

Educational Perspectives

Journal of the College of Education/University of Hawai'i at Mānoa

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Healthy Keiki, Healthy Hawai'i: Teaching Personal and Social Skills
with the Hawai'i Health Education Standards
Volume 34 ■ Number 2, 2001

Introduction: Important New Directions in Hawai'i's School Health Education

Beth Pateman and Dan Yahata

What was health education like when you were in school? When asked this question, many adults have to think hard to remember any K-12 school health education at all. When they do remember, they typically respond that it was almost non-existent, boring, embarrassing, not enough, not relevant, a waste of time, or taught on rainy days when the weather was too bad to go out for PE.

Given these experiences, educators, parents, and community members do well to ask whether school health education is important today. Is this a subject that should be included in the curriculum when schools are grappling with the need to improve test scores in subjects such as reading and mathematics? Data from the Hawai'i Youth Risk Behavior Surveys of middle and high school students during the past decade indicate that our students bring other important needs to school, as well (Pateman, Saka, & Lai, 2001). When young people suffer from physical illnesses or injury, mental health problems, hunger, pregnancy, alcohol and drug use, or fear of violence, they are less likely to benefit from school instruction, regardless of efforts to improve educational methods, standards, or organizations (Kolbe, Collins, & Cortese, 1997).

The new Hawai'i Health Education Standards are designed to help young people develop the personal and social skills they must have to deal effectively with the health-risk issues they often encounter during their school years and beyond. The Hawai'i Health Education Standards, adapted from the National Health Education Standards (Joint Committee on National Health Education Standards, 1995), are based on evidence that healthy children learn better and that school efforts can improve child and adolescent health (Centers for Disease Control and Prevention [CDC], 2001).

The Hawai'i Health Education Standards were added as a distinct content area to the Hawai'i Content and Performance Standards (HCPS II) (Hawai'i State Department of Education [DOE]) in 1999. The new focus on developing and practicing personal and social skills stands in sharp contrast to traditional methods of having teachers serve primarily as information givers about health content. The Hawai'i Health Education Standards identify the core concepts that students must learn to promote and protect their health, and the skills young people need to help them navigate safe passage to adulthood.

The authors of this issue of *Educational Perspectives* describe partnership efforts throughout Hawai'i to promote

teaching and learning with the Hawai'i Health Education Standards. Beth Pateman, Thomas Sileo, and Ku'ulei Serna provide a fuller explanation of the new standards and their application to important health-risk areas. Douglas Smith describes positive new approaches to school violence prevention, a tremendously important health issue in today's educational settings. Michael Salzman shares the implementation of a new professional development summer institute for teachers, counselors, and administrators in building resiliency to prevent substance abuse and other health problems. Julie Maeda and Scott Shimabukuro explain the critical need to improve nutrition and physical activity for Hawai'i's children and adolescents. Beth Pateman, Rhonda Black, Ku'ulei Serna, Lynn Shoji, and Amy Stone Murai describe a standards-based approach to healthy sexuality education in Hawai'i. Cathy Kawamura shares information about the Hawai'i Peer Education Program, in which students learn and practice advanced health education skills. In summary, Lola Irvin, Virginia Pressler, Alex Santiago, Dan Yahata, and Deanna Helber describe Hawai'i's partnership efforts to support the health of children through the Healthy Hawai'i Initiative, funded with Hawai'i tobacco settlement dollars, and the Hawai'i Partnership for Standards-Based School Health Education, initiated by the American Cancer Society, Hawaii Pacific, Inc.

The authors of this issue are pleased to share the results of the partnerships that have been forged to support school health education and coordinated school health programs. These partnership efforts echo the words of Dr. Jeffrey Koplan, Director of the Centers for Disease Control and Prevention:

School health programs can play a critical role in promoting healthy behaviors while enhancing academic performance. It is critical for public health and education officials to work in partnership with schools and communities to enable schools to implement effective school health programs and help youth develop and maintain healthy lifestyles. Supporting school health programs to improve the health status of our nation's youth has never been more important, and we all must be involved (CDC, 2001, p. 251).

We look forward to continued collaboration to support the academic achievement and health of the young people of Hawai'i and the future parents, community members, and leaders they will become in our state.



Dr. **Beth Pateman**, guest editor for this issue of the journal, is an Associate Professor in the Department of Teacher Education and Curriculum studies, College of Education, University of Hawai'i at Mānoa. Her research interests include the assessment of health-risk behaviors among youth over time and the implementation and evaluation of standards-based school health education programs to promote health and reduce risks.



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About the cover: "Little Grass Shack Hula" by artist Alfred Furtado. A working artist, teacher, and lecturer for more than 40 years, Mr. Furtado's fine art work captures vivid memories of the people of the islands of Hawai'i. His work may be seen on the web site at: www.merchanthawaii.com. Contact Mr. Furtado at: 1629 Wilder Avenue, #501 Honolulu, HI 96822; 808/941-9545; leialfurt@aol.com

The Hawai'i Health Education Standards: Teaching 21st Century Skills for 21st Century Youth

Beth Pateman, Thomas W. Sileo and Ku'ulei Serna

A New Focus for School Health Education

The inclusion of health education as one of ten distinct content areas in the 1999 Hawai'i Content and Performance Standards (HCPS II) marked an important milestone in bringing school health education to life in Hawai'i's K-12 public school classrooms. The new Hawai'i Health Education Standards (Hawai'i State Department of Education [DOE], 1999) were designed to help young people learn and practice skills to gather accurate information; analyze internal and external health-related influences; make thoughtful decisions; set short- and long-term health-related goals; communicate effectively and act to promote their own health and that of family, friends, and community members. The Hawai'i Health Education Standards provide guidelines for teaching and learning in ways that genuinely engage young people in thinking through tough issues and decisions that they will encounter in all likelihood during their school years and beyond. The purpose of this article is to describe these new standards, their application in helping to prevent and reduce problems in priority health-risk areas, and their relevance to teacher education and professional development efforts for health education in Hawai'i.

Priority Health-Risk Behaviors Among Hawai'i's Youth

What are the difficult health-related issues that Hawai'i's young people face in the new century? The Centers for Disease Control and Prevention (CDC) identified six categories of priority health-risk behaviors: (1) behaviors that contribute to unintentional and intentional injuries; (2) tobacco use; (3) alcohol and other drug use; (4) sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infection; (5) unhealthy dietary behaviors and (6) physical inactivity (Kann et al., 2000). These health-risk behaviors contribute to three-fourths of all deaths among young people aged 10-24 (i.e., motor-vehicle crashes, other unintentional injuries, homicide, and suicide) and to two-thirds of all deaths among people aged 25 and older (i.e., cardiovascular disease and cancer). In addition, substantial morbidity and social problems among young people result from unintended pregnancies and STDs, including HIV infection. These behaviors often are established during youth and extend into adulthood. They are interrelated and preventable (Kann et al., 2000). Table 1 provides data about health-risk behaviors

among Hawai'i's high school students. Additional middle and high school health-risk data can be found in Pateman, Saka, & Lai (2001).

The Hawai'i Health Education Standards

With a clear focus on potential threats to the health and well-being of young people, questions arise about how best to educate students in ways that help them to deal effectively with health-related problems and to make informed decisions. Health education focused primarily on information

Table 1
Selected Results from the 1999 Hawai'i High School Youth Risk Behavior Survey

Unintentional and Intentional Injuries <ul style="list-style-type: none"> • 11% rarely or never used safety belts • 38% rode with a drinking driver during the past month • 14% carried a weapon during the past month • 10% attempted suicide during the past year 	Tobacco Use <ul style="list-style-type: none"> • 67% have smoked cigarettes • 28% smoked cigarettes during the past month • 13% smoked cigarettes on 20 or more days during the past month • 8% smoked cigars during the past month
Alcohol And Other Drug Use <ul style="list-style-type: none"> • 45% drank alcohol during the past month • 27% reported episodic heavy drinking during the past month (5 or more drinks on one occasion) • 25% used marijuana during the past month • 13% have sniffed or inhaled intoxicating substances 	Dietary Behaviors <ul style="list-style-type: none"> • 16% at risk for becoming overweight • 9% overweight • 79% ate less than 5 servings of fruits and vegetables per day during the past 7 days • 85% drank less than 3 glasses of milk per day during the past 7 days
Sexual Behaviors <ul style="list-style-type: none"> • 41% have had sexual intercourse • 12% have had 4 or more sex partners • 28% had sexual intercourse during the past 3 months • 53% of sexually active students (those who had intercourse during the past 3 months) did not use a condom during last sexual intercourse 	Physical Activity <ul style="list-style-type: none"> • 36% did not participate in vigorous physical activity (3 or more of past 7 days) • 80% did not participate in moderate physical activity (5 or more of past 7 days) • 58% were not enrolled in physical education class • 91% did not attend physical education class daily

giving in the 1960s and on affective (i.e., values clarification) education in the 1970s. These programs influenced students' knowledge and personal attitudes positively but had little effect on changing their actual risk-taking behaviors. In the 1980s, psychosocial theories of learning offered more promising approaches to teaching students important skills and problem solving strategies (Fetro, 2000).

During the past decade, evaluators identified curricular approaches that demonstrated positive results in preventing

and reducing youth risk-taking behaviors. For example, CDC (2001) developed the “Programs that Work” project to help educators identify curricula that are effective in reducing risk behaviors that contribute to HIV and other STD infections, unintended pregnancy, and tobacco use. Similarly, Hansen (2000) identified twelve targets of substance abuse prevention programs; Kirby (2001) reported ten characteristics of effective sex education and HIV education programs. These and other studies recognize personal and social skills practice as common prevention factors in successful programs. In a newly released study of alcohol use among minority, inner-city, middle school students, Botvin, Griffin, Diaz, and Ifill-Williams (2002) reported that *LifeSkills Training*, a school-based prevention program in which students were taught drug refusal skills and other essential behaviors (i.e., building self-esteem; thinking critically and making independent decisions; resisting advertising and media pressures; managing common adolescent anxieties related to social situations and academic performance; communicating effectively with parents, friends, and authority figures and developing personal

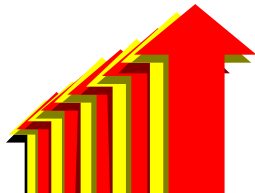

relationships and asserting one’s rights) significantly decreased binge drinking for as long as two years after the initial intervention. Students in the experimental group were more than 50 percent less likely to engage in binge drinking at the follow-up assessments.

In discussing a comprehensive approach to violence prevention, Dwyer and Osher (2000) explained:

Just as students learn how to read, write, and calculate math equations, they must also learn how to interact appropriately with peers and adults and how to solve interpersonal conflicts nonviolently. A school will have an increased risk of having students who solve problems with violence if the students are not encouraged and taught to interact appropriately and to use problem-solving skills. Thus, safe schools develop interpersonal, problem solving, and conflict resolution skills in all students (p. 8).

The 1995 National Health Education Standards (Joint Committee on National Health Education Standards) painted a detailed picture of the personal and social skills critical to the healthy development of children and youth.

Table 2
Hawai‘i Health Education 7 X 7 Curriculum Focus

<p align="center">Build Health Knowledge and Skill 7 Hawai‘i Health Education Standards</p>	<p align="center">Prevent & Reduce Health Problems 7 Risk/Content Areas</p>
<ol style="list-style-type: none"> 1. Core Concepts 2. Access Information, Products, and Services 3. Self Management (practice healthy behaviors, such as stress management) 4. Analyze Influences 5. Interpersonal Communication 6. Decision Making & Goal Setting 7. Advocacy 	<ol style="list-style-type: none"> 1. Injury and Violence Prevention 2. Alcohol and Other Drug Use Prevention 3. Sexual Health and Responsibility 4. Tobacco Use Prevention 5. Nutrition and Physical Activity 6. Mental and Emotional Health 7. Personal and Consumer Health
<div align="center">  <p>Build knowledge and skills to promote health</p> </div>	<div align="center">  <p>Prevent and reduce risks for health problems</p> </div>



The Hawai'i State DOE adopted these seven standards in 1999 as the Hawai'i Health Education Standards. Table 2 shows the health standards and the priority risk/content areas to which they apply. The goal of the standards is to increase students knowledge and skills, thereby promoting health and preventing and decreasing health problems in critical risk areas.

Teaching and Learning about Personal and Social Health Skills

This new way of teaching and learning for Hawai'i's teachers and students focuses primarily on practicing health skills rather than simply acquiring health knowledge. What do the Hawai'i Health Education Standards require students to know and be able to do from kindergarten to twelfth grade? What capacities do "health literate" students possess? The following explanation describes each of the seven health education standards in further detail.

1. Core concepts: Comprehend concepts related to health promotion and disease prevention.

Core concepts emphasize functional knowledge—the understandings that students must have to protect and promote the health of themselves and others. For example, in the risk/content area of sexual health, functional knowledge is the ability to differentiate fact from fiction about the ways that HIV infection is transmitted. However, understanding precisely how the virus that causes AIDS works is not essential for protecting and promoting health. This example also illustrates how health education differs from science or biology education. Health education specifically targets what children must know and do to stay healthy, while creating further opportunities for integrated learning across the curriculum.

