



Targeting HIV: Higher Education, Student Health and Stakeholder Theory

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Abstract

This paper focuses on the interplay between behavioral risk factors, social and demographic indicators, age, and restricted access to health care education and services. According to the 2020 Sexually Transmitted Disease Surveillance Report by the Centers for Disease Control and Prevention (CDC), sexually transmitted infections (STIs) and sexually transmitted diseases (STDs) remain among the most pressing global health challenges.

The compilation of these data points juxtaposed the age of higher infection (youth ages 14 - 24) focuses on sexual health services and education as a priority for student wellness [1]. In previous writing, Williams'[2] research suggests that successful aspects of sexual health education for today's students should include: required wellness programming, well-rounded topics that are on the continuum of wellness (to include sexual health education), current in delivery and information, and culturally competent messaging. As more first-generation students enter higher education institutions, prioritizing sexual health services and education within broader wellness programs for college students will enhance lifelong outcomes.

Key Words: Public Health, STI's, College Students, Wellness, Sexual Awareness and Health Education, Comprehensive Relationship Education

The Development of Student Wellness

Dr. Halbert Dunn introduced the concept of wellness in 1950, defining it as a blend of well-being and physical fitness (sourced from the History of Wellness). Approximately two decades passed before research on wellness began to develop [3]. The modern definition of wellness is described as "the maximum functioning of an individual that integrates the mind, body, and spirit as opposed to measuring the individual components of functioning" [4]. However, early studies in this field focused primarily on college student behavior, particularly regarding alcohol consumption [3].

In a different direction during this time, the United Kingdom focused on issues related to mental health [3]. To date, the UK and the USA are the largest producers of research and services in wellness with China arriving on this platform several decades later [3]. A summary

of research in wellness mostly focuses on college students and general health. This can be attributed to the number and availability of students. According to Sweeting et al. [3], mental health and nutrition are among the leading areas of focus in wellness research, followed by substance use—particularly alcohol consumption—and, more recently, limited topics related to sexual behavior. Much of this research emphasizes gathering information about student behaviors, with less attention given to strategies for altering or addressing these actions. Sweeting's [3] scoping review of wellness literature underscores the interconnected nature of holistic wellness, highlighting its critical ties to mental health, substance use, and sexual health as foundational elements for promoting lifelong wellness.

Within the realm of wellness in higher education, the emphasis on fostering overall student well-being is intrinsically connected to academic success, student retention, and on-time graduation [5, 6, 7]. Research consistently highlights that students who engage in wellness programs often experience improved mental health, enhanced academic performance, and greater satisfaction with their college experience [8, 9]. However, despite this well-established link, there remains a notable gap in the literature regarding the specific wellness needs of unique groups of college students [6].

As Watson and Kissinger [5] emphasize, there are "few studies designed to promote the wellness of the college student-athletes" (p. 155) or to evaluate the impact of existing wellness initiatives on this unique population. Student-athletes often face distinct challenges, including the demands of rigorous training schedules, academic responsibilities, and social pressures, which can contribute to heightened stress levels and mental health concerns [10, 11]. Furthermore, while universities may offer general wellness resources, these programs are not always tailored to the specific needs of student-athletes, potentially limiting their effectiveness [12].

To address this gap, researchers suggest the development of targeted wellness interventions that incorporate mental health support, stress management strategies, and academic resources specifically designed for student-athletes [13, 14]. Additionally, further empirical studies are needed to assess the efficacy of these initiatives and to

explore best practices for fostering holistic well-being within athletic populations. By prioritizing the wellness of student-athletes, institutions can contribute to both their personal development and their academic and athletic success [5, 11]. Sweeting et al. [3] summarize the difficulty in developing and determining the efficacy of wellness programs by concluding in their scoping review of this type of research:

Whole institution' approaches to improving health within tertiary education settings have evolved from a handful of agenda-setting aspirational publications in the 1970s to roadmap websites and charters and growing international recognition. However, progress towards a solid and significant research evidence base has been relatively slow. The challenges are enormous, both for institutions aiming to fully, rather than tokenistically implement such interventions and for researchers aiming to evaluate them within a funding and evidence context that is skewed towards trials, short-term outcomes and simple linear models of cause and effect.

