ALPHA Resolution

2009-01 Support for a Sugar-Sweetened Beverage Tax

Sugar-sweetened beverages with little or no nutrition are staples of today’s Alaskan diet. Sugar-sweetened beverages are soft drinks sweetened with sugar, corn syrup, or other caloric sweeteners and include carbonated and un-carbonated drinks, such as sports drinks, energy drinks, and soda pop.

More than for any other category of foods, rigorous scientific studies have shown that consumption of sugar-sweetened beverages is associated with poor diet, increasing rates of obesity, and risk for diabetes. In addition, consumption of sugary beverages can cause tooth decay and dental erosion. Chronic diseases related to poor diet cost the country billions of health care dollars annually and are complex problems which must be addressed through multifaceted strategies. Taxing certain classes of products to reduce consumption has been proposed as one means of improving the nation’s nutrition, raising revenue for health programs, and recovering costs caused by consumption of calorie dense, nutrient-poor foods.

Consumption Trends
Since the 1970s, there has been a substantial increase in the per person consumption of sugar-sweetened beverages to an average of 50 gallons per person per year. A 2004 study found that soft drinks are the single largest contributor of calorie intake in the United States\(^1\). U.S. per capita consumption of calories from sugar-sweetened beverages doubled between 1977-2002 across all age groups\(^2\).

Twenty-two percent of Alaskan high school youth drink one or more sugar-sweetened beverages per day, and American Indian/Alaska Native girls are significantly more likely to do so (35%) than are White girls (11%).\(^3\) Consumption of soda and other sugar-sweetened beverages is even common among 2-year-olds—29% of toddlers statewide and 58% in the northern and southwest parts of Alaska consumed some form of sugar-sweetened beverage on any given day.\(^4\) Nearly one-third (29%) of adults report drinking one or more cans of non-diet soda each day, with 14% of adults drinking 2 or more cans.\(^5\)

Impact on Health
Evidence strongly supports a positive association between the intake of sugar-sweetened beverages and body fat in children.\(^6\) Systematic reviews of evidence conclude that greater
consumption of sugar-sweetened beverages is associated with increased calorie intake, weight gain, diabetes, and obesity.\textsuperscript{7}

**Public Support for Tax**
Taxes whose revenues are designated to promote the health of key groups (such as children and underserved populations) are most likely to receive public support.\textsuperscript{8} In 2005, 30\% of Alaskans supported or strongly supported a junk food tax.\textsuperscript{9} According to a recent Kaiser Family Foundation survey, 53\% of Americans support taxes on soda and sugary soft drinks if the revenue generated went toward health care reform.\textsuperscript{10}

**Revenue – Generating Potential**
Based on the Rudd Center for Food Policy and Obesity calculator, if Alaska were to impose a one-cent per ounce tax on all sugar-sweetened beverages (not just regular soft drinks) sold, it would generate $33.4 million of tax revenue in 2010.\textsuperscript{11}

**Impact of Price on Consumption**
Based on the best estimates to date of the responsiveness of demand for soft drinks to changes in price\textsuperscript{12}, a 10\% tax could result in an 8\% reduction in consumption. The effects may be higher for heavy users of soft drinks\textsuperscript{13}. Additionally, experiments show that decreasing the cost of healthy foods relative to that of less-healthy foods is effective in promoting the purchase of healthy items.\textsuperscript{14}

The Director for the Centers for Disease Control and Prevention, Thomas R. Frieden, stated during his *Weight of the Nation* address that a substantial soda tax would probably be the single most effective means to reduce obesity.\textsuperscript{15}

As with any public health intervention, the precise effect of a tax cannot be known until it is implemented and studied, but research to date suggests that a tax on sugar-sweetened beverages would have strong positive effects on reducing consumption.\textsuperscript{16} In addition, the tax has the potential to generate substantial revenue for obesity prevention and address other external costs resulting from the consumption of sugar-sweetened beverages.

**THEREFORE BE IT RESOLVED** that the Alaska Public Health Association supports a tax on sugar-sweetened beverages.

**BE IT FURTHER RESOLVED** that the Alaska Public Health Association supports the use of the revenue generated from the sugar-sweetened beverage tax to help finance obesity prevention efforts, chronic disease prevention efforts, improve health promotion efforts, and support other health related programs.

**AND BE IT FURTHER RESOLVED** that the Alaska Public Health Association will promote and advocate for the establishment of a sugar-sweetened beverage tax by engaging board members and other members in low and no-cost advocacy efforts for this purpose such as:
- Circulation of advocacy action requests to membership,
- Circulation of advocacy action requests to partners and other individuals,
- Posting of ALPHA resolutions on the Alaska Public Health Association’s website and/or making this resolution publicly available,
- Participation in email advocacy campaigns,
- Contact with policy makers via phone, letter, email and/or in-person meetings,
- Public testimony in legislative hearings, town hall meetings, and other public forums,
- Contribution of op-ed articles and/or letters to the editor,
- Contributions to radio programs via calling-in or scheduled interviews,
- Distribution of this resolution statement to policy makers and key stakeholders.

Fiscal & Public Health Impact Statement

Fiscal Impact on ALPHA: This action will result in minor costs associated with sending this resolution and accompanying cover letter to political leaders.

Public Health Impact: Successful obesity prevention efforts must be multifaceted. Increasing the price of unhealthy beverages in combination with other prevention strategies will increase the quality of life for Alaskan citizens, decrease the burden of obesity related diseases, and decrease both public and privately paid medical costs.

3 Fenaughty AM, Fink K, Peck D, Utermohle CJ. *Childhood Obesity in Alaska*. Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion. March 2009.
4 Ibid.
5 Ibid.
6 Ibid.
9 Alaska BRFSS, 2005.
11 Rudd Center for Food Policy and Obesity, Revenue Calculator for Soft Drink Taxes, [http://valeruddcenter.org/sodatакс.aspx](http://valeruddcenter.org/sodatакс.aspx)
13 Gustavsen, G. W., & Rickertsen, K. Public policies and the demand for carbonated soft drinks. Working paper prepared for presentation at the XIth Congress of the European Association of Agricultural Economists, Copenhagen, Denmark, August 24-27, 2005.
ALPHA Resolution

2009-02 Improving Health through Transportation and Land Use Policies

Transportation and land use policies are significant factors in the built environment and impact rates of injury and death due to traffic crashes, ease and safety of physical activity, air quality, greenhouse gas emissions, and access to key community resources such as health care and healthy food. Transportation and land development patterns have historically favored automobile travel, spawned sprawling development, and have taken an unnecessary toll on human life.¹

This resolution considers four major health impacts of transportation and land use policies that take the largest tolls on health, social equity, and the economy: (1) traffic injuries and fatalities, (2) physical activity and non-motorized transportation, (3) air and water quality, and (4) the disparate impact on vulnerable populations.

