

Free Chapstick and Condoms!: Student Knowledge and Motivations for Campus Wellness Centers

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Executive Summary

In the fall of 2018, students in the Sociology/Anthropology 371 course conducted research on student attitudes and experiences regarding wellness and the Wellness Center (WC) at St. Olaf College. We sent an anonymous online survey to 1200 non-first-year students and received 308 responses, a 25.7% response rate. Our sample reflects many demographics of the student body, and it matches the general rule of thumb for a sample of a population of approximately 2,200 (non-first-years only). Prior studies are somewhat limited because on-campus wellness centers are a relatively recent development. Scholars have found that greater student involvement with wellness programs can positively influence health behaviors.

Our research focuses on 4 main questions:

1. What WC services do students use the most and least?
2. How do students learn about the WC? How do students prefer to do this?
3. How much do students know about health, and which students tend to have higher or lower health knowledge?
4. How do students' knowledge and understanding of wellness influence their WC use?

The most important results of our research are as follows:

- For WC use in Fall 2018 (first 10 weeks only), students most commonly read Toilet Talks, used the website, and attended an event for an SPM credit
- For WC use ever, students most commonly read flyers, visited the WC for supplies, and attended WC swiped events for credit
- Most students learned about the WC through flyers, promotional posters, Peer Educators, and Resident Assistants/Junior Counselors
 - Most students also report these as their preferred ways to learn about the WC
- Most students rate themselves as moderately/very knowledgeable on health knowledge
- A few significant relationships exist between health knowledge and demographics: LGBTQ+ students and females rate themselves higher on mental health knowledge, and seniors and juniors rate themselves higher on alcohol and other drugs knowledge

Based on our research, we offer five recommendations:

1. The WC should continue to use print media to promote itself, particularly promotional posters and Toilet Talks.
2. The WC should promote its website and social media accounts.
3. The WC should encourage a stronger partnership with Residence Life.
4. The WC should target disparities in mental health knowledge on campus, primarily through Toilet Talks, WC presentations/events, internet sources, and social media.
5. The WC should target sophomores regarding information and events about alcohol and other drugs.

Background and Review of Literature

This study focuses on how students' knowledge and understanding of wellness – *a holistic and proactive approach to health* - and of wellness centers influence students' wellness behaviors and their wellness center usage on a college campus. Prior scholarship has identified many factors that influence knowledge and understanding which we consider in our study. We consider the history of wellness programs, wellness definitions, dimension, and issues, as well as college students and wellness.

History of Wellness Programs for College Students

Wellness programs on college campuses have developed over the past 50 years. Health education on college campuses began as early as 1836 (White et al. 2009). In the 1950s and onwards, campuses included health education began as student movements worked to target relevant public health concerns like influenza outbreaks, drug use, and birth control. Health education, however, is not the same thing as wellness centers or programs. The reason universities shifted from health education to the wellness programs (or added wellness programs to health education) was likely influenced by corporate wellness programs, which began between the 1950s and the 1970s (Owens 2006; Reardon 1998). Similar to wellness centers on college campuses, corporate wellness programs aim to improve employees' health and well-being (Goetzel and Ozminkowski 2008). Universities have implemented similar programs that target students' health and well-being. For example, the Wellness Center at the University of California Berkeley promotes student wellness by having peer health educators who specialize in different dimensions of wellness (White et al. 2009).

Wellness: Definitions, Dimensions, and Issues

Wellness has been defined in many ways and with varied dimensions. Overall it is a "lifestyle approach to health behavior" (Gieck and Olsen 2007:29). A *lifestyle approach* can have many different dimensions, depending on how broadly wellness is defined. For example, one definition of wellness has six dimensions; physical; psychological; social; spiritual; intellectual; and emotional (Sidman, D'Abundo, and Hritz 2009). Despite varying definitions, wellness usually involves some *aggregate measure of different health-related behaviors*. The definition of wellness used by St. Olaf's Wellness Center has four dimensions; physical health; mental health; sexual health; and health related to the use of alcohol and other drugs. Wellness however is not always properly defined, and we will discuss the consequences of that below.

The Importance of Shared, Thorough Definitions of Wellness

Even though there is no consistent definition of wellness in the scholarly literature, defining "wellness" and "wellness management" has been important for implementing wellness approaches in institutions. Unfortunately, as recent literature on wellness management has demonstrated, institutions often lack clarity regarding detailed definitions of wellness. One consequence of this lack of clarity is that wellness definitions may vary across patients, family caregivers, and professionals. Grace and Gleasure (2015) found that patients, family caregivers, and health professionals often misunderstand the different components of wellness and how to maintain it, which negatively affects the health of the patient (e.g. a health professional not clearly explaining to a family caregiver how different components of wellness can positively impact a patient's health).

A potential cause of this problem is the lack of common and thorough definitions of wellness. Thus, Grace and Gleasure's (2015) study implies that in order for an institution to implement a

wellness program effectively, the term “wellness” must be defined correctly and thoroughly. According to Grace and Gleasure (2015), many individuals assume a simple heuristic of wellness, which bases the concept of “wellness” on one’s personal experience with the term rather than on a general common understanding of the concept. For instance, due to their lack of exposure and personal experience with the subject, an individual may explain wellness as just the betterment of one’s health but not identify specific components of the concept. Other studies have also pointed to this problem of wellness being misunderstood (Grace and Gleasure 2015).

Fullerton (2011) further analyzes how incomplete and unshared definitions of wellness can persist when there is a lack of collaboration between a college’s or university’s student health and wellness programs. His study looks at several schools and gathers that a lack of communication between an institution’s wellness program and its other health services (ex. counseling centers, athletic facilities, and etc.) contributes to students having incomplete knowledge and understanding of wellness. Fullerton (2011) suggests that collaboration among institutional wellness and health entities is beneficial because it builds a common understanding of wellness. By combining these programs, facilities, and services under one roof, colleges and universities can reach a broader student audience and provide a wide range of specialized and coordinated services (Fullerton 2011). Through institutional collaboration, the college’s and/or university’s general population benefits from the institution’s concept of wellness, because wellness and health entities have agreed upon and promoted a thorough and common definition of wellness. Collaboration between wellness entities and other institutional facilities help improve students’ knowledge and understanding of wellness.

College Students and Wellness

Research on college wellness courses and peer educators has found that students’ self-efficacy, knowledge, and understanding of wellness influence their health behaviors. Health behaviors refer to an array of behaviors that influence health, such as alcohol consumption, eating habits, and physical activity (Lockwood and Wohl 2012). They are the physical, emotional, social, mental, and sexual behaviors that promote or harm the health of an individual. Three primary themes emerged from literature on the impact of wellness courses and peer educators: 1) how wellness courses impact *self-efficacy*, an important factor in changing health behavior; 2) how *wellness courses* improve students’ wellness knowledge, understanding, and health attitudes; and 3) how *peer educators* improve students’ health behaviors as well as their knowledge and understanding of wellness topics.