The majority of wellness research centers on college students [3], emphasizing the link between different facets of wellness, including significant studies on mental health, substance use, experimentation, misuse, and sexual health among this population.

This research builds upon the focus on the pursuit of wellness throughout the lifespan. Due to the mission of universities and colleges, the connection between degree completion and level of performance (including sports) has been linked to aspects of wellness in this study population [5]. Although some behavioral relationships are studied, Watson and Kissinger [5] highlighted the paucity of research in this area.

Students and Sexual Health: An Integrative Process

In an extensive research review spanning thirty years, Edwards & Coleman [15] examined approximately 2000 abstracts, narrowing their focus to 150 articles that mainly address the construct of sexual health. This scoping review outlines the evolution of the concept of sexual health. The authors highlight that the World Health Organization (WHO) presented the first globally recognized definition in 1975, and the three key principles from this WHO definition continue to be reflected in later interpretations.

In a separate review of sexual health on a global level, Mace, Bannerman, & Burton, [16] summarized three cornerstones of the World Health Organization (WHO) Public Health Papers, No. 57. These three key elements set the stage for the current foundation of freedoms and fundamental definitions of sexual health. In summary, sexual health is having the capacity to enjoy and control sexual and reproductive behavior in relation to societal and personal beliefs while being free from emotional and environmental factors impeding sexual relationships; and, having access to sexual health treatments that will ensure sexual relationships and the capacity to have desired reproduction [16].

In 1987, WHO attempted a revision of sexual health that would be more generic and not focus on individuality – trying to avoid defining sexual health that would be used in a norming process with behavior outside of this revision being deemed abnormal [15]. Lottes [17] further contributed to this perspective by asserting that sexual health is dynamic and process-oriented, rather than fixed and unchanging, challenging the notion of a rigid definition. Lottes [17] stressed that while healthy sexual relationships and reproductive rights are separate, they are both crucial aspects of sexual health, arguing that the absence of abuse, coercion, and discrimination is fundamental for fostering healthy sexual relationships. These core principles are integrated into the WHO's [18] latest definition of sexual health in the following way:

Sexual health is a state of physical, emotional, mental, and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. Retrieved June 11, 2023, from <https://www.who.int/reproductive-health/gender/glossary.html>

Although there is limited research focused on college students and results of sexual health services and education, several scholars highlight that this group faces an increased risk for adverse outcomes, such as higher transmission and infection rates, as well as unintended pregnancies, compared to other demographics [2, 19]. The Centers for Disease Control (CDC) further adds to this position by stating there are multiple barriers college students face in accessing sexual health care – particularly preventative care [20]. Additional research suggests that addressing these barriers produces benefits, as improved sexual health has been linked to more positive psychological outcomes [21]. Additional research has demonstrated a positive link between sexual well-being and various other dimensions of wellness, including physical, mental, emotional, and social health [2, 22]. A commonly proposed strategy of this research is recommending the development of overall wellness education programming to address common health issues with sexual health as a component for young adults [2, 19, 22]. Approximately half the population of young adults (18-24-year-olds) in the US attend a post-secondary school [23]. As this number continues to grow, Williams [2] suggests that university and college systems – by the nature of their design, present a readily accessible platform to provide wellness and sexual health education. The humanistic necessity of this recommendation is further strengthened by the CDC's report on Sexually Transmitted Diseases (STDs) showing a continual rise in infection rates that are disproportionately significant in the under-25 age group [1].

HIV and Young adults

The research and information stemming from HIV and young adults (ages 13-24) has not improved over the decades since its first identification [2]. Dennison, Wu & Ickes [24] in a sentinel piece of research using CDC data and information reaffirm young adults (13–24-year-olds) as having the highest infection rates and lowest STD testing rates. Behavioral attributions correlated with this data are multiple. The significance of this group's HIV infection spread according to Dennison [24] is further exacerbated by the fact that 60% of youth infected are unaware, making the disease spread essentially unpreventable. To combat this untenable situation, post-secondary education systems should provide services such as testing, prevention, and education in sexual health [1, 2, 24].

