Introduction

The purpose of this journal is to publish the work of undergraduates in the Community Health Education Program. This issue is limited to the work of students in Community Health Education 440-Program Development in Community Health Education. Students authored brief reports explaining their collaborative efforts to promote and protect health using their newly acquired skills in community health education.

This journal was distributed at the start of 2013 to all faculty in the Department of Health Education and Health Promotion and to all students who have declared their major to be Community Health Education. Student authors benchmark their thinking and professional practice each time an issue of this journal is published. Student authors will remember these projects as their early work and they will undoubtedly improve with each subsequent project in their practice of community health education.

Students reading these pages before starting their own service learning in Community Health Education 440 are encouraged to match and surpass the efforts reported in this issue. Journals are never published to stop progress; instead journals are an invitation to build on past efforts in research and practice.

Students are encouraged to think more about the importance of publishing examples of their work. Sharing ideas and experience through publication contributes to both the profession and the people who are served by Community Health Education.

Forward,

Robert Jecklin, M.P.H., Ph.D.
Editor-for-now

About the cover: Garlic woven into a peace sign is at the entrance to Chez Panisse, the restaurant in Berkeley, California founded by Alice Waters, a chef and activist for better nutrition. Ms. Waters advocates that the food economy should be "good, clean, and fair". Berkeley is also home to a School of Public Health at the University of California and the city is across the bay from San Francisco which was the site of the 2012 annual meetings of the Society for Public Health Education and the American Public Health Association.
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Reader's Guide:

What should preprofessionals look for in these pages?

Robert Jecklin, M.P.H, Ph.D., Assistant Professor, Coordinator of Undergraduate Preceptorships, Department of Health Education and Health Promotion, University of Wisconsin-La Crosse

Abstract: Reader's Guide appears in each issue and suggests what preprofessionals should look for when they are reading the articles in this journal. This guide varies from one issue to another, while it is not intended to be a complete text on program development, the guide always emphasizes something important about the process of program development in community health education. This edition emphasizes the areas of responsibility recognized by the National Commission for Health Education Credentialing, Inc.

Key Words: Assessing Needs/Assets/Capacities, Planning, Implementing, Evaluating and Researching, Administering and Managing, Resource Person, Communicating and Advocating

Introduction

The National Commission for Health Education Credentialing, Inc. recognized seven areas of responsibility for Certified Health Education Specialist (CHES) and Master Certified Health Education Specialist (MCHES). Preprofessionals in an undergraduate program are encouraged to look for the seven areas of responsibility when they read the articles in this journal. Look for how the authors explained their work assessing, planning, implementing, researching-and-evaluating, communicating-and-advocating, and serving as a resource person.

Assessing

When you read an article, look for how the authors described their assessment work. Were any theories or models used to guide the authors assessment? Did the authors use existing sources of information or did they develop instruments to collect information? What kinds of information did the authors collect about needs, assets, or capacities? What was the population of interest for the authors? Did the authors define important terms?

How many people were in the population of interest and what were their demographic and social characteristics? What health concerns were identified? What kinds of rates were used to measure morbidity, disability, fertility, and/or mortality in the population of interest? What genetic, behavioral, and environmental factors were identified in the causation, mediation, and/or prevention of the health concern(s) in the population(s) of interest? What knowledge, skills, attitudes, and/or beliefs were assessed in the population?
Did the authors look for what fostered or hindered important learning? Did the authors describe the influence of existing resources and programs on the health concern(s)? Did the authors identify priority segments in the population? How did the authors summarize and prioritize needs based on assessment findings?

**Planning**

When you read an article, look for how the authors described their planning work. Who did they involve in making decisions about a plan to promote health? How were members of the population(s) being served involved in the planning decisions? Who and how were other stakeholders involved in planning decisions?

What goals, objectives, or other forms of direction were established through planning? What resources were identified as necessary for progress in the directions identified in the plan?

What strategies and interventions were described in the plan? How was the selection of strategies and interventions influenced by legal, ethical, and cultural considerations? What pilots were conducted to assess the viability of strategies and interventions? Did the plan describe a scope, sequence, and overall logic that was consistent with assessment findings and the results of pilot interventions and/or strategies?

**Implementing**

When you read an article, look for how the authors described their implementation work. As part of their implementation, did the authors write about collecting baseline data and then initiate implementation of their plan? Did they describe monitoring their plan and making modifications that were responsive to emergent conditions? Did implementation involve training others to assume important roles in implementation?

**Evaluating and Researching**

When you read an article, look for how the authors described their evaluation and research work. Did they describe a plan for evaluation or research? What instruments did they use to collect data? How did they analyze and interpret their data?

How did they explain their findings? What relevance did their findings have for future program efforts or further research? What conclusions were made and did the findings support those conclusions?

**Administering and Managing**

When you read an article, look for how the authors described their administrative and management work. What financial, personnel and other resources were managed and/or administered by the authors? How much time and how much money were required to do this program?

What actions did the authors perform to assure acceptance and support for the program? Did the authors describe collaboration with one or more community organizations?

**Communicating and Advocating**

When you read an article, look for how the authors described their communication and advocacy work. What marketing analysis and planning did the authors describe to assure sufficient participation and support for their program? Did their program include promoting the use of health care or other related services?
Did the authors advocate for changes to the physical or social environment?

What messages were important? What theories were used to understand populations of interest, tailor important messages, and select important channels for communication?

**Serving as a Resource Person**

When you read an article, look for how the authors discuss the use of health-related information to guide assessment, planning, implementation, evaluation, and managing resources. What sources of health information were used, and were those sources credible, current, and complete for the type of program being described in the article? In addition to providing health-related information to the public, how do the authors describe the sharing their health education expertise with other workers and professionals through consultation and training.

**Summary**

Become a critical reader of literature about health education practice and research. Read what was written and identify how the narrative describes different areas of responsibility in health education. Notice what appears to be missing and compose questions you would ask the authors. Take advantage of the author's experience and think about how you would do this differently based on the author's experience.

The following resources may be helpful.


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I. Freshman/Sophomore Years

A. General Education Requirements

B. Interdisciplinary Requirements

<table>
<thead>
<tr>
<th>Credits</th>
<th>Course #</th>
<th>Course Title</th>
<th>Prerequisites</th>
</tr>
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<tbody>
<tr>
<td>4</td>
<td>BIO 103/105</td>
<td>Introductory/General Biology</td>
<td>*</td>
</tr>
<tr>
<td>3</td>
<td>CHE 240</td>
<td>Community Health Education Foundations</td>
<td>*</td>
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<tr>
<td>4-5</td>
<td>CHM 100</td>
<td>Contemporary Chemistry (4 credits)</td>
<td>MTH 150 or concurrent enrollment or placement into MTH 151 or higher</td>
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<td></td>
<td>Or CHM 103</td>
<td>General Chemistry I (5 credits)</td>
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<tr>
<td>3</td>
<td>HED 205 (F/S)</td>
<td>Introduction to Health</td>
<td>*</td>
</tr>
<tr>
<td>3</td>
<td>HPR 105</td>
<td>Creating a Healthy, Active Lifestyle</td>
<td>*</td>
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<tr>
<td>4</td>
<td>MTH 145</td>
<td>Elementary Statistics</td>
<td>Math placement level</td>
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<tr>
<td>4</td>
<td>MIC 130</td>
<td>Global Impact of Infectious Disease</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>ESS 205</td>
<td>Human Anatomy (or Bio 312)</td>
<td>BIO 103/105</td>
</tr>
<tr>
<td>3</td>
<td>ESS 206</td>
<td>Human Physiology (or Bio 313)</td>
<td>BIO 103/105</td>
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<tr>
<td>3</td>
<td>CST 365</td>
<td>Communication in Teams</td>
<td>CST 110</td>
</tr>
<tr>
<td>3</td>
<td>Psychology/Sociology or other Social or Behavioral Science</td>
<td>Check Catalogue</td>
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*Grade of "C" or better required in the courses listed above

II. APPLY FOR ADMISSION TO COMMUNITY HEALTH EDUCATION PROGRAM

a. Please contact Department of Health Education and Health Promotion for details.

b. Must be admitted to CHE program in order to enroll in core courses.

III. AFTER ADMISSION TO THE COMMUNITY HEALTH EDUCATION PROGRAM

A. Core Course Sequence

<table>
<thead>
<tr>
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<tr>
<td>3</td>
<td>CHE 340</td>
<td>Epidemiology &amp; Community Health Problems</td>
<td>HED 205, CHE 240; CHM 100/103; BIO 103/105</td>
</tr>
<tr>
<td>3</td>
<td>CHE 350</td>
<td>Biometry and Research Design</td>
<td>HED 205, CHE 240, MTH 145</td>
</tr>
<tr>
<td>3</td>
<td>HED 335 (F)</td>
<td>Human Ecology &amp; Environmental Health</td>
<td>BIO 103/105; CHM 103*</td>
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<tr>
<td>3</td>
<td>HED 345 (F)</td>
<td>Mental and Emotional Health</td>
<td>HED 205</td>
</tr>
<tr>
<td>3</td>
<td>HED 437 (F)</td>
<td>Theories of Health Behavior</td>
<td>HED 205, CHE 240</td>
</tr>
<tr>
<td>3</td>
<td>CHE 440</td>
<td>Program Development in CHE</td>
<td>HED 205, CHE 240, 340, 350</td>
</tr>
<tr>
<td>3</td>
<td>CHE 441</td>
<td>Human Disease Prevention &amp; Control</td>
<td>ESS 205 and 206 or BIO 312 and 313</td>
</tr>
<tr>
<td>3</td>
<td>HED 477 (F)</td>
<td>Grantseeking in Health, Human Services,</td>
<td>HED 205, CHE 240, 340, 350</td>
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<td></td>
<td></td>
<td>and Education Professions</td>
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<tr>
<td>2</td>
<td>CHE 491(F/SP)</td>
<td>Senior Seminar in CHE</td>
<td>Final Semester on Campus, b/4 CHE 498</td>
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B. Content Courses

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<tbody>
<tr>
<td>3</td>
<td>HED 320 (SP)</td>
<td>The U.S. Health Care System</td>
<td>Junior Standing</td>
</tr>
<tr>
<td>3</td>
<td>HED 425 (F)</td>
<td>Violence and Injury Prevention</td>
<td>Junior Standing, BIO 103 or 105</td>
</tr>
<tr>
<td>3</td>
<td>HED 469 (SP)</td>
<td>Drugs, Society, and Human Behavior</td>
<td>Junior Standing, ESS 205 &amp; 206 or BIO 312 &amp; 313</td>
</tr>
<tr>
<td>3</td>
<td>HED 472 (SP)</td>
<td>Sexual Health Promotion</td>
<td>Junior Standing</td>
</tr>
<tr>
<td>3</td>
<td>HED 473 (SP)</td>
<td>Health Aspects of Aging</td>
<td>Junior Standing, HED 205 and CHE 240*</td>
</tr>
<tr>
<td>3</td>
<td>HED 474 (SP)</td>
<td>Nutrition Education</td>
<td>Junior Standing</td>
</tr>
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</table>

