Service-Learning Research for Development:
An Option for the Poor *in Practice* through Social Analysis and Community Engagement

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Abstract

A group of faculty, staff and students from Creighton University conducted a research project using a strengths-based approach to create a community health needs assessment (CNHA) in the fall of 2017. The instruments, including a survey to determine health status, a focus group questionnaire, an environmental scan and an individual interview instrument, were developed to help shift the paradigm from which many international medical missions are conducted with Creighton's community partner in the Dominican Republic, the Centro de Educación para la Salud Integral (CESI). In the process of creating, developing, implementing, assessing and reformulating this strength-based CHNA, researchers encountered both unexpected challenges and opportunities. Results showed that diabetes, hypertension and hypercholesterolemia were prevalent to a degree which suggests the charity model for a medical mission may be ineffective at preventing disease and may inhibit community agency. The goal was to encourage both individual and community agency through knowledge gleaned from the assessments. With better knowledge of the community, its strengths and deficiencies, both CESI and Creighton are better positioned to make an option for the poor in practice that will help reduce the prevalence of chronic disease and improve long term quality of life. This bi-national, bi-

lingual and interdisciplinary research project was both an educational and cautionary tale.

In February 2019 Arturo Sosa, S.J., Superior General of the Society of Jesus, presented four universal apostolic preferences of the Society to Pope Francis. The second of these preferences is "To walk with the poor, the outcasts of the world, those whose dignity has been violated, in a mission of reconciliation and justice."[1] This preference can be pursued "by promoting social organizations committed to seeking the Common Good, . . . [which] help counteract the pernicious consequences of the diverse forms of 'neo-liberalism,' fundamentalism and populism."[2] Creighton University collaborates with a medical mission and social services organization in the Dominican Republic (DR) that is actively "seeking the Common Good." This collaboration and its ongoing evolution are one way in which a Catholic and Jesuit university can make an option for the poor. We attempt this by accompanying the people of the DR as they develop their own agency and improve their quality of life.

With a grant funded by the Creighton Global Initiative (CGI), Creighton University faculty and students collaborated with the *Centro de Educación y Salud Integral* (CESI) in the DR to create and implement a community health needs assessment (CHNA) in two of the villages they serve. This piloting of the CHNA instruments is intended for use by more than the 160 other campos served by CESI. This bi-national, bi-lingual, interprofessional collaboration sought to develop a process through which to gain a deeper understanding of CESI communities with the goal of improving their health. Additionally, the team sought to establish a strategy to maximize the effectiveness of visiting health and development teams through a better understanding of the communities they serve. As part of the implementation process, the team was able to identify vulnerable members within some of the communities served by CESI, as well as contribute to a prioritization of health issues to be addressed. In the process,

Creighton students learned knowledge and skills they could not have easily learned in other ways. Results suggest that chronic illness, lack of potable water and electricity, and few available nutritious foods contribute to a cycle of poverty and poor quality of life. Clinical and educational approaches are needed. Further, an environmental scan revealed the isolation of members of cultural minority groups, the need of repair of many houses, and land that is not always usable for family agriculture. Many of the residents are elderly and are under the care of family members who also struggle to survive.

Communities are sometimes viewed as locations where problems reside, and services are delivered rather than where people live and flourish. The ways in which a university enters into collaboration with its partners determines its own capacity to implement programs for and with the poor and marginalized. While it is possible for the community to sometimes be part of the problem, it must always be an integral part of any solution. To assist in improving Creighton's engagement paradigm with its partner in the DR, our team began with a definition of community as an "associative, self-generated gathering of common people who have sufficient resources in their lives to cope with life's demands. . . "[3] In the spirit of this definition, our team sought to assist communities to become empowered to activate their own agency and locate sufficient resources and assistance to ensure their sustainability for their future.

In this paper we describe the process of implementing a strengths-based community health needs assessment within the communities served by Creighton University's medical mission in the Dominican Republic as well as what information our instrument revealed about one community and its health. In addition, we describe the learning experienced by Creighton students who were integrated into this from

research to implementation. We conclude with how this knowledge from our journey revealed many possibilities for realizing concrete "options for the poor."

