Chapter 1: Introduction
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Higher Education: Past, present & future

Since times immemorial, India has always been a Center of Learning. Universities like Takshashila and Nalanda (Prabhu & Joseph, 2006) attracted scholars from the world over. Ranging from the landmark contributions of Ramanujan, Aryabhata, Sir C.V. Raman and others to the traditional and conventional ‘Guru’ (teacher) – Shishya (student) tradition, the “Gurukulam” model of imparting education, all have endorsed, India’s contribution to the cause of education. Perhaps, this ‘Aashram’ (Setty, E.D. and Ross, E.L., 1987) system of education was well suited to the societal requirements at that point of time.

Given the present technological advancements, the increasing number of students, the demographic diversity of students, the quest for quality education and a fiercely competitive global market etc., the overall education system has undergone a sea change (Hans De wit, Agarwal Pawan, et al, 2008). A paradigm shift has been noticed in higher education, from ‘national education to ‘global education’, from ‘one time education for a few’ to ‘lifelong education for all’, from ‘teacher-centric education’ to ‘learner centric education’ (University Grants Commission Report, 2010). These changes make new demands and pose fresh challenges to the established education systems and practices. Basic subjects have metamorphosed into specialties and super specialties. Medium of instruction have changed. Conventional class room “chalk and talk” methodology has been supplemented (if not replaced) by virtual universities – Netversities (Suri R.K. and Rajaram Kalapana, 2008). Prototype course syllabi and curricula have been redefined, fortified and augmented with “add on” components which aim to contribute to the overall development of the student. Academic programmes offered today are required to provide the necessary flexibility and room to develop, hone and fine tune certain traits / talents in the individual.

To meet these global challenges of imparting quality education and with a view to meet the customer (student) demand, educational institutes are getting transformed from conventional academic bodies to “Centers of Excellence”, offering a variety of academic programmes in diverse academic disciplines and aiming to develop the overall personality of the student (Sadlak Jan & liuNianCai, 2009).
India has truly lived up to this global challenge. According to the Association of Indian Universities (AIU) India Handbook of January 2010 (Appendix “A”), India today, has 26,000 institutions across varied fields of study. These include 40 Central Universities, 130 Deemed University, 33 Institutions of National Importance, 5 Institutions established under State legislation, 53 State Private Universities and 243 State Universities, statistics which indicate the ample opportunities which India offers for higher education.

**Graph 1**

**Number of Higher Education Institutions**

![Bar Graph](source:image)

**Source:** MHRD: Annual Report 2009-10:

*Making the Indian higher education system future ready*
Higher education in India has seen an unprecedented boom in the number of colleges and universities in the last decade. The numbers of colleges and universities have almost doubled.

**Graph 2**

**Growth in number of Higher Education Institutions in India**

![Graph showing the growth in number of universities and colleges in India from 1950-51 to 2009-10. The number of universities and colleges have increased significantly over the years.](image)

**Source:** MHRD: Annual Report 2009-10:

*Making the Indian higher education system future ready*
The Indian higher education system has established itself as one of the largest in the world, not only in terms of number of institutions but also in terms of student enrollment.

**Graph 3**

*Student enrollment in higher education (in million)*

![Graph showing student enrollment in different countries](image)

*Source: MHRD: Annual Report 2009-10*

*Making the Indian higher education system future ready*

India has the largest target population for higher education in the world. Currently the Indian population in the relevant age group to enroll into a higher education course is more than that of Europe, USA and Australia combined (Netscribes Higher Education Report, 2009). Current estimates indicate the spends on higher education in India to be nearly `46,200 crores.

The higher education system in India thus has grown in a remarkable way, particularly in the post-independence period, to become one of the largest system of its kind in the world, with a national resolve to establish several universities, technical institutes, research institutions and professional / non-professional colleges all over the country to generate and disseminate knowledge. The country is now engaged in the use of higher education as a powerful tool to build a knowledge-based information society of the 21st Century.
This development is in true conformity with Alwin Toffler’s philosophy quoted in his book on “Power Shift” wherein he states that “power has shifted from military power to economic power and now to educational power” (Toffler Alvin, 1990) India has thus truly emerged as an educational hub. This in turn entails, enrollment of students not only from different states of India but other countries as well.

Some of the fallouts of this development are:

a. The students hail from different countries, communities and cultures, thereby leading to cross-cultural interactions & influences.

b. Large numbers of students stay away from their homes.

c. Lack of parental care & guidance.

d. Groups living in hostels / staying as paying guests have their own issues & problems (health related).

e. Propensity to fall prey to a faulty lifestyle with consequent adverse implications on student’s health: fast food, fast vehicles, fast peers– in general “life in the fast lane”! This has led to the emergence of many lifestyle related disorders, aptly also referred to as “designer diseases” (Cmich, D. E. 1984).

The offshoot connotation of all the above is that, deprived of the tender loving care, guidance, counseling and in general the umbrella protection of the elders at home, the student therefore is forced to fend for oneself. In the absence of proper guidance, coupled with unfavorable (media) exposure and under the influence of undesirable peer pressure, one often, if not always, ends up in making the wrong choices and / or indulging in risk related activities.

In light of the above background, looking back and introspecting, one may safely and surely conclude that the educational system has come a full circle! Educational institutions today therefore cannot and should not harp on academic instructions alone. Like the Gurukulams of yester years, these institutions need to be responsible for the overall development of the student. It therefore becomes imperative and
mandatory that higher educational institutions provide comprehensive care to students during their academic sojourn within the institute. This spectrum should be all encompassing and aimed at ensuring a wholesome and a quality development of the student (beyond academic achievement alone) who in times to come will not only make a meaningful contribution but a positive difference to society. The student has to be empowered for a ‘responsible global citizenship' (Hans De wit et al, 2008).

**Inextricable linkage between health & academic success:**

The need to address health in educational settings has been recognized as early as the mid-nineteenth century. It is through its influence on learning that health advances student success. Thus emerges a new and powerful concept in higher education linking health and academic success.

Student success refers to the ability of students in college to achieve certain desired outcomes (beyond academics alone) as a result of their complete engagement with higher education. An educational institution would be considered contributing to its students’ success, provided, that the academic programmes and campus experiences obtained help the student in achieving these desired outcomes. These desired student outcomes are a combination of knowledge acquired and more importantly, its application, which helps the student prepare for life, work and citizenship. It is thus a combination of learning and the application of this learning in real life which is referred to as student development (Keeling, R P et al, 2008).

Contemporary perspectives of learning affirm that it is a complex, multi-centric, brain-based, transformative process that occurs throughout and across the educational experience integrating academic learning and student development. The learner as a whole person matters in the learning (Keeling R P, 2006).

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1**Responsible** implies education that enables learners to make their own critical choices and decisions. It also contains an expectation of responsible action. Where there are action agendas, competence tends to be gained through experience. To become a responsible citizen, a student must practice being responsible.

**Global** implies a holistic view of global responsibility that includes responsibilities relating to sustainable development.

Though approaches & outcomes vary from institution to institution, the common denominator is student success. It is this concept of student success which is a unifying, comprehensive concept that links academic and student affairs educators in the education and transformative preparation of the whole student.