The level of learning involved in acquiring core concepts varies across age groups. In an attempt to prevent the spread of disease, including HIV infection and hepatitis, kindergarten children learn that we do not touch other people's blood, that we get adults to help with blood spills, and that we can take care of our own nosebleeds and scrapes. At a more advanced level, middle and high school students learn that the only certain way to prevent HIV infection is to avoid contact with blood and body fluids through sexual abstinence. They also learn to avoid needle sharing of any kind, including tattoo and acupuncture needles. Students must make connections among and demonstrate comprehensive understanding of important health concepts to meet this standard.

2. Access information, products and services: Access valid health information and health-promoting products and services.

Health education teachers too often have functioned primarily as information givers. In contrast, meeting the

Hawai'i Health Education Standards requires that students of all ages learn to obtain their own health information from valid sources. For example, first grade students learn to ask health-related questions of parents, teachers, nurses, doctors, other caregivers and community helpers. Older students build their skills by exploring the websites of health-related government agencies and professional organizations and by calling or visiting agencies and organizations for current information. To help students access information, a teacher might provide the toll-free telephone number 1-800-342-AIDS for students to call the Centers for Disease Control and Prevention, with their parents' permission, to ask questions they and their classmates have developed (e.g., why don't mosquitoes transmit HIV?). Students also might interview classmates, teachers, and parents about their knowledge and attitudes toward HIV issues.

Meeting this standard assists students' learning about where to get the products and services they need for good health. Do middle and high school students know how and where to get assistance if they or their friends show signs of depression or eating disorders? Can students compare and decide between two personal health care products? To meet this standard, students identify valid versus invalid sources of information, products, and services.

3. Self management: Practice health-enhancing behaviors and reduce health risks.

Self management skills are healthy behaviors in action. Essential self management skills include learning and practicing health-enhancing ways to manage stress, anxiety, anger, and conflict and building a personal support group of family members, friends, and others on whom students can rely. In addition, practicing self management encompasses healthy dietary choices and a regular program of physical activity. Self management skills include personal self care, such as thorough hand washing and dental care, and basic emergency care, such as stopping bleeding or calling 9-1-1 for emergency services.

4. Analyze influences: Analyze the influences of culture, family, peers, media, technology, and other factors on health.

Meeting this standard requires students to think deeply about questions such as, "Why do we do what we do in relation to our health?" and "How do internal likes, dislikes, fears, moods, curiosity, and needs influence our health choices?" In addition, students must deal with "external influences," such as families, friends, culture, technology, and the media that affect behavior. The recent anti-tobacco "Truth" media campaign launched by the American Legacy Foundation helps students to investigate the deceptive practices

of big tobacco company advertising. Similarly, new anti-tobacco public service announcements from the Hawai'i State Department of Health (DOH) emphasize the short-term effects of tobacco use in a humorous format that appeals to young people.

Learning this skill engages children and youth in examining pressures from others to engage in risky behaviors and determining whether those who apply pressure truly are friends. In meeting this standard, students consider and explain how competing influences can work for, and against each other to affect behavior. An essential component of learning to analyze influences also includes examining and respecting the important role that diverse cultures in Hawai'i play in health-related decisions and behaviors.

5. Interpersonal communication: Use interpersonal communication skills to enhance health.

Practicing the standard of interpersonal communication helps students to acquire the verbal and nonverbal tools they need to respond to pressures, while "saving face" and, when possible, maintaining friendships. Students practice communication skills in a variety of situations that require speaking, listening, message analysis, nonverbal communication, overcoming barriers to communication, asserting one's rights, and giving clear messages. Elementary children practice asking for help from safe adults in an attempt to minimize tattling and increase problem solving (Coffee, Coffee, & Elizalde, 2000). Secondary students contrast respectful communication with language and behaviors that constitute sexual harassment and identify appropriate channels for reporting a harassment situation (Stein & Sjostrom, 1994). An important facet of this standard is the ability to compare the ways in which communication skills are used in different types of risk-behavior situations and with different individuals and groups (e.g., family members, friends, authority figures). Would students use similar or different types of communication skills to refuse cigarettes, to decline to be drawn into a fight, or to avoid risky situations that could lead to pressures to engage in sexual activity? In standards-based health education, students identify real-life scenarios based on their own experiences to practice communication skills.

6. Decision making and goal setting: Use decision making and goal setting skills to enhance health.

Helping students to learn a realistic, health-promoting process for making decisions and setting goals is an important purpose of standard six. In addition to examining their own experiences, students analyze the decisions and goals of others (e.g., incidents in local, state, and national news) and the resulting outcomes. Students learn to talk about the "courageous thing to do" in given situations and what it means to "listen to

Peer to Peer Education for Health in Hawai'i
by Cathy Kawamura

The Hawai'i Peer Education Program (PEP) was established in 1988 to address serious teen health issues, such as pregnancy, sexually transmitted diseases, substance abuse, violence and suicide. The Peer Education Program is an important component of the Health and Physical Education Program in the Hawai'i State Department of Education (DOE). The Peer Education Program supports the Hawai'i Health Education Standards and the Comprehensive Student Support System (CSSS). PEP is a standards-based, adolescent health promotion and disease prevention program in 26 public secondary schools across Hawai'i. The DOE Health and Physical Education Program closely monitors implementation and assessment of PEP services.

The mission of the Peer Education Program is to assist students in developing a healthy lifestyle by fostering positive self-esteem and responsible decision-making. Students who attend PEP classes in their schools are chosen carefully to represent a cross section of the total school population. Through the guidance of their school's Peer Education Program Coordinator, PEP students learn to deliver programs in teen health promotion and disease prevention. Once trained, PEP students have many opportunities to make health-related presentations to their peers, feeder school students, parents, community groups and others. The students are expected to create and develop lessons, skits, and activities that appeal to their target audiences and provide accurate information in an appropriate and relevant manner. PEP students are encouraged to make formal and informal one-to-one contacts with friends and family to help with referral, problem solving, and peer support in crisis situations. These students are the vital, "first line" reporters to improve the health and wellness of all students and to assist in early identification of students who need referral services.

Focus on Advocacy

The seventh Hawai'i Health Education Standard is "advocacy for personal, family, and community health." Students who serve as Peer Educators in their schools and communities develop advanced skills in researching health topics, taking a strong position and backing it up with evidence, and delivering effective health-enhancing messages to a specific target audience. The Peer Education Program Coordinator and students plan, organize and provide many opportunities for their schools and communities to participate in fun, healthy celebrations and events throughout the year. Networking with local and state agencies to support health issues in the communities is critical for PEP. National and local observances include the National Red Ribbon Week (campaign against illicit drug use), Hawai'i Drug Free Month, the American Cancer Society's Great American Smokeout, the American Heart Association's Save A Sweet Heart, World AIDS Awareness Day, Teen Pregnancy Prevention Month, and the American Lung Association's "Music with a Message."

The Peer Education Program represents an important adolescent health promotion and disease prevention program available in selected secondary schools in Hawai'i. The peer-to-peer model is well documented as an effective vehicle to teach students personal responsibility and empowered decision making. The PEP students earn elective credit in advanced health education and become positive role models as teens advocating for healthy lifestyles. The Hawai'i Peer Education Program makes an important investment in the future health of Hawai'i's youth.

Cathy Kawamura, State Peer Education Program Resource Teacher, Hawai'i State Department of Education.

your strong side” (Froschl, Sprung, Mullin-Rindler, Stein, & Gropper, 1998). Students also identify short-term and long-term goals that benefit from healthy decisions. Dramatization and videotaping of original student scripts are excellent ways to bring this skill to life. To meet this standard, students learn to set achievable short- and long-term goals, identify steps for reaching them, and consider alternatives and consequences fully in making health-related decisions.

7. Advocacy: Advocate for personal, family, and community health.

Acting to protect and promote health for others indicates a high level of health literacy. Meeting this standard requires students to take a stand for a health-enhancing position, provide support for their position, target a particular audience, and speak with conviction. An example of a health advocacy project in Hawai‘i includes the work of students in Diane Parker’s classroom at Waikele Elementary, who developed a multi-year campaign to keep their new school free of litter. Middle and high school students in Hawai‘i’s Peer Education Program (see sidebar on page 7), an advanced health education course, develop and deliver programs about important health issues, such as suicide prevention, healthy alternatives to alcohol and drug use, and sexual abuse prevention to students in their own and neighboring schools. Meeting this standard helps students to learn how to act for the good of others as well as for themselves. Examples of advocacy actions include writing letters or providing testimony on health-related issues (e.g., healthy food choices in vending machines, no smoking in restaurants) to the Hawai‘i State Board of Education, the local City Council, or the Hawai‘i State Legislature.

Teaching the Hawai‘i Health Education Standards in the context of real health-risk situations that occur in students’ lives in school, family, and community settings makes health education relevant to young people. Table 3 provides an example of how the standards can be applied to tobacco education for middle school students.

New Support for Teacher Education and Professional Development

Newly established systems of support for teacher education and professional development in health education abound! The American Cancer Society, Hawai‘i Pacific, Inc., initiated the Hawai‘i Partnership for Standards-Based School Health Education in 1999 to support professional development for teaching health education in Hawai‘i’s public and private schools. This partnership includes representatives from the Hawai‘i State Departments of Education and Health; the Hawai‘i Board of Education; the College of Education at the University of Hawai‘i; community organizations; and

Table 3
Middle School Standards-Based Tobacco Education

Standard	Example Learning Opportunities
1 CC Core Concepts	• Explain that most people do not use tobacco • describe why quitting tobacco use is difficult, but doable • list short- and long-term benefits of being tobacco-free • describe short-term (e.g., bad breath, yellow teeth, smelly hair and clothes) and long-term (e.g., cancer, heart disease) effects of different kinds of tobacco use
2 AI Accessing Information	• Access valid information on the effects of tobacco • access valid information on tobacco advertising • investigate resources for quitting tobacco use • access anti-tobacco advertising (e.g., www.thetruth.com for The Truth Campaign)
3 SM Self Management	• Demonstrate (role play) ways to avoid or leave situations where there is pressure to use tobacco • practice healthy alternatives for stress management and relaxation other than tobacco use
4 INF Analyzing Influences	• Analyze internal (e.g., curiosity, like & dislikes, need to be accepted and fit in) and external influences (e.g., family, friends, culture, media) on tobacco use • analyze tobacco advertising strategies • design counter-advertising anti-tobacco messages • analyze new DOH anti-tobacco public service announcements
5 IC Interpersonal Communication	• Role play ways of resisting pressure to use tobacco (e.g., clear “no” message, suggest an alternative, delay, fogging statements) • suggest healthy alternatives to tobacco use • communicate personal attitudes and commitment to be tobacco-free
6 DG Decision Making & Goal Setting	• Describe your personal decision-making process not to use tobacco • set goals that benefit from being tobacco free (e.g., participation in sports or dance, saving money for things that are important to you)
7 AV Advocacy	• Advocate for a truly tobacco free campus • support others to be tobacco free or to quit using tobacco • write and perform a skit or play about tobacco prevention in your school • design and perform an anti-tobacco campaign for closed-circuit television at school

corporate sponsors, such as Meadow Gold Dairies; HECO, HELCO, and MECO and the Bank of Hawaii Charitable Trust (Pateman, Irvin, Nakasato, Serna, & Yahata, 2000). Major support comes from the Healthy Hawai‘i Initiative (HHI), created with a portion of the Hawai‘i tobacco settlement funds. In 2000, the Hawai‘i DOH awarded HHI funds to the Hawai‘i State DOE for state and district resource personnel positions in health education and physical education, pilot programs in coordinated school health, and professional development for educators throughout the state. The Hawai‘i State DOE institutionalized a professional development plan that includes district-level K-12 health teaching workshops on the island of Oahu and the neighbor islands each spring; graduate level Summer Institutes at the University of Hawai‘i for graduate credit and a state-wide “Health Celebration” conference each fall. These efforts, which include state-of-the-art curricular materials and in-service education, have the enthusiastic support of teachers, counselors, and administrators state-wide. After the spring 2001 district workshops, a high school teacher wrote:

I don't know what I would do without these workshops. Besides hearing the presenters and networking with colleagues, the most valuable thing for me is the "rejuvenation" I feel. When I come to these, I feel excited all over again about being a health educator! It is truly an exciting time to be a

health teacher! And, with all those summer classes being paid for mostly by DOE . . . what a privilege for us. It makes excellent education affordable for more students like me who would not be able to afford \$500-\$600 a class. Thank you so much to all of you!

