Chapter 3

Review of Literature
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- Health & Higher Education: Historical perspective

- Historical review of Student Health Services in India

- Historical review of Student Health Services globally

- Public Health

- Changing Concepts of Public Health

- Public Health in India:
  a. Health Committees
  b. Health through Five year plans: Relevant healthcare provisions

- Public Health: Global initiatives:
  a. Healthy Cities.
  b. Health Promoting Hospitals (HPH).
  c. Healthy Campus & Healthy People.
  d. Healthy College.
  e. Health Promoting University (HPU).

- The International Union for Health Promotion and Education (IUHPE)

- National & International Healthcare Models:
  a. Healthcare systems on campus of educational institutions in India
  b. Healthcare systems on campus of educational institutions abroad
Health & higher education: Historical perspective

The need to address health in educational settings has been recognized as early as the mid-nineteenth century. By 1902, Thomas Storey had concluded that poor health impaired the effectiveness of college graduates. In 1927, Storey published *The Status of Hygiene Programs in Institutions of Higher Education in the United States* to advance the standing of health programs and services on college campuses (Christmas, WA & Dorman, J M, 1996). In 1987, Allensworth and Kolbe expanded the school based health related programmes & services (Allensworth, DD & Kolbe, L J, 1987). In writing about the link between health and education, McKenzie and Richmond observed: “If schools do not deal with children’s health by design, they deal with it by default” (McKenzie, F D & Richmond, J B, 1998). Heather Munro Prescott, a professor of history at Central Connecticut State University has written a comprehensive and compelling new history of the origins and development of health-related programs and services in U.S. colleges and universities (Prescott H.M et al, 2007).

In 2005 Sacher L reported that in higher education, health and learning are interdependent and that today’s students need more than the traditional provision of on-campus health services based strictly on a medical model. She emphasized the need for student health to be embraced as part of the mission of the university because keeping students healthy improves the entire learning community of students, faculty and staff alike.

In 2005 Moses K reiterated the view that the health of college students greatly influences the quality and productivity of students not only while in attendance at the university, but also throughout their lives, in the workplace and in the community.

Quirolgico, Moses and Keeling, 2005 suggested that an integration of opportunities for encouraging student health into student services improves student retention, learning, student success and academic achievement and that each of these outlined benefits is often cited throughout the educational literature as being a major aim of higher education.
✓ Historical review of Student Health Services in India:

Student wellness has been stressed by many of our leaders. Much has been said but little has been done. Pandit Jawaharlal Nehru once said “In my opinion, child welfare should have the first priority in all our activities. If we neglect our children today, if we do not look after them well we will be creating many more difficult problems for ourselves in the future” (Nehru J., quoted by Ray R, 1961).

Student Health Services in pre independent era: In India, the first medical examination of the students was carried out at Baroda in 1909 (Edward J S, 1960). Most of the reports of the subsequent surveys carried out in the different parts of the country include the results of measurements of height, chest and weight and a general medical examination. Though most of the studies pertain to school health, the confronting and therefore limiting constraints apply equally well to university health services. These include issues pertaining to logistics management such as resource allocation, infrastructure development, manpower training etc. (Godhbole N.K., 1965).

The problem of establishing health services for students staying in college and universities was not however considered seriously. One finds that other than the Universities of Bombay, Calcutta and Allahabad, no such work was done by other universities in India, prior to independence. In 1935-36, the first investigation in regard to college students in former Bombay state was sponsored by the Bombay University by introducing medial inspection of the students of the colleges affiliated to that university. However, the university could not provide for adequate and precise results. The information was collected only for a few colleges and the number of students was limited (Deshmukh C. D., 1966).

Student Health Services in post independent era: After independence many political leaders stressed the problem of student health. Recognizing an urgent need of adequate health for the student community throughout the country, the Central Council of Health adopted a resolution in their IIIrd meeting held in 1955, stating that all the State Governments should take immediate steps to establish student health
services under their health departments, so as to give the entire student population proper medical care including nutrition and physical education (Ray R, 1961).

Education Commission was set up by the Government of India in 1964 to survey the entire field of educational development in the country and advice the Government on a National System of Education & Welfare of the Students, at all stages of education. Among the special committees that were formed to access the committee, was a task force on student welfare. Student health services actually got its due importance as a result of the recommendations made by this committee.

Early information available on University Health Services in India is from the National Seminar on Student Welfare in Indian Universities, held in New Delhi during August & September 1965. This report indicated that we are in a situation, where no norms exits, no standard for unit of measurement and accuracy exist (Doraiswami S., Sarupria S, 1966). In 1937, it was stated at the National Conference on College Hygiene that constantly changing information, a lack of interest from students and resistance to change provided health educators with a challenging teaching assignment. This statement wholes true even today. Student health services continue to adapt to new information and are constantly challenged to provide a myriad of services to the colleges and universities that they serve.

**Historical review of Student Health Services globally:**

Founded in 1636, Harvard College was the first institution of higher learning to implement student health program (Patrick, K., 1992). The earliest health programs revolved around a student’s physical education and hygiene. Over time, health replaced hygiene as the overriding term for the overall well-being of an individual. Institutions soon realized that a student health service was necessary in maintaining a healthy student.

In the early 19th century, new approaches for dealing with “infirmities” were being developed (Turner, H., & Hurley, J., 2002). These approaches were highly clinical in nature and were the precursors of preventive measures and hygiene programs. This
plan would focus mainly on the immunization of students. According to Olson K and Autio L 1999, “the early health centers, mirroring the health care system of the times, were mainly infirmaries for sick students”. The next step in the development of student health services was the initiation of hygiene and physical education programs.

**Physical Education and Hygiene in Higher Education in the 1800’s:**

In 1861, Hitchcock created a health and physical education program that attempted to fill what he saw as the college’s role in combating the failing health of nineteenth century students (Sloane, D. C., & Sloane, B. C. 1986). According to Sloane and Sloane 1986, Hitchcock was the creator of health education. Hitchcock’s programs focused on educating students of the need for a nutritious diet and against the dangers of drinking and smoking and offered information on reproductive health. Hitchcock offered a new, holistic approach which focused on a student’s wellbeing. Hitchcock developed physical fitness classes, standardized student health records, created courses on health and hygiene, and instituted comprehensive individual student medical care (Sloane, D. C., & Sloane, B. C. 1986). The “Amherst system” became the model college hygiene program (Christmas, W A, & Dorman J. M., 1996).

Several factors contributed to the adoption of physical education and hygiene programs in institutions of higher education. Programs developed with activities both in and out of the classroom. According to Patrick K, 1992 “there was an effort to import the *mens sana in corpore sano* [a sound mind in a healthy body] model of fitness from European higher education with instruction in physical activity and gymnastics”. At Harvard, administrators were concerned with the “sedentary existence” of their students. It was thought that exercise was the best way to improve students’ health. Perhaps it is better stated that Harvard brought hygiene into the classroom while Amherst instituted the first student health service (Turner, H., & Hurley, J. 2002).

Although Harvard is consistently cited as being the first college to introduce hygiene into the curricula, it would be the administrators at Amherst College who would be responsible for many innovations in hygiene education.
President of the Amherst College, Reverend Dr. Hitchcock started the first college physical education program in the United States at Amherst in 1830.

He wrote about the diet, physical regimen, and employment of the Amherst student. Hitchcock was concerned with retention issues at Amherst. He expressed “concern over the wasted effort represented by a student’s dropping out of college before the completion of his academic requirements” (Christmas, W. A., & Dorman, J. M. 1996).

Though initiated by Reverend Dr. Hitchcock, his son Dr. Edward Hitchcock would be given the title, “Father of American College Health” (Turner, H., & Hurley, J. 2002). Dr. Edward Hitchcock, director of physical education at Amherst College, is credited as being the first person to establish a formal college health program (The American College Health Association: A Brief History, 2001).

**Hygiene and Health in Higher Education in the early 1900’s:**
In the early 1900’s, colleges and universities found that they needed health practitioners to care for their athletes (Crihfield, C. 1995). This led to the creation of health services in conjunction with the athletic and physical education departments. In 1901, The University of California established the first comprehensive student health service (Turner, H. & Hurley, J., 2002).

In 1920, interest developed in forming a national organization after college health programs had developed on numerous campuses throughout the country (The American College Health Association: A Brief History, 2001). Thus, an association dedicated to the field of college health was formed. It was called the American Student Health Association. In 1948, the association name was changed to the American College Health Association (ACHA).

**Student Health Services: Today**
College health programs have evolved considerably since the early 1800’s. Issues that affect today’s university or college students include: tobacco use, alcohol and other drugs, sexually transmitted infections, pregnancy, contraception, infectious illnesses,
diet related disorders and vaccine-preventable diseases (Turner H and Hurley J, 2002). The health issues which affect students’ success are often attributed to behavior. Emphasis is placed on health education and promotion. (Miller et al., 2003) Additionally, student health services of today collaborate with the greater academic community in which they reside (Patrick, K, 1992).

Some of the contemporary issues concerning student health services today are:

a. Accreditation and certification:
Accreditation and certification are an important part of student health service, today. Although it is expensive and time consuming, student health services can benefit immensely if they are accredited. Accreditation can provide evidence that a student health service is providing a quality service that is comparable to other student health services (Turner H and Hurley J, 2002).

Health educators are increasingly becoming Certified Health Education Specialists (CHES). According to the National Commission for Health Education Credentialing (NCHEC), the CHES is an indication of professional competency and commitment to continued professional development (2002). 80% of all colleges and universities in the United States have “some organized arrangement for advancing student health” (Miller, T. (Ed.). 2003). The principal associations for student health services are the American College Health Association and the American Public Health Association. In 1998, the college health education Competency Update Project was started by the National Commission for Health Education Credentialing (NCHEC).

b. Virtual Services:
The student health services office of today extends far beyond its “brick and mortar” walls. The Internet has increased the reach of student health services and in some cases the online presence is more familiar than the real office. Such is the case for Columbia University’s Go Ask Alice! service. Go Ask Alice! is an online health question and answer service. Since 1993, Go Ask Alice! receives nearly 2,000 questions weekly from college and high school students, parents, teachers, professionals, older adults and others, on every conceivable health topic. Universities across the nation have adopted this method of information exchange. In fact, a Google
search of the education Internet domain yields over one hundred “health questions and answers” websites.

