The contribution of health discussion groups with students to campus health promotion

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SUMMARY

Based on the idea of implementing health promotion in the university setting, this project is aimed at identifying determinants of health and well-being in the working and living environment of students and at developing targeted health interventions. The approach of health discussion groups is a well-established tool in workplace health promotion to enable participation and empowerment. This concept was innovatively applied and evaluated with the student body.

There were seven sessions held at the University of Bielefeld with students from five different areas, a representative of the university management and a representative from the compulsory accident assurance. Process evaluation was done through standardized questionnaires and guided interviews with the participants while its impact was assessed in a follow-up period of 3 years by the amount of effects.

Data included 11 distinct topics from the areas of study conditions, learning and their living environment with a total of 46 ideas for health-promoting actions. The process evaluation showed highly positive results, both in quantitative as well as qualitative approaches. Critical points were the resistances of students to participate in health discussion groups and the low confidence of students in the implementation of the proposed measures.

The follow-up after 3 years showed that 11% of proposed actions could not be implemented, while 43% have resulted in recommendations for policy guidelines, 20% were fully implemented and 26% is still in progress.

In conclusion, the health discussion group proved to be a useful instrument for student participation in university-based health promotion. Special emphasis should be given towards decreasing barriers for participation. The implementation of the proposed actions is highly depending on well-established structures of health promotion, such as a steering committee, and the commitment of the university management.

Key words: health promotion; university students; health discussion group

INTRODUCTION

The university is a setting in which knowledge and skills should be taught and a safe, healthy and supportive social and physical environment should be created (DeRoos, 1977). As educational and research institutions health-promoting universities have the potential to outreach into the wider community and society through multiplying and modelling effects (Abercrombie et al., 1998). Therefore, universities have a special responsibility to create supportive environments for health and to work towards emphasizing and increasing the students’ capacity to gain control over and improve their health (Lee, 2002).

Students, the largest population group at universities, are generally seen as a ‘healthy’ population. However, various health problems were observed in a survey among students at the Bielefeld University (Allgöwer et al., 1998). Those problems were reported as symptoms of
stress as well as discomfort due to structural aspects in the university environment (Stock and Krämer, 2001). Comparing this data with those of other European countries revealed that single aspects of students’ health, especially those related to psychological stress and psychosomatic complaints, may raise general concern (Stock et al., 2004). Other studies have shown that unhealthy lifestyle and habits are prevalent in the student population and there is a strong need for health promotion in the university setting (Svenson et al., 1997; Emmons et al., 1998). There are indications that university-based health-promotion programmes are able to improve students’ knowledge and ultimately their behaviour and lifestyles substantially (Sun et al., 1999; Walsh et al., 1999). However, most of these interventions were lifestyle oriented and did not set a special emphasis on participation and empowerment.

In contrast to this, the present project study used an approach aiming at increasing students participation in the institutions decision-making and therewith strengthening the active organization of their working and living environment. Current health promotion practice places a high value on participatory processes and bottom–up planning enabling communities to identify problems, develop solutions and facilitate change (Israel et al., 1994; Labonte, 1994; Wallerstein and Bernstein, 1994; Blackburn, 2000). Such community development approaches aim at empowering communities to have more influence in the shaping of policies with impact on health (Bracht and Tsouros, 1990).

Within workplace health promotion based on an empowerment approach, the health discussion group has been shown to be an effective instrument to increase participation in health-related decision making and planning in employees (Westermayer and Bähr, 1994).

In the context of occupational health, the University of Bielefeld, as well as other universities, has already made positive experiences with the employees of health discussion groups (Simm and Unnold, 2000). However, to date, there have not been any reports about health discussion groups with students. Therefore, this project aims at making a substantial contribution to health promotion with and for the student population.

In Germany, the Health Promoting University has developed as a relatively new setting for health promotion, while in other countries a longer tradition of Health Promoting Universities exists (Tsouros et al., 1998a). Ten years ago, the University of Bielefeld was one of the first universities in Germany to set health onto the institution’s agenda. The structures established since then formed the basis for the implementation of the project to develop health discussion groups with students.

