lost traditional knowledge keepers and elders.

Hospital visits during the pandemic. Since the pandemic began (March 2020), AIAN participants identified the top institutional experiences they had with relatives and family members who had been hospitalized for any illness during the pandemic. One in three (32%) were only able to visit a loved one through a glass barrier or via an ipad/ip-hone, while 20% said that they were NOT allowed access to “visit” via Iphone or Ipad.

Experiences with Family Members, Relatives and Social Group Members Who Were Hospitalized or Passed Since the Pandemic Started (March 2020)



Family, elders, and medicine people access to sick relatives. Nearly one out of four participants said they were able to send someone to the hospital to pray for recovery (outside of the building or through a partition/barrier) and one out of five said that a family member, elder, medicine person, or spiritual leader was allowed inside the hospital to conduct ceremonies for healing or give traditional last rites.

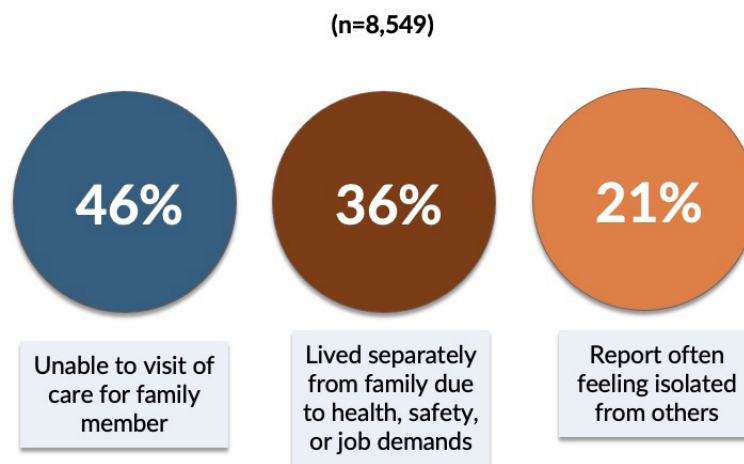
Customary burial or funerary rites prohibited. Twenty-three percent said that the hospital, state or tribe had to bury their loved one right away so they were not able to hold customary burial or funerary rites and ceremonies.

Social distancing at memorials. Eleven percent of the participants noted that it was difficult to follow social distancing guidelines after the passing of loved ones. Cultural expectations and customary practices include feasts, feeds, sings, and visiting during a ritualized memorial process, and some participants felt conflicted or had a hard time keeping to social distancing practices. It is important to note that the majority of Native communities created clever ways to provide memorial feasts and feeds while still physically distancing. For example, family members of the deceased provided to-go food plates that were delivered during car/truck drive-by memorials as one way to adhere to social distancing guidelines.

Social Isolation

Tribal communities took immediate action and created some of the most robust efforts to minimize the spread of COVID-19 through strict “stay-at-home” orders, lockdown of roads to prevent outsiders from entering reservation communities, and shelter-in-place orders. Response to the pandemic has led, in part, communities and families to “turtle up” - intensifying strong-tie interactions among family members and clustering in pods/small family groups or households.¹⁸ Nonetheless, nearly half of the participants reported high levels of isolation from their social networks and extended family members that disrupted their ability to provide care or increased their sense of loneliness. Almost half (46%) were unable to visit or care for a family member. One in three (36%) had to live separately from their family during the pandemic for health, safety, or job demand reasons. Over one in five (21%) often felt isolated from others.

High Rates of Isolation from Social Networks



Mental Health Impact

The pandemic itself and high rates of mortality exposures, coupled with economic loss impacts and social network isolation has seriously impacted AIAN community mental health and well-being.

COVID-19-related PTSD. Over half of the respondents (55%) met criteria for COVID-19 related Post Traumatic Stress Disorder (PTSD; > 1.75 scored on the Impact of Events Scale)- also known as symptoms of a trauma and stressor related disorder (TSRD). This finding is significantly higher than a MMWR report among non-Natives (26.3%).²¹

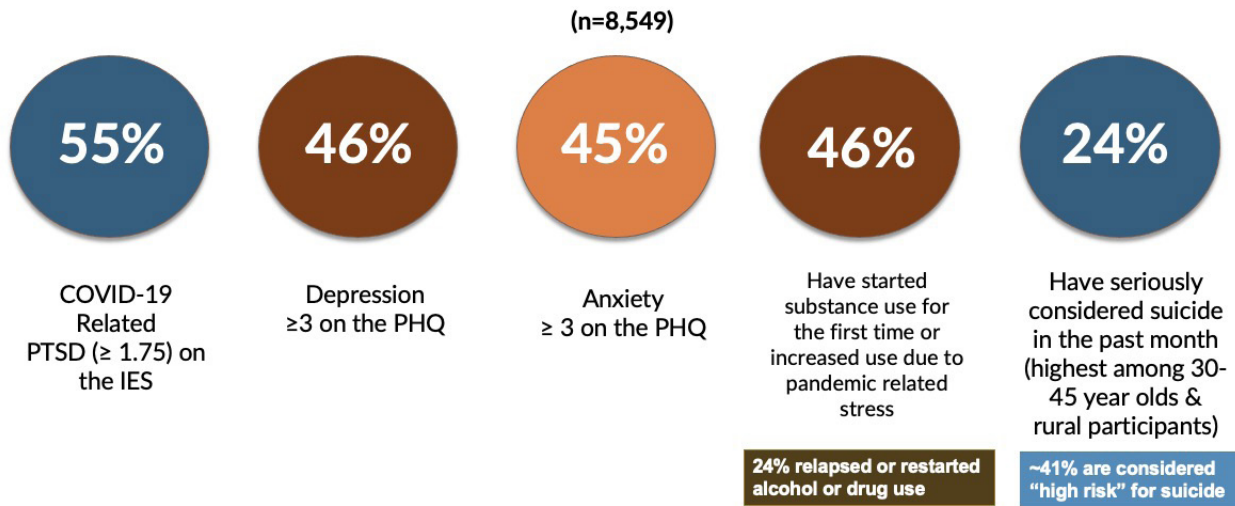
Depression and anxiety. Nearly half of the participants (46%) reported symptoms of a depressive disorder or anxiety disorder (45%) in contrast to the MMWR report among non-Natives (30.9%).

Substance use initiation, increase, and relapse. Nearly half (46%) initiated substance use for the first time during the pandemic or increased their use due to pandemic related stress. One in four (24%) relapsed or restarted alcohol or illicit drug use since the pandemic started.

Suicide. Nearly one out of four AIANs reported seriously considering death by suicide in the past month; this was highest among those ages 30 to 45 years and AIANs living in rural settings. Forty-one percent of the participants were considered “high risk” for death by suicide. This is in stark contrast to the MMWR non-Native findings where 10.7% of respondents seriously considered suicide in the past month. Among young Native adults (ages 18-29 years), 55% of them were at moderate to high risk for suicide, and 1 in 5 of them seriously considered suicide in the past month.