Another technology which has enabled student health service administrators to communicate nationally has been the list serve. The SHS List serve, created at the University of Tennessee-Knoxville, has over 1,600 members. The List serve has become a major source of information, discussion and debate on college health issues in the United States and the world (Turner H and Hurley J, 2002).

c. Financing Health Services:
The economic climate in which college health programs exist is one that is filled with uncertainty and opportunity. Funding sources are no longer limited to university general funds and student fee revenues. Grant funded programs can now supplement or increase overall service offerings. College health programs can have multi-million dollar budgets especially when health education services are incorporated into “multi-specialty clinics” which offer services to students, faculty, staff, spouses, dependents, and in some cases, the general public. Forced to eliminate student health service offerings, some institutions have begun to outsource clinical services (Turner H and Hurley J, 2002).

❖ Public Health:

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 XXth edition February 2009, pp 43).

“The new public health” is defined by the WHO Regional Office for Europe as follows: “Professional and public concern with the effect of the total environment in health.” The term builds on the old (especially 19th century) public health, which struggled to tackle health hazards in the physical environment (for example, by building sewers). It now includes the socioeconomic environment (for example, high unemployment). “The new public health” tends to be restricted to environmental
concerns and to exclude personal health services, even preventive ones such as immunization or birth control.

This definition summarizes the philosophy of public health, which remains largely true, even today. 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 of healthcare professionals alone. It is particularly applicable to “on campus” healthcare delivery systems, especially so with the changing paradigm in the concept of “health on campus”, envisaging a collective ownership across the community, as outlined in the previous chapter of introduction.

❖ Changing Concepts of Public Health:

In the history of public health, four distinct phases may be demarcated (Park’s Textbook of Preventive and Social Medicine, 2009, pp 8):

a. Disease Control Phase (1880-1920):
Public health during the 19th century was largely a matter of sanitary legislation and sanitary reforms aimed at the control of man's physical environment, e.g., water supply, sewage disposal, etc. These measures vastly improved the health of the people due to disease and death control.

b. Health Promotional Phase (1920-1960):
At the beginning of the 20th century, a new concept, the concept of "health promotion" began to take shape. Public health departments began expanding their programmes towards health promotional activities. Two great movements were initiated for human development in this period, namely (a) Provision of "basic health services" through the medium of primary health centers and sub centers. (b) The Community Development Programme to promote village development through the active participation of the whole community and on the initiative of the community. Thus, as early as the beginning of the 20th century, there was an understanding of the importance of involving the community.
c. Social Engineering Phase (1960-1980):
With the advances in preventive medicine and practice of public health, the pattern of disease began to change in the developed world. Many of the acute illness problems have been brought under control. However, as old problems were solved, new health problems in the form of chronic (non-communicable) diseases - NCD began to emerge, e.g., cancer, diabetes, cardiovascular diseases, alcoholism, drug addiction etc. especially in the affluent societies. These problems could not be tackled by the traditional approaches to public health such as isolation, immunization and disinfection nor could these be explained on the basis of the germ theory of disease. A new concept, the concept of "risk factors" as determinants of these diseases came into existence. The consequences of these diseases, unlike the swift death brought by the acute infectious diseases was to place a chronic burden on the society that created them. These problems brought new challenges to public health which needed reorientation, more towards social objectives. Social and behavioral aspects of disease and health were given a new priority. Public health moved into the preventive and rehabilitative aspects of chronic diseases and behavioral problems. Public health then entered a new phase in the 1960s, described as the "Social Engineering" Phase.

d. Health for All phase (1981-2000 AD):
As the centuries unfolded, the glaring contrasts in the picture of health in the developed and developing countries came into a sharper focus, despite advances in Medicine. Most people in the developed countries enjoy all the determinants of good health - adequate income, nutrition, education, sanitation, safe drinking water and comprehensive health care. In contrast, only 10 to 20 per cent of the population in developing countries enjoys ready access to health services of any kind (Global Strategy for Health for All by the year 2000, 1981).

7 Germ Theory of Disease: Promoted by Sir Louis Pasteur and others, the theory ascribes individual microbes as the causative agent for a disease. It proposes a one to one relationship between causal agent and diseases as: Diseases agent – Man Dasename (Park’s Textbook of Preventive & Social Medicine, 2009, pp 5).

8 Risk factors: An attribute or exposure that is significantly associated with the development of a disease; a determinant that can be modified by intervention, thereby reducing the possibility of occurrence of disease or other specified outcomes (Park’s Textbook of Preventive & Social Medicine, 2009, pp 36).
A global awakening concerning this disparity arose seeking to ameliorate, if not eliminate this inequality. Against this background, the members of the WHO pledged themselves to an ambitious target to provide Health for All by the year 2000, that is: attainment of a level of health that will permit all people to lead a socially and economically productive life. Currently public health is engaged in this broad field of effort.

❖ Public Health in India:

After India attained freedom there was continuous growth of population which caused a number of medical and health problems. Special efforts were therefore made to solve those health problems and various committees were set up from time to time (Goyal R C, 2002, pp 7-14).

a. Health Committees:

The Bhore Committee (1943-1946):
In 1943, a committee was set up under the Chairmanship of Sir Joseph Bhore to work out an integrated system of health services in India. The recommendations of the Bhore Committee took the form of the short term and long term plans based on an integrated system of curative and preventive services. Even today, the report is still considered as a landmark in the history of medical services.

The Mudaliar Committee (1961):
The Mudaliar Committee was appointed to review the progress made in medical relief and public health since the submission of the Bhore Committee's report and to formulate guidelines and proposals for inclusion in the subsequent Five Year Plans.

The Jain Committee (1966):
The Jain committee was appointed to undertake a study of the working of different classes of hospitals in the country with a view to improving the standards of medical care and developing sound guidelines for the future expansion of hospital services.
The Kartar Singh Committee (1973):
This committee was appointed to make recommendations on the structure for integrated services, the feasibility of having multi-purpose workers in the field, the training requirements for such workers and lastly the utilization of mobile service units.

The Srivastava Committee (1975):
This committee was set up to report on medical education and manpower requirement.

The Sidhu Committee (1977):
This committee was appointed to report on strengthening of the accidents and emergency services in hospitals.

The Bajaj Committee (1986):
The Government of India appointed the Bajaj Committee for health manpower planning.

b. Health through Five Year Plans: Relevant healthcare provisions

The Government has been constantly keeping funds out of the total plan outlay of the five year plans for the health plans of the country (Goyal R C, 2002, pp 20-38). Currently the XIth plan is underway.

First Five Year Plan (1951-56):
The plan presented by India’s first Prime Minister, Shri. Jawaharlal Nehru on December 8, 1951 emphasized that health is a vital part of a concurrent and integrated programme of development of all aspects of community life.

Second Five Year Plan (1956-61):
The general aim of health programmes during the Second Five Year Plan was to expand existing health services, both quantitatively as well as qualitatively.
Third Five Year Plan (1961-66):
The broad objective was to expand existing health services pertaining to family planning. Increased emphasis was laid on preventive health services. Specific programmes were formulated for specific issues e.g. environmental sanitation, communicable diseases, maternal and child welfare services etc.

Fourth Five Year Plan (1969-74):
During the Fourth Five Year Plan, efforts were made to strengthen the primary health centers. Medical and nursing education and the training of paramedical personnel were expanded. Family planning found a place in the Fourth Five Year Plan as a programme of the highest priority.

Fifth Five Year Plan (1974-79):
The primary objective during the Fifth Five Year Plan was to provide minimum public-health facilities integrated with family planning and nutrition. The emphasis was on consolidation of medical education.

Sixth Five Year Plan (1980-85):
During the Sixth Five Year Plan, health-care programmes were restructured and reoriented according to the National Health Policy (NHP). Priority was given to extension and expansion of the rural health infrastructure. Efforts were made to develop promotive and preventive services along with curative facilities.

Seventh Five Year Plan (1985-90):
In the Seventh Five Year Plan, the major thrust areas were control and containment of non-communicable diseases, training and education of medical / para-medical personnel & medical research, especially development of the Indian System of Medicine (ISM). The possibility of establishment of Universities of Health Sciences with the objective of linking all the training centers and institutions functionally on state, regional and national levels was explored.
Eighth Five Year Plan (1992-97):
The approach and strategy for health manpower development during this plan was based on the draft of the National Policy on Education in Health Sciences. Realizing that the goal of "Health for All by 2000 AD" laid down in the National Health Policy was unlikely to be achieved within the time specified, the Eighth Plan consciously recognized and restated the goal as "Health for Underprivileged by 2000" and consistently promoted health care to the underprivileged segments of the vulnerable population.

Ninth Five Year Plan (1997-2002):
During the Ninth Plan, efforts were made to enhance the efficiency of the health system. The objectives were to establish an Education Commission of Health Sciences to strengthen the educational process for all categories of health professionals and to ensure continuing knowledge and skill up-gradation of all health care providers through continuing education programmes.

The National Rural Health Mission (NRHM) & Janani Suraksha Yogana was launched during this five year plan in 2005. The focus areas were:

- Mainstreaming ISM&H practitioners to help in improving the coverage of the National Disease Control Programmes and Family Welfare Programme.

- Horizontal integration of all aspects of the current vertical programmes.

- Exploring alternative systems of health care financing including health insurance so as to make affordable health care available to all.
- Improving content and quality of education of health professionals and para professionals including skill up-gradation of all health care providers.

- Building up a fully functional, accurate Health Management Information System (HMIS).

- Building up an effective system of disease surveillance and response at all levels.

- Increasing the involvement of voluntary and private organizations, self-help groups and social marketing organization in improving access to health care.

- Developing capabilities at all levels, for emergency and disaster prevention and management; evolving appropriate management systems for emergency, disaster, accident and trauma care at all levels of health care.

**National Health Policy (NHP)-2002**

(Park’s Textbook of Preventive and Social Medicine XXth edition, 2009, pp 775):

Keeping in view the national commitment to attain the goal of Health for All by the year 2000, the Ministry of Health and Family Welfare, Government of India evolved a National Health Policy in 1983. Since there have been significant changes in the determinant factors relating to the health sector, a new National Health Policy was evolved in 2002.

The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. Emphasis would be given to ensure a more equitable access to health services, specially focusing on those diseases which are principally contributing to disease burden in India. To achieve the above objectives, the NHP has laid down specific goals to be achieved by the year 2005-07-10 & 2015.
National Rural Health Mission (NRHM)

Recognizing the importance of health in the process of economic and social development and to improve the quality of life of its citizens, the Government of India launched "National Rural Health Mission" (NRHM) on 5th April, 2005 for a period of 7 years (2005-2012). The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care, and bridging the gap in rural health care through creation of a cadre of Accredited Social Health Activist (ASHA). By making necessary changes in the basic health care delivery system, the mission adopts a synergic approach by relating health to determinants of good health viz. of nutrition, sanitation, hygiene and safe drinking water. It also brings the Indian System of Medicine (AYUSH) to the mainstream of health care.