Traffic Injuries and Fatalities
Traffic crashes are the leading cause of death in Alaska for people younger than 35.² Annually in Alaska, traffic injuries and fatalities account for more than 86 deaths and over 3,000 nonfatal injuries.³ In 2007, there were 13 pedestrian and 2 bicyclist fatalities in Alaska, and over 600 reported combined injuries from non-motorized travel.⁴

Traffic injuries and fatalities can be prevented through effective traffic safety policies, designs and practices.⁵ Providing for safe walking, bicycling, and public transportation can result in fewer traffic injuries than building for motor vehicles alone.⁶ Contrary to the belief that increased bicycle and foot traffic lead to more cyclist and pedestrian injuries, increasing the numbers of non-motorized travelers may actually make walking and bicycling safer.⁷ There is also evidence that residents of communities designed to facilitate non-motorized transit have lower per capita traffic fatality rates.⁸

Physical Activity and Non-Motorized Transportation
According to the Alaska Department of Health and Social Services, 42% of Alaskan adults do not meet recommended levels of physical activity, and 20% are completely sedentary.⁹ The causal link between physical activity and health is well established; physical inactivity is a major contributor to the rising rates of chronic illnesses such as obesity, type 2 diabetes, and heart disease.¹⁰

An emerging body of evidence shows that transportation and land development patterns influence people’s decision to engage in physical activity, making transportation and land-use decisions an opportunity to increase levels of physical activity.¹¹,¹²,¹³,¹⁴,¹⁵,¹⁶ These land-use characteristics include higher-density and mixed use development, good public transportation, and proximity to destinations such as shopping, schools, and workplaces.¹⁷ Bicycle and pedestrian facilities, good street connectivity, presence of parks and open space, and residents’ perceived safety also enhance physical activity.¹⁸,¹⁹,²⁰,²¹
Air and Water Quality
Particulate matter and other pollutants are present at high concentrations along traffic-heavy roads, especially when a large fraction of this traffic uses diesel fuel. Several studies have documented that children attending school near major roadways have higher rates of respiratory symptoms, asthma diagnoses, and allergic sensitization, and children living near major roadways are more likely to suffer from asthma. Adults living or working near major roadways are also more likely to suffer from asthma and other respiratory diseases, as well as atherosclerosis and other cardiovascular problems. Roads, highways, and bridges are a source of significant contributions of pollutants to our nation’s waters. Runoff of oil and gasoline pollutes waterways, and increasing the amount of impervious surfaces, such as roadways and parking lots, generates further runoff pollution.

Health Equity and Disparate Impact on Vulnerable Population
Nearly one-third of the American population, including children, older adults, people with disabilities, low-income people, women, and rural residents do not have access to transportation or cannot purchase transportation. Low-income households may spend up to 40 percent of their income on transportation expenses, further perpetuating the gap in economic disparities and isolation from essential opportunities and resources.

THEREFORE BE IT RESOLVED that the Alaska Public Health Association supports the following transportation and land use goals:

1. Federal transportation policy must include health, equity, and safety as a high priority for all travelers. Roadways should be safe and accessible for all travelers rather than being designed exclusively for motorized travelers. Maintenance of transportation infrastructure should be adequately funded in all seasons.
   a. A greater portion of federal, state, and local transportation dollars should be invested in safe infrastructure for walking and bicycling.
   b. A greater portion of federal, state, and local transportation dollars should be invested in public transportation (including transit operating funds).
   c. All new construction and redevelopment of roadways should apply the Complete Streets model to make roadways safe for all users.
   d. Federal, state, and local policy should create incentives for investing in underserved communities, particularly those that spend a disproportionate percentage of their household income on transportation as well as those communities with existing infrastructure to support non-motorized travel and transit-oriented development.
   e. Roadways should be designed to maintain lower speeds that encourage people to walk and bike and create greater distances and attractive barriers between moving traffic and non-motorized travelers (i.e., pedestrians and bicyclists).
   f. Community residents, public health, social justice, housing experts, developers, and other diverse stakeholders should be engaged in transportation policy, planning and design.
2. Transportation policy and subsequent implementation must set a high priority on using cleaner energy sources and reducing harmful emissions, including greenhouse gases.
   a. Reducing the transportation sector’s contributions to global climate change should be prioritized at the federal, state, and local level.
b. Environmental justice goals to reduce the disparate exposure to harmful emissions from mobile sources should be honored and advanced in transportation and land use activities.

3. Community development and redevelopment activities should preserve historic, environmental, agricultural, and aesthetic resources.

4. State Departments of Transportation and local agencies should partner with community groups to conduct Health Impact Assessments for major transportation and land use activities.
   a. All agencies that make decisions that impact health should be held accountable and be responsible for these health outcomes.
   b. Public health should work with transportation and city planners to identify the health indicators and performance measures by which to evaluate such activities.

5. State and local transportation and land-use decisions should promote equity by:
   a. Improving multimodal linkages between housing, employment centers, health care facilities, healthy food retailers, and schools, particularly in low-income communities and communities of color.
   b. Encouraging high-density, mixed-use, and transit-oriented development with affordable housing and transit options in major employment and neighborhood centers.
   c. Building roadways to accommodate safe non-motorized travel of people with disabilities, older adults and children.
   d. Prioritizing local and regional food transportation networks and infrastructure over long-distance transportation.
   e. Ensuring that jobs in the transportation and land use sectors are open to all, including people of color, immigrants, and women.

BE IT FURTHER RESOLVED as an organization ALPHA, as well as individual Board Members and other Members will engage in low and no-cost advocacy efforts to promote Improving Health through Transportation and Land Use Policies thorough, but not limited to:

- Circulation of advocacy action requests to membership,
- Circulation of advocacy action requests to partners and other individuals,
- Posting of ALPHA resolutions on the Alaska Public Health Association’s website,
- Participation in email advocacy campaigns,
- Contact with policy makers via phone, letter, email and/or in-person meetings,
- Public testimony in legislative hearings, town hall meetings, and other public forums,
- Contribution of op-ed articles and/or letters to the editor,
- Contributions to radio programs via calling-in or scheduled interviews,
- Distribution of this resolution statement to policy makers and key officials.

Fiscal Impact
The fiscal impact on ALPHA by the proposed resolution will be minimal. This action will result in minor costs associated with sending this resolution and accompanying cover letter to the Governor and key political leaders.

Public Health Impact
This action will benefit public health by reducing traffic crashes and fatalities; improving opportunities to be physically active in safe, healthy places; improving air and water quality; and reducing the health disparate impact of vulnerable populations.


ALPHA Resolution

2009-03 Protecting Vulnerable Populations from Exposure to Toxic Chemicals

WHEREAS, in addition to the alarming rates of heart disease, diabetes and obesity that afflict Alaska residents, Alaska also has a birth prevalence of major congenital anomalies (MCA) twice as high as the 3% reported rate for the United States as a whole;  

WHEREAS, Alaska Native infants have twice the risk of MCAs as white infants, with 10% of the birth cohort affected versus 4% of whites and even during multivariate analysis, controlling for gender and maternal age, prenatal alcohol and cigarette use, and prenatal care initiation, Alaska Natives continue to be associated with a higher risk of a MCA;  

WHEREAS, the causes of birth defects remain largely unknown, the majority of birth defects are considered the result of multiple environmental and/or genetic causes acting together;  

WHEREAS, there is a growing body of scientific evidence suggesting environmental contaminants are linked to birth defects and other harmful reproductive health effects in both males and females;  

WHEREAS, exposure to environmental contaminants have been linked to a wide array of adverse health effects including cancer, diabetes, learning and intellectual disabilities, reproductive and developmental damage, and birth defects;  

WHEREAS, as of June, 2006 over 2,800 contaminated sites remain in Alaska containing hazardous substances that continue to pose a risk to human health and the environment, including military sites, open dump sites throughout rural Alaska, mining sites, other waste sites, and five major military sites that have been listed on National Priority List as among the most polluted sites in the nation (known as Superfund sites);  

WHEREAS, Alaska and the circumpolar Arctic are also subject to pesticides and industrial chemicals that originate from thousands of miles away, traveling northward via oceanic and atmospheric currents and eventually settle in cold climates, accruing in the north because the cold climate and fat-based food web favor retention of these persistent toxics;  

WHEREAS, even though some toxic chemicals that have been banned in the U.S. (such as the insecticide DDT and class of industrial chemicals known as PCBs), they continue to accumulate in the Arctic and sub-Arctic and threaten the health of northern peoples who rely on traditional diets of fish and marine mammals;  