Adverse COVID-19 mental health impacts on Native Peoples



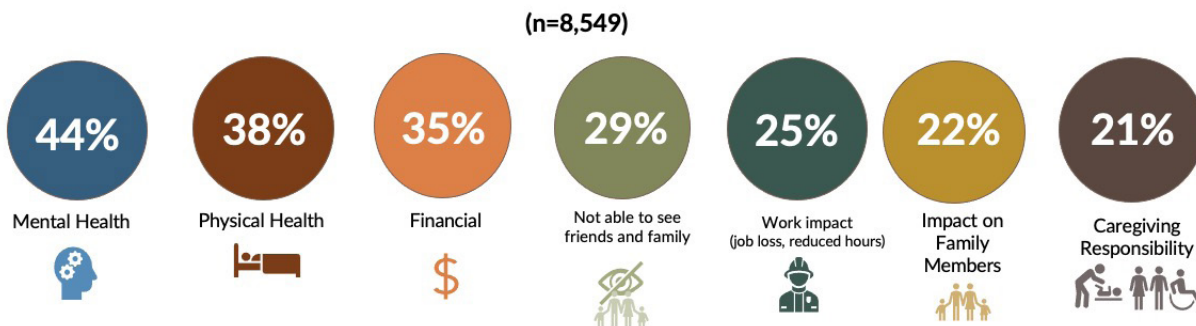
Greatest sources of stress

Given high rates of COVID-19 prevalence, COVID-19 related losses and mortality among family and social networks, and high rates of job loss due to COVID-19 and corresponding food and housing insecurity, it is not surprising that participants reported that the top seven greatest sources of stress during the pandemic include: mental health (44%), physical health (38%), finances (35%), isolation (29%), impacts on work (25%), impacts on family members (22%), and caregiving responsibilities (21%).

Greatest Sources of Stress: Physical, Financial, and Isolation Impacts



Top 7 greatest stressors during the COVID-19 pandemic



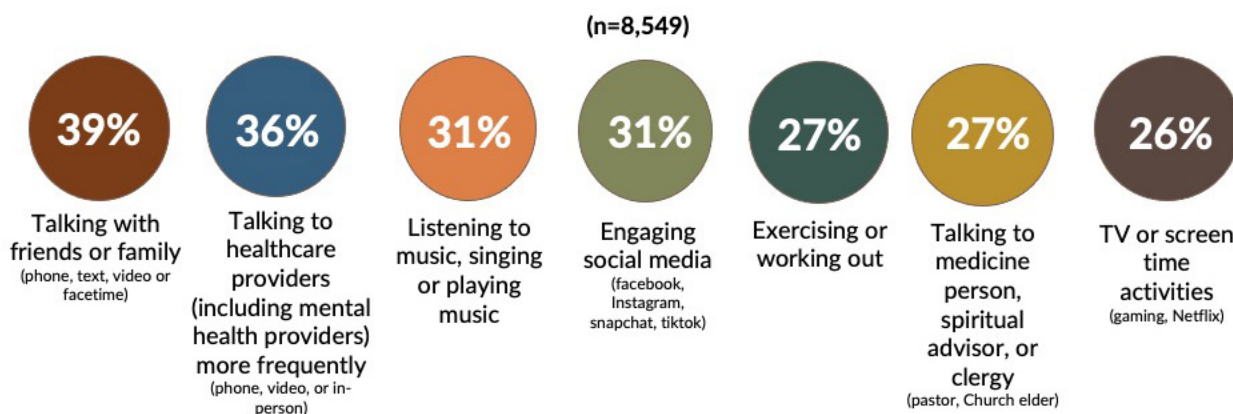
Resilience and coping strategies

While many AIANs reported increased stress during the pandemic, participants also reported a number of coping strategies to deal with their stress. To help cope with stress, over a third of participants (39%) talked with family or friend, 36% talked to healthcare providers, and 27% talked with a medicine person or spiritual advisor. Other coping strategies included: music-related activities (31%), engaging in social media such as Facebook (31%), exercising or working out (27%), and watching TV or other screen time to help with stress (26%).



Strategies to Cope with & Manage COVID-19 Stress

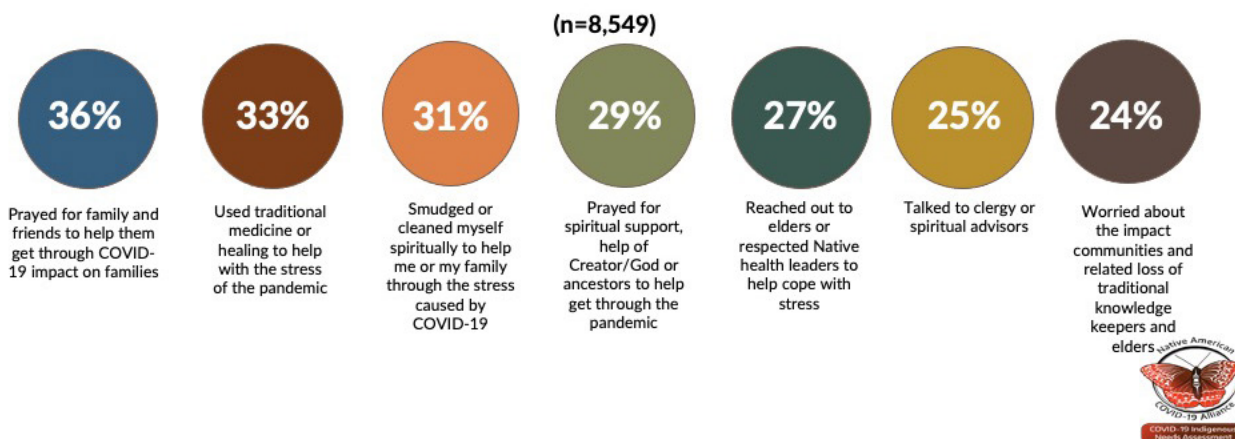
Top 7 Coping Strategies to Manage COVID-19 Stress



Spiritual coping. A number of participants also reported the use of spiritual and cultural activities to help with stress including: praying for family and friends (36%) or for spiritual support (29%), using traditional medicine (33%) or smudging/cleaning oneself spiritually (31%), and reaching out to elder or Native leaders (27%).