The desired student learning outcomes cannot be achieved in the classroom alone - nor without the classroom. The outcomes have to be achieved from both indoor as well as outdoor experiences (experiential learning). Health creates capacity; students whose health status is positive and flourishing have greater ability and readiness to learn and engage fully in all meaningful educational experiences both inside and outside the classroom e.g., residential life, outdoor social activities, civic engagement, etc. (Silverman Daniel C & Underhile Ric, 2008). The health and well-being of students therefore largely contribute to and indeed make possible student success.

In true conformity to the old adage: *mens sana in corpore sano*—“sound mind in a healthy body”, it is but obvious that the health status of an individual is intimately related to and is inseparable from a desire to achieve quality education and to excel academically.

A healthy body, brain and mind then are prerequisites to optimal student learning. Learning happens in a real, physical organ – the brain – that is part of a real, physical person – the student. Anything that affects the students’ state of mind – or brain – influences learning. So students’ overall state of mind and brain – or, more properly, their health and well-being – is a learning concern, and health-related programs and services are learning support services. Health and therefore provision of health care services and facilities becomes the logical derivative of this scenario which educational institutes now have necessarily to cater to. This interrelation between health and academic performance has been cited by McKenzie and Richmond 1998 & Munro Prescott 2007 amongst others. It is therefore no longer an *add on* facility, but a crying necessity!
In this way of thinking, health-related programs and services are not incidental or ancillary; rather they demand a much more central place in the conversation about and achievement of desired student learning outcomes which in turn define student success. Health-related programs and services then become fundamental to institutional effectiveness in promoting student success. These relationships among health, learning, and student success are as depicted below:

**Figure 1:**

**Student Health as a Foundation of Student Success**

![Diagram](image)

*Source: Keeling & Associates, LLC: Final Report of Consultation, Ohio University, Hudson Health Center, Review and Recommendations: Student Health-Related Programs and Services, August 6, 2007*

Student health is then a critical foundation with which students can optimize their learning, reach their potential and achieve their goals.
Figure below represents the core relationships among the major elements of health (emotional, spiritual, physical, relational, and social dimensions), portrays an integrative relationship among these dimensions and suggests the intersection of each of those elements and of health as a whole quality of wellbeing, with learning.

Figure 2:

Multiple dimensions of health in relation to learning


Thus, there is a complex interrelation of health issues with the vicious cycle of academic, personal and financial health concerns sometime resulting in dropping out or reduction in academic performance. One aspect of the lives of students invariably collides and impacts on other aspects. This is popularly referred to as Domino effect.

2Domino Effect: It is the complexity or interrelation of health issues with the vicious cycle of academic, personal and financial health concerns sometime resulting in dropping out or reduction in academic performance. Thus, one aspect of the lives of students collides and impacts on other aspects (Spectrum June 2008, ACHA edition).
Paradigm shift in the concept of health:

In these times, as our understanding of the close association between health and academic success evolves, the very concept of health itself is undergoing a paradigm shift. In the theme of ‘Health For All’, WHO defines Health as: ‘A state of complete physical, mental, social and spiritual wellbeing and not merely an absence of disease or infirmity’ (Park’s Textbook of Preventive and Social Medicine, 2009, pp 13). One should achieve the goal, as given in our age-old Sanskrit teachings, “Sarvetra Sukhinah Santu, Sarve Santu Niramayahi e.g. “Let all be happy everywhere, let all remain healthy without disease or infirmity”.

Although health is defined above as “…a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity”, the concept is often limited in modern society to treatment of illnesses i.e. curative care alone. Therefore, when one compares the existing health care systems pyramid with the one proposed by the researcher, the following glaring disparities become obvious.

Figure 3:

Existing Health Care Systems Pyramid | Proposed Health Care Systems Pyramid

Existing System | Proposed System
Today, our current understanding of health in general and student health services on campus healthcare services, is myopic, to say the least! Campus health related programs and services for students are conservative structures organized around a traditional medical model that sees student health merely as the absence of or eradication of student illness. Health and health services are classified as per different “pathies” (Allopathy, Homeopathy etc.) and within each such pathy, there may be a further sub classification into various specializations! “Student health” on most campuses has come to mean the “clinic,” the actual physical space, where students go for diagnosis and treatment of illnesses and injuries. Thus the facilities and services are focused on curative care alone.

Many colleges and universities believe they have sufficiently addressed health when they put in place some level of clinical services. It is as if direct clinical services represent the “core curriculum” and other components of comprehensive campus health programs are merely “electives” that may or may not be available!

Therefore, as depicted above, the existing health care system is tilted on a pencil point precipice. The long term cost ineffective but short term rewarding “Curative Health” care occupies a position of prominence, wherein the all-important and long term reward fetching “Promotive Health” occupies an inconspicuous basal position. Such a model, based on primary geometric knowledge is bound to be unstable and therefore unsustainable.

Proposed model is the one proposed by the researcher, in tune with the changing concepts of health in general and evolution of the concept of health on campus. One needs to shed this conservative understanding and have a broader understanding of health. One needs to have a far broader, more holistic and complete understanding of student health. Student health does not and should not merely mean the absence of illness or more precisely, “not needing to be seen in the clinic today. In line with this new understanding of the concept of health in its totality, the National Association of Student Personnel Administrators (NASPA) has developed and advocated a comprehensive campus ecology model to embrace a holistic, contextual, and environmental understanding of health in college communities (National Association of Student Personnel Administrators, 2006). Just as we would differentiate merely
not-being-sick-today from a state of student health, Keyes emphatically differentiates not-having-mental-illness from flourishing; flourishing is a complete state of health which includes dimensions of physical, emotional, psychological and social well-being – an approach that aligns well with numerous models of human development (Keyes, CLM, 2007). This also correlates well with the concept of Wellness (refer later).

Thus, the proposed model, with its focus and thrust on “Promotive and Preventive Health” is bound to be successful in the long run. Today, one needs to focus time, energies and resources on preventive & promotive health care services as well, rather than focusing on curative care alone!

This perspective on health “as a complete state in which individuals are flourishing with high functional levels of emotional, psychological, and social well-being”, enables the student to optimize all academic experiences and emerge as a wholesome individual – indisputably, a desired outcome of academic engagement. What this point of view does not support surely, is a limited concept of student health that considers clinical services a blanket solution to the problems of health on campus.

However, despite understanding the changing concept of health beyond the physical dimension alone and appreciating the all-important relationship between health and academic success, yet, what transpires in thought does not get implemented in practice! This is because one tends to separate mind from body. Academic credit is awarded to minds, not bodies. We fail to realize the fact that the student is a whole person and the mind and body cannot be considered separately.

Keeling, Underhile, and Wall have written that institutions of higher education “operate in silos; their various schools, colleges, business operations, student support services operate in parallel with one another, more focused on promoting their own internal goals and objectives than accomplishing broader institutional purposes” (Keeling R P, Underhile, R & Wall, AF, 2007). In contrast, health-related programs and services address the needs of all students in all schools and must work across the vertical structures or silos with cross connectivity. Student success requires meaningful collaboration among the vertical units – an outcome often facilitated, if it occurs at all, by the horizontal programs, services, and goals.
Further, institutional structures, reward systems, and conventional academic policies and practices discourage integrative approaches to education, the creation of holistic learning environments and the facilitation of student engagement and learning. Instead, they encourage a narrow definition of roles, responsibilities, and opportunities that discourages collaboration and perpetuates fragmentation of programs and learning opportunities (e.g., the consistent designation of faculty, student affairs staff and health service providers rather than the use of the shared, integrative identification of “educators” for all university staff members). It is no surprise that systems that are so fragmented themselves demand fragmentation from students as well – or that campus health professionals working in those environments also become segregated and marginalized (either by choice or circumstance). Student health professionals from all disciplines must make the case to leadership of the academy for the integrative power and importance of student health and those policies, programs, and services.