METHODS

Structural prerequisites

Health discussion groups

The concept of health discussion groups—known in this context also as health circles—has grown up from a 1980s support programme in order to humanize working life in Germany. Two pioneers, the ‘Berlin model’ and the ‘Düsseldorf approach’, gained special attention. Nowadays, we find different structural and process concepts summarized under the name of health circles. All of them have in common the following characteristics: participation of employees, heterogeneous/homogeneous composition, transparency, voluntary participation, openness towards themes, moderation, rules for communication, time limitation and organizational integration (Slesina, 2001a). It is the aim of all health circles to make use of the employees’ practical, everyday experience with health aspects at their workplace in order to find solutions and create supportive health conditions on their own authority (Schröer and Sochert, 2000). The conditions for the success of a health circle are integration into management processes (Badura et al., 1999) and support from key persons at the company (European Network for Workplace Health Promotion, 1997).

Health management at the University of Bielefeld

At the Bielefeld University the activities in health promotion are managed by the steering committee for health. The steering committee for health is a forum with representatives from different university sectors (leadership, administration, employees, students, health services) organized by the university coordinator for health promotion. It does not have any decision-making authority, but fathoms
requirements and possibilities to act; it initiates and attends new activities, makes suggestions and gives advice for decision-making. The activities are realized in associated working groups. The department of human development as part of the university administration supports the activities of the steering committee for health and its working groups and communicates regularly with the university leadership (Simm and Unnold, 2000).

Integrating the project ‘health discussion group’ into the structures of health promotion at the university

The project was driven by the authors as a team of researchers at the School of Public Health, University of Bielefeld. At first, the project was presented to university leadership, the steering committee for health and the student union of the university. The project raised interest and encouragement among these authorities. The university leadership as well as the student union appointed a representative to participate in the health discussion group. The steering committee for health was asked to establish a working group. The task of this working group was to communicate the activities of the health discussion group to the steering committee and later on implement its short-, medium- and long-term objectives. In this group, the university coordinator for health promotion, the moderator of the health discussion group, a representative of the accident insurance and a students’ representative cooperated in initiating actions to put the health discussion groups proposal for problem solution into practice.

Realisation of the health discussion group

Invitation of participants

In January 2001, an open day on the topic of Health Promoting Universities took place at the University of Bielefeld organized by the steering committee for health (Universität Bielefeld, 2001). All students committees in the 19 faculties received an invitation for this event and a letter inviting for participation in the health discussion group. The invitation was followed by phone calls. Finally, seven students, a representative of the university leadership and a representative of the Accident Insurance Company participated as stakeholders. Figure 1 shows the composition of the health discussion group.

From May to June 2001, the health discussion group met seven times, moderated by a social worker trained in public health. The circle followed the recommendations of the German National Institute for Occupational Safety and Prevention (Schröer et al., 1997). At the first session, the moderator presented the concept of a health discussion group, the goals of the Bielefeld group and structures of health support at this university. In addition, results from previous studies on students’ health were presented at this university. As a common base for further cooperation, the participants discussed individual health concepts on the background of definitions of the World Health Organization (WHO, 1998). Furthermore, students agreed on a group ‘working agreement’. After this introduction, participants started to develop themes led by the question ‘Which themes should the group deal with?’. After this first step thematic health priorities were established. During the following meetings, the predominant task was to discuss the themes with the aim of prioritizing possible solutions. At the final meeting, specific strategies and methods were documented. The work of the health discussion group was kept transparent, by publishing protocols on a homepage, which was promoted through posters across the university. There was a follow-up meeting half a year after the start of the health discussion group. The participants
were informed about the progress of the project and information continued thereafter by E-mail.

Evaluation

Process evaluation

The evaluation tools were a guided interview and a standardized questionnaire. The questionnaire comprised 12 items from a questionnaire developed and validated by others (Müller et al., 1997). Each question had a four or five point Likert-like answering format. First, the participants were asked about their contentedness concerning the general set up of the discussion group: frequency and duration of sessions (5), interval between the sessions (5) and regular participation of the same persons (4). Further items assessed the quality of the communication processes: if the students gained information about general and health promoting structures of the setting (5), if the presence of visitors limited the freedom of speech (4), if the rules of communication were attended (4) and how the students judge the working atmosphere (5). The participants were asked how the moderator used the technique and how the moderator himself affected the operating process (4). In the last part of the questionnaire the participants were asked about the protocols: if they have read them (4), if they could understand them (4), if the session protocols informed them about the progress of the working process (4) and if they enabled other students getting informed (4). In the final question a summarizing assessment of the health discussion group was asked for. The questionnaires were handed out to the participants, who were asked to complete them before they were interviewed. The interview guide started with a question on the conditions of participation and the motivation to join the group. Furthermore, it contained more detailed questions concerning the moderation, the techniques used and the personality of the moderator. The interviewees were asked about their appraisal of the general results of the working group, the quality, the choice and thoroughness of themes and the overall experience. Six participants (four females, two males) were interviewed 1 week after the last session took place. The interviews took 35–70 min (47 min on an average) and were tape-recorded with the permission of the interviewees. After transcription, the texts were encoded with a confidential encoding system using the software WinMAX (VERBI Software Consult, Sozialforschung GmbH, Germany).