Self-efficacy, Health Behaviors, and Wellness

The first primary theme in the literature on health behavior change and participation in wellness courses is *self-efficacy*. Self-efficacy is defined as an individual’s belief in their ability to execute behaviors and achieve goals (Lockwood and Wohl 2012). Research has found that simply disseminating health information does not guarantee positive health behavior changes among students (Lockwood and Wohl 2012, Beauchemin 2018). It is necessary for students to be taught skills in order to promote healthy behavior change, including how to improve self-efficacy, how to self-reevaluate, and how to seek support from helping relationships (Lockwood and Wohl 2012). Several studies have found that changes in wellness knowledge, understanding, and self-efficacy influence self-reported health behavior over time (Baldwin et al. 2017, Lockwood and Wohl 2012).

People’s health behaviors are related to their self-efficacy, a person’s belief in their ability to succeed in a situation or to accomplish a task. A study by Sidman et al. (2009) found a positive

relationship was found between students' *physical self-efficacy* (their belief in their capacity to perform physical activity) and their *self-reported levels of physical activity*. That is, students who believed they had stronger physical abilities also performed at high levels of physical activity. We further discuss how self-efficacy relates to health behaviors and wellness later.

Gender

Gender has been shown to influence knowledge and understanding. Baldwin, Towler, and Oliver (2017) examined gender as an important factor in knowledge and understanding regarding wellness and wellness centers use. Their research showed how attitudes about wellness behaviors and knowledge and understanding of wellness are socialized through normalized, gendered behavior. Men and women are socialized into having different wellness patterns (e.g. types of self-care) by outside influences (e.g. an individual's parents or media) (Baldwin et al. 2017). For example, the assumption that men generally spend less time grooming themselves than women reflects a difference in social understandings of gender and wellness. Women are expected to be concerned about their appearance, which influences their self-care and how they are expected to take care of themselves.

These social norms influence both male and female knowledge and understanding of wellness. As a result of this, male students' understanding of wellness may focus more on physical well-being rather than social well-being, and female students may tend to focus more on social well-being than physical well-being. Female students may also be more inclined than male students to participate in wellness center events focusing on self-care or social well-being.

Bersamin et al. (2017) found that differences in knowledge about health-related services affected male and female students' use of those services. The main barrier to male students' use of reproductive health services was that they lacked knowledge of those services. Females, however, were more likely to be deterred from using reproductive health services because they were concerned about social disapproval (embarrassment, being recognized and gossiped about). Women may be less likely to use wellness center services related to sex and reproductive health because of the negative connotations associated with visiting the wellness center. These studies indicate that gendered knowledge, behavior norms, and stigma differently influence wellness center knowledge and use for men and women.

Promoting Student Wellness: Wellness Courses

The second central research theme is the effectiveness of required *wellness courses* in increasing students' knowledge of health topics and changing their attitudes (Robbins et al. 1992; Carlson et al. 1994; McCormick et al. 2006). Studies by Carlson et al. (1994) and McCormick and Lockwood (2006) examined the health knowledge and attitudes of undergraduate students before and after taking a required course about health and wellness. Both studies found that the required wellness courses significantly improved undergraduate students' attitudes about health, increased their health knowledge, and promoted positive behavior change (Carlson et al. 1994 and McCormick and Lockwood 2006). Lockwood and Wohl (2012) found that the required wellness course significantly improved students' physical self-efficacy, self-perception, perceived physical self-efficacy, positive health behaviors, and nutrition and exercise-related knowledge and understanding. Another study conducted by Baldwin, Towler, and Oliver (2017) determined that educating students about wellness, knowledge, and understanding of wellness improved students' self-reported self-efficacy and health behaviors. They found that college students who reported higher levels of self-efficacy also reported higher levels of physical activity, emotional intelligence, mental health, and self-esteem.

Promoting Student Wellness: Peer Educators

Peer health educators on college campuses improve students' knowledge and understanding of wellness topics, as well as promote positive health behaviors (White et al. 2009, Lockwood and Wohl 2006). Wellness education is a way in which students can learn about health behaviors, self-efficacy, and wellness. One way wellness education works on college campuses is through peer health education, the teaching or sharing of health information, attitudes, values, and behaviors by members of groups who are similar in age or experience, in this case, other students. Peer health educators are credible role models within the informal social network of a college campus. They have been shown to generate positive personal outcomes for students (White et al. 2009).

As discussed earlier, several studies have found that peer health educators are effective disseminators of knowledge on college campuses (White et al. 2009, Lockwood and Wohl 2006). White et al. (2009) studied undergraduate students at a California university, and examined students who had contact with peer health educators compared to those who had no contact. This study found that students who had contact with peer health educators had improved health knowledge and understanding when compared to students with no contact. This improved health knowledge and understanding led to some positive changes in self-reported health behaviors. Specifically, they found that students who had contact with peer educators were more likely to decrease alcohol consumption over time and to have healthier alcohol and other drug behaviors, as opposed to students with no contact with peer educators. White et al.'s (2009) research also indicates that the outcomes of peer health education can be varied and unexpected, as shown by the finding that students with contact with peer educators had lower rates of sexual activity under the influence of alcohol as opposed to students with no contact, but unsafe sexual behaviors increased for all students over time regardless of contact.

Gaps in Scholarly Literature

There are gaps in scholarly knowledge regarding mental health sexual health, social health, and alcohol and other drugs, as well as literature about mental and sexual health in relation to self-efficacy. We did not find research on the relationship between self-efficacy and mental health, sexual health, or alcohol and other drugs use. We theorize however, that given the interconnectedness of different parts of wellness, self-efficacy in one dimension could plausibly contribute positively to other dimensions of wellness. Another gap in the literature is that Baldwin et al. (2017) do not consider differences in knowledge for people who do not identify as male or female but non-male/female people may experience unique barriers to wellness knowledge.

In our literature review we found previous research on student knowledge and understanding relating to students' interactions with peer health educators and wellness courses, however we found no studies that examined student knowledge as it relates to campus wellness centers. Our research is unique in that we directly study student knowledge and understanding of on-campus wellness centers.

Bearing this in mind, our research focuses on how knowledge and understanding of wellness and wellness centers can influence students' wellness behaviors and wellness center usage at a small private liberal arts college in the Midwest.

Methods

The purpose of this research is to understand how students' knowledge and awareness of the Wellness Center affects their Wellness Center use. We used a focus group and a survey to

examine how students feel about the Wellness Center's purpose, its events and presentations, and the health-related information it provides. Our focus group results were used to construct a survey that would be sensitive to the wellness-related understandings and experiences of the students at our institution. Our survey questions focused on why students use the Wellness Center and their level of knowledge and understanding about wellness and the Wellness Center. Our cross-sectional survey was conducted in November of 2018, and thus measured student knowledge and understanding at only one point in time.

Our main variables were student use of the Wellness Center at St. Olaf College and student knowledge and understanding regarding the Wellness Center and health in general. There are three main relationships this study explores; 1) how knowledge and understanding impact Wellness Center usage, 2) which students know more about health, and 3) how health knowledge predicts Wellness Center usage.

