HEALTH PROMOTING UNIVERSITIES

CONCEPT, EXPERIENCE AND FRAMEWORK FOR ACTION

ORGANIZATIONAL

DEVELOPMENT

21ST

CENTURY

HEALTH POLICY

HEALTH PROMOTION

HEALTH FOR ALL

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Health Promoting Universities

Concept, experience and framework for action

Edited by

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| **TARGET 14** |
| **SETTINGS FOR HEALTH PROMOTION** |
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| *By the year 2000, all settings of social life and |
| activity, such as the city, school, workplace, |
| neighbourhood and home, should provide greater |
| opportunities for promoting health.* |
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Abstract

Institutions of higher education have long been concerned about promoting health among students. The settings-based approach to health promotion can potentially enhance the contribution of universities to improving the health of populations and to adding value in the following ways: 1) by protecting the health and promoting the wellbeing of students, staff and the wider community through their policies and practices, 2) by increasingly relating health promotion to teaching and research and 3) by developing health promotion alliances and outreach into the community. This working document provides conceptual and practical guidance on how to set up and develop a health-promoting university project. It combines a series of innovative case studies from the United Kingdom and the outcome of a WHO round table meeting on the criteria and strategies and operational attributes of the Health Promoting Universities project and an action framework for a European Network of Health Promoting Universities.

Keywords

UNIVERSITIES
HEALTH PROMOTION
PROGRAMME DEVELOPMENT
PUBLIC HEALTH – trends
SUSTAINABILITY
HEALTH FOR ALL
HEALTHY CITIES
EUROPE

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4. The way forward

Preface

Universities can do many things to promote and protect the health of students and staff, to create health-conducive working, learning and living environments, to protect the environment and promote sustainability, to promote health promotion in teaching and research and to promote the health of the community and to be a resource for the health of the community. The challenge is to develop health-promoting university projects that encourage all these aspects. There is considerable enthusiasm for and interest in the concept of the health-promoting university. Demand for guidance is also growing. This is a working document that explores, visualizes and develops the health-promoting potential of universities using the settings-based approach to health promotion.

The development of the strategic framework for health-promoting university projects and networks has drawn on a number of sources: expertise developed by the WHO Healthy Cities Project Office; the experience of health-promoting university ongoings, especially those at Lancaster University and the University of Central Lancashire in England; the experiences of other settings-based projects, such as Health Promoting Schools and Health Promoting Hospitals; the ideas and papers presented at the First International Conference on Health Promoting Universities in Lancaster, England in 1996; and the WHO round table meeting on the criteria and strategies for a new European Network of Health Promoting Universities in 1997.

The commitment and active engagement of senior university executives is essential to the success of health-promoting university projects. I am therefore delighted that two inspired and committed vice-chancellors (rectors) in the United Kingdom have endorsed this document.

I would like to express my gratitude and appreciation to Gina Dowding for her valuable contribution as the principal technical adviser in drafting the papers on strategy and in the preparation of this book. Many thanks are also due to Mark Dooris and Jane Thompson, the other two co-editors of the book, for their input. Appreciation and many thanks are due to the following people whose initial commitment to the idea of the

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Foreword

We are very pleased to endorse this book, which provides a timely introduction to the concept and practice of the health-promoting university.

Lancaster and Central Lancashire were two of the very first universities in Europe to establish health-promoting university projects. Though very different – Lancaster is an "old" university, whereas Central Lancashire is a "new" university, and Lancaster is a campus university some five kilometres from the city, whereas Central Lancashire is situated in the heart of the town of Preston – the processes involved in setting up and developing the projects have had many similarities. These are reflected in the case studies later in the document. Both situated in the north-west of England, the two universities have been well placed to exchange ideas and experiences. This collaborative approach to the development of good practice has been a refreshing expression of the projects' underlying principles within an increasingly competitive environment.

The heart of any health-promoting university initiative must be a top-level commitment to embedding an understanding of and commitment to sustainable health within the organization in its entirety. This means a number of things.

- As large institutions, universities can build a commitment to health into their organizational culture, structures and practices – creating supportive working, learning and living environments.

- As major employers, universities can promote staff wellbeing through appropriate management, communication and operational policies.

- As creative centres of learning and research, universities have the potential to develop, synthesize and apply health-related knowledge and understanding.

- As educators of future generations of decision-makers, universities have the potential to develop a critical understanding of sus-

tainable health and a sense of personal and community steward-ship – which will affect society at large.

- As settings within which students become independent, universities have both a responsibility and the potential to enable healthy personal and social development.

- As a resource for and a partner in local, national and global communities, universities have a crucial role in advocating and mediating for healthy and sustainable public policy.

As the twenty-first century approaches, universities occupy a unique position in society, drawing on a rich educational and cultural heritage, while being at the cutting edge of technological and other innovative developments. As such, they are ideally placed not only to be part of the part of the exciting and expanding movement for health-promoting settings but also to provide a testing ground for critically applying, evaluating and further developing this approach.

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Introduction

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

This is a working document that explores, visualizes and develops the health-promoting potential of universities. It aims to provide conceptual and practical guidance on how to set up and develop a health-promoting university project. Many people intuitively understand the concept of a health-promoting university. The meaning, however, the scope and focus of university actions aiming at promoting health, can vary widely. This variation can be partly explained by differences in the perception of health and its determinants and partly by the interests, strategic choices and the power and authority of the health advocates for the university.

The approach and guidance offered in this document are firmly rooted in the principles of health for all and sustainable development, the Ottawa Charter for Health Promotion and the theory of and experience with settings-based projects. Introducing such concepts as the settings approach to health promotion and organizational development for health promotion could be impossible without first grasping health in its broadest sense. Indeed, broadening the understanding of health among university executives and academic disciplines is a crucial step in any attempt to introduce and encourage comprehensive health-promoting university projects.

This document is mainly the result of two key events: the First International Conference on Health Promoting Universities, in 1996, which was organized by Lancaster University in collaboration with the WHO Regional Office for Europe and a WHO round table meeting on the criteria and strategies for a new European Network of Health Pro-

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moting Universities in 1997. The WHO support and input was provided through the Healthy Cities Project Office.

The document blends practice with theory, experience with potential and vision with pragmatism. Section 1 concentrates on the theory, the principles and the strategic elements that underpin the development of the healthy settings approach to public health and health promotion. All three chapters of this contextual and guiding section draw on the expertise from and experiences with a wide range of settings-based projects including healthy city, healthy prison and health-promoting hospital projects.

Sections 2 and 3 unfold into a fascinating account of visions and efforts to enhance the health of universities in the United Kingdom and their role in working for health. They are used as a comprehensive example and source of inspiration, to allow the reader to appreciate the multifaceted aspects of the health-promoting university in a real-world context and through the specific experiences of several actors. The United Kingdom has always provided fertile ground for a host of innovative health promotion and healthy settings initiatives.

Section 2 explores the role of health in higher education from the perspective of university leaders. The opportunities and constraints for the health-promoting university in are discussed in the context of national policies and organizational realities. Section 3 consists of a set of case studies from six universities. They offer an interesting mix of approaches and solutions addressing most aspects of university life and activity. Some of them represent fully fledged efforts to translate and apply the healthy settings and organizational development theory into practice. The reader will find plenty of valuable insights and innovative ideas in this section. A glossary of terms related to higher education and the health care system in the United Kingdom is provided at the end of the document.

Section 4, consisting of two chapters, provides a strategic framework for developing health-promoting university projects and also the terms of engagement and the standards for a new European Network of Health Promoting Universities. The first chapter covers the aims, objectives, processes, infrastructures and expected outcomes of the Health Promoting Universities project. This is not meant to be prescriptive but a guiding framework for those interested in developing health-promoting university

projects based on health for all and a settings-based approach to health promotion. Networking is a powerful means for promoting commitment, change and innovation. Enthusiasm and demand are growing for guidance on and support to developing the health-promoting university in Europe today. This area of development has a very promising future.

The historical shift in public health

John Ashton

INTRODUCTION

The idea of a health-promoting university is not really novel. The original universities, rooted as they were in the ecclesiastical tradition, were concerned with the development of the whole and spiritual person – and their academic years were synchronized with nature through the agricultural cycle.

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. Human and personal development must run hand in hand with economic development and with custodianship of the environment.

There are eight universities and five degree-awarding colleges in the north-west of England and, like those in other regions and other countries, they all have the potential to promote health through institutional activities, research, teaching and training. The National Health Service Executive North West gives a great deal of support for the idea and practice of the health-promoting university, which is a natural expression of the new public health thinking.

THE EVOLUTION OF PUBLIC HEALTH:
FROM THE SANITARY IDEA TO THE SETTING

The nineteenth-century public health movement centred on the squalor of industrial towns and cities. It was geographic in its focus, environmental in its emphasis and mechanistic in its thinking – the driving force being the sanitary idea with its concern to separate human and animal waste from food and water. The response was a locally driven public health movement backed up in time by public health legislation – the streets were paved, sewers were built and safe water was supplied. A significant impact was made on the problems of the day – and if the rivers were polluted downstream of the city limits or plumes of industrial smoke from the tall chimneys came to blacken the countryside some distance away, what price was that to pay if urban lives were saved?

In time, the environmental emphasis was modified by the advent of new technologies such as immunization, vaccination and birth control and by an emphasis on individual health and hygiene education. This combination of environmentalism and personal prevention led to a blossoming of public health characterized by the establishment of training courses, professional societies and public health departments *(1)*.

During the 1920s, public health entered its wilderness period – which was to last for some 30 or 40 years – as science began to provide an array of pharmaceutical treatments that previous generations could only have dreamt of. The assumption that the decline in the death rate from infectious diseases and the introduction of new pharmaceutical agents were causally rather than coincidentally related encouraged a shift away from the earlier foci on the environmental determinants of health and personal prevention.

The credit for the renaissance of public health and for the rise of what has come to be known as the new public health is shared by a range of critics who challenged the ascendancy of what was seen as a reductionist and deficient approach to the existential dilemma of life, health and death *(2–7)*. Of particular importance was McKewan's analysis of the decline of deaths and infectious diseases in England and Wales between 1830 and 1970, which showed that most of the decline in

deaths from infectious diseases such as tuberculosis in England and Wales occurred before any specific prevention or treatment was available and that one third of the decline occurred before the cause was known. This argument for refocusing on the environmental determinants of health and personal prevention coincided with an emerging emphasis on ecological thinking that moved beyond the mechanistic sanitary approach of the old public health. This new movement for public health found expression in three related WHO initiatives: the 1977 Declaration of Alma-Ata *(8)* – which described a vision of primary health care integrating public health, population and environmental concerns; the strategy for health for all by the year 2000 *(9)* – with its emphasis on equity, public participation, intersectoral collaboration and the need to reorient heath systems and services; and the 1986 Ottawa Charter for Health Promotion *(10)* – with its focus on supportive environments and public policies to support health development.

The new and ecological public health has led naturally to a focus on settings as environments or habitats within which people live and work. One of the first practical attempts to operationalize the new way of thinking on a systematic basis came with the WHO Healthy Cities project, the intention of which was to take the health for all strategy off the shelves and into the streets of Europe *(11,12)*. This has been followed and complemented by a developing focus on other settings, as witnessed by the publication of a national health strategy for England *(13)* that specifically advocated action within homes, schools, cities, workplaces, hospitals, prisons and environments. In some ways this can be seen as a shift from vertical thinking – whereby individual public heath problems remain compartmentalized, to horizontal thinking – whereby links and interactions are made explicit and a synergistic approach is adopted through coordinated action on a range of health determinants.

DEVELOPING SETTINGS

Although each setting is unique, drawing on the experience of other settings-based work is valuable in developing the concept of the health-promoting university. The framework developed in the north-west of

England for healthy prisons *(14)* offers one possible model – looking at the setting from the perspective of five parameters: demography, the built environment, organizational culture, medical issues and relationships with the community.

Demography

It is necessary to know about the population that spends time in the setting – their characteristics, health beliefs, cultural values and risk factors. Without a baseline of demographic knowledge, it is difficult to address health needs effectively and efficiently.

The built environment

Many people spend more than 90% of their time indoors or between buildings. The built environment can affect health and wellbeing through such factors as access, air quality, energy consumption, appropriate use of materials and aesthetics.

Organizational culture

In order to be effective, settings-based projects must understand, work with and, when necessary, seek to change the cultural values of the institution.

Medical issues

Like any other setting, universities have specific medical issues that affect their particular populations and that are obvious foci for health promotion work. Examples include contraception, sports injuries, substance misuse and stress.

Relationships with the community

The relationship of the university to its community is an essential component of a settings-based project. Does it sit there like a visiting spaceship with no relationship to its community, or is it an inherent part of its community and a resource to it?

Universities are educating an increasing number and diversity of students; they are centres of excellence in research and they are large-scale employers. These characteristics, together with the rapid pace of

change within the higher and further education sectors, offer enormous potential for improving the public health. The pioneering work of Lancaster, Central Lancashire and other universities in developing health-promoting university projects presents a timely opportunity to reflect on their experience, develop methods and apply them to other higher education institutions.

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From the healthy city to the healthy university: project development and networking

Agis D. Tsouros

INTRODUCTION

The strategy and operation of the WHO Healthy Cities project offer a useful framework for developing health-promoting university projects. This chapter outlines the strategy and operations and provides insight and guidance for strategies for implementing such projects.

The concept of the health-promoting university is powerful. The challenge is to give it, from the very start, a broad and strategic scope, objectives that reflect the philosophy and principles of health for all and sustainability and tools that are appropriate for a settings-based approach to health promotion. The concept of the health-promoting university means much more than conducting health education and health promotion for students and staff. It means integrating health into the culture, processes and policies of the university. It means understanding and dealing with health in a different way and developing an action framework that blends such factors as empowerment, dialogue, choice and participation with goals for equity, sustainability and health-conducive living, working and learning environments.

Universities can potentially develop into model health-promoting settings. They have the intellectual capacities, the skills, the authority and the credibility for this purpose. Universities are also a valuable resource for the communities in which they are located. Investing in the health-promoting university is above all an investment in the future.

CONCEPT AND PROCESSES:
THE MAKING OF A NEW PROJECT

Health is everybody's business. One of the most important aspects of the settings-based approach to health promotion is that it creates processes that enable many new actors and systems encouraging initiative, participation and creativity to contribute. Perhaps the most difficult barrier to overcome is the tendency to perceive health only as the absence of disease, unhealthy behaviour or the application of safety standards. The new public health movement inspired by the strategy for health for all and the experience with health-promoting settings such as the healthy city and the health-promoting school and hospital have generated a climate that is much more favourable to change than was the climate a few years ago.

Defining the concept of the health-promoting university and the process by which it can be developed is not an academic exercise. It is a strategic exercise that should combine visionary thinking with pragmatism and clear principles with tangible outcome. Failing to give the health-promoting university project a holistic breadth on the basis of (narrow-minded) pragmatism would be as erroneous as presenting the project as an abstract exercise in organizational development without spelling out what benefits it will bring.

A project is used to implement the concept. Projects, in the modern sense of the term, are important tools for achieving change, dealing with uncertainty and building alliances across sectors and departments.

The strategies and experience of healthy city projects can be used as a reference framework for developing the concept of health-promoting university projects. The following aspects thus need to be defined and developed:

- aim and mission statement
- philosophy and principles
- objectives
- the qualities of the health-promoting university
- processes for change and development
- expected outcome
- monitoring and evaluation

- project infrastructure
- project leadership and management
- start-up process.

The first three aspects are just as related to scope and clarity as they are about to marketing the idea. Being able to capture the imagination of university leaders, sponsors and the mass media is essential. Being able to capture the imagination of students is also important. The idea of a healthy university may not be terribly appealing to young people who just left home (or anyone else) if it is interpreted as establishing control over and policing lifestyles. For all these reasons it is important to define the qualities of a health-promoting university: describing and visualizing the institution in terms of a set of desirable attributes.

The 11 qualities of a healthy city *(1)* have contributed significantly in explaining and developing the Healthy Cities project. Implementing strategies based on settings for health promotion and health for all requires explicit political commitment, enabling infrastructure, openness to innovation and institutional reform, broadly based ownership and effective leadership. Box 1 shows the four key aspects of the process of developing healthy city projects. They are clearly relevant and adaptable to the health-promoting university. Given the breadth and scope of such a project, endorsement of and political support for the project by the top executive and academic officers and bodies of the university is crucial.

Box 1. The process of creating a healthy city

A healthy city project strives to achieve its goals through a process that involves:

- **securing political commitment** – providing the necessary leadership, legitimacy, direction and resources for the project;

- **giving visibility to health** – promoting wide appreciation and recognition of the major health challenges in the city and the economic, physical and social factors that influence them;

- **making institutional changes** – encouraging and establishing inter-sectoral partnerships, modernizing public health structures and processes and promoting the active involvement of the community; and

- **developing innovative actions for healt**h – such as promoting equity and sustainability, addressing the health needs of elderly people and women, mobilizing action to tackle environmental pollution and accidents and developing healthy municipal policies and integrated health plans.

Making health visible is necessary to promote awareness, dialogue, participation and trust. For example, investigating stress among staff and students, absenteeism or inequity in health and publicizing reports can generate momentum and commitment to address the problems seriously.

Health for all and sustainable development can only be achieved through institutional changes at all levels. Integrating health (in its broadest sense) into the university culture and creating horizontal cooperation and decision-making processes is a long-term process. Nevertheless, integrated approaches to health policy and planning based on participation and cooperation across sectors and departments cannot be implemented without creating enabling mechanisms and the capacity for managing and implementing the project. These project-linked enabling mechanisms should provide the basis for exploring and developing permanent organizational solutions in the longer term.

Balancing the development of long-term strategic plans with short-term deliverables (through a series of carefully chosen projects) is an essential aspect of the viability and sustainable future of the project. Innovation must be evident not only in the large visionary exercises. Innovation means:

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- tackling a problem or issue in a new way (such as by involving new actors or by addressing its cause rather than focusing on treatment);

- legitimizing action for an issue about which there was little or no recognition or appreciation before (such as addressing inequality); and

- introducing new ways of working, making decisions and ensuring accountability as well as new ways of making policy and planning.

Defining the project in terms of specific outcomes and deliverables over a specified period will provide the basis for developing indicators and targets as well as a framework for monitoring and evaluation.

Settings-based projects must have adequate implementation capacity. To fulfil their objectives they require space, time, resources, leadership and management skills. They need to be strategically located within the institution and they need easy access to senior management. Developing and coordinating such projects is a complex and demanding full-time job and requires people that can provide leadership and enjoy the respect of senior management.

An aspect of project development that is often overlooked or underestimated is the need to invest in creating the preconditions for change through a carefully thought out start-up process. Having a good understanding of university power and decision-making structures, identifying and convincing the key stakeholders, including the students, negotiating resources for the project and producing briefings and supporting evidence for different groups are some of the important actions in exploring and preparing the ground for the official launch of the project. *Twenty steps for developing a healthy cities project (2)* can provide useful strategic guidance in this context.

PROMOTING COMMITMENT AND ENGAGEMENT THROUGH NETWORKING

Networks represent key mechanisms for change and innovation. Networks are organizational forms that provide for collective learning processes and can thus reduce uncertainty in the implementation of innovation. Networks provide an ideal basis for promoting commitment, creating legitimacy for change and promoting solidarity and mutual support. Networks can help their members avoid repeating mistakes or having to reinvent the wheel. The WHO Healthy Cities project in Europe has used networking as its principal tool for promoting innovation and commitment. It does this through a system of interconnected networks (Box 2) and a set of concrete terms of engagement (standards) that cities committed to comprehensively developing the concept of the Healthy Cities project should endorse.

The project has developed over two phases (1988–1992 and 1993–1997) and is now entering its third phase (1998–2002) with a renewed set of goals and standards. The WHO project cities network represents the forefront of innovation and commitment and a source of valuable experience and expertise. It is relatively small so that it can be managed appropriately. National and subnational network cities can also follow suit and develop fully fledged projects.