The pace of implementation of the Mission however is very slow. Garg and Nath, 2007 have opined that the progress of the Mission in Uttar Pradesh, one of the most populous states is very dismal. A government-funded review of NRHM also revealed its slow progress. The major problems in the implementation of the NRHM are: administrative constraints, governance issues, inadequacies in human resources as well as the poor investment in public health services in the recent past (Shrivastava, 2008)

Eleventh five year plan (2007-2012)

Thrust areas to be pursued during the Eleventh Five Year Plan are:

- Improving health equity through National Rural Health Mission (NRHM) & National Urban Health Mission (NUHM)

- Adopting a system-centric approach rather than a disease –centric approach

- Taking full advantage of local enterprise for solving local health problems
Preventing indebtedness due to expenditure on health/ protecting the poor from health expenditures

Decentralizing Governance

Establishing E-health

Improving access to and utilization of essential and quality health care

Increasing focus on health human resources

Focusing on excluded / neglected areas

Providing focus to health system and Bio-medical research

**Public Health: Global initiatives:**

Globally, the world over, initiatives pertaining to public health *in general* and health on campus *specifically* are exemplified by the numerous initiatives undertaken by the World Health Organization (WHO). These are:

**a. Healthy Cities:**

(http://www.euro.who.int/healthy-cities/introducing/20050202_1):

The Healthy City projects initiative began in 1987 with World Health Organization (WHO) support. It is a developmental activity that seeks to put health on the agenda of decision makers in cities, to build a strong lobby for public health at the local level and to develop a local, participatory approach to dealing with health and environmental problems. The Healthy Cities initiative seeks to put health high on the political and social agenda of cities. Strong emphasis is given to equity, participatory governance and solidarity, intersectoral collaboration and action to address the determinants of health. Ultimately, the initiative aims to improve the physical, mental, social and environmental well-being of the people who live and work in urban areas.
Each Healthy City is encouraged to develop a city health profile and to use it as a basis on which to develop its health plans in conjunction with broad partnerships for health and the community. The profile provides the evidence for work to promote health at the local level, create unique opportunities for intersectoral work and community involvement and act as a basis for setting priorities. As such, they are essential tools for change and must be an integral part of local decision-making and strategic planning processes. Tools and guidance are developed on profiles and indicators which helps a city to "draw a picture" of its health and its determinants. The WHO only recommends a set of guidelines for establishing Healthy City Project. Because of the city specific, process oriented nature of Healthy Cities Projects, it is impossible to draw up a comprehensive list of activities to be undertaken.

Healthy Cities is a continuously evolving and dynamic concept. A Healthy City is defined by a process, not an outcome (Goldstein, G. Kickbusch I., 1996). Some of the characteristics of a Healthy City are:

- It is conscious of health and striving to improve it. Thus any city can be a "healthy" city, regardless of its current health status.

- A healthy city is not one which has achieved a particular health status.

- What is required is a commitment to health and a process and structure to achieve it.

- A healthy city is one that is continually creating and improving the physical and social environments and expanding the community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.

Healthy City Projects are popular around the world with more than 1000 cities or towns adopting them. There are networks of Healthy City Projects in regions of the world, linking different continents. Over 1200 cities and towns from over 30 countries in the WHO European Region are Healthy Cities. The WHO European Healthy Cities
Network consists of a network of cities from around Europe that are committed to health and sustainable development. The Healthy Cities Programme in Europe has evolved over five year phases, each giving special attention to a number of priority themes. The overarching goal of Phase V (2009–2013) is Health and Health Equity in all local policies. Successful implementation of this approach requires innovative actions addressing all aspects of health and living conditions and extensive networking between cities across Europe and beyond. This entails explicit political commitment, leadership, institutional change & intersectoral partnerships. These are characterized as the four elements for action.

As per information hosted on the website, accessed on 7th April 2010, India has 29 cities which have registered for the Healthy Cities Campaign. Individual citizens also can register for a unique WHO initiative – 1000 Cities – 1000 Lives by logging on www.who.int/whd2010


The International Network of Health Promoting Hospitals and Health Services (HPH) is a similar network initiated by the World Health Organization - Regional Office for Europe in 1988. In 1990, the WHO International Network of Health Promoting Hospitals was founded as a multi city action plan of the larger WHO Healthy Cities Network.

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. 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. 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. This correlates very well with the role of academia in ensuring the health status of students, interaction between multiple agencies towards maintaining the same and the concept of ownership of health, across individuals in various professional capacities.

Accordingly, HPHs aim at improving the health gain of hospitals (and other health services) by a bundle of strategies targeting patients, staff and the community. The HPH standards and strategies are based on the principles of the settings approach, empowerment and enablement, participation, a holistic concept of health (somato-psycho-social concept of health), intersectoral cooperation, equity, sustainability, and multi-strategy.

In order to realize the full potential of the comprehensive HPH approach for increasing the health gain of hospital patients, staff, and the community, HPH needs to be supported by an organizational structure. This needs to be supported by evaluation and monitoring, professional training and education, research and dissemination. One way to implement HPH in a hospital or other health care organization is by linking HPH aims and targets with quality management, thus understanding health promotion as one specific quality aspect in hospitals and health care.

c. Healthy People & Healthy Campus (www.healthypeople.gov):

Each decade since 1980, the U.S. Department of Health and Human Services (HHS) releases a comprehensive set of National Public Health Objectives. Known as Healthy People, the initiative has been grounded in the notion that setting objectives and providing benchmarks to track and monitor progress, can motivate, guide, and focus action. Since then, HHS regularly issues updated national health promotion and disease prevention goals and objectives each decade, i.e., Healthy People 2000 (issued in 1990) and Healthy People 2010 (issued in 2000).
This year i.e. 2010, HHS began developing the next decade’s objectives, Healthy People 2020 (U.S. Department of Health and Human Services, 2007). The audience-base, involved in Healthy People 2020 includes the general public, voluntary organizations, faith-based organizations, businesses, health care providers, decision-makers, researchers, community-based organizations, grass root advocates and other sectors whose actions have significant health consequences.

Healthy People 2020 provides the best available information on certain key factors relating to each Healthy People 2020 objective to help organizations and individuals prioritize potential actions in response to the objectives.

**Vision, Mission & Overarching Goals of Healthy People 2020:**

**Vision:**
A society in which all people live long, healthy lives

**Mission:**
To improve health through strengthening policy and practice, Healthy People will:

- Identify nationwide health improvement priorities;

- Increase public awareness and understanding of the determinants of health, disease, and disability and the opportunities for progress;

- Provide measurable objectives and goals that can be used at the national, state and local levels;

- Engage multiple sectors to take actions that are driven by the best available evidence and knowledge;

- Identify critical research and data collection needs.
Overarching Goals:
- Eliminate preventable disease, disability, injury, and premature death.
- Achieve health equity, eliminate disparities and improve the health of all groups.
- Create social and physical environments that promote good health for all.
- Promote healthy development and healthy behaviors across every stage of life.

A feedback loop of intervention, assessment, and dissemination of evidence and best practices would enable achievement of Healthy People 2020 goals. The results of such interventions can be demonstrated through assessment, monitoring, and evaluation. Through dissemination of evidence-based practices and best practices, these findings would provide feedback to intervention planning to enable the identification of effective prevention strategies in the future.

The Healthy People 2020 is not intended to be known primarily as a print-based reference book to be kept on the shelf for a decade. It is meant be a web-accessible database that is searchable, multilevel, and interactive. Through this medium, Healthy People 2020 is meant to more effectively assist stakeholders to improve population health by helping them to access metrics and guidance about effective interventions.

Healthy Campus 2010:
The Healthy Campus 2010 is an initiative to improve the health of the campus community. It is a set of health objectives of the nation that can be used to develop programmes to improve health. These objectives reflect the health issues that affect students wellbeing and academic performance.

The Healthy Campus approach 2010 advocates that there be:

- A campus-wide commitment to collaboration for health – with a need for health professionals to create and be involved in new networks of care and support with many campus leaders, faculty and staff.
• An institutional commitment to health promotion – and a recognition that, as campuses represent multicultural communities, the selection of objectives and strategies must be diverse, creative and flexible.

• Multidisciplinary networks – with the incorporation of those with expertise that includes, but is not limited to, human development, health assessment, counseling, exercise, nutrition, self-care, coping skills, conflict resolution and management of chronic illness and disabilities.

• Promotion of, and support for, personal involvement in health – with a recognition that individual health, community well-being and academic accomplishment are all mutually reinforcing components of a healthy campus.

To link national health objectives to a college programme, it is recommended that four key steps are taken:

• Identify the demographic profile of the campus

• Assess future changes in the campus environment

• Create new networks of multidisciplinary collaboration

• Make a commitment to Healthy Campus 2010 at all levels

To initiate and carry forward work on a campus, five key steps are outlined:

1. Generate campus interest and involvement.

2. Review national health objectives to provide direction for developing campus health objectives.

3. Assess what campus programs, policies, services, facilities and information exist or are needed.

4. Set new campus health goals and objectives and develop or strengthen interventions.

5. Evaluate periodically.
It is recommended that representatives from different sectors of campus are brought together – as a Task Force, a Working Committee and a Steering Group – in order to create and work towards a blueprint for the work which draws on the national strategy.

d. Healthy College:

As mentioned in the introduction, 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. However, there is a growing interest in the development of healthy college approaches and Escolme et al, 2002 have outlined five reasons why those in colleges should be concerned with the health and well-being of students and staff:

1. First students’ sense of well-being and of belonging to a college can have a positive impact on their achievement.

2. A concern about health and well-being held by college staff can improve the quality of students’ college experience.

3. Addressing the health and well-being of students should be part of a college’s overall offer to students to provide them with the best opportunities for learning.

4. Many different factors can negatively affect students’ health and consequently their educational achievement, so colleges should be geared to mitigate the influence of these factors.

5. A concern for students’ welfare, well-being and health is likely to aid student recruitment and retention.

The most explicitly specified healthy college standard in the UK – with regard to structure and implementation processes – is the Kirklees Healthy College Standard (Huddersfield Central and South Huddersfield PCT and Kirklees Local Education Authority, 2003). Current interest in healthy colleges appears to have been stimulated by the National Healthy Schools Programme and its predecessor, the National Healthy School Standard.
e. Health Promoting Universities (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 (Tsouros, A. D., Dowding, G., Thompson, J. & Dooris, M. 1998). This approach drew on a number of principles and perspectives outlined in Health for All, the Ottawa Charter for Health Promotion, and Agenda 21 (The local Agenda 21 planning guide, 1996) and included a commitment to understanding and acting on a range of factors that influence health and well-being in university settings (Whitelaw, S., Baxendale, A., Bryce, C., Mac Hardy, L., Young, I. & Witney, E. 2001). The concept of a Health Promoting University (HPU) also fructified on the experiences of a number of WHO initiatives such as the Healthy City initiatives, Health Promoting Hospitals etc.