The focus on HIV and the student is derived from the convergence of several facts isolated in different silos of information. Once these pieces of vital information are combined, the body of facts highlights the urgency of the need to focus on HIV and the student:

Fact One: HIV has no current cure.

Fact Two: Young adults, specifically those aged 13 to 24, experience the highest rates of infection and the lowest rates of STD testing [24].

Fact Three: At least 60% of youth infected are unaware, making the disease spread unpreventable [24].

Fact Four: With treatment, the individual can live a productive life and reduce the spread of HIV infection [25]; and

Fact Five: Men continue to be heavily affected (80% of new cases in 2020) with racial, ethnic, and healthcare disparities driving these disparities [26]

These findings serve as the driving force behind the focus of this article, which examines HIV within the broader context of sexual

health services and education, integrated into a holistic wellness approach for students. The goal is to explore how addressing sexual health, particularly concerning HIV, can be effectively incorporated into overall wellness initiatives that support students' physical, mental, and emotional well-being. By emphasizing the importance of comprehensive sexual health education and services, this article aims to highlight the vital role they play in promoting healthier outcomes for students and ensuring a more well-rounded approach to their wellness.

Brief Background of HIV

The CDC released the first case definition in September 1982, for Human Immunodeficiency Virus (HIV) [25]. This designation came about after clinicians in New York, Los Angeles, and San Francisco began to treat young homosexual men with pneumocystis carina pneumonia (PCP) and Kaposi's sarcoma (KS), both diseases were extremely unusual for young adults who had no known immunosuppressant diseases [27]. In 1981, 26 homosexual men from New York and San Francisco were diagnosed with KS (4 of which also had PCP). Shortly after, a similar disease was recognized in IV-drug users. It was discovered all these individuals shared an immunodeficiency, the trademark of which was a depletion in CD-4 cells. However, though not clinically recognized until 1981, AIDS is suspected to date as far back as the 1960s in the United States [28]. Frozen tissue and serum samples were available from 1968, a 15-year-old African American male from St. Louis who was hospitalized and died from KS [25]. When tested on a Western blot (used to test for HIV) his tissues and serum were positive for HIV-antibodies [28].

Treatment Intervention

Although HIV can be treated there is no cure for the virus. There are more than 1.2 million people in the US living with HIV, and 1 in 8 of them do not know it [28]. Over the last decade, the annual number of new HIV diagnoses declined by 19% with gay and bisexual men, particularly young African American gay and bisexual men, most affected [28]. The numbers of individuals diagnosed continue to increase even though awareness and preventative methods have increased as well.

When treating and assisting HIV positive individuals: treatment goals are client-oriented and very specific to the nature of the disease and meeting the client where they are at. The first goal always made with the client is to be adherent to medical care, reduce viral load, take all medications as prescribed, eat healthily, and exercise as tolerated by the individual. The second important goal to make with the client is helping the client to access resources such as the food bank, transportation, and any emergencies dealing with finances. The goal is essential to maintain compliance with medical care. The third important treatment goal is to make sure clients are making all other provider appointments whether that is mental health, cardiology, or the dentist.

Medication Costs

There are seven drug classes approved by the Food and Drug Administration (FDA) to create a treatment regimen for the individual newly diagnosed. The approved drugs can also be used to readjust the medical needs of individuals living with HIV for a time. The cost of medications is around \$3,000- \$5,000 a month; this tends to be the reason that most individuals don't want to get tested and get into treatment. If states required testing, it would be assumed that there would be a requirement for treatment. The cost of treatment would be too much for the system to handle.

To help combat the significant costs of treating this disease, Ryan White funding, Part A provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic, Part B provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and 5 U.S. Pacific Territories or Associated

Jurisdictions. MAO does not receive C-F, but another ASO in the South receives funding from the other three; Part C provides comprehensive primary health care in an outpatient setting for people living with HIV disease. Part D offers family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS and Part F provides funds for a variety of programs [29].

Healthcare rights

Individuals living with HIV in the United States have rights to healthcare. There are several Federal regulations to protect from discrimination from medical providers due to HIV status. Section 504 of the Federal Rehabilitation Act of 1973 prohibits discrimination by providers who accept Federal funds or other forms of Federal assistance [30]. The American with Disabilities Act (ADA) prohibits state and local government agencies from discrimination on the basis of HIV status, regardless of whether they accept Federal funds [30]. Although individuals with HIV have rights to healthcare, this doesn't always mean they have access to adequate healthcare to help with HIV and all other related disorders caused by HIV.