In 2000, the College of Education at the University of Hawai'i created a new Teacher Education Committee in Health Education (TECHE), which is composed of university and community partners who make recommendations about curricular requirements and teaching experiences. As a result of the deliberations of the TECHE and the Elementary and Early Childhood Education faculty, all students in the Elementary and Early Childhood Education program now take a new required course in teaching "Personal and Social K-6 Health Skills." At the graduate level, College of Education faculty from the Departments of Teacher Education and Curriculum Studies, Counselor Education, Special Education, and Kinesiology and Leisure Science are collaborating to offer a series of graduate level Summer Institutes for educators in areas such as school violence prevention, building resiliency to prevent substance abuse, healthy sexuality education, the coordinated school health program, and teaching for healthy nutrition and lifelong physical activity. In a new collaboration with faculty members from the John A. Burns School of Medicine, the 2002 Summer Institutes will include a new course on Problem Based Learning for Health Education. The Hawai'i State DOE underwrites a portion of the cost of these courses with Healthy Hawai'i Initiative funds provided by the Hawai'i State DOH, and with funding from the Division of Adolescent and School Health, Centers for Disease Control and Prevention. The College of Education also is working to reinstate a health education major at the baccalaureate level for secondary majors.

Healthy Keiki, Healthy Hawai'i

Dr. Joycelyn Elders, former US Surgeon General, stated: *You can't educate a child who isn't healthy and you can't keep a child healthy who isn't educated. . . . We must give greater priority to policies and programs that advance preventive health care practices. At issue is whether we want to invest now or pay later. We can invest in strategies that make a positive difference in our children's health and future, or we can continue to pay for costly intervention and treatment of preventable problems. I think the most promising strategy we can invest in is comprehensive school-based health education (1994, pp. xi-xii).*

The adoption of the Hawai'i Health Education Standards has helped to forge important new partnerships among professionals in health and education in Hawai'i. We join hands for health education that is real and engaging in children's lives, believing that healthy children are vital to Hawai'i's future and that quality health education can make an invaluable contribution to that future.

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Positive Prevention Strategies for School Violence

Douglas C. Smith

In Hawai'i, as in the rest of the nation, there is increasing concern about violence on school campuses. Recent data from the Hawai'i Youth Risk Behavior Survey (Pateman, Saka, & Lai, 2001) indicate that approximately one third of Hawai'i's middle and high school students had been involved in physical fights during the past year and 6% had carried a weapon to school during the past 30 days. More than 40% of Hawai'i middle school students surveyed indicated that they felt unsafe at school or on their way to and from school. Findings such as these have all but destroyed the illusion of safety previously thought to exist on school campuses.

In an effort to stem the rising tide of violence, many schools have now instituted a broad range of policies designed to deter antisocial behaviors. These policies include using metal detectors and/or security guards, establishing dress codes, implementing "zero tolerance" policies resulting in suspension or expulsion for certain classes of aggressive or threatening behavior, creating strategies for identifying or "profiling" students most likely to commit violent acts, and employing strong disciplinary tactics as a means of controlling disruptive behaviors. While the intent of such policies is to make a strong statement against violence on school grounds, the emphasis clearly is on reliance on punitive techniques rather than on providing support for positive social behavior. Most of these approaches are problem-focused in that they seek to modify negative behaviors as opposed to building alternative prosocial skills. Finally, most of these strategies are reactive, in the sense that they occur in response to undesirable behavior rather than proactively working to prevent the occurrence of such behaviors.

A Positive Approach to the Prevention of Violence at School

In contrast to problem-based approaches, a positive approach to the prevention and/or reduction of violent behavior focuses on building a set of social and emotional strengths that serve to preclude or inhibit the occurrence of antisocial behavior. Strength building may take the form of teaching emotional intelligence or emotional literacy skills, boosting resilience or protective factors, and establishing a high degree of "connectedness" between students and their families, peers, schools, and communities. Unlike traditional problem-focused approaches, the positive approach to school violence is preventive, solution-focused, and systemic in its efforts.

Recently in the field of psychology, and more specifically in the delivery of mental health services, there is growing acceptance of a model of human functioning that, rather than attempting to repair psychological disease or dysfunction,

attempts to promote optimal levels of development (see Seligman & Csikszentmihalyi, 2000, for a discussion of positive psychology). In short, positive psychology is primarily involved with the facilitation of psychological health and well-being. With regard to prevention of school violence, a positive approach engenders development of prosocial interpersonal skills and such noble personal qualities as wisdom, courage, altruism, civility, and tolerance for the views of others.

Components of the Positive Approach

Although positive approaches to the prevention of violent behavior in schools can take many forms and occur across multiple settings, a common theme among these approaches is establishing a sense of "connectedness" between youth and elements of their environment, including peers, family, school, and community. A growing body of evidence suggests that youth who feel nurtured, supported, and accepted by one or more of these entities are more likely to report subjective feelings of happiness and well-being, greater levels of commitment, and better performance in school (Resnick et al., 1997). Moreover, such youth are less likely to engage in negative, antisocial behaviors in the context of school and more likely to engage in cooperative, helpful, and prosocial behavior.

Connectedness is an important aspect of resiliency. Students who feel connected to family, peers, school, and community experience greater levels of support and are better able to cope with a wide range of adverse conditions, including those that promote antisocial behaviors in school (Catalano & Hawkins, 1996; Furlong, Pavelski, & Saxton, in press). In the following sections, I offer an overview of connectedness across several contexts and describe the role of schools in fostering these connections.

Connecting With Family

A very large literature emphasizes the important role that attachment to family plays in the prevention of antisocial behavior (see Lyons-Ruth, 1996, for a review). Children who experience secure, meaningful attachments to caretakers generally are better adjusted and are less likely to engage in troublesome and problematic behavior both in and out of school (Greenberg, Speltz, & DeKlyen, 1993). Conversely, caretaker-child interactions characterized by lack of responsiveness, inconsistency, hostility, and rejection are important aspects of a developmental trajectory leading to early onset of antisocial behavior. Although schools are unlikely to play a

major role in parent-child attachments during the critical early childhood years, their contributions to ongoing parent-child relationships cannot be underestimated. Schools are perhaps the most important resource for parent education leading to more positive connections between children and family members. What skills are important for parents and other family members to develop in order to promote prosocial behavior in their children?

Parent- and family-based interventions. These approaches focus on helping parents develop better communication and conflict resolution skills and also educate parents about child development and factors that may contribute to violent behavior (US Department of Education, 2000). Research findings indicate that the earlier these family-based interventions begin, the more effective they are in reducing aggression and other forms of antisocial behavior (Webster-Stratton & Hancock, 1998). Successful family-based interventions are individualized, culturally sensitive, home-based, and involve parents directly in planning goals and establishing appropriate responses to children's transgressions. These strategies are designed to increase parents' sense of control and feelings of efficacy.

One model program developed by Reid, Patterson, and Dishion (1992) teaches parents prosocial behaviors, alternatives to aggression as a discipline strategy, and problem-solving skills. In addition, parents are taught to nurture and communicate effectively with children, to establish and negotiate family rules and consequences, and to reward prosocial behavior. The model has been shown to be effective in reducing family conflict and increasing a sense of family unity. Long-term effects include a stronger sense of connectedness among family members with a greater likelihood of positive social interactions.

Parents as emotional coaches. John Gottman and colleagues at the University of Washington have written extensively about the advantages of training parents as emotional coaches for their children (Gottman and DeClaire, 1997). Emotional coaches are empathetic and accepting of their children's negative emotions but guide children in generating and choosing positive response strategies, while setting limits for acceptable behavior. An emotional coach is one who, rather than ignoring or discouraging negative emotional reactions such as anger or unhappiness, views the enactment of such emotions as opportunities for the child to develop a deeper understanding of self and others, particularly with regard to these potentially troubling feelings. Emotional coaches directly assist their children in exploring and discussing negative emotions while, at the same time, insisting upon socially appropriate expression of such feelings.

Connecting With Peers

Friendships are an important source of support and nurturance for both children and adults. Students who are

well liked by peers are happier at school, better adjusted both psychologically and emotionally, and considerably less likely to engage in aggressive and violent behaviors. On the other hand, children who are isolated or rejected by peers suffer loss of self-esteem and other emotional distress, tend to dislike school, and are at-risk for a wide range of destructive personal and interpersonal outcomes, including substance abuse, gang involvement, teen pregnancy, and violence at school (American Psychological Association, 1996). Helping children develop and maintain effective, rewarding relationships with peers is a critical aspect of violence prevention.

In a comprehensive review of prevention strategies designed to enhance social and emotional competence, Weissberg and Greenberg (1998) discuss a range of competence-enhancement strategies for elementary age students. The major goal of such programs is "to teach children to make use of both personal and environmental resources to achieve prosocial goals" (p. 890). Because aggression is viewed primarily as a learned behavior, it can be unlearned and thus prevented by acquisition of more prosocial and positive behaviors. Hawkins, Catalano, Kosterman, Abbot, and Hill (1999) suggest that healthy bonding of children to adults, peers, and institutions that promote healthy beliefs and prosocial attitudes is likely to result in adoption of similar views. There is growing national support for comprehensive, kindergarten through grade 12 health education that (a) emphasizes personal and social skills training, (b) promotes positive social values and health attitudes, and (c) provides honest, relevant information about health issues including violence. Strategies that increase the probability of positive prosocial interactions with peers can be loosely grouped under the categories of emotional literacy and cognitive-behavioral skills training.

Emotional Literacy

Daniel Goleman's 1995 book, *Emotional Intelligence*, popularized the notion that one's emotional quotient may be equal to or more important than intelligence as a predictor of life success. There is now compelling evidence that emotional competence is indeed related to a range of positive outcomes both at school and in the larger community, including friendships, social status, and achievement. More importantly, emotional competence also is generally regarded as an important protective factor and deterrent to violent behavior at school.

Goleman and others have identified at least five domains of emotional competence important to overall functioning and success. The first and most basic, *self-awareness*, refers to the ability to recognize and identify internal feeling states such as anger, disappointment, fear, and exhilaration. Closely related, but at a higher developmental level, is *awareness of others* which includes such skills as empathy, or understanding others' feelings, and role-taking, or understanding others' points of view. Both self-awareness and awareness of others

are critical to positive interactions with others, resolving interpersonal conflicts, and ultimately preventing and reducing the likelihood of violent, aggressive behaviors.

The third domain, *managing one's emotions*, refers to the ability to regulate and control potentially troublesome emotions such as frustration, resentment, guilt, and despair. One such emotion that has been the subject of numerous school-based intervention projects is anger. Anger management and regulation is an important skill in reducing violence potential at school (see Smith, Larson, DeBaryshe, & Salzman, 2000, for a review of anger management strategies for youth).

The fourth domain, *motivating oneself*, has particular relevance for students' performance in school. Students who have the ability and skill to motivate themselves, both extrinsically and intrinsically, are likely to view school as a positive experience, are less likely to engage in problematic or antisocial behaviors, and generally achieve at higher levels than their less motivated counterparts.

Finally, *skill in negotiating/resolving conflicts* is critical for reducing the probability of violent behavior at school. If disagreements, grievances, and other relatively minor conflicts can be resolved effectively, it is unlikely that these events will lead to aggressive/violent confrontations. Negotiation/conflict resolution builds upon a number of more fundamental interpersonal skills including cooperation, problem solving, and empathy.

Cognitive-Behavioral Skills Training

Cognitive-behavioral skills training focuses on helping children analyze and respond to challenging social situations. Two major focal points of these efforts have been on impulse control and social problem solving.

Phillip Kendall at Temple University has conducted extensive research on the role of impulsivity in children's aggressive behavior (Kendall, 1991; Kendall & Braswell, 1993). As a group, aggressive children tend not to think through the consequences of their behavior prior to acting. Based on these findings, Kendall and colleagues designed a series of activities to teach children self-control through verbal self-instruction (e.g., "what am I supposed to do?" and "how am I doing?"). These efforts are geared toward helping children restrain the tendency to respond without reflecting on the situation at hand. Evaluation of this and similar programs suggest that impulse control is an acquired skill and can be an important deterrent to aggression.

Nowhere is the link between impulsivity and aggressive behavior more evident than in the experience and expression of anger. School- and clinic-based anger management programs for children have proliferated in recent years. Because anger is conceptualized as a multidimensional construct including affective, cognitive, and behavioral dimensions, most of these programs include multiple prevention and treatment components. In a review of anger

management programs for youth, Smith, Larson, DeBaryshe, and Salzman (2000) found that the most successful programs included emotion-focused strategies such as relaxation, increased self-awareness and awareness of the feelings of others, cognitive strategies such as problem-solving and self-



Peer Education Program students from Konawaena School at the Great American Smokeout (l-r) Dana Libre, Ayla Peterson, Sharlee Kitaoka, Dena Ikeda and Gloria Jaeger

regulation, and behavioral strategies such as developing specific skills in communication and assertiveness. As a group, school- and clinic-based anger management programs for youth appear to exert a strong influence on the control and regulation of aggressive behavior.