The idea of a health-promoting university is not really novel. Drawing an analogy with the Ashram system of education mentioned previously, the original universities were concerned with the development of the whole and spiritual person – and their academic years were synchronized with nature. As with many aspects of people’s fragmented lives today, urbanization and industrialization probably lies behind the demise of this vision of universities as institutions committed to providing truly holistic education. Yet even with the current emphasis on providing marketable skills to equip students for a global market, such a viewpoint can be challenged on cost-effectiveness and other grounds if anything other than a short-term perspective is applied.

Several other studies conducted by Meier, S. et al have indicated that there is a strong need for health education / promotion in the university setting (Meier, S. Stock, C. and Krämer, A 2006), and university-based health promotion programs could change student knowledge, behaviors and lifestyles substantially (Whitelaw, S., Baxendale, A., Bryce, C., Mac Hardy, L., Young, I. & Witney, E. 2001)
Chronology of events leading to the development of Health Promoting Universities Project:

- Ottawa Charter for Health Promotion, 1986.
- Strategic plan for the 3rd phase of 'Healthy cities'
  (Included a commitment to developing Health Promoting Universities).
- Call for action: Health Promotion in Developing Countries, Geneva, 1989.
- First International Health Promoting University (HPU) Conference – Lancaster, UK. 1996.
WHO round table meeting on the criteria and strategies for a new European Network of Health Promoting Universities - (The Jakarta declaration on health promotion into the 21st century), 1997.

American College Health Association (ACHA), 1998.


Health Promoting School Movement UK, January 2003.

1st International Conference for Health Promoting Universities (HPU) in the Pan American region: Chile, November 2003.


Health Promoting College Conference: Wigan 27-02-07.


Dooris, 2001 has outlined a number of key processes which play a part in the development of a health promoting university. These include:

- Integrating a commitment to, and vision of, health within university plans and policies.
- Creating health promoting and sustainable physical environments.
- Developing the university as a supportive, empowering and healthy workplace.
- Supporting the healthy personal and social development of students.
- Increasing understanding, knowledge and commitment to multi-disciplinary health promotion across all university faculties and departments.
- Supporting the promotion of sustainable health within the wider community.

The experience of other WHO projects has confirmed that organizational development requires time, energy, commitment and skills. The process involves four elements:

1. Generating visibility – increasing the profile and understanding of health issues;
2. Securing commitment by senior-level management – placing health and sustainability high on the agenda of decision-makers and securing their commitment;
3. Institutional and cultural changes – embedding the principles and aims of the project into the organizational structures and culture and developing the organization’s capacity and ability to maintain and promote health; and
4. Innovative action for health promotion and sustainability – implementing healthy policy and health promotion interventions that emphasize the interconnected relationships between people, environments, lifestyles and health.
The International Union for Health Promotion and Education (IUHPE) (www.iuhpe.org):

The International Union for Health Promotion and Education (IUHPE) is over half a century old and is a unique worldwide, independent and professional non-governmental association of individuals and organisations committed to improving the health and wellbeing of the people through education, community action and the development of healthy public policy.

The IUHPE has earned a strong reputation as an expert organization providing health promotion research, training and capacity building services to a broad range of clients. It works in close cooperation with UN agencies, such as WHO, UNESCO, UNICEF, or UN-Habitat, as well as other major intergovernmental institutions, non-governmental organizations, networks, national agencies, academic institutions and a broad range of practitioners in the field to influence and facilitate the development of health promotion strategies and projects.

Vision:
The vision of the IUHPE is a world where all people achieve optimum health and wellbeing.

Mission:
The mission of the IUHPE is to promote global health and to contribute to the achievement of equity in health between and within societies of the world. The IUHPE fulfills its mission by building and operating an independent, global, professional network of people and institutions to encourage the free exchange of ideas, knowledge, knowhow and experiences, and the development of relevant collaborative projects, both at global and regional levels.

Strategies of the IUHPE are:
- Advocacy and Partnership Building
- Knowledge development, translation, exchange and dissemination
• Professional and technical development

• Strengthening the organization’s capacity

❖ National & International healthcare models:

In studying the healthcare models both nationally and internationally; it would be worthwhile to study the various initiatives, linking health and higher education. The study includes their historical evolution.

The researcher therefore presents a comprehensive account of current generic information linking health & higher education, highlighting the SHEU / Kirklees Healthy College Standards (Huddersfield Central and South Huddersfield PCT and Kirklees Local Education Authority, 2003) and American College of Health Association- National College of Health Association (ACHA-NCHA) study surveys (http://www.achancha.org), before presenting a brief summary of the model of healthcare delivery systems (services) on campus of educational institutions, country wise, highlighting case studies where in HEI / universities have adopted practices of health promotion in their march towards becoming a Health Promoting University (Dowding, G 1995) and obtaining membership of International Union of Health Promotion and Education, IUHPE (http://www.iuhpe.org).

a. Healthcare delivery on campus of educational institutions in India

➢ University of Pune (www.unipune.ernet.in):

The University of Pune has a University Health Service operational since July 1962. Initially, these services were focused on curative & preventive care alone and services were restricted to the hostel students of the constituent colleges in Pune & the post graduate students in the University hostel only (Reports of Student Health Services, University of Pune, 1962-67). Today, round the clock medical facilities are available on the campus by way of a resident medical officer for the resident staff and students. The health centre provides preventive (checkup) and curative healthcare services. Ambulance service for emergency cases is also available. Comprehensive information is provided on various
diseases and health related issues. The University of Pune ‘Help Line’ (telephonic counseling), provides guidance on issues related to STD / HIV / AIDS, and sexuality. A fitness centre including yoga education center, has been established through a University Grants Commission (UGC) grant to promote a healthy lifestyle.

➢ University of Delhi (www.du.ac.in):
With assistance from the World University Service (WUS), a Geneva based International NGO, WUS Health Centre caters to health related needs of the Delhi University students & staff including their family members. Eligible members have to enroll themselves by payment of the prescribed subscription fee. Entitlements of eligible members varies depending upon whether they are full time resident students & full time / visiting / contractual staff.

➢ University Health Services, Kolkata (www.caluniv.ac.in):
The University has a Board of Health to take care of health problems of the students of the University and its affiliated colleges. The Board has set up a clinic with a view to rendering all kinds of medical assistance to the students and staff of the University. Additionally, there are four peripheral students’ health clinics to cater to the health care needs of the students.

Facilities for medical and health care offered by the Board of Health of the University include health and medical examinations, diagnostic procedures, laboratory investigation and chest radiography, etc., free of cost. On a limited basis, free hospitalization is also possible.

➢ Tata Institute of Health Sciences (TISS), Mumbai (www.tiss.edu)
A Health Centre is operational on campus. In case of a medical emergency, students are advised to consult the doctors on campus / warden. The student is required to pay for any out of turn visit made by the Doctor. In case of infectious diseases and other medical emergencies, the Institute admits the student to a hospital on the recommendation of the Institute Doctor. A first-aid kit is made available with all the hostel representatives. Counseling services are also provided on campus. All students of TISS are medically insured under the Group Health Insurance Scheme.
Shreemati Nathibai Damodar Thackersey (SNDT) Women's University, Mumbai (www.sndt.digitaluniversity.ac):

SNDT University provides all basic facilities to the students such as hostel accommodation, regular health check-ups, canteen, etc. Doctors are appointed by the University for conducting regular health check-ups of the students. The university has established Fitness Centre Gymkhana Hall and Yoga Centre to ensure overall development of the students. The Department of Students’ Welfare at the University conducts various departmental, co-curricular and extra curricular activities for the students of the affiliated colleges. There is a University Library that supports the teaching, research and extension activities of the University by providing to students, faculty and staff, information and documentary resources and services.

Jawaharlal Nehru University, New Delhi (www.jnu.ac.in):

The on campus Health Centre provides comprehensive health care i.e. preventive, curative and promotive services under one roof to students only, at nominal subsidized annual fees. Ambulance Service is available. Health education and counseling services are also provided. Foreign students are extended medical facilities, as are admissible to the Indian students. However, the foreign students who wish to avail of nursing home / private hospital facilities have to obtain medical insurance cover at their own expense to meet medical expenses on hospitalizations etc.

Health Advisory committee: Student representation on the Health Advisory Committee provides a liaison between the providers and the users of the service. The committee assesses, recommends programs for development of services for the benefit of the students.

Indian Institute of Technology, IIT, Kanpur (www.iitc.ac.in)

IIT, Kanpur has an on campus Health Centre. The Health Centre provides free (and at nominal cost for relatives) medical services round the clock 24X7 in a year. At least one medical officer is always available in the Health Centre. On
Saturday evenings, Sundays and gazetted holidays, only in case of emergency the Doctor on duty may be contacted.

An updated list of consultants and recognized hospitals in the city is provided. Prescribed medication is to be procured from the on campus pharmacy. If unavailable, purchases are reimbursed. Likewise, consultation fee, lab investigations fee and hospital bills are also reimbursable.

The health center also hosts a website which is regularly updated. The objective of the site is to 'closing the health gap', a campaign to bring the latest health information to community and help Health Center users to take charge of their health. The health tips and resources help one get started, or continue on the road to a healthier life.

➤ Symbiosis International University (SIU), Pune (www.schcpune.org):

The SIU has been cited in lieu of the unique features regarding the origins of the healthcare services on campus. The on campus healthcare centre was established in the absence of a dedicated medical school, health studies department or even an individual academic to champion health promotion or advance the settings-based approach to health promotion. Literature or models on the application of the “settings-based approach” on campus of educational institutions was sparse and networking with other Universities revealed that there was no blueprint for this approach in the University sector. Help and guidance were therefore sought from professionals working in other sectors. The establishment of such broad based holistic healthcare services on campus of educational institutions was then (and even today) a revolutionary thought process.

Healthcare services for all students and staff of the Symbiosis International University are provided by the in-house health care centre of Symbiosis viz. Symbiosis Centre of Health Care (SCHC). The SCHC takes care of the health care needs of the entire ‘Symbiosis Family’ by providing preventive, curative and promotive health care services. These include annual Health Check Up of students and staff, day care & Out Patient Department (OPD) services, Health Education, Medical Insurance Scheme & Promotive Health Care Programmes inclusive of a
gymnasium, aerobics studio, yogashala with meditation hall and a swimming pool. Recreational and wellness facilities are also promoted through the University Sports Board (USB).