Methods

Using a strengths-based approach, a group of faculty, staff and students from Creighton University began a research project in the fall of 2017 to shift the paradigm from which some of its international health missions are conducted along with its community partner in the Dominican Republic, the *Centro de Educación para la Salud Integral* (CESI). The faculty members involved represented Medicine and Theology while staff from Creighton University's Institute for Latin American Concern (ILAC) helped guide and implement this entire effort.[4] Assessments such as these have never been conducted and therefore presented the opportunity to explore the impact of services provided as well as establish the needs that may still exist. This process was initiated from the recognition that we likely did not know enough about the people in the Dominican Republic even though we have served them for more than 40 years. Therefore, we could not always be certain that we were helping them leverage their strengths or were collaborating with their agency. During the implementation phase of these instruments, we collaborated with medical students from the Pontificia Universidad Católica Madre y Maestra (PUCMM), a Catholic University in Santiago, DR and with some of the community leaders with whom CESI works. We introduced the utility of creating, developing and implementing strengths-based community health needs assessments (CHNA) which would give us multi-dimensional and critical information about the communities that both CESI and Creighton serve.

Unexpected challenges as well as opportunities arose in the process of creating, developing, implementing, assessing and reformulating these strength-based CHNA instruments which made this bi-national, bi-lingual and interdisciplinary research project both an educational and a cautionary tale. A commitment to social justice

necessitates a recognition that charity models of service continue to be influential today and have in many cases not been effective in the long-term. Foremost among them are health interventions done with little or no knowledge of the community or a plan for long term sustainability of the interventions within those communities.

The Process

The process to develop community health assessment instruments for CESI villages in the Dominican Republic began with the realization, over time, that visiting groups of health professionals did not know the communities they tried to serve. When some consensus was reached on this view both by those who work at CESI and the ILAC office at Creighton, an outreach e-mail was sent to the Executive Director of CESI. This communication formally asked whether there was interest in assessing the communities targeted by the health interventions of the annual Summer Medical Program as well as other visiting health groups sponsored by Creighton University's Institute for Latin American Concern (ILAC). The ILAC Summer Medical Program sends inter-professional teams of health professionals into five or six different communities for a month each summer to serve the health needs of the people there. When this outreach was accepted, a grant proposal was submitted to the Creighton Global Initiative and awarded.

Shortly thereafter, research team directors established a competitive process for undergraduate and graduate students to apply to participate in this research project. Early in the fall 2017 semester, interviews were conducted from the 25 applications received. Questions asked were specific and related to suitability for this unique work in the DR. Characteristics of a qualified candidate included adaptability, cultural flexibility, language acquisition, familiarity with Dominican culture and motives for participation. Given the centrality of reflection in Ignatian pedagogy, students also had to express interest in or have the ability to reflect upon this lived experience.

After an extensive interview process, eight students (six undergraduates and two graduate) were invited to participate in the work, research, and development of various forms of community assessment instruments. All eight students accepted our offer and meetings began in October of 2017.[5]

Research and Development of Assessment Instruments

Throughout the 2017-2018 academic year, the research group held weekly meetings to research the published literature and develop draft community assessment mechanisms with the goal of understanding the health needs of the identified pilot communities. The focus at this stage was on developing familiarity with strengths or asset-based assessments of the social determinants of health within each village. Social determinants of health include such things as stable housing, employment status, transportation options and education level.[6] Permeating this work was a philosophical approach consistent with a Jesuit way of proceeding. As the Society of Jesus states in its document *Renewing Our Commitment to a Faith that Does Justice*, "We accompany others and let ourselves be accompanied. We become true companions."[7] This goal guided the team from beginning to end. Further, the four assessment instruments developed in consultation with our Dominican partners at the CESI Center, could serve to inform future visiting medical groups that travel to the DR each year through Creighton University's Institute for Latin American Concern (ILAC) office.

Faithful to the intent of the CGI grant program, we embraced the philosophy of a "strength-based" or "asset-based" approach to instruments for community health needs assessment throughout these meetings. This initial scholarly inquiry began with John Kretzmann and John Mcknight's *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*.[8] We read and discussed this text as a group and it became the roadmap for the trajectory of our work. In addition, other approaches to global health, cultural competence, community health needs

assessments, global medical missions, and international service-learning were investigated. Overall, a variety of sources influenced the methods, instruments and implementation utilized.[9]

Tantamount to the success of a CHNA is the collaboration with and voices of the community members. The research team communicated with their Dominican counterparts at CESI from the beginning of this process to seek the information that would be of interest to the community and providers of care. Categories of interest included: demographics, physical attributes of a community, health, human/spiritual, social, natural resources, financial, political and access/influence on social capital. Researchers were divided into four work teams of two students each dedicated to developing one of the instruments—in dialogue with professionals in sociology, anthropology, medicine, public health and social work. The following approaches to collecting assessment data were identified from all these discussions: focus groups, interviews, questionnaires and an environmental scan.[10]

Each team consulted experts in fields that utilized instruments like those being developed. Interdisciplinary faculty oversaw and evaluated the instruments and the group held weekly meetings to discuss progress. Additionally, guest speakers who were experts in their areas of research spoke to the group about strengths-based assessment practices. Finally, with rough drafts of the instruments complete, the translation process began in collaboration with our counterparts in the Dominican Republic.