WHEREAS, research demonstrates that industrial chemicals, pollutants, and pesticides cross the placenta as readily as residues from cigarettes and alcohol and these and other contaminants are
similarly hazardous to the health of developing fetuses and children, as the following studies have found:

- A review of scientific studies revealed contaminants such as solvents, heavy metals, and pesticides are linked to birth defects such as heart abnormalities, oral clefts (lip and/or palate) and neural tube defects (incomplete development of the brain, spinal cord and/or protective coverings of these organs). xii
- Exposure to plasticizers (used in consumer products) is linked to feminization of baby boys while PCBs and fine particulate matter are linked to low birth weight. xiii A recent study in Alaska found that women from villages with “hazardous” open dump sites were more likely to deliver preterm or low birth weight babies. xiv, xv
- Maternal and pre-conception paternal exposure to environmental contaminants may also contribute to the newly discovered male-to-female sex ratio declines. xvi Nationwide, the number of males being born is declining, xvii and skewed sex ratios have been observed in populations exposed to man-made chemicals. xviii, xix

THEREFORE, BE IT RESOLVED that the Alaska Public Health Association:

- Promotes the use of public health principals in evaluating the impact of proposed policies, balancing the risks and benefits in the decision making process;
- Insists that we preventatively protect Alaskans from hazardous chemicals by supporting policy that works to phase out persistent, bio-accumulative chemicals and/or those linked to birth defects, cancer, genetic harm, endocrine disorders, immune and neurological damage;
- Urges and supports the enactment of regulations and policies that prevent the release of toxic chemicals from military and industrial sources;
- Urges the establishment of protective standards for environmental cleanup; and
- Supports policies and activities that would ensure that rural Alaska villages have adequate resources for waste minimization, sanitation, recycling, and the design and maintenance of solid waste management facilities;

Fiscal and Public Health Impact Statement
This action will result in minor costs associated with sending this resolution and accompanying cover letter to the Governor and key political leaders. This action will benefit public health by helping to eliminate the negative health effects associated with toxic chemicals.

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ALPHA RESOLUTION

2009-04 Opposition to the Death Penalty in Alaska

WHEREAS, House Bill 9 was pre-filed for the 26th Legislature – First Session to allow imposition of the death penalty in Alaska for certain state crimes; and

WHEREAS, the Alaska Territorial Legislature abolished capital punishment in 1957 in a measure stating, “The death penalty is and shall hereafter be abolished as punishment in Alaska for the commission of any crime.”; i and

WHEREAS, the wrongful execution of an innocent person is an injustice that can never be rectified. Since the reinstatement of the death penalty nationally, at least 124 men and women have been released from death row nationally; ii and

WHEREAS, since 1977, blacks and whites have been victims of murders in almost equal numbers, yet 80% of the people executed in that period were convicted of murders involving white victims; iii and

WHEREAS, in jurisdictions outside Alaska, people of color comprise 43% of total executions since, 1976, while comprising only around 25% of the population; iv

WHEREAS, in Alaska, eighteen (18) percent of Alaska’s total population is American Indians and Alaska Natives v yet represent 30-40% of the state’s inmate population at any given point in time; vi and

WHEREAS, access for the majority of Alaska Natives and people residing in rural areas of the State of Alaska do not have the means to acquire adequate legal defense counsel when charged with serious crimes; vii and

WHEREAS, there is no evidence to indicate with any persuasiveness that capital punishment serves as a deterrent to crime any more than long term prison sentences; viii and

WHEREAS, more that 128 nations worldwide have abandoned the capital punishment in law or in practice. Year after year only three countries execute more prisoners than the USA - China, Iran, and Saudi Arabia; ix and

WHEREAS the Alaska Public Health Association is committed to promoting sound health policy, reducing health disparities and improving health outcomes for Alaskans,
NOW THEREFORE BE IT RESOLVED that the Alaska Public Health Association is opposed to the enactment of the death penalty in the State of Alaska, and

BE IT FURTHER RESOLVED THAT the Alaska Public Health Association urges the members of the Alaska State Legislature, to oppose any effort to enact the death penalty in Alaska, including but not limited to House bill 9 (HB 9).


ALPHA Resolution

2009-05 Support for an Institute of Medicine Report Regarding Mental and Behavioral Health Issues in Alaska and Other Parts of the Arctic

WHEREAS the Institute of Medicine of the National Academies (IOM) is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public; and

WHEREAS the IOM provides advice on a wide range of topics from the quality of medical care to conflicts of interest in medical research, from malaria treatment to environmental hazards, and from vaccine safety to childhood obesity; and

WHEREAS, since 1970, when Congress established the IOM as the health arm of the National Academy of Sciences, the IOM’s recommendations have shaped health policies to improve the lives of millions of people around the world; and

WHEREAS the IOM applies the National Academies’ rigorous research process, aimed at providing objective and straightforward answers to difficult questions of national importance using committees of leading national, international scientists, stakeholders and those with special knowledge of the topic all of whom serve pro bono in the development of IOM’s consensus reports; and

WHEREAS the committee’s task is developed in collaboration with the study’s sponsor, which may be a government agency, a foundation, or an independent organization; and

WHEREAS once the statement of task and budget are finalized, the committee works independently to come to consensus on the questions raised; and

WHEREAS as a final check for quality and objectivity, all IOM reports undergo an independent external review by a second, independent group of experts whose comments are provided anonymously to the committee members.

WHEREAS a consensus report which may include findings, conclusions, and recommendations based on available scientific evidence, reflects a committee’s agreement following deliberations; and
WHEREAS investigations have been conducted on a variety of populations in other Arctic regions including Canada, Finland, Norway, and Russia and some studies indicate high rates of depression, anxiety, and alcohol abuse and seasonal shifts in mood for adults as well as children; ix and

WHEREAS mental and behavioral health indicators reveal rates of obesity, smoking, alcohol use and suicide in Alaska that are above national averages x; and

WHEREAS the Alaska Suicide Follow-back Study Final Report provides data collected on 426 suicides from September 1, 2004 – August 31, 2006, xi

WHEREAS the average annual suicide rate for Alaska for the three year study period was 21.4/100,000 (U.S. Census, 2005 estimated population) and in 2004, there were 155 suicides in Alaska, giving Alaska the highest rate in the U.S. The suicide rate for Alaska was 23.4/100,000 population, more than double the U.S. rate of 11 per 100,000. xii and

WHEREAS amongst those having committed suicide, males out-numbered females 4 to 1 in the study xiii; and

WHEREAS Alaska Natives had a significantly higher average rate of suicide than the non-Native population (51.4/100,000 compared to 16.9/100,000) xiv; and

WHEREAS during the three year reporting period suicides in 20-29 year olds in Alaska had the highest rate at 46.4/100,000, followed by 30-39 at 27.8/100,000. Nationally, suicide rates in the 20-29 age group is ranked in seventh place xv; and

WHEREAS although Alaska Natives comprise 16% of the population, they accounted for 39% of the suicides. The ethnic disparity is even greater for Alaskan youth 19 and younger, where, over the past 15 years, Alaska Natives accounted for 19% of the youth population and 60% of the suicide deaths in that age group xvi; and

WHEREAS a collaborative effort by the Alaska Department of Health and Social Services, the Centers for Disease Control and Prevention, and the Indian Health Service in the early 1990s to ascertain cases of Fetal Alcohol Syndrome and determine the prevalence in Alaska Natives resulted in a synthesis of various research efforts on the topic leading to other studies and state and federal funding for fetal alcohol syndrome prevention efforts and services; and

WHEREAS the Alaska Public Health Association is committed to promoting sound health policy, reducing health disparities and improving health outcomes for Alaskans, and

WHEREAS the Alaska Public Health Association recognizes the potential benefits of an Institute of Medicine consensus report on mental and behavioral health issues in Alaska and the Arctic that would examine the science base, gaps in knowledge, and strategies for the prevention and treatment of mental and behavioral health problems faced by populations people living at high northern latitudes xvii;
NOW THEREFORE BE IT RESOLVED that the Alaska Public Health Association is in support of efforts to secure funding ($1.2 million minimum) from state, federal and local sources for an Institute of Medicine report of mental and behavioral health issues, including suicide, in the Arctic with a special emphasis on Alaska:

AND BE IT FURTHER RESOLVED that the Alaska Public Health Association will promote and advocate support for the study through:

- Posting of ALPHA resolutions on the Alaska Public Health Associations’s website and/or making this resolution available
- Distribution of this resolution statement to policy makers, key decision makers and funders in the Alaska Native community, State of Alaska, Alaska legislature, University of Alaska, and the Alaska federal legislators.