Social problem-solving training is designed to help students recognize interpersonal conflict situations, increase their repertoire of problem-solving strategies, analyze and evaluate the consequences of various actions, and select and implement socially appropriate solutions (Goldstein, 1999). Most programs utilize modeling, role-playing, and didactic teaching methods to teach problem-solving skills. The goal of such programs is to build positive peer relations by helping children learn to avoid interpersonal conflict and to handle those conflicts that are unavoidable in nonviolent, socially appropriate ways. One of the best known social problem-solving programs for young children is *I Can Problem Solve: An Interpersonal Cognitive Problem-Solving Program* developed by Myrna Shure from Hahnemann University in Philadelphia (Shure, 1992). A related program based on an information processing model is the *BrainPower* program (Hudley, 1994), which is designed to change hostile attributional biases among aggressive children. Evaluation of the program indicated increased self-control and fewer judgements of hostile intent in a sample of 3rd-6th grade boys (Hudley et al., 1998).

Ecologically-Based Programs

In addition to the skill-based approaches, another means of reducing the likelihood of antisocial behavior is the establishment of an ecology that supports social competence. These approaches seek to prevent violent behavior by establishing a school climate fostering respect for the rights of others, positive social relationships, and peaceful resolution of interpersonal conflict. By establishing school norms supporting prosocial actions toward others, the goal is to reduce the occurrence of antisocial behavior that run counter to these norms.

In the classroom this may take the form of an effective classroom behavior management strategy that reinforces prosocial behaviors while simultaneously discouraging thoughtless, inconsiderate, or hurtful behavior. On the other hand, ecological interventions may take the form of repairing or restructuring school environments to reduce the likelihood of violence. For example, schools may reduce the sheer volume of students in hallways, lunchrooms, restrooms, and other potentially troublesome areas simply by staggering student schedules. Additionally, schools can reduce the likelihood of violent behavior by creating a more attractive and nurturing physical environment that also creates a safer, more welcoming atmosphere.

The *Resolving Conflict Creatively Program* (DeJong, 1999) is one example of such an ecological approach that incorporates a classroom and school-wide value system of nonviolence. Another example is the *Peacemakers Program* (Johnson & Johnson, 2000) for students in grades 4-8 which incorporates a violence prevention curriculum in the classroom and seeks to infuse a nonviolence ethic into the entire school culture. Evaluation of this program with 1,400 students in Cleveland indicated significant decreases in aggressive incidents and subsequent disciplinary actions. More work is needed to determine the long-term effects of such ecological interventions and their applicability to students from varying backgrounds, cultures, and ethnic groups.

Summary and Conclusions

Given the multiple pathways through which violent behavior develops in youth and the many factors that contribute both to its inhibition and disinhibition, effective prevention and intervention must necessarily be comprehensive, broadly applied, and developmentally focused. Programs meeting these criteria tend to include multiple treatment components such as individual skill building, family training, and environmental reorganization delivered across multiple contexts including home, school, and community.

Longitudinal research clearly indicates that, left unattended, aggressive behavior in early childhood often continues unabated into later stages of childhood, adolescence, and beyond. The more serious the form of early aggression, the more likely is this pattern to occur. What then can be done to

prevent the formation of early patterns of aggressive behavior in childhood? A review of research in this area suggests a number of principles that should be considered "best practices" for prevention of aggressive behavior during childhood.

First, and most importantly, prevention efforts must begin early and include multiple components delivered across multiple settings (minimally, the home and school). In the home setting, early intervention means implementing programs that engage parents in their child's education at as early a date as possible. These programs provide the context in which to disseminate effective parenting skills to all and to focus attention on parents who may be locked in a cycle of coercive child disciplinary practices. At the school level, early intervention means targeting low levels of aggressive behavior such as teasing and bullying and simultaneously establishing a school climate that reinforces positive social behaviors.

And what are the recommended treatment strategies for preventing aggressive behavior in young children? At the individual level, available data suggest that cognitive-behavioral strategies offer the most promise with specific training in impulse control and interpersonal problem solving receiving the most empirical support. Anger management appears to be a particularly fruitful intervention direction within the broader context of cognitive-behavioral treatment. These programs seek to prevent and/or reduce the occurrence of aggressive behavior by teaching children to recognize and utilize internal cues, develop a more reflective problem-solving style, and promote usage of alternatives to aggression. Given the pervasiveness of aggression in the typical school, comprehensive aggression management programs should be a key component of all student support services plans.

At the family level, parent education and training focused on improving communication skills and fostering authoritative parenting styles appears to offer the most promise. Both strategies result in the building of stronger family bonds and a more cohesive family unit, one of the more fundamental protective factors in establishing resiliency in children. In addition, assisting parents to acquire skills necessary to become effective emotional coaches is a major step toward reducing antisocial behavior.

Finally, successful prevention of school violence means not only seeking to reduce negative affect and behaviors but also fostering higher levels of social and emotional competence. All programs need to attend to the fundamental issue of providing a positive reason for *not* being aggressive. Encouragement of prosocial behavior such as cooperation and respect, self-awareness and empathy is the foundation for pursuing the ultimate objective of raising competent, caring, and compassionate human beings.

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Developing Resiliency in Youth: A Professional Development Summer Institute for Educators

Michael B. Salzman

The issue of resiliency has never seemed more important or relevant than now. As we contemplate the horrendous events of September 11, 2001, and their implications for ourselves and the young people with whom we work, we are moved to consider the sources of human strength and resilience.

Human beings can be incredibly strong in the face of adversity. It is necessary to nourish those sources of strength and resilience in order to help us deal with the adversity and tragedy that life may unexpectedly or predictably present to us. Recent events suggest that the nourishment of resiliency has never been more relevant or imperative than it is now. Building resiliency in our young people and in ourselves is particularly compelling and relevant today.

A New Professional Opportunity

In June, 2001, my colleagues and I joined 54 teachers, counselors and school administrators for a two-week, intensive new course that focused on the construction and nourishment of resiliency in young people in order to combat such pathological responses to human problems as substance abuse and other self-destructive behaviors. This Summer Institute was sponsored by the Hawai'i State Department of Education (DOE) and the College of Education, University of Hawai'i Mānoa (UHM) and offered through the UHM Outreach College for graduate credit. The DOE underwrote the cost of the institute with tobacco settlement funds provided through the Hawai'i State Department of Health (DOH) as part of the Healthy Hawai'i Initiative. My purpose in this article is to report and reflect on the ideas and strategies that emerged from the examination of resiliency that we engaged in during those two weeks.

We were fortunate to bring outstanding presenters to the Summer Institute. Dr. Joyce Fetro, from Southern Illinois University, conducted three sessions on learning to teach essential personal and social skills to young people, such as communication, decision-making, goal setting, and stress management. These skills promote the development of essential "internal assets" that have been identified as contributing to the nourishment of resiliency in youth. Mervlyn Kitashima, a local guest presenter, was one of the original participants in the classic longitudinal study of resiliency in Kauai (Wener & Smith, 1992). Mrs. Kitashima spoke movingly of her grandmother, who served as a source of stability and unconditional love during difficult family

times. Geneva To dikozi, a high school teacher in Oahu, described a mentorship program that she coordinated in Alaska. Manu C. Kaiama, director of the *Native Hawaiian Leadership Project*, and Kamana'opono Crabbe contributed an invaluable session on the power of culture as a powerful source of resiliency and guidance. Dr. Douglas Smith provided a general framework and model as well as invaluable web-based resources that educators could access in order to encourage the nourishment and development of resiliency. I offered specific examples and elaboration of the essential elements of the model such as operationalizing how "meaningful" student participation can be achieved.

An effective way to prevent pathology and dysfunction is to build health, resiliency, and strength. In psychology, the principle of reciprocal inhibition holds that two incompatible behaviors cannot occur simultaneously and that a response that is incompatible with an undesirable response can be substituted for that undesirable response. Health is incompatible with pathology. Thus, promoting mental, emotional, social, and physical health can help alleviate pathology, suffering, and dysfunction; promoting peace can help decrease violence; creating institutions infused with social justice can combat injustice and nourishing strength and resiliency can mitigate the negative effects of adversity and trauma.

As I considered how to approach the issue of resiliency in the Summer Institute, I sought root meanings. Webster's *Third International Dictionary* (1971) includes the following in its definition of resilience and resilient:

1. An act of springing back.
2. Capable of withstanding shock without permanent deformation or rupture.
3. Tending to regain strength or high spirits after weakness or depression.

The *Concise Oxford Dictionary* (1990) describes a resilient person as one who readily recovers from shock. The Random House Webster's *College Dictionary* (1999) defines resilience as the ability to recover readily from illness, depression, adversity or the like—buoyancy.

Singer and songwriter Bob Dylan wrote a song for his newborn son that wished him "a strong foundation when the winds of changes shift." Thus, I began the two-week resiliency course by asking, "What kind of humans are we trying

to help develop?" I suggested that the answer to this question would be the central organizing principle for our efforts as educators. It was heartening to read the list of responses generated by the educators, counselors, and administrators present. There was widespread agreement that we wished to help develop *strong*, healthy, competent and courageous young people. These characteristics are components of that quality we call resiliency. How can we help develop young people who are strong, healthy, competent, courageous and, therefore, resilient to the adversities of life?

A Resiliency Model

In psychology and education, we have used a medical model to identify problems, deficits, and pathologies. The assumptions of this model rarely are questioned, and educators too often are trained mechanically in the logic of the medical model without seriously examining its premises. At times, we have found pathology where only normal human variation is expressed. New trends in positive psychology present an alternative orientation to promoting human and social health. The development of strong, resilient human beings is related to protective factors built into the environment and cultivated within the person. Protective factors refer to the influences modifying, ameliorating or altering the response of an individual to various hazardous events preceding maladjustment (Rutter, 1985). These protective factors can be environmental or personal factors, which protect the individual against the effect of various stressors (Losel & Bliesener, 1994). At the root of these factors are human needs. What do humans in general and young humans in our schools really need?

Psychologist Abraham Maslow (1970) proposed a hierarchy of human needs. His hierarchy suggested that these needs are as follows:

- Physiological needs (e.g., air, water, nourishment)
- Safety needs
- Belonging
- Self esteem
- Self-actualization

Maslow thought that higher order needs (e.g., self-esteem, self-actualization) could not be satisfied unless the lower order needs (e.g., physiological, safety needs) were first satisfied. However, these needs may not exist in a strict linear relationship. For example, a school that does not foster a real sense of belonging and participation will not support the establishment of a safe environment. Young people in schools where they feel alienated and marginalized will not be invested in that school and may be motivated to meet their needs by alternative means, including gang membership, substance abuse or even revenge seeking behaviors. Educators are responsible for providing the healthiest and most socially useful opportunities for young people to meet their

human needs and aspirations. We cannot blame recourse to gangs if we fail to offer viable alternatives.

The work of Bonnie Bernard (2001) informed the model of resiliency that we used in the Summer Institute. This model identified a set of youth needs that must be addressed, those external and internal assets that promote resiliency, and its associated enhancement of health, social and academic outcomes. What do young people really need? Bernard suggested that young people need safety, love, belonging, respect, mastery, and challenge. The model also suggests internal and external assets that positively address these core needs. They are:

External Assets

- Caring relations
- High expectations
- Meaningful participation

Internal Assets

- Cooperation
- Empathy
- Problem-solving
- Self-efficacy
- Self-awareness
- Goals and aspirations

To help develop strong, competent and resilient young people, our efforts should support the construction of school environments where students feel cared about, where high expectations are held, and where students participate meaningfully in the decisions that affect them and in the life of the school community. Additionally, the development of strong, competent and resilient human beings requires the development of the ability to cooperate, empathize with others, and solve problems. It also requires a belief that one's actions have consequence to achieve self-awareness and the development of challenging and valued goals. Participants in the Summer Institute considered how to build protective factors into school environments that can support the cultivation of internal assets (e.g., empathy, problem solving, and self-efficacy). These internal assets serve a protective function in the face of adversity, thereby making improved health, social and academic outcomes more probable.

Caring Relations

One caring person can make a difference. Discouraged youth who are convinced that they lack value and significance can have that devastating conviction challenged by just one caring person. Needless to say, the more caring people the better, but one caring person can, as the Werner and Smith (1992) study shows, positively alter the course of a young person's life.

The outcome data from Ms. To dikoz's mentorship project in Alaska indicated the power of such interventions. Mentors are, by definition, people who care and take a special interest in their mentees. Caring relationships were built into that program in two ways. First, high school students who were

having academic, social or emotional difficulties were identified. They were not severely disturbed but were displaying problems or risk factors that were considered likely to become more severe without effective intervention. These high school students were paired with elementary school students in the community who needed help with their school-work. The older student was charged with the task of coming to the elementary school on a weekly basis and helping the youngster. Secondly, a community person was paired with the high school student in a mentor-mentee relationship. The community mentors were matched carefully with mentees on the basis of likely compatibility and shared interests, and they were supported with training after their initial screening for appropriateness. This approach effectively put the "at-risk" high school student in the role of helping another, thus making a real contribution to the community and to the elementary school student. Adler (1973) called this "social interest." Social interest is that potential that exists within all people to contribute and focus beyond self. Since teenagers are often heroic, transcendent figures to young children the teenagers found their charges to be thrilled to have their very own teenager who cared and would work with them in their subject of difficulty. The community mentor would meet at least once a week with the targeted high school student and the mentor's role was to develop a caring and supportive relationship with that young person. This relatively inexpensive intervention had a powerful effect and is now considered to be a model program. Such inexpensive interventions can provide the crucial protective condition of caring relations. It is difficult for young people to maintain the conviction that they are worthless and unlovable when there is clear evidence to the contrary that exists in the form of a respected person who truly cares.