C. Electives (6 credits total from HED, CHE, SHE, or Advisor Approved Courses Outside the Department)

<table>
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<th>Course Title</th>
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<tr>
<td>3</td>
<td>HED 412 (SP)</td>
<td>Women’s Health Issues</td>
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<tr>
<td>3</td>
<td>Elective</td>
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</table>

D. Final Semester-Fall or Spring (15 credits)

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<th>Credits</th>
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<th>Course Title</th>
<th>Prerequisites</th>
</tr>
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<tbody>
<tr>
<td>15</td>
<td>CHE 498</td>
<td>Preceptorship**</td>
<td>**2.75 MGPA &amp; CGPA; Apply for and receive recommendation from HED faculty, Successful Completion of ALL CHE/HED Requirements IA &amp; B; II A-C</td>
</tr>
</tbody>
</table>

TOTAL HEHP CREDITS: 20 (CHE core) + 30 (HEHP content) + 15 (CHE Preceptorship) + 6 (elective) = 71 credits

TOTAL GEN ED/INTERDISCIPLINARY CREDITS: 51 credits minimum

*See HEHP Dept., room 203 Mitchell, for override if you have not satisfied these course prerequisites.
Risky Drinking: Addressing the Norms, Changing the Culture

Erin Lunt, Jenna Wilson, Tessa Whitemarsh, Kaitie Ringelstetter, Chris Griffith  Undergraduate Candidates in Community Health Education in the Department of Health Education and Health Promotion at the University of Wisconsin-La Crosse

Abstract: Binge drinking is and has been a problem for the University of Wisconsin- La Crosse (UWL) community, the city of La Crosse, the state of Wisconsin, and our nation as a whole. Because of this we created the program- Binge Drinking: Addressing the Norms, Changing the Culture program targeted towards UWL athletes, UWL students under the age of 21, and UWL students over the age of 21. Literature available pertaining to this topic indicates that using a harm reduction approach, addressing social norms, making a plan for drinking, and teaching safe drinking behaviors are the best ways to prevent risky drinking behaviors. Presentations were given to different target populations using the harm reduction approach. To evaluate effectiveness of this program, a pretest and posttest were designed.

Key Terms: binge drinking, health determinant, heavy drinkers, moderate drinking
Introduction

Alcohol is one of the world’s leading health risks and is an underlying factor in over 60 types of diseases and injuries, accounting for approximately 2.5 million deaths each year ("Global status report," 2011). In the United States there are approximately 80,000 deaths attributable to excessive alcohol use each year, making it the 3rd leading lifestyle related cause of death in the nation. Alcohol consumption is responsible for almost 2.3 million years of potential life lost (YPLL) annually ("Alcohol and public," 2012).

In 2008, Wisconsin had the highest rates of binge drinking (23%), current alcohol use (67%), and heavy drinking (8%) in the country. In addition, Wisconsin when compared to the United States had the highest underage drinking (ages 12-20), underage binge drinking, and drinking in women of childbearing age (Population Health Information, 2010).

Binge drinking among college students is on the rise globally, nationally, and at the state level. Globally, alcohol consumption in younger aged individuals is especially detrimental and is the world’s leading risk factor for death in males aged 15-59 ("Global status report," 2011) Nationally, individuals 18-20 years old binge drink the most of all current drinkers (51%) and among full-time college students in 2009, 63.9 percent were current drinkers, 43.5 percent were binge drinkers, and 16.0 percent were heavy drinkers. These rates have remained relatively constant since 2002 and are expected remain that way ("Results from the," 2009).

As stated above, Wisconsin has the highest rates of binge drinking in adults and of underage. Binge drinking in college students is correlated with an increased risk for unintentional injuries (car crashes, burns, and falls), intentional injuries (domestic abuse, sexual assault, and firearm incidences), sexually transmitted diseases, and unintended pregnancy in heavy, occasional and unintentional alcohol users.

Based upon the literature reviewed, alcohol consumption is a multidimensional complex behavior that encompasses genetic, social, behavioral, and environmental determinants. The physical environment is a significant determinant for binge drinking among the college student population. According to a journal article in the Alcoholism & Drug Abuse Weekly, “In a review of the landmark Harvard School of Public Health College Alcohol Study (CAS), study director Henry Wechsler, Ph.D., concludes that environment is the driving force contributing to binge drinking on campus. Colleges with a drinking culture, few policies on or off campus, and easily accessible alcohol on or off campus, are most likely to have binge drinking” (“Binge Drinking Most Affected,” 2008).

The social environment is a substantial determinant of binge drinking among college students. Drinking alcohol is typically a way for college students to socialize. Students see drinking as an opportunity for social interaction. When individuals, under the legal drinking age of 21, drink, they binge drink. According to the CDC, “About 90% of the alcohol consumed by youth under the age of 21 in the United States is in the form of binge drinks” (CDC 2010). However, most individuals who drink binge drink, “About 75% of the alcohol consumed by adults in the United States is in the form of binge drinks” (CDC 2010). This indicates a need for individuals to avoid alcohol due to the prevalence of drinking in excess. Individuals may feel pressured to drink when in a social environment where alcohol is present, so it is best to engage in an alternative activity.

Due to the high rates of binge drinking in Wisconsin, especially among college students, and the numerous risks that can occur due to binge drinking, the topic is one of great importance. Through implementing programs
educating individuals on harm reduction methods it is possible to reduce the risk and improve health in college students, specifically individuals under 21, over 21, and athletes who live in a drinking cultured environment.

**Method**

**Global Distribution**

Alcohol is one of the world’s leading health risks and is an underlying factor in over 60 types of diseases and injuries, accounting for approximately 2.5 million deaths each year. Globally, alcohol consumption in younger aged individuals is especially detrimental and is the world’s leading risk factor for death in males aged 15-59 (“Global status report,” 2011).

**National Distribution**

For individuals under the age of 21 in the United States from 2001 - 2005 there were 4,700 alcohol-attributable deaths and close to 300,000 YPLL (“Alcohol and public,” 2012). Annually in the United States more than 500,000 students are unintentionally injured while under the influence of and more than 600,000 students are hit or assaulted by another student who has been drinking (Saltz, 2009).

**State Distribution**

In 2008 there were 1,624 deaths due to alcohol use/misuse in Wisconsin. These deaths were a result of motor vehicle accidents, Liver Cirrhosis, or other alcohol-related causes. Alcohol-related deaths are ranked fourth in the leading cause of death in Wisconsin, following heart disease, cancer, and stroke (“Alcohol and other,” 2010). In 2008 there were 4,319 alcohol-related injuries in Wisconsin.

**Local Distribution**

In La Crosse County, there were 14 alcohol-related injury deaths for 15-24 year olds from 2003-2007. Of the 14 alcohol-related injury deaths, males accounted for 13 deaths and 1 female (“Alcohol related injury, 2008”).

**Genetics as determinants of binge drinking**

Based upon the literature the researchers reviewed, a majority of evidence gathered from various studies identifies that alcohol addiction is a multidimensional complex disease with both genetic and environmental influences. Furthermore, research has revealed a wide assortment of theories concerning possible genetic predispositions, there is however no single genetic factor considered being an absolute determinant of excessive alcohol consumption.

**Physical environment as determinants of binge drinking**

The physical environment is a significant determinant for binge drinking among the college student population. According to a journal article in the Alcoholism & Drug Abuse Weekly, “In a review of the landmark Harvard School of Public Health College Alcohol Study (CAS), study director Henry Wechsler, Ph.D., concludes that environment is the driving force contributing to binge drinking on campus. Colleges with a drinking culture, few policies on or off campus, and easily accessible alcohol on or off campus, are most likely to have binge drinking” (“Binge Drinking Most Affected,” 2008).

The physical environment includes the proximity of the bars to campus or other student housing. The physical environment may also include how many stores are near the college in which students are able to purchase alcohol. The physical environment can also include drink
specials. Bars come up with drink specials to bring in more business, so it ends up being a win-win for all: the businesses make more money while the consumers get more alcohol. Along those lines as well, it is important to note that the sizes of the drinks served in the bars vary. The article “Binge Drinking in Young Adults: Data, Definitions, and Determinants” shows previous studies that have been conducted. A study conducted in 2003 indicates, “Students who reported that they were exposed to ‘wet’ environments (prevalent and cheap alcohol availability) were more likely to engage in binge drinking than peers without exposure” (Courtney & Polich, 2009).

Social environment as determinants of binge drinking

The social environment is a substantial determinant of binge drinking among college students. Drinking alcohol is typically a way for college students to socialize. Students see drinking as an opportunity for social interaction. According to the article “Binge Drinking in Young Adults: Data, Definitions, and Determinants,” “Drinking in a group leads to the experience of greater euphoria than drinking the same quantity alone and drinking in a social setting facilitates more consumption than solitary drinking” (Courtney & Polich, 2009). The Harvard School of Public Health College Alcohol Study (CAS) found that “campuses emphasizing fraternity and sorority life, for example, have higher levels of binge drinking. Students who live off campus with friends are also more likely to binge drink” (“Binge Drinking Most Affected,” 2008).

Peer influence, without question, contributes to binge drinking. College students want to feel accepted by their peers. Along those lines, a person tends to go at the same pace as their fellow drinkers when they are together. For example, if a person is with slow drinkers, then they find themselves drinking slower as well, and vice versa. When a campus is under the assumption that “everyone” drinks excessively all the time, then that’s how people will act and so will their followers, which creates the idea of an alcohol-dependent campus culture.

Behavioral Determinants of binge drinking

In La Crosse, WI there are numerous bars that implement drink specials. For example certain bars offer wristbands for specific nights of the week where an individual can get as many drinks as they want for the night after paying the wristband fee, which is typically less than ten dollars. This is influential on the amount of alcohol consumed as well as the nights of the week that individuals typically go out.

According to the article, The Effects of Price on Alcohol Consumption and Alcohol-Related Problems, “Other studies determined that increases in the total price of alcohol can reduce drinking and driving and its consequences among all age groups; lower the frequency of diseases, injuries, and deaths related to alcohol use and abuse; and reduce alcohol-related violence and other crime.” (Chaloupka, Grossman & Saffer, 2002)

The article Stress and Binge Drinking: A Daily Process Examination of Stressor Pile-up and Socioeconomic Status in Affect Regulation states, “we found that the odds of binge drinking were greater on days in which more severe stressors were experienced and on days when stressors accumulated” (Grzywacz & Almeida, 2008). This indicates that individuals need to find a coping method to their stress which will make binge drinking less likely. There are many activities that can help relieve stress in a healthy way, some of these activities include exercising, listening to music, reading, breathing exercises, and laughing to name a few. An individual most likely will have the assets to do most of these activities with ease. They may have more difficulty with the capacity to do these activities; however if a person is able to engage
in binge drinking it is probable they will be able to engage in other stress relieving activities.