**Fiscal and Public Health Impact Statement:** This action will result in minor costs associated with sending this resolution and accompanying cover letter to the Governor and key political leaders. This action will benefit public health by promoting an examination of the science base, gaps in knowledge, and strategies for the prevention and treatment of mental and behavioral health problems faced by populations in Arctic regions, with a focus on Alaska.

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3. Ibid.
5. Ibid.
6. Ibid.
7. Ibid.
9. Ibid.
10. Ibid.
11. Draft Developing Project: Mental and Behavioral Health Issues in the Arctic. The National Academies Polar Research Board and Institute of Medicine Board on Health Sciences Policy.
14. Ibid.
15. Ibid.
16. Ibid.
17. Ibid.
18. Ibid.
19. Ibid.
20. Ibid.
21. Draft Developing Project: Mental and Behavioral Health Issues in the Arctic. The National Academies Polar Research Board and Institute of Medicine Board on Health Sciences Policy.
"In a world full of complex and conflicting health information, the Institute of Medicine is a beacon to those seeking objective, evidence-based guidance."

—Harvey V. Fineberg
President, Institute of Medicine

ABOUT THE INSTITUTE OF MEDICINE

WHO WE ARE
The Institute of Medicine (IOM) is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public. Established in 1970, the IOM is the health arm of the National Academy of Sciences, which was chartered under President Abraham Lincoln in 1863.

Nearly 150 years later, the National Academy of Sciences has expanded into what is collectively known as The National Academies, which comprises the National Academy of Sciences, the National Academy of Engineering, the National Research Council, and the IOM.

OUR MISSION
The Institute of Medicine serves as adviser to the nation to improve health.

OUR WORK
The IOM asks and answers the nation’s most pressing questions about health and health care. Our aim is to help those in government and the private sector make informed health decisions by providing evidence upon which they can rely. The IOM applies a distinct research process to provide objective and straightforward answers to difficult questions of national importance. Committees who conduct these studies are carefully composed to ensure the requisite expertise and to avoid conflicts of interest. These leading national and international scientists, all of whom serve as volunteers, are asked to set aside preconceptions and to rely on evidence in their pursuit of knowledge and truth.

Many of the studies that the IOM undertakes begin as specific mandates from Congress; still others are requested by federal agencies and independent organizations. While our expert, consensus committees are vital to our advisory role, the IOM also convenes a series of forums, roundtables, and standing committees, as well as other activities, to facilitate discussion, discovery, and critical, cross-disciplinary thinking.

Each year, more than 2,000 individuals, members, and nonmembers volunteer their time, knowledge, and expertise to advance the nation’s health through the work of the IOM. Membership in the IOM is offered to 65 individuals each year, elected by the current membership, and drawn from a range of health care professions; the natural, social, and behavioral sciences; and fields such as law, economics, administration, engineering, and the humanities. For those at the top of their field, membership in the IOM reflects the height of professional achievement and commitment to service.
SUMMARY

In recent years there has been significant improvement in the general health of the Arctic resident populations, but significant health disparities remain, especially between native populations and populations on the whole. These health disparities, in part, account for a shorter life expectancy and increased mortality related to suicide and accidents in Arctic residents, compared to residents in more temperate climates. Although Alaskans face many of the same behavioral and mental health issues faced by communities in other states, the severity of many of the problems is often greater and there are special challenges posed by the remoteness of many communities. Some of the health problems of greatest concern include, but are not limited to elevated suicide prevalence, child abuse/neglect, and sexual assault, abusive alcohol use, high prevalence levels of Fetal Alcohol Spectrum Disorder, high incidence of diabetes, high blood pressure, and high rates of unintentional injuries. As described in the Arctic Monitoring and Assessment Program’s 2002 assessment of human health in the Arctic, the younger age structure of the Alaskan population makes the State’s communities particularly vulnerable; however, it also provides an opportunity for establishing treatment programs that emphasize resiliency and preventive measures for behavioral and mental health promotion. Many agencies and organizations have recognized the need to invest in further research and improve current services. There is also increased attention to the issue of appropriate training of health care providers. Coordination of these efforts will provide a maximal benefit to the effected communities.

POLICY CONTEXT

The indigenous populations and other residents of the high northern latitudes face a variety of mental and behavioral health and health-related social issues. Although many of these issues parallel those faced by residents of other rural areas, and are similar to those faced by other Native American populations in the lower 48 states, the problems in Alaska are compounded by the challenging physical environment (including extreme cold and photoperiod changes) and limited availability of and access to health services in the region, and aggravated by the rapid social changes of the past few decades.
The Arctic Research and Policy Act, passed in 1984 (PL 98-373) and amended in 1990 (PL 101-609) was enacted to establish national policy, goals, and priorities for Arctic research. The act established the Arctic Research Commission and an Interagency Arctic Research Policy Committee (IARPC). The Commission publishes a report on goals and objectives every two years to help guide the activity of the IARPC and its member federal agencies. In its 2009 report the commission outlined several research program recommendations. In addition to studies of the Arctic Region, Bering Sea Region, and research on resource evaluation and civil infrastructure, the commission called for studies on the health of Arctic residents (USARC, 2009).

The Commission’s recommendation for a program of research on Arctic health calls for a focus on mental health in the Arctic since behavioral problems such as alcoholism, drug use, suicide and accidents are among the most frequent causes of ill health and death in Arctic populations (USARC, 2009). The commission recommended that the IARPC begin planning an interagency program to coordinate and emphasize research on mental health concerns in the Arctic, with the National Institutes of Health as the focal point for the effort.

TECHNICAL CONTEXT

The eight nations with territory and populations in the Arctic are Canada, Denmark, Finland, Iceland, Norway, the Russian Federation, Sweden and the United States of America. In the United States, the health of our northern residents in Alaska depends on many factors. Essential infrastructures, such as housing, water, waste, energy, and transportation systems, are far more difficult to design and provide than in temperate regions, bringing a variety of health implications. Providing adequate health care in rural areas of the Arctic is equally challenging.

The issue of mental health care for northern residents has been called a “neglected disparity.” Certain behavioral health indicators in Alaska such as binge drinking, and alcohol induced deaths are considerably higher than the national norm. (DHSS Alaska 2008). Sexually transmitted diseases are increasing dramatically (Wooley, 2008). Rates of obesity and diabetes among Alaskans are increasing as well (CDC, BRFSS ).