Collaboration

From the inception of this project the leaders of CESI were part of all communications regarding our intent, methods and continued desire for collaboration. This communication began during the proposal phase. CESI's

contribution to the collaboration was to share resources such as a discount on the room and board costs for the research group. Numerous drafts of the instruments were reviewed by CESI (in Spanish) and a feedback loop continued throughout the instrument development phase. The "bridge" between Creighton and the CESI Center was Creighton's ILAC Program Coordinator who resides and works in the DR for most of the year. As part of the DR team, the ILAC program coordinator facilitated all communications, assisted with editing and translation of the instrument, provided feedback, and oversaw the preparation of CESI for the arrival of the research group in May 2018.

On April 15, 2018, researchers were informed of another group in the Dominican Republic that wished to collaborate on this project. The Director of the School of Medicine at the Pontificia Universidad Católica Madre y Maestra (PUCMM, the local Catholic University in Santiago) indicated that medical students in their final year would be interested in participating in this CHNA. Including these additional local students was the result of a collaboration between faculty and administrators from the school of medicine at PUCMM and Creighton University. In person discussions began at PUCMM to discuss expectations and orient the seven interested students through a presentation on the goals and values of the research team. All the Dominican medical students spoke fluent English. The presence of the Dominican students to the project was invaluable. They were helpful in overcoming linguistic barriers, especially with translation during the interviews and conversations with community members. More importantly, connecting local Dominican medical doctors (all of whom have since graduated) with CESI was an important local collaboration which continues today. The late integration of the PUCMM students into the project enhanced the team dynamic and the quality of outcomes and community interactions.

As mentioned earlier, collaboration was critical for this project to succeed. Five key lessons stood out throughout this process. These emerged through post-action reflection on the entire implementation process.

- Lesson #1: It is not enough to be "in relationship" because power dynamics also matter. Collaboration was complex, both here at Creighton and between various international institutions. Medical students from PUCMM contributed more than anticipated by accompanying Creighton students as guides and language mentors. Always being aware of power dynamics was difficult and made daily interactions much more complex. For example, if a community turned down a CHNA by the team, would it affect whether the summer program (medical services mission program provided by ILAC) visited that community or not in the future? This was a fear that community leaders articulated. As a research team we needed to continually put ourselves in the position of the community members and consider how we interacted with each other. Power dynamics could make every answer to the CHNA suspect because it is difficult to know for certain if community members felt comfortable answering honestly or were only communicating what they believed the research team wanted to hear.
- Lesson #2: Recognizing community agency is an act of mutual trust. Listening to the collective voice of a community is hard work. We needed to overcome the "expert" temptation and realize that people understand their own health quite well and often articulate their needs clearly when they communicate them. Some communities were unaccustomed to being asked about their own desires, as well as being listened to, so their willingness to respond was hesitant at times because the team consisted of outsiders (historically the source of mistrust). We realized that mutual trust is necessary for community agency to emerge naturally; therefore, the research team worked hard to balance the desire for

outcomes with the capacity to listen and trust that people would communicate their health needs.

- Lesson #3: Moving from a "charity" model to a "sustainable justice" model is difficult and requires honestly acknowledging the deficiencies of former approaches. This was difficult for many people who have been involved for years in working with CESI and ILAC because a charity model has been the approach to community work for decades. The resistance of moving from an "assistance" model to a long-term evidence-based health care model became evident. There is no doubt that charity is vital for meeting the immediate needs of a person, but it often fails to encourage community agency long-term. Counting the "successes" by numbers served or hours served is different than sustaining real agency and fostering actual change from within a community.
- Lesson #4: Collaboration can be challenging and must include as many stakeholders as possible. Focus groups provided the opportunity for people to lend their voices to the project thereby allowing for a comparison of themes between groups as they emerged from the group responses. The focus groups consisted of community leader groups, mothers' groups and various other neighborhood groups to take a blended approach to collecting information about life in the community.
- Lesson #5: A community assessment project provides opportunity for the assessment team members to heighten awareness of their own personal biases. Many of the questions developed, despite collaborative efforts with Dominican partners, still reflected American cultural beliefs rather than the true beliefs of those we were attempting to serve. For example, we assumed that traditional methods of medicine would be evident, if not prominent. We found that Dominican communities largely default to modern medicine when confronted with health challenges. The team learned and grew significantly in knowledge

and practice because of this. The change in perspective of team leaders and students was essential to this project. It both fostered personal growth and improved our understanding of the importance of the immersive experience.