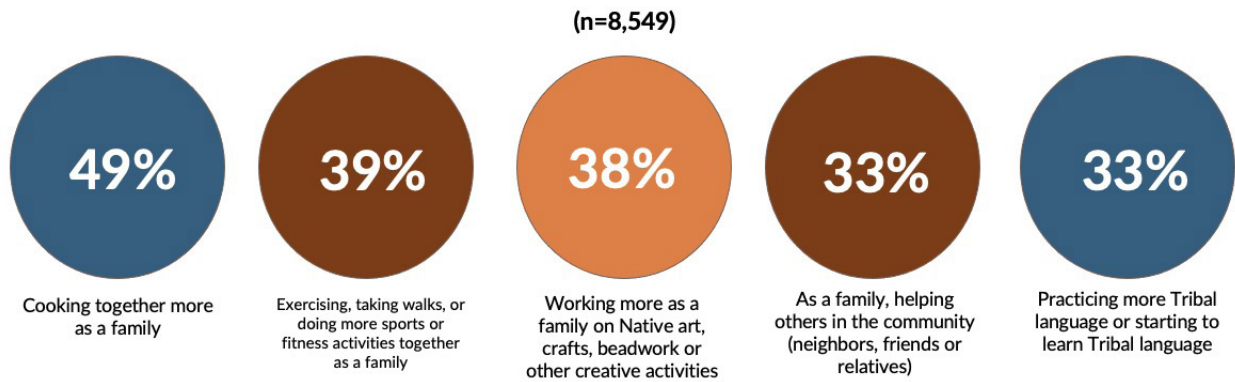
Spiritual Coping and Thoughts During the COVID-19 Pandemic

Top 7 Spiritual/Cultural Coping Strategies and Thoughts During Pandemic



Resilience and healthful outcomes. Over a third to almost one half of participants reported engaging in at least one healthful behavior or activity as the result of families being together more. Almost half (49%) cooked together more as a family, 39% reported exercising more, and 38% reported working together as a family on culturally-related arts and crafts. In addition, 33% reported helping others in the community as a family and 33% practiced or learned Tribal languages.

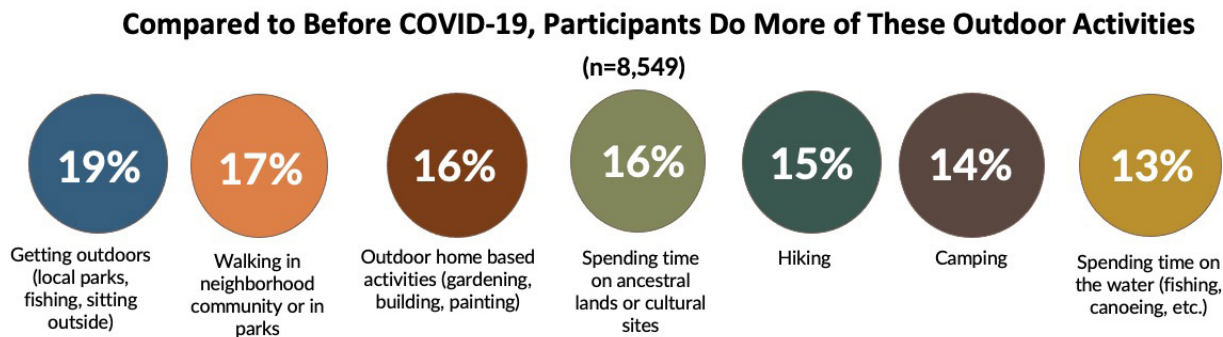
Healthful pandemic outcomes as a result of families being together more



Nature-based coping and outdoor activities. The reconnection to land, water, and sacred places is fundamental to Native cultures and identities. Land-based activities can activate remembering ancestral teachings, elevate mood, decrease stress, and revive the spirit.

Nearly one in five people reported an increase in physical activities during the pandemic including getting outdoors (19%), walking (17%) or hiking (15%), outdoor home-based activities such as gardening (16%), spending time on ancestral lands or cultural sites (16%), camping (14%), and spending time on the water (13%).

For nearly 1 out of 5 people, outdoor physical activities increased during the COVID-19 pandemic



Vaccines

Vaccine uptake. Results related to vaccination were mixed. As of March 2021, 21% of participants reported receiving a vaccine shot. The percentage reporting vaccinations varied tribally and regionally. For example, in one south-western tribe, 41% of tribal members reported already receiving the vaccine.

Vaccine hesitancy. Of those unvaccinated participants, 27% reported being unlikely or extremely unlikely to get the vaccine and almost a quarter (24%) indicated they were unsure whether they would get the vaccine.

There is reason to be hopeful about vaccination but there is still much work to be done...

(n=8,549)

21%

Report already receiving a vaccine shot [as of March 2021]

HOWEVER, of those unvaccinated...

27%

Report being unlikely or extremely unlikely to get the vaccine

24%

Report being unsure about whether they will get vaccinated



Vaccine motivation. The vaccine is not just personal, it is about protecting family and community. The greatest motivations for getting a vaccination included protecting elders (28%) and vulnerable family members (27%), living without fear of the virus (27%), and returning to family gatherings (21%).

Trusted vaccine information sources. Notably, several factors were related to increasing trust and included: vaccinations being backed by science (26%), having a most trusted family member or tribal leader recommended the shot (24% and 21% respectively) or having the CDC/ Dr. Fauci or a health professional recommend the vaccine (22% and 21% respectively).

The vaccine isn't just personal, it is about family and community

Greatest motivations for getting the vaccine

- To protect elders (28%)
- To protect vulnerable family members (27%)
- To live without fear of virus (27%)
- Personal health and safety (26%)
- Return to family gatherings (21%)

Factors most likely to increase trust

- Backed by Science (26%)
- Most trusted family member recommends (24%)
- CDC or Dr. Fauci recommends (22%)
- Tribal Leaders recommend (21%)
- Practitioner or family doctor recommends (21%)

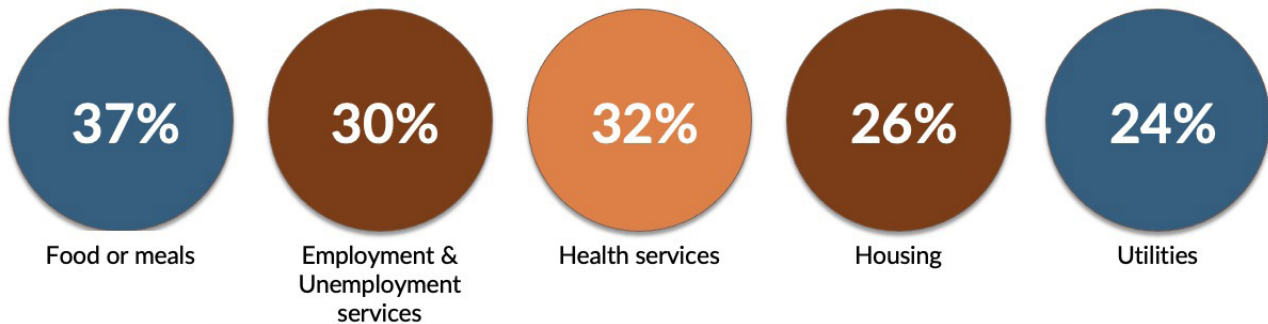


What people need most help with

Although mental health and physical health worries and concerns are high priorities for AIAN people, meeting basic needs was a primary and critical concern. When asked what they needed most help with, participants identified food (37%), health (32%), employment (30%), and housing (26%) as top priorities. Along with basic needs, participants reported that assistance with cultural and spiritual needs was key to health and healing.