❖ Evolution of the concept of “Student Health Services” and “Health on Campus”:

The changing paradigm of health in general also holds true for health on campus. Campus health initiatives are too often focused on providing curative care services alone. Further, they are operated in organizational silos in which individual departments with discrete responsibilities (health center, counseling center, psychiatry service) respond to illnesses. Today, the academia undervalues and sidelines student health services primarily because they fail to understand the close interrelation between student learning, engagement and success. Health services therefore are given a secondary, ancillary or “may provide” status which does not find a place in the list of priorities.

More broadly, the concept of “health on campus” has become uncomfortably equated with its delivery systems – “health services” – which are in turn categorized as and reduced to “auxiliary” student services. These limited ways of understanding and addressing health, ignore the well-documented linkages between the health of students and their personal, social, and academic success – and neglect important opportunities to strengthen student engagement and promote student success by
removing or ameliorating health-related barriers to learning and create healthy learning environments in campus communities that improve learning and student outcomes.

Addressing and investing in students’ health, understanding these varied perspectives is essential to the education and preparation of the whole student. It is time for a renewal of thought, discussion and action about student health. Our expanding knowledge of the processes and paradigms of learning, emerging institutional commitments to student success and a revised formulation of the elements of health itself demand that our facility-centered, service-oriented, illness-focused, and program-driven model of student health be reconsidered (Meier, S. Stock, C. and Krämer, A, 2006).

Public health is defined as: The science and art of preventing disease, prolonging life and promoting health and efficiency through organized community effort (Park’s Textbook of Preventive and Social Medicine, 2009, pp 43). This definition summarizes the philosophy of public health, which remains largely true, even today. The definition applies equally well to health on campus as well, if we consider “campus” as a component of a community. The important element of this definition is promoting health and the concept of organized community effort which implies that health is to be owned collectively by each and every one, across the campus. It is not, cannot and should not be the domain / prerogative of healthcare professionals alone. It is particularly applicable to “on campus” healthcare delivery systems, especially so with the paradigm change in the concept of “health on campus”.

Given the paradigm shift in our understanding of health in general and specifically, health on campus, we therefore must first understand the importance of student health services and then the importance of establishing students health services on campus.

College students risk some of the highest numbers of person years of life, affected or lost from illnesses and injuries. These are largely preventable through alterations in their risky health behaviors. Unfortunately, no other age group is perhaps so thoroughly misunderstood and overlooked when it comes to planning and financing their medical care.
In strategizing student health services, one must keep track of the paradigm shift concerning student health services. It is based on the following:

1. **Student demographics**: College populations have changed dramatically in the past several decades and college health centers are now serving a larger number of students who are different from what they used to be (or rather what we are used to seeing). They are thus in a sense “nontraditional” i.e. they may be older, coming beyond the conventional 9 to 5 timings, financially independent or on the contrary, may pose financial challenges. In essence, these “nontraditional” students of the 1960s and 1970s are becoming the traditional students of today; the challenge lies in trying to find ways to reduce the barriers this heterogeneous student body encounters as it attempts to use campus health services.

Nontraditional students by way of their age are more likely to need treatment for chronic medical problems, such as hypertension (high blood pressure), cardiovascular disease (diseases of the heart and blood vessels), arthritis (inflammation of the joints), gynecologic (relating to females) problems, cancer, Diabetes Mellitus etc. Consequently, campus health education and health promotion services should reflect these diversified needs. Traditional activities that focused on nutrition, general hygiene, substance abuse, sex education etc. need to be diversified to include programs that address midlife stress, relationship counseling, cancer awareness and so forth.

The hours of functioning of a student health service can impact student usage. Hence, it is important to have extended / flexible hours of functioning. According to Grace T, 1997, it is “not uncommon for students to delay treatment of acute respiratory and gastrointestinal infections until an opportune time in their class schedule; then they request immediate access to healthcare”. Having extended hours can allow students to utilize services at their convenience. Further, on campus healthcare centers need to accommodate the schedules of part time students who may arrive after 5 pm and spend only a couple of hours per day on

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1. **Health Promotion**: It is the process of enabling people to increase control over and improve their health (the Ottawa Charter for Health Promotion, WHO Europe, 1986). Health promotion comprises efforts to enhance positive health and prevent ill-health through the overlapping spheres of health education, prevention and health protection (Dunne, C. Somerset, M. 2004)
campus. Student health services need to constantly evolve and change with the needs and requirements of the students that they serve.

With education getting costlier by the day, financial difficulties are a stark reality. Many students may be living at home or finding part-time or full-time jobs to finance their college fees. Balancing academic and job responsibilities is common among these "nontraditional" students, who spend relatively little time on campus and therefore may access on campus healthcare services beyond the conventional timings. Students pursuing distance education programs pose further unique problems of accessing healthcare facilities on campus. Scheer B & Lockee B 2003, stress the need for student services, not to ignore the health needs of the online learners. They point out that the health needs of this population are more invisible than other student groups. They opine that this population of students has a “variety of roles other than that of being a student” and as a result, the need for these students to balance their responsibilities causes heightened stress levels that impact their health and their ability to be successful learners.

Students in India have the highest likelihood of being uninsured and those students who have coverage may be greatly underinsured (Bhat Ramesh & Mavlankar Dileep, 2000). Many students may be enrolled in their parents' managed care plans, which may offer excellent benefits locally but do not pay for medical care delivered outside of their service areas. Students' basic medical needs may be met at the campus health center, but this does not protect the students from financial hardships in the event of a serious medical problem. Although most adolescents and young adults do not incur great expenses for healthcare during any given year, average expenditures can be misleading!

2. **Health Problems:** It is often believed that students are a healthy population and do not have any of the health problems which the general population has. Not only do students have their unique health problems (especially so in case of lifestyle related disorders mentioned above), the kinds of problems occurring in college students have changed over the past few decades. The changes are with respect to:
a. **Acute and chronic conditions:** Although some conditions present more commonly in the college-age population, students come to the centers with essentially the same acute health problems that are seen in a general medical practice. These include an array of musculoskeletal (affecting muscle and bones) conditions, trauma (e.g., sprains, fractures, and lacerations) and minor infections. However, college students’ use of medical services is different from that of the general population. It is not uncommon for students to delay treatment of acute respiratory and gastrointestinal infections until an opportune time in their class schedule; when they request immediate access to healthcare—*walk in* services (Fingar, 1989).

Serious medical and surgical problems are not uncommon in college-age populations. College students, traditionally considered a healthy group, may also develop some very severe medical problems, such as appendicitis (inflammation of the appendix), severe upper / lower respiratory tract infections, food poisoning etc. The challenge arises due to delay in seeking treatment due to unauthenticated information (including half-baked knowledge), (un)solicited advice of peers, financial / academic deadlines to be met or financial difficulties or simply complacency!