To measure use, we asked whether students had ever used any of eight Wellness Center services. We chose which services to include based on which ones commonly came up in our focus groups. The eight services are listed in Appendix B, Figure 4. An ESAC/SPM course is a required studies in physical movement course (SPM) offered by the exercise science department. Students indicated on our survey if they had ever used any of these services.

We also measured use in the first ten weeks of school, and had the same eight services. Instead of students indicating if they had ever used any of these services during fall 2018, we had response categories of *0 times this semester (I was UNAWARE that this service/option existed until now.)*, *0 times this semester (I was AWARE of this option but have not used it.)*, *1 time this semester*, *2 times this semester*, *3 times or more this semester*.

To measure knowledge and understanding, we asked students to assess their own levels of knowledge about different wellness topics such as mental health and sexual health using a 4-point Likert scale ranging from *not at all knowledgeable* to *very knowledgeable*. We also asked students about the different ways they *have learned* and the different ways they *prefer to learn* about the Wellness Center, in terms of its resources and events, and about wellness in general. We used our focus group results to identify common ways of learning about the Wellness Center, but also included an *other* category for students to write in other ways of learning.

We surveyed students' demographics as well. The survey asked for *year in school*, *gender identity*, *racial/ethnic identification*, *sexual orientation*, and *hours/week of non-work study related work*. The questions on gender, racial/ethnic identity, and sexual identity were all open-ended to ensure they were inclusive of all respondents' identities. We measured hours working at paid employment per week with the response categories of 0 hours, 1-5 hours, 6-10 hours, 11-15 hours, and 16 or more hours.

We addressed validity in our research. Validity exists when an indicator correctly measures its target construct (Neuman 2013). Our study's internal validity comes from our thoroughly and intentionally developed research questions that accurately measure the construct we are interested in. Internal validity helps ensure that the independent variable influences the dependent variable and helps reduce the influence of confounding variables (Neuman 2013). Face validity is judgement by scientific community members that the indicator accurately measures the construct (Neuman 2013). We achieved face validity by using similar survey questions and Likert scales as prior research on college student wellness. Content validity is when a measurement represents all ideas and areas of the concept (Neuman 2013). Our

literature review informed our content validity which ensured all measures of our conceptual definition were represented in the survey questions and response categories (Neuman 2013).

Reliability is consistency and dependability of a variable (Neuman 2013). Reliability is achieved by pilot testing, clearly conceptualizing concepts, using multiple indicators, and precise measurements. Our measurements were pilot-tested in order to make sure they were reliable and the results were replicable before our survey was distributed. We clearly conceptualize our concepts in our questions by using specific language that students are familiar with. We carefully developed our survey questions to have multiple indicators that measure the same constructs. Our survey questions use precise and objective measurements of nominal, ordinal, interval, and ratio levels in order to make sure they are clearly conceptualized and reliable.

The population of our study was non-first year students currently enrolled full-time at St. Olaf College. We did not sample freshmen because when our survey was distributed freshmen had only been on campus for ten weeks and lacked significant time to interact with the Wellness Center. Students were eligible to be included in our sample if they were not in an off-campus studies program, students who worked at the Wellness Center, peer educators, students who had already been asked to take a survey by another class, students in our research course, and the course's teaching assistants. In order to ensure our response rate was high and students were able to recall their interactions with the Wellness Center, we did not sample students who were studying off-campus during the semester (fall 2018) when our survey was distributed.

We distributed the survey via an invitation to the survey in an email, and we informed students that all who completed the survey were eligible to enter a random drawing to receive a gift card to Amazon or to the college bookstore. Five students received \$20 gift cards and two received \$50 gift cards.

Our attempted sample size was 1,200 of the 1,600 students who remained in our population after our exclusions. Our sample was randomly selected by the director of St. Olaf's Institutional Review Board before our survey was distributed in November 2018. The number of respondents was 308, providing a response rate of 25.7%. For a population under 1,000 and the rule of thumb sampling ratio is 30% which our study meets (Neuman 2013). For a population over 10,000, the rule of thumb sampling ratio is 10% which our study also meets (Neuman 2013). Given our response rate of 25.7% and our population size of 1,600, we were able to generalize our results to our target population.

Considering the respondents who provided demographic information (nearly all of them), our sample was 26.7% male (73), 71.4% female (195), and 1.1% nonbinary (3), 0.4% female transgender (1), and 0.4% male transgender (1). The respondents were 37.4% sophomores (104), 31.7% juniors (88), and 30.2% seniors (84), and 0.7% other (not first-year; possibly fifth-year seniors) (2). Our sample self-identified as 75.8% Caucasian/White (201), 9.8% Asian (26), 5.7% multi-racial/ethnic (15), 4.9% Hispanic/Latinx (13), 2.3% Black/African American (6), 0.8% Middle Eastern (2), 0.4% African, and 0.4% Native American. Our sample was comprised of 78.8% heterosexual/straight students (201), 10.2% bisexual (26), 3.9% gay/lesbian (10), 3.1% pansexual (8), 1.6% queer (4), and 1.6% questioning/don't know (4). See Appendix tables 24-31 for a complete list of the percentages and frequencies of our demographics.

We carefully considered the ethical aspects of our research. An ethical researcher must be cognizant of potential harm to the participant, meaning they must weigh the possible risks to participants against the possible benefits of the research (Neuman 2013). The process of conducting the survey surfaced potential ethical issues about maximizing benefits and

minimizing risks while securing anonymity. In order to eliminate any unnecessary stress to participants, we carefully worded our survey and did not include any threatening questions (Neuman 2013). Threatening questions are questions that respondents may feel uncomfortable answering and may undermine their presentation of self, such as questions about sexual behavior or drug use (Neuman 2013). Our survey questions were designed to not elicit any greater discomfort than usual in students' daily lives. In addition, our professor and co-researchers also reviewed the content of the survey questions in order to identify any misuse of terms and to address any potentially sensitive or threatening aspects of the questions.

Another ethical issue we addressed was privacy. In order to protect participants against the risk of a negative impact on their careers, reputations, or incomes if personal information was released, we established and maintained participant anonymity. The survey did not record any names of participants or ask for information that would have enabled us to identify respondents. Our data set was stored with password-protection to prevent accidental or intentional viewing by others.

Informed consent is permission given with full knowledge of the research method and its potential consequences (Neuman 2013). Participants must know that their participation is voluntary, they can stop the survey at any time, and the intentions of our research. Participants gave informed consent by reading our research statement of purpose in the initial email invitation with the survey link, then agreeing to log onto the website and take our survey. By doing this, they agreed that they were willing to participate and understood what the research procedures would involve.

Results

To answer our research questions, we ran univariate and bivariate analyses of our data surveying student use, knowledge and understanding of wellness, knowledge and understanding of the Wellness Center, and student demographics.