People need help most with meeting basic needs

(n=8,549)



However, people also want help with cultural and spiritual needs:

- 20% want help with traditional healing
- 19% with spiritual or faith-based care
- 13% with funeral services

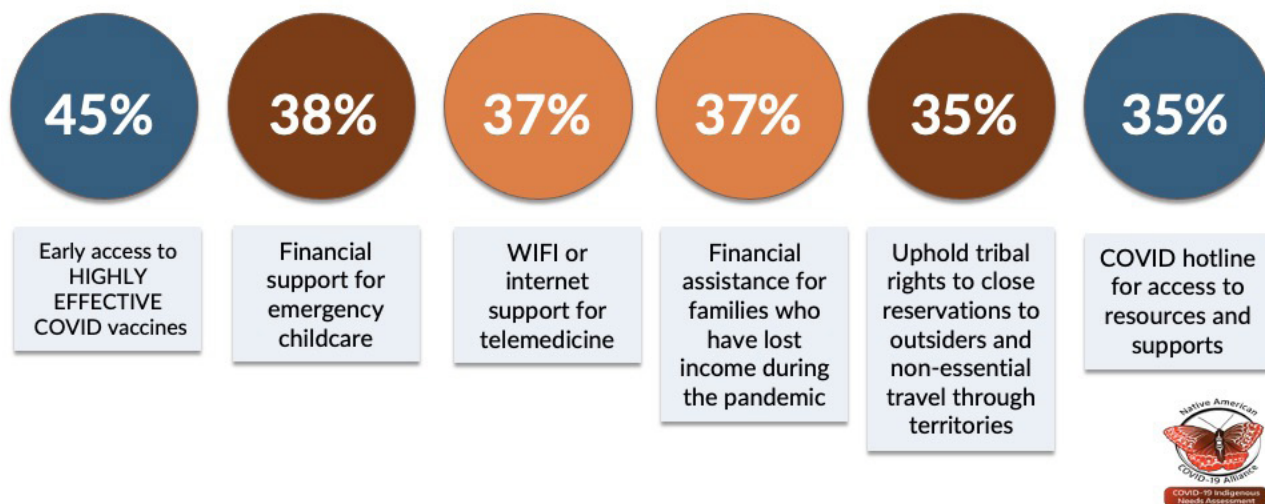


Policy Priorities

Six areas of priority were identified for policymakers to take into account. The top priority identified by nearly half of the respondents (45%) was early access to a highly effective vaccines, followed by financial support for emergency childcare (38%), WI-FI support for telemedicine (37%), financial assistance for help with lost income (37%), and a COVID-19 hotline for access to resources and support (35%). In addition, 35% of respondents identified the need to support tribal rights to close reservations to outsiders as a high priority.

Policy Priorities

(n=8,549)



Summary and Recommendations for Federal Policy

Native people have been severely impacted by the COVID-19 pandemic particularly with respect to food and housing security, job/income loss, high rates of COVID-19 exposure and illness, as well as family and social network COVID-19 mortalities. This negative impact is leading to collective grief, sense of despair/hopelessness, and possible long-term impact on mental and physical health, community cohesiveness, and the ability of Native people to be resilient in the future.

These findings are based on a U.S. and Associated Territories national sample of American Indian/Native American, Alaska Native, and First Nations, Métis, or Inuit sample of 8,549 adults (85% American Indian/Native American, 14% Alaska Native, 1% First Nations, Métis, Inuit), stratified by U.S. Census Divisions/regions and gender. The total sample was collected between January 18, 2021 and March 19, 2021. Findings indicate that COVID-19 exploits underlying structural inequities as well as health and mental health vulnerabilities. Although physical and mental health were identified as high priorities, meeting basic needs such as food, housing, and medical care is critically important at this stage of the pandemic. Despite such stressors, healthful behavioral, spiritual, and cultural coping practices and resilience emerged during the pandemic- including more family land-based/outdoor activities, engaging in more cultural and traditional health practices, strengthening family togetherness, galvanizing spiritual and/or traditional healing and health practices, revitalizing tribal language practices, and stimulating innovative online cultural activities (e.g., tribal language development, cultural virtual gatherings such as virtual pow wows). Although the data revealed progress in vaccination uptake, there remains concern that one out of four Natives stated they were unlikely to get or remain unsure about getting the vaccine.

Five major areas of top priorities have emerged from the data and are summarized below along with policy recommendations.

1. Socio-Economic Basic Needs: Covid-related job/income loss, housing and food insecurity

Job/Income loss

- 60% of participants said they experienced pandemic-related job or income loss
- Among the unemployed, 69% said their unemployment was the result of a pandemic-related layoff
- 23% said they had to quit their job to become a full-time caretaker
- 5% said they had to quit their job to care for someone with COVID-19

Housing Insecurity

- 1 out of 4 Native adults are not confident in their ability to pay their rent/mortgage or utilities on time
- 24% said they needed help with utilities
- 18% live in overcrowded housing

Food Insecurity

- 38% of Native American adults are food insecure
- 21% had to ration/skip meals because they did not have enough food to eat
- One out of 10 AIANS (10%) had to eat spoiled or rotten food

Recommendations

- After free and reduced lunch benefits expire this year, extend benefits and eligibility through the Agriculture Appropriations process to include a tribal set aside for SNAP, special supplemental nutrition programs for WIC to increase participation and improve benefits for tribes, support tribal and Native organizations to continue pandemic EBT.

Recent investments in the bipartisan COVID-19 relief for Tribes and Native Hawaiians (3.3 billion) and the one-year extension to the \$8 billion in Tribal Coronavirus Relief fund in the CARES Act will help tribes to retain access to funds they need to maintain safety net programs; however, given the dire food security concerns, an increase and greater flexibility in benefits may be warranted- particularly with respect to the Tribal Self-Determination demonstration program for food procurement for the Food Distribution Program on Indian Reservations (FDPIR), a provision in the 2018 Farm Bill. We would love to see these funding levels maintained when the new Farm Bill begins debate in 2023.

- Further support the USDA's plans to increase the amount and variety of traditional foods including wild salmon, caribou, reindeer and elk for FDPIR.
- Create a tribal set aside for rental and utility assistance under the CPD Appropriations package to work with HUD to prioritize housing improvements to reduce overcrowded and unsafe living conditions in tribal communities.
- Increase benefits to the current Native American Housing programs and the Tribal HUD-VASH Program for rental assistance for Native American veterans that are homeless or at risk of homelessness.
- Increase benefits to the Low-Income Household Water Emergency Assistance Program (\$19 million)-Sets aside approximately \$19 million for Tribes to carry out activities under a Low-Income Household Drinking Water and Wastewater Emergency Assistance Program.
- Eliminate the work requirement for Medicaid benefits. Eligibility for Medicaid needs to be delinked from TANF eligibility criteria.

2. Behavioral Health: Mental Health and Substance Use

Traumatic Stress, Depression, and Anxiety

- 55% of Native adults have COVID-19 related traumatic stress/PTSD, 46% have depressive symptoms, and 45% have anxiety.
- 44% of Native adults said that mental health was their greatest source of stress.