**Priority Population Segments Based on Epidemiology**

Individuals who are classified as either binge drinkers, or heavy drinkers are at the most risk of experiencing the consequences of alcohol consumption. These individuals are more likely to partake in risky behaviors leading to unintentional injuries (morbidity), disabilities, and potentially death. Thus it is critical that harm reduction techniques is primarily focused to this target population.

First year students would also benefit greatly from this program in that they are adjusting to college life and may not have any knowledge or experience with alcohol and the social pressures associated. The program would be able to educate students on harm reduction techniques so that if they choose to drink, they know how to safely.

**Priority Population Segments Based on Accessibility**

Freshman and sophomores at UW-L would be the most accessible because they are all most likely living on campus. This provides an opportunity to target this population in dorm hall settings which is an accessible, comfortable environmental and location for the participants. If sophomores, juniors, or seniors are not living on campus they more than likely live close to campus and thus, travel should not be an issue.

**Priority Population Segments Based on Homogeneity**

Tailoring our program to specific homogenous groups would be very beneficial in enhancing the transfer of learning among participants. For example, a program geared toward minimal drinkers would require different material than a program for heavy - moderate drinkers. Individuals in these different levels of drinking are experiencing a wide range of influences and behaviors, which in turn require programs to be designed and implemented differently.

**Rational for priority population segments**

Initially the identified priority populations were individuals considered moderate, heavy, and unintentional drinkers. Although there are distinct characteristics of each of these populations which could be identified and addressed, it was concluded, in order to sufficiently reach the aforementioned types of drinkers’ further specificity would be necessary. As a result, the three priority populations were identified as college students under 21, over 21, and student athletes as our populations.

**Participants and Design**

Our first priority population is college students under the age of 21. The theory we chose to align our intervention activities is the Theory of Planned Behavior. The most important constructs for this population are attitude toward the behavior, subjective norm, and actual behavioral control. We wanted to be able to influence student’s attitudes towards binge drinking by showing them how practicing safe drinking behaviors will affect them more positively. We wanted to address the social pressure to engage in binge drinking because it is something that younger college students are faced with when they come to campus. Students are often surrounded by opportunities to go to house parties where binge drinking takes place to fit in or meet new friends as an underclassman. We also felt it is important to give younger college students the skills, resources and knowledge they need to make safe drinking decisions. If these three constructs are addressed in our assessment we can then see how effectively our program influenced this population.
Our second priority population is college students over the age of 21. We also chose Theory of Planned Behavior for this population. The same three constructs are important for this population but in slightly different ways. We wanted to influence attitudes towards binge drinking in the same way as our first population by showing them how safe drinking practices can affect them in a more positive way. We also want to address social pressure to engage in binge drinking but the pressure for this population is coming from a different place. This pressure may come from drink specials encouraging students to drink as much as they can, pressure to go to the bars just because of your age, or pressure to fit in at the bars because everyone is drinking more than you. Also we felt the need to provide these students the knowledge, skills, and resources needed to make safe drinking decisions. Students who don’t have proper alcohol knowledge may not know how much alcohol they are actually consuming making it difficult to control binge drinking. These three constructs are the most important to assess for this population.

Our third priority population is college athletes. The theory we chose to align our intervention activities with is the Health Belief Model. The constructs that we found most important are the sociopsychological and structural modifying factors, perceived susceptibility and severity, and likelihood of taking recommended preventative action. Of all the sociopsychological variables we wanted to address peer pressure to engage in binge drinking. Athletes tend to have higher rates of binge drinking than non-athletic counterparts. Therefore, they are more likely to be pressured into fitting in with those people that are closest to them. The structural factor we wanted to address is knowledge about alcohol and binge drinking. Students are unable to make informed decisions when lacking a proper education on alcohol. Perceived susceptibility and severity were also important to address. If students don’t think they are susceptible to consequences of binge drinking or they don’t believe the consequences are severe, they are more likely to participate in binge drinking.

Results

With the allotted time, we were able to help the Wellness Resource Center give presentations using a harm reduction approach regarding binge drinking. These presentations took form in various UW-L 100 classes, one large presentation required for freshmen college athletes, and dorm programs.

We were not able to implement a formal assessment in any of the aforementioned presentations, because we were not introduced to the assessment process in program planning until after we completed our program. We did, however, come up with assessment tools to implement if there were more time. For all three priority populations (under 21, over 21, and athletes), we would dispense a questionnaire prior to the presentation. The questionnaire is one that was already created and had been used to assess college students' behaviors and knowledge concerning alcohol.

Ideally, we would like to follow-up the presentations with a post assessment. We chose a readiness to change questionnaire. The pre-assessment asked various questions about the person's current alcohol behaviors (if any). After attending our presentation, we would like to assess how willing they are to change their behaviors or if they were even affected at all.

Although we were not able to formally assess our programs, the Wellness Resource Center coordinator, Jason Bertrand, informed us he has had students coming to him to talk about certain aspects of our presentation. It was great to hear of that.
Discussion

If we had additional time, we would like to infuse more sessions into different classes. The Wellness Center has the right idea in presenting to the UW-L 100 classes and athletes, because they are at higher risk of binge drinking, but we could expand and reach out to more students. If we had more time, we would also like to implement booster sessions to refresh knowledge. We would like to plan more hands on activities for the programs, cutting out the lecture format. We were bound by the standards of the classes we presented to, so we were unable to "put our own spin" on the presentations.

There is research that would be helpful for other health professionals to understand our health concern. It is important for other health professionals to know how to teach using a harm reduction approach. Almost all literature we came across was condoning a harm reduction approach, rather than an abstinence-based approach. Many studies have proven that harm reduction approach works. Also, through our initial literature review, it had been brought to our attention that a harm reduction approach needs to be taught even earlier than being a freshman in college; it should begin in high school. It is important to give students the knowledge and tools necessary to make informed decisions in the future. We want high schoolers to transition into their freshman year at college feeling confident that they can make their own decisions and not feel like they need to copy others' actions to "fit in."

There are a few things we learned throughout this semester-long binge drinking program that will influence future practice efforts. First, we discovered how influential social norms are on college students in regards to binge drinking. Studies show that students overestimate how much their peers are drinking. Secondly, as mentioned previously, understanding a harm reduction approach is very important. Thirdly, motivational interviewing would be beneficial to students who chose to do one-on-one sessions with a health professional. We were not skilled in motivational interviewing, so we did not pursue this aspect.

References


Alcohol and public health. Retrieved from website:
http://www.cdc.gov/alcohol/faqs.htm


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Community Health Education
Admission to the Undergraduate Program

1. **Know yourself and your interests.**
   A career in Community Health Education is not for everyone, but almost everyone can find interesting knowledge and experience in this major.

2. **Make a decision.**
   If you want to major in Community Health Education, contact the advising assistants to the Dean in the College of Science and Health to declare your major as Community Health Education. Once you declare, you will be assigned an advisor and you will receive important information about the major.

3. **Follow through on your commitment.**
   Do your best in all classes to assure that you have a high grade point (2.75 is required for admission, and higher grade points are required by most graduate programs). Prioritize successfully ("C" or better) completing all interdisciplinary requirements. You may take Content Courses before completing your interdisciplinary requirements, but Core Courses are reserved for those who are admitted to the major when they successfully completed all interdisciplinary requirements with an overall UWL cumulative grade point of 2.5 or higher. Interdisciplinary requirements and Core Courses are detailed on the Advising Sheet which appears in this manual.

4. **Develop your interests.**
   Be aware that your interests may change and you should reflect on this as you start to think about "where you want your education to take you". If you are interested in graduate or professional schools, what will best prepare you for those challenges? If you are focused on work, what health concerns interest you most? What populations do you want to serve? What coursework or minors will help you be successful? See your advisor, talk to other faculty and other knowledgeable persons, volunteer, and do unassigned reading about your interests.

5. **Bridge to work and continuing education.**
   Align yourself with a preceptorship that is consistent with your interests.
Painkillers: A Gateway to Heroin

Nina Gregerson, Quinn Devlin, Meghan McClellan, and Amanda Barfknecht
Undergraduate candidates in Community Health Education Program at the University of Wisconsin-La Crosse

Abstract: Pain Killers: A Gateway to Heroin is an educational program designed for patients who will be prescribed opiate pain medication. This program is aimed to increase their knowledge, self-efficacy, awareness, and skill sets for safe management of prescription opioids and prevention of the use of heroin. The program was to be implemented at the La Crosse Gundersen Lutheran Hospital and included an informational session and addict presentations. Brochures were created for program participants to take home which would include all of the important take home messages from the program. pre- and post-tests were designed to evaluate the effectiveness of this program.

Key Terms: dependence, addiction, narcotics, heroin, opiates, analgesics

Introduction

With the increasing rate of prescribed opiates, opiate abuse and overdose is becoming ever more common. According to the Centers of Disease Control and Prevention (CDC, 2012), the misuse and abuse of prescription painkillers was responsible for more than 475,000 emergency department visits in 2009, a number that nearly doubled in just five years. The
National Institute on Drug Abuse (2011) claims that opiates, or narcotics, tend to have immediate effects that either slow down or speed up the nervous system. The most serious side effect resulting from opiate abuse is trouble with breathing, called ‘respiratory depression’. They [opiate medication] can be very dangerous, and even fatal, if taken incorrectly. Even a single large dose can cause severe respiration depression and death. Not only does opiate abuse pose a significant health concern, but there has been evidence to suggest that the increases in opiate prescriptions are associated with a rising incidence of heroin use.

Hennepin County Sheriff Rich Stanek can attest to just that. “An increase in prescription drug abuse is fueling a rise in heroin and synthetic drug use. Drug dealers charge more for prescription opiates such as Oxycodone, so addicts eventually switch to the cheaper and more potent heroin. They [prescription opiates] are the gateway to heroin. Pick any addict, come to my jail and ask them!” (Star Tribune, 2012).

People who have become dependent on prescription opiates may run out of financial resources or begin to experience greater barriers in obtaining their medications. As a result, prescription opiate users may shift to heroin in order to experience the same ‘high’ at a significantly lower price. “I’ve never met a heroin addict who didn’t start with prescription narcotics,” stated Shean Wheeldon, a recovering addict (Shean Wheeldon, personal communication, December 1, 2012). In agreement, Police Chief Dean Mooney from Mound, MN said (Star Tribune, 2012), “Teens that can’t get painkillers—or have developed a tolerance [to these painkillers]—are moving to heroin.” The association between prescription opiate abuse and heroin use increases the weight of the health concern. The two most prevalent sources of obtaining prescription opiates are from friends/relatives and from a doctor prescription. Fifty-five percent of people who abuse prescription painkillers get their drugs from a friend or a relative, whether they are aware or unaware of the abusers use; while 17.3% of abusers get their drugs directly prescribed from a doctor (CDC, 2012).