Team and individual formation

While the faculty and student team met to develop assessment tools, there also was an important formation component related to international service learning unique to a Catholic and Jesuit institution. Not only did the team come to know and appreciate each other's perspectives, skills, knowledge, and experiences, but a personal bond was built which became vital to the cross-cultural and emotional challenges that happen during an immersion. All members of the team needed to feel "safe" with each other. The team prayed together, reflected together, and were rooted in a shared focus on the success of this project for CESI. There were six main principles of formation instilled prior to departure and expected to continue throughout the immersion. These principles included the following:[11]

Principle #1: Respect and Value the People You Will Encounter

Respecting and valuing others are first and foremost choices.[12] It is a choice to enter relationships already having decided that all human beings are worthy of love and accompaniment and that ultimately, agency must come from within the community itself. As good as the team's intentions may be, the people from these communities must become the agents of their own future.

Principle #2: Build Trust through Relationships

When the framing narrative changes from one of triumphal service to equal relationship, very important things happen. First, participants understand that the purpose of the trip is not to "save," "rescue," or "salvage" anyone. This is often articulated through "assistance" trips which participants embark upon with the best of

intentions. A different kind of relationship develops when a community knows you want a deeper knowledge of their lives and health challenges. This qualitative difference in relationships can have important long-term consequences. The purpose of the trip is to encounter an "other" on pilgrimage and if, while remaining attentive, it is possible to learn things that result in mutual growth in faith, hope and love. Building trust required that we remain open to learning from our host families and community leaders.

Principle #3: Do with Rather Than for and Recognize Privilege

According to the faith-justice process put forth by the Jesuits, "service happens when we realize that we possess resources that we make available to others to help them improve their living conditions."[13] Thus, it is important for us as foreign groups to recognize that our participants and our institutions have advantages not shared by the people we visit. We should state that clearly, honestly and openly and see in this recognition a responsibility and an opportunity to create a more just world. At the same time, we recognize and engage the agency of those we serve understanding that to simply do "for" would not lead to sustainable development.

Principle #4: Ensure Research, Reflection, Feedback and Accountability

This principle applies to those responsible for short-term trips and courses where participants entrust themselves to the expertise and guidance of leaders.[14] It is a commitment to an ongoing quest for learning, reflection and assessment that never ends. By assessing student learning before and after the trip, feedback was received about the lived experience. Additionally, continuing to communicate with CESI staff and share the results of our work has ensured accountability for the project.

Principle #5: Consciousness-Raising, Continuity, Sustainability

While formation and implementation are essential to a short-term service or course trips, consciousness-raising continues into the future and is important for long-term sustainability.[15] "One and done" (a single trip with no others planned) experiences are not worthy of the resources or time it takes to enter another community's reality—the purpose must include an effort for sustainability where the work took place and to heighten awareness among others upon return. Students have presented at various health conferences and discipline specific academic gatherings on what was learned and why it is important.

Principle #6: Structural Transformation

How a university engages marginalized communities and people experiencing poverty is a "structure" that is possible to change. The goal of our project in part was to influence the manner in which the university chooses to teach students about poverty. According to the Society of Jesus:

> Structural transformation takes many forms: proposals regarding public policies, active presence in the realms of political decision-making, consequential dialogue with the authorities, denunciations and protests, collaboration with social movements, monitoring and evaluation of legislation, etc. . . . The Congregation refers to political advocacy as one of the preferred methods for promoting structural transformation.[16]

Timeline

Throughout the academic year faculty in the discipline of public health was present to assist with the cultural sensitivity of the instruments as they were developed, and to consult on the progress the research team was making. It became clear to the team that a public health/community health professional was needed to assist in the

Dominican Republic who possessed the skills and experience in CNHA implementation, process evaluation and analysis. When a public health professional was added to the team, daily process evaluations and reflections improved the implementation, practice, and approach to community members.