Suicidality

- 41% of Native adults are at high risk for suicide; 25% had seriously considered suicide in the past month.
- 55% of Native young adults (ages 18-29 years) are at moderate to high risk for suicide (22% seriously considered suicide in the past month)
- Natives aged 30-45 years old are at highest risk for suicide (60% are moderate to high for suicide)

Substance Use

- 46% had initiated or increased substance use to deal with pandemic-related stress & 24% had relapsed
- 30% of young adults (18-29) relapsed and 28% initiated drug use for the first time during the pandemic
- 58% of young adults (18-29) report re-starting or increasing substance use to deal with pandemic stress

Recommendations

- Extend the time period for states, tribes and territories to draw down substance abuse treatment and other mental health resources identified under the **SUPPORT for Patients and Communities Act (HR 6)**.
- Aggressive implementation efforts are needed to implement the mental health and substance abuse treatment provisions outlined in the Family First Prevention Services Act (FFPSA). Due to the narrow interpretation of FFPSA, only 17 of the more than 600 tribal nations are currently able to benefit from this policy. Eligibility under FFPSA should include all IV-B eligible tribes in addition to the 17 IV-E eligible tribes that benefit currently. In addition, culturally relevant evaluation methods should be considered appropriate methods for tribes to meet evidence-based standards. Current interpretations of the law have impeded tribal engagement in building culturally adapted evidence-based child abuse and neglect prevention programming.

The December 2020 COVID-19 relief bill set aside \$87 million for behavioral health and substance use disorder treatment, including \$2.5 million for Indian Health Service (IHS), Alcohol and Substance Abuse Program, provides \$21 million to continue the SAMHSA Tribal Behavioral Health Grant Program; and sets aside \$50 million within the SAMSHA for Indian Tribes or Tribal organizations to address opioid and substance use disorders in their communities; and provides \$11 million to support tribal SAMHSA grants for medication-assisted treatment. However, given the COVID-19 related mental health concerns, a 5% increase in funding as well as greater flexibility in foci may be warranted- particularly with respect to treatment for PTSD, depression, and anxiety and suicide prevention, among young adults and Native adults aged 30-45 years old- in urban, rural, and tribal communities. It is recommended that these additional formula allocations be added to the DHHS Appropriations Budget and be funneled through SAMSHA for distribution and monitoring.

- Increase funding for the direct transfer to the Indian Health Service from the FCC to enhance mental health focused telehealth access at federal, Tribal, and urban health programs.

3. Physical Health: Covid-19 Health Vulnerabilities, Covid-19 Exposure, Illness, and Vaccines

- 38% of the sample rated physical health as their greatest source of stress during the pandemic

COVID-19 Co-Morbidities and Vulnerabilities

- **Pre-existing health conditions.** 21% of the sample had 3 or more pre-existing health conditions (e.g., High blood pressure, diabetes, heart disease).
- **COVID-19 prevented health care access.** 34% had difficulty getting healthcare when needed; 30% had difficulty getting medicine when needed; and 25% lost health insurance or benefits since the pandemic started.
- **Physical activity levels dropped since the pandemic.** 52% of the sample have been less physically active since the start of the pandemic, increasing probability of worsening pre-existing physical and mental health conditions.

COVID-19 Exposure and Illness

- 25% were told by a healthcare provider they had COVID-19
- 10% had an overnight stay in the hospital (on average, for 6 days)
- Nearly 1 out of 5 experienced long hauler symptoms for at least a month after being diagnosed with COVID.

Traditional Medicine and Healing

- 40% accessed traditional medicines (e.g., cedar, roots, and traditional teas) or healing ceremonies (e.g., sweat lodge) to manage or treat symptoms of illness after they had COVID-19 exposure
- 23% of those with COVID did NOT have access to traditional medicine/healing but wanted access

The COVID-19 Vaccine

- 21% report already receiving a vaccine shot
- 45% want early access to a highly effective vaccine
- Among unvaccinated, 27% report that they are unlikely or extremely unlikely to get the vaccine
- Among unvaccinated, 24% are unsure about whether they will get vaccinated
- Greatest motivation to get the vaccine: 28% to protect elders or 27% vulnerable family members
- Trusted vaccine information sources: science (26%), trusted family member or tribal leader recommended (24% and 21%) or if CDC/Dr. Fauci recommends (22 and 21%)

Recommendations

- The COVID relief package signed in December 2020 provided \$1 billion direct transfer to the Indian Health Service to distribute to federal, tribal and urban Indian health programs for vaccine distribution and testing, tracing and mitigation for COVID. Specifically, this bill allocates \$210 million for vaccine distribution and administration, and \$790 million for testing, culturally grounded contract tracing, and other COVID mitigation efforts. We applaud this set aside but need to ensure tribes receive additional resources to build capacity and infrastructure to carry out the provisions of the bill as timely as possible. Funding for community-based testing sites and mobile testing units need to be increased particularly for medically underserved areas throughout tribal, rural, and urban Native communities. We applaud President Biden's new executive order signed January 2022 to expand testing capacity and increase access to free at-home rapid testing kits for all American households; however, we believe that partnering with tribal communities on these efforts would maximize the impact of these efforts.
- Missing in the December 2020 COVID-19 relief bill were resources to build public service campaigns in tribal communities to strengthen confidence (and thus uptake) of vaccines. Increased funding to the Good Health and Wellness in Indian Country program, the CDC's largest annual investment in Tribal public health could be used to address this gap.
- Increased funding to support the Special Diabetes Program for Indians (SDPI); reducing co-morbidities, such as diabetes, could reduce COVID death rates in tribal communities.
- Develop new discretionary grant opportunities to support tribal and urban Native programs to design and test demonstration projects using community-driven solutions such as: (a) incorporating health care services within community-based or tribally-based recreational or cultural centers; (b) promoting community health and prevention for children and youth; (c) expanding, through Native community-enhanced research, the evidence-based set of culturally grounded preventive interventions for physical and mental health and wellness; (d) cultivating access to traditional health and healing; (e) developing culturally derived prevention interventions that target health conditions or risk for health conditions that place people at greater risk for mortality or poor health if exposed to COVID (e.g., obesity, diabetes, cardiovascular disease); (f) develop other upstream demonstration projects that improve physical activity levels and improve health, BMI, lung capacity etc. via traditional cultural practices (e.g., creating and cultivating community gardens, developing traditional indigenous games and outside activities for youth, and creating other outdoor-based/placed-based health promotion activities and interventions). These demonstration grant programs should support culturally promising practices at the Tribal and urban Native community levels that capitalize on cultural strengths and resilience and build on cultural knowledges and practices to create culturally relevant COVID-19 policy and effectiveness of strategies for improving overall community health, reducing co-morbidities, improving vaccine uptake, and promoting health equity.
- SEC. 3014 of the COVID Relief Bill stipulates funding for data modernization and forecasting center to CDC to support public health data surveillance and analytics infrastructure modernization initiatives at the CDC. We recommend expanding this proposal to include establishing, expanding, and maintaining efforts to modernize U.S. infectious disease warning systems and to forecast and track hotspots for COVID-19 in tribal, rural, and urban Native American communities.
- The American Rescue plan makes important changes to the Medicaid program which include Extension of 100 percent federal medical assistance percentage to Urban Indian Health Organizations and Native Hawaiian Health Care Systems. For two years, the bill would temporarily apply the 100% FMAP available to Indian Health Service (IHS) providers furnishing care to Medicaid beneficiaries to include Urban Indian Health Programs and Native Hawaiian Health Care Systems services; such providers are grantees of the IHS and serve IHS-eligible patients on Medicaid, but they are not formally part of the IHS and, as a result, do not receive the 100 percent FMAP like other IHS providers.