Considering the most prevalent sources where abusers obtain their drugs, this health concern can be most effectively be addressed by increasing awareness and education among patients who are prescribed opiates.

**Methods**

Before decisions could be made about what populations to focus on and what activities would be most beneficial to implement, existing research on social, physical, and genetic determinants was reviewed.

Physical environments that have been associated with heroin use and abuse include homelessness, lack of adequate healthcare services, and high school quality. Heroin use among homeless populations is seen as a method for alleviating uncomfortable realities of living on the streets such as inclement weather and criminal activity. The state of homelessness is also associated with inadequate healthcare services and, therefore, minimal drug treatment options for those suffering from addiction. Among youth, associations included the condition of high schools that were attended and the link to alternative/charter schools and those they may be in ‘despair’.

Further, social environments play a significant part in helping to narrow down populations that
should be considered priorities. Lower socioeconomic statuses have been linked to the issue of heroin addiction, as well as those who have less than a 12th grade education, are unmarried, or have lower rates of social integration during young adulthood. There were also some indicators of protective qualities that were associated with resisting or non-addictive tendencies such as those who associate with religious or spiritual affiliations.

One last consideration that was made was genetic links to heroin abuse. It was found that the specific genotype pattern, AG-TT-GG, was associated with heroin addiction. Recovering heroin addicts may have a more difficult time resisting cravings due to the length of a specific polymorphism, DRD4VNTR, which is related to dopamine function and may make sobriety more difficult. Psychiatric comorbidities, especially those with antisocial personality and mood disorders, have been found to be a significant factor in heroin use among youth.

After a review of the necessary literature, three priority populations were selected: unintended users, patients being prescribed opiate pain medication, and physicians, residents, and pharmacist. Activities chosen for unintended users included an informational session, a skill-building seminar, and a brochure was given for an at-home resources. Activities chosen for physicians, residents and pharmacists included a similar informational session, a video on prescription opiates leading to heroin use, and a brochure was created to summarize important notes touched on during the informational session.

Due to accessibility and our research findings, our collaborative decided that patients being prescribed opiate pain medication would be the best population to address. *Pain Killers: A Gateway to Heroin* was implemented at the Gundersen Lutheran Hospital in La Crosse, Wisconsin. During pre-operative doctor visits, patients were asked if they were interested in attending an informational session about the medication that would be prescribed after their procedure. Interested patients would be asked to sign a sign-up sheet and provide contact information.

After all of the sign-up sheets were collected, the program facilitators contacted the patients to confirm their participation and gave a brief overview of the session including the time and itinerary of the program. The participants were also asked to fill out a pre-assessment prior to the program and to bring it with them when they attended.

The program was held at the Gundersen Lutheran Patient Education Auditorium. When participants entered, they were asked to drop the pre-tests into a basket sitting on the table by the door. If a participant had forgotten their pre-test, they were promptly given a new one and asked to take a minute to complete it before the session began.

A PowerPoint presentation guided facilitators as they discussed the necessary information. First, facilitators gave global opiate use statistics, as well as nationally and locally. They also explained what an opiate is and how it can lead to heroin use. Additionally, safety concerns were covered including the importance of following prescription directions, overdose, and the addictive nature the medication. Finally, the facilitators covered how to safely discard of ‘leftover’ medication so it does not get in the hands of unintended users. A brochure was
handed out conveying concurrent take home messages.

Approximately a week after the program, post-test evaluations were to be mailed to the participants in order to rate the effectiveness and likability of the program. We would expect to receive the results from the evaluations within a month of the program. Program facilitators would gather and analyze the responses received.

**Evaluation Design**

The effectiveness in achieving the goals and objectives of this program were evaluated by the use of pre- and post-tests. To create baseline knowledge from the participants, a ten question assessment was mailed to the participations upon agreement to attend the program. This created a basis of participant knowledge before the program was implemented. The post-tests, consisting of the same questions as the pre-test, were mailed to those who attended the program one week after the program implementation. We expected responses from the participants within a month of the program. The post-test also evaluated the likability of the program.

Responses from the pre- and post-assessments was compiled and analyzed by the program facilitators. Differences between the pre- and post-assessments will be used to evaluate the effectiveness of this program in hopes to continue the efforts.

**Results**

Due to time constraints, this program has not yet been implemented. If interest continues, this program could be implemented by students in future CHE 440 classes.

It is expected that upon completion of this program, the evaluation will demonstrate an increased awareness and knowledge amongst patients. As a result, it is anticipated fewer people will abuse opiate pain medication. The results should achieve the goals and objectives set out by our collaborative.

**Discussion**

The results listed in the previous section are ideal projections if the program were to be implemented. Therefore, since we were unable to fully implement our program, it is difficult to determine what can be changed or done differently in terms of the program itself. However, since we were able to move through all of the planning steps, we do have recommendations of what we could have done differently. One recommendation is to understand the importance to review the literature before making conclusions on intervention strategies or population segments. When beginning our journey, we picked out populations before we had evidence they were the correct choices. After further research and key informant interviews, we finally had a better understanding on what populations to use and what activities would be the best fit.

If more time and resources were available, this program could easily be implemented. We would have been able to implement the program at Gundersen Lutheran for patients being prescribed opiates. Also, if more time allowed, pre- and post-evaluations could have been administered in order to assess the program in order to improve it for future use. Further, we believe that with additional resources, time, and positive feedback from the initial implementation, we could possibly implement this same program at other Gundersen Lutheran
Hospitals and Clinics throughout the tri-state area.

Overall, this program taught us a lot about the program planning process. We learned from the literature review that it is imperative to exhaust the literature in order to get an accurate idea on what priority populations to reach and what activities are the best to administer to them. The rationale allowed us to state what the fundamental reason why we chose the topic. This task made us search to see if our health concern was recognized on a national, state, and local level. The Plan for Assessment and the Program Plan permitted us to really think about implementing our program and understanding all of the important aspects that go into doing so, such as the budget and timeline. Even if we were unable to implement our program, I believe my collaborative group learned a great deal and was able to benefit greatly from this semester-long collaborative project.

Resources


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MISSION OF ESG

The mission of the honorary is promotion of the discipline by elevating the standards, ideals, competence and ethics of professionally prepared men and women in Health Education.

GOALS

The goals of the honorary include:

• Supporting the planning, implementation and evaluation of health education programs and resources
• Stimulating and disseminating scientific research;
• Motivating and providing health education services
• Recognizing academic achievement
• Supporting health education advocacy initiatives
• Promoting professional standards and ethics
• Promoting networking activities among health educators and related professionals

To learn more about joining the Eta Sigma Gamma chapter at University of Wisconsin-La Crosse, you may contact a student member or Drs. Rees or Caravella in the Department of Health Education and Health Promotion.
The Unfortunate Reality of Sex Trafficking

Vanessa Bauer, Rachel Hessel, Garrett Scray and Lindsay Seccombe Undergraduate candidates in Community Health Education Program at the University of Wisconsin-La Crosse

Abstract: With our program, we aimed to raise awareness about sex trafficking in the area among the general public. Sex trafficking is a health concern that very few people recognize as a local issue, even though it is occurring every day in our own backyards. We began with a literature review that helped us to narrow our focus and identify what types of activities our program should include. We learned about the high prevalence of sex trafficking in Minnesota, and that although it has actually been identified as a major health concern in the state, there is still a lot to be done in terms of raising awareness so that it can be controlled and eventually prevented. We used this knowledge to develop a program that would reach a great amount of people in a short amount of time (given we only had one semester to plan, implement, and evaluate). We decided to host a screening of Nefarious: Merchant of Souls, an award-winning documentary that guides viewers across several continents, exposing the different aspects of sex trafficking and sexual exploitation. Following the film screening, we had a representative from Mission21 (an anti-sex trafficking organization out of Rochester, MN) discuss sex trafficking on a more local level to emphasize that sex trafficking is a concern right here in La Crosse, WI in addition to all of the places discussed in the documentary. The feedback we received from program participants revealed that our program did what it was intended to do—increase peoples’ awareness about sex trafficking, especially on a local level.

Key Words: sexual exploitation, sexual trafficking, sexual denigration, human trafficking, temperament, Stockholm syndrome, crude mortality rate, street girls, pimp, prostitute, John School
Introduction

Each year between 100,000 and 300,000 children are exploited by the sex industry in the United States alone (Schauer & Wheaton, 2006). The average age of children being sex trafficked is between 12 and 14 years old (CBS MN, 2012). The sex industry operates underground, which means there is inadequate regulation from the government and awareness in the public regarding this health issue. Take 13 year old Sara Slattery for example, as a sixth grader in Coon Rapids, MN she first met her 20 year old pimp Nikki at a friend’s birthday party. After opening up to Nikki about her problems at home, Nikki offered Sara an escape and a way to earn her own money and independence. Three days later Sara turned her first ‘trick’ and entered the world of sex trafficking. After 18 months of being sexually exploited, beaten, and raped, Sara and a friend escaped via bus to her hometown of Coon Rapids, MN where she told her story to the authorities. Only a few months later Sara and her friend disappeared; after living a life of violence and abuse they could not function within society (Critchell, 2003). Sara’s story is not unlike many of the other girls being forced into the world of sex slavery and is a good example of how the sex industry works. The sequence of events that were described above are unacceptable and attention needs to be brought to this important health issue, which is why our program strives to raise awareness about the sex industry.

Through our literature review and the course of our program development and implementation, three factors became evident within the issue of sex trafficking: the demand or market for sex, strained family or interpersonal relationships, and substance use. The level of demand or active decision to buy sex provides a market for pimps to sell and profit from exploiting other human beings. An individual’s family can hold significant influence in their decisions regarding high risk behaviors and/or their vulnerability to predators. And substance use can put an individual at an elevated risk depending on the type of substance and the setting in which it is used. Further research provided that there are also three target population within which efforts can be made to address these three factors of trafficking, they are: legislators, law enforcement and college students. The results of our research within this program provide that legislators in Minnesota and Wisconsin are a vital piece to improving the health and well-being of victims or potential victims of sexual exploitation. They have the power to create laws that may either encourage or discourage sex-trafficking behaviors. The laws they create affect everyone living in the area they represent, so changes on a larger scale such as this will have a trickle-down effect. Law enforcement officials in Minnesota and Wisconsin have the possibility of playing a significant role in improving the outcomes of sex trafficked victims. Many times law enforcement officials come in contact with sexually exploited women and girls because of criminal atmosphere the individuals are trapped in. This creates a great access point to the sex trafficked population and is an epidemiologically critical reason to educate these law enforcement officials. College Students in La Crosse Wisconsin have the potential to play a large role in the prevention of Sex Trafficking. La Crosse is unique in terms of geographic location because it is within three hours of three major cities, Milwaukee, Minneapolis, and Madison.