Judging from the enthusiasm expressed so far, the idea of the health-promoting university is likely to become very popular in Europe. It would be a good idea to set up a small manageable network of committed universities from across Europe to work together to

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Box 2. The main operational elements (networks) of the Healthy Cities project in the European Region

The WHO project cities network

The project cities network comprises 35–40 cities across Europe committed to a comprehensive approach to working towards and attaining the goals of the project, including a process of joint decision-making, exchange of experience, systematic monitoring and evaluation.

National and subnational networks of healthy cities

National and subnational networks of healthy cities link cities that are also implementing healthy city projects but are not necessarily committed to developing all aspects of the project. These networks facilitate the exchange of information and advocacy at the national level and support member cities through training initiatives, specialist consultations and information packages.

Multi-city action plans

Multi-city action plans are implemented by subnetworks of cities working together on specific issues of common concern. There are multi-city action plans for accidents, local Agenda 21, AIDS, alcohol, active living, nutrition, women, drugs and tobacco-free cities.

Cities participating in a multi-city action plan must have an overall commitment to the principles and goals of the Healthy Cities project.

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further develop and implement all aspects of the project while encouraging and supporting the development of national or regional networks in parallel. Thematic subnetworks (the equivalent of multi-city action plans) will probably emerge at a later stage.

The WHO Healthy Cities Project Office is committed to supporting the development of health-promoting university projects. One option would be to launch a new European Network of Health Promoting Universities, and the other is to launch the projects under the umbrella of a Healthy Cities multi-city action plan, as was done in the first phase of the Health Promoting Hospitals project. The former option requires substantial in-house and external resources for support and coordination that may not be available at the start. The latter option is probably more realistic for starting up this project.

REQUIREMENTS FOR PARTICIPATING IN THE NETWORK

Project cities participating in the WHO Healthy Cities network need to demonstrate commitment to a set of standards that represent the building blocks for action for the whole project (Box 3).

Box 3. Healthy Cities standards: the four elements of action

Endorsement of project principles and philosophy and political commitment to implementing its goals
The requirements include a letter by the mayor and resolution by the city council endorsing the principles of health for all and sustainable development and demonstrating commitment to implementing the goals of the project.

Endorsement of project objectives, products, deliverables and outcomes
The requirements include demonstrating commitment to developing products such as city health profiles and health development policies and plans or introducing measures that reinforce accountability or policies that address equity.

Commitment to establishing project infrastructure and management capacity
The requirements include setting up a project office, appointing a full-time coordinator, establishing an intersectoral steering committee and securing resources for the project.

Commitment to international cooperation, networking, monitoring and evaluation
The requirements include an obligation to contribute to and participate in regular business meetings and information exchange events and to support the development of national networks and twinning links with other cities, especially in the countries of central and eastern Europe and the newly independent states of the former Soviet Union. Cities are encouraged to invest in formal and informal networking at the local, metropolitan, regional, national and international levels.

Engagement in and designation of cities to a European Network of Health Promoting Universities could be based on a set of standards similar to that used for the Healthy Cities network of project cities.

Settings-based projects are dynamic processes that are shaped through a continuous process of experimentation, learning and innovation. The project should define clear conceptual and strategic frameworks but should also allow flexibility and adaptation to local cultures and circumstances. The three key words that run through all settings projects are leadership, strategic scope and ownership. Universities have a unique potential to make all this happen.

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

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The settings-based approach to health promotion

Mark Dooris, Gina Dowding,
Jane Thompson & Cathy Wynne

INTRODUCTION

The concept of the health-promoting university has emerged as part of the movement for health-promoting settings. This chapter provides an overview to the settings-based approach to health promotion and attempts to summarize:

- the historical development of the theory and practice to date; and

- the key characteristics of the settings-based approach, based on the interpretations and definitions currently in use.

The theoretical and practical development of health promotion spans progression from biomedical models of health education to a socioecological paradigm, informed by a more holistic understanding of the influences on, and prerequisites for positive health *(1–3)*. Although the emergence of the settings-based approach is sometimes portrayed as a result of linear developments in health promotion *(4)*, a review of the literature suggests that the reality is far more complex. The theoretical underpinning to the settings-based approach is both sparse and disparate, and its practical development has been characterized by a diversity of perspectives and emphases.

ORIGINS AND DEVELOPMENT OF THEORY AND PRACTICE

Health promotion has been concerned with settings for many years – most commonly in terms of carrying out health promotion within a setting, for example, in schools and workplaces. However, the concept of an actual settings-based approach has begun to take shape only in the last 10 years. It is widely accepted that its roots lie within the WHO strategy for health for all *(5,6)*, which during the 1980s increasingly came to be seen as a coherent and balanced framework for the new public health.[1]

The publication of the Ottawa Charter for Health Promotion in 1986 *(8)* was a critical point in the development of settings in that it reflected a growing consensus that health is not primarily the outcome of medical intervention but is a socioecological product arising from a complex interplay of social, political, economic, environmental, genetic and behavioural factors. The natural corollary of this understanding was a shift of focus away from problems – as characterized by specific types of unhealthy behaviour (for example, unsafe sex or smoking), by specific at-risk groups (for example, gay men or pregnant women) – and towards environments and settings.

The Ottawa Charter drew on the principles and concepts of health for all and on the work of a number of theorists concerned not so much with avoiding ill health as with creating positive health – what Antonovsky *(9,10)* has called salutogenic research. The Ottawa Charter stated that *(8)*:

> Health is created and lived by people within the settings of
> their everyday life; where they learn, work, play and love.

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[1] "The new public health" is defined in a health promotion glossary commissioned by the WHO Regional Office for Europe *(7)*: "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). "Public health" has sometimes been used to include publicly provided personal health services such as maternal and child care. "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.

> Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

This focus on the creation of environments supportive to health was strengthened by the publication of a number of publications and documents by the WHO Regional Office for Europe during the late 1980s and early 1990s *(11–13)* and further reinforced by the 1992 United Nations Conference on Environment and Development and the resulting Rio Declaration and Agenda 21, which highlighted the convergence of the sustainable development and health agendas *(14,15)*.

The emergence of the settings-based approach, then, has been influenced by a range of developments within health promotion, public health and environmental and social policy. It has increasingly been guided by a recognition that health gain[2] can be most effectively and efficiently achieved by investing outside the health care sector. Interventions in a range of social systems in ways that take account of the processes of personal, organizational and political development are essential for improving the health of populations *(17)*.

The first and best known example of settings-based health promotion is Healthy Cities *(18)*. Beginning as a small WHO project in 1987 with the aim of taking the rhetoric of health for all and the Ottawa Charter "off the shelves and into the streets of European cities" *(19)*, Healthy Cities rapidly expanded to become a major global movement *(18)*. The late 1980s and early 1990s saw parallel initiatives take root in a number of smaller settings. These initiatives included the Health Promoting Hospitals project, coordinated by the European Office of WHO *(20)*, and the Health Promoting Schools project (Ziglio, E. *How can the health promoting school contribute to the current role of education in society today?* Unpublished conference presentation) – a collaborative initiative of the European Union, WHO and the Council of Europe.

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[2] Health gain has been defined as: "a measurable improvement in health status, in an individual or population, attributable to earlier intervention" *(16)*.

Within the United Kingdom, the settings-based approach was given further legitimacy when the Government of the United Kingdom published *The health of the nation – a strategy for health in England* in 1992 *(21)*. This document stated that:

> Opportunities to work towards the achievements of the targets, and indeed of other health gains, will be ... enhanced if action – above all joint action – is pursued in various discrete "settings" in the places people live and work. Such settings include "healthy cities", healthy schools, healthy hospitals, healthy workplaces, healthy homes [and] healthy environments. They offer between them the potential to involve most people in the country.

Although this list did not explicitly mention universities, it was only a matter of time before initiatives were set up to explore what it might mean to apply the settings-based approach to health promotion within a higher education context.

Attempts to develop settings-related ideas into a defined and conceptually coherent approach have accompanied and grown out of, rather than preceded or necessarily informed, early practice, creating a praxis-based theory. For instance, the growing interest in organizational development and management of change within Healthy Cities has emerged out of the experience of cities seeking to introduce new ways of working in sectoral and compartmentalized structures. In the past few years, writers such as Baric *(4,22,23)*, Kickbusch *(17)* and Grossman & Scala *(24)* have drawn extensively on the work of management, organization and systems theorists, and this sparse but growing body of literature on settings-based health promotion has proved to be an important influence in guiding recent practice.

CHARACTERISTICS OF THE SETTINGS-BASED APPROACH

The ideas of the above writers and other theorists and practitioners (Dooris, M., personal communication, 1996) *(25,26)* provide the basis to outline the main characteristics of the settings-based approach to

health promotion in terms of principles and perspectives, processes and techniques and key elements of health-promoting settings.

PRINCIPLES AND PERSPECTIVES

The settings-based approach is underpinned by a number of principles and perspectives, drawn largely from health for all, the Ottawa Charter for Health Promotion and Agenda 21.

A holistic and socioecological understanding of health

A holistic, positive (salutogenic) and socioecological model of health promotion takes account of the dynamic interaction between personal and wider environmental factors in determining health and recognizes that the settings in which people live, work and play have a key determining role in their health.

Focus on populations, policy and environments

A primary focus on populations rather than individuals leads naturally to a focus on building healthy organizational policy to facilitate the creation of supportive environments.

Equity and social justice

A commitment to equal opportunities ensures that organizations work for justice and protect human rights and that settings-based investments and developments promote equity in health.

Sustainability

Human health depends on sustaining global resources, and thus it must be ensured that institutions practise environmentally and socially sustainable development, taking account of the wider impact of their policies and practices on people and environments locally, nationally and globally.

Community participation

Community participation enables people from all parts and all levels of a community or an organization to get involved, to articulate their concerns and needs, to be listened to, to assess their capacities and to participate actively in every stage of the process.

Enablement and empowerment

Individuals, groups and communities need to be enabled to take increased control over their lives and to take action for change.

Cooperation

Building effective interdisciplinary, interdepartmental and interagency cooperation harnesses the imagination, innovation and mutual support that can come from working across professional and organizational boundaries.

Consensus and mediation

Organizations and society as a whole are characterized by divergent interests, and it is thus important to mediate for a new means of decision-making that gives priority to conflict resolution and consensus-building, rather than token consultation and power-wielding, in the process of change.

Advocacy

The capacity and responsibility of organizations for advocating and speaking out on public health issues should be acknowledged and developed.

Settings as social systems

A setting is a social system in which people live, work, learn, love and play – characterized by a particular organizational culture, structure, functions, norms and values – into which health must enter through appropriate entry points *(25)*.

Sustainable integrative actions

Mechanisms should be incorporated that ensure sustained development and impact beyond the life of a discrete project, through integrative rather than additive actions *(27)*.

Settings as part of an interdependent ecosystem

All settings are interconnected, and each setting is a distinct but not separate part of a wider, interdependent ecosystem.

PROCESSES AND TECHNIQUES

Resulting from the above principles and perspectives, the settings-based approach is characterized by the use of particular processes and techniques drawn from organizational, management and systems theory. Grossman & Scala *(24)* use systems theory in recommending organizational development for health promotion. They argue that the so-called health services provide a ready-made system for addressing illness in many societies, but no particular system exists to address health (Fig. 1). The consequence of this is that health must enter each system – finding a place within institutions and organizations created and structured for other (problem-solving) purposes. Organizational development is the overall means of achieving this. The organizational development process seeks to identify how health can make the system perform better and how a commitment to and investment in health can
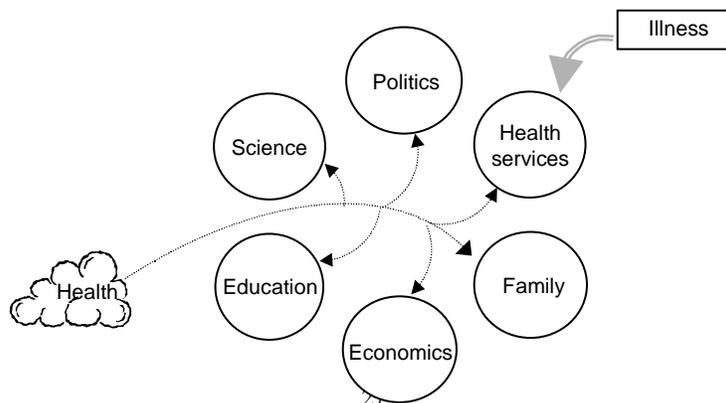
be embedded within the structures, mechanisms, culture and routine life of the learning organization *(28)*.

Fig. 1. There is no particular system for health. Health must enter each system.

Grossman & Scala *(24)* also argue that organizational development can be most effectively put into operation through project management. Establishing and managing a defined project with its own organizational structure, within or between existing organizations, makes it possible to facilitate innovation, cooperation, mobilization, development and change. Key processes in the management of a settings-based health promotion project include:

- sensitive and planned management of change within organizational cultures, structures and processes;

- policy development and the introduction of health as a key criterion in organizational decision-making;

- *Source*: reprinted with permission from Grossman & Scala *(24)*.   new knowledge and skills, in what Baric *(29)* has called retrofitting; and

- the development and integration of health into quality, audit and evaluation procedures – which ensure clear accountability and enable the development of a foundation for settings-based work, built on evidence related to health gain *(22)*.

KEY ELEMENTS

Baric *(23)* has argued that the settings-based approach is characterized by three key elements: a healthy working and living environment, integrating health promotion into the daily activities of the setting and reaching out into the community.

A healthy working and living environment

A health-promoting setting seeks to create and maintain the health and wellbeing of staff, clients (consumers) and other participants, through taking action within the organization to create supportive working, social and living environments. Good practice in this area would seek to apply the above principles, perspectives and processes.

Integrating health promotion into the daily activities of the setting

A health-promoting setting seeks to integrate an understanding of and commitment to health within its routine activities and procedures. A health-promoting manufacturer thus focuses on its products and production systems. Do the products themselves promote or damage health? Are the materials used healthy and sustainable?

A health-promoting university focuses on its education and research. Where does health feature in the curriculum? Do the educational methods reflect principles such as participation and empowerment? Does the research profile reflect a commitment to health promotion?

Reaching out into the community

A health-promoting setting seeks to develop its role as a key influence for health within the wider community in a number of ways, which include building partnerships and alliances, providing resources for the local community, reviewing its impact on the local, national and global communities – through its purchasing, financial management and other practices *(30)* – and practising advocacy and mediation roles.

CONCLUSION

The settings-based approach to health promotion is characterized by the dynamics of ongoing praxis-based development. Nevertheless, key distinguishing characteristics can be summarized in terms of principles and perspectives, processes and key elements. Like any new development, it can only benefit from critical analysis and reflection – and a

survey of the literature suggests that such a critique is beginning to emerge *(31–34)*.

Settings, when put into operation in accordance with the underpinning principles and perspectives outlined above, have the potential to make a powerful contribution to health promotion practice and ultimately to population health. In the lead-up to the twenty-first century, universities – with their particular culture, their position in society and their unique mix of skills – offer an ideal testing ground to apply, evaluate and further develop health promotion.

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Universities and health in the twenty-first century

*Nicholas Abercrombie, Tony Gatrell
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What characteristics make a university distinctive? Drawing on a number of publications, including a recent series of lectures on universities in the twenty-first century *(1)*, we can highlight a number of key roles that should be visible within a university.

- A university is a centre of learning and development, with roles in education, training and research.

- A university is also a centre of creativity and innovation – expressed in the processes of learning and in combining, managing and applying knowledge and understanding within and between disciplines.

- More broadly, a university provides a setting in which students develop independence and learn life skills – through living or spending time away from home and frequently through experimenting and exploring.

- As the structure of higher education has changed, universities have increasingly provided a setting in which mature students undertake learning.

- A university is a resource for and a partner in local, national and global communities.

- Lastly, a university is a business – increasingly concerned with its image, performance and balance sheets within a competitive market.

All these roles provide opportunities for a university to affect the health and wellbeing of its members and outside communities and to

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

OPPORTUNITIES

Universities are large organizations in which people learn and work, socialize and make use of a wide range of services such as accommodation, catering and transport. They are major employers, with staff making up one of their major communities. Consequently, universities have the potential to significantly and positively affect the lives and health of their members. This can be done through broad organization-wide practices such as adopting appropriate management styles and communication and decision-making procedures and through policies that affect day-to-day procedures such as scheduling the student programmes and providing leisure facilities. Among other virtues, universities are supposed to promote reflexivity, the capacity to look at their own practices and activities with a critical eye and with a view to changing them.

Arguably, the key roles of universities are teaching and research. Through their teaching activities, academics can be encouraged to ensure that health-related research finds its way to student audiences and hence to the wider community when these students leave the university. Health-related research and health issues may be a core component in some curricula, but where this is not the case, health research and health topics could be used to illustrate themes and issues, thus raising health consciousness. For example, students studying law, literature, government or politics or other subjects not apparently related to health could be introduced to health matters in ways relevant to their foci of study. This integration of health into the curriculum may encourage graduates in these and other fields to enter the professions, business or other sectors of employment with greater awareness of the potential health effects of their individual and collective activities.

Almost all universities have some kind of health-related research underway, and in some it is a major focus of research activity. Sometimes this research can be usefully categorized in terms of health services research and so on. Other ways of classifying such research may be in relation to the discipline or combination of disciplines working together, which inform the research questions and methods. In addition to research that is explicitly related to health, much other research undertaken in the arts, humanities, social sciences, natural sciences and other areas influences the health of the population.

Not all research has the potential to shape health experience in one way or another, but it is important for the Health Promoting Universities movement to champion the view that not all relevant health research carries health or medical labels. This means challenging the reproduction within the university sector of wider cultural tendencies to think narrowly about health and its determinants: equating health with illness, disease, biological processes and health care systems. Many people within universities consider that, if it is not medical and it is not about the health services, then it cannot be health research. In fact one way of increasing universities' contribution to health gain could be to encourage researchers to think about the health implications of their research and to incorporate this into the presentation and dissemination of their results.

A university provides an environment in which students are not only formally educated but develop personally and socially at a significant time in their lives. This development has profound effects not only during their time in higher education but throughout the rest of their lives – in the choices they take, in their values and priorities and in their jobs, homes and communities. A health-promoting university should support healthy personal and social development – enabling students to discover and explore their potential, facilitating them in making healthy choices and encouraging them to explore and experiment safely.

Finally, the literature on both the role of universities and health-promoting settings emphasizes the potential contribution of the university within the wider community *(2,3)*. It can contribute to enriching and developing local social, economic, cultural and recreational activities. Through partnership and collaboration with the business, public and voluntary sectors, a university becomes an integral part of

the community. It has the opportunity to set an example of good practice in relation to health and, using its influence and expertise, can become an advocate for developing healthy public policy and practice at local and national levels.

CONSTRAINTS

Structural and financial constraints operate at different levels within the university system in the United Kingdom and are largely shaped by national policy. Perhaps the most obvious constraint in the United Kingdom over the last few years has been the sequence of funding cuts, equivalent to 3% less funds to all universities. These, combined with a large programme cut in November 1995, have left many universities in very dire circumstances.

There is pressure to increase the number of students and take them through a system originally designed for far fewer. Class sizes have increased and students are taught more intensively. For staff, this means an increased and more intensive workload. The number of part-time and full-time students in higher education increased by 64% between 1984 and 1994 in the United Kingdom and the number of academic teaching staff by only 11% *(4)*. Financial restrictions may lead to the call for voluntary redundancy and the restructuring of the administrative and academic components of the institution. This creates practical difficulties but also fosters a culture of insecurity that is new among British academics who, until a few years ago, had worked within the system of tenure. These pressures go hand in hand with the need to attract research grants and contracts, sometimes to compensate for structural under-funding of the system, as well as to maximize research output for the prestige it gives the institution and its departments as a research-led university. At the same time, universities are subject to greater external scrutiny, which imposes further strain on staff who have to work under new systems for evaluating research and teaching.

The effects of this under-funded expansion are that many staff, of all categories, are reporting longer working hours, increased stress and reduced job satisfaction as the repercussions spread through an organization *(4,5)*. Everybody is trying to do more with less.