Rates of suicide in Alaska are also among the highest in the nation. The state ranked 3rd in death rates by suicide in 2006, at 19.9 deaths per 100,000 people (Centers for Disease Control and Prevention, National Center for Health Statistics, 2006). Within the state of Alaska, rates of suicide by Alaska Natives were much higher than rates for non-Native Alaskans. Since 2005 the suicide rate has been increasing despite the best efforts of the State of Alaska, the Alaska Mental Health Trust and private groups. The suicide rate is much higher among the Native Alaskan Population. The Native Alaskans comprise 16% of the population but had 39% of the suicides during the study period 2003-2006. The suicide deaths per 100,000 for Alaska Natives was 51.4 per 100,000 compared to 16.9 per 100,000 for non Natives. (Alaska Suicide Prevention Council, 2006). A story from the Anchorage Daily News quoting Alaska’s Bureau of Vital Statistics indicated that the suicide rate had increased 4 years in a row in Alaska and that
the current rate is 24.6 per 100,000, the highest rate in a decade, and a 25% increase since 2005 (Hopkins 2009).

The suicide incidence in Alaska natives is highest among their youth. In replies to a recent survey questionnaire of Alaska, an astonishing 35% of both native Alaskan boys and girls stated they had “made serious plans to take their lives in the prior year” (CDC, Alaska Youth Survey 2007). Alaska Native youth less that age 19 year old comprise 19% of Alaska’s population in that age range yet 60% of the suicides during the past 15 years (Alaska Suicide Prevention Council, 2006). The Alaskan native males aged 15-25 years seem to be at especially high risk.

It is estimated that 10 percent of Alaska’s children and youth have severe emotional disturbances and 6.2 percent of the adult population under age 55 have severe mental illness (Alaska Department of Health and Social Services, 2001). Access to care is limited by financing shortages of both the mental health systems and its clients, and by shortages in mental health personnel in rural areas. Lack of services lead many to have contact with the criminal and legal systems. The Department of Corrections is the largest provider of mental health care in the state (Alaska Department of Health and Social Services, 2001). While Alaskans have a higher incidence of mental and behavioral health disorders, a 2000 study by the Substance Abuse and Mental Health Services Administration places Alaska as the state with the third highest unmet need for substance abuse treatment (University of Alaska, 2004).

The international literature shows similar problems for northern residents more broadly. Suicide incidence data for Canadian and Greenland native residents are similarly excessive.(Haggerty 2008; Bjerregaard 2006). Investigations have been conducted on a variety of populations in other Arctic regions including Canada, Greenland, Finland, Norway, and Russia and studies indicate high rates of depression, anxiety, and alcohol abuse (Haggarty et al., 2000) and seasonal shifts in mood for adults (Haggart et al., 1990; Haggarty et al., 2002;; Bjerregaard 2004; Nayha, Vaisanen, and Hassi, 1994) as well as children (Sourander et al., 1999).

Although a great number of Northern Residents are at risk and experience mental and behavioral health complications there is also a portion of inhabitants who are resilient to these risk factors. These differences can be seen not only between individuals but between communities or villages suggesting an important socio-cultural component to the resilience. It is unclear what makes some individuals or villages more resilient to the same factors that put so many others at risk. With few exceptions, there is no current, compelling framework that guides development of a primary prevention approach for mental illness or addictive disorders. That is, it is not known which societal strategies should be pursued to fundamentally lower incidence and prevalence of these disorders. These might include modifications in housing, socioeconomic status, education, environmental hazards, behavior and violence.

In Alaska, multiple Federal, State and Local agencies and in some cases in collaboration with international agencies, such as the Canadian Ministry of Health, are
involved in promoting, preventing and treating mental and behavioral health disorders. Each one of these agencies comprises a critical piece of the infrastructure that supports and maintains the health of Alaskans’. For example, within the Federal government there at least five agencies active in providing assistance, including the Indian Health Service, Centers for Disease Control, National Institutes of Health, National Science Foundation, and the Health Resources and Services Administration. In addition there are well over 20 non-federal agencies involved in behavioral health services in Alaska. Therefore a coordinated effort among the various agencies and organization will be needed.

Researchers in the behavioral and social sciences are exploring resilience factors that allow better coping and recovery from social and physical trauma. Research in neuroscience is identifying mediators and mechanisms of altered brain functioning and behavior. Community based researchers are employing educational programs that center teaching cultural values and traditions within the context of the modern society. Medical research is finding new approaches to diagnose and pharmacologically treat depression.

Focused research is desperately needed to identify more effective and comprehensive strategies for promoting resilience and recovery in individuals who live in the Northern communities. Despite many trials of intervention or “pilot programs” there is little effectiveness testing of interventions and no interventions have been scaled up to a statewide level. The mental health research agenda for Northern residents is much broader than can be accommodated by a single funding agency. Despite the enormity of the problem a minuscule amount of funds are devoted to mental health research in Alaska. Need data here if possible; NIMH less than $50,000/yr; perhaps the Mohatt group can give an estimate of total mental health Research funding.

PLAN OF ACTION

Statement of Task

This study will examine the science base, gaps in knowledge, and strategies for the prevention and treatment of mental and behavioral health problems faced by populations in Arctic regions, with a focus on Alaska. Specifically, the committee would:

1. Summarize the scope and nature of mental and behavioral health problems among residents of Arctic regions, with special emphasis on Alaska and Alaska Natives.

2. Assess the infrastructure for research into the mental and behavioral health issues in Alaska to determine if current mechanisms and resources are appropriate to facilitate progress in the field. This should include an analysis of which federal agencies are funding research programs and the mechanisms used for recruitment and selection of proposals and assessment of their value?
3. Describe factors that contribute to promoting resilience and recovery in Northern residents. Learn if any of these have been robustly tested for effectiveness. Learn if any of these have been scaled up beyond a single village to regions and states. Have any scaled up programs been tested?

4. Provide recommendations for strategies of implementation and testing of programs designed to increase resilience in the affected populations and reduce health disparities.

5. Describe and assess the infrastructure for prevention and treatment of mental and behavioral health in Alaska; including federal, state and community based programs. Special emphasis will be given to suicide prevention programs and in examining the usefulness and effectiveness of native health workers in rural communities using technologic assistance in making psychiatric diagnoses, and instituting surveillance using telepsychiatry in arctic rural areas. This should include examination of collaborative efforts and discussion of ways to improve coordination between the multiple public and private agencies involved in promoting improved mental and behavioral health. The testing of pilot programs for effectiveness will be emphasized, and the scaling potential of pilot therapeutic efforts will be examined.

6. Identify steps that could be taken in the short-, medium-, and long-term to improve the mental and behavioral health of northern US residents, including research needed to understand the impact of abrupt Arctic climate change and rapid social changes on mental and behavioral health, improvements in community infrastructure directly related to health, changes in prevention and treatment programs, and mechanisms to improve selection and training of personnel for mental and behavioral health care services. Special emphasis will be made on the use of telepsychiatry to augment these efforts.

**EXPERTISE REQUIRED**

Expertise required includes mental and behavioral health, suicidology, community-based health research, Alaska Native culture, medical care delivery in the arctic (including IHS and the ANTHC), sociology, academic, health promotion and prevention, substance abuse, family violence, epidemiology and biostatistics, information technology and telepsychiatry, academic training and health policy. This study will also include international perspectives from other Arctic nations grappling with these problems.

**CONSIDERATION OF BALANCE**

The committee will be selected to ensure the presence of native Alaskans and individuals with expertise in a variety of fields, with knowledge of mental and behavioral health in Arctic regions including Alaska.
PRELIMINARY WORK PLAN

The IOM (BSP/HSP) and NRC (BPR) proposes to assemble a study committee of 12 to 14 experts knowledgeable in the fields of mental and behavioral health, suicidology, community-based health practice and research, Alaska Natives, medical care (IHS and ANTHC, CDC, etc), sociology, academic, health promotion and prevention, substance abuse, family violence, epidemiology and biostatistics, academic training and health policy. Committee nominations will be solicited from the Academies membership, relevant organizations and associations, federal and Native agencies, and other experts and stakeholders. Special efforts will be made to consider experts familiar with the Native American social and cultural attributes. The committee will meet over an 18 to 24 month to period in order to assess the scope and nature of mental and behavioral health problems among residents of Alaska and Arctic regions of other nations, and make recommendations to improve the mental and behavioral health of northern US residents through research, education and training, and practice as well as advanced technology including telepsychiatry.