Nontraditional students (all categories as mentioned above) broaden the range and complexity of health problems seen on campus and many chronic medical problems actually begin during the college years. Increasing numbers of disabled students with physical or mental impairments that substantially limit major life activities are also enrolling at colleges and universities today.

b. **Communicable diseases:** Communicable diseases such as varicella (chicken pox), scabies (contagious skin disease with intense itching) etc. sometimes occur in newly aggregated young people who live and work in close proximity. In addition to managing such communicable diseases, student health services need to be responsible for preventing the spread of these infections to other students.
3. **Diet Related Disorders (DRDs):** It is so important for students to fuel themselves with healthy, high energy foods to support themselves to meet and sustain the academic rigor of higher education; unfortunately, it is not always so observed. It is extremely common for most students to have fast food, which has high concentrations of fats and sodium (Grace, 1997). Eating disorders represent another contemporary problem on academic campuses. Mass media and the advertising industry have been extremely successful in setting norms that influence the behaviors of the youth. e.g. the zero figure of film stars! These norms have led to tremendously low self-esteem and unreasonably thin body images in many of our young people because they cannot separate these make-believe images from the real world. Hence, food fads including bulimia and anorexia (both eating disorders) are increasing rapidly. These eating problems are difficult and require prevention programs aimed at enhancing the psychological health and self-esteem of students before they even get to institutions of higher education.

Current epidemiologic evidence (Gupta A K & Ahmed A J, 1990) supports links between diet and many chronic diseases, cardiovascular disease, cancer, diabetes, obesity, and osteoporosis (bone disorder). A hallmark of most student diets is fast food that is high in fat and sodium content. The college years present a distinct set of nutritional priorities and poor eating habits often worsen during this time.

4. **Health Risk Behaviors:** It may be a unanimous opinion that alcohol abuse is the leading problem on today's college campuses (Singh A K et al, 2006). Besides the inherent adverse effects of alcohol consumption, the accompaniments of alcohol consumption include violent behavior resulting in physical injuries causing both intentional & unintentional injuries, emotional difficulties, academic problems, as well as unplanned and unsafe sexual activity, sexual assault and physical and cognitive impairment.

The negative health consequences of tobacco consumption are also well known and cigarette smoking remains an important preventable cause of premature deaths in our youth today (Simmons, V N and Brandon, T H, 2007). A disturbing trend is the rising incidence of smoking amongst girls, probably attributable to the
current generation of the women of today who believe in gender equality and women liberation! Further, one also needs to address the adverse effects of passive smoking.

5. **Sexual Health:** The need for health professionals to develop and implement more effective programs for preventing sexually related problems on campus is critical. Despite successful efforts to educate college and university students about risky sexual activities, all indications are that this knowledge is not resulting in preventive behavior changes which adopt safe sex practices. The AIDS epidemic is therefore increasing more rapidly among persons infected through heterosexual contact.

Studies suggest a significant proportion of sexually active college students use contraceptives inconsistently. More innovative behavioral intervention techniques are needed for us to achieve one of the primary national health objectives for the college-age population: a reduction in unintended pregnancy and transmission of sexually transmitted diseases (STDs) including Human Immune Deficiency Virus (HIV) infection (Abrahm L. and Kumar A. K., 1999).

6. **Violence:** As with society in general, college campuses are experiencing a noticeable increase in violence and sexual assault (Baltimore, 2005). College health professionals today are required to deal with the clinical manifestations of violence, both physical and mental, on a daily basis. The system is being challenged not only to provide support services that address the consequences of assault but also to develop innovative educational programs that prevent assault.

7. **Wellness** & Promotive Health: Fitness levels of our youth are fast declining or failing to improve and the most rapid reduction in physical activity levels occurs between the ages of 18 and 24 years (Grace, T. W. 1997). A sedentary lifestyle characterizes a substantial proportion of young adults on a college campus. This is a particular concern for college health providers, given the strong epidemiologic

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4 As defined by Dunn in 1961, Wellness is “an integrated method of functioning which is oriented towards maximizing the potential of which the individual is capable”. It is multifaceted, involving 6 dimensions (i.e. Physical, occupational, social, spiritual, intellectual and emotional) that are enmeshed, related and when balanced properly, provide the individual with optimum health
evidence supporting positive relationships among physical activity, physical health, and psychological health. Programs focusing on behavioral maintenance for physically active students need to devise distinct intervention strategies that are necessary to help more sedentary students.

In light of the above opportunities and challenges, establishment of student health services is therefore justified for the following reasons:

1. Inextricable linkage between health and academic performance and student retention.

2. Education today, more so higher education and especially so university education introduces newer challenges to the students e.g. change in medium of instruction, financial difficulties, instructional methodologies (35 minute period is replaced by a 1 hour lecture), evaluation parameters (continuous internal assessments, cumulative grade point average-CGPA system) etc. The student therefore is exposed to a totally new academic environ. Added to this may be exposure to a new societal fabric e.g. co-education with students of opposite sex, a more liberal society etc. with consequent stresses and strains. All these factors undoubtedly may affect the student’s health and therefore ultimately academic performance.

3. Higher education is mostly pursued in urban settings. Students may originate from a rural background. Given the huge urban – rural divide that exists today between India & Bharat, this migration amply justifies the provision of student health services to facilitate adjustments of the student on various fronts, as mentioned below.

4. Higher education today usually entails staying in closed cohorts such as hostels, halls of residence etc. Students originating from different socio-economic –cultural background thus may get grouped together. This, for some (if not the most), may be the first such interaction. These conditions are conducive for a host of psychological interactions, which are /should be ideally addressed by the student health services.
5. All the above and other factors necessitate provision of stress management and counseling services through the student health services: Mental health problems that college students are dealing with today are extensive. In fact stress alone can be responsible for a plethora of health problems, culminating ultimately in an inability to cope. Stress-related disorders are responsible for a significant number of visits to healthcare professionals nationwide and there is no reason to believe that college students are any less vulnerable to emotional problems. In fact, a number of unique stressors are present in the college environment: examinations, public speaking, interpersonal relationships, and the transition from structured home environments to independent living conditions. How students cope with such stressors can have major lifetime consequences. Stress contributes too many of the emotional and physical symptoms common in the college population, such as fatigue, hypertension, headaches, depression, anxiety and an inability to cope. Excessive stress reduces work effectiveness, contributes to bad habits and results in negative long-term consequences, including addictions, crime, absenteeism, poor academic performance, school dropouts, professional burnout, and, ultimately, career failure (Froehle Thomas C, Rai Hegde Surekha & Krishna G R, 2002).

As mentioned earlier, stressors inherent in the college environment often exacerbate a preoccupation with weight or precipitate eating disorders in those who are susceptible. The increasing attention to problems of inadequate nutrition on campuses today, however, has probably resulted in too little attention being paid to the other end of the spectrum of eating disorders—overeaters and therefore the emergence of a global epidemic of obesity! (Van der Horst, K; Oenema, A; Ferreira, I et al, 2006)

6. Closed communities such as hostels etc. as mentioned above provide a unique setting for spread of specific medical disorders with specific problems. e.g. varicella, Swine Flu etc. which may spread rapidly and the issue of isolation / quarantine may pose a genuine problem of control and preventing spread.
7. Immunizations: Despite recommendations for effective prevention programs, vaccine-preventable diseases continue to have an adverse health and economic impact on college campuses today. Besides ensuring that every student on campus has followed the expanded immunization programme as laid down by the public health authorities, immunizations against Rubella, Hepatitis B etc. can also be implemented through the student health services.

8. Student health services provide an ideal setting for screening: With a rise in the number of nontraditional (by way of age) students, college population today may consist of students who may be having many age related medical problems. However, these may be asymptomatic and risk factors are only detected through routine screening. Population screening aimed at early detection of such hidden diseases in presumably healthy students’ needs to be and can be implemented with advantage at campus-based health centers.