Methods

Our research was focused in three main areas of the environmental, genetic and behavioral causes within sex trafficking. It provided that one’s home environment clearly has a tremendous impact on their behaviors throughout their entire lifespan. For example, if a child does not feel safe or secure in their household, they have an increased likelihood of running away. According to Estes and Weiner, an estimated 60% of the 250,000 U.S. children involved in commercial sexual exploitation annually are runaway, throwaway, or homeless children under the age...
Sex Trafficking of 18 (Allen, 2010). What is even more unfortunate is that having experiences like this early in life can determine one’s expectations and vulnerability to high risk behaviors later in life, which could ultimately determine the type of environment they stay in throughout adulthood. Another determinant related to victimization is a lack of resources within the community, which may be due to factors such as low socioeconomic status and early motherhood (Lalor & McElvaney, 2010). A final determinant within one’s physical environment has to do with sex in the media. Sex is everywhere. Members of our society are exposed to sex at a very young age and are bombarded with sexual messages throughout childhood, adolescence, and adulthood. A research study guided by The Kaiser Family Foundation states that exposure to media sources can influence one’s behavior (Huston et al., 1998). So, with sex being such a “common” phenomenon, it is no surprise that sex trafficking has become such a profitable business.

Behavioral genetics has been a major topic of interest for researchers in the past couple of decades as well, and while there is still much to learn, recently connections have been made that link personality to genetics. According to Jean Mercer, biological factors, having to do with the central nervous system, determine an individual’s temperament (Mercer, 2009). Additionally, one particular gene has been proven to be linked to personality. This gene produces the protein that is responsible for forming a dopamine receptor known as DRD4. DRD4 is linked to novelty-seeking behavior, drug abuse, and attention-seeking (Azar, 2002). All of which can play a role in one’s involvement with sex trafficking; however, these do not provide a feasible or noteworthy effort towards prevention and intervention within this health issue, so more reliable and behavior related methods will be the focus.

There are several contributing behavioral determinants within this health issue which are summarized in the table on the next page.

The demand market for sex and consequently sex trafficking as well as the behavior of the pimps or traffickers is at the top of this chart because they are the primary cause for this health issue. Following these behavioral concerns are that of child sexual assault and child abuse, these behaviors introduce children to the inequalities and violent atmosphere of sexual abuse at an early age and therefore change their understanding and perception of their own sexuality. This is represented by the following behaviors of the victims themselves, sexual denigration and engagement in high risk sexual activities, which not only show the negative impact this violence has within the victim’s personal sexuality, but also how early sexual violence puts victims at risk for re-victimization. The last three rows of behavior rows of behavioral determinants are independent and can be a result of many factors, but are all indicators and even possible predictors of sex trafficking victimization.

Research in these areas was the basis for our three target populations and the programs that are directed towards their activities within ending sex trafficking. The first is legislation and the goal of our program would be to engage legislators in several educational sessions where we, along with collaborative partners and professionals, share relevant information related to sex trafficking. Before actually bringing everyone together, we would have to establish partnerships with various organizations, groups, and individuals who are willing to participate in the educational aspect of the program. We would then share research
### Behavioral Determinants of Sex Trafficking

| **Demand market for sexual prostitution.** | “The purchasers of sex acts are the primary actors and constitute the primary level of the demand. Without them making the decision to buy sex acts, prostitution would not exist.” (Hughes et al., 2004, pg 2) |
| **Pimps/Traffickers seeking a profit from industrializing sex.** | “The second factor or level of demand is the profiteers in the sex industries. They have vested economic interests in maintaining the flow of women from sending to receiving countries.” (Hughes et al., 2004, pg 2) |
| **Child Sexual Assault** | “Child sexual assault leads to impairments in attachment, psychological symptoms, and negative attributes and coping behaviors, resulting in behaviors that increase the risk of rape.” (Lalor and McElvaney, 2010, pg 166) |
| **Child Abuse** | “Abuse in childhood interferes with the development of affect regulation and interpersonal relatedness, which in turn affects women’s awareness of danger and ability to respond to threatening situations.” (Lalor and McElvaney, 2010, pg 166)  
“Experiencing child maltreatment was linked to running away, initiating substance use at earlier ages, and higher levels of sexual denigration of self/others. Sexual denigration of self/others was significantly related to the likelihood of prostitution as a minor.”(Reid, 2011, pg 146) |
| **Sexual Denigration** | Sexual denigration of self or others was significantly related to eight of the variables, including indicators of child maltreatment, running away, initial age of drug and alcohol use, and being prostituted as a minor. (Reid, 2011, pg 150) |
| **Engagement in high risk sexual activity.** | “Numerous studies have noted that child sexual abuse victims are vulnerable to later sexual re-victimization, as well as the link between child sexual abuse and later engagement in high-risk sexual behavior.” (Lalor and McElvaney, 2010, pg 166) |
| **Running Away** | The Bridge for Youth was founded by members of the Sisters of St. Joseph Catholic order in 1970 in response to the growing number of unaccompanied youth on the streets of Minneapolis. The sisters noticed these youth were increasingly vulnerable to exploitation, prostitution, violence, and illness.  
Between 10,000 and 12,000 youth under 18 in Minnesota experienced at least one episode of homelessness on their own. On any given night 500 to 600 youth are homeless (Wilder Research Center, “Homelessness in Minnesota 2006”). The majority of these homeless youth are in the metropolitan area served by The Bridge. |
| **Early Child Bearing**  
**Single Motherhood**  
**Divorce** | These behaviors often result in a lack of resources; this in combination with a lack of alternatives (due to weak family ties or support and social isolation) leads to greater risk of victimization and/or prostitution. (Lalor and McElvaney, 2010, pg 166) |
| **Alcohol and Drug Abuse** | Alcohol and drug consumption increase the risk of having an initial victimization experience. (Lalor and McElvaney, 2010, pg 167) |
findings and other valuable literature with legislators related to sex trafficking, emphasizing more local information. We would also involve key informants in the educational sessions, where they are able to share personal experience related to sexual exploitation so as to demonstrate the need for change. These sessions would include a review current laws and policies related to the sex trafficking in each state via an interactive lesson. This would ideally result in legislators applying what they had learned through the literature review to analyze the current laws and policies and why they do not work as effectively as they could. The next initiative of this program would be to motivate legislation to develop their plan of action by setting goals and creating a timeline. This process will be most effective by identifying barriers and the available resources of the surrounding community and then involve stakeholders and key informants in that process. It would also be essential to incorporate follow-up sessions with the program to monitor the progress and impact our educational sessions had in the implementation of legislation regarding sex trafficking.

The second target population is law enforcement. The focus of our program within this population would be to implement training on the effective administering of a sex trafficking risk factor screening tool. This will allow law enforcement officials to aid and act as a resource for victims of sex trafficking. In situations where sex trafficked victims slipped through the cracks of the system or they were prosecuted for crimes they were forced to do by their pimps; they will now be able to be helped. The training on a risk factor screening tool will take some of the guess work out of screening individuals under arrest and should make police officers’ jobs a little easier. Training and implementation of the risk factor screening protocol will involve:

i. Two community health educators to run the training

ii. New policy in the police department requiring the use of screening protocol in situations where trafficking is suspected

iii. Handouts with how to identify a trafficked victim

iv. Handouts with screening questions to be asked

v. Training on how and when to use the handouts

After getting the screening protocol approved by cities with known sex trafficking issues (Minneapolis, MN; Rochester, MN; St. Paul, MN) the implementation training will be mandatory to attend by police officers who work in the field. The training will become mandatory and police officers will attend because of the increasing prevalence of sex-trafficking within the U.S., their state (MN), and their city (Minneapolis, Rochester, or St. Paul). Each year between 100,000 and 300,000 children are victims of sexual exploitation in the United States alone (Schauer & Wheaton, 2006). Minneapolis in particular, has come to be known as a factory that produces sex workers, and ranks among the top 13 U.S. cities for commercial sex trafficking. Las Vegas law enforcement has referred to the Twin Cities as an assembly line for adolescent prostitutes (Critchell, 2003). They have stated that between 8 and 12,000 individuals are involved in the said industry every day in Minnesota (Carter, 2006). The activity will take place in a police station meeting room. It will be mandatory for them to attend the training. If the issue in the community is as startling as statistics show, officers will want to attend the training and use the tools we are supplying. Participants in the event will have to give up their time in order to participate in the training. Funding for the program will come from the police department budget and the trainings will be performed when each shift has a day off. This will count for continuing education hours for participants for their continuing education requirements, but they will not be paid for the training. In making the training free and locating it at the police department we reduced financial and
convenience barriers to attend the training session. We will communicate to the police officers via their captain’s orders during weekly meetings that they must attend the training session. As well as supply handouts with the activities that will be taking place. It will also include PowerPoint/Prezi presentation by community health educators on:

1. situations to use the screening tool
2. how to use the screening tool
3. how to identify a trafficked victim
4. resources that you can direct victims to
   a. Scenario walk-throughs using the screening the tool
   b. Question and Answer Session
   c. Follow-Up Session to Address Issue (2 weeks after original training)
   d. Evaluation of screening tool use and effectiveness

The end results will to empower police officers to be able to properly identify sex trafficked victims through the proper training and use of a screening tool.

Results

Our group only had sufficient time and resources to address the priority population of college students. This was an efficient choice being students on campus and having resources available through the University and Mission21. We implemented the showing of Nefarious with a question and answer session afterwards. Participants were able to receive a “Live free. End Slavery” bracelet as well as a handout that references several ways they could help end trafficking, such as memorizing a hotline number. A total of around 100 participants attended our program, in comparison to 30 participants for a showing of Nefarious put on in a similar setting by a Winona State student (Figure 1). Our evaluation revealed that participants felt the event was valuable and that the clear layout of information empowered them to discuss what they had learned within their conversations with friends and family. We received comments such as “I had some previous knowledge of sex trafficking …but the global layout within the documentary was fantastic and really gave me a better understanding of how this issue works itself into communities.” And “I was somewhat aware of the trafficking in Eastern Europe but I was unaware of how widespread the issue is...this film opened my eyes.” These comments, though not in as formal of an evaluation as we would like to have implemented, suggest that this experience was beneficial (Table 2). Also, the variety of students that attended from this science based university ensures that this information is and will become more useful for participants in future years and professions.

Discussion

The results that we gathered and depicted above displayed a positive outcome from our program that made an impact on a few select individuals from the University of Wisconsin – La Crosse campus community. Although we would consider our program a success, if we were given an ample amount of time and resources, we would have changed quite a few things about our program. One of the major aspects of our program that we would have liked to address is advertising for the event within the community of La Crosse. We had originally planned to do so but we ran out of time and money. In advertising to the community we would have contacted radio stations to air advertisements, posted flyers in popular communal areas, and really tried to spread the word of the event. Additionally we would have liked to incorporate a short session for a sex trafficking victim to speak. Danielle Allen from Mission21 had mentioned this idea to us and we feel like it would really have gotten people emotionally involved to see a survivor. The final adaptation we would make to our program is to have an assessment of attitudes and knowledge before the program as well as after. The responses we received for our results section paint a good picture, but it would be great to
have some concrete assessment data in order to prove our programs success or failure.

