The Founding of Student Health Services at Indiana University: A Brief History (1833-1924)
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This paper traces the establishment of health services at Indiana University (IU) between 1833 and 1924, and delineates the factors, successes, and individuals who contributed to this growth. In the late 19th and early 20th centuries, efforts to conserve student health at IU were sluggish, primarily in response to epidemics, and were weighed down by scarce fiscal resources. Over the years student health services gained attention, becoming a standard element on campus.

It is widely acknowledged that education and health are intertwined, and the health of students is recognized to be an important determinant of educational and occupational achievement (Diehl & Shepard, 1939; Marx, Wooley, & Northrop, 1998). This premise is echoed in the current mission statement of the Indiana University Health Center (IUHC), which emphasizes provision of high quality health care (IUHC, 2007). The mission statement links physical and mental well being to the successful pursuit of academic goals, and stresses the importance of education, support, and counseling to make possible informed choices, positive behaviors, and healthy lifestyles (IUHC, 2007). The link between student health and academic activities cannot be overemphasized and underscores the need for comprehensive student health services in academic institutions.

The current focus of student health services is on both preventative care as well as treatment. The wellness of students is not limited to physical well being, but also includes dimensions such as mental, intellectual, vocational, emotional, environmental, and spiritual health (Rainer, Johnson, & Jeffery, 1998). By expanding the dimensions that define student health and wellbeing, colleges and universities have recognized the importance of incorporating these aspects into the overall educational experience and care of students. The move to include comprehensive health care to students on campus is a result of propositions by leaders and health practitioners in the late 19th century who became aware that tragedies such as death and disability could have been prevented by a greater use of modern protective and educational measures (Diehl & Shepard, 1939).

From their inception until the mid-1800s, institutions of higher education in the United States did not have formal student health services or regular physicians on staff. In the mid-1850s, these institutions began to recruit physicians to care for students on campus, as did other social institutions, including almshouses, penitentiaries, and houses of industry (Rogers, 1937; Turner & Hurley, 2002). The focus of student hygiene was centered on treatment of students, not on preventative care, as we know it today.

There is speculation about why student health centers were established, and while the thrust may have differed from campus to campus, there are numerous similarities in the structure and precursors to their establishment. These include (a) the perceived need to safeguard and improve the health of students by presidents, (b) institutional responsibility for the provision of accessible health care to students, (c) traditional medical practices in the community did not meet the required short access time and could not cope adequately with a large number of students, (d) tendency of students not to pay their medical bills, and (e) the need to deal with epidemics and other infectious diseases (Christmas, 1995).

This paper traces the growth of student health services at IU from the cholera epidemic of 1833 to the period following World War I (WWI). The student health service environment in 19th century American colleges and universities will be examined, followed by an investigation of the factors, individuals, and challenges that influenced the development of student health services at IU. This paper argues that the establishment of student health services was erratic, beleaguered by financial difficulty, and primarily a reaction to epidemics. The conservation of student health gradually gained attention as the student population increased and institutions sought to deal with epidemics and contagious diseases that afflicted students. This paper concludes with recommendations for increased earmarks for student health services.

Student Hygiene and Physical Health in the United States

Student Health on Campus

In the early 19th century, emerging institutions of higher education in the United States followed the European philosophy of “a healthy mind and a healthy body” to introduce the idea of teaching hygiene and physical education to students (Christmas, 1995, p. 241). The introduction of mass physical education to colleges and universities in the United States was an adaptation of practices in Germany and Scandinavia (Boynot, 1961). Harvard was the first to initiate mass physical education and provided a gymnasium for students as early as 1825, and was followed by Dartmouth, Wil-

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1 "Hygiene" was the term used in place of what we now call "health", but was limited to physical aspects of health such as prevention and treatment of infectious diseases. A substitution of the term occurred in the 1940s. It followed advancements in the teaching of health, which began to infuse concepts of behavior and attitudes in preservation of health. See Diehl & Shepard (1939) and Christmas & Dorman (1996).