Workplace rights

The workplace has seen a significant rise in employers between the ages of 20-44 as the most affected by HIV/AIDS (HIV.gov, Workplace section, para.1). Laws have been put in place to protect individuals living with HIV. Here is a list of the most important ones: American with Disabilities Act of 1990(ADA), Occupational Safety and Health Administration (OSHA), Family Medical Leave Act of 1993(FMLA), Health Insurance Portability and Accountability Act of 1996 (HIPPA), and Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) [30]. As political and societal opinions and calls to action move into relevant issues concerning the value of higher education and the employment aspects of the college students, the issues of workplace rights and the coinciding benefits will push multiple aspects of health care (including sexual health) into the litigation arena.

Targeting HIV

Numerous factors contribute to the HIV infection rates in young adults including socio-economic status, race, age, and use/abuse of substances [1, 2, 24]. As earlier stated, young adults and their younger peers have the highest rate of infection and the equally detrimental lowest rate of testing (CDC). The most direct way to target HIV in this age group is to provide clear messaging concerning the use of condoms, safe sex techniques, testing, taking pre-exposure prophylaxis (PrEP), limiting multiple partners, and seeking sexual health care [2]. The alarming findings from the CDC's Sexually Transmitted Disease Surveillance Report [1] highlight a troubling trend: "The overall number of reported STDs is on the rise since 2014 and shows no signs of slowing, with infections disproportionately affecting young people under the age of 25, racial and ethnic minority groups, and gay or bisexual men." This increase in sexually transmitted diseases (STDs) is particularly alarming given the populations most affected—young adults, minority racial and ethnic communities, and men who have sex with men—who experience these health disparities at higher rates. These findings indicate not only a growing epidemic but also highlight the need for targeted health interventions that focus on the groups most vulnerable to these infections. The persistence of this trend calls for an urgent reevaluation of prevention strategies and a deeper commitment to addressing the root causes of these disparities in health outcomes.

The research from various organizations suggests that during and in the aftermath of the pandemic, many individuals likely encountered significant barriers to accessing healthcare services, which may have contributed to the worsening of certain diseases. The CDC's 2020 report reveals a concerning 147% increase in the overall rate of heterosexual syphilis—an STI closely associated with HIV—between 2016 and 2020. In addition, the report documents an alarming 254% rise in congenital syphilis cases within the same

period [1]. This surge in syphilis cases, particularly among younger populations, highlights the potential consequences of limited access to preventive care and treatment during the pandemic. As earlier presented, the CDC [1] notes that over half (53%) of reported STDs occurred in individuals aged 15–24, with certain racial minority groups experiencing disproportionately high infection rates. This trend points to the urgent need for more targeted outreach and healthcare access for these vulnerable populations. The WHO [31] also emphasizes that many sexually transmitted infections (STIs) present without symptoms, which further stresses the importance of widespread education, regular testing, and accessible treatment options to effectively combat the spread of STIs and reduce the associated risks.

The overall findings of this collection of data support the need to rethink the purpose of higher education student health programs for college students. Higher education and the intact infrastructure of the university setting can be the mechanism for developing the most opportunistic programs to target the negatively skewed rise of STDs in this population [1]. Recently, the National Healthcare Quality and Disparities Report shows treatment access was 35.8% lower for youth living below the poverty line [32] – this data will impact post-secondary institutions as they continue to widen their recruiting strategies to include larger numbers of first-generation students. Further triangulating data from the NCAA Student-Athlete Health and Wellness Study [33] and recruiting maps for the largest universities [34], solidify the need to develop wellness programs to target the healthcare disadvantages of these new student populations.

The percentage of post-secondary institutions that report providing student health services is high – at least 91% in Habel's study reports a student health center with at least a 73% rate of ability to diagnose and treat simple illnesses [4]. While there seems to be an adequate number of programs, these services do not take an active educational and preventive approach within the college environment. Student health services are often minimally staffed, do not operate on the weekends, and refer out large sections of services – especially dealing with sexual health care, testing, and preventive services. The CDC points out that the structure is already there in the post-secondary system to fully develop wellness and sexual health education and services that will impact a significant footprint within the targeted age group [19].