Follow-on and impact evaluation

A working group established by the steering committee of the University of Bielefeld supported the work of the health discussion group as described earlier. All steps of the implementation were well documented (Which action was undertaken and when?; Who was approached to change current praxis? What were the intermediate and final outcomes of change?). The process was observed during the follow-up period of 3 years. During this period, the impact of the health discussion group was assessed based on the quality (completeness) and quantity (number) of changes documented.

RESULTS

Outcomes of the health discussion group

The brainstorm and subsequent prioritization based on group consensus resulted in the collection of 11 separate topics either related to study conditions or to living and learning conditions at the campus (Table 1). The highest priority was given to the four single barriers to studying. To promote effective learning, four themes were reflected: places for learning, places for retreat and relaxation, the quality of chairs and the indoor climate. The themes canteen food and sports were given less priority at the university. Related to these problem categories, the group selected 46 problems to address and recommended specific implementation steps for each individual item.

Implementation of the proposed actions

Table 2 shows the proposed implementation of the proposals for health-promoting actions 3 years after the health discussion group was concluded. All proposals were forwarded to appropriate authorities within the university. The decisions were effected by the policies and the capacity of each single department. A total of 20% of the proposals for health promotion could be fully implemented, while 26% are still being worked on. A higher proportion of
high prioritized proposals could be fully implemented (32%) when compared to those with lower priority (5%). Some proposals (11%) were rejected by the responsible authorities. Nearly one-half of the proposals (43%) have lead to recommendations for policy guidelines. These recommendations were passed on to the university management by the steering committee. The working group gave feedback to the university community on the outcomes of

Table 1: Outcomes of the health discussion circle

<table>
<thead>
<tr>
<th>Topics</th>
<th>( n = 46 )</th>
<th>Examples for proposed actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems related to studies(^a)</td>
<td>11</td>
<td>Electronic course schedule</td>
</tr>
<tr>
<td>Planning and organization</td>
<td>2</td>
<td>Mentor and support system</td>
</tr>
<tr>
<td>Counselling offers and practice</td>
<td>2</td>
<td>Adequate workload</td>
</tr>
<tr>
<td>Content of studies</td>
<td>2</td>
<td>Comprehensiveness of study regulations</td>
</tr>
<tr>
<td>Examination procedures</td>
<td>5</td>
<td>Single and group work places</td>
</tr>
<tr>
<td>Practice of information flow(^b)</td>
<td>1</td>
<td>Clear structure of information</td>
</tr>
<tr>
<td>Quality and quantity of (Library) work places(^b)</td>
<td>5</td>
<td>Excess to green yards</td>
</tr>
<tr>
<td>Relaxation areas(^b)</td>
<td>3</td>
<td>Back friendly chairs</td>
</tr>
<tr>
<td>Comfort of seats and chairs(^b)</td>
<td>5</td>
<td>Adequate workload</td>
</tr>
<tr>
<td>Quality of canteen food offer(^c)</td>
<td>1</td>
<td>Better offer of vegetarian diet</td>
</tr>
<tr>
<td>Quality and quantity of the sports programme(^c)</td>
<td>4</td>
<td>‘Training the trainers’ to increase quality of programmes</td>
</tr>
<tr>
<td>Indoor climate(^c)</td>
<td>3</td>
<td>Smoke-free environment</td>
</tr>
<tr>
<td>Architecture and structure of the outside campus area(^c)</td>
<td>6</td>
<td>Meeting facilities for groups</td>
</tr>
<tr>
<td>Architecture and design inside the building(^c)</td>
<td>6</td>
<td>More plants</td>
</tr>
<tr>
<td>Possibilities for discussion, networking and coalition building(^c)</td>
<td>1</td>
<td>Internet forum</td>
</tr>
</tbody>
</table>

Priorities of discussion topics and quantity (\( n \)) of proposed actions as well as one example for each topic.
\(^a\)High priority topics.
\(^b\)Medium priority topics.
\(^c\)Low priority topics.