Implementation began with months of preparation before the immersion in May. Goals and methods of the project were shared with the CESI leadership and staff in February of 2018. Leaders of the DR partner institution visited the two selected communities for the pilot of the CHNA. The first visit was to explore whether a village was interested in receiving a health needs assessment and to ask whether they were open or interested in participating. The second visit was to share with the village additional details of how the project would be implemented and describe the role of the community members in this process.

These visits were followed by a visit in May of 2018 to the first pilot community, Vaca Gorda, to brief the CESI health promoters as well as other community leaders on the purpose of our visit. The CESI health promoters were essential for articulating to other community leaders what the team intended to do and discuss the project purpose. Though there were some initial misunderstandings about the project's purpose from earlier communications, the team was satisfied that the community was ready for our assessment team. The meeting was helpful in allaying concerns of community members, answering questions to clarify and finalizing housing arrangements for the visiting team.

Creighton students arrived on May 6th and the project work began by first printing, collating and numbering the questionnaires and discussing the best method for tracking information. A process was then established to secure participant anonymity and information security in the village. The PUCMM medical students were introduced to the Creighton students during this orientation day. The students were

acquainted and oriented to the project in terms of expectations, methods, inter-cultural challenges, etc. The group practiced orally presenting the informed consent, as well as each instrument. Possible challenges to implementation were also discussed during this orientation.

The following day, the team travelled to the village of Vaca Gorda arriving late in the morning. After dividing up the group with one Creighton student and one PUCMM student paired for most of the homestays, we had lunch at the home of the community leader and began an orientation to the community geography, its people and rules of engagement. The CESI health promoters and community leaders were helpful in guiding us to destinations throughout the community and accompanying our teams as they knocked on doors and engaged residents. Additionally, the team public health leader served as a "rover" walking throughout the community and shadowing various teams as they implemented the instruments. The purpose of this was to provide immediate feedback and adjustment as needed for how to read body language, be patient as a respondent sat quietly to think of an answer, and to provide general guidance on demeanor and cultural sensitivity.

Implementation Review, Debrief, and Adaptation in Process

Following dinner each day, the team met to conduct a debrief of the implementation of the questionnaire and a process evaluation (discussion of the process of implementation and perhaps the need for adaptation) of the day's work. Many questions arose about the presentation of certain questions on the instrument. These presented a challenge for the implementation process as it was originally planned. Several, but not all, of those challenges are enumerated below.

1) Most community members were unable to read the questionnaire and understand its content on their own. While the team was aware that community

members had only acquired a basic level of education, the need to orally collect data was surprising. The instrument was intended to be administered with the community member writing and answering the questions as a self-report survey. Feedback from the team revealed that most of the individuals chose to have the instrument orally administered by the students as their literacy level was basic or below what was required.

2) Interpretation of both the administration of the survey process as well as the intention of the respondents answers by the students was not consistent from student to student and comprehension of questions regarding spirituality were difficult to adapt. Lively discussion over the use of certain words related to spirituality led the group to agree to ask the original question with fidelity and record the answer regardless of understanding.

3) Issues arose with CHNA questions about the use of traditional remedies before seeking medical care. For example, when mentioning "herbs" as a home remedy, participants confused the question with "hierba" which are weeds for cows. Furthermore, "traditional remedies" were sometimes confused with superstitions or "voodoo." This then presented a cultural barrier to collecting data for this question. The decision was made to eliminate some of the examples to language that would mitigate confusion such as "teas."

4) Students were challenged by a lack of training on how to implement a survey instrument that was intended to be a written self-report survey by the participant. Some students were impatient with participants while they thought about what to say in answer to a question. Further, the Creighton students tended to lean more heavily on their Dominican partners to lead the questioning. The process then was changed

to alternating between students who would ask the questions and who would record answers.

5) Students were challenged by family members sitting on the periphery of the survey participant and answering for the participant and/or supplementing a participant's answer with an opinion of their own. This added to the risk of bias in the answers. From a cultural perspective, it also allowed *machismo* to influence a female participant who may not have agreed with the answer but would not have said so.[17] The Dominican culture is a patriarchal one. Further, it would not have been culturally sensitive, nor competent, to ask the family member to refrain from answering. Also, the family member would have biased their own answers to the questionnaire through a practice effect. The process was changed to ask permission to interview the respondent privately while maintaining culturally appropriate practices.

Each evening we discussed, as a team, what worked during implementation and what didn't work. The first evening, for example, we discussed how difficult it was for community members to answer the first question—1. *What three things are you proud of in your community?* Community members tended to answer this question by stating the "needs" of their community rather than what they were proud of. It was almost as if they had not heard the question. This revealed important information to the team. It appeared that community members were accustomed to deficit-approaches to community assessment and were more comfortable speaking about their deficits rather than their assets.