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Students too, are affected as structural constraints manifest themselves. Some, though not all, are finding crowded classrooms, libraries and laboratories. Students receive less support from stressed student welfare services and staff with less time to devote to problems, enquiries and the creative exchange of ideas. Reductions in financial support have resulted in an increasing proportion of students finding employment not only in the vacations but also during weekends and evenings too. These pressures during study are coupled with the added realization that the job market is volatile, with no guarantee of secure employment in the years to come. Students from untraditional backgrounds (such as mature students) may be especially vulnerable to such pressures.

These constraints affect different institutions in different ways, and universities and those working within them respond differently to pressure imposed from above. The culture of the workplace operates differentially on the staff employed in the institution: members of the academic staff have more flexibility – what Karasek *(6)* has called job decision latitude – in structuring their working day than do members of the administrative and support staff, whose work programme is likely to be more closely scrutinized *(7)*.

HEALTHY FUTURES FOR UNIVERSITIES

A health-promoting organization is based on certain core values, including democracy, mutual empowerment, individual autonomy and community participation *(8)*. Ways are needed of enabling those who work within universities to take responsibility for shaping their well-being within the context of an environment that supports health. Universities need to recognize that they are part of a wider community and to extend their responsibilities beyond the campus limits.

Translating ideals into practice requires exploiting opportunities and a sanguine acknowledgement of the constraints within which the university operates. It also calls for setting performance indicators to monitor the effectiveness of health promotion strategies. Tofield *(9)* suggests the following key indicators:

- employee satisfaction
- stewardship of the environment

- absence of discrimination
- beneficial long-term relationships with other organizations.

Employee satisfaction means that members of the university should find their work fulfilling and creative. This requires mechanisms for consultation, one vehicle of which should be staff and student appraisal. Environmental stewardship demands links to environmental sustain-ability agendas, and Ali Khan & Toyne consider such links elsewhere in this document. Discrimination can and should be banished from higher education through formal and informal mechanisms. Great progress has been made in some areas, notably in disability. Some institutions, including Lancaster, have taken considerable strides in widening access.

Relationships with others demand environmental and health audits, a dialogue with others in the local community and building stronger links with experts in health promotion. Universities forming part of a city participating in a healthy city project or with good contacts to other healthy settings (such as health-promoting hospitals) could seek to benefit from the knowledge already gained by others. Of all healthy settings, universities should be among the leaders in seeing change implemented.

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A common agenda?
Health and the greening
of higher education

Peter Toyne & Shirley Ali Khan

People are a part of the environment and not apart from it. As such, the health of individuals and the health of the physical and social environment are mutually dependent. Many familiar environmental challenges are described as problems simply because they constitute potential human health hazards, whereas some healthy behaviour is now being adopted for essentially environmental reasons, such as choice of food and mode of travel. The health agenda broadly overlaps with the environmental agenda and, as such, there is much common ground between the Health Promoting Universities project and the movement to green universities. Those involved in these two separate movements have the option of joining forces to push forward a common agenda, and in the process to attempt to move from the peripheral to the mainstream business of universities. But what can be said about from where we have come? What do we have in common? Where might we be going?

BACKGROUND TO THE GREENING OF HIGHER EDUCATION IN THE UNITED KINGDOM

The idea of the health-promoting university is relatively new, whereas the idea of a higher education institution as a setting for the promotion of environmental responsibility goes back eight years. Similar to the Health Promoting Universities movement, developments in the greening of higher education began with action by small numbers of people coming together with similar concerns and interests and deciding to get these issues onto the agendas of universities.

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The issue was first formally raised in the United Kingdom in 1990, in *Greening polytechnics (1)*, the same year as the Government of the United Kingdom published its environmental strategy *(2)*. As a result of this, an expert committee chaired by Professor Peter Toyne, Vice-Chancellor of Liverpool John Moores University, was convened to consider:

- the environmental education needs of the business community;

- the environmental education needs of the student body at large; and

- responsibilities relating to good housekeeping in further and higher education institutions.

This reflected recognition that any attempts to foster a sense of environmental responsibility through the curriculum would be negated if housekeeping practices within the institutions were environmentally unsound. The committee published its deliberations in 1993 *(3)*. Explicit recommendations were targeted at government, further and higher education institutions, funding councils and professional bodies, yet the report was non-prescriptive. The report's key recommendation stated:

> After consultation with its staff and students, every higher and further education institution should formally adopt and publicize, by the beginning of the academic year 1994/5, a comprehensive environmental policy statement, together with an action plan for its implementation.

Because of the "softly, softly" approach adopted in the report, a recommendation was made to review progress after three years. The review findings were subsequently published and launched by Government Ministers for Education and the Environment in 1996 *(4)*.

HOW GREEN ARE THE UNIVERSITIES IN THE UNITED KINGDOM?

The conclusions of the 1996 review make somewhat depressing reading. Most of the institutions and organizations targeted in the initial recommendations, including government, had demonstrated complete indifference to the recommendations of the 1993 report. Although this might be a disappointing response to the recommendations of a government report, it is not the same as saying that there has been no progress (Box 4).

Box 4. A summary of the review of the *Environmental responsibility* report

The bad news

- Only 15% of further and higher education institutions had policies in place.

- Where policies existed, implementation was generally at an early stage.

- Most progress was being made in good housekeeping, especially in areas in which cost savings are obvious, such as energy efficiency, or where the "green" ticket can help institutions in introducing otherwise unpopular measures, such as car parking charges; less progress was made in such areas as purchasing.

- In curriculum development, less than 3% of further and higher education institutions had set out in general terms what all their students need to learn to be able to take account of sustainable development in their work and daily lives.

- Of the above 3%, fewer than 10 institutions were making any progress.

The good news

- In 1993 only about 12 further and higher education institutions had environmental policies; in 1996 there were 114.

- A number of trail-blazing institutions are making significant progress.

RECOMMENDATIONS FOR A GREEN FUTURE IN HIGHER EDUCATION

The 1996 review sets out six key recommendations.

- "Enabling responsible global citizenship" should be recognized as the core business of learning institutions and a legitimate purpose of lifetime learning.

- Within three years, all further and higher education institutions should have developed the capacity to provide all students with the opportunity to develop defined levels of competence relating to responsible global citizenship.

- Within three years, all further and higher education institutions should be accredited to a nationally or internationally recognized standard for environmental management systems.

- Funds should be made available for a national programme to support the response of the further and higher education sector to the challenge of sustainable development.

- National standards relating to industrial and professional practice should be set to ensure that reference is made to sustainable development issues.

- Within three years, funding councils should link environmental performance to the allocation of funds.

The first recommendation of enabling responsible global citizenship takes account of an evolution in language: from the use of the term "environmental education" to "education or learning for sustainability". The learning agenda for sustainable development goes far beyond knowledge of the physical environment, and the desired outcome of learning for sustainability is often expressed as "responsible global citizenship" (Box 5).

Box 5. What is enabling responsible global citizenship?

Responsible implies education that enables learners to make their own critical choices and decisions. It also contains an expectation of responsible action. There is nothing new about action agendas in further and higher education – for example, students learn information technology skills so that they can use information technology. Where there are action agendas,

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competence tends to be gained through experience. So students learn information technology skills by practising information technology and they learn to drive by driving and to speak French by speaking it. The conclusion one draws is that, to become a responsible citizen, a student must practise being responsible.

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

Citizenship calls for the development of a range of twenty-first-century skills.

The concept of responsible global citizenship brings together the interests of many lobbying groups currently on the margins of the education system (such as those promoting environmental education, development education, education for sustainability, citizenship education, health education and industrial understanding) and those at the sharp end of the learning debate (such as those working on lifetime learning, community and work-based learning, service learning, core skills and the learning purposes of the further and higher education sector).

There is already considerable consensus about the core themes of the learning agenda for responsible global citizenship, which is based on a combination of core knowledge and core skills (Box 6).

The call for enabling responsible global citizenship as a key purpose of lifetime learning is of fundamental importance. According to the current policy of the Government of the United Kingdom, enabling responsible citizenship for sustainability is now the common task of the education community. The review starkly illustrates that most further and higher education institutions have opted out of this common task. The big question is whether they should be able to. What is the purpose of learning institutions? One might argue that little progress will be made towards realizing the vision of a learning society until learning institutions become proactively involved in ena bling responsible global citizenship.

PROGRESS

Several key agencies have made a greater commitment to achieving some of the other review's recommendations.

- The Higher Education Funding Council has developed an environmental review workbook to enable higher education institutions to conduct their own environmental reviews.

- The Department of the Environment has awarded funding to the Forum for the Future[3] to facilitate the response of the further and higher education sector to the challenge of sustainable development. Twenty-five universities have made a commitment to work with the Forum for the Future in delivering the project output.

Box 6. Core themes of the learning agenda for responsible global citizenship

Sustainable development
The cornerstone of the learning agenda for responsible global citizenship is understanding the concept of sustainable development. This multidimensional concept describes a type of development that provides real improvements in the quality of life and at the same time maintains or enhances the vitality and diversity of the earth.

Holistic view
A holistic view is a matter of perspective, as opposed to a comprehensive view, which relates to fullness of detail. It is facilitated by systems thinking and analysis. Sustainable development problems are embedded in interconnected ecological, physical, cultural, economic and political systems. This obliges analysis and thought focused on the interrelationship of systems.

Interdisciplinary perspective
Many sustainable development problems are investigated through scientific methods, yet are explained, managed or find expression in social structures and responses. Any learning agenda for responsible global citizenship must include natural and social scientific perspectives.

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[3] The Forum for the Future is a partnership of independent experts committed to building a sustainable way of life. Through research, education, consultancy and communications, it aims to inform and inspire people to accelerate the process of positive change.

Responsible citizenship

A prerequisite for responsible citizenship is an experience of community that can be fostered by service in the community and through developing a deep understanding of locality – its nature, history, distinctiveness, systems for getting things done, problems and plans for the future. Skills that enable responsible global citizenship include self-awareness, self-motivation, self-promotion, creative thinking, action planning, networking, decision-making, negotiation and political awareness.

Managing change

The concept of managing change embodies a number of interrelated themes: a thoughtful consideration of global and local futures; long-term solutions; comfort with uncertainty, associated with an understanding that knowledge will always be incomplete; the application of the precautionary principle; a commitment to life-long learning; learning from one's own experiences and those of others – good or bad; and the development of flexibility of mind.

The main thrust of this work is focused on pursuing the following outcomes:

– a published set of case studies of best practice for sustainability, covering good housekeeping activities, curriculum greening initiatives and community responsibility initiatives;

– a set of performance and responsibility criteria in terms of sustainable development for further and higher education in the above areas; and

– environmental management guidelines in a number of targeted areas, including the curriculum.

• The National Union of Students has for the first time given priority to the environment as one of its three key campaigns.

• The government has established a high-level panel on sustainable development education.

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LESSONS FOR HEALTH

The whole challenge of greening universities is now much more firmly on the political agenda within the United Kingdom than it was eight years ago. A number of specific lessons can be drawn from the experience of progress over the past few years.

The Health Promoting Universities initiative definitely needs to address curriculum issues. Although "condom dips" and other health promotion campaigns may be attractive to students, health awareness and "healthiness" must be incorporated into the curriculum if the initiative is to have a significant impact. This means facing similar questions to those that have been posed within the greening of the curriculum, such as: How can environmental responsibility be integrated into the English curriculum? How can health issues be incorporated into the theology curriculum? There are solutions, and with creativity and commitment it is possible, even if in some circumstances bolt-on modules in health will be required.

Second, the way ahead requires addressing issues of ethics, morality and values. What is the ethical, moral and value underpinning of the environmental and health promotion agendas? In making this explicit, a clear framework can be developed, which will be at the heart of the curriculum.

Third, what is the most successful approach? The greening of higher education has now published two reports, both based on non-prescriptive recommendations. Experience shows that there is a balance to be achieved between a top-down approach and a nonprescriptive bottom-up approach. On the one hand, it is essential to lead from the top – for vice-chancellors to commit themselves to the issues and to action. But there are two reasons for caution: the first is the scepticism of those in the organization who will be suspicious of vice-chancellor involvement, and the other is that excess zeal will turn people away. Extreme patience is required and a "drip, drip" process that infiltrates the organization. The key is common ownership.

Finally, there are now opportunities for synergy with the Health Promoting Universities initiative. There is a danger that greening and Health Promoting Universities project are running in parallel. Some universities have strategies for health promotion and environment that

do not refer to one another. An opportunity now exists to combine the two agendas: healthy eating can be promoted with reference to sustainable food production, and the exercise benefits of cycling can be promoted with reference to the damaging impact of cars.

Some researchers think that community is a more important determinant of individual and collective health than the combined risks of any or all of the secular sins of public health, including smoking *(5)*. Responsible global citizenship is not only essential to the creation of community, which in turn is a prerequisite for sustainable development, but it is also essential for people's immune systems. In short, failing to practice civil behaviour may be dangerous to human health. An opportunity now exists to exert considerable collective pressure for core subject status for responsible global citizenship in the name of good education, both in the national curriculum, and in education programmes in further and higher education institutions.

Those promoting health and those promoting sustainable development in universities must move beyond exchanging the kind of coy glances usually reserved for familiar-looking strangers. The two must develop a much stronger liaison and work with the common agenda.

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Action learning for health on campus: muddling through with a model?
University College of St Martin, Lancaster

Alan Beattie

BACKGROUND: ROOTS AND INSPIRATION

The sources of the project at the University College of St Martin lie in part in the challenge of teaching health promotion in universities. Universities in the United Kingdom have three distinct strategies for developing professional preparation for health education and health promotion *(1)*: 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 *(2–4)*.

The work on St Martin's as a Health Promoting College was undertaken as a sort of practicum on the campus itself to link academic studies of health education and health promotion to practical action at the local level *(5,6)*. Another relevant model was what a 1977 report from the Organisation for Economic Co-operation and Development *(7)* had called "a regional health university" – committed to developing teaching and research across a range of health professions on public health issues relevant to the local population. Finally, a third and crucial influence was a 1993 book called *The health promoting college (8)* that reported on a major study of a settings-based approach to

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health education and health promotion in the further education system in England.

CONCEPTUAL FRAMEWORK

The health promoting college came to hand in summer 1993 just in time to inform the work on the St Martin's as a Health Promoting College Project, and the case study evidence it provides from around the country is highly revealing. In addition, it draws on the Beattie fourfold health promotion grid *(9)* for structural analysis and strategic planning in health promotion. 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). The St Martin's as a Health Promoting College Project adopted and further adapted their health-promoting college grid as a key tool of thought and a basic guideline for the implementation its work (Table 1).

This framework is used to explore and implement (with students and colleagues) an approach to health education and health promotion practice that, borrowing from the literature of social planning *(11)*, can be labelled purposeful opportunism. Recent discussions of the settings-based approach to health education and health promotion tend to dismiss older forms of practice, which are characterized as (mere) "health-promotion-in-a-setting", implying that practice that is not informed by the grander vision of organizational development *(12,13)* is no more than ad hoc tinkering, one-off bits and pieces – what social planners (with some irony) call "disjointed incrementalism or the science of just muddling through" *(14)*. On the other hand, the organizational development model of health education and health promotion applied to the institutional or corporate setting (such as a university) is a clear example of the "rational-comprehensive systems" approach to social intervention – an approach that itself encounters many problems because it tends towards abstraction, an autocracy of expertise and the

short-circuiting of debate and discussion towards making social choices on technical grounds *(15)*.

Purposeful opportunism emerged as a third way in social planning precisely to move on from these polarized positions. Purposeful opportunism suggests that, rather than constructing one grand system, scheme or plan that when (eventually) mobilized will bring about

Table 1. Beattie's fourfold grid applied to the health-promoting university

	Courses	Services	Facilities	Policies
Health information and advice-giving to reflect individual behaviour	Talks, films and seminars on health risks, such as stress, smoking and HIV/AIDS	Exhibitions and events and information packs on current health topics	Space and resources for health education and preventive action	Whole-campus policies on individual risks such as smoking, stress and personal safety
Personal counselling for health to support life review and self-empowered change	Discussions and role play on peer pressures and social skills in health such as sex and HIV, drugs, etc.	Opportunities and support for self-review and self-help	Facilities for self-help and group activity	Policies to support staff who need to adapt to new rules and codes such as those related to smoking
Administrative action for health to reform regulatory systems	Assignments and projects that explore and assess the health profile of the university	Channels for information exchange about issues related to being a healthy university	Design, labelling, sign-posting and way-finding to support the healthy campus idea	Fully worked out university policies and rules on health agreed with students and staff
Community development for health to identify common ground and facilitate joint action	Programmes of adult and community health education and of local outreach	Meetings, forums, fairs and street events to open up debate and decision-making on a health agenda across the university	Provision for dual and multiple use of space and resources: a healthy university is an open university?	Explicit and open structures for policy-making on health as an aspect of the corporate ethos and quality of life

Sources: adapted from Beattie 1990 *(6)*, 1991 *(9)*, 1996 *(10)* and O'Donnell & Gray *(8)*.

fundamental change, it is helpful to work on many fronts simultaneously, at many different levels, to intervene from many different angles. No opportunity should be turned down, however small and modest. Initiatives should be undertaken by whoever can be persuaded, on whatever topics come up – so long as wider and longer purposes are kept fully in mind and a very clear picture is maintained of the full repertoire of strategic change that is in principle possible and desirable (perhaps along the lines set out in Table 1).

As an approach to settings-based health promotion, this can be called muddling through with a model. In the case of the St Martin's as a Health Promoting College Project, it means that attempts are made to seek out and nurture whatever examples of local enthusiasm, enterprise and creativity can be found (as regards action for a health-promoting campus), while at the same time ensuring that all such specific initiatives are reviewed within a systematic audit of strategic choices for the health-promoting university, for which Table 1 provides one tool, although other health education and health promotion planning schemes and models are also used *(10)*.

ORGANIZATIONAL STRUCTURE

During the academic year 1993–1994, the first of what became a series of forums on St Martin's as a Health Promoting College was held, attended by members of College senior and middle management (both administrative and academic) and Student Union officers. A range of examples of settings-based approaches to health promotion were reviewed – health-promoting school, health-promoting hospital and health-promoting workplace – as well as the national health-promoting college project. Using various versions of Table 1, the current activities of the University College of St Martin to promote health were audited, and this was used to spot gaps and to discuss what other action for health could be carried out on campus. Successive cohorts of undergraduate health education and health promotion students have also reviewed the work undertaken on the St Martin's as a Health

Promoting College Project. Diverse and challenging sets of ideas for action have emerged from these forums.

IMPLEMENTATION PROCESS

Since autumn 1993 the main vehicle for exploring and implementing action for health on campus has been project work undertaken by students. As a major part of their second-year studies within a full-time Bachelor of Arts in Health Promotion (in a double module on health promotion theory and practice), four successive cohorts of students have undertaken action planning and practical interventions around the College. Accounts have already been published of the design of the study programme *(16)* and of progress up to the end of the second year *(17)*.

The work undertaken always combines different approaches to action – both individual and institutional change and both expert-originated and client-centred intervention; but the scope and emphasis of the work undertaken has evolved over the years. In fact, each cohort is asked to write letters to next-year's students, offering them advice on what issues to address and how. This has proved to be an invaluable means for learning from each successive cycle of action.

The first cohort of students addressed mostly orthodox lifestyle risk factors but undertook a great deal of lobbying behind the scenes for policy change, and they put a lot of effort into displays and events for an Open Day (on St Martin's as a Health Promoting College).

The second cohort moved on to a new emphasis on wider contexts of student life (such as stress, poverty and accommodation). They began to apply full-scale social marketing strategies to these aspects of student health, with a much greater concern for the diversity of interest groups on the campus.

The third cohort introduced a new focus on lively visual and written communications, prompted and supported by major inputs by designers from a local agency called Celebratory Arts for Primary Health Care *(18)*. They prompted ethical debates such as on providing abortion advice services on campus and also succeeded in getting out-

side agencies actively involved, such as the Lancaster City Environmental Health Department.

The most recent cohort was greatly impressed by the high profile for health issues their immediate predecessors had achieved by creative writing for student publications on campus. This fourth cohort has invested a great deal of energy in journalistic and desk-top publishing skills; they have also decisively opened up an agenda of off-campus and town-and-gown health issues; and they have been particularly imaginative in devising health education and health promotion policy documents for discussion and use by key agencies on and off campus.