In the future I believe that research in the area of sex trafficking should focus on determining how a given sex trafficking industry operates, the exact communities and individuals they target, how to reach women and girls when their trapped in the industry, and how laws and policies can take control of sex trafficking. All of these areas have been researched before, but they need to be researched in communities in our back yards, such as Minneapolis, MN; Rochester, MN; and La Crosse, WI.

In working with this program we have learned that many health issues are very complicated and need to be attacked from multiple directions. We’ve also learned that there’s never an easy answer and that in order to make a difference on a certain health issue, its going to take a lot of hard work, time, and resources. As health educators we can’t fight these issues alone; many times other agencies and organizations need to be involved in order to make the program work. In the future we will use the lessons we have learned in this program to, “go forth and do great things.”
<table>
<thead>
<tr>
<th>Response #</th>
<th>Participant Response from “The Unfortunate Reality of Sex Trafficking” Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&quot;I had previous knowledge of sex trafficking and knew about some of the global issues prior to attending, but the global layout within the documentary was fantastic and really gave me a better understanding of how this issue works itself into communities.&quot;</td>
</tr>
<tr>
<td>2</td>
<td>&quot;I was amazed at how much I didn't know about prostitution in the U.S., those people have really been through a lot!&quot;</td>
</tr>
<tr>
<td>3</td>
<td>&quot;I felt empowered to bring this issue up within my conversations because the film gave a clear outline of the issue and helped me understand it a lot better.&quot;</td>
</tr>
<tr>
<td>4</td>
<td>&quot;I had never really heard of sex trafficking before, but it definately stuck with me for the rest of the night. I just kept thinking about it.&quot;</td>
</tr>
<tr>
<td>5</td>
<td>&quot;Nefarious was a great film that took a very in depth look at a topic I was not very familiar with. I thoroughly enjoyed it and learned tons. It's a topic that does not have much awareness and this film brought that. Great film!&quot;</td>
</tr>
<tr>
<td>6</td>
<td>&quot;Before watching the film I was aware of sex trafficking in Eastern Europe, but I wasn't aware of how wide spread it was. This film opened my eyes to the prevalence of this problem.&quot;</td>
</tr>
<tr>
<td>7</td>
<td>&quot;It was extremely eye opening. When my roommates asked how it was I could hardly put in to words the things I learned.&quot;</td>
</tr>
<tr>
<td>8</td>
<td>&quot;I thought it was a good film, but I think some people in the audience thought the message was watered down because of the religious standpoint that came in at the end. In general though, extremely informative&quot;</td>
</tr>
<tr>
<td>9</td>
<td>&quot;Thought the film was really interesting, definitely eye opening and very sad. Was kind of thrown off by the religious ending.&quot;</td>
</tr>
<tr>
<td>10</td>
<td>&quot;It made me very angry that these children are being targeted and subjected to this lifestyle. The fact that these young girls know that they have to prepare themselves for this life is something I cannot even imagine. Also, the fact that some of these parents are trading their daughters for luxury items makes me sick, I just can't grasp the concept of putting tvs or furniture over your own child. I found it interesting that some of the young girls in different countries believe that prostitution is their only option and feel the need to do so to provide for their family, and women who prostitute themselves in the US do so because they think they will live this glamorous, rich life like the movie &quot;Pretty Woman&quot;. The movie definitely increased my awareness of the human trafficking issue, especially its prevalence in the US. I never realized it was this big of an issue, the facts about the rates shocked me.”</td>
</tr>
<tr>
<td>11</td>
<td>I enjoyed the film going through different countries and showing how sex trafficking is different in Southeast Asia compared to Eastern Europe compared to the U.S. I would have never expected this kind of trafficking in the U.S., but it makes clear sense when you hear about it. I also think it brings up bigger questions in terms of pornography in the mainstream and the accessibility of that. This is debatable, but I think that looking at porn and what not can easily transfer to buying some pleasurable experiences from women. It would be interesting to interview women in the pornography industry and find out if their backgrounds are similar to those that are trafficked.&quot;</td>
</tr>
</tbody>
</table>


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Get Involved in a Professional Organization

Public Health

Visit their website for information on membership and their annual meeting which convenes the many professionals who care about public health in Wisconsin.
http://www.wpha.org/

Visit their website for information on membership and their meetings which convene the many professionals who care about public health in the United States and around the world.
http://www.apha.org/

Health Education

Society for Public Health Education
Visit their website for information on membership and their meetings which convene primarily health education professionals who practice in an unlimited variety of settings where they educate and promote health.
http://www.sophe.org
Strong Women. Strong Bones. Strong Future: Increasing the Physical Strength of Women through Education, Empowerment, and Enhancement to Reduce the Risk of Low Bone Mass and Osteoporosis

Amanda Anderson, Xi Wang, Abby Jamison, and Molly Vossekuil All Undergraduate Candidates in Community Health Education in the Department of Health Education and Health Promotion at University of Wisconsin-La Crosse

Abstract: The “Strong Women. Strong Bones. Strong Future,” program was designed to educate women on osteoporosis prevention through nutritional education and proper strength training techniques. The program featured an educational booth on osteoporosis and handouts, as well as strength training demonstrations. The program was implemented to Logistics Health Promotion and Kaplan University employees at the Riverside Corporate Wellness Health Expo on November 7, 2012. An important factor in our decision of location and priority population was the fact that the average age of the employees is thirty-eight years old. Women start to experience the transition and symptoms of menopause between forty to sixty years old. We found that if women participate in weight-bearing activities, they will have a stronger bone structure and more bone mass. Also, it is important for women to incorporate vitamin D and calcium in the diet. Women are then able to delay the onset of osteoporosis and decrease their risk in late adulthood.

Key Words: osteoporosis, prevention, nutritional education, strength training
Introduction

From a global perspective, over 200 million people have osteoporosis (Reginster & Bulnet, 2006). According to the NOF’s Prevalence Report, there is an estimated 35 million women (in 2010) age 50 or older who have osteoporosis or who are at risk for developing it. This number is expected to increase to 41 million in 2020. Low bone mass is also a concern and it is estimated that almost 26 million women in 2010 will have low bone mass. As shown in the chart below, osteoporosis is expected to continue to increase.

Table 1. Prevalence of Osteoporosis and Low Bone Mass in People Aged 50 and Over**

<table>
<thead>
<tr>
<th>Prevalence</th>
<th>2002</th>
<th>2010</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteoporosis and Low Bone Mass in Women and Men</td>
<td>43,600,000</td>
<td>52,400,000</td>
<td>61,400,000</td>
</tr>
<tr>
<td>Osteoporosis in Women and Men</td>
<td>10,100,000</td>
<td>12,000,000</td>
<td>13,900,000</td>
</tr>
<tr>
<td>Low Bone Mass in Women and Men</td>
<td>33,600,000</td>
<td>40,400,000</td>
<td>47,500,000</td>
</tr>
<tr>
<td>Women with Osteoporosis or Low Bone Mass</td>
<td>29,600,000</td>
<td>35,100,000</td>
<td>40,900,000</td>
</tr>
<tr>
<td>Women with Osteoporosis</td>
<td>7,800,000</td>
<td>9,100,000</td>
<td>10,500,000</td>
</tr>
<tr>
<td>Women with Low Bone Mass</td>
<td>21,800,000</td>
<td>26,000,000</td>
<td>30,400,000</td>
</tr>
<tr>
<td>Men with Osteoporosis and Low Bone Mass</td>
<td>14,100,000</td>
<td>17,300,000</td>
<td>20,500,000</td>
</tr>
<tr>
<td>Men with Osteoporosis</td>
<td>2,300,000</td>
<td>2,800,000</td>
<td>3,300,000</td>
</tr>
<tr>
<td>Men with Low Bone Mass</td>
<td>11,800,000</td>
<td>14,400,000</td>
<td>17,100,000</td>
</tr>
</tbody>
</table>

*The current prevalence statistics used by NOF are based on data from the 2000 Census. As the 2010 Census data is available and analyzed, NOF will make every effort to update these statistics. **The above figures have been rounded
Regular physical training has been proven to increase physical strength of women, as well as decrease the risk of osteoporosis. The level of functional health, or the physical ability of an individual to function independently, can help determine bone strength and osteoporosis in women. Aging has also been proven to decrease the level of functional health in individuals, as well as osteoporosis.

Osteoporosis limits the functional health of individuals and increases the risk of falling and breaking or fracturing bone. According to Platen,

“Besides the instability of the bone, the elevated risk of falling is another factor of the increased bone fracture risk in old age. Balance disorders, low muscle strength in the lower limbs, poor coordination and flexibility, decreased visual acuity, neuromuscular impairment, cognitive impairment, residence in a nursing home, poor general physical health, use of medications that diminish alertness, low body weight secondary to poor appetite and poor health, and a low amount of soft tissue in the hip region are contributing factors for bone fractures due to falling” (2001).

Individuals at risk of developing osteoporosis and those who are diagnosed with osteoporosis need to be aware of their environment, specifically stairs and other challenging obstacles in their home.

Worksite wellness programs are deemed effective because most individuals spend more than half of their waking hours at the workplace (Lawrence, 2002). It is then realistic to assume that worksite fitness facilities are utilized more often than not by employees. Unfortunately, a study completed by Lawrence found that worksites with cardio and strength training fitness rooms were underutilized (2002). It was found that programs with one-on-one outreach were utilized more; therefore, worksite wellness programs should focus on access to care and education rather than accessibility to an on-site fitness center.

It is obvious that there is a need for our standardized osteoporosis prevention program that includes education about the multiple benefits of strength training, the risks of low bone mass, and how nutrition is important for developing strong bones. In addition to the “Strong Women. Strong Bones. Strong Future.” program, the social environment needs to be one in which women feel confident. Women may have increased confidence if they are educated on how to properly perform exercises. The Growing Stronger program provided by the CDC is based on scientific research that has been shown to have many benefits. It is suited for people of various types of exercise ability (CDC, 2011). Assets that are available are plentiful in regards to information on strength training, osteoporosis, and nutrition. The role of assets is to provide them to the priority population in a way that will elicit positive change. Communities also have the opportunity to employ health educators and certified strength and conditioning specialists to help disseminate information in an appropriate manner. Capacities will limit how much a community can do for the population at risk. La Crosse has a high capacity since there are two major hospital systems in the area that are very involved in preventative care. Areas with limited access to hospitals and or clinics would be harder to administer the program since the community members may not have the support that they need.