1. What Wellness Center services do students use the most?

We surveyed Wellness Center use among students, asking about whether students had ever used any of eight WC services/options, as shown in Table 1 below. The services students had used most commonly were reading a Toilet Talk flyer (87.0%), followed by visiting the Wellness Center for free supplies (46.9%), and attending a Wellness Center swiped event for SPM credit (40.1%). The least commonly used services were meeting with a Peer Educator (3.6%), visiting the Wellness Center to use the space (7.2%), visited the Wellness Center for wellness information (13.7%), and using the Wellness Center website (23.1%). See Appendix, Table 15 for the complete list of frequencies.

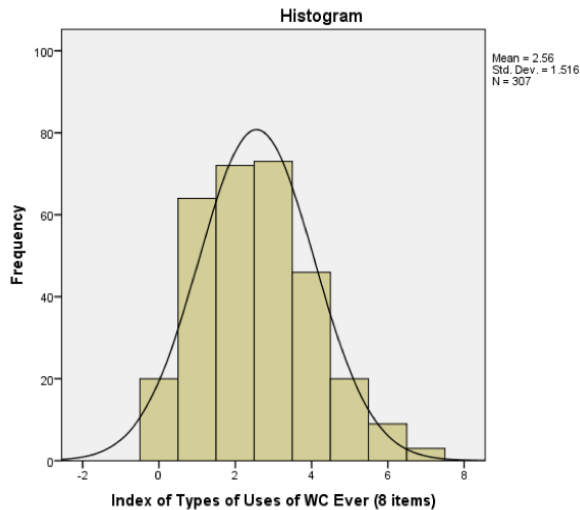
Table 1. Use of Wellness Center Services – Ever (in descending order)

Type of service	Percentage
Read a Toilet Talk flyer	87.0%
Visited the WC for free supplies (condoms, tampons, chapstick, etc.)	46.9%
Attended a WC swiped event for SPM credit	40.1%
Attended a WC swiped event NOT for SPM credit	34.5%
Used the WC website	23.1%
Visited the WC for wellness-related information	13.7%

Visited the WC to simply use the space	7.2%
Met for a one-on-one with a Peer Educator	3.6%

We also created an index of these eight types of uses by scoring each type of use as one and summing the scores. The histogram below (Figure 1) represents our *Index of Types of Wellness Center Use Ever*. The distribution is approximately normal, with a mean of 2.56 and a median of 2.0. The number of types of Wellness Center services ever used ranged from 0 to 7. The standard deviation was 1.516, which means 68% of students scored between 1.044 to 4.076. This means most students use the Wellness Center between one to four times.

Figure 1. Histogram of the Index of Types of Uses of WC Ever



In addition to Wellness Center use ever among students, we also asked about the frequency of uses of the eight different Wellness Center services during the first 10 weeks of the fall 2018 semester, as shown in Table 2. The most used types of Wellness Services during fall 2018 in the category of 3 or more times were reading a Toilet Talk flyer (78.0%), using the Wellness Center’s Website (9.2%), and attending a Wellness Center swiped event for SPM credit (8.1%). The most used types of Wellness Services during fall 2018 in the category of once were visited the Wellness Center for free supplies (15.9%), used the Wellness Center website (15.5%), and attended a Wellness Center swiped event for not SPM credit (15.3%). The least used types of Wellness Center services were meeting for a one-on-one with a Peer Educator (98.1%), visiting the Wellness Center to simply use the space (90.8%), and visiting the Wellness Center for wellness-related information (89.3%). See Appendix, Table 18 for the complete list of frequencies.

Table 2. Frequency of Use of Wellness Services in Fall 2018 (first 10 weeks)*

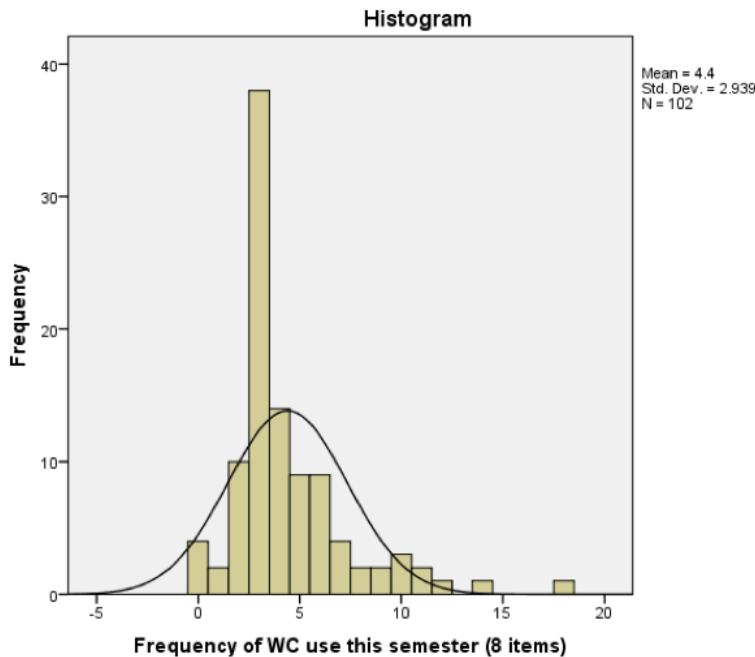
Type of service	0	1	2	3 or more
Read a Toilet Talk flyer	4.7%	4.7%	12.5%	78.0%
Visited the WC for free supplies (condoms, tampons, chapstick, etc.)	64.4%	15.9%	11.7%	8.0%
Attended a WC swiped event for SPM credit	72.9%	7.1%	6.8%	8.1%
Attended a WC swiped event NOT for SPM credit	83.1%	15.3%	0.8%	0.8%
Used the WC website	66.7%	15.5%	8.6%	9.2%

Visited the WC for wellness-related information	89.3%	7.5%	2.4%	0.8%
Met for a one-on-one with a Peer Educator	98.1%	0.9%	0.5%	0.5%
Visited the WC to simply use the space	90.8%	5.7%	1.7%	1.7%

*Analysis excluded students who reported being unaware of the service.

Again, we created an index that summarized the frequency of use of all eight WC services, scoring each student's use of each service as 0, 1, 2, or 3, and summing the scores. As shown in the histogram below (Figure 2), the scores on the Index of Frequency of Wellness Center Use Fall 2018 ranged from 0 to 18. The mean score was 4.4, and the standard deviation was 2.939, which means that 68% of students fell between 1.461 and 7.34. The histogram is not normally distributed and has an apparent left skew. Considering the distribution, this tells us many students have used the Wellness Center about four times this semester, and a smaller group of students used it at a greater rate.

Figure 2. Histogram of Frequency of WC Fall 2018



2. How do students learn about the Wellness Center? What are the best ways to do this?

We then asked how respondents had learned or heard about the Wellness Center. The most common source respondents reported was Toilet Talk flyers (91.2%), followed by promotional posters (80.5%) and peer educators (62.5%), as shown in Table 3. Notably, the top two information sources were items posted on walls and in bathrooms. We also asked students if they had learned about the WC in any other ways.. Their most common answers were from friends (39 respondents) and tabling in Buntrock (28 respondents). See Appendix, Table 19 for the complete list of frequencies.