Relevant Theory of Change

Stakeholder Theory

R. Edward Freeman developed and explained stakeholder theory in the book *Strategic Management: A Stakeholder Approach* [35]. In this book, Freeman presented a fully developed theory and provided recommendations for how organizations could engage stakeholder groups within their organization. Reversely so, he also provided ways the stakeholders within the organization could engage their workplace toward mutually beneficial arrangements. Renowned social researchers and authors Rubin and Babbie [36] expanded the concept of stakeholders, defining them as "those with vested interests" (p. 204) in an organization's processes and outcomes. This broader interpretation of stakeholders underscores the importance of recognizing various groups that have a direct or indirect interest in the success of an initiative. Stakeholder theory, when applied to post-secondary education, offers a valuable framework for institutions to address the critical issues of student well-being, including sexual health education, prevention, and treatment. By recognizing students as primary stakeholders, colleges and universities are better positioned to develop programs that focus on critical needs, ensuring that students have access to the resources, education, and support necessary for promoting sexual health. This approach fosters a more holistic perspective on student wellness, aligning institutional goals with the health and success of the student body. Such efforts not only benefit individual students but contribute to the overall well-being of the campus community, enhancing both academic and personal

outcomes. Without the student – the university and its footprint of research, service, teaching, sports, alumni, and endowments, would not exist.

An abbreviated summary of key principles of Stakeholder Theory includes the Principle of (a) entry and exit, which states that hiring and termination procedures should be understandable and clear; (b) governance, which applies to how rules within the organization can be amended; (c) externalities, which concerns the negative impacts on external stakeholders who do not gain from a corporation's actions; (d) contract costs, which suggests that costs associated with contracts should be shared equitably among parties based on their respective benefits; (e) agency, indicating that a firm's manager acts as an agent for both stakeholders and shareholders; and (f) limited immortality, asserting that organizations should be sustained for a reasonable period and managed with the idea of long-term survival [35].

A cornerstone of Stakeholder Theory is the emphasis on intricate relationships within corporate structures and how these connections can positively or negatively influence each other. The theory recognizes individual independence and the dual relationship of contribution to larger systems. Freeman's theory prioritizes relationship dynamics and their multifaceted effects on the complex systems that make up the organization.

Freeman et al. [37] provide a more detailed exploration of Stakeholder Theory in their work "Managing for Stakeholders," where they outline ten core principles that guide organizations in their interactions with stakeholders. These principles include the idea that (a) the interests of stakeholders should evolve in alignment over time; (b) encouraging volunteerism can empower stakeholders, allowing them to actively manage their relationships with the organization; (c) solutions should be found that meet the needs of multiple stakeholders simultaneously; (d) actions must be designed to serve stakeholders effectively, minimizing the need for ongoing trade-offs; (e) organizations must act with intent and integrity to honor their commitments to stakeholders; (f) fostering open, transparent communication is crucial for maintaining healthy relationships with stakeholders; (g) it is important to recognize that stakeholders are individuals with unique, multifaceted identities; (h) a generalized marketing strategy should be employed to address various stakeholder needs; (i) both primary and secondary stakeholders should be engaged in meaningful ways; and (j) there should be a continuous process of assessment and adaptation of strategies to better meet stakeholder needs and improve outcomes (p. 60). These principles offer a comprehensive approach for organizations to effectively manage their relationships with stakeholders, ensuring that they are responsive and responsible in their efforts to serve diverse interests.

Freeman et al. [38] contend that Stakeholder Theory plays a significant role in guiding management practices across various industries, especially in the areas of ethics and corporate social responsibility (CSR). This body of research particularly focuses on the intersection between Stakeholder Theory and CSR. In their work, Freeman et al. [38] draw on Carroll's [39] framework to outline four key categories of business responsibilities toward stakeholders: (a) economic responsibilities, which involve the duty to offer goods and services that meet societal needs while generating profit; (b) legal responsibilities, emphasizing the necessity of complying with laws and regulations; (c) ethical responsibilities, suggesting that businesses should go beyond legal obligations to meet societal expectations; and (d) discretionary responsibilities, which encourage companies to engage in charitable or philanthropic activities that align with the values of the community [38]. These categories provide a comprehensive approach for businesses to balance their obligations to various stakeholders while pursuing ethical and socially responsible practices.