Table 2: State of implementation of the health discussion group’s proposals for action after 3 years

<table>
<thead>
<tr>
<th>Topics</th>
<th>( n = 46 )</th>
<th>Status of implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems related to studies(^a)</td>
<td>11</td>
<td>A</td>
</tr>
<tr>
<td>Planning and organization</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Counselling offers and practice</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Content of studies</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Examination procedures</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Practice of information flow(^b)</td>
<td>1</td>
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</tr>
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<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Possibilities for discussion, networking and coalition building(^c)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total (%)</td>
<td>46 (100)</td>
<td>9 (20)</td>
</tr>
<tr>
<td>Medium or high priority topics (%)</td>
<td>21 (100)</td>
<td>8 (32)</td>
</tr>
<tr>
<td>Low priority topics (%)</td>
<td>25 (100)</td>
<td>1 (5)</td>
</tr>
</tbody>
</table>

A, fully implemented; B, recommended for policy guidelines; C, work ongoing; D, not going to be implemented.
\(^a\)High priority topics.
\(^b\)Medium priority topics.
\(^c\)Low priority topics.
the student health discussion groups during a ‘Health Day’ held in December 2004.

**Questionnaire and interview-based evaluation**

The results from the qualitative and the quantitative part of the evaluation are reported according to four categories: participation/organization, moderation/communication, results, conclusions/recommendations. Items from the questionnaire were considered as being positively answered, when at least five out of six respondents answered in the two highest of the five answering categories.

**Participation/organization**

In the questionnaire, all respondents assessed the work in the health discussion group as positive and the vast majority was satisfied with the frequency and intervals of meetings and duration. The protocols allowed students to be kept well-informed about the progress of the working process; in addition other students were able to keep up with the work of the health discussion group.

In the interviews, the students described two ways of getting in touch with the project: direct invitation to a committee (department) to send a representative or personal contact. Also new findings about the motivation for participation were found. The most important factor was an interest in health promotion. Students’ expectations of the circle work were widely met as shown by a student mentioning in the interview: ‘Through my participation I became more aware of some problems’.

**Moderation/communication**

The questionnaires revealed that techniques of facilitation were perceived as motivating, well-aimed and structured. The students felt they were taken seriously by the moderator and appreciated that the needs of participants were taken into account. All respondents felt that their freedom of speech was unrestricted.

Students reported in the interview that they were aware of the technique that was used but not had much practical experience of it. Altogether, students felt that they were taken seriously and were well supported. The communication processes were described as productive, objective and relaxed. One participant characterized the working atmosphere as ‘very relaxing, very comfortable’. It was felt that the moderator motivated the participants to active participation. Positive opinions about the moderators’ personality and techniques and about working atmosphere were reported in the questionnaire and in the interview. When asked for discussion group anecdotes, it became obvious that all interviewees had been communicating in different ways about the project in their social environments (facultys, fellow students and friends). Outcomes from these conversations were in term used in the health discussion group.

**Results**

The questionnaire-based evaluation showed that participants were highly satisfied with the general results. In addition, in the interviews they expressed high satisfaction with the quality and thoroughness of themes, choice and the overall experiences received. The following citation points up the students’ notion: ‘I was really surprised that it was so much fun and that I got so much out of it.’ The number of actions taken as a result of their proposals were appreciated. However, students expressed scepticism about the implementation of the health discussion group’s proposals into university practice.

**Conclusions/recommendations**

When students were asked in the interviews about their perception of other students’ barriers to participation in health discussion groups, problems with time and organization were perceived as important. Furthermore, they commented that one possible barrier could be that students are widely considered as a healthy population with no particular health needs. The interviewees made suggestions to motivate future students for planning and conducting future health discussion groups. Students were positive about the idea of health discussion groups as an integral part of their studies, for which the participants would receive a record or certificate. In addition, students suggested an information desk in the central hall would attract then attention.
DISCUSSION

Approaches to health promotion in the university setting have their roots in occupational safety, social advice, treatment of addictive behaviour and supporting healthy choices. In the German speaking countries, health promotion in the university setting has been mainly focused on employees. Even though students are the largest population group in universities, fewer health initiatives were undertaken in this group. Therefore, this project was aimed at new findings in students’ well-being related to the university environment. This was realized on two different levels. First, identifying the priorities of health themes extended our knowledge about students’ needs, and second the evaluation provided new insights about the feasibility of this approach for the students. A review of English-speaking journals studying university-based approaches promoting health and well-being found 104 articles dealing with health topics in the university setting. None of the articles informed about a similar approach like the presented project of health discussion groups with students (Doherty, 2005).