2 Indiana College officially became Indiana University following a legislative act in 1838; see The Chronology of Indiana University History at http://www.indiana.edu/~libarch/iuschron/iuschron.html. In this paper Indiana College is used when reference is made to the university prior to 1838, of health, which began to infuse concepts of behavior and attitudes in preservation of health. See Diehl & Shepard (1939) and Christmas & Dorman (1996).
lians, Yale, and Amherst thereafter (Boynton, 1961; Turner & Hurley, 2002). Physical education was mandatory for all students at some institutions, a practice that continued into the early 20th century. For instance, at the University of Chicago, students had to work in the gymnasium four times a week as part of the curriculum offered through the Department of Physical Culture (Capps, 1900). Intercollegiate and intramural sports developed towards the end of the 19th century, following the inclusion of hygiene in the curriculum (Christmas, 1995).

The concern for student health on campus grew out of the parental role ascribed to ante-bellum colleges. As the Yale Report of 1828 outlined, the object of the college was “to lay the foundation of a superior education; and this is to be done, at a period of life when a substitute must be provided for parental superintendence” (Best, 1976, p. 176). Although the primary function of colonial American colleges was to prepare competent rulers, learned clergy for the church, cultured men for the society, and “youth who were piously educated in good letters and manners,” the college was also responsible for the welfare of students (Rudolph, 1962, p. 7).

Students in the colonial American colleges, who had spent their younger years under the direct care of parents, were now expected to know what to do in the event of sickness. They were expected to know where to seek competent healthcare and how to make proper decisions on personal care. Despite the fact that many students in the early American colleges did not seek education at institutions outside their home state, those who did were away from the familiar home environment. For these students, educational experiences involved not only academic learning, but also included aspects of survival in a new social environment. The impetus for institutions of higher education to find the means by which to care for sick students grew out of a concern for students missing class and institutional closure due to epidemics, e.g. Indiana College in 1833 and 1918, and Mount Saint Mary’s College in 1882 (“Mount St. Mary’s Closed”, 1882, April 13). Christmas (1995) argues that college presidents and faculty were concerned about the absenteeism of students as a result of epidemics and sickness. These factors, among others, resulted in the creation of university policies that provided for the employment of college physicians. In an 1856 address, President Stearns at Amherst College passionately described the need to preserve student health as follows:

The breaking down of the health of the student, especially in the spring of the year, which is exceedingly common, involving the necessity of leaving college in many instances, and crippling the energies and destroying the prospects of not a few who remain, is in my opinion, wholly unnecessary if proper measures could be taken to prevent it. (Cited in Diehl & Shepard, 1939, p. 11)

Dr. John W. Hooker is the first known college physician in the United States and was appointed as Professor of Hygiene at Amherst in 1859 (Turner & Hurley, 2002). Hooker resigned after one year of service and Dr. Edward C. Hitchcock Jr., who is now credited as the “Father of American College Health,” filled the position (Turner & Hurley; p. 3). Dr. Hitchcock introduced a system of anthropometric measurements, as suitable indices of health status. These became a model for college hygiene and were copied by many campuses across the United States and the world (Christmas & Dorman, 1996; Turner & Hurley, 2002). There were other health professionals such as Dr. Thomas A. Storey, who had a lasting positive influence on the development of college hygiene in the United States through their vision to improve the health status of people in the nation (Boynton, 1961).

Infirmaries and Isolation Wards

Although pneumonia and influenza led to the largest number of deaths in the United States in the 20th century (Armstrong, Conn, & Pinner, 1999), health services in colleges and universities were greatly influenced by the typhoid and scarlet fever epidemics, (Turner & Hurley, 2002). In order to care for students with communicable diseases, many colleges established infirmaries and isolation wards (Boynton, 1961). This practice reflected the developments and scientific advances in epidemiology, imported to the Americas from Europe in the early 19th century, that demonstrated that typhoid and cholera were waterborne diseases (Christmas & Dorman, 1996). These and other scientific findings on the transmission of disease necessitated the quarantine of populations who were infected or had been exposed to the disease-causing pathogens.

Some institutions had affiliated medical schools, which afforded students the opportunity to observe and participate in the treatment and care of patients. In his 1890 account of the history of IU, Theophilus A. Wyile, Professor Emeritus of Physics, stated that the College in Indianapolis had a “…dispensary where gratuitous professional services were rendered enabling the students to witness and take part in the management of… cases” (Wyile, 1890, p. 79). However, Wylie did not indicate whether health services, such as vaccinations and treatment, were extended to students. The recruitment of college physicians and the establishment of infirmaries and isolation wards signaled the advent of student health services in institutions of higher education in the United States.