9. All opportunities for health promotion as outlined above can be effectively implemented in an institution of higher education adopting the “settings based approach”\(^5\), since the students represent a closed cohort and therefore a captive and respective audience. The emergence of lifestyle related diseases necessitates health promotion, health education and risk analysis initiatives to sensitize our youth. As healthcare providers for a significant segment of our youth, college health professionals have a unique opportunity to have a positive influence on the health of future generations through the assessment and reduction of risk factors that may result in injury and diseases in later life.

10. National investment: Provision of student health services with a holistic view point, which aims beyond clinical care services alone and seeks to develop the overall personality of the individual can be considered as a wise investment in our future citizens! From the economic view point, higher education

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\(^5\) **Settings Based Approach**: A setting is a social system in which people live, work, learn, love and play – characterized by a particular organizational culture, structure, function, norms and values –into which health must enter through appropriate entry points. Setting may be formal organizational environments e.g. schools, hospitals, prisons, geographic areas e.g. communities, cities or may be informal settings such as street corners, bars, homes etc. All settings are interconnected and each setting is a distinct but not separate part of a wider interdependent eco-system. (Doherty, S. and Dooris, M. (2006). ‘The healthy settings approach: The growing interest within colleges and universities’. *Education and Health, 24*(3): 42-43)
represents an investment of capital by the nation and failures/drop outs is a loss in return of this investment.

11. Research: Healthcare services to students present a good field of research to study the normal developments of this age group, the physiological, psychological and anthropometric data. National database can be prepared which form the basic prerequisite for global comparisons and therefore further research.

Campus health professionals deal with a range of medical problems and risky behaviors. Some medical conditions occur more frequently in the college-age population, but college health is not unique only because of the types of medical problems seen. Young people have been recognized as experiencing higher rates of morbidity, disability, and mortality from various developmental, environmental, and behavioral risk factors than the general population. These risk factors are so interrelated that successful efforts to change them require a more comprehensive approach that extends beyond the health of individuals to the wellness of an entire campus community. On the continuum of health and well-being, college health must therefore move away from focusing on disease and move toward community wellness on campus, or rather community wellness!
Thus, a summary statement of the changing paradigm of health on campus can be depicted as follows:

**Table I: Past and Emerging Paradigms of “Health on Campus”**

<table>
<thead>
<tr>
<th>Past (Historical)</th>
<th>Emerging ( Desired / Responsive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasis on clinical services</td>
<td>Balanced clinical and preventive services</td>
</tr>
<tr>
<td>Secondary prevention</td>
<td>Primary prevention</td>
</tr>
<tr>
<td>Understood as purely</td>
<td>Community influence &amp; effects recognized</td>
</tr>
<tr>
<td>Private &amp; personal</td>
<td>Population-based models and practice</td>
</tr>
<tr>
<td>Individual client</td>
<td>Shared by disciplines: Interdisciplinary</td>
</tr>
<tr>
<td>Owned by disciplines</td>
<td>Diffused organizationally</td>
</tr>
<tr>
<td>Organized discretely</td>
<td>Data-driven practice and Allocation of resources</td>
</tr>
<tr>
<td>Allocation of resources based</td>
<td>Systematic, community-based, contextual mental health service</td>
</tr>
<tr>
<td>on traditional patterns, history, status</td>
<td></td>
</tr>
<tr>
<td>Primarily traditional counseling</td>
<td>Integrated</td>
</tr>
<tr>
<td>services; often separate mental health</td>
<td></td>
</tr>
<tr>
<td>Treated in isolation</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Keeling & Associates, LLC: Final Report of Consultation, Ohio University, Hudson Health Center, Review and Recommendations: Student Health-Related Programs and Services, August 6, 2007*

On the continuum of health and well-being, college health must therefore move away from merely treating outcomes of disease and toward community wellness, where health is an outcome unto itself. These programs should focus beyond primary medical care. The establishment of effective community relationships connects students with each other, students with faculty and staff and students with the rest of the world. We have to move away from treating individuals and move towards building teamwork and healthy student communities--communities where students
care about themselves as well as about each other. Institutions of higher education must now develop a global definition of wellness that is everyone's responsibility that promotes program ownership, reaches a broader constituency, and enhances the opportunity for cultural and social change on campus (Baltimore, 2006).

Addressing and investing in student’s health is therefore essential to the education and preparation of the whole student and to achieving institutional effectiveness in pursuit of student success. What is needed is a complete reconsideration of the idea of what student health is, what it means, and how it is achieved and supported. Student health will not emerge from the delivery of specific health care services alone, no matter how good, up-to-date, or well evaluated those services are. If student health is to be more than the absence or removal of disease (i.e., a state of wholeness, resiliency, and flourishing), it cannot be addressed through a purely or primarily clinical paradigm.

One may therefore propose for a model of student health that is not centered in facilities, disciplines, and health care services – but rather an approach that is holistic and integrative enough to achieve the broader goal of supporting the development of students’ full potential. This demands a systematic way of thinking that goes beyond specific programs and services to envision the whole campus as an increasingly healthy learning community within which students – and members of the faculty and staff – can flourish.

Health requires more than health services. The message is not that clinical services are not necessary and important; it is that clinical services are not enough! Health is inextricably linked to learning. Healthy students (and healthy faculty and staff) are more able to engage fully in deep learning. Promoting student health is then a core responsibility of the institution, not merely a sideline, or auxiliary, project assigned to the clinic. Creating conditions that will advance student health and sustain healthy learning environments requires colleges and universities to create plans for student health in a large, cross-institutional framework that are comprehensive, coordinated, and linked to the learning mission of the institution.
A comprehensive, well-conceptualized student health model associated with a clear campus-wide plan can, if executed well, increase the overall resiliency of the student population; resilient students will flourish, and students who flourish will learn. These plans should be linked to broad institutional learning goals; students should learn from all their experiences in college, including their visits for primary healthcare or mental health services, engagement with prevention programs and involvement with health protective services (Silverman Daniel C & Underhile Ric, 2008)

Given the fact that by 2015, India is predicted to have the youngest population the world over (Reddy K.S, Shah B, Vardhese S, Ramdoss A, 2005) if we as professionals committed to student success are to ensure rearing a Healthy Generation Next, comprehensive strategies catering to all dimensions of health of this vital segment of the population is undoubtedly the logical need of the hour.

Agenda of health promotion has to be adequately incorporated and endorsed so as to inculcate good habits at a younger / tender age. Although several National Programmes for prevention and control of diseases exist, inculcating this sense of responsibility is best done by educating the individual. This again is in concurrence with the ancient Chinese proverb:

When planning for a year, sow corn.  
When planning for a decade, plant trees.  
When planning for life, educate.

It thus naturally extrapolates to the potential yet vital role of educational institutions in fulfilling this responsibility.

As aptly described, young adults undergoing higher education in universities are the most important resource of the nation. They are the “Human Capital”. “Students’ Health” is indeed “Nation’s Wealth”! Students pursuing higher education, therefore should be the logical beneficiaries of this comprehensive health care delivery programmes. Needless to say this should be an integral part of the overall responsibility of the administration of the higher educational institutes and universities.
Colleges and universities must invest more intentionally and fully in a continuum of health-related programs that foster, support, and sustain a campus culture in which students’ growth, resiliency and learning are fostered. These programs would include, but not be limited to, clinical interventions that teach health self-management and self-efficacy skills as well as experiential efforts aimed at linking classroom learning and student life programs and experiences with academic and student affairs curricula. Such efforts would more effectively inspire students to learn about population-based preventive health, foster healthy lifestyles, and become more fully informed and competent consumers of health care services.