The committee will hold five meetings throughout the course of the study. The first full committee meeting will be held in Alaska and will involve the required bias and conflict of interest discussion as well as clarifying the important tasks of the study. In addition the committee and staff will break up into small 2-3 person teams and visit selected arctic communities to speak with the local Native Alaskans and observe first-hand the environmental context of the complex and difficult issues under study. Their observations will be reported back to the committee as a whole. Each of the next two meetings will be held in conjunction with a workshop; each workshop will be dedicated to data gathering and identification of current knowledge and information gaps. At least one of the two workshops will be held at a location in the northwest, such as Seattle, where it would be easier for relevant experts from Canada, Alaska, and other arctic areas to converge. The specific topics to address in the workshops will be determined at the first meeting of the committee. The final two meetings will be devoted to formulating the recommendations, writing, and reviewing the report.

As part of the study process, the committee will: a) critically review published literature, b) convene public workshops at which leading mental and behavioral health professionals and scientists will summarize current knowledge and identify critical questions and possible solutions, and c) interview the leaders of community, state and federal programs regarding the infrastructure needs required for improved research, education and training, and medical treatment. d) make site visits to selected Alaskan communities to obtain first hand knowledge and understanding of the behavioral and mental health issues, assess barriers to their mitigation, and to receive feedback from local residents. The committee also will commission international leaders in Arctic mental and behavioral health to supply in-depth analyses on specific aspects of the study charge. The committee will produce a report of value to the State of Alaska and the Alaska Mental Health Trust as a blueprint for future research and change. During the review phase IOM will be select some reviewers from Alaska intimately familiar with local values and programs. Public release will take place in Alaska with representatives of Alaskan native community present.
<table>
<thead>
<tr>
<th>Month</th>
<th>Project Start (NOTE: Projects cannot begin until receipt of funds)</th>
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<tr>
<td>Month 1 - 3</td>
<td><strong>Committee Nominations and Selection Process</strong></td>
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<tr>
<td>Month 1</td>
<td><strong>Plan meeting 1 and first workshop</strong></td>
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<tr>
<td>Month 1</td>
<td>• Advance meeting with Chair of Committee</td>
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<td>Month 1</td>
<td>• Chair and staff to develop preliminary draft report outline with input from committee</td>
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<tr>
<td>Month 1</td>
<td>• Assemble background materials and distribute agenda book</td>
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<td>Month 3</td>
<td><strong>1st meeting, 4 days (Alaska):</strong></td>
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<tr>
<td>Month 3</td>
<td>• Committee will meet for 4 full days, split between open and closed session</td>
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<tr>
<td>Month 3</td>
<td>• Workshop on the Public Health Impact of Arctic Mental and Behavioral Health, and State and Community Based Programs</td>
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<td>Month 3</td>
<td>• Charge to the committee</td>
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<td>Month 3</td>
<td>• Orientation to IOM and NRC process</td>
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<td>Month 3</td>
<td>• Briefings from sponsor regarding expectations and needs.</td>
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<td>Month 3</td>
<td>• Discussion of statement of task, study plan, timeline</td>
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<td>Month 4</td>
<td>• Information gathering and writing assignments.</td>
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<td>Month 4</td>
<td>• Follow-up on assignments from meeting #1</td>
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<td>Month 4</td>
<td>• Prepare site visit reports</td>
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<td>Month 4</td>
<td>• Commission additional background papers?</td>
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<td>Month 4</td>
<td>• Collect, review, and distribute background materials</td>
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<tr>
<td>Month 4</td>
<td>• Data collection and analysis</td>
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<td>Month 4</td>
<td>• Assemble and distribute agenda books for meeting #2</td>
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<tr>
<td>Month 5</td>
<td><strong>2nd meeting, 3 days (Northwest Regional Area- like Seattle)</strong></td>
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<td>Month 5</td>
<td>• Committee will meet for 3 full days, split between open and closed session</td>
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<tr>
<td>Month 5</td>
<td>• Workshop on Federal and International based Mental and Behavioral Health Programs</td>
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<td>Month 5</td>
<td>• Begin drafting report, identify information needed, writing assignments, draft preliminary findings</td>
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<td>Month 5</td>
<td>• Plan meeting 3</td>
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<td>Month 6</td>
<td>• Committee prepares draft sections</td>
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<td>Month 6</td>
<td>• Teleconference calls with working groups</td>
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<td>Month 6</td>
<td>• Reference verification</td>
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<tr>
<td>Month 6</td>
<td>• Assemble and distribute agenda books (first draft)</td>
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<tr>
<td>Month 7</td>
<td><strong>3rd meeting, 2 days (Washington, DC):</strong></td>
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<tr>
<td>Month 7</td>
<td>• Review commission paper</td>
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<td>Month 7</td>
<td>• Review draft sections and finalize report outline</td>
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| Month 8 | • Committee prepares first draft  
• Teleconference calls with working groups  
• Draft Executive Summary and Preface, laying out themes  
• Reference verification  
• Assemble and distribute agenda books (first draft) |
|---|---|
| Month 9 | **4th meeting, 2 days (Washington, DC):**  
• Committee reviews first draft  
• Review conclusions and recommendations  
• Complete information gathering  
• Outline Executive summary |
| Month 10 - 11 | • Committee prepares second draft  
• Draft Executive Summary and Preface  
• Finalize data analysis  
• Reference verification  
• Prepare graphics for report  
• Assemble and distribute agenda books (second draft) |
| Month 12 - 13 | **5th meeting, 2 days (Washington, DC):**  
• Plenary review and discussion of final draft  
• Committee sign-off for review |
| Month 14 | Final Report compiled. Committee review finalize findings. Committee sign-off that report is ready for review. |
| Month 15 - 16 | **External Review:** Final Report prepared, cleared by NAS, and sent to external review (2 weeks). |
| Month 16 | **Response to Review:** Committee response to review comments (email and teleconferences). Final editing. Academy RRC approval that final report is acceptable for release. Preparation of prepublication copies. |
| Month 17 | Release Final Report at a Native Community of Alaska site with distribution to Alaskan state government, other Alaskan agencies (Mental Health Trust, ANTHC, etc); USARC; relevant federal agencies; and the general public. Further dissemination activities as needed. |
| Month 21 | Published volume available. Additional dissemination as needed. |

**PRODUCT AND DISSEMINATION PLAN**

All reports will be prepared subject to the standard NRC and IOM review procedures. Reports resulting from this effort shall be prepared in sufficient quantity to ensure their distribution to the sponsor and to other relevant parties, in accordance with Academy policy. Project staff will coordinate with the NRC Office of News and Public Information to produce materials appropriate for dissemination to interested audiences. The report will be made available to the public without restriction and will be posted on the NAS World Wide Web site.
FEDERAL ADVISORY COMMITTEE ACT

The Academy has developed interim policies and procedures to implement Section 15 of the Federal Advisory Committee Act, 5 U.S.C. App. § 15. Section 15 includes certain requirements regarding public access and conflicts of interest that are applicable to agreements under which the Academy, using a committee, provides advice or recommendations to a Federal agency. In accordance with Section 15 of FACA, the Academy shall submit to the government sponsor(s) following delivery of each applicable report a certification that the policies and procedures of the Academy that implement Section 15 of FACA have been substantially complied with in the performance of the grant with respect to the applicable report.