Student Health at Indiana College: 1829 to 1899

From the inception of Indiana College in 1829 until the late 1890s there was no formal system for treatment and care of students on campus. The cholera epidemic of 1833 was lethal and resulted not only in the dis-
ruption of classes, but also in the demise of some students and citizens of Bloomington. In August 1833, students at Indiana College were sent home after Cuthbert Huntington, a student from Indianapolis, died after a cholera attack (Roache, 1890). In his letter dated December 27, 18903 to Judge D. D. Banta, Addison Locke Roache stated that Huntington was buried the morning after his death and also noted,

Almost immediately after the funeral the students left for their homes. Those who were able to secure conveyances, or horses, went that way, but my recollection is that the great majority could not secure any conveyance, and in their wild hurry to escape from the pestilence, left town on foot. (Roache, 1890)

Following this incident President Wylie authorized the immediate closure of the institution. The College did not reopen until September 1, 1833. In addition to the cholera epidemic, the College was facing other pressing matters, which prompted the residents of Bloomington to prepare a statement to be sent to the public. They addressed the cholera epidemic of which they stated: "...the epidemic which has visited us has been mild here in its operations and has now subsided" (Brandon et al., 1833, p. 1). They also dealt with concerns about the negative public image, financial viability, and prejudices4 that they believed were operating against the image of the College and the city of Bloomington.

By 1890, fifty-seven years after the cholera epidemic, IU still did not have a student health facility. A health committee chaired by Professor W. D. Hamer5 carried out an assessment on student health and care for sick members of the college using a four-item questionnaire (Hamer, 1890). The assessment wanted to obtain student responses on (a) how many terms they had been at IU, (b) whether they had been sick, (c) for how long they had been sick, and (d) who provided attention to them while sick. While this assessment marked the beginning of coherent steps to review and initiate

formal student health services, the findings did not lead to the immediate establishment of formal mechanisms to care for the sick.

In the fall of 1895, a meeting was organized to elect another committee to look into means of providing health care to students in the event of illness. The urgency of the matter was given impetus by numerous incidents of sickness among students at the college the preceding year. The call to the student body read in part:

Last year's experience with sickness among the students has suggested the idea of an organization on the mutual benefit plan for the care of its members during sickness. This object might be secured by renting a house, equipping in a suitable manner as many rooms as deemed necessary, and putting a trained and competent nurse in charge. If deemed advisable bathrooms could be fitted up in connection with such a sanitarium. Every student interested in this movement is invited to meet at Mitchell Hall on Thursday evening, Sept. 26, at 4 p. m. to appoint a committee to investigate the details of such a work and report the most feasible plan of organization. ("To the student body," 1895, September 24)

This announcement was secured by a group of individuals,6 some of whom had been on the 1890 health committee. There is little evidence to demonstrate that any action was taken by IU to formally establish student health services until 1900. At the turn of the century, the scarlet fever and smallpox epidemics caused the IU administration to refocus their attention to student health. President Swain commissioned Professor G. H. Stempel to investigate what other colleges and universities in the United States were doing to conserve student health. This commission indicates that IU did not have a student health policy in place and lacked a unified concept regarding the structure and delivery of health services to students.

Student Health Services at IU: 1900-1921

By 1900, a total of 600 students were enrolled at IU (IU, 1833). On November 10, 1900, Stempel submitted to President Swain his findings and recommendations on what other institutions were doing to conserve student health (Stempel, 1900, November 10). He proposed a student health insurance plan for IU to be organized in a manner similar to the Studentische Krankenkasse7 at Leipsic (Stempel, 1900, November 10). Stempel arrived at this proposition after a series of inquiries to personal friends who were

3 A. L. Roache wrote this letter to Judge Banta in response to a controversy regarding a historical document authored by Dr. Wiley. Three professors involved in this controversy were Dr. Wiley, Professor Hall, and Professor Harney. In his letter, Roache provided a description of events in Bloomington during the cholera epidemic of 1833, and stated that he was too young to recall the difficulty between Wiley, Hall, and Harney.