High Expectations

Are any of us wise or prescient enough to truly know the upper limits of anyone's human potential? Do aptitude tests really tell us what a person may be capable of? Do the diagnostic labels with which we describe students really have validity? Do we, in fact, commit a grave injustice on young people by placing them in "diagnostic prisons" from which there rarely is escape? For example, are low expectations inherent in diagnostic labels such as "learning disability?" Does such labeling result in a self-fulfilling prophecy as teachers, parents, and the labeled student expect less and thereby produce less? When we note the requisite discrepancy between assessed intelligence and achievement that is the essence of a learning disability diagnosis, do we consider plausible alternative explanations for that discrepancy, such as discouragement, lack of motivation, cultural differences, irrelevant curriculum and, yes, even hunger? Do we, with the best of intentions, in fact do harm? Can we hold realistically



Peer Education Program students from Honoka'a School at the Great American Smokeout (l-r) Amber Bannister, Ashlynn Dias, Natasha Hui, Jayleen Chong & Joshua Martin.

high expectations for our students while supporting them as they reach to achieve them? These are questions that challenge the assumptions of some of our practices. It is necessary to periodically re-examine such assumptions because even well intentioned, but erroneous, assumptions can lead to great harm. A useful principal is first to consider plausible alternative explanations for observations of low achievement before *inferring* that the low achievement has a biological or "information processing" disorder requiring a medical or pseudo-medical explanation that then requires a "Felix" response. The idea of resiliency raises questions about such assumptions and invites educators to examine them more thoroughly.

Meaningful Participation

Young people need options other than the extreme choices of conformity or rebellion. A third option exists that rarely is developed—to participate in the decisions that affect them and to be responsible for those decisions. What responsibilities can appropriately be given to students in our schools? Discipline plans, for example, directly affect students—but how often do we include them as partners in the development of such plans? We purport to be preparing our students to live in a democratic society, to solve problems and participate actively in their own lives, but do we provide them with the kinds of experiences that prepare them to do so?

Student councils and governments exist in most schools. What are they responsible for? What can they be responsible for? Schools often are bound by certain requirements set by policy makers or by necessity. These may be called the non-negotiable "givens." However, the demands placed by reality on schools are relatively few. They are that the school must be safe and that learning takes place to prepare young people to function successfully in the modern world. But there is more to educating a person than just fitting them into the system.



Peer Education Program students from Castle High School at the Great American Smokeout (l-r) Samantha Ameperosa and Chastity Ah You

Injustice demands change, and young people need to learn how to critically assess their world and the courage to transform it if necessary. Beyond these requirements, much remains negotiable. Indeed, even these "givens" invite student participation. For example, students can become involved in decisions about how to make schools safer. They can become participants in the construction and maintenance of a safe school environment where learning can take place. As a result, they can learn to function effectively in the world as it is and to work to transform it if necessary. By struggling and participating in their worlds and their lives, young people gain competency and courage.

Building an Inclusive School Community

Can we develop school communities where each student and teacher feels respected as a thinking, feeling, meaning-constructing human being? Can we develop school communities where each person feels connected and experiences a real sense of belonging? Can we construct schools where all feel valued and significant; where all feel they can make contributions and are valued by the school community; where all feel challenged by high expectations to develop themselves to their maximum potentials and feel supported by encouragement and resources to achieve those expectations? The goal of resiliency as an educational aim demands that we should.

Much can be accomplished by creating opportunities for students to feel that they truly belong and that the school is *their* school. Consider how many clubs, organizations, service opportunities exist in our schools. How often and how broadly are students acknowledged for their accomplishments? Unfortunately, the real opportunities for recognition and the achievement of a sense of belonging frequently are available only to a few students. What are the others to do? How will they meet their need to feel respected, valued, challenged and, yes, needed and useful? We prevent human problems by addressing human needs.

Culture as a Source of Resiliency

E Becker (1971), an interdisciplinary scholar, thought that culture was the highest form of human adaptation. In the Summer Institute, we asked students to consider sources of strength and resiliency derived from their own cultural traditions. Since people have varying levels of awareness of themselves as cultural beings, this was an interesting and stimulating assignment. Cultures tell us how to be in the world and how to act. Cultures tell us how to achieve a sense of value and significance. Different cultures provide different solutions to common human problems, but all cultures address human needs and aspirations in creative ways. For example, they provide ceremony and ritual to assist us with difficult transitions, such as grief and loss. Cultures, therefore, are a source of strength and resilience in the face of life's adversities.

Manu C. Kaiama, director of the Native Hawaiian Leadership Project, offers the following description of Hawaiian culture as a rich source of strength and resiliency.

Resiliency and The Native Hawaiian People

Hawaiian people have a rich culture and history spanning more than one thousand years. Hawaiian culture includes all the necessary ingredients for a collective society to develop and flourish. The culture contains deep sources of meaning and adaptation such as religion, government, music and dance. In the past, for example, struggles for resources and power nurtured a warrior class who were trained and taught to die for their ali'i. The qualities of warriors were identified and clear. After contact with Europeans, diseases were introduced that the population had little resistance to, and the Native Hawaiian population was dramatically changed and scarred forever. In a period of just 100 years, Hawaiians witnessed the overthrow of their monarch and familiar government system, the desecration of their sacred sites, and the death of their people. In a time where the population went from 900,000 to a mere 40,000, they were taught by well-meaning missionaries that they were uneducated savages. A law was passed forbidding them from using their own language. They must learn English. The hula was banned.

How do a people survive when they are not allowed to sing their own song? How did 40,000 survive the oppression imposed on them by foreigners? This resiliency, this warrior spirit is housed and nourished in the na'au. The na'au is located where the intestines are. A western "gut feeling" helps to describe the na'au. But interestingly enough, Hawaiians believe that not only is the na'au the home of the guts, but also the home of the mind, affections, emotions and feelings. The po'o or head, houses the spirit; the na'au houses the heart. Hawaiians listen and respect their na'au, or gut instinct in combination with their feelings, their heart. They recognize that there is no way to separate intellect and emotion, nor should they be separated. These very tools can help keep them

strong, guide them to make good decisions, enable them to overcome the challenges of life itself. Finely tuned instincts are gifts from the kupuna and aumakua (ancestors) who came before. Ancestors act as protectors and guides. You are a culmination of all of them who came before. Your very existence has mana (spiritual power) and that is a sacred thing. To be taught to respect your na'au because it is all these things, and to listen to it, is the piko (very beginning) of developing resiliency. To trust your instincts, to believe you are guided by a greater force in this life, develops confidence. To value instinct, feelings and intellect as a gift from those who came before you, knowing that it is there to assist you to live a life that is pono (balanced), is the building blocks of resiliency. The Hawaiian value system teaches you that you do not stand alone. Even in despair, there is hope when there is help. Having faith and knowing, not just believing, that the mind, spirit, body and aina (land) are all connected and have good purpose, gives Hawaiians the strength to go forward—the spirit to continue and search for that which is pono, and not to give up.

Conclusion

What kind of humans are we trying to help develop? Many, if not most, of the readers of this issue of *Educational Perspectives* would agree with educators in our Summer Institute that we want to help develop strong, courageous, competent, compassionate and, resilient human beings. The world needs such people. We must work to construct school environments that make such desirable outcomes more probable. As educators, we can draw on the beliefs of our respective cultures to strengthen our capacity for resilience. To quote Bobby Kennedy, "It is not too late to seek a newer (and better) world." Let's do it with intention, courage, compassion and an implacable belief in the nobler and higher natures of our fellow humans and in our ability to cultivate and nourish those potentials.

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Building an Essential Foundation: Healthy Nutrition and Lifelong Physical Activity

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Healthy lifestyle—what does that mean? In our minds, it implies a lifestyle that is well-balanced in areas such as nutrition, education, physical activity, and overall wellness of the mind and body. It is fitness in more than just the physical sense. A healthy lifestyle also includes academic fitness, social fitness, and ethical fitness—so much more than just a nicely toned body that is “all muscle.”

Information abounds relative to the benefits of exercise, the harms of smoking, and the advantages of a nutritious diet. These basic messages are intended to try to influence people to make more healthy choices. Indeed, the benefits of physical activity are many. However, benefits are incurred only through participation in physical activity. In other words, to gain benefits such as lower blood pressure, reducing fat, or controlling weight, one must actually participate in some form of physical activity. Physical activity can range anywhere from walking more at work or at home, to gardening, aerobics or lifting weights. The bottom line is to be more active and to increase one's level of physical activity.

The 1996 *Surgeon General's Report* targeted physical activity and health (US Department of Health and Human Services [DHHS], 1996). According to that report, approximately 25% of adults reported no physical activity in their leisure time. Relatedly, participation in all types of physical activity was reported to decline dramatically as age or grade in school increased, and physical inactivity was more prevalent among women than men (DHHS, 1996). The problem with obesity and physical inactivity is not a problem exclusive to adults or those who live on the mainland. “It's not ‘cool’ to be fat, but that has not prevented an obesity epidemic from occurring among American youth” (Poussaint, 2001, p. 1). Data accrued from a locally conducted obesity study indicated that the majority of school-aged children in Hawai'i are overweight and at risk for being obese (Chai, Kaluhiokalani, Little, Hetzler, Zhang, Mikami & Ho, in review). Those statistics are incredible given the research evidence that lower mortality rates exist for those who are moderately active on a regular basis and maintain good health and nutrition practices.

Healthy People 2010 (National Center for Health Statistics [NCHS], 2000) listed indicators that will be used to measure the health of the nation. Physical activity is one of those indicators. The *Surgeon General's Report on Physical Activity and Health* and *Healthy People 2010* are two national documents that call for a need to build a stronger foundation of health and physical activity for all people. Both documents

promote the necessity of a balanced approach to health, nutrition, and physical activity.

Health, nutrition, and physical activity are as complementary as socks and shoes or a well coordinated ensemble of clothing. Making healthy choices about what we put into our bodies and what we do with our bodies is an important practice that can lead to healthy habits. Modeling healthy behaviors and educating children while they are young and turning them on to being healthy and active is key. Healthy eating and physical activity help children to learn better. Physical activity may, in fact, contribute to improved academic achievement (Sallis, McKenzie, Kolody, Lewis, Marshall & Rosengard, 1999). According to Jensen (2000, 1998), movement and physical education contribute to enhanced brain function. This article will discuss the importance of a balanced foundational approach to nutrition and physical activity, physical education, and strategies to increase physical activity inside and outside of physical education.

Importance of Good Nutrition

“Supporting the health of the whole child is essential for optimal achievement” (Wolfe, Burkman, & Streng, 2001, p. 18). Healthy habits and choices contribute to a healthy lifestyle. Parental involvement is essential, as it is the most important key for children to have a healthy diet (Poussaint, 2001). Among the activities (eg, tutoring, talking with friends) that take place before school, one particular activity is among the simplest to do (i.e., for both parents and children)—something that can help to increase attention, decrease illness and help with learning (Wolfe et al., 2001). This activity is eating breakfast. In one study, nearly half of the children did not eat breakfast (Dixit, Houser & Sampson, 1999) before school. This news is surprising given findings that eating breakfast is an important way to start a child's day. Positive findings from studies conducted on the importance of breakfast included better performance on standardized tests, improved attention in late-morning task performance and fewer errors in problem solving activities (Tufts University School of Nutrition, 1995). Mom was right, and she is supported by research—breakfast is the most important meal of the day.

Although breakfast is an important start to the day, what is eaten is equally important. Meals that are high in starch and

sugar will provide sustenance for only a couple of hours, whereas a meal that includes protein and fat, in addition to the starch and sugar, will allow for longer periods of energy and concentration (Wolfe et al., 2001). Food provides the fuel with which the brain and body can grow and work. Many people consider it important to have a car that has fuel to get around; we also should consider it important for children to have fuel in their tanks to get around during their day. The Dietary Guidelines for Americans (US Department of Agriculture, [USDA], 2001), which go hand-in-hand with the Food Guide Pyramid (USDA, 2000), recommend eating a variety of foods and balancing food intake with physical activity. Good nutrition in the morning and throughout the day is but one part of the foundation for a healthy lifestyle. Physical activity is the other part.