Symbiosis International University provides education to over 27,000 students through 197 different academic courses offered by its 37 branches. SCHC has always expanded its spectrum of activities with the aim of empowerment of communities through health promotive programmes that can effectively enhance knowledge, motivation and foster awareness in every individual. Since 1997, SCHC has made conscientious efforts towards overall development of Symbiosis students/staff and community by implementing various preventive, curative and health promotive programmes to enhance optimal health, reduce risk of disease and promote healthy a lifestyle.

Various programmes envisaging holistic approaches of health are being implemented at Symbiosis during past 10 years. The brief details of these programmes are as described below:-

**Preventive Health Care Programmes:**

**i. Annual Health Check Up of students and staff:**
SCHC, the in-house health care center of Symbiosis takes care of the health care needs of the entire Symbiosis family. SCHC, conducts an initial pre admission health checkup followed by annual health checkup programme for the students and staff of Symbiosis and maintains a detailed record as individual health cards (Appendix “B”). More than 35 consultants / specialists from different faculties such as Medicine, Paediatrics, ENT, Ophthalmology, Dentistry, Pathology and Radiology including Ultrasonologists visit SCHC regularly and provide their expertise to the comprehensive health checkup programme.

**ii. Health Education:**
Health education is an integral part of the activities of the SCHC. The health education programme implemented by the SCHC at the school, college and post graduate level is based on internationally accepted modules designed by UNESCO but suited to the Indian scenario.
Towards this end, SCHC organizes numerous seminars, camps, workshops on various aspects of student’s health, particularly focusing on the preventive aspects of health. A formal training programme in First Aid & Integrated Disaster Management is conducted by the SCHC for all the staff and student of SIU as also for the community at large.

Various health educative and health promotive initiatives are undertaken in commemoration of International days e.g. World Diabetes Day (November 14), World Heart Day (September 26), World First Aid Day (September 11) etc.

Curative Health Care Programmes:

i. Day care & Out Patient Department (OPD) services:
SCHC as a primary health care center offers round the clock OPD services at all campuses of Symbiosis. It also provides laboratory facilities for routine pathological investigations and ultrasonography services.

ii. Health Insurance Scheme:
SIU is one of the pioneering educational institutions to initiate a health insurance scheme for its staff and students. Perhaps, it was the 1st University to launch a cashless medical insurance scheme. SCHC implements a unique scheme of ‘Health Insurance’ for all the students and staff of Symbiosis through the National Insurance Company (NIC), a Government of India undertaking. Accordingly, every beneficiary is insured for a sum of Rs. 50,000/- (in case of non-accident cases under Mediclaim policy) and Rs. 100,000/- (in case of accident cases under Rail / Road Traffic Accident Policy).

The insurance policy aims at supporting the medical problems, especially emergencies, of all students/ staff of Symbiosis. The objective is to make instantaneous payment towards the hospital admission / immediate medical expenditure, so that treatment is neither delayed nor denied / deferred to the beneficiary, for lack of finances. A student can continue to avail the health insurance scheme even after one passes out from the university i.e. alumni may also avail of the same benefits, as students. Similarly, each staff member is also covered by the above
medical insurance policies. Additionally, a staff member may opt for the Family Floater Scheme, whereby his/her family members are also medically insured.

Going beyond the call of duty and provision of financial support services, any staff / student who gets admitted is personally visited by the doctors of the SCHC so as to render a personalized touch and tender loving care. Further, parents / guardians of out station students are also informed and kept updated regarding the health status of their ward, on a regular basis.

**Promotive Health Care Programmes:**

**i. Recreation and Wellness programmes:**
All campuses of Symbiosis have an ultramodern, state-of-the-art recreational & wellness facilities which include a gymnasium, aerobics studio, yogashala with a meditation hall and a swimming pool. Designed by doctors, the innovative fitness programmes blend the finest of Eastern and Western techniques. Fitness schedules are customized to suit individuals based on Physical Activity Readiness Questionnaire (PARQ-Appendix “C”). A fitness card of all clients is maintained and monitored (Appendix ‘D”). Physiotherapy services are also provided on campus.

**Community Oriented Outreach Services:**
A number of community oriented outreach services are undertaken by the SCHC. These include health education lectures e.g. on adolescent health, influenza pandemic, First Aid etc.; blood donation camps, wellness programmes, awareness programmes on disaster prevention and management, community sensitization towards the use of helmets etc.

Besides this, community based research projects on global issues such as School Based Interventional Strategies for Childhood Obesity, Anthropometric Indices correlation with Pulmonary Function Tests, immunizing adolescent girl students against Rubella etc. are also implemented.

**Mid-Day Meal Programme:**
The SCHC started “Mid-Day Meal” programme for all school going children of Symbiosis schools. The main objective of this Mid-Day Meal programme is to
inculcate sound dietary practices in school going children with a view to curb the rising incidence of childhood obesity and its associated medical problems.

**Campus Health Advisory Committee (CHAC):**
The SIU has set up a Campus Health Advisory Committee (CHAC) (Appendix “E”) on all the campuses of Symbiosis. The objective of this committee is:

- To establish and review the student communications strategy for health care services
- To review all health care policies and make recommendations accordingly
- To advice the management on aspects relating to student & staff health care facility
- To receive representations by or on the behalf of students on strategic matters relating to the health care facilities and the educational experience.

**Preventive, curative and promotive health care services at SIU**
c. Healthcare delivery on campus of educational institutions abroad:

In this section, the researcher proposes to correlate health and higher education initiatives and cite healthcare services operational in few randomly selected Universities in the United Kingdom (U.K), United States of America (USA), Canada, China, Middle East & South East Asia, South Africa, Australia & New Zealand.

Health & Higher Education in the UK:
Higher education institutions in the UK have been working to address health issues for a number of years. Initiatives have often been conceptualized at a grass roots level with a focus on specific topics such as drugs and sexual health. It has tended to develop in areas where there has been interest and capacity among both higher education and health partners. Topic-based work continues to take place but in addition, the concept of a healthy college has emerged and is continuing to develop at a local, regional and national level. The concept of ‘health promoting universities’ has been around longer, since the early 1990s (Tsouros, A. D., Dowding, G., Thompson, J. & Dooris, M. 1998).

A report entitled: Healthy & Health Promoting Colleges – Identifying an Evidence Base, was published by Thomas Coram Research Institute, Institute of Education, University of London (Warwick Ian, Statham June and Aggleton Peter, 2008). The report identifies existing initiatives which aim to promote physical and emotional health and wellbeing of young people (aged 14 -19) within Further Education (FE) settings in England (or comparable college settings in other countries).

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9 Higher Education colleges and universities offer degree level courses. Some also offer post graduate courses and vocational courses. Higher education institutions may also operate research programmes (Warwick Ian, Statham June and Aggleton Peter, 2008)

10 Further education colleges generally offer courses below degree level for people older than 16 years old (after compulsory education). They have strengths in vocational as well as purely academic educational programmes (Warwick Ian, Statham June and Aggleton Peter, 2008).
The exhaustive report provides background information about the nature of the further education sector in the UK and the current policy within which colleges operate. It also provides information about potential approaches to “healthy college” work in the UK. It also provides information about the health related needs and concerns of young people attending Further Education (FE) colleges and finally what are successful promising approaches to promoting health among younger students in further education (or comparable settings in other countries).

The report acknowledges that although there are differences in the Further and Higher Education sectors in England when compared with the US, in the absence of substantial ‘home-grown’ evidence, the considerable amount of work that has been undertaken to develop the American College Health Association – National College Health Assessment (ACHA-NCHA) database and Healthy Campus 2010 may provide some useful insights into developing healthy college work in England (Please refer later under: Healthcare in the USA).

The most explicitly specified healthy college standard in the UK – with regard to structure and implementation processes – is the Kirklees Healthy College Standard (Huddersfield Central and South Huddersfield PCT and Kirklees Local Education Authority, 2003).

As highlighted in paragraph 101 of Choosing health: Making healthier choices easier (Department of Health, 2005) the Government’s public health strategy, a health promoting college works to integrate health into its organizational structure and aims to:

- Create healthy working, learning and living environments
- Increase the profile of health in teaching and research
- Develop healthy alliances\(^\text{11}\) in the community.

\(^{11}\) Alliances are partnerships of intersectoral organizations and /or individuals working together to achieve shared objectives. Healthy alliances have long been recognized as the best way to achieve real lasting changes to improve the health of communities (Department of Health, 2005)
Kirklees Healthy College Standard:
The Kirklees Healthy College Standard was developed as part of a pilot scheme by Huddersfield New College and the Kirklees Healthy Schools Team to develop a Healthy College standard similar to the National Healthy Schools Standard (Huddersfield Central and South Huddersfield PCT and Kirklees Local Education Authority, 2003). It offers a step-by-step guide to developing a healthy college and covers nine criteria:
- Whole college awareness
- Active citizens
- Smoke-free environment
- Healthy eating
- Environment
- Community involvement
- Student wellbeing
- Physical activity
- Staff health and wellbeing.

The Healthy College Network:
The Healthy College Network has attracted a high level of interest from colleges and provides a much needed forum for sharing practice and linking colleges and health professionals together. It has grown quickly, although, colleges do not have the support of a national healthy college team (unlike schools).

Health Promoting Universities in England:
In much the same way as colleges, universities in UK address health issues with students and staff, providing services, training, health education and campaigns. However, few universities deliver this within the context of a ‘whole system’ commitment to promoting health and until recently, only a handful of universities worked in this way. However, over the past few years there has been an increase in interest and an attempt has been made to apply the healthy settings approach (Doherty, S. and Dooris, M. 2006). Internationally, Health Promoting Universities now exist in Germany, Canada, Chile, Spain, Australia and Hong Kong.
Universities in the United Kingdom have three distinct strategies for developing professional preparation for health education and health promotion. The new cadres approach, which sets out to create new health education and health promotion specialist practitioners; the mainstreaming strategy, which aims to install effective health education and health promotion practice as a central element in the role of the existing major helping professions; and the alliances approach, which invests in developing patterns of teamwork for health education and health promotion for specific settings

**Key developments in health promoting universities in England:**

- In 1994, Lancaster University established the first Health Promoting University project

- In 1995, the University of Central Lancashire established its Health Promoting University initiative.


- In 2006, the Healthy Settings Development Unit hosted the inaugural meeting of an informal health promoting universities network.

In the UK, the Students Health Education Unit (SHEU) offers, at no cost, their online questionnaire for use in higher education settings (Balding A, 2005). Authorities use the SHEU information to deliver appropriate services and design interventions that support young people to take more care of their health.
SHEU has a long history of successful collaborative work in schools, and in 1995 collaborated in a study of university students, aged 18 and over. A student survey instrument, The Further Education Student Health and Lifestyle Survey, was successfully trialed and piloted with colleges. The information gained provided feedback on local health campaigns.