An important and revolutionary understanding of the perceived role of academia revolves around student retention. How & why is retention important to colleges & Universities? Some of the possible explanations include:

- It is the academia’s responsibility and mission to ensure exit of students with the desired knowledge, skill sets and competencies. Non retention till term i.e. drop outs would be contradictory to the same.

- Most students have expectations to complete the programme successfully.

- It helps attract future students, including outstanding students.

- It is less expensive to help current students succeed, than to recruit new students.

- May (rather should) affect College’s national rankings.

To summarize therefore, in contemporary higher education, health is increasingly appreciated as a quality of well-being that constantly, intentionally and unintentionally affects student learning. This syndemic view links health, student development, and environment and informs higher education policy and practice in important ways that can promote and sustain student engagement and success. In this view, student health, just like student learning, is collectively owned across the campus (Keeling & Associates, LLC, 2007).
Having well understood and appreciated the linkage between health and academic success and the undisputed role of campus health professionals, one now can further correlate academic achievement with a higher standard of living. There are well-established links between educational achievement and a higher standard of living. Higher education pays off both for the individual and the wider community. In countries, where most of the workforce has an upper secondary education, a college or university qualification gives recipients extra earnings power and generates tax revenues for the country in which they work (The Economist Newspaper Limited, 2010). A higher income resulting from higher achievement in education should help avoid some of the inequalities in health related to poverty (Acheson Report, 1998). If the act of learning and the acquisition of a good education is inherently health-promoting then it stands to good reason that education and learning needs to take place in a healthy environment. Maximizing the health promoting impacts of the act of learning would hopefully increase the health outcomes. Moreover, as is obvious from the foregoing discussion, that the act of learning is more effective and successful when the learner is healthy (Hammond C, 2002). Thus emerges the concept of a Health Promotion and its application in higher educational institutions.

In light of the above, it becomes pertinent at this stage to understand the concept of Health Promotion and its practice in a close cohort / setting. An higher educational institution provides an ideal setting for health promotion.

**Health Promotion & Settings Approach to Health Promotion:**

**Health Promotion:**

Health Promotion is the process of enabling people to increase control over and improve their Health (*The Ottawa Charter for Health Promotion* WHO Europe, 1986). "Health promotion comprises of efforts to enhance positive health and prevent ill-health, through the overlapping spheres of health education, prevention and health protection." (Dunne, C. Somerset, M. 2004).

Health promotion seeks to respond to social change and political process. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also actions directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health.
Health promotion is not just the responsibility of the health sector. Health promotion extends beyond the health care sector. It networks with all relevant stakeholders in society and works on the policy agenda in all sectors and at all levels of government. To be effective, health promotion requires a comprehensive, integrated approach. It helps to generate political commitment for health supportive policies and practices and heighten public interest and demand for health. It promotes complimentary approaches and interventions. It helps in providing individuals and groups with the knowledge, values and skills that encourage effective action for health.

Health promotion aims to give people control of the things which determine their health. It strengthens skills and capabilities of individuals and the capacity of groups to exert control over the determinants of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems. Health promotion is thus all about a process of empowerment. Such empowerment is a virtuous circle.

Figure 4: Virtuous Circle

Empowered People

Empowered Communities

Health promotion is not synonymous with health education and should not be confused with the transmission of health messages. Its basic strategies include advocacy, enabling and mediating. Advocacy to generate political commitment for healthy public policies and to highlight interest and demand for health. Health promotion action aims at making all conditions favourable through advocacy for health. It enables people to achieve their full health potential and helps equip individuals and groups with the knowledge, values and skills, to mobilize the social
forces that encourage effective health action. It mediates between the different interests in society in support of health, building bridges between the public, civil society, NGOs and the private sector.

**Health Promotion action involves:**

**a. Building Healthy Public Policy:**
Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

**b. Creating supportive environment:**
Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable. Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization - is essential and must be
followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

c. **Strengthening community action:**
Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support and to develop flexible systems for strengthening public participation and direction of health matters.

d. **Developing personal skills:**
Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments and to make choices conducive to health. Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies and within the institutions themselves.

e. **Reorienting health services:**
The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services alone. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life and open channels between the health sector and broader social, political, economic and physical environmental components.
Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.

**Combinations of these five strategies are more effective than just a single-track approach. Health promotion stresses the importance of participation; its work is carried out by and with, and not on, or to people. Participation is essential to sustain effort. People have to be at the centre of health promotion action and decision-making processes for these to be effective.**

There are four basics steps to indentify and implement health promotion. These are **Diagnosis, Planning, Implementation and Evaluation**

**Current relevance of health promotion:**
The World Health Report 2002 documented the public health impact of several major risk factors related to diet, nutrition, tobacco, alcohol, physical activity, hygiene, and unsafe sex. Failure to address these risks has led to cardiovascular and chronic respiratory diseases, diabetes, injuries and violence, several mental disorders and causes of substance dependence, HIV/AIDS and sexually transmitted diseases becoming major constraints to health development. All of these are amenable to health promotion interventions.

Student learning is at the core of the higher education academic mission. Health promotion serves this mission by supporting students and creating healthy learning environments. A wide range of professionals work to enhance health, both on the campus and individual level. It is common to find health educators, nurses, physicians, counselors, faculty, and staff from residence life, student activities, campus recreation and other student affairs departments leading or collaborating on health promotion initiatives that advance student learning and the mission of higher education. Programs and policies surrounding issues such as alcohol and other drug use, sexual misconduct, and mental health are increasingly viewed as campus wide concerns that affect student health and academic progress.
In 1996, the American College Health Association (ACHA) appointed the Task Force on Health Promotion in Higher Education to study the scope and practice of health promotion in colleges and universities. The goal of this task force was to develop standards of practice to enhance the quality of health promotion in higher education, recognizing the multidisciplinary background of professionals who work to advance the health of students and campus communities. In 2001, ACHA published the culmination of that research as the first edition of *Standards of Practice for Health Promotion in Higher Education (Standards)* (ACHA, 2005a). These have been subsequently modified based on feedback in 2004 and again in 2005.

The Standards are guided by several premises about the mission and scope of practice of health promotion in higher education as well as health itself. The mission of health promotion in colleges and universities is to advance the health of students and to contribute to the creation of healthy and socially just campus communities.

**Health promotion and the academic mission of higher education are natural allies.**

**Standard 1: Integration with the Learning Mission of Higher Education**

Effective practice of health promotion in higher education requires professionals to incorporate individual and community health promotion initiatives into the learning mission of higher education.

**Standard 2: Collaborative Practice**

Effective practice of health promotion in higher education requires professionals to support campus and community partnerships to advance health promotion initiatives.

**Standard 3: Cultural Competence**

Effective practice of health promotion in higher education requires professionals to demonstrate cultural competency and inclusiveness in advancing the health of individuals and communities.
**Standard 4: Theory-Based Practice**
Effective practice of health promotion in higher education requires professionals to understand and apply professionally recognized and tested theoretical approaches that address individual and community health.