Table 3. How Students Learned or Heard About the Wellness Center

Source of Information	Valid Percentage
Toilet Talk flyers	91.2%
Promotional posters for WC or its events	80.5%

Peer Educators	62.5%
Resident Assistant or Junior Counselor	41.0%
SPM/ESAC (physical movement class in Exercise Science)	38.3%
Social media	38.0%
WC Website	22.5%

Table 4. How Students Prefer to Learn About the Wellness Center

Source of Information	Valid Percentage
Toilet Talk flyers	76.9%
Resident Assistant or Junior Counselor	76.9%
Promotional posters for WC or its events	70.4%
Social media	52.4%
Peer Educators	28.7%
SPM/ESAC (physical movement class in Exercise Science)	28.3%
WC Website	21.5%

We also asked students about their top two preferred ways of learning health-related information. As shown in Table 5, the most preferred source by far was Toilet Talks (109), followed by WC presentations, events, speakers/panels (50), internet (49), and social media (48).

Table 5. Preferred Sources of health-related information

Information Source	Frequency
Toilet Talks	109
WC presentations, events, speakers/panels	50
Internet	49
Social media	48
Posters	41
Email	37
Personal reading	26
Peer educators	23
Health professionals (physicians, trainers, counselors)	22
Friends, family, word-of-mouth	14
WC website	12
Videos	12
Flyers, pamphlets, brochures	10
WC tabling	8
SPM/ESACs	8
Residence Life, RAs, JCs, corridor events	7
Displays around campus (e.g. Buntrock/library hallway)	5
In-class speaker	1
Visit WC	1
Let's Talk (at Boe House)	1
Boe House appointment	1

3. How knowledgeable are students about health, and which students tend to have higher/lower health knowledge?

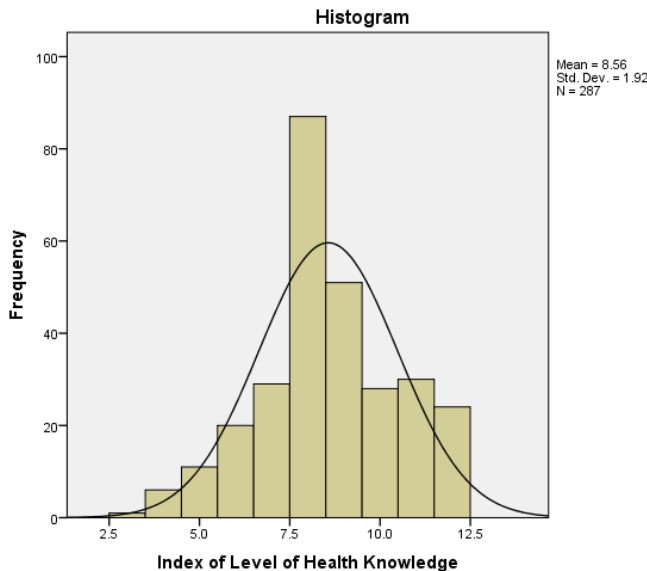
We asked students how they would rate their knowledge about health in four different areas. As demonstrated in the table below, students reported being most knowledgeable about physical health (40.1%), followed by mental health (30.4%). For each health area, the large majority of students (over 80%) reported at least being moderately knowledgeable about all areas of health knowledge.

Table 6. Self-Assessed Knowledge Scores

Knowledge Area	Very knowledgeable	Moderately knowledgeable	Slightly knowledgeable	Not at all knowledgeable
Physical Health	40.1%	51.9%	8.0%	0.0%
Mental Health	30.4%	50.9%	17.6%	1.0%
Sexual Health	26.4%	55.9%	15.3%	2.4%
Alcohol and Other Drugs	26.4%	55.9%	16.3%	1.4%

We created an index of self-rated knowledge of different areas of health based on our four areas. The range of responses was 0-12. The Index of Level of Health Knowledge (Figure 3) is approximately normally distributed with a slight left skew (with data cluster on the right). The mean level of knowledge score is 8.56 (s.d. = 1.92). Again, most students rated themselves as at least moderately knowledgeable.

Figure 3. Histogram of Index of Level of Health Knowledge



In order to understand which groups of students tend to have higher and lower health knowledge, we conducted tests that used participant demographics as the independent variable. The demographics we chose were year in school (sophomore; junior; senior), gender (binary: male and female), and sexual orientation (binary: heterosexual and LGBTQ+). Our survey had a greater variety of identities in both gender and sexual orientation, but the numbers were too small for running statistical tests. We acknowledge that students in the non-binary categories may have different experiences and perspectives that our study is not able to test with statistics.

Which gender tends to have higher/lower health knowledge?

The first bivariate relationships we explored were between the demographics above (gender; sexual orientation; year in school) and self-assessed knowledge (index; physical health; mental health; sexual health; and alcohol and other drugs). We conducted a t-test of the relationship between gender and the self-assessed health knowledge index as well Chi-square tests (Cramer's V) for each of the factors that comprise that index (knowledge of physical health; mental health; sexual health; and of alcohol and other drugs). As shown below in Table 7, gender was related only to self-assessed knowledge about mental health.

Table 7. Gender and Self-Assessed Health Knowledge

Knowledge area	T-test value or Cramer's V	Sig. (p-value)
Knowledge index	t=1.563	0.119
Physical health	V=4.221	0.121
Mental health	V=6.946	0.031*
Sexual health	V=0.195	0.907
Alcohol and other drugs	V=0.040*	0.980

*indicates $p < .05$

As shown in Table 8 below, females were more likely than males to indicate that they are very knowledgeable or moderately knowledgeable as compared to males (33.3% versus 22.2%). Females report greater knowledge of mental health as compared to males.

Table 8. Gender and Self-Assessed Mental Health Knowledge

Level of mental health knowledge	Female	Male
Very knowledgeable	33.3%	22.2%
Moderately knowledgeable	51.8%	50.0%
Slightly and not at all knowledgeable	14.9%	27.8%

Which sexual orientation tends to have higher/lower health knowledge?

Next, we compared sexual orientation with self-assessed knowledge (the index; physical health; mental health; sexual health; and alcohol and other drugs). As shown in Table 9 below, sexual orientation was related only to level of self-assessed knowledge about mental health. As shown in the table below, LGBTQ+ students were more likely than heterosexual students to indicate that they are very knowledgeable about mental health (47.2% and 27.9% respectively), while heterosexual students were more likely than LGBTQ+ students to indicate that they are moderately knowledgeable (52.7% versus 43.4%) or slightly or not at all knowledgeable (19.4% versus 9.4%) about mental health.

Table 9. Sexual Orientation and Self-Assessed Health Knowledge

Knowledge area	T-test value or Cramer's V	Sig. (p-value)
Knowledge index	t=1.909	0.057
Physical health	V=0.002	0.999
Mental health	V=8.030	0.018*
Sexual health	V=0.003	0.999
Alcohol and other drugs	V=0.049	0.736

Table 10. Sexual Orientation and Self-Assessed Level of Mental Health Knowledge Values

Level of mental health knowledge	LGBTQ+	Heterosexual
Very knowledgeable	47.2%	27.9%
Moderately knowledgeable	43.4%	52.7%
Slightly and not at all knowledgeable	9.4%	19.4%

Which class year tends to have higher/lower health knowledge?