CRITICAL REFLECTIONS

Some problems have recurred every year, and they seem likely to crop up in most initiatives attempting to implement health promotion strategies on a campus-wide basis.

For example, action learning and peer teaching have great benefits for the students undertaking project work, and 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.

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 (even using the purposeful opportunism mode) is almost always a highly contested matter, sometimes ethically controversial and sometimes politically explosive or divisive.

The agencies on campus that are often the most sympathetic, responsive and cooperative (such as the medical centre, counselling, student welfare, catering and the health and safety committee) run the risk of being pushed into early burn-out by successive battalions of rampant stu-

dents who charge in each year with enthusiastic and well meaning criticisms and brilliant new ideas for improvement (yet again ...), especially when the permanent staff have been struggling anyway with the agenda of almost constant larger-scale reorganization in higher education in these past few years.

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 remain to be seen.

Inevitably, our students bump up repeatedly against the debate around theoretical models for health promotion planning and practice *(19)*. They study these intensively, and they are encouraged to figure out their own position on what model or models they favour. But using a portfolio to guide students' build-up of expertise in health education and health promotion practice is still often a hectic, pell-mell business, emphasizing that the professional artistry exercised in health education and health promotion in the wider world is imperfectly understood and therefore imperfectly assessed *(20–22)*.

THE FUTURE: CONSTRAINTS AND OPPORTUNITIES

The way the health-promoting campus project is developed ensures that neither an individual academic nor anyone else on the senior staff of the University College of St Martin can decide what will happen in advance. Each successive cycle of action will be shaped by the dialogue between students from one cohort to another and within each cohort. Even so, several wider issues are likely to be at the forefront of action and research in health promotion in this setting for the next few years. What follows is only a bare summary.

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. I believe that much can be learned from the new ways health-promoting schools are approaching emotional health *(23)*.

In parallel with this, I suspect that everyone involved in settings-based health promotion will need to become much more aware of the emotional dimension of organizational life, at all levels. It is being (re-)discovered both in management sciences *(24)* and in the sociology of health *(25)*, and I hope that the radically new insights and strategies this perspective suggests can be used *(26)*.

At the same time, approaches to the management of universities are becoming more attuned to the cultural dynamics associated with major organizational transitions *(27)* and reflect new understandings of the importance of attending to and reworking the metaphors and stories that are in circulation in an organization *(28)*. Learning to change together in a university setting requires engaging in work of this kind. It will involve new initiatives of which we have seen very few examples so far, such as psychodrama or the forum theatre of Freire and Boal *(29)*.

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 organization development for health *(31)* and community development for health *(32)*, 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 *(33,34)*.

Fortunately – and perhaps just in time from the point of view of the health promotion specialist – the health education and health promotion field itself has also evolved to the point where rethinking the health agenda and revising our means of practical action can cope with these new challenges of learning to change in the university setting. It is to be hoped and anticipated that, in the near future, action for health on campus will show that *(35)*: "successful work in health promotion will be an art as much as a science, and practitioners will need to be able to improvise creatively to put together an appropriate mix of in-

terventions, combining and adapting a range of different approaches on the basis of 'theoretical pluralism'...".

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Creating a healthy medical school
University of Newcastle

Martin White

BACKGROUND: ROOTS AND INSPIRATION

This chapter discusses and critically evaluates the development of the University of Newcastle's Healthy Medical School initiative – focusing on the processes adopted, the outcomes achieved and the lessons learned.

The roots of the initiative can be traced back to 1991, when the Dean of the Faculty of Medicine asked the newly appointed Professor of Public Health what he would like to achieve during his tenure. His answer emphasized that one of the challenges for an academic Department of Public Health is to practise what it preaches – to ensure that the opportunities for health among students and staff within the Faculty are maximized. The Dean liked this idea, as he was concerned already about apparently high levels of alcohol consumption among medical students and felt that the development of a health promotion initiative might be one way of tackling this problem.

The initiative has developed in several stages and continues to evolve. Although at its heart the initiative embodies the settings-based approach to health promotion *(1)*, the focus and methods used have been shaped by a variety of local constraints requiring a measure of pragmatism.

CONCEPTUAL FRAMEWORK

Following the decision to develop an initiative, an informal brainstorming and discussion meeting was held, bringing together enthusiastic and interested parties. These included academics from public

health and occupational medicine, colleagues with policy development experience from the National Health Service, the Newcastle Healthy City Project Director, a representative of the Faculty administration and two students The principal outcome of the meeting was a paper outlining aims and action proposals, as detailed in Box 7.

Box 7. Aims and key policy areas for the Newcastle Healthy Medical School initiative

Aims

- to enable staff and students to maintain and improve their health;

- to develop and promote the image of the Faculty of Medicine as a "healthy" and health-promoting organization, and a leader in effective health policy;

- to increase organizational efficiency by investing in the Faculty of Medicine's most valuable asset: a healthy work force and student population;

- to contribute to the wider promotion of health in the north-east and elsewhere by:

    - encouraging staff and students to gain appropriate knowledge and skills to enable them to be effective health promoters

    - developing a model for the development and implementation of organizational health policy that can be used by other local organizations.

Potential policy development areas

- smoking
- alcohol
- diet
- exercise
- stress
- economic hardship
- drugs
- screening and other occupational health services
- counselling and other student health services
- workplace safety

- sexual behaviour
- environmental protection
- equal opportunities

These proposals were presented to the Dean and Faculty Board. The aims and process were agreed, but some amendments were made to the proposed areas for policy development. It was felt that the initiative should focus primarily on issues directly related to student and staff health – such as smoking, physical activity, diet, and occupational health and safety – and that issues such as economic hardship and the wider environment were too peripheral or too far outside the control of the Faculty. It was thus agreed that policies should initially be developed in eight key areas: smoking, alcohol, diet, drugs, physical activity, sexual health, stress, and occupational health and safety.

ORGANIZATIONAL STRUCTURE

When the conceptual framework was agreed, the next stage was to establish a structure and process to take the initiative forward. First we set up a steering group drawn from participants present at the initial brainstorming meeting to oversee the initiative as a whole. The steering group undertook three tasks at the outset:

- preparing a consultation document outlining the proposed initiative to inform heads of departments and services;

- widely consulting all students and staff, using a newsletter summarizing the consultation document and a questionnaire to gather ideas and expressions of interest in the initiative; and

- conducting an anonymous sample survey of students and staff to gather baseline measurements relating to key policy areas to underpin future evaluation.

A number of small specialist working groups were also established – involving academic staff, service staff and students – with the task of developing policies in the agreed areas.

IMPLEMENTATION

The process followed by each specialist working group involved four main steps:

- establishing an evidence base by gathering information from local surveys and published literature;

- preparing objectives and draft proposals for each policy;

- testing out policy ideas by wide consultation with students and staff using specially convened sounding boards; and

- finalizing the policy, taking on board comments and including the development of a implementation plan with a time schedule and estimated costs.

The Alcohol Policy Working Group developed and tested this process first, providing a model for others to follow *(2,3)*.

From 1993 to 1995, four policy working groups (diet, alcohol, physical activity and sexual health) completed this process. Each of the resulting policy documents has a similar structure, with policy proposals being made in four key areas:

- changes to the environment (physical, organizational and social);

- training and education;

- provision of appropriate services;

- identification, management of and support for those with problems.

The Dean and the Faculty Policy and Resources Committee endorsed these policy documents in June 1995 *(4)*, and a small budget was made available to help with implementation. However, as this was insufficient to employ any staff, it was agreed that the crucial next step was to secure sufficient funding to enable meaningful policy implementation. A year later, a grant from the Northern Regional Health Authority enabled a full-time research and development officer to be employed for three years to coordinate the second phase of the initia-

tive – which involves further development, implementing policies and evaluating outcome.

In addition, several other tasks were carried out on agreed issues.

Smoking

Following the introduction of a campus-wide University no-smoking policy in 1993, the Smoking Policy Working Group undertook to support and monitor implementation of the policy within the Faculty.

Occupational health and safety

Occupational health and safety issues became part of a University-wide contract for occupational health services from an independent agency, set up by the University Department of Environmental and Occupational Medicine. Staff in this University Department have also contributed to the development of other policies, in particular those on alcohol, drugs and stress.

Drugs

A major national survey was funded at Newcastle University to explore patterns of drug use among students *(5,6)*. A Drugs Working Group was established in October 1997 to develop a policy for the Faculty.

Stress

The anonymous questionnaire survey and consultation exercise revealed that stress is considered to be the single most important health problem among both staff and students. A Stress and Mental Health Working Group was convened in January 1997 and is developing a policy.

REFLECTIONS ON THE PROJECT

The Newcastle initiative has made slow but steady progress over a five-year period. However, this process has not been straightforward, and there are lessons to be learned from our experience.

Divergent health promotion paradigms

Throughout the development of the initiative, there has been tension between two divergent health promotion paradigms *(7)*. The Steering Group espoused a positive and socioecological paradigm – derived from the WHO strategy for health for all *(8–10)*; the Faculty Board largely supported a more biomedically based disease prevention paradigm, with a strong focus on individual behaviour and lifestyle. The resulting tension can be likened to that between the health strategy for England, *The health of the nation (11)*, and health for all *(8–10)*.

To address this constraining influence, we have attempted to apply the aims and principles of health for all in developing and implementing each policy area in numerous ways.

Collaboration

We have developed a collaborative process of policy development, working together with experts from different departments within the Faculty and from outside.

Community participation

We have undertaken several forms of consultation and, whenever possible, involved students and staff in the policy development process.

Openness and accountability

We have attempted to develop policies in an open and accountable way, using a newsletter to make information and ideas available for comment and allowing flexibility of membership of the Steering Group and working groups.

Sharing ideas and experience

We have learned from others in the field by reading the literature and by direct communication and have shared ideas and experience as the project has evolved by publishing articles in journals and newsletters with a variety of audiences *(2,3,12–15)*.

Empowerment

The ideas for action are intended to be empowering and, using the principles of healthy public policy, either aimed at making healthy choices easier or creating healthy and supportive environments by effective policy measures *(10)*.

Communication and consensus

Despite differences in understanding and views about appropriate approaches, senior academic staff and management have strongly supported the policy development process, and this has been a valuable source of legitimacy for the initiative. Central to achieving this support has been frequent and clear communication of proposals from the Steering Group to the Faculty Board and the achievement of consensus at an early stage on the overall aims of the initiative. By keeping these aims in mind, the initiative has been able to demonstrate that there are many different ways to achieve them: universities are large and bureaucratic organizations, and the difficulty of bringing about organizational change should not be underestimated.

Communication has also been important for raising the initiative's profile within the wider Faculty community. By using a variety of methods, it has proved possible to increase receptivity to changes in the policy framework for health and to enhance participation in the initiative.

The process of developing policy: an evidence-based approach

A further important factor has been adherence to a logical process for policy development, when possible involving a thorough review of published literature in the field. In an academic environment, such

rigour and reliance on evidence-based approaches has been an important factor in gaining credibility for what was initially viewed as a somewhat marginal activity.

Financial constraints

Higher educational institutions in the United Kingdom are currently operating in a difficult financial environment. In practice, this means efficiency savings, research selectivity and increasing student numbers – all of which make significant demands on the system and represent major counteracting forces for any health promotion initiative.

Student and staff turnover: a challenge for integrative health promotion

Newcastle tends to have a high annual turnover of students and, to a lesser extent, staff. This means that institutional memory for policy issues is relatively short, and the community needs to be frequently reminded of the rules and the messages in each policy area. There is less room for one-off campaigns, and this emphasizes the importance of introducing health promotion as an integral rather than an added-on element of the organizational structure and development.

Curriculum development

An obvious opportunity has been to introduce the ideas underpinning the initiative within appropriate curricula. For example, in the undergraduate medical degree programme, seminars have been introduced within a health promotion course. In the first seminar, students take part in a practical exercise to work through different approaches to promoting health within the Faculty. In the second seminar, students work in small groups to develop educational materials and messages linked to the initiative. These second-year sessions are followed by a one-hour small group seminar as a part of a third-year clinical rotation in public health medicine, which is run as a focused group discussion to test out ideas and proposals for specific interventions.

From October 1997 a new personal and professional development strand has been introduced into the medical undergraduate curriculum,

and this will involve further lectures on personal health and health promotion in the Faculty for first-year students.

A wider understanding of health

The fact that both students and staff have identified stress as their most important health priority has several implications. First, it emphasizes the importance and centrality of having a health policy that can contribute significantly to achieving corporate goals, such as efficient and effective research and teaching. Second, internal discussions and negotiations have led to the conclusion that stress needs to be addressed by both proactive and reactive strategies, including appropriate counselling and referral services for students and staff. However, it has also been recognized that positive health promotion – in the form of organizational, personal and staff development – and a focus on leisure activities involving arts, humanities and physical recreation are all appropriate ways to address the concerns of the Faculty community. Thus, views have gradually started to change, and a greater understanding of the scope of health promotion is being fostered – gently challenging orthodoxy and presenting more radical approaches as attractive alternatives to the more familiar and traditional, biomedically oriented methods.

THE FUTURE: CONSTRAINTS AND OPPORTUNITIES

Although the initiative has presented many challenges, it has also demonstrated the potential for great success. The university population, which tends to be largely young (students) and employed (staff), is not the most unhealthy. Nevertheless, it is at risk from specific problems, and patterns of behaviour students develop at medical school may lay down trends for the future *(12)*. Health promotion in higher education is similar to health promotion in any occupational environment. However, although it is a more complex challenge within universities, it arguably presents greater opportunities for teaching and learning about health promotion *(1,12)*. Nowhere is this more so than in medical schools, where staff and students have a fundamental interest in health *(12–15)*. In the future, major challenges will continue to include:

- integrating the initiative into mainstream corporate activity – ensuring that a holistic and organizational development approach is adopted;

- developing practical and effective health promotion interventions for new policy areas (such as drugs, stress and the environment) while maintaining the activities already initiated; and

- securing the funding needed to ensure that the time, energy and expertise already invested results in tangible and successful outcomes.

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Public health education for medical students: a problem-based curriculum and new opportunities
University of Liverpool

Gillian Maudsley

BACKGROUND: ROOTS AND INSPIRATION

The General Medical Council published its *Tomorrow's doctors* recommendations on undergraduate medical education in 1993 *(1)* with the aim of producing doctors appropriate and sensitive to individual and population needs. These are currently being implemented, in various ways, in medical schools in Great Britain. The recommendations broadly encompass curricular change to:

- reduce factual overload by identifying and integrating core content – as part of a core plus options structure;

- promote appropriate knowledge, skills and attitudes – including communication skills and making public health a prominent theme – for pre-registration house year and for a subsequent medical career practising life-long learning; and

- adapt to changing patterns of health care.

The recommendations encourage educational innovation in moving towards a philosophy and methods that are more student-centred, such as promoting curiosity, self-directed learning and critical appraisal, supported by appropriate assessment, supervisory structures, technological resources and the sharing of good practice.

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One of the striking features of *Tomorrow's doctors* is the attention paid to the population perspective on health *(1)*:

> The theme of public health medicine should figure prominently in the curriculum, encompassing health promotion and illness prevention, assessment and targeting of population needs, and awareness of environmental and social factors in disease.

Such a distinguished challenge to the status quo in undergraduate medical education is particularly welcome to those weary of justifying trivial amounts of, often disconnected, public health teaching time. *Tomorrow's doctors* builds on international recommendations taken from the Edinburgh declaration of 1988 *(2)*, which aspired to producing health-promoting doctors with a wider view of medicine and of their role in health.

When *Tomorrow's doctors* was published, the University of Liverpool Faculty of Medicine was already redesigning its undergraduate medical curriculum *(3)*. This Faculty-managed curriculum originated in a Curriculum Strategy Group set up in 1990 *(3)*. The General Medical Council recommendations provided further impetus for this landmark change. Launched for the October 1996 intake, the curriculum is being rolled out for subsequent intakes.

CONCEPTUAL FRAMEWORK

The Liverpool Faculty of Medicine drew upon the practical experiences and philosophies of many successfully innovative undergraduate medical curricula around the world. Much of the medical education literature, however, is not explicit about the impact of curricular innovation on public health education.

Starting anew, the five-year core plus options curriculum is constructed using integrated problem-based learning tutorials as the building blocks, with two to three tutorials per module. Students work through each one- to two-week module in small groups facilitated by a tutor to identify group learning objectives to research between tutorials. They are supported by a spectrum of learning materials. The mod-

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ule case scenario is designed to trigger an indicative set of faculty objectives across four curricular themes:

- structure and function in health and disease
- individuals, groups and society
- a population-wide perspective
- professional values and personal development.

Students generate similar objectives according to their perceived relevance and tutor guidance. These objectives underpin the assessment system, which has both formative (giving feedback) and summation (counting towards progress or a degree award) elements.

Conceptually and structurally, this integrated problem-based framework replaces the former emphasis on isolated disciplines and subject-based learning, obliterating the traditional divide between pre-clinical and clinical work. Commitment has also been made to providing early clinical context, specific training in communication and clinical skills and a community orientation.

Along with this striking change in curricular structure, process and philosophy – based on learning relevant material in context – came the increased emphasis on public health education. Previously, the medical students received a solitary two-week public health medicine module in the third year of the traditional five-year curriculum (and approximately 36 hours of medical statistics teaching in the first year). There had been little room for innovative manoeuvre within the practical and philosophical constraints of the traditional curriculum.

Public health and epidemiology – supplemented by medical statistics, and to a much lesser extent health economics, public health nutrition, and history of public health – now form the thrust of the population perspective theme.

In the first 4 years of the curriculum, the emphasis given to the four themes differs between modules but is continuous, encouraging a more comprehensive approach to dealing with clinical problems.

ORGANIZATIONAL STRUCTURE

The responsibility for planning and implementing a Faculty-managed curriculum is centralized. Whereas the Faculty of Medicine is currently

reviewing its organizational structures to meet major challenges in research and educational commitments, the problem-based curriculum was introduced into a Faculty organized around traditional departments. The planning and implementation of the population perspective theme therefore made heavy demands on the relatively small Department of Public Health because, unlike the others, this theme was essentially within the remit of a single department.

A small Departmental Steering Group provided the operational and strategic support required, drawing on expert advice from the remaining academic staff as appropriate. Numerous requests were made of departmental staff for guidance, representation at meetings and responses to documentation, and these were coordinated and delivered through this group to maintain an overview and make the best use of staff effort.

PROJECT IMPLEMENTATION

The input to planning from the Department of Public Health was helped greatly by forming a discipline map early on to chart the proposed core learning objectives under the population perspective theme, for each module. The map was updated as the objectives were modified through discussions in the multidisciplinary curricular consensus groups planning each module. The progression of objectives across the years of this spiral curriculum could then be cross-referenced to check that concepts were being revisited at increasing depth without unnecessary duplication. Hundreds of self-assessment questions were then written to address the agreed year-one faculty objectives for the population perspective and make an initial deposit in the central assessment bank. Resource lists were compiled incrementally to identify core texts and references for the modules. In this rolling programme, efforts needed consolidating progressively as the next stages were reached.

Commitment to the problem-based learning staff development programme meant that three of the four members of the Departmental Steering Group joined the first cohort of problem-based learning tutors for the first 208 students (32 groups). Two of these members were then able to use the problem-based learning experience to inform their

writing of computer-based learning materials to support the population perspective theme.

REFLECTIONS ON THE PROJECT

The population perspective theme in Liverpool enables consideration of the trends and patterns of diseases and their determinants, the opportunities for preventing disease and promoting health and the implications for health (and other) service organizations. This learning is integrated with that in the other themes and is complemented particularly by consideration of the behavioural (individuals, groups and society) and legal, ethical, moral and personal development (professional values and personal development) implications in a scenario. In turn, these three themes support the primary task of acquiring core knowledge and skills related to normal and abnormal structure and function.