**Standard 5: Evidence-Based Practice**
Effective practice of health promotion in higher education requires professionals to understand and apply evidence-based approaches to health promotion.

**Standard 6: Continuing Professional Development**
Development and service effective practice of health promotion in higher education requires professionals to engage in on-going professional development and service to the field.

The Standards delineate a set of indicators to evaluate comprehensive health promotion programs and guide recognition of those programs.

**Global Programme on Health Promotion Effectiveness (GPHPE)**
The GPHPE is a multi-partner project coordinated by the International Union for Health Promotion and Education (IUHPE) in collaboration with the WHO and it aims to raise the standards of health promoting policy-making and practice world-wide.

The rationale of the Global Programme on Health Promotion Effectiveness (GPHPE) is to focus on the principles, models and methods that relate to best health promotion practice, taking regional and cultural diversity into consideration.

**The Settings Approach to Health Promotion:**
Subsequent to the Ottawa Charter the World Health Organization developed the *settings approach* to health promotion. This approach focuses on the “setting” or place where people are at work or play. Key settings are healthy cities, healthy schools, healthy hospitals and healthy workplaces (Doherty, S. and Dooris, M. 2006).

A setting is a social system in which people live, work, learn, love & play- characterized by a particular organizational culture, structure, functions, norms & values – into which health must enter through appropriate entry points (Kickbusch, I, 1995).
A setting is also where people actively use and shape the environment and thus create or solve problems relating to health. Settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organizational structure

The values that underpin the healthy settings approach are participation across the whole setting, empowerment, equity, partnership working and sustainability ((Dooris M, 1993)

Settings may be formal organizational environments (schools, workplaces, hospitals, prisons, long-term care facilities), geographic areas with social ties (communities, cities, islands, regions), or informal settings (washrooms, street corners, virtual communities, homes)

At their simplest, settings such as schools and workplaces are convenient places for health promotion and interventions. However, healthy settings are about more than this, because they use whole systems thinking. This aims to integrate a commitment to health into the fabric of settings - within their cultures, structures, processes and routine life.

The settings approach is usually applied to organizational settings such as healthy schools, healthy colleges, healthy universities etc. but it is also part of broader-based initiatives such as Healthy Cities. All settings are interconnected, and each setting is a distinct but not separate part of a wider, interdependent ecosystem.

The settings-based approach is characterized by the use of particular processes and techniques drawn from organizational, management and systems theory. The consequence of this is that health must enter each system – finding a place within institutions and organizations created and structured for other (problem-solving) purposes. Organizational development is the overall means of achieving this. The organizational development process seeks to identify how health can make the system perform better and how a commitment to and investment in health can be embedded within the structures, mechanisms, culture and routine life of the learning organization. Grossman & Scala argue that organizational development can be most
effectively put into operation through project management. Establishing and managing a defined project with its own organizational structure, within or between existing organizations, makes it possible to facilitate innovation, cooperation, mobilization, development and change.

Baric has argued that the settings-based approach is characterized by three key elements: a healthy working and living environment, integrating health promotion into the daily activities of the setting and reaching out into the community (Kickbusch, I, 1995).

Key processes in the management of a settings-based health promotion project include:

- Sensitive and planned management of change within organizational cultures, structures and processes
- Policy development and the introduction of health as a key criterion in organizational decision-making
- The harnessing of existing, and the development of new knowledge and skills, and
- The development and integration of health into quality, audit and evaluation procedures – which ensure clear accountability and enable the development of a foundation for settings-based work, built on evidence related to health gain.

The concept of the health-promoting university has emerged as part of the movement for health-promoting settings.

**Healthy College:**

The concept of developing a “Healthy College” at present is largely perceived as being more concerned with the development of a contented, happy and healthy student body and workforce which in turn is more likely to produce a successful learning organization (O’ Donnell T & Gray G, 1993).
A Healthy College is one that understands the importance in investing in the health and welfare of its staff and pupils to maximize achievement, through providing a physical and social environment that is conducive to teaching and learning. The concept of a Healthy College means thinking about how things are done as well as what is done. The process is as important as the outcomes. A health promoting college is concerned with health in its broadest sense, extending beyond traditional health education. It is concerned with wider issues such as empowerment, self-esteem and the environment (Vincent, D. 2007).

Key features of a Healthy College should include; the institutional procedures, values and policies; the environment; the curriculum and the staff/student relationship including pastoral support for students (O’Donnell, T. & Gray, G 1993). They further suggest that all aspects identified in their model must be developed jointly if the College is to achieve its goal of becoming a health promoting organization.

- **Health Promoting University (HPU):**

Based on the above mentioned idea and concept of health promoting colleges of O’Donnell & Gray, a few years later, emerged the concept of Health Promoting Universities which highlighted interest in the application of a settings-based approach in health promotion to higher education.

**Why universities?** The potential of universities to promote health:

University is a setting in which knowledge and skills should be taught, and a safe, healthy and supportive social as well as physical environment should be created (Ofsted et al, 2007). Moreover, the university has a responsibility to work towards

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6The association of European universities has defined universities or equivalent institutions of higher education as those that:

a. Are equipped to provide teaching and research in several disciplines.

b. Admit student who have successfully completed secondary school or past an equivalent entrance or competitive examination.

c. Award, of their own authority, academic degrees in the disciplines taught and in particular, doctorates or their equivalent.

d. Enjoy autonomy, including the right, through their members at least, to participate in the appointment of teaching staff and the appointment of executive bodies

e. Have proved their viability by reaching a critical mass, generally over a number of years
emphasizing and increasing the students’ capacity to gain control over and improve their health and to reorient the focus of health services from merely addressing illness to prioritizing illness prevention and health promotion.

Universities committed to the principles of “Health for All” and sustainable development can be a tremendous asset to their staff and students, to the communities in which they are located and to the wider society where their students and trainees will eventually assume professional roles.

According to the WHO report of 1997: Health Promoting Universities project: Criteria and Strategies for a new WHO European network, Universities can do many things to promote and protect the health of students and staff, to create health-conducive working, learning and living environments, to protect the environment and promote sustainability, to promote health promotion in teaching and research and to promote the health of the community and to be a resource for the health of the community. The challenge is to develop health-promoting university projects that encourage all these aspects.

The concept of the health-promoting university is powerful. The challenge is to give it, from the very start, a broad and strategic scope, objectives that reflect the philosophy and principles of “Health for All” and sustainability and tools that are appropriate for a settings-based approach to health promotion. The concept of the Health Promoting University means much more than conducting health education and health promotion for students and staff. It means integrating health into the culture, processes and policies of the university. It means understanding and dealing with health in a different way and developing an action framework that blends such factors as empowerment, dialogue, choice and participation with goals for equity, sustainability and health-conducive living, working and learning environments. Universities can potentially develop into model health-promoting settings. They have the intellectual capacities, the skills, the authority and the credibility for this purpose. Universities are also a valuable resource for the communities in which they are located. Investing in the health promoting university is above all an investment in the future (Health Promoting Universities Project, 1997).
Therefore universities that become involved in health-promoting university projects may obtain several benefits, including:

1. Improving their public image.
2. The profile of the university.
3. The welfare of students and staff and
4. Working and living conditions.

1. **Public image:**
   Environmental and health standards are becoming more highly valued as the twenty-first century approaches. A project links research and practical work in the university. A project enables health research to be given more credibility.