It is important to note that the health discussion group involved a limited number of students and was not meant to be representative. However, comparison of the results of the health discussion group with data from a health survey among 650 students at the same institution showed a high correspondence between the qualitative and quantitative findings (Stock et al., 2002; Meier et al., 2003). Moreover, the project revealed additional information on student’s needs concerning the organization of studies. It also gained insight into students’ own ideas on how to improve the conditions of health at the campus. The follow-up showed that these suggestions and strategies for problem solving were well-thought and realistic, since a substantial number of suggestions were adopted by responsible administrations and put into practice. Particularly successful was the proposal and implementation of a ‘non-smoking university hall’. Another proposal that altered the structures of the university was to announce overlapping lectures by establishing an electronic course schedule. In addition, the proposal to implement a system of mentors for the students was realized.

Some of the problems the students discussed in the group were already known problem areas for the university decision makers, but this was not realized by the students so far. In this respect, the health discussion group stimulated vertical communication in the institution, which is another positive outcome of the project. Overall, the impact of the health discussion group on university health policies and practices can be regarded as high. However, it needs to be considered that at least some of the issues due to the health discussion group were not only addressed, but also the input from this group enforced already ongoing change processes.

Recommendations

However, there are some essential preconditions for the successful use of this approach in university-based health promotion. In order to achieve sustainable effects, the integration of the health discussion group into a wider concept of health promotion at the university is important. Without the link between the health discussion group and a steering committee, and moreover the support and commitment of the university leadership, the outcomes of the group work are unlikely to be put into practice. This is in line with the common agreement that appropriate leadership and effective organizational structures are crucial to successful community participation (Rifkin, 1990; Labonte, 1998; Zakus and Lysack, 1998).

In order to produce a fruitful working atmosphere and to motivate students for participation, the following conclusions can be drawn from this project.

(i) Discussion group set-up: Professional moderators should be employed. One person needs to be responsible for the organization. Coordination should not only include the preparation and delivery, but also self-evaluation. The general set-up chosen for this project was largely equivalent to that of the health discussion groups, ‘health circles’ developed and tested in occupational health projects and was proved to be suitable for the student group without any substantial changes required. The number of proposed actions corresponded to experiences made in other health discussion groups (Schröer, 1992).

(ii) Composition of the health discussion group: To include students from different faculties/departments was shown to be
adequate to obtain a picture of the students’ general health needs. However, faculty-or department-based groups may offer advantages to work on more specialized, local problem areas. Based on our experience, students did not wish teaching staff representatives in the health discussion group.

(iii) Students’ participation: We experienced difficulties in mobilizing students. Our initial approach by way of a formal request for participation in the student committees was not very promising. Personal communication with students was more successful in gaining the interest. This was supported in the evaluation interviews where students emphasized the importance of personal contact. Therefore, an information desk on the campus, as one interviewee proposed, could be a promising option to motivate students to participate. Despite the initial scepticism of students, the participants cooperated very actively and were positively impressed by the outcomes. Students with positive experiences could act as role models to motivate others to participate in consecutive groups.

Based on the overall positive experiences with students of the health discussion group, we recommend integration of such or similar approaches into the curricula of higher education. Such a student-centred approach has a high likelihood of resulting in sustainable effects in raising health awareness and motivating students to actively take part in health decision-making in the university environment. This is supported by the WHO Regional Office for Europe, which emphasized the importance of curricula in realizing Health Promoting Universities (Tsouros et al., 1998b).

In summary, the project has shown that the concept of health discussion groups can be successfully applied to student groups when certain characteristics of this target group are taken into account. The same features as those of the ‘health circles’ in occupational settings seem to be important: participation of employees (students), heterogeneity (different faculties) as well as homogeneity (only students), transparency, voluntary participation, openness towards themes, employment of trained moderators, agreement on rules for communication, termination and organizational integration (Slesina, 2001b).

Comparative studies involving students from different European countries showed that students’ health needs vary substantially (Steptoe et al., 2002; Stock et al., 2003; Wardle et al., 2004). In addition to survey studies, health discussion groups can be an appropriate tool to identify relevant health problems in the context of different university environments. Health discussion groups have the potential to affect sustainable changes in environmental conditions for health and therefore go beyond individual behaviour-oriented interventions. In the context of the Health Promoting University, this approach can help to identify weaknesses and to develop specific tailor-made solutions for universities.

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