Next, we compared year in school (sophomore; junior; senior) with self-assessed knowledge (the index; physical health; mental health; sexual health; and alcohol and other drugs). As shown in Table 11 below, year in school was significantly related only to self-assessed level of knowledge about alcohol and other drugs.

Table 11. Year in School and Self-Assessed Health Knowledge

Knowledge Area	One-Way ANOVA or Kendall's tau-b	Sig. (p-value)
Knowledge index	F=1.599	0.204
Physical health	tau-b=0.067	0.237
Mental health	tau-b=0.022	0.687
Sexual health	tau-b=0.088	0.116
Alcohol and other drugs	tau-b=0.125	0.020*

As you can see in Table 12 below, seniors were more likely than junior and sophomore students to indicate that they are very knowledgeable about alcohol and other drugs (32.1% versus 23.9% and 21.6% respectively). Conversely, sophomores were more likely than juniors and seniors to report being slightly or not at all knowledgeable about alcohol and other drugs (22.5% versus 17.0% and 10.7%).

Table 12. Year in school and Self-Assessed Alcohol and Other Drugs Level of Knowledge Values

Level of Alcohol and Other Drugs knowledge	Sophomore	Junior	Senior
Very knowledgeable	21.6%	23.9%	32.1%
Moderately knowledgeable	55.9%	59.1%	57.1%
Slightly and not at all knowledgeable	22.5%	17.0%	10.7%

4. How do knowledge and understanding of wellness influence wellness center use?

We tested the relationship between level of health knowledge and use of the Wellness Center using Spearman's rho and Kruskal-Wallis H-tests and found only one significant relationship, which is shown in Table 13. Students' self-reported level of mental health knowledge has a statistically significant relationship with their score on the index of Wellness Center Use Ever. A significant difference was found ($H(2) = 9.63, p < 0.05$), indicating that the groups differed from each other. No significant differences were found between level of health knowledge and scores on the index of Wellness Center use during fall 2018.

Table 13. Correlation coefficients for Health Knowledge and WC Use

Knowledge Area	Index of WC Use Ever	Index of WC Frequency of Use Fall 2018
Index of Level of Health Knowledge	rho=0.081 (p=0.169)	rho=-0.085 (p=0.420)

Physical Health	F=1.073 (p=0.343)	H=0.322 (p=0.851)
Mental Health	F=3.573 (p=0.029*)	H=1.362 (p=0.506)
Sexual Health	F=2.975 (p=0.053)	H=4.672 (p=0.097)
Alcohol and Other Drugs	F=0.049 (p=0.953)	H=2.372 (p=0.305)

*p-value .05 or less

As shown in Table 14 below, Students who reported being very knowledgeable and slightly and not at all knowledgeable about mental health had a higher average score (2.83 and 2.74, respectively) on Index of WC Use Ever compared to those who reported being moderately knowledgeable.

Table 14. Mental Health Knowledge and WC Use

Level of Mental Health Knowledge	Index of WC Use Ever
Very Knowledgeable	2.83
Moderately Knowledgeable	2.33
Slightly and Not at All Knowledgeable	2.74

Discussion

The univariate analysis above found that the Wellness Center services students were most likely to have used during their time at St. Olaf College so far were reading Toilet Talk flyers, visiting the Wellness Center for free supplies, and attending Wellness Center swiped events for SPM credit. The services students were least likely to have used at all were visiting the Wellness Center to use the space or to get wellness information and using the Wellness Center website.

During fall of 2018, students most frequently read Toilet Talks, used the website, and attended an event for an SPM credit. The least frequently used types of Wellness Center services were meeting for a one-on-one with a Peer Educator, visiting the Wellness Center to simply use the space, and visiting the Wellness Center for wellness-related information. The mean frequency of Wellness Center use (all services) in fall 2018 was 4.4.

Most students learned or heard about the Wellness Center through Toilet Talk Flyers, promotional posters for the Wellness Center or its events, and through Peer Educators. Students said that the best ways to learn about the Wellness Center and its events were through Toilet Talks, promotional posters, and Resident Assistants/Junior Counselors. Resident assistant/Junior counselors were not the most frequent ways in which students learned about the Wellness Center, but they were the second most frequent response for how students *prefer* to learn about the Wellness Center. We therefore recommend that the Wellness Center partner with Residence Life to spread information and awareness of the Wellness Center during Week One orientation, in dormitories, and at corridor events.

The average score on our 12-point index of health knowledge was 8.56, meaning that most students would rate themselves as moderately knowledgeable or very knowledgeable. Students reported knowing the most about physical health and the least about sexual health. We speculate that this is related to the relative effectiveness of SPM courses and their required Wellness Center presentation attendance. As noted in our literature review, Lockwood and Wohl (2012) found a link between required wellness courses (like St. Olaf's SPM requirements)

and positive health behaviors leading to physical self-efficacy. Given the connectedness of health behaviors, perhaps the self-efficacy students gain during their SPM courses could lead to self-effective behaviors in other parts of their lives. This could explain the relatively low frequency of students meeting with Peer Health Educators or going to the Wellness Center to learn about wellness. However, it is also important to recognize that this measure is self-reported, and that students may under or overestimate their health knowledge.

Our bivariate analysis found that between gender and self-assessed health knowledge, the only significant relationship was between gender and self-assessed mental health knowledge. Females asserted greater knowledge of mental health than males. This is consistent with the findings of Bersamin et al. (2017) and Baldwin et al. (2017) which identified a difference in knowledge and understanding of wellness as a result of social norms. They found that males have a lack of knowledge of health services in comparison to females. This gap between male and female knowledge of health services they identified is related to our findings that females self-assess themselves as more knowledgeable about mental health than males. We therefore recommend that the Wellness Center target mental health-related information and events towards males.

Our analysis also found a statistically significant relationship between sexual orientation and self-assessed knowledge about mental health. LGBTQ+ students were more likely than heterosexual students to indicate being very knowledgeable about mental health, compared to heterosexual students who were more likely to indicate being moderately, slightly, or not at all knowledgeable about it. No other statistically significant relationship between sexual orientation and self-assessed levels of health knowledge were found. This relationship suggests a gap in mental health knowledge between LGBTQ+ students and heterosexual students. We therefore recommend that the Wellness Center target mental health related information and events towards heterosexual students.

Finally, our analysis found a significant relationship between year in school and self-assessed knowledge about alcohol and other drugs. Seniors were more likely than junior and sophomore students to indicate that they were very knowledgeable about alcohol and other drugs. Sophomores were more likely than juniors and seniors to report being slightly or not at all knowledgeable about alcohol and other drugs. We recommend that the Wellness Center focus on promoting events and information towards sophomores about alcohol and other drugs.