The prominence of public health education in the new thematic structure at Liverpool demanded much effort from the Department of Public Health. Strategic and operational input was required at most of the levels of Faculty planning and implementation. The third-year public health medicine modules are still required for the traditional curriculum (until 1998), without initial redistribution of resources between departments. All this also happened at a time when major departmental savings were being made because of higher education expenditure cuts. Indeed, a departmental structure is probably counterintuitive to a curriculum without explicit subject boundaries. Letting go of the responsibility for and control of public health education to the Faculty-led problem-based curriculum structures raised mixed emotions but was necessary to make public health everyone's business.

THE FUTURE: CONSTRAINTS AND OPPORTUNITIES

The problem-based approach provides a welcome opportunity to improve public health education for medical students in Liverpool. Sustaining the momentum may well require the curricular philosophy to

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be reflected more explicitly in Faculty organization, resource allocation and reward and appointment procedures. For now, however, Faculty-level commitment to a wider view of medicine is in itself laudable given that British academic departments of public health have been eager for medical schools to recognize and address the public health implications of *Tomorrow's doctors (4)*.

Admittedly, overall, doctors *per se* can only make a relatively minor contribution to the health gain of a population. Nevertheless, this can be pivotal. There are two main ways in which the major and innovative curricular development in Liverpool could potentially contribute to health gain by the University.

First, although it is too early for evaluation evidence locally, the physicians ultimately produced by this process should be sufficiently aware of public health principles, practice and issues to make a more informed contribution to health gain. This involves the ability to recognize and act on the determinants of health in clinical practice and to make their actions evidence-based using their epidemiological and life-long learning skills. The educational climate now makes it easier for the students to make informed choices about such learning.

Second, there could be an increase in health gain for students – and staff – themselves. The enjoyable learning environment – building on the students' experience, empowerment, and a more balanced relationship with the tutor – is conducive to a more health-promoting philosophy.

It would be unwise to make ambitious claims about the virtues of a curriculum only in its infancy through its first year. Nevertheless, health promotion content and philosophy is now higher on the educational agenda of the medical school for both staff and students. Together with healthier staff-student working relationships, these are modest yet important steps for the University overall given the considerable pressures prevailing related to funding, educational and research.

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Embracing organizational development for health promotion in higher education
Lancaster University

Gina Dowding & Jane Thompson

BACKGROUND: ROOTS AND INSPIRATION

One of the key founders of the Lancaster Health Promoting University Project has described the origins of the Project as being grounded in a very real concern about student welfare, growing interest in a multidisciplinary approach to health, and opportunism.

The student Services Department and the University's management led concern about student welfare and health. The two key proponents of the Project were the Head of Student Services and the Pro-Vice-Chancellor (who have both since left and been promoted in other universities). Both individuals were active non-executive members of health authorities (health authorities had non-executive members at that time). Their interest in health promotion was mirrored by staff across the University, and in particular, in the Students' Union, the Health Centre and the personnel department. Health promotion initiatives, supported by the local health service's Health Promotion Unit, had become a well established part of University life over the years.

In summer 1994, after the Chairman of the Regional Health Authority visited the University briefly, the opportunity arose to bid for money from the Regional Health Authority for a programme of health promotion. Funding to set up the Health Promoting University Project was subsequently granted: £30 000 over two years to fund the post of a project coordinator. (The Project Coordinator's part-time post

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was job-shared after the first year of the Project.) The aim of the Project, as defined in the bid, 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 is 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. Nevertheless, the University does have experience of health-related research within a range of schools, from Geography to the Management School. An Institute for Health Research was founded in 1996.

CONCEPTUAL FRAMEWORK

The original brief of the Project emphasized high profile, topic-based action on the five priority areas identified. The primary task was therefore 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 *(1,2)* and the Ottawa Charter for Health Promotion *(3)* 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. Help and guidance were therefore sought from professionals working in other sectors, and especially those involved in the European Health Promoting Hospitals Network (in particular with Dominic Harrison, Coordinator of the English Health Promoting Hospitals National Network), in developing a framework and methods for the Lancaster Health Promoting University Project.

AIMS AND OBJECTIVES

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

- 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 – or, as the Chair of the Steering Group said at the time – "to change hearts and minds".

During the first six months, Leo Baric of the University of Salford was contacted. He subsequently came to the University to run a workshop with the Steering Group and to give a public lecture at the University about the settings-based approach. Using Baric's organization model *(4)*, three elements of a health-promoting university were identified:

- creating healthy working, learning and living environments for students and staff;

- increasing the health promotion and health education content of the academic work of the university; and

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

It was agreed that the Lancaster Health Promoting University Project should focus, primarily, on the first element.

Grossman & Scala *(5)* endorse organizational development as a means of achieving long-term change. Nine months into the Project, the health promotion specialists on the Steering Group participated in a WHO training workshop in organization development for health promotion. This confirmed their conviction that the settings-based approach requires new and different skills than those required by traditional health education or health promotion interventions.

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ORGANIZATIONAL STRUCTURE

A Project Steering Group was established, chaired by the Pro-Vice-Chancellor, with representatives from most key services and functions of the University perceived by the authors of the Regional Health Authority bid to be interested in health: Personnel, the Students' Union, Student Services and the Health Centre. A number of Steering Group members, including the Pro-Vice-Chancellor, were members of senior-level committees of the University, but the Steering Group itself had no direct responsibility or lines of accountability to the existing committee structure.

Instead of establishing a group for each of the specified key areas in the bid (which would have focused explicitly on a problem or lifestyle-defined area), the Steering Group agreed to set up three multidisciplinary working groups to take a holistic view of the context of staff and students' experience of the University. The names of the working groups reflected the areas they were being asked to address (Fig. 2).

Fig. 2. Working groups

Steering Group

| Promoting a healthy social life | Promoting a healthy working life | Promoting a healthy environment |
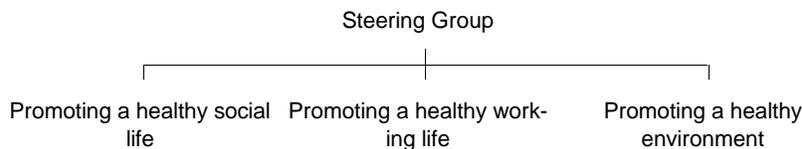
Members of the Steering Group either chaired or joined one of the above working groups, and individuals from other specialist services were invited to join in an effort to ensure a balance between the individuals perceived to be:

- potential stakeholders in the project;
- representatives or gatekeepers to a large number of staff or students;
- enthusiasts with innovative ideas for change; and
- decision-makers with the authority to affect change.

The Safety Officer, for example, was invited to join the Promoting a Healthy Working Life Group, and the Deputy Director of Buildings and Estates joined the Promoting a Healthy Environment Group.

PROJECT IMPLEMENTATION

The project was implemented in four ways:

- planned health promotion interventions by the three working groups;

- proactive lobbying and mediation on behalf of the Project by members of the Steering Group and working groups and the Project Coordinator;

- opportunistic health promotion interventions (as they arose); and

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

The working groups

Each of the working groups was asked to:

- identify health promotion needs within their area;

- design, set priorities for and implement a strategy of health promotion action programmes using a variety of interventions – including health information campaigns and advocacy to improve services, facilities and environments;

- make policy development recommendations to the Steering Group for action requiring the support of other decision-making bodies in the University.

Promoting a healthy social life

The Promoting a Healthy Social Life group was to focus on the potential for health gain in the non-academically-related aspects of the lives of students, staff and visitors to the University. The group decided to

give priority to the needs identified previously: mental health, alcohol and sexual health, building on the campaign work of the Students' Union, with the aim of taking on board other issues as appropriate. Outcomes, in both the short term and the long term, often in parallel, resulted in a focus on sexual health, alcohol use, provision of social spaces and mental health.

Sexual health

Concern existed in the University about the accessibility of contraception services and in particular the availability of condoms (provided by a range of local service providers, including the health centre on campus). Action included:

- setting up a user group to enhance dialogue about services between health centre users and doctors and nurses, with attempts to make services more accessible;

- a major publicity campaign on existing contraceptive services and the production of a new sticker placed on all toilet doors on campus advertising the existing range of services; and

- arrangements for a regular supply of condoms to the University Night Line, where they are available free 24 hours a day.

Alcohol use

There was no shortage of ideas for encouraging sensible drinking on campus, from wider publicity about the alcohol content of beverages to reducing the profit mark-up on non-alcoholic drinks on campus (which, as in most licensed premises in the United Kingdom, is higher than on alcoholic drinks). Nevertheless, ideas for progress in this area were hampered by perceived organizational barriers. At Lancaster all colleges depend on bar profits to finance other welfare activities. In the light of other organizational issues, the issue of bar profits was too sensitive to address at that time.

Provision of social spaces

Alongside the debate around alcohol on campus, the group vigorously pursued providing a new location for meeting and socializing on campus. It was felt that the bars on campus were not meeting the social needs of some students (in particular, mature students, families and overseas students) and staff and that providing a different type of venue would create a healthy choice in socializing opportunities on campus, especially in the evenings. The group capitalized on the idea through:

- needs assessment: an extensive in-house survey using questionnaires was commissioned from the Centre for Medical Statistics and complemented by students carrying out individual and group interviews as part of academic projects (for example, in qualitative methods);

- dialogue with the catering review committee, which was near the end of reporting on financial arrangements of catering provision on campus;

- lobbying the Estates Department for support; and

- recommendations, based on the needs assessment, to guide the Estates Department in the future franchising of University accommodation for catering providers.

Mental health

Concern for action to promote the mental health of all staff and students in a climate of increasing pressure resulted in:

- mental health promotion campaigns and events on World Mental Health Day; and

- the creation of a Mental Health Working Party, which has subsequently been successful in securing external sources of funding for a three-year Student Mental Health Project to embed appropriate mental health services into the existing University structures.

Promoting a healthy environment

The tasks of this group were defined broadly because environmental themes inevitably overlap and interact with challenges relevant to other working groups within the project. Two key elements were central to the work of the group: issues relating to the immediate campus environment and the health of students and staff and the wider impact of University activities on the environment beyond the campus and on the population of Lancaster and Morecambe. It was felt important to try to develop a portfolio of projects in which some provided an immediate payback and others took longer to mature.

Promoting access to and use of the University's grounds

Improving and promoting access to the attractive campus grounds was viewed as a project that could be tackled quickly, involved action only within the University and could potentially improve the quality of life for those living and working on campus. In cooperation with the University Building and Estate Office:

- new signed footpaths were established around the campus;

- a footpath map was produced and widely distributed;

- an existing nature trail was upgraded; and

- the use of the campus was promoted through a series of lunchtime guided walks around the footpath network focusing on points of ecological interest.

Developing and implementing a policy to minimize waste and promote recycling on campus

The challenges of minimizing waste generation and promoting recycling involved extensive negotiations both within and outside the University. Policy development was informed by a comprehensive report commissioned by the Health and Environment Working Group (and produced by a Lancaster master of science student) that highlighted the extent of the problem and suggested a variety of strategies. The University has adopted a number of the proposals outlined in the report, and an increasing amount of waste is recycled. Nevertheless,

progress has been more rapid in some parts of the University than others, and there is still no structure that minimizes waste and ensures that a high proportion of waste is recycled throughout all sections of the University.

Developing the University's environmental policy, influencing the University's transport strategy and researching the impact of noise on campus

The issues raised by this group were taken to the Steering Group for further action, some with more success than others (see later). Individuals continue to push for these changes because policies that encourage a healthy environment can save money and are essential for the long-term future of the University. The University has a strong commitment to high-quality environmental teaching and research, and the institution must be seen as practising what it teaches and researches.

Promoting a healthy working life

This group was to promote a healthy working environment and a positive working experience for all staff and students. Given the breadth and complexity of this remit, the group decided to give priority to the working experience of University staff. The University is one of the major employers in the district and, at the time when the group was established, had staff at three different sites (subsequently consolidated to one). Its employees include very disparate groups of staff – some permanent and others on fixed-term contracts.

The group decided to pursue its objectives through long- and short-term measures, including assessing the health needs of staff, producing a report on stress, promoting staff health action weeks and reclaiming the lunch hour.

Assessing the health needs of staff

As a starting-point, the group decided to formally assess staff perceptions of influences on their health at work. Twelve categories of staff were represented in the focus group sessions, which considered:

- how working at the University affected their own health and that of their colleagues;

- the extent of University responsibility for protecting and promoting the health of staff (beyond legal requirements);

- the extent of University responsibility for promoting a healthy environment; and

- recommendations for measures the University could take to promote individual and environmental health.

The results gave a clear picture of common concerns.

- Stress affected all categories of staff. In some cases this was directly linked to the actions of students and in others it was the result of increased workloads (with perceived pressures to work through lunch) and organizational and contractual issues (fixed-term contracts).

- Poor communication within the organization both increased staff stress and obscured knowledge of facilities and good working practices already available to staff (for instance, reviews of seating and lighting).

- Facilities and services for staff were often seen as inadequate: for instance, there was a demand for improved seating and lighting, less expensive sports facilities, more showers (for staff who wanted to cycle to work), more social spaces and increased opportunity to take lunch breaks.

Dissemination of the findings of the research coincided with a period of severe financial cutbacks within the University, which resulted in genuine concern, for some staff, about the security of their current employment. The efforts of the group targeted staff stress.

Report on stress

A two-part report was compiled by members of the group, Staff Development and the Counselling Service and circulated through the Steering Group, to the Vice-Chancellor and heads of departments. The report

summarized current theory on the issue of organizational stress and the specific concerns within the University. It emphasized the importance of clear communication, particularly in a period of rapid change. The report did not suggest specific outcomes but was intended to raise awareness among senior management and highlight the importance and opportunity for positive change as part of the long-term restructuring programme.

Staff health action weeks

In parallel with the efforts for long-term improvement in working environments, the group was keen to raise the profile of health among staff and to offer practical events for staff participation. Two weeks of health-related events and activities were organized, to which every member of staff received an invitation. The programme of events included a Look After Your Heart Health Fair provided by the local National Health Service Trust. An interdepartmental Bike to Work Challenge encouraged over 100 participants and highlighted both the enthusiasm of individuals and the organizational barriers to cycling to work.

Reclaiming the lunch hour

As a follow-up to the previous year's Staff Health Fair, this two-week initiative was intended as a fun and short-term alleviation of the stress many staff experience by failing to take their lunch hour. Such daily events as guided walks, aroma therapy sessions and yoga were well attended despite the justifiable observations by some staff that they did not tackle the causes of stress. Staff Development organized a number of follow-up courses.

Suggestions to repeat the very successful Bike to Work Challenge of the previous year were rejected by the event's organizers because of a perceived lack of commitment, by the University, to improving facilities for cyclists. Instead, a series of public meetings was arranged that resulted in the formation of the University Cyclists Action Network – a group of staff and students who are committed to cycling to work and lobbying for secure cycle racks and showers. The University Cyclists Action Network is now an active lobbying force in the University.

Proactive lobbying and mediation

Members of the Steering Group and working groups agreed to take on a lobbying role for health challenges in the University. This activity increased as members grew in confidence, and examples of success include:

- a commitment to ensure that information on health, prevention programmes and primary health services is given during induction talks to all new students;

- the removal of cigarette machines from most catering outlets; and

- representation of the Project on the University Transport Policy Working Group, which gave a credible specific voice to concerns for the implications of transport policy for health and the environment. These have since been reflected, with some dilution, in the statements of the Transport Policy Working Group.

Opportunistic health promotion interventions

In September 1995, Lancaster University hosted a major first-aid training event for members of the community. Following this, the opportunity was seized for securing a commitment from the major voluntary organization involved to provide first-aid training each new academic year for volunteers.

Reactive work to ideas generated by staff and students

Publicity for action underway in the Project encouraged other parties to take on board such health promotion issues as the following.

- One of the colleges expressed interest in becoming a health-promoting college. a session was held with college members to create a vision of the health-promoting college, and a subsequent meeting helped clarify a programme of action. The University, however, did not grant the college funding for the proposals. Had more time been available for lobbying and mediation, it may have been possible to secure commitment from the college to re-direct existing funds to the proposals.

- A member of the Health Centre staff, who was also on the Promoting a Healthy Working Life Group, expressed concern about the number of students exhibiting health problems resulting from overuse or inappropriate use of visual display units. Group members carried out initial research – including the collation of national information gathered through an e-mail discussion group. An internal bid was submitted for action research in this area but was unsuccessful, and insufficient resources were available to allow the project's development.

REFLECTIONS ON THE PROJECT

Understanding and commitment to the settings-based concept

The settings-based approach was new to everyone involved in the project (including the Project Coordinator appointed). The University staff were committed to enhancing health promotion programmes, both in terms of quality and quantity, but 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 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 of the development phase are, essentially, 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.

Interestingly, the preparatory work for hosting the First International Conference on Health Promoting Universities at Lancaster at the end of the pilot Project has been significant in developing an understanding of and commitment to the concept of the settings-based approach both internally and externally.

Communicating the settings-based approach

The results suggest 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. Simnett *(6)* has highlighted this in her work on evaluating health-promoting colleges.

Nevertheless, the benefit of hindsight can mask the fact that much of the time and resources of the Project Coordinator at Lancaster have been spent in translating the settings concept to the University. Any subsequent phase can build on this pioneering work.

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 its concerns in terms of distinct health promotion activities to remain marginal to the mainstream University business. Responsibility for action – or outcome – was, in effect, passed to the working groups, which consisted of fewer senior managers than the Steering Group and thus 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.

The working groups gave priority to opportunistic intervention processed through a series of subprojects. Although these have, arguably, helped to nurture and cultivate the understanding and enthusiasm of the individuals concerned, this has been achieved at the expense of bringing about integrative organizational change and development.

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.

External factors

The university sector in the United Kingdom is 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.

The role of the Project Coordinator

Experience suggests that the Coordinator's role is shaped by a number of factors, including:

- the origins of the project: where the idea first developed;

- the paymaster: the funding sources and their aims;

- location: the strategic location of the project coordinator within the organization; and

- the stakeholders involved.

Funded by external sources, the Project sometimes seemed to have no home in the University. 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 engaging a different social system (higher education) in the debate and action about health, developing the concept of the settings-based approach to health promotion and international networking.

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

In addition to increasing overall health promotion activity and embedding the health agenda into the work of some sections of the University, the Project made significant progress in generating debate about organizational development for health promotion across the University as a whole.

Developing the concept of the settings-based approach

Lancaster was one of the first universities to pilot the health-promoting university concept and proactively engage in its dissemination through networking. In hosting the First International Conference on Health Promoting Universities, the Project acted as a catalyst for debate about developing the concept and practice of the settings-based approach to promoting health in higher education. This led to a commitment from the WHO Regional Office for Europe to develop the Health Promoting Universities project and, with other co-sponsors, to publish this document.

International networking

The WHO Healthy Cities Project Office recognized Lancaster's pioneering role and invited Lancaster to assist in the strategic development of the concept of the WHO Health Promoting Universities project.

The future: constraints and opportunities

The development phase of the project at Lancaster finished in December 1996. The University has expressed interest in creating a post of Health Promoting University Coordinator, based within the administrative function. This, however, depends on whether the University's financial situation improves and on greater appreciation by senior management of the worth of the post and project as a resource for good times and bad times.

Lancaster University's excellent ratings in the recent Research Assessment Exercise are helping to create a more optimistic mood with a focus on the future. The process of restructuring, which will occur along-

side the University's gradual financial recovery, will create positive opportunities for building on the concepts embedded within the health-promoting university ideal.

The new Institute for Health Research provides a focus for health interests within the University. Regular communication of the Institute's activities is helping to raise the profile of health in its broadest definition to a significant number of academics and to increase the scope for developing health-related research. The cumulative effects of this growing interest create positive opportunities for the future of the Lancaster Health Promoting University Project.

Through the commitment of key individuals within the University and the local Health Service, Lancaster has had a key role in shaping the conceptualization of the Health Promoting Universities project. The opportunity exists for Lancaster to reap the benefits of its earlier commitment should it continue to invest in the Lancaster Health Promoting University Project.

During the development phase, the Project concentrated on developing the first of Baric's three elements of a setting: the housekeeping functions of creating healthy learning, working and living environments for students and staff. Efforts to extend the scope of the Project were limited. This means that the fundamental business of the University – teaching and research across the whole of the University curriculum – is still untapped in terms of health-promoting university developments. This is an area in which progress could engage the academic community of the University and could make a very significant contribution to improving the health of the wider community.