PUBLIC INFORMATION ABOUT THE PROJECT

In order to afford the public greater knowledge of Academy activities and an opportunity to provide comments on those activities, the Academy may post on its website (http://www.national-academies.org.) the following information as appropriate under its procedures: (1) notices of meetings open to the public, (2) brief descriptions of projects, (3) committee appointments, if any (including biographies of committee members), (4) report information, and (5) any other pertinent information.

ESTIMATED COSTS

The total estimated cost of this study is $XXXX for 21 months. The period of performance is expected to be 4/1/10 to 12/30/11.
References
Centers for Disease Control and Prevention; National Center for Chronic Disease Prevention and Health Promotion; Behavioral Risk Factor Surveillance System. Accessed 08/3/09.
DHSS Alaska Division of Public Health Bureau of Vital Statistics Alaska Scorecard (Dec2008)
Hopkins , Kyle, Anchorage Daily News, Suicide Rate rises for 4th Consecutive Year, May 27th, 2009


ALPHA Resolution

2009-06 Supporting Adoption and Implementation of Statewide Comprehensive School Health Education

Whereas health-related factors such as hunger, physical and emotional abuse, and chronic illness can lead to poor school performance\(^1\); health-risk behaviors such as substance use, violence, and physical inactivity are consistently linked to academic failure and often affect students’ school attendance, grades, test scores, and ability to pay attention in class\(^2\), 3, 4, 5, 6, 7, 8, and

Whereas schools have more influence on the lives of young people than any other social institution except for the family;\(^9\) and

Whereas academic success is an excellent indicator for the overall well-being of youth and a primary predictor and determinant of adult health outcomes\(^10\), 11, 12, 13, 14; and

Whereas students who receive health education that includes the use of effective curricula improve their health-related knowledge and skills increase their involvement in healthy behaviors,\(^15\) and decrease their involvement in risky behaviors;\(^16\), 17, and

Whereas promoting academic achievement is one of the four fundamental outcomes of modern school health programs; scientific reviews have documented that school health programs can have positive impacts on educational outcomes, as well as health-risk behaviors and health outcomes;\(^18\), 19, 20, 21, 22, 23, 24, 25, 26, and

Whereas leading national education organizations recognize the close relationship between health and education, as well as the need to embed health into the educational environment for all students;\(^27\), 28, 29, 30, 31, 32 and

Whereas the Institute of Medicine defines coordinated school health programs as “…an integrated set of planned, sequential school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social and educational development of students”\(^33\) and

Whereas in 1987, Lloyd Kolbe and Diane Allensworth first described an “expanded concept” of school health, now called the Coordinated School Health Program Model;\(^34\) and
Whereas comprehensive health education is an essential component of the Coordinated School Health Program Model; and

Whereas the following are key elements of comprehensive health education, making up part of an overall coordinated school health program:

1. A documented, planned, and sequential program of health instruction for students in grades kindergarten through twelve.
2. A curriculum that addresses and integrates education about a range of categorical health problems and issues at developmentally appropriate ages.
3. Activities that help young people develop the skills they need to avoid: tobacco use; dietary patterns that contribute to disease; sedentary lifestyle; sexual behaviors that result in HIV infection, other STDs and unintended pregnancy; alcohol and other drug use; and behaviors that result in unintentional and intentional injuries.
4. Instruction provided for a prescribed amount of time at each grade level.
5. Management and coordination by an education professional trained to implement the program.
6. Instruction from teachers who are trained to teach the subject.
7. Involvement of parents, health professionals, and other concerned community members.
8. Periodic evaluation, updating, and improvement;

Whereas, comprehensive health education curriculum includes a variety of topics such as personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse; and. (CDC)

Whereas, comprehensive health education should promote health literacy and include appropriate instructional strategies to enable students to achieve the following National Health Education Standards so that students will be able to:

1) Comprehend concepts related to health promotion and disease prevention to enhance health
2) Analyze the influence of family, peers, culture, media, technology and other factors on health behavior
3) Demonstrate the ability to access valid information and products and services to enhance health
4) Demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks
5) Demonstrate the ability to use decision making skills to enhance health
6) Demonstrate the ability to use goal setting skills to enhance health
7) Demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks
8) Demonstrate the ability to advocate for personal, family and community health
9) Acknowledge that certain behaviors result in consequences, including incarceration.
Whereas, secondary schools in Alaska have the lowest percentage (16.2%) of lead health education teachers with professional preparation in health and physical education (combined)\textsuperscript{37}; and

Whereas approximately 128,762 Alaskan students K-12 in public schools are impacted by Alaska lack of consistent comprehensive school health standards\textsuperscript{38};

Therefore, be it resolved that the Alaska Public Health Association supports:

1. The development and adoption of new state health education standards based on national health education standards
2. Dedicate resources to support a full-time health education specialist within the Department of Education and Early Development
3. Require at least one credit of health education for graduation from Alaska high schools
4. Provide professional development for teachers responsible for teaching health topics
5. The development of comprehensive school health guidelines that incorporate all eight elements of a coordinated school health model
6. Calls upon the legislature and administration to make coordinated school health a priority for Alaskan schools; and
7. Encourages ALPHA members to support schools in their efforts to implement coordinated school health programs and practices in all K-12 schools.

Fiscal Impact: This action will result in minor costs associated with sending this resolution and accompanying cover letter to the Governor and key political leaders.

Public Health Impact: This action will improve the health of students by enabling them to make responsible decisions; use negotiation, communication, and decision-making skills; develop positive self-esteem; express feelings; and practice conflict resolution skills. Studies demonstrate that students who receive comprehensive health education are more likely to form healthful and responsible friendships, accept physical appearance, recognize that all people are different and have different needs, volunteer, use healthcare providers, and work to keep the air and environment clean. Well-prepared students: care for their bodies; follow a dental health plan; recognize the importance of sleep, rest, and exercise; reduce their risk of violence; and follow safety guidelines.

Students who receive comprehensive health education have health knowledge and life skills that can help them know the difference between wellness behaviors and health-related risk behaviors. They know the difference between healthful relationships and destructive relationships. They have decision-making skills and can evaluate options before deciding what course of action to take. They have resistance skills and can say "No" when pressured to participate in risky behaviors. Students feel empowered and are critical thinkers, problem solvers, responsible, self-directed learners, and effective communicators.\textsuperscript{39}
19 Society of State Directors of Health, Physical Education and Recreation, Making the connection: Health and student achievement.
20 Society of State Directors of Health, Physical Education and Recreation. Summary research documents for components of a Coordinated School Health Program.
28 Council of Chief State School Officers, Assuring school success for students at risk: A policy statement of the Council of Chief State School Officers, November 1987
29 Policy statement on school health, Council of Chief State School Officers, 2004
www.ccsso.org/content/pdfs/SchoolHealthPolicyStatement.pdf.
38 EED, Alaska Department of Education and Early Development Assessment and Accountability District Enrollment as of October 1, 2008
39 National Center for Health Education.
http://www.nche.org/growinghealthy_comprehensiveschoolhealthed.htm
ALPHA Resolution

2009-07 Support and Membership in the Alliance for Aviation Across America to improve medical access, emergency services, and disaster relief in rural communities

WHEREAS, aviation touches all aspects of life in rural Alaska, and is a basic mode of transportation; and

WHEREAS, approximately 82% of Alaskan communities are not served by roads and most of the time there is no practical alternative to medical access for our citizens to hub community hospitals other than by the aviation system according to the Alaska Department of Transportation & Public Facilities; and

WHEREAS, aviation medical evacuation is an essential part of the health care system in Alaska; and