4. Community, Family and Child Impact: Loss and Connectedness

There are more than 140,000 children in the United States that have become orphaned as a result of the COVID epidemic. These deaths have disproportionately impacted children and families of color. Kinship caregivers have stepped in to parent, but these families need targeted supports to ensure that can remain stable . 18 SUPERSCRIPT HERE FOR REF: (USA TODAY, December, 7 and 31, 2021).

High Rates of COVID-19 Death and Community Loss

- 54% had someone in their social circle get sick with COVID-19 and 10% had someone die from COVID-19
- Of those who knew someone with COVID-19, on average, 3.5 people in their social circle died of COVID-19 and 1 person in their household died from COVID-19
- Based on their reporting of COVID-19 related mortality among family and friends- the crude estimate of COVID Deaths for Native population in this sample is: 765/100,000 – which is 3x higher than current estimates

High Levels of Social Isolation

- 46% unable to visit or care for family member
- 36% lived separately from family for health, safety, or job demands
- 21% reported often feeling isolated from others

Childcare & Education

- 38% said that financial support for emergency childcare was highly needed in their community.
- 21% said that the impact on their family members was one of their primary sources of stress
- 74% have children in the house, and among parents, 21% are concerned about their children being separated from friends and isolation from school, particularly the impact on their children's social and emotional development
- 12% of parents are worried about pandemic impact on their children's behaviors (e.g., staying up late at night, sneaking out)

Family Connectedness and Cultural Resilience Activated During the Pandemic

- 38% said they were working more together as a family on Native beadwork, art, crafts, exercising and doing sports and fitness activities together since the pandemic started
- 33% said as a family, they are helping others in the community more (e.g., helping friends, neighbors and relatives)
- 33% said they are practicing more their tribal language or starting to learn their tribal language

Recommendations

- We applaud the new FEMA COVID-19 Funeral Benefit which provides financial aid to those who have lost a loved one to COVID-19. Tribal governments with COVID-19 emergency or major disaster emergency declaration will not have to pay a cost-share to carry-out this provision. While this is helpful, given the high rates of mortality and the remote locations of reservations in relation to major hospitals that are providing COVID-19 emergency and ICU care, the costs associated with bringing their deceased relatives to their home communities combined with other funeral needs warrants an increase in funding for this benefit.
- Extend benefits and eligibility through the Education Appropriations Bill to include a tribal set aside (see SEC. 2001) to address learning losses and implementation of culturally promising practices as well as evidence-based interventions to respond to students' academic, social, and emotional needs.
- Increase by 5% the \$409 million dollars have been set aside to transfer to the Bureau of Indian Education from the Department of Education to distribute to BIE K-12 schools and Tribal Colleges and Universities for COVID-19 mitigation and distance learning costs in the upcoming Education Appropriations Budget .
- Increase supplemental funding for the Department of Health and Human Services early childhood programs, from which participating Tribes will receive allocations to cover operating costs, reopening costs, personnel costs, and COVID-19 mitigation costs, does not extend to urban Native organizations. We are recommending a 5% increase and set-aside funding for urban Native early childhood programs. We also ask that these Urban Indian early childhood programs be prioritized in the next Maternal Infant Child Home Visitation reauthorization package.
- Increase by 5% the \$264 million for education construction and maintenance backlogs at the BIE to include specific construction on improving classroom space and buildings for mitigating COVID-19 impact (e.g., ventilation).
- Co-sponsor the Tribal Family Fairness Act (Rep. Bass sponsor) is another opportunity to co-sponsor legislation that will help to mitigate the impact of COVID-19 on Native children and families and will increase the well-being of these family units.

Children and family are top priorities for Native communities. The NACA findings highlighted the priority needs for Native children, young adults and families. It is critical that we invest in tribal child welfare systems that support the provision of culturally appropriate services to tribal families. Tribes seeking sovereign authority to protect the best interests of tribal children are hampered by the lack of infrastructure and stable housing. Policy priority areas include increased funding for Title IV-B under the Social Security Act formula grants for tribes as this would enable tribes to build capacity to meet the needs of tribal children and their families. Currently, the tribal share of this funding is less than \$7 million per year. Based on current funding formulas, many tribes will get nothing. Additionally, the Tribal Family Fairness Act (Rep. Bass sponsor) is another opportunity to co-sponsor legislation that will help to mitigate the impact of COVID-19 on Native children and families.

The COVID-19 relief package signed in December 2020, provided \$16 million to continue and to increase funding for Native American language instruction and immersion. Given the significant increase in Native language revitalization during COVID-19 and how Native languages play an integral role in the social, cultural, and spiritual health of tribal nations, we recommend developing a similar set aside in the upcoming Education Appropriations Package.

5. Infrastructure Development

We applaud passage of the Infrastructure Bill passed as of Nov. 2021. Given our findings, we suggest that in order to ensure capacity to implement the vision of priority 1 (i.e., socio-economic needs/safety net concerns), three critical infrastructure development needs were identified: broadband/WI-FI capabilities, workforce infrastructure development, and needs for brick and mortar development so that tribes have the capacity to deliver the services identified earlier in this policy brief.

Broadband/WI-FI capabilities

- 38% of Native adults said they need WI-FI or internet support for telemedicine/telehealth

Workforce Development

- 45% of Native adults want a COVID-19 hotline developed for Native Americans to improve access to resources
- 35% of Native adults want better COVID-19 data and surveillance-specifying a national Native American task force to track and report Native community outbreaks and coordinate responses
- 30% said they need most help with employment services
- 22% said they need help with transportation (e.g., to hospitals at great distance where relatives are taken for COVID-19 treatment)

Recommendations

- \$1 billion has been set aside for direct support to Native American communities, including Tribal Colleges and Universities and Native Hawaiian communities, for access to broadband through the Department of Commerce. Increase benefits to the COVID-19 relief for Tribes and Native Hawaiians (3.3 billion) and the one-year extension to the \$8 billion in Tribal Coronavirus Relief fund in the CARES Act to ensure broadband capabilities and access for telemedicine/telehealth and for education.
- Broadband expansion should be sustained after the period of COVID-19 relief. This can occur through priority inclusion in the House transportation infrastructure bill planned for introduction in the 117th congress. Internet and highways are just as critical for long-term community health and well-being as well as roads, bridges, and skyways.
- Much of the unspent funds from earlier COVID-19 relief packages has been due to the lack of infrastructure in place to funnel money quickly from the federal government to states, tribes and territories and then down from states to the communities and citizens in need. The COVID-19 bill offers tight turnaround times for spending down funds. Investments need to be made to develop community capacity through brick-and-mortar projects to create safe and healthy spaces for resource dissemination as well as workforce expansion to ensure timely delivery of these services.