Importance of Physical Activity

“People of all ages, both male and female, benefit from regular physical activity” (DHHS, 1996, p 4). Physical inactivity and unhealthy eating contribute to obesity, cancer, cardiovascular disease, and diabetes (DHHS, 1996, 2001). When put together, these health problems are responsible for at least 300,000 preventable deaths each year (DHHS, 2001). Becoming physically active on a regular basis is the key, and the activity need not be strenuous in nature. Becoming moderately active on a regular basis is all that is necessary to reap benefits from physical activity.

Moderate amounts and levels of activity are needed to incur benefits. Adults can benefit from daily bouts of moderate levels of physical activity. Moderate amounts of intense activities (e.g., 30 minutes of brisk walking) or shorter bouts of more strenuous activity (e.g., 15-20 minutes of jogging) can be used to gain some of the benefits of physical activity (DHHS, 1996, 2001). Guidelines for adolescents suggest that they should be physically active daily, or nearly every day as a part of play, games, sports, work, physical education or other activities (Sallis & Patrick, 1994). Younger children should accumulate at least 30-60 minutes of age- and developmentally-appropriate physical activities on all or most days of the week (Corbin & Pangrazi, 1998).

Recess is an important and often forgotten opportunity for promoting physical activity. While it is a separate and distinct event from physical education, it is still an important part of a child’s educational experience (Burgeson, Wechsler, Brener, Young & Spain, 2001; Council on Physical Education for Children [COPEC], 2001b). Recess is discretionary time that can be filled with opportunities for children and youth to be physically active, which can help to facilitate improved attention and focused learning during class time (COPEC, 2001). While recess should not be a substitute for physical education, it also should not be viewed as a reward or as a means of punishment for work not being completed. Most but not all elementary schools (96.9%) nationwide provide

regularly scheduled recess nearly five days a week (Burgeson, et al, 2001). For children and youth, this unstructured play time allows for a release of energy and stress, socialization with peers, as well as a time for practicing and using skills developed and learned in physical education. COPEC (2001b) sums it up best with this statement, “quality physical education along with daily recess are necessary components of the school curriculum that enable students to develop physical competence, health-related fitness, self responsibility, and enjoyment of physical activity so that they can be physically active for a lifetime” (p.2).

Physical Education

Schools provide an ideal place to help improve and develop more healthy habits (DHHS, 2000). Werner, Timms, and Almond (1996) reported that panelists from a news briefing by the American College of Sports Medicine (ACSM) noted that “schools are the most likely place to change physical activity patterns and that physical education curricula should provide movement experiences that are enjoyable, provide significant amounts of physical activity, and promote lifelong participation in physical activity” (p. 49). However, with increasing pressures for academic achievement and high test scores, levels of physical activity, particularly participation in physical education, has declined and continues to decline in the wake of the continued push for more time spent in the so-called “core” subjects. According to the Surgeon General’s report, 42% of high school students attended physical education classes daily in 1991 (DHHS 1996; 2000). That percentage declined to 29% in 1999 (DHHS, 1996; 2000). Illinois is the only state to require daily physical education K-12. However, the full effect of this stance has been mitigated by the fact that students may opt out of physical education in high school (DHHS 2000). Here in Hawai’i, there is no such requirement other than one semester at the middle/intermediate school level and one year in high school. The most recent Hawai’i Youth Risk Behavior Survey (YRBS) revealed that only 65% of middle school students and 42% of high school students were enrolled in physical education at the time of the survey. Only 9% of high school students were enrolled in daily physical education, compared to the U.S. average of 30% (Pateman, Saka & Lai, 2001).

Physical education is for all students and plays a critical role in the education (COPEC, 2001) and development of the whole student. It is through physical education that children and youth are provided opportunities to develop the knowledge and skills to value and become physically active for a lifetime. Despite what your own physical education experience may have been and/or what you may have heard, athletes are not the outcome of our programs. In physical education, students not only develop their motor skills and knowledge of sports and fitness, they also learn about respecting each other, working together, fairness, doing their

best and not giving up, in addition to many other characteristics deemed important by schools and society. Furthermore, physical education can affect learning more than people think. Inherent to physical education is a way of learning that is considered to be very brain compatible. Our students learn through movement. Recent findings in brain research indicated that learning and movement have more connections than previously thought (Jensen, 2000). According to Hannaford (1995), areas of the brain thought to be solely associated with movement also have been found to be important in coordinating thought. Relatedly, in physical education, we are presenting material in a way that is compatible with the way about 85% of children learn best—kinesthetically (Hannaford, 1995).

Physical education is learning by doing. Moving to learn is another cornerstone of this field. The outcomes of physical education programs are individuals who have learned skills, are physically fit, participate in physical activity regularly, are knowledgeable about the benefits of physical activity, and value physical activity and the contributions it makes to a healthy lifestyle (National Association for Sport and Physical Education [NASPE], 1995). Put simply, the goal of physical education is a physically educated person. Consequently, NASPE (1995) developed seven physical education content standards. The standards have given physical education a guide that school administrators, classroom teachers, physical education teachers and students are able to follow to strengthen their physical education programs. There are seven content standards:

1. Demonstrate competency in many movement forms and proficiency in a few movement forms.
2. Apply movement concepts and principles to the learning and development of motor skills.
3. Exhibit a physically active lifestyle.
4. Achieve and maintain a health-enhancing level of physical fitness.
5. Demonstrate responsible personal and social behavior in physical activity settings.
6. Demonstrate understanding and respect for differences among people in physical activity settings.
7. Understand that physical activity provides opportunities for enjoyment, challenge, self-expression, and social interaction (NASPE, 1995).

Physical education standards have clearly defined “what a child should know, be able to do and be like.” Through the implementation of the standards, students can understand and become competent movers, which in turn can increase the likelihood of their being physically active. According to NASPE (1995), the expectation is that through adequate support and sustained efforts, students in every school should be able to reach these standards. Yet, despite the standards and the need for more physical activity by children and youth, physical education programs are often the first to

be cut or reduced to allow more time for other academic areas.

Movement has been linked to learning more substantially through recent findings in brain research. The belief that physical activity negatively affects cognitive function is untrue (Sallis, et al., 1999). In fact, as a result of the outdated thinking that physical education is a frill, many students miss the neural benefit that movement can have on academics (Summerford, 2001). As reported by COPEC (2001), children learn through a variety of modalities (e.g., visual, auditory, tactile, and physical) and academic concepts that are taught across the three domains (i.e., cognitive, affective, and psychomotor) can have greater meaning for children. Furthermore, research findings also have suggested that exercise boosts the number of brain cells in the hippocampus, a part of the brain important to learning and memory (Summerford, 2001). Fuel needed by the brain to support movement and learning are glucose and oxygen (Blaydes, 2001). While glucose comes from food sources, oxygen intake can be enhanced through movement. According to Blaydes (2001), we exchange about 10% of our oxygen with each normal breath, thus leaving about 90% in our body and brain unchanged unless we breathe deeply or move around. Moderate to vigorous physical activity, like that which can be obtained in a physical education class and during recess, literally can give the brain an added boost of fresh air.

According to the most recent *Shape of the Nation Report*, improvements are being made relative to standards-based reforms in physical education. However, most states have not made much progress toward educating people on the physical dimension (NASPE, 2001). Unfortunately, with the significant pressure on school leaders to increase academic achievement per other subject area standards, efforts to stave off the rising epidemic of obesity may be placed on hold.

In Hawai'i, approximately 24% of our 184 elementary schools have a person who has been designated to teach physical education. Of those 45 schools, only 14 of those elementary physical education Instructional Resource Augmentation (IRA) teachers have a professional background in physical education. This number is very low, considering the importance of movement in the early years of a child's education. Many students' first experiences with a structured physical education program do not occur until the middle or intermediate school level. All children should be provided with a strong movement foundation that helps them to develop skills at their own level and rate and also provides numerous opportunities to practice (Graham, 2001). Quality physical education programs from elementary school through high school can do that.

Strategies for Increasing Physical Activity

There are a number of ways that the physical activity levels of children and youth can be increased while in and out of

school. With much of a child's or youth's waking hours spent in school, what better place to help them get "turned on" to physical activity? As suggested by Corbin and Pangrazi (1998), many opportunities exist within daily physical education and in events outside of physical education (e.g., intramurals, walking clubs, family activity nights). Schools can do much to promote and encourage students, faculty, and staff to become more physically active.

To supplement physical education programs, other activities during recess and before or after school could be planned and implemented. The following ideas and suggestions are strategies to increase physical activity levels during the school day aside from physical education:

- Walking clubs and/or programs can be started where paths are set-up around the school. Students, faculty and staff can be encouraged to use the paths at various times during the day.
- Running clubs and/or programs can be started for those who enjoy running.
- Sports clubs (e.g., four square, basketball, volley ball, jump rope) also can be developed that allow students to use equipment to practice their skills in a particular sport they learned in PE or to teach others a new activity.
- Intramurals are a typical part of secondary school programs. Such programs also could be developed and implemented in an elementary school for the upper elementary grades, with alternative activities for the lower grades.
- Energizer stations can be set up during recess, before, or after school where students can participate in a variety of activities that promote skill development with short or long handled implements, moving to music, or other activities that children find exciting and challenging such as cup stacking.

These are all activities that have a direct relationship to physical education outside of the classroom, but what about incorporating more movement inside the classroom or at home?

In the classroom, the incorporation of movement can only help to enhance learning. With 85% of children being kinesthetic learners (Hannaford, 1995), it behooves us as educators to teach students in the ways they learn best. Interdisciplinary teaching and learning can easily be done in physical education, and it is done much of the time. Movement inside the classroom is often limited by structures within the classroom such as desks, chairs, and learning centers. However, these should not limit a teacher's imagination relative to planning movement activities that may be done while seated or while on the way to the library or cafeteria.

Ideas include:

- Counting activities that have a rhythm that could be tapped out by students stepping up and down from the walkway to the ground (e.g., multiplication tables—putting a physical movement to the rhythm of counting).
- Physically moving around the room to different learning centers using different speeds and locomotor skills (e.g., walking with large steps from desks to floor for circle time).
- The concepts of pathways and speed may be covered as a class walks from their classroom to the library as very rarely is a class a straight pathway from the library, cafeteria or field.
- Having students act out parts of a story can help with comprehension or putting a movement to letter sounds from a story—for example, a round shape for words starting with the letter 'C'.
- Using one's whole body to write his/her name in the air (e.g., ink is person's hair).

Teachers who incorporate movement into their class on a daily basis help their students to activate their brains and stimulate the turnover of fresh oxygen to enhance learning. While physical activity will not make them smarter, it will help them to concentrate and focus on what is important for them to learn and, perhaps, to become smarter. Using physical movement may also help teachers to teach concepts like greater and fewer if groups of students are used to demonstrate that concept. For example, the class could be given a math problem that will divide them into unequal groups with one having less in the group than the other. Math manipulatives serve the same purpose of providing a visual way to show the concept. However, by using the students themselves, teachers not only provide a visual but also help increase blood flow to children's brains through their movement, allowing for both sides of the brain to be stimulated due to the alternate swinging of their arms and legs as they walk or skip.

Conclusion

John F. Kennedy stated that, "Intelligence and skill can only function at the peak of their capacity when the body is healthy and strong." The brain and body can only function in top form when both are healthy and maintained in a way where its functions are supported. A healthy lifestyle is a combination of many factors. Indeed, a clean environment, clean living conditions and support from others is helpful. However, in addition to those elements a healthy lifestyle can enable one to benefit and grow. Medical technology can now prolong life. However, what is the quality of that life if one's body can no longer function in the way it was built? We can

prevent many of the diseases that diminish one's quality of life such as heart disease, diabetes, and even minimize several forms of cancer, by making healthy choices about what we put into and do with our bodies.

Children are our future. Unhealthy children grow up into unhealthy adults. Let's teach them about healthy eating, living, and the joys of being active. Technology has made life easier and, in effect, also contributes to making us unhealthy because of all of the conveniences that have been developed. Schools are one place where students learn about the importance of a healthy mind and healthy body. Learning the core subjects is important. Yet, we must not forget the balance that must be kept between developing the mind and developing the body. Both are necessary parts of the whole and while neither should be sacrificed for the other, it turns out that one can actually help to enhance the functioning of the other. Movement does that, and quality physical education programs can do that.

Children go to school to be educated. Being educated means having the knowledge, understanding, and skills to make good choices—in this sense, healthy choices. Let's put more of an effort toward educating the whole child and taking a more balanced approach by putting academics and movement together into a more complete package. We already know that moderation is a good thing when it comes to healthy eating. Striking a balance between and being supportive of brain and body learning is essential not only for learning but for a healthy lifestyle. Learn about children's physical education programs and be as critical about them as you would enrichment or other school academic programs.

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Promoting Sexual Health and Responsibility: Healthy Sexuality Education for Hawai'i's Youth

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In June, 2001, Surgeon General David Satcher released the *Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior* (US Department of Health and Human Services [DHHS], 2001). The report recognized that:

- Parents are the child's first educators and must help guide other sexuality education efforts so that they are consistent with their values and beliefs.
- Families differ in their level of knowledge, as well as their emotional capability to discuss sexuality issues. School sexuality education is a vital component of community responsibility in moving toward equity of access to information for promoting sexual health and responsible sexual behavior.