WHEREAS, the Alliance for Aviation Across America (AAAA), formed in 2007, is a non-profit, non-partisan diverse coalition of aviation enthusiasts and professionals, local airports, civic organizations representing rural and agriculture voices, city, county and state officials, economic development entities, non-profit organizations, small and mid-size businesses and others dedicated to supporting interests of the general aviation community across various public policy issues; and

WHEREAS, AAAA’s goal is to protect the economic lifeline supported by aviation to rural and small communities, which is a crucial resource for business, medical care, disaster relief and a key transportation asset to residents isolated areas; and

WHEREAS, AAAA supports modernizing the Air Traffic Control System with Satellite Technology from today’s ground-based navigation system, and

WHEREAS, AAAA opposes user fees in any form because of the burden that they would place on Americans who depend on small planes for their livelihood, and supports current “pay at the pump” fuel tax system as a simple, efficient way to pay in to the Airport and Airways Trust Fund; and

WHEREAS, AAAA opposes unworkable and counterproductive provisions of the Transportation Security Administration’s (TSA) Large Aircraft Security Program because
it would create huge financial and operational burdens for general aviation, while not making us any safer;\(^5\) and

WHEREAS, AAAA encourages investment in our aviation infrastructure by supporting the Airport Improvement Program, which helps to provide upgrades, renovation, and improvements to small airports which boosts local economies, creates jobs, and ensures the viability of small communities;\(^6\) and

WHEREAS, AAAA, because commercial air service is critical to many small and mid-sized cities, supports funding for the Essential Air Service program;\(^7\) and

WHEREAS, Alaska has 45 communities with Essential Air Service subsidies; and

WHEREAS, membership in the Alliance for Aviation Across America (www.aviationacrossamerica.com) is free and because improving aviation means better medical access, and improves delivery of emergency services and disaster relief in rural Alaska communities.

NOW THEREFORE BE IT RESOLVED, the Alaska Public Health Association supports the Alliance for Aviation Across America and will apply for membership within 60 days of passage of this resolution.

AND BE IT FURTHER RESOLVED that the Alaska Public Health Association will promote and advocate support for the study through:

- Posting of ALPHA resolutions on the Alaska Public Health Association’s website and/or otherwise making this resolution available to the public
- Distribution of this resolution statement to policy makers and key decision makers in the Alaska Native community, State of Alaska, Alaska legislature, University of Alaska, and the Alaska federal legislators.

FISCAL AND PUBLIC HEALTH IMPACT STATEMENT: This action will result in minor costs associated with sending this resolution and accompanying cover letter to the Governor and key political leaders. This action will benefit public health by supporting aviation infrastructure critical to aviation safety in small and rural communities and support communities reliant on aviation for essential services.

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2. Ibid
3. Ibid
4. Ibid
5. Ibid
6. Ibid
7. Ibid
ALPHA Resolution

2009-08 Support for Quality Physical Education in Alaska

WHEREAS quality physical education programs are critical to providing and teaching skills needed to achieve and maintain physical fitness

WHEREAS regular physical activity yields health benefits and helps reduce the risk of developing obesity and chronic diseases such as diabetes and cardiovascular disease

WHEREAS physical inactivity contributes to a variety of chronic diseases including diabetes, high blood pressure, high cholesterol, asthma, arthritis and dying prematurely

WHEREAS prevalence of obesity among children aged 6–11 more than doubled in the past 20 years and the rate among adolescents aged 12–19 more than tripled and children; and adolescents who are overweight are more likely to be overweight or obese as adults

WHEREAS 27% of Alaska high school students are overweight or obese

WHEREAS direct medical expenditures alone for obesity are estimated to total $147 billion each year in the United States, and an estimated $477 million is spent annually in Alaska for direct medical expenditures related to obesity

WHEREAS physical education provides a dose of the scientifically recommended 60 minutes or more of physical activity per day for children and adolescents, and most of the hour or more should be moderate to vigorous activity

WHEREAS 58% of Alaska high school students do not get the recommended amount of physical activity each day and more than half of Alaskan high school students did not participate in physical education class in the past week

WHEREAS less than 25% of Alaskan physical education instructors are certified specialists

WHEREAS Alaska has the lowest percentage of secondary schools with certified physical education staff in the United States and has the lowest percentage of secondary physical educators who received professional development in their content area in the United States

WHEREAS research indicates that schools that provide time for quality physical education with life long physical activity programs generate a positive effect on academic achievement even
when provided as part of the regular school day – including increased concentration; improved mathematics, reading, and writing scores; and a reduction in disruptive behaviors.\textsuperscript{11,12}

WHEREAS a high quality physical education program includes the following components:\textsuperscript{13}

1) The opportunity to learn by providing instructional periods totaling 150 minutes per week (elementary) and 225 minutes per week (middle and secondary school); qualified physical education specialists providing a developmentally appropriate program; and adequate equipment and facilities.

2) Meaningful content that includes: instruction in a variety of motor skills that are designed to enhance the physical, mental, and social/emotional development of every child; fitness education and assessment to help children understand, improve and/or maintain their physical well-being; development of cognitive concepts about motor skill and fitness; opportunities to improve their emerging social and cooperative skills and gain a multi-cultural perspective; and promotion of regular amounts of appropriate physical activity now and throughout life.

3) Appropriate instruction defined as: full inclusion of all students; maximum practice opportunities for class activities; well-designed lessons that facilitate student learning; out of school assignments that support learning and practice; no physical activity for punishment; and uses regular assessment to monitor and reinforce student learning.

WHEREAS the school grounds, physical plant, athletic and playground structures must be maintained to ensure a safe and healthy environment for physical activity.

WHEREAS Physical Education is an essential component of the Coordinated School Health Program Model.\textsuperscript{14}

WHEREAS there is strong scientific evidence from the Task Force on Community Preventive Services that school-based Physical Education is effective in increasing levels of physical activity and improving physical fitness.\textsuperscript{15}

THEREFORE BE IT RESOLVED that the Alaska Public Health Association supports quality standards-based physical education in grades K through 12 as a critical component of a balanced curriculum. To that end, ALPHA supports:

- The adoption of State of Alaska Physical Education Content Standards based on National Physical Education Standards;
- 150 minutes per week for elementary or 225 minutes per week for secondary schools of physical education instruction;
- Establish a statewide Physical Education Coordinator position to assist districts with implementing quality physical education programs.
- A requirement that state funding for new schools or substantial school capital improvements include indoor and outdoor physical education facilities; and
- Creation of an Alaskan educational system for certificated teachers to earn a physical education teaching endorsements.
• Professional development for those teaching physical education in schools.

Fiscal Impact on ALPHA: This action will result in minor costs associated with sending this resolution and accompanying cover letter to policy makers.

Public Health Impact: Increased school-based physical education will improve the health of students, develop physical competence and cognitive understanding about the importance of physical activity, and encourage students to adopt healthy and physically active lifestyles throughout the lifespan. It will help students maintain a healthy weight, prevent overweight and obesity and reduce the risk of developing chronic diseases or dying prematurely. It will also reduce the burden to health care costs to society. In addition, it may improve academic achievement which in turn can result in an improved health status.

1 National Association for Sport and Physical Education (NASPE), What Constitutes a Quality Physical Education Program? Position Statement. Prepared by the National Association for Sport and Physical Education. Reston, VA 2003
2 Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Physical Activity and the Health of Young People. October 2008
3 Centers for Disease Control and Prevention, Physical Activity and the Health of Young People. October 2008
8 Alaska Department of Health and Social Services, Division of Public Health, Youth Risk Behavior Survey (YRBS) 2007
13 National Association for Sport and Physical Education (NASPE), What Constitutes a Quality Physical Education Program? Position Statement. Prepared by the National Association for Sport and Physical Education. Reston, VA 2003