4 These prejudices against the College had apparently arisen out of a continuing feud between Professors Baynard R. Hall, John H. Harney, Samuel Givens, and the recently recruited President Wylie. In his book Indiana University: Its history from 1820-1890, Theophilus A. Wylie (1890) briefly alludes to this controversy and states "...the cause and nature of which it is unnecessary to inquire into..." (p. 49). However, Thomas Clark gives some detail in his rendition of the same period in Indiana University: Midwestern

5 The committee chaired by W. D. Hamer consisted of the following members: Georgetta Bowman, President Swain, Kerr, F. B., Knipp, C. T., Craig, H. V., and Spain, P. A.

6 The announcement was prepared and sent out by the following: Endicott, C. E., Binford, E. A., Cook, G. M., Knipp, C. T., Bush, E. D., Hindman, E. E., Brooks, R. C., & Hamer, W. D.

7 Studentische Krankenkasse refers to student health insurance programs. These programs were being utilized in Germany, as at Leipsic where Prof Stempel was a student from 1895-1897. Prof Stempel had benefited from the Krankenkasse and saw the need to have a similar program initiated at Indiana University.
employed at various universities across the United States, some of whom had been his colleagues at Leipsic, e.g., President MacLean and Professor Loos at the University of Iowa, and George Howe at Cornell (see Table 1). Stempel was firmly convinced that the best approach to provide suitable and efficient health care for students was through a health insurance plan, even though some of his peers felt differently. Howe affirmed in his letter to Stempel that the plan “...might not work in this country as well as in Europe and if you are trying to push it through I wish you all success” (Howe, 1900).

Some institutions had a fund, managed by the university bursar or treasurer, which was used to offset the medical costs incurred by students. For instance, the Universities of Nebraska, Cornell, Illinois, and Princeton had a sick-fund into which students made annual contributions (see Table 1). Stempel favored the plan in use at Princeton, which required each student to contribute $3.00 per term, and in turn students could use the services provided at the infirmary (see Table 1).

As he concluded his letter, Stempel outlined several health hazards in the city of Bloomington that college students were exposed to:

There are some special reasons for urging action in the matter for Indiana University. -1. The drinking water in Bloomington is more than usually dangerous. -2. There is no sewerage system in Bloomington. -3. The railroad facillities are such that in many cases a trip home is fraught with undue danger, especially on account of waits in unsanitary stations. -4. There is no city hospital. (Stempel, 1900, November 10)

Bloomington was a relatively small city at the time; therefore the absence of a city hospital was not unique. Some institutions such as the University of Michigan and University of Iowa, relied on their medical hospitals to provide health care for their students, albeit students had to pay full or two-thirds the regular rates (see Table 1). The University of Wisconsin did not have an infirmary, nor was there a city hospital in Madison. Walter M. Smith, a librarian at the university, believed that the university would not need its own infirmary once a city hospital was built (see Table 1).

President Swain did not immediately follow through with the recommendations given by Stempel, but set up a Faculty Committee on Hygiene chaired by R. Lyons. The purpose of this committee was to investigate how to care for students who fell sick and how the expenses incurred for medical services rendered could be paid. On October 23, 1901, the faculty committee submitted their report, which recommended that, (a) each student to be charged 10 cents per term to be deposited in a fund to pay for medical expenses, (b) rooms to be reserved for use in emergencies as a sort of hospital, and (c) competent nurses and proper food be provided for sick students (Lyons, 1901). In principle, the recommendation to charge students a fee of 10 cents per term is similar to the proposal Professor Stempel had given the previous year.

**Founding of Student Health Services**

Student health care was established at IU in 1902 mainly to tackle infectious diseases, and was limited to the quarantine of students infected with “smallpox, diphtheria, and typhoid” (D’Amico, 1992, p. 37). This necessitated the acquisition of a building to be used as an isolation hospital, which was a common measure taken by many colleges to protect against the spread of epidemics (Diehl & Shepard, 1939). In his Presidential Report of November 6, 1902, President Swain pointed out the difficulty the institution had finding a house for a small pox hospital, and that the identified loca-
of Physical Training and changing the name of this department to Physical Training and Hygiene or Student Health” (Pohlman, 1913, p. 1). He also recommended that the University Physician be responsible for the University Hospital.