A unique confidential databank was developed and currently holds information from students about their attitudes and lifestyle behaviours in relation to health. This unique resource enables comparisons to be made across a range of questions. Not only would colleges have information with regard to their students, they may also have comparative, anonymous data from students in their region or elsewhere.

**b. Case studies of Universities in the U.K. which have health promotion initiatives:**

- **University College of St Martin, Lancaster, U.K** (Beattie, Alan. 1998):

  The work on St Martin’s as a Health Promoting College was undertaken to link academic studies of health education and health promotion to practical action at the local level.

  *The Health Promoting College* project at St Martin’s provides case study evidence that is highly revealing. It draws on the Beattie fourfold health promotion grid for structural analysis and strategic planning in health promotion (Beattie, A 1991). It offers a very helpful extension and elaboration of the model by examining how each of the (four) strategically different approaches to health education and health promotion may be translated into action at different levels within the College environment and it gives a range of examples on specific topics (such as stress and smoking). This framework is used to explore and implement (with students and colleagues) an approach to health education and health promotion practices.

  Thus, applying the above principles, attempts were made to seek out and nurture whatever examples of local enthusiasm, enterprise and creativity could be found (as regards action for a health promoting campus), while at the same time, ensuring
that all such specific initiatives were reviewed within a systematic audit of strategic choices for the health-promoting university.

The main vehicle for exploring and implementing action for *health on campus* was the project work undertaken by students. As a major part of their second-year studies within a full-time Bachelor of Arts in Health Promotion, four successive cohorts of students undertook action planning and practical interventions around the College. Each cohort of students was asked to write letters to next-year’s students, offering them advice on what issues to address and how. This proved to be an invaluable means for learning from each successive cycle of action.

**Reflections:**
Some problems recurred every year and they seem likely to crop up in most initiatives attempting to implement health promotion strategies on a campus-wide basis. The reflections can be summarized as follows:

a. Action learning and peer teaching have great benefits for the students undertaking project work.

b. Students make a wonderful army of health activists: they bring fresh ideas and enthusiasm to each turn of the annual cycle and they reach places where staff and outsider consultants can less easily go. But as a pedagogy, it is challenging for the tutor to sustain and support (and can be expensive in labour and resources) and it makes great demands on student energy, time and inventiveness.

c. Attempts to change institutional policies (such as those on drugs and alcohol, student accommodation and disability) rapidly expose the limits of student authority, even when interventions are made in full cooperation with the student union and/or with backing from senior academic staff. Organizational development for health is almost always a highly contested matter, sometimes ethically controversial and sometimes politically explosive or divisive.
d. The agencies on campus that are often the most sympathetic, responsive and cooperative (such as the medical centre, counseling, student welfare, catering and the health and safety committee) run the risk of being pushed into early burn-out by successive battalions of rampant students who charge in each year with enthusiastic and well-meaning criticisms and brilliant new ideas for improvement, especially when the permanent staff have been struggling anyway with the agenda of almost constant larger-scale reorganization in higher education in the past few years.

e. Trying to extend the scope of health promotion to student life off-campus (such as to problems around accommodation, private landlords, noise and safety on the streets) raises many further difficulties. There are often complex legal issues and a fundamental problem is student poverty and the increasing necessity for them to work part time. How much health promotion can actually achieve in these areas and whether health arguments are especially helpful in such contexts, remains to be seen.

f. Inevitably, students bumped up repeatedly against the debate around theoretical models for health promotion planning and practice (Rawson, D 1992). They studied these intensively and they were encouraged to figure out their own position on what model (s) they favoured. But this acquired knowledge and expertise was, at times, at logger heads with established bodies of knowledge and principles of practice of health education and health promotion, emphasizing yet again that the practice of health education and health promotion in the wider world is probably imperfectly understood and therefore imperfectly assessed.

g. The way the health-promoting campus project developed ensured that neither an individual academic nor anyone else on the senior staff of the University College of St. Martin could decide what will happen in advance. Each successive cycle of action is shaped by the dialogue between students from one cohort to another and within each cohort.
h. As the economic constraints on higher education tighten and as central directives on the content of curricula become more pressing (along with other political and personal pressures), the problems of student stress and mental health will loom larger. Much can be learnt from the new ways health-promoting schools are approaching emotional health (Weare, K. & Gray, G. 1997).

i. One crucial aspect of this new kind of work in the university setting will be much greater sensitivity to the social ethics of intervention in the name of health. There are many parallels between organizations development for health (Smithies, J. 1991) and community development for health (Beattie, A. 1986) and the conflicts of value that are inescapable in discussions of health policies across a whole campus increasingly need to be addressed if health codes are to be “owned by members of the community” within the university setting (Beattie, A. et al 1993 & Henry, C 1995).

➢ **Lancaster University** (Gina Dowding & Jane Thompson, 1998):

(Embracing organizational development for health promotion in higher education)

The Lancaster Health Promoting University Project was grounded in a very real concern by the Student Services Department and the University’s management about student welfare growing interest in a multidisciplinary approach to health. Their interest in health promotion was also mirrored by staff across the University. The aim of the Project was “to improve student and staff health” with a focus primarily around the Health of the Nation key areas of alcohol, exercise, mental health, staff health and safer sex.

One of the more unusual factors about the origins of the Project was the absence of a dedicated medical school, health studies department or even an individual academic to champion health promotion or advance the settings-based approach to health promotion. This model is very similar to the Symbiosis International University which has been cited as a case study.
The five priority areas mentioned above were identified. The primary task was to ensure that health promotion activity already underway in the University was extended and unified within a coherent framework. The Project was guided by the principles of Health for All (European Health for All Series, No. 4, 1993) and the Ottawa Charter for Health Promotion (Ottawa Charter for Health Promotion, 1986) in providing standards of good practice for health promotion.

Nevertheless, it was recognized that the Project presented an opportunity to take a lead in embracing the newly emergent *settings based approach within a higher education institution* in a time-limited experiment. Literature on the settings-based approach was sparse and networking with other Universities with project-based health promotion underway revealed that there was no blueprint for this approach in the University sector (Similarity to Symbiosis International University). Help and guidance were therefore sought from professionals working in other sectors and especially those involved in the European Health Promoting Hospitals Network in developing a framework and methods for the Lancaster Health Promoting University Project.

During the first six months, the aims for the Project were:

- To build on existing concern for good health and health promotion;
- To develop new aspects of the role of the University in promoting health; and
- To integrate health promotion into routine structures and values of the organization “to change hearts and minds”.

These aims and objectives are exactly similar to the setting up of the on campus healthcare centre at Symbiosis International University.

During the first six months, using Baric’s organization model (Baric, L, 1994), three elements of a health-promoting university were identified:
1. Creating healthy working, learning and living environments for students and staff;

2. Increasing the health promotion and health education content of the academic work of the university; and

3. Creating health-promoting alliances by outreach into the community and developing the role of the university as an advocate for health.

Again, these three priority areas are similar to the activities undertaken by the Symbiosis Centre of Health Care (SCHC) in its initial years.

The project was implemented in four ways.

1. Planned health promotion interventions by three working groups to:
   a. Promote Healthy Social life
   b. Promote Healthy Working Life
   c. Promote Healthy Environment

2. Proactive lobbying and mediation on behalf of the Project by members of the Steering Group

3. Opportunistic health promotion interventions (as they arose); and

4. Reactive work to ideas generated by staff and students in the wider University during the course of the Project.

Yet again, all the above four strategies were and are implemented on an ongoing basis at Symbiosis International University.

Reflections:

1. Understanding and commitment to the settings-based concept: The settings-based approach was new to everyone involved in the project. There was little understanding of the processes required to embrace a settings-based approach and by necessity, therefore, even less commitment to do so. The challenge was and
remains, to understand and therefore develop a commitment to the settings-based approach, with its emphasis on organizational development and University-wide structural changes for health.

Many of the practical outcomes were similar to those that might have emerged had, a more traditional health promotion approach been adopted. The pressure to develop high-profile, opportunistic interventions diverted time and resources from the process of securing a commitment to organizational change, reiterating the importance of first incorporating organizational change before undertaking or seeking to undertake fanciful interventions.

2. **Communicating the settings-based approach:** The results suggested that more time should have been devoted to developing and communicating the concept of settings for health promotion in the early stages of the project.

3. **Structures and processes:** Universities are large organizations with a number of disparate cultures and subcultures. The Project Steering Group was a new committee outside the existing University committee structure that was not accountable to any one group. It was easy for the committee to remain marginal to the main- stream University business. Responsibility for action – or outcome was, in effect, passed to the working groups, which had limited opportunity to affect organizational and policy development. It could therefore be argued that the structures created by the project reflected a framework for health promotion within the University rather than for the organizational development of the University.

4. **Time scales:** In retrospect, insufficient time was allowed for the development of the initial idea and for the process of integrating a health promotion agenda into both the culture and the organizational structure of the University. The Project was funded for less than two years, which is an unrealistic time frame for organizational change.
5. **External factors:** The university sector in the United Kingdom was (and is even today, as elsewhere) under increasing pressure from a number of sources. Halfway through the Project’s development phase, this national trend severely affected Lancaster’s financial position, and it faced bankruptcy at one stage. The short-term focus of the University management was forced towards survival and consolidation rather than expansion. Not surprisingly, managers and individual staff were left with little time or enthusiasm for developing new and voluntary projects or tasks.

6. **The role of the Project Coordinator:** Experience suggests that the Coordinator’s role is shaped by a number of factors. Although this meant that the Coordinator avoided departmental constraints, it also led to isolation from the administrative, management and academic departments. It is interesting that the physical base of the Project moved from the Health Centre to an office within the Management School. This was because of practical expediency, but this move from medical to management also reflects the underlying shift in emphasis in the Project during its pilot stage.

**Outcomes:**
The Project was successful in contributing to:

1. Engaging a different social system (higher education) in the debate and action about health,

2. Developing the concept of the settings-based approach to health promotion and

3. International networking

➢ **University of Central Lancashire** (Dooris Mark, 1998):

The University organized an international seminar on the settings-based approach to health promotion in collaboration with WHO. This seminar served as a catalyst within the University, leading to a growing interest in exploring the potential for applying the settings based approach within the institution itself.
The first task in establishing the Health Promoting University Project was to define the essential characteristics of the settings-based approach and to consider how this approach could be applied to the University. It was thus agreed that the aims of the Health Promoting University Project should be:

1. To promote the health and wellbeing of staff, students and the wider community.

2. To integrate within the University’s structures, processes and culture, a commitment to health and to developing its health promoting potential.