The IWRI Native American COVID-19 Alliance Research Team

IWRI UNIVERSITY OF WASHINGTON INVESTIGATORS

Karina L. Walters, Ph.D.

(Choctaw Nation of Oklahoma)
IWRI Co-Director and NACA Lead Investigator

David Huh, Ph.D.

IWRI Research Methods Division Director

Tessa Evans-Campbell Ph.D.

(Snohomish Tribe)
IWRI Co-Director

Angelique Day, Ph.D.

(Hochunk descendant)
IWRI Faculty

Michael Spencer, Ph.D.

(Kānaka Maoli/Native Hawaiian)
IWRI Director NHPI and Oceanic Affairs

RISE UNIVERSITY OF MICHIGAN AND UNIVERSITY OF CALIFORNIA INVESTIGATORS

Stephanie Fryberg, Ph.D.

(Tulalip Tribes of Washington)
Director, Research for Indigenous Social Action and Equity (RISE),
University of Michigan and Project Lead for Indigenous Futures
Project (IFP)

Ariane E. Eason, Ph.D.

Co-Lead, Indigenous Futures Project (IFP), University of California,
Berkeley, Co-partner, Research for Indigenous Social Action and
Equity (RISE) Center

IWRI RESEARCH STAFF

Christopher Charles

Project Manager
(Duwamish, Cowichan, & Nanaimo)
University of Washington

Karen Segar

Data Manager, Analyst

Nocona Abrams, BA

Student Research Assistant
(Yakama Tribe)
MSW Student

ADVISORY BOARD TEAM

Nikki Pitre

(Coeur d'Alene Tribe (Red Bird Clan)/ Kalispel, Yakama,
Nisqually, Cowlitz, Squaxin Island)
Executive Director, Center for Native American Youth (CNAY)
[invited to join the Advisory Board.]

Alayna Eagle Shield, MPH

(Lakȝóta Húŋkpaŋǵa/ Standing Rock Sioux Tribe/Arikara)
Co-Executive Director, Mni Wiconi Clinic and Farm

Tasha Peltier, MPH

(Lakȝóta Húŋkpaŋǵa/ Standing Rock Sioux Tribe)
Co-Executive Director, Mni Wiconi Clinic and Farm

Bonnie Duran, DrPH

(Coushatta/Opelousas)
IWRI Director of Community Engagement

Danica Brown, MSW, Ph.D.

(Choctaw Nation of Oklahoma)
Behavioral Health Manager, Northwest Portland Area Indian
Health Board

Birdie Wermey

(Southern Cheyenne)
EpiCenter National Evaluation Project Specialist at
the Northwest Portland Area Indian Health Board

Michelle Johnson-Jennings, Ph.D.

(Choctaw Nation of Oklahoma)
University of Saskatchewan and University of Washington, IWRI

Roberto Orellana, Ph.D.

(Mayan)
Portland State University

Andrew J. Jolivéte

(Ishak [Tsikipl/Opelousa/Heron Band])
Director of Native/Indigenous Studies
UC San Diego

Keawe Kaholokula, Ph.D.

(Kānaka Maoli/Native Hawaiian)
Dir. Dept. of NH Health
University of Hawaii

COMMUNITY PARTNERS

Center for Native American Youth (CNAY): At the Aspen Institute
IllumiNative
Native Organizers Alliance
Mni Wiconi Clinic and Farm
American Indian Cultural Center of San Francisco

Department of Native Hawaiian Health, University of Hawaii
Papa Ola Lokahi
Native American Indigenous Studies, University of California,
San Diego
Pacific Islander Community Association of Washington

Appendix

Participants, Recruitment, and Sampling

Participants. This was an online, cross-sectional survey of adults 18 years and older identifying as American Indian (AI), Alaskan Native (AN), First Nations (FN), Native Hawaiian (NH), and/or Pacific Islander (PI) conducted between January 18 and March 19, 2021. Eligible individuals were residents of the 50 United States, U.S. territories, Puerto Rico, the U.S. Virgin Islands in the Caribbean Sea, Guam and the Northern Mariana Islands in the North Pacific Ocean, or American Samoa in the South Pacific Ocean. For the present report, we focused on 8,549 respondents who identified as AI, AN, or FN, either alone or in combination with one or more other racial/ethnic groups.

Recruitment. This study utilized a two-pronged recruitment approach that included participants recruited via (a) Qualtrics panels (n = 715) or (b) snowball sampling (n = 7,834) through outreach to a national network of AI/AN researchers, community partners, and national AI/AN organizations (e.g., Center for Native American Youth, American Indian Higher Education Consortium). Participants recruited through Qualtrics panels were compensated directly for their participation by the Qualtrics with points redeemable for incentives (e.g., gift card). Upon completion of the survey, respondents recruited through snowball sampling were granted access to a secure online form where they could provide their contact information to receive a \$10 gift card and request entry to an additional raffle, as incentives for survey completion. To maintain respondent anonymity, the online form for requesting incentives was separate from the survey itself and thus was not linked with individual survey responses.

Sampling. To ensure a diverse and balanced sample we utilized census-based sampling that accounted for tribal diversity. There are currently 578 federally recognized tribes, and an estimated 400 non-federally recognized tribes.⁷ Since population distributions derived from the U.S. Census Bureau inform allocation of resources at both the federal and state levels, we based our sampling areas on the four U.S. Census Regions,⁸ which include the: (1) Northeast, (2) Midwest, (3) South, and (4) West. To assess the relative distribution of AIAN-identified individuals (i.e., only AIAN and those identifying multiple racial/ethnic groups) across the four Census Regions, we utilized recent estimated AIAN population counts from the 2019 American Community Survey (ACS).⁹ As summarized in Table 1, the distribution of respondents in the survey sample aligned closely matched the recruitment targets based on ACS data. To ensure adequate demographic representation, recruitment was balanced marginally by gender and rural vs. urban location. With respect to gender, we required a minimum 40% recruitment for female or male gender. We targeted a 22% rural vs. 78% urban split, as defined by the U.S. Census Bureau as off- and on-AIAN areas¹⁰ and a 50% (female) vs. 50% (male) split, across the entire sample. To ensure adequate representation by residential setting, we required a minimum 20% rural and 60% urban recruitment, respectively.