The *Surgeon General's Call to Action* recommended that education about sexuality should be thorough and wide-ranging, and that it should begin early and continue throughout the lifespan. The report also recommended that such education should:

1. Recognize the special place that sexuality has in life.
2. Stress the value and benefits of remaining abstinent until involved in a committed, enduring and mutually monogamous relationship.
3. Assure awareness of optimal protection from sexually transmitted diseases and unintended pregnancy for those who are sexually active, while also stressing that there are no infallible methods of protection, except abstinence (DHHS, 2001).

The *Surgeon General's Call to Action* and findings from evaluation research conducted on sexuality education and human immunodeficiency virus (HIV) prevention education efforts suggest that well-planned, school-based programs can contribute to responsible sexual behavior and health among young people (Kirby, 2001). Sexuality education should help young people develop the knowledge and skills they need to contribute to caring families, foster respectful relationships, set and respect limits and boundaries, get answers to their questions about sex and growing up, and protect their health

by preventing unintended pregnancy and sexually transmitted diseases. The purpose of this article is to describe school-based sexuality education in terms of the new Hawai'i Health Education Standards (Hawai'i State Department of Education [DOE], 1999).

Good News and Important Challenges

Teen pregnancy, abortion, and childbearing rates declined significantly during the past decade among all racial and ethnic groups and in all parts of the United States (Kirby, 2001). Teen birth rates are now at their lowest recorded level. Teen pregnancy rates among adolescent females aged 19 years or less in Hawai'i dropped from 92 per 1000 in 1995 to 82.6 per 1000 in 1997 (CDC, 2000). In addition, the most recent Hawai'i Youth Risk Behavior Survey (YRBS) of middle and high school students indicates that Hawai'i's youth generally demonstrate lower levels of health-risk behaviors when compared with US youth overall (Pateman, Saka, & Lai, 2001). However, Hawai'i YRBS data specify important areas of concern in the area of sexual health-risk behaviors.

Among Hawai'i high school students, 41% reported that they have had sexual intercourse, and 6.8% reported that they first had sexual intercourse before age 13. More than one-fourth (28.5%) of high school students reported having had sexual intercourse during the past three months, and 12.2% reported having had four or more sexual partners. Among the 28.5% of students who were sexually active during the past three months, more than half (52.9%) did not use a condom to protect themselves against sexually transmitted disease or unintended pregnancy. Alarmingly, 26.8% of sexually active students reported using alcohol or other drugs before their last sexual intercourse.

The health-risk behaviors identified by the Hawai'i YRBS data provide a succinct picture of the challenging situations in which Hawai'i youth often find themselves. In his article "Wanted: AIDS Education That Works," well-known educator and Kauai resident, Dr. James Popham (1993) calls for education designed to help young people acquire the functional knowledge they need to keep themselves safe; interpersonal skills to avoid, get out of, or take protective action in risk situations; motivation to use relevant knowledge and skills (i.e., realizing, "this can happen to me") and support from peers and adults for health-promoting actions. The Hawai'i Health Education Standards are designed to assist young people in meeting health-related challenges

through building a strong foundation of knowledge, respect for self and others, and skills to set and enforce limits and boundaries to protect health.

What does research tell us about effective sexuality education programs?

In a recent report from the National Campaign to Prevent Teen Pregnancy, Dr. Douglas Kirby (2001) cited encouraging findings from research studies about sexuality education efforts. Some sexuality education and HIV education programs have demonstrated sustained positive effects on adolescent sexual behavior for as long as three years. Further, there is good evidence that sexuality education, youth development, and service learning programs can work together to reduce adolescent sexual risk-taking and pregnancy. Kirby described ten common characteristics of effective sexuality education and HIV education programs, which:

1. Focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection.
2. Are based on theoretical approaches that have been demonstrated to influence other health-related behavior and identify specific important sexual antecedents to be targeted.
3. Deliver and consistently reinforce a clear message about abstaining from sexual activity and/or using condoms or other forms of contraception. This appears to be one of the most important characteristics that distinguishes effective from ineffective programs.
4. Provide basic, accurate information about the risks of teen sexual activity and about ways to avoid intercourse or use methods of protection against pregnancy and STDs.
5. Include activities that address social pressures that influence sexual behavior.
6. Provide examples of and practice with communications, negotiation, and refusal skills.
7. Employ teaching methods designed to involve participants and have them personalize the information.
8. Incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students.
9. Last a sufficient length of time (i.e., more than a few hours). Generally speaking, short-term curricula—whether abstinence-only or sexuality education programs—do not have measurable impact on the behavior of teens.
10. Select teachers or peer leaders who believe in the program and then provide them with adequate training (p. 6).

Parents, educators, and community members often have questions about various kinds of sexuality education programs. School-based programs generally are of two types: abstinence-only programs that emphasize sexual abstinence as the most appropriate choice for young people; and sexuality and STD/HIV education programs that also cover abstinence as the most appropriate choice but, in addition, include information about condoms and other methods of contraception to provide protection against sexually transmitted diseases and pregnancy. The *Surgeon General's Call to Action* summarizes the evaluation research on the two kinds of programs as follows:

To date, there are only a few published evaluations of abstinence-only programs. Due to this limited number of studies it is too early to draw definite conclusions about this approach. Similarly, the value of these programs for adolescents who have initiated sexual activity is not yet understood. More research is clearly needed. Programs that typically emphasize abstinence, but also cover condoms and other methods of contraception, have a larger body of evaluation evidence that indicates either no effect on initiation of sexual activity or, in some cases, a delay in the initiation of sexual activity. This evidence gives strong support to the conclusion that providing information about contraception does not increase adolescent sexual activity, either by hastening the onset of sexual intercourse, increasing the frequency of sexual intercourse, or increasing the number of sexual partners. In addition, some of these evaluated programs increased condom use or contraceptive use more generally for adolescents who were sexually active.

Standards-Based Sexuality Education in Hawai'i

The Hawai'i Health Education Standards provide a personal and social skills-based approach to sexuality education. Rather than merely providing students with information, educators structure opportunities for students to discuss the health-risk situations that young people encounter and to practice skills for dealing with those situations in health-promoting ways—truly, to educate or “draw out” students' deliberations on issues related to sexual health. The Hawai'i Health Education Standards encompass the characteristics of effective programs identified by Kirby (2001) and provide the following guidelines to questions for educators to consider in planning sexuality education:

1. Core Concepts

- What knowledge must my student have to promote and protect their health—to keep themselves safe in terms of sexual health?
- What do my students already know about sexuality? Is their knowledge accurate? What misperceptions do they have?
- What do my students want to know? What questions do they bring to the classroom?

2. *Accessing Information, Products and Services*

- Where have my students obtained their information about sexuality to date? Do my students know how and where to get accurate and timely answers to their questions? How can my students increase communication with their parents about their sexuality questions?
- What are valid information sources for my students and why (e.g., the Centers for Disease Control and Prevention)? What are invalid sources and why (e.g., many popular magazines that students read)? How do I help my students make distinctions between valid and invalid sources for themselves?
- What products and services do my students need to be able to access (e.g., counseling or other assistance for students who experience dating violence)? How do my students locate and evaluate the reliability and validity of health-related products and services?

3. *Self Management*

- What personal and social skills can my students practice, in a safe classroom environment that can help them become more effective decision-makers and communicators? What types of scenarios are most realistic to help them practice dealing with pressures they may face? How do my students describe and respond to “real-life” pressure situations?
- What personal and social skills do my students need to help them avoid, get out of, or stay safe in risky situations? How do my students set limits and boundaries for themselves—and act respectfully toward the limits and boundaries set by others?

4. *Analyzing Internal and External Influences*

- What internal influences (e.g., likes, dislikes, fears, moods, curiosity, needs) do my students believe affect their thoughts and decisions about sexual behavior? What examples of internal influences can my students provide from their own experiences? How do these influences affect them? How do my students respond to internal influences?
- What external influences (e.g., peers, culture, family, media, technology) do my students believe affect their thoughts and decisions about sexual behavior? What examples of external influences can my students provide from their own experiences? How do these influences affect them? How do my students respond to external influences?

- How do these influences work together? How can my students respond to influences and pressures with good decision making, even when the decisions are difficult ones?

5. *Interpersonal Communication*

- What communication skills (e.g., clear messages, refusal, negotiation, suggesting alternatives) do my students need to practice to avoid risk situations, get out of risk situations, or protect themselves in risk situations?
- How can my students apply communication skills they have practiced in other situations to the area of sexual health and responsibility?
- How can my students learn to give clear “no” messages, both verbally and nonverbally?
- How can my students learn to communicate in effective ways and, when possible, still save face and keep friends/relationships?

6. *Decision Making/Goal Setting*

- What decisions will my students be called on to make with regard to sexual behavior? How will they think through and make those decisions?
- What constitutes a good decision? What are the consequences, positive and negative, of various decisions? How can my students support each other in their decision making?
- What personal and professional goals do my students have that can influence their decisions and behavior related to sexual health? Which goals are important enough to influence students to postpone sexual involvement? How can my students support each other in working toward their goals?

7. *Advocacy*

- Which school and community sexuality issues matter to my students? On which issues do they want to take a strong and public stand?

Importantly, planning and teaching with the Hawai'i Health Education Standards means involving students throughout the process. For example, students typically know more than adults do about the actual pressure situations and “lines” that young people experience related to sexual risk-taking. When students discuss these situations together in a safe classroom environment, they can help to create important peer and social norms for supporting decisions among peers to remain abstinent during their school years. At the same time, Amy Stone Murai, Health Specialist for the Hawai'i State Parent Teacher Student Association (PTSA), reminds us that teachers must be skilled enough in discussions of sexuality to help students make

connections or “bridges” across the standards (skills) to health-risk areas and situations that are more familiar to them. For example, when students discuss interpersonal communication skills, such as suggesting alternatives and giving clear messages about sexual limits and boundaries, teachers can help students consider how they have used similar communication skills to suggest alternatives or set boundaries related to tobacco or alcohol use—or to refuse to let other students copy their homework or entice them to skip class.

Teachers, as well as parents, have many questions about teaching sexuality education—no one wants to approach this subject unprepared. The Hawai‘i State Department of Education, Health and Physical Education Program, and the University of Hawai‘i College of Education (COE) provide teacher education and professional development for educators on skills-based teaching and curriculum materials, such as those recommended by the Division of Adolescent and School Health, Centers for Disease Control and Prevention, as “Programs That Work” (CDC, 2000). These curricula have undergone rigorous evaluation studies, identified in the *Surgeon General’s Call to Action* (DHHS, 2001) and in Kirby’s (2001) research on program effectiveness. For example, one such high school program, *Reducing the Risk: Building Skills to Prevent Pregnancy, STD, and HIV* (Barth, 1996), focuses on abstinence, refusal skills, delaying tactics and alternative actions, skills to avoid high-risk situations, pregnancy and sexually transmitted disease prevention, and skills integration (i.e., further skills practice to manage difficult predicaments). DOE and COE provide workshops, summer classes, and conferences for educators to learn about standards-based curricula and about Hawai‘i State DOE policies about sexuality education. For example, students in Hawai‘i’s schools must have parental consent to participate in sexuality education.

Healthy Sexuality Education for Students with Disabilities

Thinking of our children and students as potential sexual beings is difficult for many adults. It proves even more difficult when thinking along these lines about children and students with disabilities. Several myths exist within our society that prevent children with disabilities from receiving much needed sexuality education. These myths include:

1. People with physical disabilities are asexual beings.
2. People with cognitive disabilities are eternal children.
3. People with cognitive and/or emotional disabilities are sexual time bombs who cannot control sexual urges, and who do not understand the consequences of sexual activity.
4. People with disabilities are undesirable as sexual partners.

5. People with disabilities are not ready for, so must be protected from, the world of sex (Black, 2001; Black & Smalley-Bower, 2001).

These myths not only prevent many youth with disabilities from receiving adequate and appropriate sexuality education but also increase these individuals’ vulnerability to sexual victimization. Therefore, educators must move from a paradigm of paternalism to a paradigm of self-determination. This includes giving students choice in a variety of areas such as choice in the curriculum and choice in their personal and leisure activities. We cannot expect a person to make good decisions with respect to sexuality if the adults in their lives have never given them opportunities to make independent decisions. Most often, students with disabilities are expected to be compliant. However, explicitly teaching the right to refuse—to set boundaries with peers, to set sexual limits, to discern the difference between being polite and being exploited—is a necessary component of sexuality education (Maurer, 2001).

Next, we must approach the topic of sexuality honestly. We cannot treat adolescents and young adults with disabilities as if they are children. We must answer questions honestly and respect students’ growing maturity by speaking about sexuality, especially the risks, in a straightforward manner. We must arm young people with information. We must give young people the tools they need to make informed decisions. Unfortunately, in the area of sexuality education, misinformation abounds. As educators, parents, and community members, we must counter misinformation by providing accurate, age-appropriate and relevant facts (Black, 2001; Maurer, 2001).