Freeman et al. [38] describe corporate social responsibility (CSR) as a framework that allows organizations to foster socially responsible

behaviors toward their stakeholders and the broader public. This aspect of Stakeholder Theory forms the foundation for the theoretical model guiding this research. By applying Stakeholder Theory to CSR, it is argued that organizations, including businesses, government bodies, and educational institutions, have a duty to their stakeholders—such as students—to offer services and education in areas like sexual health as part of promoting overall well-being. Utilizing the principle of costs within this framework supports the provision of sexual health services and education, that not only benefits the organization and its stakeholders but also has positive impacts on the wider community.

Recommendations

The following recommendations are based on survey results, supplemented by additional research on sexual health education, sexually transmitted infections (STIs), and concerns related to sexually transmitted diseases (STDs) among college students, along with several studies by the NCAA focused on student wellness. Current data show that higher education institutions are increasingly prioritizing sexual health, with 91% of student health services reporting their involvement in this area [4]. Furthermore, at least 73% of these colleges have the capacity to diagnose and treat related sexual health issues. These efforts are in line with the CDC's guidelines, which call for improved sexual health support for all college students. Given that college students are at an elevated risk for negative sexual health outcomes, it is essential to establish comprehensive sexual health and wellness education and services [19]. However, the research also points to a gap in services specifically targeted toward this population. Below are best practices recommendations designed to effectively deliver the necessary services, prevention strategies, and education to this group of students.

Mandatory Programming in Lifelong Learning

At present, the sole mandatory educational program concerning sexual health in higher education is the NCAA's training initiative on sexual violence [40]. Although the NCAA provides training materials, it neither mandates specific training nor advocates for its implementation [40]. In light of this, we suggest strengthening the current vague educational requirements by integrating more comprehensive sexual health education and incorporating critical public health elements, such as STI testing and prevention, as mandatory components of athletic programs [41]. Furthermore, we advocate for broadening student wellness initiatives to address other essential aspects of health, including mental health, substance abuse, and nutrition, with a particular focus on eating disorders. Mental health support received unanimous endorsement from all survey participants, and this view is further supported by findings from the NCAA Student-Athlete Health and Wellness Study [42], which highlights the significant need for robust mental health services within college athletics. Expanding wellness programs to cover these areas would ensure a more holistic approach to student well-being, ultimately fostering a healthier and more supportive environment for student-athletes.

Free Programming Across Various Learning Platforms

NCAA bylaws dictate that member institutions must provide insurance coverage for injuries sustained during athletic activities [43]. While currently not motivated to do so, the NCAA could support preventive care and treatment for overall wellness (including sexual health) by collaborating with student health clinics to deliver services in an on-site clinic format. In a decade of research, Mowreader [41] supported by Lechner et al. [19] re-emphasizes that access to services correlates directly with their availability. Factors such as work, extracurricular commitments, and academic responsibilities often restrict students' access to conventional student health clinics [19], highlighting the need for alternative service delivery methods. These models such as Telemedicine and MHealth are currently in use in

the United States. Though the sole governing institution for student sports vaguely acknowledges its major part in this issue, it does report the disparities in healthcare access [43]: "The inconsistencies in level of care stem from the lack of any uniform health insurance standards in the United States, an issue that the membership may address further."

Programming Addressing Lifelong Wellness with Integrated Sexual Health

This recommendation focuses on two critical areas regarding education in sexual health and reciprocating services. The first area concerns HIPAA, which may necessitate the involvement of external healthcare providers for testing and prevention. The second pertains to ensuring that sexual health education encompasses a broad range of topics with an emphasis on cultural competence. This educational approach should avoid a one-size-fits-all model, taking into account various cultural, religious, and gender considerations when designing the curriculum and supportive services for sexual health education.