Measures and Data Collection Procedures

Measures. The survey instrument included questions on demographics (e.g., tribal background and enrollment, age, gender, employment status, partner status, housing situation), food security, sources of stress, physical health status and comorbidities, mental health, alcohol and other drug use, COVID-19 exposure/diagnosis/and impact to self and family, access to traditional and western health care, COVID-19 vaccination status, and coping behaviors to deal with COVID-19 stress.

Data Collection. The online survey was administered using the Qualtrics survey platform and was designed to take approximately 20-25 minutes to complete. Survey responses were carefully reviewed to exclude responses from participants who were not eligible based on study criteria or exhibited evidence of not being a legitimate response (i.e., Foreign language responses, nonsense responses to open-ended questions, improbable completion time, duplicate surveys from the same IP address with identical responses).

References

1. Urban Indian health Institute (2021). *Data genocide of American Indians and Alaska Natives in COVID-19 Data*. Seattle, WA: Urban Indian Health Institute.
2. Arrazola, J., Masiello, M., Joshi, S...Landen, M. (2020). COVID-19 mortality among American Indian and Alaska Native persons- 14 states, January-June 2020. *Morbidity and Mortality Weekly Report*, 69 (49), 1853-1856.
3. Williamson, L.L., Harwell, T.S., Koch, T.m., Anderson, S.L...Tesfai, H.F. (2021). COVID-19 incidence and mortality among American Indian/Alaska Native and White Persons-Montana, March 13-November 30, 2020. *Morbidity and Mortality Weekly Report*, 70 (14), 510-513.
4. Centers for Disease Control (2019). Deaths involving coronavirus disease 2019 (COVID-19) by race and Hispanic origin group and age, by state; includes deaths reported through February 10, 2021; <https://www.brookings.edu/research/american-indians-and-alaska-natives-are-dying-of-covid-19-at-shocking-rates>.
5. Walters, K. L., Spencer, M.S., Smukler, M., Allen, H.L., ... Uehara, E. (2016). *Health equity: Eradicating health inequalities for future generations*. Grand Challenges for Social Work Initiative, Working Paper 19, 1-31.
6. Burki, T. (2021). COVID-19 among American Indians and Alaska Natives: Limited resources, lack of data, and years of neglect and discrimination are worsening the impact of COVID-19 on American Indians and Alaska Natives. *The Lancet*, 21, 325-326.
7. Saenz, M. (2020). Federal and State Recognized Tribes. National Conference of State Legislatures. Accessed January 17, 2022 at <https://www.ncsl.org/legislators-staff/legislators/quad-caucus/list-of-federal-and-state-recognized-tribes.aspx#State>.
8. U.S. Census Bureau. Census regions and divisions of the United States. . In: Bureau USC, ed. https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf2020. https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf.
9. U.S. Census Bureau. (2020, October 28). American Community Survey Data. Retrieved from <https://www.census.gov/programs-surveys/acs/data.html>. In:2019.
10. Norris T, Vines P, Hoeffel E. The American Indian and Alaska Native Population: 2010 Census Briefs. In: U.S. Department of Commerce, Economics and Statistics Administration, eds. Washington, D.C.: U.S. Census Bureau;; 2012.
11. CDC; American Indian and Alaska Native Metro Populations. Accessed: <https://www.cdc.gov/tribal/tribes-organizations-health/tribes/metro-populations.html>.
12. US Census Bureau; American Community Survey, 2009–2013. American Community Survey 5-Year Estimates, Table BO2005 American Indian and Alaska Native alone for selected tribal groupingexternal icon; generated using American FactFinder. Accessed Jun 8, 2015.
13. Department of the Interior, Bureau of Indian Affairs. Indian entities recognized and eligible to receive services from the United States Bureau of Indian Affairs [PDF-189KB]external icon. *Federal Register* 2015;80(9):1942–8.
14. Native American Students in Higher Education Factsheet. Accessed 5/6/2021 at <https://pnpi.org/native-american-students/>
15. US Census. American Indian and Alaska Native Heritage Month: November 2017. <https://www.census.gov/newsroom/facts-for-features/2017/aian-month.html>.
16. Sallis, R., Young, D.R., Tartof, S.Y.,...Cohen, D.A. (2021). *British Journal of Sports Medicine*, 0:1–8. doi:10.1136/bjsports-2021-104080.
17. Gauthier, G.R., Smith, J.A., Garcia, C., Garcia, M.A., and Thomas, P.A. (2021). Exacerbating inequalities: Social networks, racial/ethnic disparities, and the COVID-19 pandemic in the United States. *Journals of Gerontology Series B: Psychological and Social Sciences*, 76 (3), e88-e92.

18. USA Today (2021). COVID-19 has taken many children's parents. Their relative caregivers face host of hurdles. Accessed January 17, 2022 at site: <https://www.usatoday.com/story/news/health/2021/12/31/covid-19-took-their-parents-now-kids-caregivers-face-many-hurdles/8983096002/?gnt-cfr=1>
19. Romero, Daniel M. , Brian Uzzi, and Jon Kleinberg . 2016. "Social Networks under Stress." Pp. 9–20 in Proceedings of the 25th International Conference on World Wide Web. Republic and Canton of Geneva, CH: International World Wide Web Conferences Steering Committee.
20. Tang, S., Xiang, Z. Who suffered most after deaths due to COVID-19? Prevalence and correlates of prolonged grief disorder in COVID-19 related bereaved adults. *Global Health* 17, 19 (2021). <https://doi.org/10.1186/s12992-021-00669-5>.
21. Hatcher, S. M., Agnew-Brune, C.,... McCollum, J. (2020). COVID-19 among American Indian and Alaska Native Persons-23 states, January 31-July 3, 2020. *Morbidity and Mortality Weekly Report*, 69 (34), 1166-1169.
22. Czeisler, M.E., Lane, R.I., ...Raharatnam, S.M.W. (2020). Mental health, substance use and suicidal ideation during the COVID-19 pandemic-United States, June 24-30, 2020. *Morbidity and Mortality Weekly Report*, 69 (32), 1049-1057.

Few events have shaped American history and our national perspective on racial inequity as profoundly as the grief, community distress and economic devastation brought about by the COVID-19 pandemic.

The pandemic unmasked the stark racial inequities in our economic, health care, education and other systems and institutions — a reality of inequities to which we can not and must not return.

— Marc H. Morial



National Urban League

80 Pine Street, 9th Floor
New York, N.Y. 10005
Tel: 212.558-5300

JOIN THE MOVEMENT AND STAY CONNECTED!

www.nul.org

follow @naturbanleague on



Asian American Psychological Association

325 W Washington St
Suite 2 #3009
San Diego, CA 92103
www.aapaonline.org



Association of Black Psychologists

7119 Allentown Road
Suite 203
Ft. Washington, MD 20744
www.abpsi.org



Indigenous Wellness Research Institute

4101 15th Ave NE
Seattle, WA 98105
www.iwri.org



National Latinx Psychological Association

2598 East Sunrise Boulevard
Fort Lauderdale, FL 33304
www.nlpa.ws



American Psychological Association

750 First St. NE,
Washington, DC 20002-4242
www.apa.org