By 1915 the University Isolation Hospital had a capacity of five beds and could accommodate up to fifteen patients in the event of an emergency (Holland, 1915). According to correspondence between Holland and President Bryan, the beds were unsuitable for a hospital, and Holland requisitioned the purchase of three beds and three mattresses for the hospital (Holland, 1916, March 2). Three beds are a relatively small number by today’s standards, however, these were deemed sufficient for the needs at the time. Also, there was no urgent need to expand this campus facility because the city of Bloomington had recently built a city hospital that had 14 beds and was equipped with a modern operating room (Holland, 1915).

With the surge in student enrollments, the office of the university physician experienced an increase in workload and responsibilities. In the spring of 1917, Fernande Hachat, M.D. was employed as the assistant University physician on a salary of $1,200 per year (1917 dollars) (Holland, 1916, November 29; Woodburn, 1940). During this period the University physician was required to perform physical examinations of all incoming students, oversee the University hospital, carry out medical consultation and treatment, review and ensure proper sanitary conditions of the boarding facilities on campus, and prepare annual reports on student hygiene. During the WWI period the University physician had additional responsibilities, such as making recommendations on whether or not students were fit to join the military.

In addition to these responsibilities, Holland was involved in private medical practice, which presented a logistical problem for him. In a lengthy letter dated February 11, 1918, to President Bryan, Holland indicated that his private practice was suffering and he needed to decide whether to keep the IU job or reduce his responsibilities to IU and keep his private practice (Holland, 1918, February 11). Although Holland decided to keep his job at IU, it was not without anxiety. In a follow-up letter to President Bryan, he indicated that he was keen to have the responsibility of rendering general medical service to students discontinued (Holland, 1918, April 15). The employment of Hachat in 1917 as the assistant physician ought to have reduced the workload for Holland, but one year later he still felt the need to have it reduced. The University faced the influenza epidemic, and the physician's office had an increase in the number of patients needing medical attention.

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8 Professor Bryan had been appointed Indiana University vice-president in 1893, a position he held until 1902. President Swain left IU in 1902 to take up a new position as President at Swarthmore College and Professor Bryan became the IU President.

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9 Although the University physician was the official medical consultant for student on campus, there were certain limitations. In his recommendations, Dr. A. G. Pohlman recommended that consultations and treatments for venereal diseases not be done by the University physician (see Report to President W. L. Bryan December 26th 1913. Indiana
While serving in the military during WWI, Holland maintained his ties to the University and was keen to address pertinent health issues with President Bryan. As medical officer in the army at Camp Greenleaf Chickamauga Park Georgia, Captain (Dr.) Holland dealt with cases of the Spanish influenza among the troops. In the fall of 1918, Holland wrote to President Bryan outlining the early symptoms of the flu and gave recommendation on how handled students who exhibited these symptoms. In his letter he stated that:

Every student taken suddenly with a chill followed by fever and grippsy symptoms should be immediately moved to a place of isolation and observed until they either have or have not got affliction. The common habit of spitting, even in the streets, should be vigorously dealt with, sneezing and coughing must be done in a handkerchief. The bowels must be kept regular and free. I think it would be well to take up the spitting nuisance with the city authorities and have an ordinance passed making it punishable (Holland, 1918).

Students Army Training Corps

At this time 60 percent of the 1,935 students at IU were enrolled in the Students Army Training Corps (S.A.T.C.). If students experienced symptoms of the influenza, they were advised to go to Maxwell Hall where the university physician would give them “cold” shots (Woodburn, 1940, p. 366). Despite these precautions, the spread of the flu continued unabated, and on October 10, 1918, the University was closed (Bryan, 1918). This order only applied to the regular students, and those in the S.A.T.C. remained in their barracks as per military regulations. Students who contracted the flu were confined in the University Isolation Hospital, but as the epidemic spread, Assembly Hall and the Student Building were converted to create the IU S.A.T.C. Hospital (IU, 1919; Woodburn, 1940).

In the fall of 1918, Dr. Holland returned to Bloomington having been excused from military service due to a “physical disability existing prior to his entrance in the service” (Bryan, n. d.). It is noteworthy to mention that President Bryan provided both the recommendation letter requested prior to Dr. Holland’s enlistment into the military and subsequently the letter requesting that he be excused from military service due to his physical disability. In addition to Holland’s disability, President Bryan’s letter also noted the doctor to patient ratio, 11 physicians served the Bloomington community of over 22,000; therefore, because of the raging influenza epidemic, the services of Dr. Holland were required as a matter of great urgency (Bryan, n. d.).