Methods

Increasing muscular strength in women is important for many reasons. Having an adequate amount of strength is a preventative measure against falls, injuries resulting from falls, and the disability that can be a result. More lean muscle mass is also associated with being able to maintain a healthy weight and
avoid becoming overweight or obese and developing certain diseases. Diseases that are linked to low strength and lean body mass are diabetes, certain cancers, heart disease, and stroke. It is also important to recognize the relationship between level of strength and osteoporosis. Women who lack physical strength are at an increased risk of low bone mass, osteoporosis, fractures and breaks. Fractures and breaks of the bone heal slowly when bones are weak and brittle.

Falling is a concern because it is linked with low muscular strength. The Centers for Disease Control and Prevention (CDC) state that one out of three adults age 65 and older fall each year (n.d.). Falling can result in lacerations, fractures, and head traumas. Those who fall may then develop a fear of falling, causing them to limit their level of physical activity; therefore, making them more susceptible to falling in the future. Participating in exercises that increase leg strength and balance can prevent falls. The National Institute of Health (NIH) Osteoporosis and Related Bone Diseases National Resource Center addressed the need of physical activity programs to build and maintain bones. The most beneficial physical activity that can be done as a preventative and or treatment program includes strength training. A study completed by 35 women, aged 65 or older, concluded that women with a history of falls were 24 percent less powerful in their legs than for those who did not fall (Skelton, Kennedy, & Rutherford, 2002).

Genes can influence behaviors and metabolism, as well as type of muscle mass, such as fast twitch dominant or slow twitch dominant, and specific risk factors that one cannot change like a family history. There is greater risk across all races and ethnicities; non-Hispanic Caucasian and Asian women have the highest prevalence of osteoporosis and low bone density at 20 percent and 52 percent respectively. A family history of osteoporosis is associated with a higher prevalence of osteoporosis. According to Robitaille et al., “the prevalence of family history was 34.8 percent among women with osteoporosis and 18.5 percent among women without” (2008). A preventative measure for women with a family history of osteoporosis is taking supplements containing calcium, vitamin D, or both; being physically active; and estrogen use than women at no familial risk (Robitaille et al., 2008). Women whose parents that were diagnosed with osteoporosis, specifically mothers were at higher risk of developing osteoporosis later in life. “Among women aged 35-49, 50-64, or greater than or equal to 65 years, osteoporosis was more common in those with a positive family history than in those with no family history of osteoporosis” (Robitaille et al, 2008).
Age, diet, certain medications and medical conditions, lifestyle, alcohol consumption and smoking will all affect the rate at which your bones weaken (NOF, 2011). Low levels of calcium and vitamin D will result in low bone mass and ultimately, osteoporosis. Those key nutrients can be found in milk, cheese, yogurt, and fish. Vitamin D is also absorbed through being exposed to sunlight. Supplementation is encouraged when individuals cannot receive all valuable vitamins and minerals. A deficiency of vitamin D inhibits the absorption of calcium in the bones. Also, support groups should be a focus because surrounding oneself with social support is important to connect with others who are going through similar situations. “Support groups, friends, and family members can help you manage the social challenges and limitations resulting from osteoporosis” (NIH, 2011 October). Support groups can also be exercise partners seeing as exercise is a tool to help combat osteoporosis. Additionally, avoiding smoking and drinking in combination with exercise and eating a balanced diet with vitamin D and abundance of calcium can prevent osteoporosis (NIH, 2011 January).

The service population, as a whole, is women between the ages of 16 and 85. This population is broken down into groups: low-risk, moderate-risk, and high-risk. Low risk women are younger adults and children because their bones are still growing. The age group for this population would range from adolescence to thirty years of age, when peak bone mass is projected. The moderate-risk age group consists of middle age women. They are at moderate risk because they have already reached peak bone mass. Unfortunately for moderate-risk individuals, they must exercise and consume a diet adequate in vitamins and minerals, specifically vitamin D and calcium if they want to maintain their bone mass. High-risk women are those who are transitioning into menopause and those who have already experienced it. This age group can range from forty years of age to sixty-five. The drop in estrogen that occurs after menopause makes the risk of developing osteoporosis much more likely since the bones do not have estrogen to protect them like they did in adolescence and adulthood. About one in two women over the age of 50 will break a bone due to osteoporosis (NOF, 2012).

For the low-risk population, our efforts would focus on recognizing the importance of physical activity. We will create strength training sessions that will teach them the “how to” as well as the importance of strength training and nutrition. We will suggest physical activity through weight bearing activities for moderate- and high-risk priority population segments. We recognize that the level of understanding in this priority population may be lower with middle aged and postmenopausal women. For those who are not able to engage in physical activity, we will focus on the nutritional aspect of health. We are hoping information given with intervene in any current static physical activity levels leading to low bone mass. Specifically for low- and moderate-risk we are hoping to prevent osteoporosis altogether. We are hoping to that our efforts of prevention and intervention will at the very least stop progression and or delay bone density loss for the high-risk priority population.

The “Strong Women. Strong Bones. Strong Future.” program focuses entirely on proper educational materials and hands on knowledge for our priority populations. It is important that they are able to pay more attention to the foods they eat by measuring the amounts of calcium and vitamin D in their food, as well as logging their daily consumption of these vital nutrients. By meeting the daily recommendations of calcium and vitamin D, their risk of osteoporosis will decline greatly. Also, the participants will be able to exercise in a safe way by using the techniques that we demonstrated as well as the exercises we suggested. Weight-bearing exercises has been
proven to increase bone mass and there by increasing bone strength. Osteoporosis results from weak and brittle bones; therefore, weight-bearing activities such as strength training will delay the effects of this condition for moderate- and high-risk participants.

Low-risk priority segment is University of Wisconsin-La Crosse freshman and sophomore female students enrolled in HPR 105. We would develop a program that focuses on increasing the knowledge of students on strength training by administering and coordinating educational sessions and demonstrations. Also, an educational video will be viewed during lecture and a discussion will follow. Discussion is important to assess knowledge gained preceding the video. Testimonials from fellow peers will also be shown and emphasized. Their life stories will be told and how osteoporosis has affected their

Table 2. Activities to be completed by at-risk populations

<table>
<thead>
<tr>
<th>Priority Segments</th>
<th>Potential Participants</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low-Risk</strong></td>
<td>250</td>
<td>Strength Training Sessions/Demonstrations</td>
</tr>
<tr>
<td>UW-L College Women</td>
<td></td>
<td>Educational video</td>
</tr>
<tr>
<td>(freshmen and sophomores in HPR 105)</td>
<td></td>
<td>Testimonials from those with Osteoporosis</td>
</tr>
<tr>
<td><strong>Moderate-Risk</strong></td>
<td>1000</td>
<td>DEXA bone density exams</td>
</tr>
<tr>
<td>Riverside Center Employees</td>
<td></td>
<td>Received susceptibility assessment</td>
</tr>
<tr>
<td>(Desk Positions)</td>
<td></td>
<td>Strength Training Demonstrations</td>
</tr>
<tr>
<td><strong>High-Risk</strong></td>
<td>10</td>
<td>Altered strength training demonstrations</td>
</tr>
<tr>
<td>Nursing Home Residents (Postmenopausal)</td>
<td></td>
<td>Educational Sessions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individual Visits</td>
</tr>
</tbody>
</table>
life, either individually or in their family. This approach is important because students will be more likely to change their health behaviors if they can relate the health concern to themselves.

Moderate-risk priority segment are employees from Logistics Health Solutions and Kaplan University. The program will be administered during the Riverside Corporate Wellness Health Expo. Employees will be educated on the DEXA bone density exam as well as having their bone density tested. The first step in changing health behavior is becoming aware of your risk as well as identifying modifiable and non-modifiable risk factors. Employees will also be able to identify their perceived susceptibility of osteoporosis and other like conditions such as low bone mass. This activity will be distributed as a handout during the health expo. Lastly, health educators will administer strength training sessions and demonstrations. Employees will be able to ask questions about strength training as well as become educated on the importance of strength training.

High-risk priority segment are nursing home residents at Hillview Health Care Center. Residents will participate in strength training demonstrations conducive to their needs and health status. This priority population needs to focus on participating in physical activity and movement; therefore, increasing strength by more muscle mass is less important. Residents will also become educated on osteoporosis and the importance of physical activity and nutrition throughout their late adulthood. Statistics show that a majority of the elderly population will experience a symptom of osteoporosis sometime in their life; therefore, it is important for the reinforcement of information and safety precaution measures that can take place in their home. Lastly, residents with osteoporosis will be allotted a one-on-one session with a health educator. Some residents are not comfortable expressing their concerns or asking questions in a group setting. Educational information will also be given and conducive to the learning capabilities of the individual.

We only developed an evaluation for one of our priority populations. We would evaluate the knowledge of the employees at Riverside Corporate Wellness. The evaluation would be given as a pre- and post-assessment. The pre- and post-assessments would evaluate the knowledge of strength training, calcium and vitamin D intake, individual osteoporosis risk, as well as resources available. The assessment would ask the individual to complete the following questions five questions in a likert-type scale format. We would also encourage comments, questions, or concerns that the participants may have.

**Results**

Within the semester, we were able to research, compile and finish a literature review on osteoporosis to further our knowledge of the disease. In addition to our review, we completed a plan for assessment, which provided us with data from our participants. Data collected allowed us to understand the prior knowledge of our participants and the transfer of information presented. We were also able to identify what the participants learned by participating in our program. Fortunately, we were able to implement our program through collaboration with Riverside Corporate Wellness. RCW provided the location, table and printed resources for our program. Approximately 600 employees attended the Health Expo from 7:00am - 5:00pm on November 7, 2012. Employees were given a “passport” and each employee was required to visit all booths. Prizes were given as an incentive if they participated. The incentive ensured us with a high volume of participants. Employees were engaged in conversation and asked us questions about our topic as well as how they can prevent osteoporosis. Questions asked by employees were our main means of
disseminating information. Visual learners were also able to read and view our graphics that were included on a tri-fold. The tri-fold consisted of facts, figures and photos.

**Chart 1. Attendance at the RCW health expo**

<table>
<thead>
<tr>
<th>Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did Attend</td>
</tr>
<tr>
<td>Did Not Attend</td>
</tr>
</tbody>
</table>

**Discussion**

Implementing our program with our priority population of RCW employees we were fortunate to reach 600+ participants. To adapt our program and expand its depth, we would provide additional strength demonstrations and private training sessions to further the transfer of knowledge. In order to complete this task, we would need help from RCW to coordinate the appointments and correspond with employees to set up each session. Rather than strength training demonstrations solely taking place within the expo, the use of the workout facility upstairs would provide more space and additional strength training equipment.

To further our program, we would reach out to two additional priority populations. These would include female students at the University Wisconsin-La Crosse as well as elderly residents at Hillview Health Care Center. Additional resources needed would be facility space and strength training equipment. We would collaborate with Dennis Kline at the Eagle Recreational Center in order to use the strength center. Also, we would invite Exercise and Sport Science students to help implement our program. Implementation at Hillview would require a large meeting space to gather residents, along with free weights and other small pieces of equipment to conduct strength training demonstrations and sessions. A television would be necessary to view an educational video on osteoporosis.