Educators’ concerns often involve teaching sexuality education to students with cognitive disabilities. Maurer (2001) suggests ways for making teaching more effective:

- *Use visual aids.* Use realistic photos or full body charts. Complicated and abstract charts can be confusing. Pictures cut from magazines, and full body charts made by tracing the outline of each youth on a large piece of newsprint, can serve this purpose. Body charts are one concrete way to show where body parts are and what they do.
- *Repeat key information.* To check for understanding, ask the group for feedback. Reinforce important concepts throughout several lessons. Provide small amounts of information spaced over time. Use opportunities to repeat key ideas in other curriculum areas.
- *Provide opportunities to practice interpersonal and refusal skills.* Role play is an excellent technique. Have youth rehearse such situations as greeting a new acquaintance or asking someone out on a date. These practice sessions can be

videotaped and viewed again by the group for constructive comment.

- *Use many approaches.* Recognize that no one approach is best. Use a variety of methods to teach concepts. Ideally, use activities that involve verbal discussion, movement, signs, colors and icons (such as a green light for "okay" and red light for "stop"). Draw upon as many of the senses as possible.
- *Use humor.* Strive to make sexuality education as matter-of-fact as other subjects. Just as in other learning situations, light or funny moments occur. Life is sometimes comical. Having a sense of humor is an invaluable teaching asset.
- *Encourage questions.* Set aside time in lessons to address questions. Don't be afraid to say, "I don't know the answer to that question—let's find out together." Model the behavior of seeking answers to questions without embarrassment. Invite youth to ask questions and discuss sexuality with people they trust.
- *Keep it simple.* Present ideas in logical ways. The specifics of biology are usually not as vital as their practical applications. For example, it is usually more useful for youth to understand that menstruation is normal and to learn ways to deal with it than it is to memorize the hormonal basis underlying the process.
- *Be as concrete as possible.* Abstract reasoning is often difficult for youth with cognitive disabilities. And some sexuality concepts are quite abstract—for example, love, communication, and risk. Practice ways of explaining or demonstrating ideas in concrete terms that relate to the students' lives.

The most important thing to remember is that youth with disabilities need sexuality education. As uncomfortable as many adults feel about discussing sexuality with young people, we are doing them a disservice to expect the "other guy" to take responsibility.

Conclusion

As parents, educators, and caring adults, we have an important opportunity to help our young people develop the knowledge and skills they need to promote and protect their health and to grow into sexually healthy and responsible adults. As part of sexuality education at home and at school, we can offer reassuring answers to kids' questions and correct potentially dangerous or frightening misinformation. For example, an elementary teacher shared the story of the five-year-old child who was crying because he learned that his school had "kindergarten aides," which he heard as "AIDS." These kinds of fears can be allayed with health

education that allows students to ask questions and receive straightforward answers about what is on their minds. Hawai'i educators often find that teaching about health issues, including sexuality, helps them build a sense of trust and respect with their students. Students trust that caring adults will listen to and help them find answers to their questions; in turn, teachers find that students act with respect toward them and toward the subject matter being discussed—subject matter that is for students particularly "real, relevant, and right now." Former middle school teacher and current State Resource Teacher for Health Education, Lynn Shoji, shared that a group of her male students asked during a discussion of refusal skills, "But, Mrs. Shoji, what if we don't want to say no?" What an opportunity for honest discussion about responsible decision making that most likely would not occur in a traditional classroom setting in which teachers are givers and students merely receivers of information.

Teaching about health issues also provides unexpected opportunities for learning and occasional moments of hilarity. Big Island middle school teacher and 2001 Milken Family Foundation National Educator Award Winner, Georgia Goeas, relates the story of a group of her early adolescent students who designed, conducted, analyzed, and reported on a survey of other students, teachers, and parents about their knowledge of sexually transmitted diseases (STDs). The students reported in amazement, "Our parents don't even call 'em STDs—they said something like, vinyl disease!"

Sexuality educators Bob Selverstone and Rhonda Wise (Children's Television Network, 1992) advise us that "the world" wants to educate our children about sex far before we are ready. Thus, we must prepare ourselves to provide the sexuality education we want our children to have early and consistently. The *Surgeon General's Call to Action* (DHHS, 2001) describes the potentially positive influence of schools on the healthy sexual development of young people in this way:

Schools structure students' time; they create an environment which discourages unhealthy risk-taking—particularly by increasing interactions between youth and adults; and they affect selection of friends and larger peer groups. Schools can increase belief in the future and help youth plan for higher education and careers, and they can increase students' sense of competence, as well as their communication and refusal skills. Schools often have access to training and communications technology that is frequently not available to families or clergy. This is important because parents vary widely in their own knowledge about sexuality, as well as their emotional capacity to explain essential sexual health issues to their children. Schools also provide an opportunity for the kind of positive peer learning that can influence social norms.

Can health education and sexuality education make a difference for our young people? During a follow-up session from a COE summer institute, a Hawai'i high school teacher

recently shared with other sexuality educators that she asks her students each Monday what the most important decision was they made over the weekend. To her surprise during the course of the fall semester, students began to relate decisions they made not to have sex or to engage in other health-risk behaviors—because they made a deliberate decision about what was best for them right at that moment.

The Hawai'i Health Education Standards are designed to provide important guidance for prevention education related to sexuality and to other important health-risk areas that young people encounter—injury and violence, alcohol and other drug use, tobacco use, poor nutrition, inadequate physical activity, and mental and emotional health problems. Teaching with the Hawai'i Health Education Standards, together with consistent support from home and community, helps to provide students with a "tool kit" for good health and good decision making. Health education can help place at their disposal the tools young people need to help them find their way from adolescence into healthy young adulthood.

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Supporting Healthy Youth: The Healthy Hawai'i Initiative and the Hawai'i Partnership for Standards-Based School Health Education

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The Healthy Hawai'i Initiative, established by the Hawai'i State Department of Health (DOH) with Hawai'i tobacco settlement funding and the Hawai'i Partnership for Standards-Based School Health Education, initiated by the American Cancer Society, Hawai'i Pacific, Inc., are major sources of support for school-based health promotion and disease prevention programs in Hawai'i. This article provides an overview of these efforts to promote child and adolescent health throughout the state.

The Healthy Hawai'i Initiative

The state of Hawai'i sued the tobacco industry in 1997 to prevent it from marketing tobacco to youth and to recover resources the state has spent on tobacco-caused health problems and disability. Under a Master Settlement Agreement (MSA) between a number of states and the nation's five largest tobacco manufacturers, Hawai'i is scheduled to receive \$1.3 billion over the next 25 years. Actual payments may be adjusted downward if any of several specified provisions occur, such as a decrease in national cigarette sales (Hawai'i Community Foundation, 2001).

In 1999, the Hawai'i legislature enacted landmark legislation (Act 304, SLH 1999), which devoted 60% of the MSA payments to public health efforts and set aside the remaining 40% for an Emergency Budget Reserve Fund. Thirty-five percent of the total amount was allocated to the DOH for the Healthy Hawai'i Initiative and the Children's Health Insurance Program. The remaining funds were allocated to a Tobacco Prevention and Control Trust Fund for tobacco education, prevention, and cessation, to be invested and administered by the Hawai'i Community Foundation. The legislation mandated that the DOH expend 25% of the settlement money towards health promotion and disease prevention programs. The DOH collaborated with its Health and Wellness Advisory Group, composed of representatives from leading community agencies and coalitions, and the Centers for Disease Control and Prevention (CDC) to create the Healthy Hawai'i Initiative (HHI). This initiative is a major, statewide effort to encourage healthy lifestyles and to establish the social and environmental conditions to support them. The HHI emphasizes the healthy development of children and adolescents in relation to three critical risk factors: poor nutrition, lack of physical activity, and tobacco use. Each contributes significantly to Hawai'i's burden of chronic disease.

The four major components of the HHI are school-based programs, community programs, public and professional education, and program evaluation. The school-based and youth programs focus on reaching youth to prevent the initiation of tobacco use and to engage them as advocates among their peers for tobacco use prevention and control. The HHI made strong progress during its first year. In terms of school-based programs, the DOH and DOE partnered to:

- Fund ten Resource Teacher positions (four at the state level and six at the district level) to implement the Hawai'i Health Education and the Hawai'i Physical Education Standards, K-12, statewide.
- Fund 17 schools statewide to implement sustainable volunteer-based health and after school programs and policies.
- Provide seed money for an Instructional Resource Center for reference materials on health-related behaviors.
- Serve as members of the Hawai'i Partnership for Standards-based School Health Education, made up of representatives from public and private organizations, to support health education and healthy school environments.
- Provide funding for health-related professional development opportunities for educators.

The HHI also provided funding for 16 pilot Coordinated School Health Program (CSHP) school sites. These schools, and their complexes, work to implement the nationally recognized Centers for Disease Control and Prevention eight-component CSHP model, which includes (1) health education, (2) physical education and activity, (3) food service, (4) health services, (5) mental health and social services, (6) school policy and environment, (7) faculty and staff health promotion and (8) family and community involvement (Kolbe, Kann, & Brener, 2001). The DOH and DOE collaborate to integrate the Coordinated School Health Program components into Hawai'i's existing DOE Comprehensive Student Support System (CSSS) model.

The Hawai'i Partnership for Standards-Based School Health Education

In anticipation of the release of the new Hawai'i Health Education Standards, the American Cancer Society, Hawai'i

Pacific, Inc., initiated the Hawai'i Partnership for Standards-Based School Health Education in July 1999. The goal of this public and private partnership is to implement standards-based school health education to promote child and adolescent health through collaboration among the state's health, education, and business communities (Pateman, Irvin, Nakasato, Serna, & Yahata, 2000). The partnership includes representatives from the American Cancer Society, Hawai'i Pacific, Inc (ACS.); Hawai'i State Department of Education (DOE); Hawai'i State Department of Health (DOH); Hawai'i Board of Education (BOE); College of Education, University of Hawai'i; Meadow Gold Dairies; Bank of Hawai'i Foundation; Hawaiian Electric company (HECO); Hawaiian Electric and Light Company (HELCO); Maui Electric Company (MECO); Hawai'i State Parent Teacher Student Association (PTSA); Area Health Education Center, John A. Burns School of Medicine, University of Hawai'i and DOE School Food Service Program.

The Partnership helped establish an annual professional development plan for K-12 educators in Hawai'i. The plan includes:

- Spring Workshops—DOE and the University of Hawai'i College of Education (COE) have collaborated for the past three years to offer professional development workshops on standards-based school health education for K-12 educators on Oahu and on Kauai, Maui, Kona, and Hilo.
- Summer Institutes—COE offers a range of health-related summer institutes for graduate credit, which are funded by the DOE and DOH. Interested participants should watch for the spring publication of the University of Hawai'i Summer Sessions 2002 Catalog of Courses.
- Fall Conference—DOE and DOH have sponsored statewide "Health Celebration" conferences for the past two years. The 2000 conference attracted approximately 350 participants. The 2001 conference, held at the Hawai'i Convention Center, drew nearly 450 participants. The next conference is scheduled for November 4, 2002.

In addition to supporting professional development for educators, the Partnership worked with Meadow Gold Dairies to publicize the new Hawai'i Health Education Standards with a 1999-2000 Got Health? campaign, featured on 300,000 milk carton side panels. The Got Health? promotion appeared on half-gallon side panels, designed for families and community members. The promotion also appeared on half-pint side panels, targeted to reach students and teachers during school meal programs.

The Partnership also submitted an article entitled, "Got Health? The Hawai'i Partnership for Standards-Based School Health Education" to the *Journal of School Health*. When the article was published in October, 2000 (Pateman, Irvin,

Nakasato, Serna, & Yahata, 2000), that issue of the *Journal of School Health* featured front cover artwork of "The Keiki Dance Class," donated by local artist Alfred Furtado, and a back cover full-page advertisement funded by Meadow Gold Dairies, HECO, HELCO, and MECO.

Together, the Partnership collaborates to build strong alliances that support and promote health education. The bridges between state departments, academia, community agencies, and businesses provide flexibility and responsiveness for a systems approach to implement standards-based school health education. Meeting the professional development and curriculum resource needs of classroom teachers is vital to effecting change for students. The Partnership pools expertise and resources and advocates for policies to support sustained and expanded health education efforts in Hawai'i's schools.

Conclusion

The quality of school health education in Hawai'i has grown at an amazing pace since the publication of the DOE Hawai'i Health Education Standards in 1999. The standards have allowed educators, health specialists, and community members, who were working in isolation, to unite for a common goal—improving the health and well being of Hawai'i's youth. The challenge is to continue this momentum for skills-based school health education and coordinated school health programs; maintain the excitement and deep interest that has characterized the state's teacher education and professional development efforts; and invite more parents, educators, policy makers, and community members to join hands for "Healthy Keiki, Healthy Hawai'i."

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