Student Health in the Post WWI Period

The use of the term health, as a substitute for hygiene, signaled a new trend and global shift in professional terminology in the field of student health services. In the early 1920s there was a shift in the principles that defined and guided the teaching of hygiene in the United States. As outlined by Christmas and Dorman (1996), imparting information about health and hygiene to students was insufficient. Health education involved alteration of human behavior; hence the health educator needed to draw from the social sciences to better understand how to work with people individually and in groups. The personal health problems of the individual student began to take precedence over daily exercise and the earlier focus on control of communicable diseases (Diehl & Shepard, 1939). At this time professionals in the field of student health and education began using the term health, though it was not until the early 1940s that a complete substitution of the term occurred.

At the end of WWI, forty institutions benefited from “federal aid to establish student health centers” (Christmas, 1995, p. 243). The federal initiative aimed at controlling infectious diseases through a unified and coordinated effort of health education, health examinations, physical training, sanitary supervision, and development of health consciousness to be delivered through a single department or service. The chief concern for the federal government was to reduce the “incidence of venereal disease in the armed forces, as well as in the civilian population” (Boynton, 1961, p. 297). Although a laudable move by the federal government, it is unclear whether IU received these federal funds to develop its student health services.

By the mid-1920s, the University hospital was being used to treat both students and faculty, even though the primary function of the hospital was to accommodate IU students. For example, in February 1924, Professor Ede contracted scarlet fever and was admitted at the University Hospital (Holland, 1924, February 28). The admission of a university professor to the student health facility may imply that the quality of service at the University hospital were equivalent to those offered by the city hospital, and also that the existence of the University hospital on campus had been legitimized. Although there were ongoing debates in the 1920s and 1930s regarding the scope of services and potential administrative structure to supervise health programs (Boynton, 1961), ultimately student health services became a fundamental feature in colleges and universities in the United States.

Scarc resources hampered the construction of a new University hospital at IU. On January 12, 1937, the Board of Trustees informed Holland that his request for funds to build a university hospital had been declined. The letter indicated in part that “…the financial questions involved are very difficult and that the Trustees are responsible for the financial admin-
istration of the University must act with prudence" ("Letter to Dr. Holland from the Board of Trustees," 1937, January 12). The decision by the Board may indicate that improvement and expansion of student health services was not a major concern of the leadership at IU. It could also mean that there was insufficient justification to allocate money towards the construction of a University Hospital.

Conclusion

This brief history outlines some of the key factors and mentions some of the individuals who contributed to the establishment of student health services at IU, but it is far from being a complete account as it only addresses the first 100 years of IU’s history. To enable a better contextualize account, decisions by the university administration may require further investigation. For instance, it would be informative to find out why the university administration did not follow through on recommendations proposed by Professor Stempel in 1900, but setup another committee chaired by R. Lyons to do another assessment on student health services the following year. Answers to these, and other administrative decisions, would require an analysis of the deliberations in the meetings of the Board of Trustees and the Faculty Committee on Hygiene regarding student health. This paper ends at the period following WWI. However, there are major advancements in medicine, epidemiology, student and adolescent health, health promotion, and health education that have occurred since then, which would enrich the overall history of student health services.

Readers have been exposed to key historical aspects regarding the growth of student health services at IU and the changing definition of, and attention to, student health over time. This is of key importance for higher education practitioners because it situates student health within the overall administrative and academic landscape on campus. It signifies that ad hoc planning for student health does not lead to favorable consequences and should therefore not be put on the back burner. It provides a lens through which to understand how the University administration in the past responded to the overall health of students relative to their academic trajectory. The interruption of classes due to infectious disease was, and still is, a concern for academic institutions. Infectious diseases, such as the avian flu, HIV/AIDS, severe acute respiratory syndrome (SARS), and multidrug-resistant tuberculosis (MDRTB) among others require consistent efforts to control incidence. As administrative, policy, and budgetary decisions are deliberated;

higher education practitioners need to keep in mind the necessity of maintaining, if not increasing, attention and earmarks to student health services.

The need for efficient health service programs in colleges and universities cannot be overemphasized. Health practitioners in higher education need to be proactive and pay close attention to the changing perceptions about health by individuals and communities. A history, such as this one, provides a lens through which interpretations can be made and insights gained to accommodate the changing health needs of students on campus.

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