Conclusion and Recommendations

Our research investigated knowledge and understanding of the Wellness Center and wellness among St. Olaf College students. Our literature review identified a gap in research on student knowledge and understanding as it relates to on-campus wellness centers. Our study is a valuable addition to research on these centers and it provides initial research in this area for future studies to consider. Our results indicate that many students prefer print media - Toilet Talks and promotional posters - to learn about the Wellness Center and its services. We found that Toilet Talks (the one-page flyers posted in bathrooms) are extremely useful in promoting the Wellness Center because many students read them and believe them to be one of the best ways to receive information. Promotional posters were the second most frequent way that students have learned about the Wellness Center and also their second most preferred way to learn about the Wellness Center. Promotional posters may play an important role in spreading information about the Wellness Center because they are both a preferred way to learn about the Wellness Center and a way that students currently receive information about it. We also found

that students are interested in learning from sources of health-related information through the internet and social media.

Most students rate themselves as at least moderately knowledgeable about the four health areas we addressed. This may be partly a result of participation in required SPM classes. This high average level of knowledge could also explain why many students do not go to the Wellness Center to learn about health or meet with Peer Health Educators specifically about health knowledge.

While St. Olaf students state that they are very knowledgeable to moderately knowledgeable about the four health areas, our analysis demonstrates that students' self-assessed levels of knowledge are mostly unrelated to the demographics we examined. Students' self-assessed levels of knowledge are mostly unrelated to the demographics we examined. This could indicate a limitation of our sample size or analysis. Possible explanations include confounding variables we did not analyze, such as racial/ethnic identity or socioeconomic status, that our sample size was too small to account for significant demographic differences, such as the relatively small number of LGBTQ+ students in our study, or it may be that there are truly very few significant demographic differences in health knowledge by gender, sexual orientation, and year in school.

A limitation of our study is that it is cross-sectional (conducted at one time only), so our analysis cannot speak to the effectiveness of different Wellness Center services. In addition, our results cannot be generalized to freshman, and our respondents were disproportionately female (71.4%) in comparison to St. Olaf student body demographics. Females often have higher survey response rates compared to males. Our survey heavily relied on self-report measures, particularly with regards to our level of health knowledge indicator, and respondents may be under- or over-reporting their level of health knowledge. Finally, in order to test for statistical significance, our study uses binary categories for both gender and sexuality, and we acknowledge that these binary categories do not encapsulate all of our respondents' identities.

A strength of our study is our sample. It was randomly selected and sufficiently large, and the demographics are generally representative of the St. Olaf population, thus allowing us to generalize our results to the sophomores, juniors, and seniors at St. Olaf. The demographics of our sample are generally representative of the St. Olaf population. Our analysis and recommendations are specific to the population that the Wellness Center serves and to the Wellness Center itself. In addition, our study used qualitative focus group data to inform our quantitative survey questions and analysis. Our study also protected the identity of our respondents through anonymous data collection and carefully worded questions that did not ask for specific information that could be used to identify our respondents.

Our results suggest the following recommendations for the Wellness Center at St. Olaf College:

1. Considering the success of Toilet Talks and the accessible nature of posters around campus, we recommend that the Wellness Center continue to use print media to promote itself and to share health-related information.
2. The Wellness Center should actively promote its existing website and social media accounts (Instagram, Facebook), as many students prefer to learn about health through the internet.
3. Additionally, since Resident Assistants and Junior Counselors were the second most popular way in which students preferred to learn about the Wellness Center, the Wellness Center should encourage more partnerships with Residence Life staff,

particularly for Resident Assistants and Junior Counselors, to disseminate information about the Wellness Center in St. Olaf dormitories.

4. Based on our identification of gaps in the level of mental health knowledge for heterosexual students and male students, the Wellness Center should specifically target disparities in mental health knowledge on campus. We recommend they do this primarily through the ways in which students indicated they would prefer to receive health-related information, including Toilet Talks, Wellness Center presentations/events/panels, internet sources, and social media.
5. Since sophomores were less knowledgeable about health related to alcohol and other drugs, the Wellness Center could promote its information and events about alcohol and other drugs specifically to sophomores.

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Appendix A

Table 15. Use of Wellness Center Services – Ever (in descending order)

Type of service	Percentage	Frequency
Read a Toilet Talk flyer	87.0%	267/307

Visited the WC for free supplies (condoms, tampons, chapstick, etc.)	46.9%	144/307
Attended a WC swiped event for SPM credit	40.1%	123/307
Attended a WC swiped event NOT for SPM credit	34.5%	106/307
Used the WC website	23.1%	71/307
Visited the WC for wellness-related information	13.7%	42/307
Visited the WC to simply use the space	7.2%	22/307
Met for a one-on-one with a Peer Educator	3.6%	11/307

Table 16. How learned about WC

Source of Information	Valid Percentage	Frequency
Toilet Talk flyers	91.2%	280
Promotional posters for WC or its events	80.5%	247
Peer Educators	62.5%	192
Resident Assistant or Junior Counselor	41.0%	126
SPM/ESAC (physical movement class in Exercise Science)	38.3%	118
Social media	38.0%	117
WC Website	22.5%	69

Table 17. How prefer to learn about WC

Source of Information	Valid Percentage	Frequency
Toilet Talk flyers	76.9%	236
Resident Assistant or Junior Counselor	76.9%	236
Promotional posters for WC or its events	70.4%	216
Social media	52.4%	161
Peer Educators	28.7%	88
SPM/ESAC (physical movement class in Exercise Science)	28.3%	87
WC Website	21.5%	66

Table 18. Frequency of Use of Wellness Services in Fall 2018 (first 10 weeks)*

Type of service	0	1	2	3 or more
Read a Toilet Talk flyer	4.7% (14/295)	4.7% (14/295)	12.5% (37/295)	78.0% (230/295)
Visited the WC for free supplies (condoms, tampons, chapstick, etc.)	64.4% (170/264)	15.9% (42/264)	11.7% (31/264)	8.0% (21/264)
Attended a WC swiped event for SPM credit	72.9% (183/251)	7.1% (22/251)	6.8% (21/251)	8.1% (25/251)
Attended a WC swiped event NOT for SPM credit	83.1% (212/255)	15.3% (39/255)	0.8% (2/255)	0.8% (2/255)
Used the WC website	66.7% (116/174)	15.5% (27/174)	8.6% (15/274)	9.2% (16/274)
Visited the WC for wellness-related information	89.3% (225/252)	7.5% (19/252)	2.4% (6/252)	0.8% (2/252)
Met for a one-on-one with a Peer Educator	98.1% (210/214)	0.9% (2/214)	0.5% (1/214)	0.5% (1/214)

Visited the WC to simply use the space	90.8% (158/174)	5.7% (10/174)	1.7% (3/174)	1.7% (3/174)
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Table 19. Have you learned about the WC in any other ways?