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The healthy university within a healthy city
University of Portsmouth

Camilla Peterken

BACKGROUND: ROOTS AND INSPIRATION

In 1995 the University of Portsmouth and the Portsmouth and South East Hampshire Health Authority initiated a two-year project to develop the University as a health-promoting university and a healthy workplace for both staff and students.

The University and the Health Authority had worked in close collaboration for several years, forming a Healthy University Steering Group a couple of years prior to the project. This group was originally focused on academic collaboration between one of the professors in social studies and the Public Health Department of the Health Authority. Over time, the group's interest developed to encompass action on health in the University. The Portsmouth City Council is committed to the Healthy Cities initiative and became another principal alliance member. The Portsmouth Health Promoting University Project was seen as the obvious next step for translating the collaboration of these three key agencies into a strategy for action.

CONCEPTUAL FRAMEWORK

The University's mission statement expresses a commitment to excellence, to the quality of the student experience and to preparing students for the future. In addition, one of the fundamental aims of the University is to provide an environment in which all students and staff can fulfil their potential. It was agreed that a framework for the Portsmouth Health Promoting University Project should build on these or-

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ganizational commitments and other local health strategies. The Health Authority is committed to working within a framework of Healthy Alliances *(1)* and towards the Health of the Nation targets *(2)*. In October 1995, the two main collaborating organizations appointed a University Health Promotion Adviser and agreed that:

- health promotion action would be based on a commitment to enabling, advocacy and mediation highlighted by the Ottawa Charter for Health Promotion *(3)*; and

- structures would be guided by the health-promoting college model *(4)*.

ORGANIZATIONAL STRUCTURE

The well established Healthy University Steering Group took over responsibility for the Project with an expanded membership. The new group included the (acting) Vice-Chancellor, the Director of Health Promotion, the newly appointed Health Promotion Adviser to the University and representatives from the Students' Union, the School of Health Studies, the School of Social and Historical Studies, Students' Services, Personnel, the Health Promotion Service and the Portsmouth City Council.

PROJECT IMPLEMENTATION

The first phase of the Project focused on assessing the health needs of the University. This was considered an essential basis for a future strategy: to paint a broad picture of health at the University – illustrating student and staff needs; showing how local statistics measured up against national targets; and identifying gaps in existing practice. It was felt that this would provide a framework to guide strategic development and enable change to be measured. The needs assessment was focused primarily around the Health of the Nation areas. However, because of the range of definitions and concepts of health, it was felt

that the needs assessment exercise should allow for a broader scope of issues to be raised.

Aims of the needs assessment

The aims of the needs assessment were:

- to provide information on the student population in relation to the key Health of the Nation targets;

- to include an additional key focus of primary health care and minor illnesses (primary health care is perceived to be an important gateway for students to access health promotion and protection);

- to clarify existing health promotion activity;

- to make recommendations based on the findings and known effective interventions and to make recommendations to pilot and evaluate new methods; and

- to make recommendations for action at a strategic level, at departmental level and for individual target groups.

Method

A literature review revealed that little had been written about student health in the United Kingdom. Various methods were used to assess the health needs within the University, including student surveys, observation, group discussion, staff surveys and informal discussion. Internal sources of data included the Personnel and Registry Departments and external sources included the Health Authority, the Regional Drugs Database, the Samaritans, national surveys and local general practitioners.

None of the official data channels, except for one general practitioner practice, specifically coded students. It was therefore assumed that information from all the above sources pertaining to young adults aged between 18 and 24 would be considered relevant to the student population (while acknowledging that many students would be mature students).

An essential element of the process of conducting the needs assessment was to convey the concept of the health-promoting university

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to key people at the University, and to explore whether, and how, they perceived their role as agents for change in the organization. Those interviewed in the six-month needs assessment period included: the General Manager and sabbatical officers of the Students' Union, student groups, the University Directorate, Heads of Department, Faculty Deans, Personnel staff, the Heads of Student Services and Residential and Catering Services, Health Authority and Trust staff and the voluntary sector.

The strategy

The detailed needs assessment report *(5)* made a range of recommendations for action in the key areas. Over the next six months, the report was used as a discussion document to secure commitment to the recommendations from the highest levels of management of both the University and the Health Authority. However, some of the recommendations were taken on board immediately, and the Health Promotion Adviser was asked to begin a programme of action. Box 8 provides examples of some of the health promotion interventions undertaken.

Box 8. Action on mental health

Staff mental wellbeing
A perceived stress scale had been used in the staff survey *(6)*, and stress had been highlighted by staff as an important determinant of their health. A presentation of the results to the Human Resources Committee led to a commitment to action at different levels within the University. Commitment was made to long-term developments in the following areas:

- staff training on managing change, team development and training for new managers;
- helping staff back after long-term sick leave;
- collection of absenteeism data; and
- staff appraisal systems.

In the short term a series of lunchtime stress management sessions was run for staff.

Student mental wellbeing
Students identified mental and emotional wellbeing as an important constituent of their health. It was agreed that their needs should be addressed

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in two ways: interventions that would affect the immediate wellbeing of existing students; and programmes and policies that would have a sustained impact on the changing student population.

A Mental Health Fair was organized over three days at exam time, using individual and group sessions with complementary therapists. Techniques for coping with revision and examination stress proved very popular, and positive messages about mental health and illness were also conveyed.

Over a longer period, a peer education programme was developed to train students to work with their own peers to promote mental wellbeing and encourage self-awareness and greater communication skills. In the future it is envisaged that these students will introduce the ideas within the existing structure of student induction and course groups, as well as working with their immediate colleagues.

The recommendations in the report formed the basis of a much broader three-year strategy and highlighted a timetable of action plans with expected outcomes over six months, one year and three years. Any resource implications were also identified, although most of the interventions were resource neutral.

REFLECTIONS ON THE PROJECT

Ensuring ongoing action

The introduction of health promotion programmes for staff and students went hand in hand with the development of the strategy. This ensured that health promotion was seen, experienced and evaluated. This is vital to the success of the project, particularly when working with people who may have had very different interpretations of the meaning of health promotion.

Sustainable programmes

The success of the health-promoting university depends on translating the concept into a self-sustaining programme. One health promotion adviser on a two-year contract with the support of a multiagency steering group cannot alone be responsible for implementing a programme in such a complex organization.

Time scales

Two years is a very short time to make an impact within a large, complex organization. The reality of translating theory into practice is extremely challenging – especially when working with other key agencies who may have different ways of working. A significant amount of time needs to be given to sharing concepts, establishing a framework, testing its viability and ensuring that long-term commitment is evident.

Links between the Steering Group and the decision-makers

Some members were in a position to make and carry out decisions on behalf of their department, but other representatives could not. It is essential to have members who can not only make decisions but are able to influence their execution by virtue of their membership of other committees. A good example of this was the Pro-Vice-Chancellor's ability to pursue staff health issues through the Human Resource Committee and the Director of Health Promotion's ability to influence the Health Authority's purchasing intentions and contract specifications.

Decision-making structures of the University

The hierarchical (and sometimes disempowering) structure within the University can hinder progress. The lack of delegation of decision-making powers means that key decisions are delayed. An efficient decision-making process is essential.

Timing of the Project

At a time when higher education is dealing with funding cuts and increasing competition, a major constraint is working with staff who may already feel vulnerable about their future and unwilling to commit themselves to what may be perceived as extra work.

The project was introduced at a time when the university was without a Vice-Chancellor. This may not have been the most opportune time to introduce the concept of change. Gaining commitment to and undergoing change is sometimes both lengthy and painful, especially in an organization already experiencing changes perceived to be

outside its control. On reflection there is probably no ideal time, but the expectations of the project need to be set within the context of the organization in relation to its own changes.

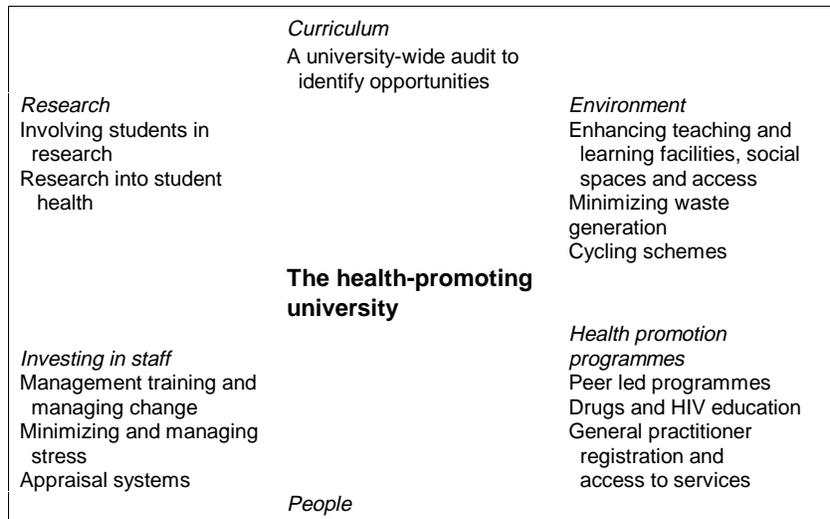## THE FUTURE: CONSTRAINTS AND OPPORTUNITIES

During the course of the Project, a framework of multifaceted interventions, using a variety of methods was developed, based on the health-promoting college model *(4)* to help clarify the areas that should be covered by the Project (Fig. 3). This framework was presented to the new Vice-Chancellor in January 1997.

Further funding has been secured for the next phase of the Health Promoting University Project.

The vital next steps for the project are:

- to delegate areas of work to small working groups and involve more staff and students in making the process of health promotion integral to their role;

Fig. 3. The health-promoting university

	Curriculum	
	A university-wide audit to identify opportunities	
Research		*Environment*
Involving students in research		Enhancing teaching and learning facilities, social spaces and access
Research into student health		Minimizing waste generation
		Cycling schemes
	The health-promoting university	
		Health promotion programmes
Investing in staff		Peer led programmes
Management training and managing change		Drugs and HIV education
Minimizing and managing stress		General practitioner registration and access to services
Appraisal systems		
	People	

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┌─────────────────────────────────────────┐
│           Policies and provision:        │
│             healthy eating, smoke-       │
│             free areas, alcohol and      │
│             drugs.                       │
│            Student induction             │
│             programmes                   │
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- to integrate the recommendations for health promotion action into existing structures such as staff development plans, Investors in People,[4] student induction programmes, estates management, Health Authority strategies and service specifications, residential and catering services and the curriculum; and

- ensuring that health promotion informs the development of new policies and programmes of work or ways of working.

Commitment at all levels to the idea of the health-promoting university is required if changes are to be made, owned and sustained. The development of a strategy for health promotion requires commitment from the Steering Group to seek continual endorsement and adoption by the key agencies, others in the university and health authority.

Evidence of effectiveness of the health-promoting university is vital. Defining success criteria for both the process and outcomes are ways of measuring the impact. In the future, evidence of integration of the project into the University structures should be sought as indicators of the success of the process. The key working papers that guide University life (University and departmental strategic plans, staff development plans and Students' Union business plans) should provide evidence of commitment. Health Authority strategies and purchasing intentions should also reflect a commitment to student health.

The opportunities for the future are exciting. There is a real opportunity to develop innovative work for a expanding group of the population that is often not recognized as having specific needs. The challenge now is to build something concrete on to the foundation of

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[4] Investors in People is a major initiative by the United Kingdom Employment Department that aims to encourage employers of all sizes and sectors to improve their performance by linking the training and development of employees to their business objectives *(7)*.

the framework at Portsmouth so that the health-promoting university ideal becomes a living experience.

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The university as a setting for sustainable health
University of Central Lancashire

Mark Dooris

BACKGROUND: ROOTS AND INSPIRATION

The roots of the University of Central Lancashire's project stretch back over several years. In 1992, the University was instrumental in Preston Acute Hospitals being selected as the pilot project for England within the WHO European Health Promoting Hospital initiative. Following representation on the Steering Group of this project, the University organized an international seminar on the settings-based approach to health promotion in collaboration with WHO and the North West Regional Health Authority *(1)*.

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. This interest was nurtured by the presence of a forward-looking Department of Health Studies within a Faculty of Health, whose understanding of health and health promotion drew extensively on health for all *(2)*, the Ottawa Charter *(3)* and Antonovsky's salutogenic focus *(4)*. In 1995, Faculty research funding was secured to appoint a Health Promoting University Project Coordinator, initially for two years, which was subsequently made into a permanent post.

CONCEPTUAL FRAMEWORK

The first task in establishing the Health Promoting University Project was to clarify its conceptual basis – defining the essential characteris-

tics of the settings-based approach.[5] Second, it was necessary to consider how this approach could be applied to the University. The University has a number of functions common to any large organization – for instance, it employs people and it provides a physical environment within which people operate – but it also has functions that infuse it with a distinctive culture and mission.[6]

As an outcome of this review, it was agreed that the aims of the Health Promoting University Project should be:

- to integrate within the University's structures, processes and culture a commitment to health and to developing its health-promoting potential; and

- to promote the health and wellbeing of staff, students and the wider community.

Within these overall aims, six objectives were set – related to priority focus areas forming an agenda for action (Fig. 4):

- to integrate a commitment to and vision of health within the University's plans and policies;

- to develop the University as a supportive and healthy workplace;

- to support the healthy social and personal development of students;

- to create health-promoting and sustainable physical environments;

- to increase understanding, knowledge and commitment to multi-disciplinary health promotion across all University faculties and departments; and

- to support the promotion of sustainable health within the wider community.

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[5] The chapters in section 1 of this document provide an overview of the theoretical basis for settings-based health promotion and of the wider critical debate concerning this approach, which have both informed the University of Central Lancashire's project.

[6] The chapters in section 2 of this document briefly review the literature highlighting the key roles of universities as the twenty-first century approaches.

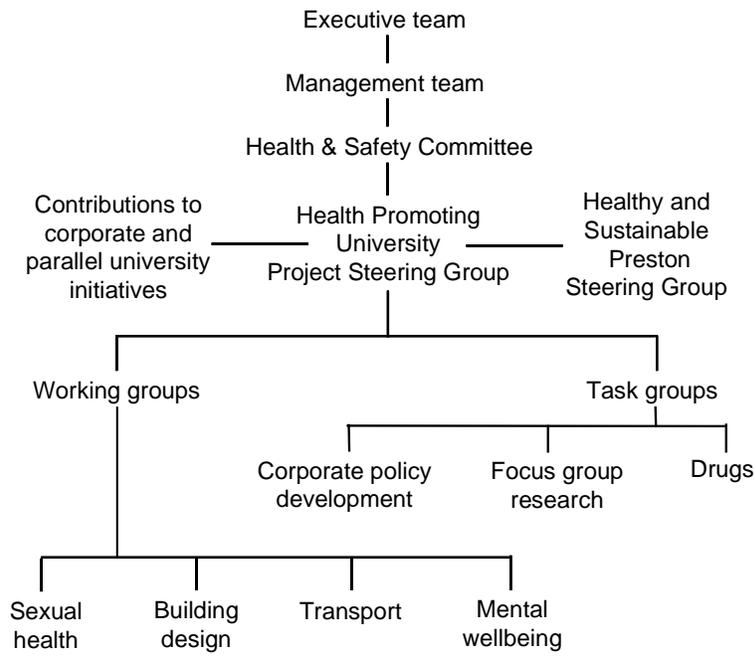Fig. 4. Agenda for action – project priority areas
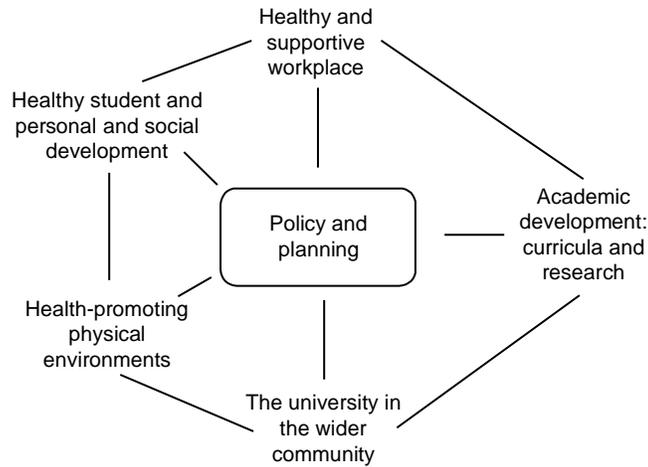
ORGANIZATIONAL STRUCTURE

When the conceptual framework was agreed, the next step was to establish an organizational structure 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. Having discussed a number of options, a Project Steering Group was established that can establish working groups and task groups as necessary, reporting through the Health and Safety Committee to Management and Executive Teams, and linking to parallel initiatives within the University and interagency alliances (Fig. 5). Chaired by a Pro-Vice-Chancellor, the Steering Group comprises the Project Coordinator (based in the academic department of Health Studies within the Faculty of Health), senior representatives from key

service areas and faculties and departments and the Health Promotion General Manager for North West Lancashire.

Fig. 5. Organizational structure

Executive team

Management team

Health & Safety Committee

Contributions to corporate and parallel university initiatives — Health Promoting University Project Steering Group — Healthy and Sustainable Preston Steering Group

Working groups

Task groups

Corporate policy development

Focus group research

Drugs

Sexual health

Building design

Transport

Mental wellbeing

Initially, it seemed that the most obvious way forward would be to establish working groups to correspond to each of the six priority areas. However, following a few experimental meetings of a Healthy and Supportive Workplace Working Group, it was decided that these priority areas were too broad and diffuse to facilitate meaningful collaboration and action. A more pragmaticand flexible approach was therefore taken, acknowledging that, within a two-year time frame, it was important to tap into exist ing initiatives, to harness and focus enthusiasm and available resources and to identify real-life entry points within the constraints of the existing organizational culture.

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Organizationally, the work was structured in a number of ways.

Contributions to corporate and parallel initiatives

The Project Coordinator and Project Steering Group carried out or supervised a number of opportunistic pieces of work, enabling the project to contribute to ongoing or planned institutional initiatives. In addition, the Project Coordinator has sat on both the Environment Committee and Ethics Committee, facilitating the integration of a health perspective into broader University structures.

Task groups

For several specific pieces of work, short-term task groups were established to achieve defined outcomes.

Working groups

Four issues were identified as appropriate foci for longer term Project working groups: sexual health, healthy and sustainable building design, transport and mental wellbeing. The selection was made pragmatically concerning relevance, interest and expertise, opportunities and resources – and the groups were set up sequentially, to avoid overload.

Sexual health

The Sexual Health Working Group was established in April 1996 – in acknowledgement of the clear relevance of sexual health issues to the University setting, in recognition that the University had not previously demonstrated a corporate commitment to addressing the issues and in response to offers from key external agencies keen to invest resources in the University.

Healthy and sustainable building design

The Healthy & Sustainable Building Design Working Group was initially convened in June 1996 following discussions between the Project Coordinator and Property Services – which concluded that there was substantial scope for developing and implementing a health and

sustainability impact assessment protocol in the design and refurbishment of University buildings.

Transport

The Transport Working Group was established in September 1996, in acknowledgement of the impact of transport on health and the environment, and in recognition of the institutional responsibility of the University to promote healthy and sustainable transport measures. The group was initially convened as an interagency alliance to facilitate coordinated and integrated action. However, it was subsequently agreed to convene two parallel working groups – one interagency and one internal. It is envisaged that, in the long term, the interagency group will be convened under the auspices of the interagency Healthy and Sustainable Preston Steering Group (see below).

Mental wellbeing

The Mental Well-Being Working Group was established in November 1996 – in recognition of the growing concern about staff and student mental health and as a way of building on the work of both the earlier Healthy and Supportive Workplace Working Group and existing institutional initiatives (for example, staff and student counselling services and the staff attitude survey).

Multiagency collaboration

In addition, the Project gave priority to developing links with the wider community. The Project Coordinator helped to set up (and now represents the University on) the multiagency Healthy and Sustainable Preston Steering Group – which serves as a vehicle for integrated and collaborative developmental work at the strategic and operational levels. In addition, the University is represented on a range of relevant interagency working groups and committees.