Within these overall aims, six objectives were set – related to priority focus areas forming an agenda for action:

1. To integrate a commitment to and vision of health within the University’s plans and policies;

2. To develop the University as a supportive and healthy workplace;

3. To support the healthy social and personal development of students;

4. To create health-promoting and sustainable physical environments;

5. To increase understanding, knowledge and commitment to multidisciplinary health promotion across all University faculties and departments; and

6. To support the promotion of sustainable health within the wider community.

When the conceptual framework was agreed, an organizational structure was established to ensure that the Project would move forward to achieve its aims and objectives. As is commonly the case, this presented dilemmas in balancing between the value of a formalized structure and the dangers of an over-bureaucratized approach. Four issues were identified as appropriate foci for longer term project working groups: sexual health, healthy and sustainable building design, transport and
mental wellbeing. In addition, the project gave priority to developing links with the wider community- Multiagency collaboration.

Reflections:
Both achievements and shortcomings could be identified in the process of establishing and developing the Health Promoting University Project at the University of Central Lancashire. A number of points can usefully be highlighted.

1. Communicating and managing integrative health promotion:
A danger of any new project within an institution is that it can be viewed as a discrete and self-contained entity – something that is added on to, rather than serving as a tool for harnessing, integrating and, where appropriate, reorienting mainstream organizational initiatives and processes. The Central Lancashire Project helped understand and develop an integrative rather than an additive approach.

2. Establishing a project team with dedicated time and resources

3. Time scale of the project – tensions between theory and practice:
The two-year time scale of the project resulted in tension between the theory of the settings-based approach and its practical implementation which necessitated showing high-visibility tangible outcomes to argue for longer-term funding. Unrealistic expectations served to enhance this tension.

4. Communication and power within organizations
The flow of communication and the exercise of power are fundamental determinants and reflectors of organizational culture. Hence, one needs to understand the University’s communication and power structures (for that matter any organization’s) for effective implementation of the project.

5. Choice and handling of focus issues
The choice and handling of focus issues might have benefited from a better understanding of the University’s culture. This would have facilitated the anticipation of points of resistance and better management of any resulting conflicts arising from differences in values and priorities.
6. Developing the University’s role in the wider community
The university is an integral part of local, national and global society and forms part of how we define our society. It underlined the potential role of a university in the broader development of the community e.g. by way of offering resources to the local community (academic, social & cultural) and advocating and mediating for public health.

7. Project base and job description
Being located within an academic department rather than a service area, the project had the important advantages of ensuring that the project was rooted in established theory and of adding academic legitimacy. On the other side, no dedicated administrative support was available. This resulted in some confusion as to the job remit – in particular as to whether it was primarily research or project coordination. Therefore, a clearer focus would have possibly enabled more defined progress to be made.

Table II:
Generic information about healthcare services provided on campus of universities in the UK

<table>
<thead>
<tr>
<th>On Campus health centre for students and staff OR Local GP</th>
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</thead>
<tbody>
<tr>
<td>Emergency Services by general practitioner when centre is closed</td>
</tr>
<tr>
<td>Preventive, Curative &amp; Health Promotive services</td>
</tr>
<tr>
<td>Referral to specialist</td>
</tr>
<tr>
<td>SOS admission to hospital</td>
</tr>
</tbody>
</table>
- All healthcare services are under the National Health Services (NHS)\(^{12}\) (http://www.nhs.uk). The service is intended to help individuals make choices about health and lifestyle decisions such as smoking, drinking, exercise etc. The NHS is committed to providing objective and trustworthy information and guidance on all aspects of health and healthcare that is evidence based. NHS is governed by the Department of Health.

- All Health Care is under National Health Insurance Scheme.

**Health & Higher Education in the United States of America (USA):**

Many colleges and universities campuses offer some sort of student health service, but there is wide variability in the healthcare resources available across campuses, with models of student health ranging from first aid stations employing a single nurse to large multi-specialty clinics with hundreds of employees. The vast majority of college health services are set up as service units rather than academic departments. The educational aspect of college health is referred to Health Promotion in Higher Education.

In the USA, college health professionals include physicians, physician assistants, administrators, nurse practitioners, mental health professionals, health educators, dietitians and nutritionists, and pharmacists. Some college health services extend to include massage therapists, and athletic trainers. College health professionals are often members of a national body, such as the American College Health Association. Another national body among college health is the National Collegiate EMS Foundation (NCEMSF), which is dedicated to the promotion and support of emergency medical services on college and university campuses.

There is one known commercial organization, COLLEGE HEALTH @ssociates (CH@), that is solely focused on the college health sector and which is currently providing health education and Continuing Medical Education (CME) for college health providers and their students. Health educators are increasingly becoming

\(^{12}\) NHS trusts are self-governing bodies providing healthcare services, either in the community, in hospitals or in both.
Certified Health Education Specialists (CHES). 80% of all colleges and universities in the United States have “some organized arrangement for advancing [student] health” (Miller, T. (Ed.). 2003). The principal associations for student health services are the American College Health Association and the American Public Health Association. In 1998 the college health education Competency Update Project (CUP) was started by the National Commission for Health Education Credentialing (NCHEC).

There is one known discussion forum focused on the college health community viz. College Health Info (CHI). CHI provides specialty specific healthcare information by and for college health professionals. The site also has a jobs board, events calendar, and a social networking area for off topic conversations. This format is unique because contributors are required to submit their credentials before they are allowed to contribute to the site, ensuring meaningful and trustworthy information.

There are currently three journals devoted exclusively to college health:
1. The Journal of American College Health,

2. College Health @dvisor a clinical e-Journal with originally authored articles by college health providers focusing on therapeutic conditions pertinent to the college health provider;

3. College health-e, a web-based journal

**American College Health Association – National College Health Assessment (ACHA-NCHA):**

The American College Health Association (ACHA) is the nation's principal advocate and leadership organization for college and university health that provides and supports the delivery of health care and prevention and wellness services for the nation's 18 million college students in the USA (http://www.achancha.org and www.acha-ncha.org). The ACHA conducts the National College Health Assessment (NCHA), a nationally recognized research survey that can assist in collecting precise data about students’ health habits, behaviors, and perceptions (http://www.achancha.org and www.acha-ncha.org).
Thus, ACHA is the parent organization which conducts the NCHA research survey.

For more than 85 years, the American College Health Association has been the nation’s principal advocate and leadership organization for college and university health. ACHA-NCHA is dedicated to strengthening the efforts of college health professionals, institutions of higher education and other key stakeholders working in the field to promote and maintain the health and wellness of the nation’s more than 16 million college students. Ongoing efforts such as the National College Health Assessment help to advocate for student health by integrating the critical role of college health into the mission of higher education.

ACHA was developed in 1998 by college health professionals & the original ACHA-NCHA was initiated in 2000 and the instrument was used nationwide till the spring 2008 data collection period. A new baseline for ACHA-NCHA II began in the fall of 2008. Although the general categories of information for which data are collected remain the same between the original ACHA-NCHA and this revised ACHA-NCHA II survey, a number of questions have been modified and new questions have been added to monitor a variety of health constructs. New items have been added to capture sleep behaviors, self-injury, the use/abuse of prescription drugs and additional mental health issues. The ACHA-NCHA II supports the health of the campus community by fulfilling the academic mission, supporting short and long-term healthy behaviors and gaining a current profile of health trends within the campus community.

The ACHA-NCHA II is not appropriate for trend comparison of items from the original ACHA-NCHA survey.

The ACHA-NCHA now provides the largest known comprehensive data set on the health of college students, providing the college health and higher education fields with a vast spectrum of information on student health.

More than 3,000,000 students at 300+ colleges and universities across the US constitute the database for this survey.
The ACHA –NCHA data facts:
1. While other health surveys of college students cover a single topic area, the ACHA-NCHA offers a way to map the widest range of health issues including substance abuse, sexual health, weight, nutrition, exercise, mental health, personal safety and violence. It is therefore the survey with the broadest reach.

2. ACHA NCHA has stood the test of time as regards Reliability, Validity & Generalizability.

3. The top five impediments to academic performance are: (1) stress, (2) cold / flu / sore throat, (3) sleep difficulties, (4) concern for friend or family, (5) depression/anxiety disorders. The top five remain unchanged in NCHA survey results since 2000.

4. Students reported their parents, the Internet, and friends to be their top sources for health information.

Other data facts are as applicable to the students’ population in the USA and therefore may not be applicable to others.

Data Caveats:
Each data point has a range that varies across the different demographic characteristics. Hence, statistical tests are needed to determine if there is a statistically significant difference between groups.

The ACHA NCHA offers their services to help other higher educational institutions to conduct surveys to:
- Prioritize student health issues
- Identify risk factors to safety and academic performance
- Identify trends and emerging problems
- Evaluate current strategies
- Determine effective allocation of resources for programs & services
- Design new programs and initiatives
The NCHA is flexible to meet the needs of educational institutions. The institute decides the primary purpose, surveying method, sample size, target population, and time period. Institute can choose to conduct either paper or online survey and when to administer the survey.

The NCHA survey takes about 30 minutes to complete. The survey is completely confidential — students’ email addresses or names are never attached to their responses. Ultimately, the information that one acquires through the NCHA can only help to advance students’ health, wellness, and overall satisfaction with their college learning and social experience.

The NCHA survey is cost-effective so that the survey can be implemented several times to evaluate campus health initiatives and map student health data over an extended period.

**Evaluation:**
With the NCHA, one can determine the most significant health priorities and trends of the student body. One can:

- Identify the most common health and behavior risks affecting students’ academic performance.
- Design evidenced-based health promotion programs with targeted educational and environmental initiatives.
- Create social norms marketing campaigns by comparing students’ actual behaviors to their perceptions about peer behavior.
- Allocate monetary and staffing resources based upon defined needs.
- Provide needs assessment data for campus and community task forces on sexual assault, alcohol use, eating disorders, etc.
• Have readily available graphs and data for policy discussions and presentations with faculty, staff, administration, and board members.

• Impact the campus culture by opening a dialogue about health with students and staff.

• Develop proposals to secure grant funding to expand or develop programs.

• Evaluate programming efforts by conducting repeat administrations of the survey.

Additional ways in which the data can be of service to the campus:
• For faculty to present in social sciences, health, communications, and research classes.

• For students to gain hands-on experience working with and analyzing data.

• For campus and local media to cite in articles and editorials.

• For administration to use in presentations for prospective students and parents and for freshmen (new students) orientation.

• For marketing professionals to draw on for promotional materials.

In March 2008, the ACHA issued 10 guidelines outlining the standards for student health insurance / benefit programmes to guide colleges and universities in the establishment of an appropriate, credible student health insurance / benefit programmes.