Source of Info	Frequency
Friends	39
Tabling	28
Events	5
WC Fairs	3
St. Olaf College Staff (Coach, Staff, Faculty)	3
Week One Orientation	2
Acquaintances/ Peer educators	2
Stickers	2
Toilet Talks	2
SPM Requirement	2
Resident Assistant/ Junior Counselor	1
Poster	1
Flyer	1

Table 20. Students' other preferred ways to learn about the Wellness Center

Source of Info	Frequency
Tabling	44
Emails	29
Friends	17
Posters	5
Class	4
P.O. Box Flyers	3
Events	3
Wellness Center Calendar	3
Speakers	1
Toilet Talks	1
Week One Orientation	1
Manitou Messenger	1
Student Government Association	1
Website	1
Peer Educators	1

Table 21. Self-Assessed Health Knowledge Scores

Knowledge Area	Very knowledgeable	Moderately knowledgeable	Slightly knowledgeable	Not at all knowledgeable
Physical Health	40.1% (116)	51.9% (150)	8.0% (23)	0.0% (0)
Mental Health	30.4% (88)	50.9% (147)	17.6% (51)	1.0% (3)
Sexual Health	26.4% (76)	55.9% (161)	15.3% (44)	2.4% (7)

Alcohol and Other Drugs	26.4% (76)	55.9% (161)	16.3% (47)	1.4% (4)
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Table 22. Gender and Self-Assessed Mental Health Knowledge

Level of mental health knowledge	Female	Male
Very knowledgeable	33.3% (65)	22.2% (16)
Moderately knowledgeable	51.8% (101)	50.0% (36)
Slightly and not at all knowledgeable	14.9% (29)	27.8% (20)

Table 23. Sexual Orientation and Self-Assessed Level of Mental Health Knowledge Values

Level of mental health knowledge	LGBTQ+	Heterosexual
Very knowledgeable	47.2% (25)	27.9% (56)
Moderately knowledgeable	43.4% (23)	52.7% (106)
Slightly and not at all knowledgeable	9.4% (5)	19.4% (39)

Table 24. Year in School

Year	Percentage	Frequency
Sophomore	37.4%	104
Junior	31.7%	88
Senior	30.2%	84
Other (not first year)	0.7%	2

*n=278

Table 25. International/Domestic Status

Status	Percentage	Frequency
International	6.1%	17
Domestic	93.9%	261

*n=278

Table 26. Gender (Full Array)

Gender	Percentage	Frequency
Female	71.4%	195
Male	26.7%	73
Female Transgender	0.4%	1
Male Transgender	0.4%	1
Nonbinary	1.1%	3

*n=273

Table 27. Gender (Binary only, for statistical tests only)

Gender	Percentage	Frequency
Female	72.8%	195
Male	27.2%	73

*n=268

Table 28. Race/Ethnicity (All categories reported)

Race/Ethnicity	Percentage	Frequency
African	0.4%	1
African American/Black	2.3%	6
Asian/Asian American	9.8%	26
Latinx/Hispanic	4.9%	13
Middle Eastern	0.8%	2
Native American	0.4%	1
White/Caucasian	75.8%	201
Multi-Racial/Ethnic	5.7%	15

*n=265

Table 29. Race/Ethnicity (Binary, for statistical analysis only)

Race/Ethnicity	Percentage	Frequency
Students of Color	24.2%	64
White Students	75.8%	201

*n=265

Table 30. Sexual Orientation (All categories reported)

Sexual Orientation	Percentage	Frequency
Asexual/Demisexual	0.8%	2
Bisexual	10.2%	26
Gay/Lesbian	3.9%	10
Heterosexual	78.8%	201
Pansexual	3.1%	8
Queer	1.6%	4
Questioning/Don't Know	2.6%	4

*n=255

Table 31. Sexual Orientation (Binary, for statistical analysis only)

Sexual Orientation	Percentage	Frequency
LGBTQ+	21.2%	54
Heterosexual	78.8%	201

*n=255

Appendix B

Figure 4. Wellness Center Use Ever

Have you ever used the Wellness Center services listed below?

- Visited the WC to get free supplies (such as condoms, tampons, pads, chapstick, or bandaids)
- Used the WC website (e.g., to get information on a wellness topic or to find the WC hours)
- Attended a WC swiped event in order to get a swipe for credit toward an ESAC/SPM class
- Attended a WC swiped event, but NOT to get a swipe for an ESAC/SPM class
- Visited the WC for wellness-related formation
- Visited the WC to simply use the space (for example, to study or to color in a coloring book)
- Met for a one-on-one with a Peer Educator
- Read a Toilet Talk flyer (flyers on health topics, posted in bathrooms in Buntrock and the library)

Figure 5. Wellness Center Use Fall 2018

So far this semester, how many times have you personally used each type of Wellness Center service listed below? Please note that if your answer is "0 times" there are two response options because we'd like to know whether it was because you were unaware that the service existed.

	0 times this semester (I was UNAWARE that this service/option existed until now.)	0 times this semester (I was AWARE of this option but have not used it.)	1 time this semester	2 times this semester	3 times or more this semester
Visited the WC to get free supplies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Used the WC website	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attended a WC "swiped" event in order to get a swipe for an SPM class	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Attended a WC "swiped" event, but NOT to get a swipe for an SPM class	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Visited the WC for wellness-related information	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Visited the WC to simply use the space	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Met for a one-on-one support talk with a Peer Educator	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Read a Toilet Talk flyer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Figure 6. Best Way to Receive Wellness Center Information

For you personally, what are (or what would be) the best ways to receive information about the Wellness Center and its programs? Check all that apply. If none of them work well for you, please check "None of these."

- Peer Educators
- The WC website
- Social media (Facebook, Instagram, emails from the Wellness Center)
- Promotional posters
- Toilet talks
- Resident Assistants or Junior Counselors (RAs or JCs)
- Information from SPM/ESAC(s) (information from the instructor or the syllabus)
- None of these

Figure 7. Preferred Health-Related Information Ways

When it comes to learning about health - mental health, physical health, sexual health, and alcohol and other drugs - there are lots of ways to get health-related information, such as the options included in the questions above (The WC website, WC presentations, Toilet Talks, Peer Educators, SPM/ESACs, social media, RAs and JCs) *along with* WC events such as The Alcohol Education Carnival, personal reading, online videos, and so on. Thinking about these options or any others that occur to you - involving the Wellness Center or not, what are the top two ways that you personally prefer to get health-related information?

Figure 8. Self-Assessed Health Knowledge

How would you assess your own level of knowledge about these topics?

	Very knowledgeable	Moderately knowledgeable	Slightly knowledgeable	Not at all knowledgeable
Physical health (such as nutrition/eating, exercise, and sleep habits)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health (such as stress, time management, and anxiety and depression)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual health (such as reproductive health, consent, sex education, and sexually transmitted infections)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol and other drugs (such as alcohol poisoning, drug addiction, marijuana)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Figure 9. Year in School

What is your year in school?

- Sophomore
- Junior
- Senior
- Other

Figure 10. International Student Status

Are you an international student?

Yes

No

Figure 11. Gender Identity

What gender do you identify as?

Figure 12. Sexual Orientation

What sexual orientation do you identify as?

Figure 13. Racial/Ethnic Identity

What racial/ethnic group(s) do you identify as?

Figure 14. Slush Question

Is there anything else you'd like to tell us about the Wellness Center and your experiences with it or your suggestions for it?