PROJECT IMPLEMENTATION

The Project's work was structured through contributions to corporate and parallel initiatives, task groups, working groups and multiagency cooperation.

Contributions to corporate and parallel initiatives

The first priority was action that contributed to ongoing or planned corporate and parallel institutional initiatives, such as a University plan, staff attitude survey, occupational health review, staff training and professional development and baseline health review.

University plan

In order to embed the ethos of the Project within the University's strategic planning process, a substantive contribution was made to the five-year University plan – ensuring that reference was made to key values, principles and concepts.

Staff attitude survey

Rather than carry out specific research on staff health needs, a decision was taken to tap into the University's first staff attitude survey – by participating in the pre-design stage of the questionnaire and liaising with Executive Team members regarding the role of the Project working groups in responding to survey findings.

Occupational health review

The Project Coordinator was actively involved in outlining health promotion priorities for the University's occupational health service and in interviewing potential providers.

Staff training and professional development

As a way of raising the visibility of the Project, a Health Promoting University logo was designed and used in the staff training and development schedule to indicate relevant courses.

Baseline health review

In order to identify the status of health within existing University policies, a review was carried out, using word searches to provide a baseline from which to recommend future revisions.

Task groups: specific short-term work

Short-term task groups were established to achieve specific outcomes in defined areas: focus group research on student health needs, corporate health policy and drug use and misuse within higher education.

Focus group research on student health needs

Following a successful bid to the University's Central Initiatives Fund, the Steering Group established a short-term task group in May 1996 to oversee a piece of focus group research into students' health needs. The research highlighted the complex interconnections between health issues and demonstrated the value of an holistic and coordinated organizational approach *(5)*.

Corporate health policy

A second task group met in autumn 1996 to write a corporate health policy – setting out a vision of a health-promoting university, expressing the University's commitment to incorporating an understanding of and commitment to health within its culture, management, structures and processes, detailing the six Project objectives and outlining principles of implementation. Adopted by the University in March 1997, the Policy places health high on the University's agenda and will be supported by the implementation guidance produced by the Project working groups (see below).

Drug use and misuse within higher education

A third group, currently meeting, has the particular task of producing practical guidance on issues relating to drug use and misuse within higher education. It was convened following a presentation to the Project Steering Group, which was itself a response to concern expressed by the Students Union and Student Services.

Working groups: action on specific issues

Third, action on specific issues was coordinated through means of four working groups. In liaison with the Steering Group, each working group adopted terms of reference and a work plan, which included:

- reviewing relevant research and practice (to provide a theoretical and practical evidence base);

- developing strategic implementation guidance to support the corporate health policy (see above);

- participating in high-visibility short-term initiatives; and

- drawing up recommendations to be included in a phase 1 evaluation report.

The Sexual Health Working Group has been extremely dynamic, facilitating the exchange of information and ideas across sectors, coordinating University activities and events for World AIDS Day in 1996, reviewing relevant research and practice and drawing up policy implementation guidance.

Because of time constraints within Property Services, the Healthy & Sustainable Building Design Working Group has made limited progress, adopting a conceptual framework for the work and drawing up policy implementation guidance.

The Transport Working Groups have shared information, coordinated activities and events for Green Transport Week 1997, reviewed relevant research and practice and drawn up policy implementation guidance.

The Mental Well-Being Working Group has explored the concept of positive mental wellbeing in relation to organizational development and the needs of both students and staff. In addition to sharing information and ideas, the Group has reviewed relevant research and practice, drawn up policy implementation guidance and coordinated activities and events for World Mental Health Day in 1997.

Multiagency collaboration: the University in the wider community

The multiagency Healthy and Sustainable Preston Steering Group has been an important vehicle for embedding the Project's theory and practice within a broader context. To date, the group has shared information and expertise, embarked on a process of developing visions and gained representation (via the Preston Borough Council and the University) on a WHO Multi-city Action Plan on Health and Local Agenda 21. The group offers the potential to develop as an umbrella body – overseeing multiagency alliances and facilitating cooperation between settings.

REFLECTIONS ON THE PROJECT

Both achievements and shortcomings can 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.

Communicating and managing integrative health promotion

A danger of any new project within an institution (even if it carries an organizational development label) 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. As indicated above, the Central Lancashire Project has had reasonable success in developing an integrative rather than an additive approach – and in particular, the corporate health policy, the baseline health review and the incorporation of the Project's philosophy into the University plan all provide a firm basis for future organizational development. Nevertheless, the frequent pressure to delineate the project and to achieve specific types of high-visibility demonstrable outcome indicate the difficulty of communicating and developing a clear understanding of the settings-based approach.

Establishing a project team with dedicated time and resources

Although the settings-based approach is concerned with integrative organizational development, the early stages of any project require the dedication of specific resources to enable it to get up and running and to develop. The success of any project thus depends in part on establishing a project team with time and resources at its disposal. At Central Lancashire, the project owes much of its success to the commitment, support, enthusiasm and understanding of both Steering Group and working group members. However, a continuing tension has been that, in most cases, individuals had to incorporate the project within their existing job – and in few cases was dedicated time made available. Consequently, limited progress was made in certain areas, not because of lack of enthusiasm or commitment on behalf of key staff but because no senior management decision was taken to give priority to and allocate time to the work. A further problem concerned lack of administrative support – exacerbated by the project's base and the culture of academic departments (see below).

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 – with its focus on long-term organizational development and cultural change and its practical implementation – and necessary short-term opportunistic initiatives that could show high-visibility tangible outcome to argue for longer-term funding. Unrealistic expectations served to enhance this tension. Similarly, pragmatism demanded that the project find entry points people could grasp – often resulting in a focus on specific issues rather than on the setting as a whole. Whether this matrix approach strengthens or compromises a commitment to settings-based work is open to debate.

Communication and power within organizations

The flow of communication and the exercise of power are fundamental determinants and reflectors of organizational culture. In retrospect, it would have been valuable to have paid more attention early on to un-

derstanding the University's communication and power structures. For instance, circulating minutes of meetings to senior management "for information" does not mean that the minutes are necessarily read; having representation on the Steering Group from particular levels or from particular services or departments within the University does not automatically achieve a comprehensive two-way flow of information; and establishing a Project Steering Group with representation from senior management does not mean that its decisions cannot be vetoed or overturned! Nevertheless, organizational development inherently involves discovering, learning, challenging and finding new ways to move forward, and the Project has demonstrated both resilience and adaptability.

Choice and handling of focus issues

In consequence, 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 conflict arising from differences in values and priorities.

Developing the University's role in the wider community

Most work during the initial phase has been internally focused to demonstrate tangible outcome. However, the Project has acknowledged its role in promoting health within the wider community, recognizing that *(6)*:

> Universities are not discrete entities...[they are] embedded in many different types of "community": some local, some global; some overlapping and interacting, some barely recognizing each other. In this sense the university is an essential part of local, national and global society, and forms part of how we define our society.

The Project has already identified a number of potential ways in which this role could be developed:

- building alliances and partnerships at the local, regional, national and international levels (which has already begun through the

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> Multi-Agency Steering Group, inter-university networking and the WHO Multi-city Action Plan on Health and Local Agenda 21);

- offering resources to the local community – academic, social and cultural;

- advocating and mediating for public health; and

- examining the University's institutional practices (such as purchasing, financial management and physical development) with a view to ensuring that they minimize negative health and sustainability effects on the wider community and, when possible, are ethical and socially, culturally, economically and environmentally supportive.

Project base and job description

A final reflection concerns the base and remit of the project coordinator. Being located within an academic department rather than a service area had the important advantages of ensuring that the project was rooted in established theory and of adding academic legitimacy. Nevertheless, it has also meant that no dedicated administrative support has been made available and has resulted in some confusion as to the job remit – in particular as to whether it was primarily research or project coordination. In retrospect, a clearer focus might have enabled more defined progress to be made.

THE FUTURE: CONSTRAINTS AND OPPORTUNITIES

The Project's first phase is now complete, and a comprehensive progress and evaluation report has been produced *(7)*. This suggests that the Health Promoting University Project has been largely successful in achieving its objectives and that its structures, processes and immediate communication mechanisms have worked effectively and efficiently. The Project itself has evolved as it has developed a conceptual framework, established an organizational structure and implemented a wide range of initiatives. This has resulted in a gradual deepening of understanding concerning the Project's values and ethos and an in-

creased clarity of purpose concerning the roles of Steering Group and working group members. It has also been accompanied by a growing recognition of the Project's potential to increase the wellbeing of staff, students and the wider community, and more broadly to add value to the University in terms of overall distinctiveness, performance and productivity.

In July 1997, the University agreed to fund a second phase of the Project for an indefinite period, appointing the Project Coordinator on a permanent basis (with 50% of his time dedicated to project management and 50% available for related research and teaching).

It was agreed that the following dimensions should be given priority within the context of the WHO European Health Promoting Universities project:

- further developing and consolidating existing priority areas;

- developing flagship initiatives that reflect the principles and values of the University Project;

- integrating the agendas for health and sustainable development;

- adopting additional priority areas;

- establishing health as a central criterion in policy review and development;

- giving priority to mediation and advocacy for health;

- implementing appropriate management training related to the University Project;

- development of a communication strategy for the University Project; and

- auditing and academic development in curricula and research.

The University is now in a strong position to build on the foundations laid during the first phase and to ensure that the long-term vision of a health-promoting university can be realized.

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Strategic framework for the Health Promoting Universities project

Agis D. Tsouros, Gina Dowding
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This chapter provides a framework for the strategic development of health-promoting university projects.

This framework for the health-promoting university has drawn on a number of sources:

- the strategic expertise developed by the WHO Healthy Cities Project Office in implementing settings-based projects;

- the experience of those involved in the European Health Promoting Hospitals Network, the European Network of Health Promoting Schools, the Regions for Health Network and the WHO Healthy Prisons Network.

- The experience of health-promoting university projects, in particular those at Lancaster University and the University of Central Lancashire in the United Kingdom.

- The ideas and papers presented at the First International Conference on Health Promoting Universities held in Lancaster in 1996 in collaboration with WHO.

- The WHO international consultation and technical meeting on health-promoting universities held in July 1997. An unpublished background working document entitled *Strategic development of health promoting universities* was prepared for the meeting as well as a report after the meeting *(1)*. This chapter and the following chapter represent revised versions of the original background working document.

WHY UNIVERSITIES? THE POTENTIAL OF UNIVERSITIES TO PROMOTE HEALTH

According to a 1995 survey by the Association of European Universities, which has members from 39 countries in Europe, there are more than 720 universities and equivalent institutions in Europe.

Many universities have been concerned about promoting student health for a long time. The settings-based approach to health promotion has the potential to enhance the contribution of universities to improving the health of populations and to add value in the following ways.

- Universities are large institutions where many people live and experience different aspects of their lives: people learn, work, socialize and enjoy their leisure time, and in some cases people make use of a wide range of services such as accommodation, catering and transport. Universities therefore have an enormous potential to protect the health and promote the wellbeing of students, staff (academic and non-academic) and the wider community through their policies and practices.

- Universities have a large throughput of students who are or will become professionals and policy-makers in their own right with the potential to influence the conditions affecting the health of others. By developing both curricula and research, universities can increase the understanding of and commitment to health of a vast number of skilled and educated individuals in a wide range of disciplines.

- As major players within the community, universities have an opportunity to set an example of good practice in relation to health promotion and to use their influence to benefit the health of the community at the local, national and international levels.

Universities can therefore potentially contribute to health gain in three distinct areas:

- creating healthy working, learning and living environments for students and staff;

- increasing the profile of health, health promotion and public health issues in teaching and research; and

- developing alliances for health promotion and outreach into the community.

Health-promoting universities strive towards excellence in teaching and research and make a commitment to promoting health and sustainability.

WHY SHOULD UNIVERSITIES GET INVOLVED?

Universities that become involved in health-promoting university projects may obtain several benefits, including improving their public image, the profile of the university, the welfare of students and staff and working and living conditions.

Public image

Environmental and health standards are becoming more highly valued as the twenty-first century approaches.

The profile of the university

A project raises the profile of a university in all health matters locally, regionally, nationally and internationally.

The welfare of students and staff

A project identifies the strengths and weaknesses of the organization in staff and student welfare and improves the opportunities for both students and staff to improve their health.

Working and living conditions

A project improves the environments in which people work and study, live and socialize.

AN UMBRELLA FOR HEALTH-RELATED ACTIVITIES

A health-promoting university project brings together existing initiatives for the wellbeing and health of students and staff, motivating and stimulating greater participation and coordination.

In academic terms, a project integrates a diverse institution: raising the profile of health and health promotion in many academic disciplines; increasing the credibility of an innovative research agenda; and supporting a shift in research focus from health care to primary health care, prevention and positive health.

A greater link between research and practice

A project links research and practical work in the university. A project enables health research to be given more credibility.

Increased opportunities for collaboration

A project offers wider opportunities for the university to link more closely with the community. It emphasizes a collaborative research agenda and opportunities to share new knowledge, practical experience and solutions to health by expanding networks.

Corporate responsibility for health

A health-promoting university project removes the focus from health professionals to senior management and thus requires corporate responsibility, providing goals towards which the university can work. All these factors may have positive effects and create benefits in kind for the university:

- enhancing the morale of those working in universities;

- maintaining a healthy and productive work force, reducing staff absenteeism and encouraging studfents and staff to be fit to perform their duties optimally;

- boosting student and staff recruitment;

- reducing employment costs;

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- reducing student dropout;

- improving academic performance – healthier students are better learners;

- increasing effectiveness; and

- creating a competitive advantage and a better reputation for the university.

THE AIMS

The aims of the Health Promoting Universities project are based on the philosophy and principles of the WHO strategy for health for all (2), the Ottawa Charter for Health Promotion (3) and local Agenda 21 (4,5). In particular, the principles of health development, equity, sustainability and solidarity represent the pillars of the health-promoting university, and these are underpinned by intersectoral and interdisciplinary cooperation and mechanisms for participation and empowerment.

The main challenge and goal of the health-promoting university is to integrate health into the culture, structures and processes of the university. The health-promoting university aims:

- to create healthy working, learning and living environments for students and academic and non-academic staff;

- to increase the health promotion aspects of teaching and research; and

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

THE OBJECTIVES

The key objectives of the health-promoting university are to promote healthy and sustainable policies and planning throughout the university, to provide healthy working environments, to offer healthy and supportive social environments, to establish and improve primary health care, to facilitate personal and social development, to ensure a healthy and sustain-

able physical environment, to encourage wider academic interest and developments in health promotion and to develop links with the community:

Promoting healthy and sustainable policies and planning throughout the university

Universities exercise substantial autonomy over the design and implementation of their policies and practices. The health-promoting university incorporates health and sustainability as key criteria in planning and policy decisions.

Providing healthy working environments

Universities are major employers, employing a wide range of levels of professional, administrative and manual staff in a wide variety of disciplines. The health-promoting university seeks to create working and learning conditions conducive to health and to adopt good practice in employment policy.

Offering healthy and supportive social environments

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

Establishing and improving primary health care

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

Facilitating personal and social development

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

Ensuring a healthy and sustainable physical environment

Universities manage large estates of built and landscaped environments. The health-promoting university – through its policies on building, landscaping, transport, waste management, purchasing and energy – seeks to create and maintain healthy and sustainable physical environments.

Encouraging wider academic interest and developments in health promotion

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

Developing links with the community

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

TARGET GROUPS

The objectives encompass all members of the university and its local community. Nevertheless, action programmes may target particular groups:

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- students or identified target groups of students
- staff or identified target groups of staff
- the local community or target populations of the community.

THE QUALITIES OF THE HEALTH-PROMOTING UNIVERSITY

Promoting the merits of the Health Promoting Universities project to laypeople and also to university executives, students and staff who are not familiar with modern approaches to health promotion is often challenging. As in the Healthy Cities project, it is generally useful to describe any given healthy (health-promoting) setting in terms of a set of qualities rather than just principles and strategies. A health-promoting university should strive to manifest characteristics that reflect its commitment and investment in health. These characteristics or qualities are the practical and successful achievement of the objectives and should be visible and evident to students, staff and the community. A health-promoting university should:

- demonstrate a clear commitment to health, sustainability and equity in its mission statement and policies and also equal opportunities in all spheres of university activity;

- offer clean, safe and health-conducive physical environments and sustainable practices that minimize the health and environmental impact of the university at the local, regional and global levels;

- provide high-quality welfare, medical and health-related support services that are sensitive to the needs of all students and staff;

- provide opportunities for everyone in the university to develop healthy and useful personal and life skills, including responsible global citizenship;

- make available social, leisure, sports and cultural facilities that reflect the diverse composition of the student population and offer healthy choices at every opportunity;

- promote a high level of participation by students and staff in the decisions that affect their learning, working and social experiences;

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- encourage interest in and incentives for promoting health in curriculum development and research across disciplines and departments;

- create mechanisms that facilitate effective listening and communication horizontally and vertically throughout the university, between students and staff, among the students and among the staff; and

- comprise a resource of valuable skills and expertise for the local community and be a willing partner in developing health.

This list represents a framework. Each university can develop lists of qualities and indicators to market and monitor the progress of its own project. Further, a health-promoting university is not one that has achieved a particular level of health; it is one that is conscious of health and striving to improve it.

THE PROCESSES

The experience of other WHO projects has confirmed that organizational development requires time, energy, commitment and skills. The process involves four elements *(6,7)*:

- generating visibility – increasing the profile and understanding of health issues;

- securing commitment by senior-level management – placing health and sustainability high on the agenda of decision-makers and securing their commitment;

- 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

- 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.

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The framework in Table 2 stratifies the key objectives against the four elements of the process. This framework could help to identify and develop the main strategic orientations of a project in the context of the local circumstances.

PROJECT MANAGEMENT AND COORDINATION

Effective leadership and good project management are essential. Projects are an important means of achieving change and tools for dealing with uncertainty and building alliances *(7,9–11)*.

Health-promoting universities should establish internal structures to develop and implement the project, including:

- a project steering group;

- a project coordinator; and

- a clearly defined role for health-related support services and other potential stakeholders.

Table 2. Setting objectives with reference to the four process stages

Objectives	Process			
	Generating visibility and promoting understanding of health issues	Commitment from senior-level management through to the entire university	Institutional and cultural changes (that is, organizational development)	Innovative action for health promotion and sustainability
Healthy and sustainable policies				
Healthy working environments				
Healthy and supportive social environments				

Improved primary health care				
Personal and social development				
Healthy and sustainable physical environments				
Research and training focus on health				
Developing community links				

Source: adapted from Tsouros *(8).*

The steering group

A steering group should be established to provide legitimacy and leadership for the project within the university.

Terms of reference

The steering group should be responsible for providing the leadership, vision and drive needed to take the project forward. The steering group may allocate certain tasks to various working groups but should retain overall responsibility for directing and implementing the project.

Membership and representation

The steering group should have representatives from both students and staff (academic and non-academic). It should involve:

- the top decision-makers of the university, including representatives of the key executive committees of the university;

- representatives from a range of functions and sections of the university whose activities influence health;

- representatives of those whose health is affected by the decisions made in the university;

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- specialists or experts in key areas to be tackled: for example, specialists in health promotion or public health;

- representatives of the local community; and

- representatives of other stakeholder agencies such as the local health care services, health-related support services, religious and spiritual leaders and the local business community.

Accountability

The steering group should be integrated with and linked, where appropriate, to other senior executive committees of the university.

Working groups and task forces

Subgroups may be set up for leading specific programme areas and for carrying out specific pieces of work and should report back to the steering group.

Administrative support

Adequate administrative support should be provided to enable the steering and working groups to run efficiently and effectively.

The project coordinator

A project coordinator should be appointed or nominated as a visible symbol of the university's commitment to the project and should be responsible for advising the steering group and managing and coordinating the overall project.

Profile

The project coordinator should preferably be full time, especially in the start-up period, and in any case no less than 50% full-time equivalent. It is advisable that the project coordinator have a background in social, health or environmental sciences with experience and expertise in public health or health promotion based on the principles of health for all. Due consideration should be given to the profile of the project coordinator within the university.