Sample form of ACHA –NCHA: Appendix “F”

Prototype format of analysis of a sample data of ACHA –NCHA (based on the above form) Appendix “G”
Case studies of Universities in USA which have health promotion initiatives:

Though healthcare services on campus of Universities in the USA are generically uniform, universities cited below have certain unique distinguishing features (highlighted as *) and hence are quoted as sample case studies.

➢ Health Services at the University of Texas at Arlington, UTA

(http://www.uta.edu/healthservices):

UTA Health Services provide a full service healthcare option for students on campus. Each semester, the students pay a medical services fee in their tuition that allows them to utilize health services including medical insurance. While many of these services are offered at no charge, others are offered at a discounted rate. All patients are required to sign a form prior to receiving services. They also have to sign a “Consent to Treat and Medical Information Form”

*Each student also signs a photographic consent and release form authorizing the university to record all findings and utilize the findings subsequently for any purpose that the university may deem appropriate including, promotional or advertising efforts.

➢ Campus Health Services at the University of North Carolina

(www.campushealth.unc.edu):

On campus healthcare services include primary care services including women’s health, pharmacy services, counseling and wellness services including services in sports medicine and physical therapy. Student medical insurance is through a Preferred Provider Organization (PPO) under the Blue Cross and Blue Shield UNC Student Medical Insurance Plan. This provides for enrollment of spouse as well as children. Students are covered on a worldwide basis. Online access regarding services for enrollments, locating providers, checking the claim status and wellness programmes etc are provided.

*An interesting feature is the provision of $100 hardware allowance of glasses and contacts.

Student Health Service (SHS) seeks to model and provide excellence throughout a full range of primary care services being a referral source for specialty services, should those be required.

Columbia University requires that all full time and residential students have acceptable medical insurance. To ensure that students have adequate insurance coverage, all registered full time students are automatically enrolled in the Basic Level of the Columbia Student Medical Insurance plan offered by the University. This provides for coverage of dependents also. The Columbia Student Medical Insurance Plan is specifically designed to meet the needs of international students including visa requirements.

The website of the Columbia University has a very self-explanatory FAQ section

*Student Health Service sends email reminders 48 hours before their appointment. To reduce waiting time for other colleagues, if student arrives more than 10 minutes late for an appointment, he/she is required to reschedule. If one arrives AFTER the time, one’s appointment is over; it is considered a “No Show” and charged @ $25. “No Show Fee” is charged for all appointments not kept by students unless they are cancelled at least 24 hours in advance. A $25 fee is also charged for any “Urgent Appointments” (made through the triage nurse) that are not kept.

*The Columbia Student Medical Insurance Plan includes a unique feature, travel assistance services. This plan helps students find appropriate medical care and will help with other travel related emergencies anywhere in the world when one are located more than 100 miles from one’s permanent address. This coverage is available at no additional cost to students enrolled in the plan.

Camden City Higher Education and Healthcare Institutions, USA:

*This case study describes and measures the economic impacts of the eight higher education and healthcare institutions within the City of Camden in the State of New Jersey, USA and their contributions to the local economy of Camden City and its surrounding areas (Roper Group in association with A. Ilan Consulting, 2004).
The operations of each of these institutions within the City of Camden has directly generated hundreds of millions of dollars in wages and thousands of jobs in New Jersey annually. The academic institutions confer over 1,500 degrees each year with graduates joining the workforce as productive workers and community and business leaders.

This case study shows the direct effects of spending, employment, wages and taxes and also quantifies the indirect and induced effects of the direct spending, as it circulates through the local and state economy. This multiplier effect, stemming from the initial spending of the academic and healthcare institutions benefits residents by creating jobs in many other sectors of the economy.

Although the institutions receive state funding, they derive most of their revenues from a variety of other sources including tuition, professional fees and research grants. For each dollar provided by the State of New Jersey in support of activities and programs at the eight institutions, eighty-two cents are recaptured by the State in the form of tax revenues generated annually!!

While many such contributions often do not lend themselves to quantification, it is clear that they make a difference in Camden City’s long-term economic growth prospects. This is particularly significant in the area of human capital development and the preparation of young people for the jobs of tomorrow, as well as working directly with government and businesses to meet social and economic goals to the benefit of all residents.

Probably a case study, similar to the above, in the Indian context, would be that of Manipal Academy of Higher Education (MAHE) & its economic and social impact on the development of Manipal Village. The researcher strongly desired to research on this aspect and so initiated correspondence with the authorities of MAHE (included as annexure). Unfortunately, however, there was no such study report available.
Healthcare Model in Canada:

The Canadian Organization of University and College Health (COUCH), a division of the Canadian Association of College and University Student Services (CACUSS), is dedicated to improving the health and wellness of college and university communities. Activities include health promotion on the campus, providing individualized care to members of their community and working with community partners on public health matters.

COUCH members believe that:

a. The primary purpose of a student health program is to contribute to the success of the parent institution's academic mission by meeting the health education and clinical care needs of its students.

b. Health education and clinical care for post-secondary students are best delivered by a health service which is located on campus and is staffed by persons who are sensitive and responsive to the particular needs of the students.

c. A caring and supportive environment enhances the learning process. Optimal health status enables students to maximize their intellectual functioning and scholastic achievements. Healthy students are then free to concentrate on their studies and to reach their fullest potential.

Healthcare Model in Australia and New Zealand:

The Australia and New Zealand Student Services Association (ANZSSA) represents a wide variety of professional and lay people who share a common concern in the welfare and development of post-secondary education students and their institutions in the two countries.
The majority of individual members work directly with post-secondary students in various aspects of student welfare and includes Campus Nurses and Medical Officers, Sport and Recreation staff amongst other intersectoral workers.

The range of institutions represented includes Universities, Technical and Further Education Colleges, Specialist Tertiary Schools and Residential Facilities. The membership thus reflects the view of ANZSSA that post-secondary education students share many common needs and problems regardless of the type of institution at which they are studying or their differing circumstances.

➢ Healthcare Model operational in South Africa:
(A rural clinical school as leverage for sustainable rural development: An opportunity for the University of Stellenbosch’s Health Sciences Faculty, Therese Fish)

The Health Sciences Faculty at University of Stellenbosch, South Africa responded to the need to educate health professionals appropriate to the needs of the country through a strategic decision to increase a community orientated education with the objective to expose undergraduate students to at least 50% of their clinical training outside the central hospitals. This includes 10% of this in a rural setting.

It was against this background that the Faculty established the Ukwanda Centre for Rural Health in 2002, which facilitates the teaching of undergraduate students and registrars in the rural areas of the Western Cape Province and beyond. It also supports the continuous professional development of district hospital practitioners through the MoComp project (Maintenance of Competence).

This case study conclusively proves that universities have the potential of adding immeasurable value to a city, town or village including sustainable rural development. The interrelatedness of human security, health, self-perceived value, economic development and social upliftment lends itself to integrate efforts by various academic departments throughout the university. Furthermore, a successful model of a rural campus which successfully improves the lives of rural communities could serve as a model for other rural communities.
Healthcare Model operational in the Middle East:

The American University in Dubai ([http://www.aud.edu/student_services/health.asp](http://www.aud.edu/student_services/health.asp)): The AUD Health Center personnel are available 24 hours a day to answer any health-related questions and concerns. The AUD Health Center maintains contact with private and government health clinics, as well as other hospitals in Dubai.

Students registered at the American University in Dubai are required to submit the Student Health History Form. This Form has to be endorsed by a physician. All health information is confidential. All student medical records are kept under a locked filing system; they are not released to others without the written consent (Authorization of Health Information Release) of the student or his/her parents.

Students with medical problems or disabilities that require care or restrict their campus activities have to submit a letter from their family physician describing their conditions, restrictions, and special requirements. If necessary, additional information can be added to the health form to describe special medical conditions.

Effective Fall 2008, private health insurance covering care in the UAE is mandatory for all AUD students. This is provided against a cost of AED 1,000.

Healthcare Model in South East Asia:

Okayama University, Japan: ([http://kymx.adm.okayama-u.ac.jp/kokusai/prospective/studentlife_e.html](http://kymx.adm.okayama-u.ac.jp/kokusai/prospective/studentlife_e.html)): The Health and Medical Center of Okayama University provides students with free consultation. The Center provides basic First Aid. However, the center cannot supply treatment and/or medications in general and introduces a clinic or a hospital, when necessary.

Students are required to enroll in National Health Insurance even though they have international medical insurance at home in order for them to receive prompt and sufficient treatment and medications in Japan. Students are required to pay approximately 2,000 yen a month, and the insurance covers 70% of treatment fees.
Students are advised to bring medications they use regularly to Japan. In this case, students are required to take some procedures to enter the country with such medications, i.e. to import the medication. It is solely the students’ responsibility to get information on this matter and the university does not provide translations regarding medication and/or the procedures either.

*Students are made aware that the Japanese climate could differ from their home country. Its culture could differ from their own and very importantly they should not expect ordinary Japanese people to be able to speak / write English as well as their native language. Students should not expect that someone who speaks good English will always be available to take them to the medical Center or hospital. Further, doctors at the medical center may not be able to speak adequate English. Students are therefore advised to prepare well for emergencies in order for them to be ready to live in such a foreign country.

Okayama University does not provide translation of medical certificates and/or receipts from a clinic or a hospital in Japan if students need to claim for medical treatment and/or medications received in Japan to be paid out from an insurance company in their home country.

➢ National University of Singapore (http://www.nus.edu.sg/uhc):
The National University of Singapore (NUS) has an on campus University Health Centre (UHC) which caters to the entire NUS community of over 30,000 students and 6000 staff.

The UHC provides preventive, curative & promotive health care services on campus to all staff & students including a pharmacy & counseling services. Additionally, it runs a satellite clinic providing basic medical services to the community. Medical Insurance is mandatory for all full time students. Medical benefits are extended throughout the course of study in Singapore only. Benefits cease when students pass their final examination and complete their course or cease to be a full-time student.
*Pre-entrance medical examinations are required for all students entering the University.

➤ **Nanyang Technological University (NTU) ([www.ntu.edu.sg](http://www.ntu.edu.sg))**: 
Ranked among the top 26 technology universities in the world, NTU has a medical & dental clinic situated on campus for the convenience of staff and students. Counseling Services are provided through the Student Counseling Centre (SCC).

The Campus Security Division provides 24x7 emergency services and ensures law enforcement and safety on campus. NTU offers all full-time matriculated students a medical scheme and insurance plans.

The Sports & Recreation Centre caters to the sporting and recreational needs of the University community and provides ample opportunities for participation in an active and healthy lifestyle. The Healthy Lifestyle Unit located herein organizes co-ordinates and implements health education and healthy lifestyle programmes and activities for the students.