When examining the research, the Centers for Disease Control lay out the need for strength training. “Falls Among Older Adults: An Overview” emphasizes the fact that strength training reduces the risk of injury for individuals with low strength. Detailing the prevalence, cost, injury rates and prevention, the article displays the incredible attention this health concern is in need of. A broad view of osteoporosis can be found at the National Osteoporosis Foundation website as well as the National Institute of Health. Research supporting our priority populations was found on the World Health Organization website explaining who is at risk. An in depth look at health behaviors related to our program can be found in the text Planning, Implementing, and Evaluating Health Promotion Programs: A Primer, 5th Edition by McKenzie, Neiger and Smeltzer, 2009.

Through the process of researching, designing, planning and implementing our program, many valuable lessons arose and we are able to take this knowledge with us in our future programs. A few insights include good communication with collaborating organizations. We were fortunate to have an organization that was efficient and clear in both e-mail and face-to-face discussions. We also learned the difficulties of collaborating with those who are not so forthcoming. When researching the possibility of working with alternate priority populations communication and collaboration with their contacts were much more sporadic and frustrating. We understand the importance of timely communication and its reflection on us...
as health educators. In the future we will strive to seek out several means of communication to find the best fit with our collaborators. Organization is crucial to a well thought out program. In order to truly flesh out all objects of interest and details, it is imperative to stay organized. Creating a timeline for each group member as well as the group as a whole helps to keep everyone on the same page and stay on task. Lastly, we have come to understand the importance of designing a program based on a recognized health priority. Without this need, a program based upon other criteria is not serving the community to meet its most immediate needs.

References


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Important texting for you...

BTW U NEED 2 KNOW...
About Undergraduate Preceptorship in Community Health Education
Watch for an email inviting you to a revised Department website with special pages all about the preceptorship.

GET MANUAL...
The Preceptorship Manual is emailed to every CHE major each September and January and will be available on the revised Department website.

GET ADVICE...
Academic advisors, other faculty, professionals in field, and other students...they all have it.

EXPLORE...WHOA!
Volunteer, summer work, internships, job shadowing, travel, and the revised Department website all offer ways to explore your interests.

SHARING SESSIONS...OMG
3 times a year students return and tell about their preceptorship experience all majors receive announcements about sessions.
The revised Department website will provide access to recorded Sharing Sessions and Final Written Reports from past students.

f1...f2...f3?
Prepare and submit forms on time to maximize the value of your required preceptorship.

<table>
<thead>
<tr>
<th>Form 1 due to Academic Adviser</th>
<th>Form 2 due to Academic Adviser</th>
<th>Term for Preceptorship And Sharing Session Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/14/2012</td>
<td>10/14/2012</td>
<td>Spring 2013-05/17</td>
</tr>
<tr>
<td>10/1/2012</td>
<td>3/1/2012</td>
<td>Summer 2013-8/30</td>
</tr>
<tr>
<td>10/1/2012</td>
<td>3/1/2013</td>
<td>Fall 2013-12/13</td>
</tr>
<tr>
<td>2/14/2013</td>
<td>10/14/2013</td>
<td>Spring 2014-5/16</td>
</tr>
<tr>
<td>10/1/2013</td>
<td>3/1/2013</td>
<td>Summer 2014-8/29</td>
</tr>
<tr>
<td>10/1/2013</td>
<td>3/1/2014</td>
<td>Fall 2014-12/12</td>
</tr>
</tbody>
</table>

Form 3 is the Proposal of Involvement and it is something you prepare with a faculty adviser and the faculty adviser submits your proposal to the preceptorship site for acceptance.
**FORM I – Community Health Education Preceptorship Site Request Form**

<table>
<thead>
<tr>
<th>Intended Preceptorship Period: Year __________  Semester(\one) fall ___ spring ___ summer ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submit this form and the required background documents so that your advisor may submit them to the Preceptorship Coordinator by October 1 for summer or fall, OR by February 14 for spring preceptorships.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student name:</th>
<th>Advisor name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home mailing address:</td>
<td>Home phone:</td>
</tr>
<tr>
<td>Campus mailing address (if different than above):</td>
<td>Campus or cell phone:</td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Majors:</td>
<td>Community Health Education,</td>
</tr>
<tr>
<td>Minor(s):</td>
<td></td>
</tr>
</tbody>
</table>

**Required Background Documents**

1. Obtain a written graduation Check-Out Summary from the Assistant to the Dean in room 205 Graf Main Hall. Call ahead for an appointment (785-8156) for this “credit check.” The completed credit check must be attached to this form when you submit it to your academic advisor.

2. Prepare a typed document describing your rationale for your preceptorship. Your rationale must clearly label and include the following elements:
   a. Your professional goals.
   b. Your interest in specific health issues, special practice settings, and particular population segments.
   c. Identify three preceptorship sites by name and location; number these from 1 to 3 indicating your first through third most preferred sites for your preceptorship. Tell how these sites would help you meet your professionals goals and specific interests.
   d. Tell about any personal connections, communications, or experiences you have with the sites you have prioritized.
   e. If you are requesting a summer preceptorship, you must include your reasoning for choosing summer over spring or fall semesters.

<table>
<thead>
<tr>
<th>Date</th>
<th>Signatures and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student:</td>
<td></td>
</tr>
<tr>
<td>Academic Advisor</td>
<td></td>
</tr>
<tr>
<td>Undergraduate Preceptorship Coordinator</td>
<td></td>
</tr>
</tbody>
</table>

Revised 09/05/2012
FORM 2 - Community Health Education Preceptorship
APPLICATION FOR ADMISSION
Department of Health Education and Health Promotion

Name: ________________________________________________________________________

Last                                            First                                            Middle

I. To be completed by the student:
A. Total credit hours to be competed at the end of this semester (or the following
   Summer session, 90 credits needed for senior standing)
B. Fields of study and grade point average:

   Major   _____ Community Health Education ________ GPA
   Second Major _______________________________ GPA
   Cumulative grade point average               ______________
   (do not list minors here)
   (see your transcript)
C. Semester for which application is being made:
   I (Fall) _______         II (Spring) _______     *(Summer) _______ 20___

This form is due March 1 for summer and fall and October 14 for spring preceptorships.

II. Student Understanding:
A. To the best of my knowledge, I have no medical deficiencies which might limit
   my effectiveness as a Preceptee or I have discussed any potential medical
   deficiencies with my Preceptorship Advisor.
B. I understand all the requirements for admission to the CHE Preceptorship.
   1. 2.75 minimum cumulative GPA
   2. 2.75 minimum major GPA
   3. completion of all required course work
   4. advisor’s recommendation

   Signature of Student                     Date

III. Faculty Recommendations:
Based on my knowledge, and pending final completion of all requirements within the
Community Health Education professional preparation program, I recommend this
student for admission to the Community Health Education Preceptorship Program.

   Academic Advisor                         Date

   Preceptorship Advisor                   Date

IV. To be completed by the Dean of the College:
This student has met all the requirements for admission to the Community Health
Education Preceptorship.

   Signature of the Dean of the College     Date
Community Health Education Major: Computation of Major GPA

1. Number of grade points per credit:  A=4,  AB=3.5,  B=3,  BC=2.5
   C=2,  D=1,  F=0
2. To compute the grade point average in the major: For each course, multiply the
   number of credits times the grade points and place total and place total in “Grade
   Points” column. Then divide the total grade points by the total credits.
3. Only grades earned at UW-L are figured in the grade point average.
4. The following courses** should be used:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Credits</th>
<th>Grade</th>
<th>Points</th>
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<td>HPR 105 Health &amp; Physical Well Being</td>
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<td>HED 205 Intro. To Health &amp; Wellness Ed.</td>
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<td>CHE 240 Community Health Ed. Foundations</td>
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<td>HED 320 The US Health Care System</td>
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<td>HED 474 Nutrition Education</td>
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<td>HED 469 Drugs, Society, &amp; Human Behavior</td>
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<td>HED 335 Human Ecology &amp; Environmental Health</td>
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<td>HED 345 Mental and Emotional Health</td>
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<td>CHE 340 Epidemiology &amp; Comm. Health Problems</td>
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<td>CHE 350 Biometry &amp; Research Design</td>
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<td>HED 425 Violence and Injury Prevention</td>
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<td>HED 437 Theories of Health Behavior</td>
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<td>HED 472 Sexual Health Promotion</td>
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<td>HED 477 Grantseeking in Health, Human Services, etc.</td>
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<td>CHE 440 Prog. Development in Community HE</td>
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<td>CHE 441 Human Disease Prevention &amp; Control</td>
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<td>HED 473 Health Aspects of Aging</td>
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<td>CHE 491 Senior Seminar in Community Health Ed.</td>
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Electives (6 credits)
1.
3.
7.

Total credits = _____  Total grade points= _____

Total grade points / Total credits = Major Grade Point Average

Revised 08/20/2009
Both of the following distinctive graduate programs will be of interest to the graduates in Community Health Education just after their graduation or following additional work experience. The graduate coursework (700-level) enables candidates from many different states and nations to experience unique cultural perspectives while learning advanced health skills from graduate faculty mentors.

The Master of Public Health (MPH) degree in Community Health Education was the first MPH program in the University of Wisconsin System. The program is designed to prepare professionals who will address quality of life enhancement through health education and health promotion, educational, policy, and partnership-based activity. The 44-45 credit program addresses advanced health education competencies, knowledge and concepts in community health education, public health standards, and many of the emerging content areas identified by the Institute of Medicine for the preparation of public health practitioners. The program has been offered since 1991, and nationally-accredited by the Council on Education for Public Health since 1992. It attracts candidates from throughout the world, and in 2004 the program was ranked 6th in the nation among all Graduate Community Health Programs by U.S. News and World Report. Two program tracks provide the candidates with a choice between conducting thesis research or developing a graduate project based upon a defined need. For additional information, contact the Program Director: Dr. Gary D. Gilmore at ggilmore@uwlax.edu or call 608-785-8163.

The Master of Science in Community Health Education (MS-CHE) focuses on preparing the candidate for employment as a health educator and/or health promotion specialist in a health-related, educational, or community-based setting. This 43-credit program, offered since 1974, has its groundings in advanced health education and health promotion foundations, focused principles of research design and evaluation, and a community health practicum, leading into the development of a graduate project based on the candidate’s area of interest and emerging expertise. Additional coursework is selected by the candidate (during scheduled advising sessions) in the areas of administration and program development, health education processes and concepts, and health content and skills. Coursework options are guided by the advanced-level competencies for health educators. This approach provides flexibility for the candidate to derive maximum benefit from the program based on assessed interests and needs. For additional information, contact the Program Director: Dr. Gary D. Gilmore at ggilmore@uwlax.edu or call 608-785-8163.