Organizational base

The project's base should be clearly located in the university. The project may be based within administration or within an academic department. In any case, the remit of the project should span across both areas and have clear links established to both. The resources for the project may stem from a variety of sources. Whatever the source of funding, the project must be based in the university.

Responsibilities

The project coordinator's main responsibilities should include:

- managing and coordinating the action undertaken by the project;

- advising the steering group on best practice in health promotion;

- facilitating high visibility of the project;

- maintaining links with networks of health-promoting universities; and

- communicating and disseminating the outcome of the project internally and externally.

The role of primary health care and support services and other key stakeholder agencies

The primary health care services (both internal and external) have a crucial role in supporting the project. Their roles may include:

- providing information for reviews of the health status of the student population;

- supporting and contributing to assessing the health needs of the students, staff and local communities;

- becoming key partners in project implementation; and

- participating in evaluating the project.

OUTCOMES OF HEALTH-PROMOTING UNIVERSITY PROJECTS

Health-promoting university projects must be able to provide demonstrable evidence of the outcome of their efforts.

The success of health-promoting university projects would ideally be measured by the extent to which they have:

- improved the health of students, staff and the wider community; and

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

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

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

PROCESS OUTPUT

The process of the project can be demonstrated through output relating to:

- adopting the underlying philosophy and values;

- achieving a higher profile for health;

- securing management commitment;

- achieving structural changes;

- taking an active role in networking, for example, with other universities.

Examples of process output are demonstrated in Table 3.

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Table 3. Examples of output reflecting the process of projects

Evidence of:	Demonstrable through output such as:
Adoption of the underlying philosophy and values	• The steering group membership reflects the range of stakeholders in the project • Equity is a guiding principle in selecting priorities for action
High profile of health	• Media coverage (internally and externally) • Newsletters • Annual reports • The university has a published health profile
Management commitment to the project	• University policy and mission statements • Resources are reallocated to the project • Health needs are assessed • An exercise to develop a shared vision of the health-promoting university • Agreed evaluation strategies and protocols
Structural changes	• New organizational structures • Relevant staff development (courses and training) • Alliances for health with external agencies
Networking	• Journal and newsletter articles and publications • Contributing to fund-raising for networking • Cooperation with other universities at the regional, national and international levels • Participation in the meetings and conferences of national and international networks

IMPACT OUTPUT

The impact of the project can be demonstrated through output in the eight objectives, taking account of any priorities or targets set in first phase of the project (Table 4).

Finally, time and special effort should be invested in the process of starting a project. Preparing the basis for acceptance and support within the university before launching a project on a large scale is essential. *Twenty steps for developing a healthy cities project (7)* provides several useful tips that can easily be applied to health-promoting university projects.

Table 4. Examples of output reflecting the impact of projects

Evidence of:	Demonstrable through output such as:
Healthy and sustainable policies and planning throughout the university	• Corporate health policy and strategy are developed • Healthy policies and strategies are adopted in key policy areas such as transport, mental health, recruitment, smoking and equal opportunities
Healthy working environments	• Healthy working practices such as health and safety regulations are implemented • New communication strategies, including consulting staff on changes to structures
Healthy and supportive social environments	• New facilities or increased access to facilities for relaxation, fitness, the arts, catering etc.
Improvement in primary health care	• Interdepartmental and interagency networking on key issues such as sexual health and mental health • Changing key services, making them more accessible and user-friendly
Improved opportunities for personal and social development	• An increase in the number of appropriate courses offered to staff and students
Healthy and sustainable physical environments	• Incentives for travelling via public transport, cycling and walking • Changing university purchasing to more ethical and environmental products and more local services • Comprehensive scheme to minimize waste and promote recycling
Wider academic interest and developments in health promotion	• Interdepartmental projects for health promotion involving, for example: arts, geography and management studies departments
Better links with the community	• Initiatives for health involving partnership with the community

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A framework for action by a European Network of Health Promoting Universities

Agis D. Tsouros & Gina Dowding

This chapter describes a framework for action by a European Network of Health Promoting Universities and the terms of engagement of universities committed to implementing the Health Promoting Universities project. The framework is based on the experience of existing health-promoting university projects and on expertise developed by the WHO Healthy Cities Project Office. The chapter discusses the strategy, operation and support attributes of the European Network of Health Promoting Universities and the standards and criteria for membership of and participation in the European Network.

The European Network could be established either as an independent new settings network or as part of a broader umbrella system such as the Healthy Cities project. The multi-city action plan framework[7] would be very suitable for a broader umbrella system, especially in the initial development of the European Network. A similar approach was used for launching and developing the Health Promoting Hospitals project.

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[7] Multi-city action plans are an important working tool of the WHO Healthy Cities project. They bring together groups of cities with common concerns to take action to implement parts of the strategy for health for all and to produce expertise for other cities. An important aspect of multi-city action plans is that the participating city needs to have a full commitment to the goals of the Healthy Cities project.

AIM OF THE EUROPEAN NETWORK

The European Network aims to put health high on the agenda of universities throughout Europe, by promoting and facilitating:

- commitment and active engagement;
- innovation and partnership-building;
- exchange of information and sharing of experiences; and
- capacity-building.

PARTICIPATION IN THE EUROPEAN NETWORK

The European Network will consist of a limited number of designated universities that are fully committed to implementing the project for five years.

The development of complementary networks at the national and international levels may also be encouraged. These will be for universities that are interested but not necessarily fully committed to implementing all aspects of the project.

ACCESS TO THE EUROPEAN NETWORK

We recommend a quota system of universities for each European country to encourage broad geographical and political representation in the European Network. The total number of designated health-promoting universities is expected to grow from a handful to around 25 in the first phase.

Criteria for membership

Universities will be invited to become partners in the European Network subject to a set of criteria for membership as outlined later. Those meeting the criteria will be designated as health-promoting universities.

We recommend that a lower level of commitment be required for membership of national or subnational networks through a set of

minimum criteria based on a similar format to the criteria for the European Network.

Nature of the European Network

In some of the other networks of health promotion settings, such as Health Promoting Schools, organizations are linked to the network via a national agency. In the European Network of Health Promoting Universities, designated universities will participate directly in the European Network and in national or subnational networks.

LINKS BETWEEN THE EUROPEAN NETWORK AND NATIONAL AND SUBNATIONAL NETWORKS

In the first phase, the designated universities will be expected to:

- lead in creating national or subnational networks;
- provide a link between the European Network and national or subnational networks; and
- assist in identifying support centres for national or subnational networks.

When more than one university is designated to participate in the European Network in one country, they will be expected to agree on a framework for sharing these responsibilities.

AUDITING NETWORK MEMBERS

The WHO Regional Office for Europe or a qualified WHO collaborating centre will assess the initial applications for membership and will designate universities as members of the European Network. The work of European Network members will be evaluated at appropriate intervals by a combination of external and peer auditing mechanisms.

SUPPORT FOR THE EUROPEAN NETWORK

The European Network will function via business meetings and conferences, communication and information exchange means, which will require developmental support through various mechanisms and systems. The available options depend on the availability of resources and the interest and offers by institutions willing to play a supportive role. The resources needed depend on the size and the intensity of the European Network. The experience of the Healthy Cities project demonstrates that an independent network would require more resources than a multi-university action plan network, which would tend to be more low key and mainly rely on the administrative support of a member university on a rotating basis.

THE ROLE OF WHO

The project is an integral part of the WHO Urban Health/Healthy Cities programme. WHO will seek to:

- identify core funding for the Health Promoting Universities project;

- provide leadership, political and strategic support;

- coordinate and technically support the development of the project and the coordination of the European Network or delegate this to an interested institution or WHO collaborating centre; and

- make links with the European Union, national governments and nongovernmental organizations.

THE ROLE OF A SUPPORT STRUCTURE FOR HEALTH-PROMOTING UNIVERSITIES

The aim of a support structure for health-promoting universities will be to assist in further developing the concept of the health-promoting university and in managing the European Network. The main functions of such a structure should be networking, administrative support, technical support and reporting and ensuring accountability.

Networking

- Assisting WHO in coordinating, administering and managing the European Network

- Being responsible for an electronic database of health-promoting universities and facilitating access to information on the database

- Keeping network and associated partners informed of the events and activities of the Health Promoting Universities movement

- Publishing a newsletter for all designated universities and national and subnational network coordinators

- Compiling progress reports for business and technical meetings

- Acting as a focal point for queries about the European Network

Administrative support

- Acting as a secretariat and providing administrative support to the European Network

- Assisting WHO in preparing conferences and business meetings for the European Network and ensuring satisfactory arrangements for meetings

- Collating, preparing and distributing reports, guidelines and examples of good practice

- Identifying funding opportunities and coordinating the preparation of bids

Technical support

- Providing technical support, in collaboration with WHO, for designated universities

- Assisting in organizing the assessment of applications from universities interested in becoming designated

- Assisting in developing tools for health-promoting universities

- Seeking funding opportunities for research and evaluation as appropriate

Reporting and accountability

The support structure will be designated by and report to WHO. If the European Network is run as a multi-university action plan, the support role of the coordinating university will be mainly administrative, including maintaining the database of the European Network members.

SUPPORT FOR NATIONAL AND SUBNATIONAL NETWORKS

National and subnational networks of health-promoting universities will encourage commitment to the philosophy, aims and goals of the European Network. They should be supported by national or subnational support structures.

The national or subnational support centres will aim to provide coordination and support for all universities committed to developing health-promoting university projects. The main functions will be networking, administrative support and technical support.

Networking

- Facilitating coordination between member universities

- Establishing or building on existing electronic national or subnational databases on member health-promoting universities and linking with other relevant databases

- Acting as the focal point between WHO and the national or subnational network members

- Being the contact point for new members wishing to join the network

- Producing a newsletter

- Assisting in organizing an annual standing conference

- Assisting in developing regional networks where appropriate

- Disseminating information to the regional networks (if appropriate)

- Publishing summaries of developments in professional journals

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Administrative support

- Acting as a secretariat and a documentation centre for the national or subnational network

- Organizing national business meetings of the network

- Raising funds for the network

- Preparing an annual report

- Assisting in organizing the assessment of applications from potential new members

Technical support

- Providing technical support

- Providing training and education workshops

- Documenting and coordinating national research and assessment of outcome

- Developing tools for health-promoting universities, such as evaluated protocols

- Preparing guidelines for implementation and lists of relevant resources

- Providing advice and guidance on evaluating health-promoting university initiatives

STANDARDS FOR THE HEALTH-PROMOTING UNIVERSITY: CRITERIA FOR MEMBERSHIP OF THE EUROPEAN NETWORK

Universities applying to become designated universities in the European Network will be required to make a commitment to:

- become involved in a process of change for health for five years; and

- network with WHO and other designated universities during that time.

Designated universities will be required to demonstrate that they are committed to the philosophy, aims and objectives of the project, have an organizational structure to implement a project, are committed to implementation and are committed to networking.

Commitment to the philosophy, aims and objectives

The chief executive officer of the university should prepare a policy statement that is ratified by the university senate or equivalent body.

Organizational structure for a health-promoting university project

The university must have a clear internal project structure based on interdisciplinary and interdepartmental collaboration to implement the goals of the project.

A steering group should be designated whose core membership involves:

- key decision-makers and senior managers in the university;

- student and staff representatives;

- representatives of the local community and other stakeholder agencies.

A project coordinator should be appointed to coordinate the project. This post should be at least half time with appropriate support and a clearly defined base and job description. The role of health and health-related support services in the project should be clear. Resources should be reallocated to the project or new resources should be identified. Mechanisms should be established to ensure that the project is accountable to the university community.

Commitment to implementation

The university must be able to demonstrate plans to implement the goals, products and organizational changes required by the project, including:

- developing and adopting a health development and sus-tainability policy, strategy and implementation plan for the entire university;

- assessing the health needs of the university, especially emphasizing the needs of disadvantaged groups and ethnic minorities and preparing a university health profile;

- formulating and implementing several clearly defined interventions in health promotion and sustainability; and

- designing and implementing an evaluation strategy that runs parallel with the project.

Commitment to networking

The university must be committed to:

- participating in the project business meetings and conferences and hosting these events in turn;

- investing in formal and informal partnerships and cooperation for health at the local, national and international levels;

- assisting in developing national or subnational networks; and

- reporting back regularly to WHO and the European Network and actively sharing information and experience with other universities in the European Network.

EXAMPLE OF A TIMETABLE FOR A HEALTH-PROMOTING UNIVERSITY

A health-promoting university project should prepare a timetable for action for the first five years of the project. The following is an example of such a timetable. In the first year, the project should:

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- create an established infrastructure to implement the goals of the health-promoting university;

- adopt an internal policy statement of the aims and objectives of the health-promoting university project and widely publicize it internally and externally;

- assess the health needs of the university population, especially emphasizing the needs of disadvantaged groups; publish a health profile of the university (and a new profile every two years), based on a consensus of indicators that reflect the health of the university; and

- establish an evaluation framework and identify an evaluating body

During years two to five, the project should:

- adopt a comprehensive health and sustainability policy and strategy for action;

- review and reform existing health promotion activity;

- design and implement several clearly defined interventions that clearly address the objectives of the health-promoting university project;

- publish annual reports on the progress of the health-promoting university project.

Glossary of terms related to higher education and the health care system in the United Kingdom

Further and higher education in the United Kingdom
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.

All higher education colleges and universities offer degree-level courses. Some also offer postgraduate courses and vocational courses and some also offer courses below degree level. Higher education institutions may also operate research programmes.

General Medical Council
The General Medical Council is the statutory, self-regulatory, licensing body for the medical profession in the United Kingdom, as laid down by the Medical Act of 1858. The Education Committee of the General Medical Council produces recommendations on undergraduate medical education approximately every 10–12 years; the most recent ones are from 1993.

The health of the nation
The health of the nation was the strategy of the Government for health in England, published in 1992. The strategy established targets in five key areas: mental health, coronary heart disease and stroke, sexual health, accidents and cancer, and laid out the foundations for achieving these targets. The strategy endorsed the concept of settings for health promotion and recognized that achieving health in England requires coordinated action by a wide range of sectors and not the health service alone. (This strategy has since been replaced by *Our healthier nation*; see below.)

Healthy alliances

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 and lasting changes to improve the health of communities. The concept was given added impetus in the United Kingdom as a result of The health of the nation in 1992, which stressed the importance of bringing together many different sectors in the quest for improved public health.

NHS Executive North West

This is the Regional Office of the National Health Service (NHS) Executive for the North West of England.

NHS trusts

NHS trusts are self-governing bodies providing health care services, either in the community, in hospitals or in both.

Our healthier nation

Our healthier nation is the current Government health strategy for England, which replaced *The health of the nation* (see above) in early 1998. The strategy builds on the key target areas highlighted in *The health of the nation*, while giving more emphasis to reducing inequality in health. *Our healthier nation* reiterates the need for developing health-promoting settings, especially healthy schools, healthy workplaces and healthy neighbourhoods, and strengthens the call for building intersectoral partnerships for health.

Primary care

In the United Kingdom, primary care is usually defined as the first point of contact between health services and patients, in the form of general services provided within the community. Primary care includes general practice, community nursing, pharmacists and dentistry.

Regional health authorities

Until 1996, the regional health authorities in England and Wales were allocated resources by the Department of Health (Ministry of Health) to provide health care within their region. The regional health authorities

were responsible for allocating resources for health care to the more local district health authorities and family health service authorities. In 1996 this middle tier was abolished, and the Department of Health now allocates resources directly to the local health authorities. The local health authorities are responsible for commissioning (purchasing) health care services from NHS Trusts. The much reduced regional tier of the health service (now called regional offices of the NHS Executive) were then given a new role (see below).

Regional offices of the NHS Executive

After the regional health authorities and their responsibilities for allocating resources were abolished in 1996, the new regional offices of the NHS Executive were then made responsible for managing the performance and standards of the local health authorities and NHS trusts.

Universities

The Association of European Universities has defined universities or equivalent institutions of higher education as those that:

- are equipped to provide teaching and research in several disciplines;

- admit students who have successfully completed secondary school or passed an equivalent entrance or competitive examination;

- award, of their own authority, academic degrees in the disciplines taught, and in particular, doctorates or their equivalent;

- enjoy autonomy, including the right, through their members at least, to participate in the appointment of teaching staff and the appointment of executive bodies; and

- have proved their viability by reaching a critical mass, generally over a number of years.

The Health Promoting Universities project has adopted this defi-nition for Europe.

Vice-chancellors and pro-vice-chancellors
In universities in England and Wales, the vice-chancellor is the chief executive of the university or, more specifically, the chief academic and administrative officer. In Scotland this role is fulfilled by the rector.

Universities often have more than one pro-vice-chancellor, who assist the vice-chancellor. They are drawn from among the professors and selected by the council or governing body of the university for a specified period of time.

Contributors

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John Ashton is Regional Director of Public Health for the North West of England and Professor of Public Health Policy and Strategy at the University of Liverpool. He was a member of the initial planning group WHO convened in 1986 to develop the concept of the Healthy Cities project.

Alan Beattie has worked in public health in the National Health Service throughout the United Kingdom, in family planning throughout Europe for the International Planned Parenthood Federation and in primary health care in developing countries for the Overseas Development Administration. He helped to introduce new courses in health sciences and health promotion at London University. In 1989 he joined Lancaster University, and in 1993 he moved to St Martin's College as Head of Health Studies and Human Sciences, becoming Professor of Health Promotion there in 1995.

Mark Dooris works at the University of Central Lancashire, where he coordinates the Health Promoting University initiative, lectures and researches in health promotion and sustainable development. He has previously worked in health authorities and local government – as a health

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Gina Dowding has worked as a health promotion specialist for the National Health Service since 1990, following a background in management science and development work in the voluntary sector. Until recently she was one of the coordinators of the Health Promoting University Project at Lancaster University. She continues to work with WHO and others in developing the Health Promoting Universities project in Europe.

Tony Gatrell is Director of the Institute for Health Research and Professor of the Geography of Health at Lancaster University. His research interests are applying geographical information systems and spatial analysis in health as well as health inequality. He is also working actively to develop and promote the research and development agenda within the National Health Service in the north-west.

Gillian Maudsley is a Senior Lecturer in Public Health Medicine in the Department of Public Health at the University of Liverpool. She has been extensively involved in many aspects of the problem-based undergraduate medical curriculum introduced in 1996, including public health education, student assessment and writing computer-based learning materials. Her research interests include undergraduate medical education and, as a problem-based learning tutor, she has researched the tutor's role.

Camilla Peterken was Health Promotion Adviser to the University of Portsmouth. She now works as a freelance health promotion specialist.

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Sheffield Health Authority in the early days of the Healthy Sheffield initiative.

Jane Thompson has a long-standing interest in health promotion and has worked in specialist health promotion units and within further and higher education. Until recently she was joint coordinator of the Health Promoting University Project at Lancaster University.

Peter Toyne is the Vice-Chancellor of Liverpool John Moores University. At the national level he is well known for his pioneering work on credit transfer systems and access to higher education as well as his work on environmental education. Two government reports bear his name: the first, in 1989, is generally regarded as the foundation of credit transfer development in the United Kingdom; the second, in 1993, initiated national debate on the need for greater environmental education.

Agis D. Tsouros is Head of the WHO Centre for Urban Health and Coordinator of the WHO Healthy Cities project. He is also responsible for the Public Health Functions and Infrastructures Programme at the WHO Regional Office for Europe. He is Special Professor of Public Health at the University of Nottingham.

Martin White graduated in Medicine at Birmingham University before training in public health medicine. He is now Senior Lecturer in Public Health at Newcastle University, where he directs the Health Promotion Research Group. His main interests include evaluating the effectiveness of health promotion and inequality in health. He has directed the development of the Newcastle Healthy Medical School Project since 1992.

Cathy Wynne is District Health Promotion Officer at Morecambe Bay Health Authority. With a background in teaching and in research in the sociology of science, she has worked in specialist health promotion since 1988. She has a special interest in developing the settings approach to health promotion. She negotiated setting up the pilot Health Promoting University Project at Lancaster University and has been involved in similar work with a young offenders' prison.