2. **The profile of the university:**
   A project raises the profile of a university in all health matters locally, regionally, nationally and internationally. In academic terms, a project integrates a diverse institution: raising the profile of health and health promotion in many academic disciplines; increasing the credibility of an innovative research agenda; and supporting a shift in research focus from health care to primary health care, prevention and positive health.

3. **The welfare of students and staff:**
   A project identifies the strengths and weaknesses of the organization in staff and student welfare and improves the opportunities for both students and staff to improve their health. A health-promoting university project brings together existing initiatives for the wellbeing and health of students and staff, motivating and stimulating greater participation and coordination.

4. **Working & Living conditions:**
   A project improves the environments in which people work and study, live and socialize. A project offers wider opportunities for the university to link more closely with the community. It emphasizes a collaborative research agenda and opportunities to share new knowledge, practical experience and solutions to health by expanding networks.
Defining the concept of the health-promoting university and the process by which it can be developed is not an academic exercise. It is a strategic exercise that should combine visionary thinking with pragmatism and clear principles with tangible outcome. Failing to give the health-promoting university project a holistic breadth on the basis of (narrow-minded) pragmatism would be as erroneous as presenting the project as an abstract exercise in organizational development without spelling out what benefits it will bring (Health Promoting Universities Project, 1997).

Further, a health-promoting university project is not and should not be seen as some sort of luxurious and trendy thing to do at times of prosperity – on the contrary, investing in such projects at times of financial difficulties can prove a tremendous asset for protecting and promoting the health of students and staff, for ensuring adequate attention to policies of equity and sustainability and for promoting a healthy dialogue, trust-building and participatory decision-making.

The success of the Health Promoting Universities movement depends on its ability to integrate a commitment to health within the policies and practice of universities. It is necessary, however, to be realistic about what health gains can be realized, given the constraints within which universities now operate.

**The Aims of the Health Promoting University**

(Health Promoting Universities Project, 1997):

The aims of the Health Promoting Universities project are based on the philosophy and principles of the WHO strategy for health for all (Global strategy for health for all by the year 2000, 1981) and the Ottawa Charter for Health Promotion (Ottawa Charter for Health Promotion 1986). In particular, the principles of health development, equity, sustainability and solidarity represent the pillars of the health-promoting university and these are underpinned by intersectoral and interdisciplinary cooperation and mechanisms for participation and empowerment. The main challenge and goal of the health-promoting university is to integrate health into the culture, structures and processes of the university. The health-promoting university aims:
1. To create healthy working, learning and living environments for students and academic and non-academic staff;

2. To increase the health promotion aspects of teaching and research;

3. To develop health promotion links with and to support health development in the community.

**Objectives of the Health Promoting University:**

The key objectives of the health-promoting university are:

1. To promote healthy and sustainable policies and planning throughout the university.

2. To provide healthy working environments.

3. To offer healthy and supportive social environments.

4. To establish and improve primary health care.

5. To facilitate personal and social development.

6. To ensure a healthy and sustainable physical environment.

7. To encourage wider academic interest and developments in health promotion.

8. Developing links with the community.

1. **Promoting healthy and sustainable policies and planning throughout the university:**

   Universities exercise substantial autonomy over the design and implementation of their policies and practices. The health-promoting university incorporates health and sustainability as key criteria in planning and policy decisions.
2. Providing healthy working environments:
   Universities are major employers, employing a wide range of levels of professional, administrative and manual staff in a wide variety of disciplines. The health-promoting university seeks to create working and learning conditions conducive to health and to adopt good practice in employment policy.

3. Offering healthy and supportive social environments:
   Universities provide a range of cultural and leisure activities and a number of facilities for the use of staff, students and local populations. Ensuring that the needs of all staff and students are addressed, the health-promoting university encourages diversity, choice and accessibility (in terms of availability and cost) in providing services and facilities.

4. Establishing and improving primary health care:
   Universities have specific health problems associated with the demographic characteristics of their student, staff and local populations. The health-promoting university seeks to identify the specific health needs of its population and to provide a coordinated response by all the primary health care and welfare agencies within and outside the university.

5. Facilitating personal and social development:
   Universities provide formal education but are also settings where students develop personally and socially, often when they are making major life changes and adjusting their values and priorities, which may affect all aspects of their lives. The health-promoting university strives to enable students and staff to discover and explore their full potential in a safe environment.

6. Ensuring a healthy and sustainable physical environment:
   Universities manage large estates of built and landscaped environments. The health-promoting university – through its policies on building, landscaping, transport, waste management, purchasing and energy – seeks to create and maintain healthy and sustainable physical environments.
7. **Encouraging wider academic interest and developments in health promotion:**

Teaching and research are the core activities of universities. As a centre of learning, the health-promoting university seeks to exploit its potential for contributing to health gain by developing the curriculum and research across all university faculties and departments.

8. **Developing links with the community:**

The university is a key player within the local or regional community. The health-promoting university seeks to maximize its role as an advocate for health in the community by creating partnerships, acting as a resource for the community, leading through example and exercising its power as a lobbying force for health.

**Outcomes of the Health Promoting University project:**

Health-promoting university projects must be able to provide demonstrable evidence of the outcome of their efforts. The success of health-promoting university projects would ideally be measured by the extent to which they have:

- Improved the health of students, staff and the wider community.

- Integrated health into the culture, structure and processes of the university.

There are two main barriers to demonstrating these outcomes. First, organizational development is by definition a long-term process. Second, the health status of individuals and groups usually improves over a long period of time, and a large percentage of the university population turns over relatively rapidly.

Nevertheless, a health-promoting university should be able to demonstrate that the project is moving in the right direction through output related to the key objectives. The output can be described in terms of the process and impact.

A Health Promoting University should strive to manifest characteristics that reflect its commitment and investment in health. These characteristics or qualities are the practical and successful achievement of the objectives and should be visible and
evident to students, staff and the community. Dooris, 2006 maintains that this list represents a framework. Each university can develop lists of qualities and indicators to market and monitor the progress of its own project. Further, a health-promoting university is not one that has achieved a particular level of health; it is one that is conscious of health and striving to improve it.

Health-promoting universities should establish internal structures to develop and implement the project, including project steering group, a project coordinator and a clearly defined role for health-related support services and other potential stakeholders. Besides the project should also have a support structure. The main functions of such a support structure should be networking, administrative support, technical support and reporting and ensuring accountability.

The Lancaster University & Central University of Lancashire in the UK have been the pioneering universities to have implemented the health promoting universities project. Numerous universities thereafter have adopted their guidelines, aiming for membership of the International Union of Health Promotion and Education (IUHPE). The focal university of the researcher is a classical example of a university attempting to implement all of the above.

**Reasons for undertaking this study:**

Having thus understood the close linkage between health and academic success, the paradigm change in our understanding of the concept of health, evolution of the concept of health on campus and finally the near ideal “settings based approach” which higher educational institutions provide for health promotion, one needs to take stock of the developments pertaining to all of the above in our country, in light of the global developments.

The focal university of the researcher is one such educational institution in the country which is in near sync with the health promoting university movement, being implemented overseas. The researcher plans to study the different models operational nationally and learn from the other models operational in other countries. Such a comparative study has not been done so far. This comparative study is therefore
exploratory in nature. The findings and conclusions arrived at, constitute the basis for policy recommendations, which would help implement the best practices on campus of educational institutions in our country which in turn could revamp the higher educational system in the country. Therefore the researcher undertook the present study.