Keeping in mind that culture does not just include consideration of the social class and race of college students, but culture also includes understanding their way of life as well as how they assign meaning to their behaviors/actions [44]. The recommendation to broaden the scope is to engage culturally competent health educators and experts to create an inclusive curriculum and structure in sexual education and services that mirrors and supports the diversity of the college student population.

Programming that is Current and Modern in design

In today's world, information is accessible through a variety of channels. The perspectives shared by Mowreader [41] and the NCAA Student-Athlete Health and Wellness Study [42] are derived directly from the students, emphasizing the importance of listening to their voices. It is crucial to equip student-athletes with the tools and opportunities to access and interact with relevant information in diverse learning settings and formats. Some educational aspects are designed to foster group engagement, while others are better suited for independent learning experiences.

Programming Integrated with Culturally Competent Peer Mentorship or Support

The evidence supporting this recommendation emphasizes the role of coaches and team peer support in facilitating peer integration. Coaches contribute to athletic success but also serve as valuable resources for life skills and personal development. According to Davis et al. (2022), a positive mentoring relationship with a coach fosters healthy growth among student-athletes. Educational programs that effectively involve coaching are perceived as crucial by student-athletes. On the other hand, when student-athletes experience poor relationships with their coaches, it often leads to challenges related to poor academic performance, mental health and behavioral issues, and substance use, and [45]. The NCAA Student-Athlete Health and Wellness Study [42] recently emphasized that one of the most critical connections for student-athletes is with their coaches. By building on this research and the positive outcomes linked to strong coach-athlete relationships, universities have the opportunity to design programs that focus on enhancing relational dynamics and fostering a sense of community within learning environments. The effectiveness of any program, whether mandatory or voluntary, largely depends on the support from the institution, its staff, and the connections established within the group. Through culturally sensitive peer support services, universities can successfully integrate key issues such as sexual health, mental health, nutrition, substance abuse, and physical wellness, ensuring that these elements are recognized as vital components of long-term well-being.

Make it Interprofessionally Collaborative

In consideration of the multiple stakeholders involved with the services, prevention, and education of college students (e.g. university clinic staff, coaches, faculty, and peer support), it is imperative to

integrate an approach that supports interprofessional collaboration. Interprofessional education collaborative practice (IPEC) is an approach that is intentional regarding strengthening the efficiency and cohesion in the relationships of the care team of stakeholders [46]. According to the World Health Organization, IPEC is when multiple health-care focused “workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers, and communities to deliver the highest quality of care across settings [47]”. In other words, interprofessional collaborative practice happens in any setting where multiple diverse professionals are working together to provide health and social services which includes universities and colleges [48]. The premise of recommending the implementation of IPEC in the provision of sexual health services, prevention, and education is to consider the significance of taking the necessary steps as identified through the Interprofessional Educational Collaborative competencies [46] to establish healthy collaborative relationships among the diverse stakeholders so they can operate as a holistic care team to support optimal wellness of college students.

Suggestions for Future Research

A critical piece of overall wellness for the college student includes sexual health education, access to prevention, and care. As demonstrated by multiple data sources, there is an intersection of risk factors such as sociodemographics, age, and limited access to healthcare education and services. As a primary stakeholder for post-secondary institutions, this deficit should create momentum for action on behalf of the student stakeholders within the institution. Recent research establishes a strong belief in the necessity of providing intercollaborative wellness services to include sexual health care and education to this age group [2, 19, 48]. This research further supports the position that post-secondary systems are uniquely poised to provide these services in a manner that would create benefits beyond the system footprint [1, 2, 19, 42, 46, 48]. Additional research in this area should include collecting information concerning the level of wellness services post-secondary schools provide. This information could move the field in the basic requirements for federally funded institutions to provide wellness. As post-secondary institutions focus on student success, the topic of wellness is inextricably tied to this construct, pushing forth the requirement for accurate healthcare information, creating the necessary momentum to change policy, and requiring services, prevention, and education as an integrated piece of student success, lifetime learning, and overall wellness. This process clarifies the function of stakeholder theory and the long-term benefits of creating programs that create mutually beneficial outcomes for all parties involved.

Conflicts of Interest: The authors declare that they have no competing interests.

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