Presentation of Results to CESI

Following immersions in both villages of Vaca Gorda and Gurabito de Yaroa the data was manually entered to an Excel spreadsheet by a Creighton University student. The

data from 400 questionnaires were then analyzed by the public health professional lead on the project and a graduate of the MPH program. Deliverables were created in the form of pivot tables and pie charts which were utilized in the dissemination phase. Because of time constraints, these data from the first pilot community, Vaca Gorda, were analyzed and results were prepared in a slide presentation for the August meeting of the CESI health promoters. What was learned about the community's health status and quality of life is summarized in the next section.

Community health information from CHNA

Community health requires the interest in, and participation of, the entire community as well as the collaborative efforts of stakeholders outside the community. As mentioned earlier, resources to ensure improved health status must be available for improvement to begin. The rural villages that participated in this CHNA, while willing to respond to questions, revealed their lack of education, generally, and lack of resources globally such as potable water, nutritious foods and strong infrastructure. These factors continue to present barriers to access to healthcare and improved health status. The first community visited, Vaca Gorda, operates and maintains a clinic. The clinic provides basic medical services related to interventions for: minor injuries, minor illnesses such as flu, minimal pharmacy services (mostly for medication management for residents with chronic disease) and vaccinations. Clinic resources are scarce and clinic hours are not necessarily regular hours as one might expect in the U.S. healthcare system. The availability of clinic staff is uncertain on any given day.

Results from the CHNA in this community demonstrated the health challenges the community leaders and health promoters, as well as CESI staff, need to overcome to improve the quality of life for residents.

In Vaca Gorda (a community of 800 residents), there were 196 respondents to the questionnaire. Of the 196 respondents, 65% asked someone to read the questionnaire for them. 137 (70%) participants answered the question about education and nearly 67% of those indicated that they have a basic level which made self-reporting of answers challenging. To overcome this challenge, the process of implementing the questionnaire needed to be adapted to this lower than anticipated literacy level. The students implementing the questionnaire were required to ask questions from the instrument in a structured interview style, where follow up questions were not permitted. However, due to potential language barriers to translation, clarification questions were allowed. 137 (70%) of respondents ranged in age between 40 and 79. 57% were identified as male and 40% female. Others chose not to identify.

Most respondents indicated they were most proud of the people in their community (nearly 40%); their school (18%) and their community clinic (11%). 78% of respondents indicated they have lived in this community all their lives, others indicated that they moved into the community as children. There was a nearly even distribution of respondents that were single, married and in a free union (36%, 27 %, and 20%, respectively). 65% had 2 - 4 people living in their household.

While 96% of respondents indicated they have enough food in their homes, the types of food available and consumed the most include rice (85%), habichuela (beans in a sauce - 85%) and meat (51%). This is one of the first concerns regarding the health of this community. Excessive intake of these types of foods can lead to pre-diabetes and/or diabetes, hypertension (high blood pressure) and/or hypercholesterolemia (high cholesterol).[18] Indeed, this community reported a prevalence rate of diabetes to be nearly 30%; 67% have been diagnosed with hypertension and 22% have been diagnosed with high cholesterol. 30% also indicated that they were told they have a combination of 2 or more of these diseases. In the absence of nutrition education,

access to vegetables (i.e., dark leafy greens like spinach) and other nutritious foods, the trajectory of health concerns related to these three diseases alone can drastically increase the prevalence of co-morbid illnesses such as heart disease and vision loss that will require medical attention beyond what stakeholders can provide.

As mentioned earlier, the community houses a clinic providing some basic services. There is little to no primary prevention except for vaccines. There are no labs for diagnoses and no basic diagnostic tools like x-ray or ultrasound machines. All respondents indicated they seek care outside of this clinic either at Partido or Santiago Rodriguez (hospitals nearby). Some of the more serious needs are complemented by visiting doctors' groups from Creighton's Institute for Latin American Concern (ILAC) during the Summer Program and/or by community members accessing care at the designated clinic time at the CESI Center in Santiago. These visits to Santiago require transportation from the community, lodging if needed for overnight stays, and return transportation to the community. Follow up care within the community is limited to family and neighbor assistance. Nearly half of all respondents indicated they have not been to a dentist in over 4 years.

More than half of the respondents (55%) indicated they have *not* received services from CESI. For those who have, more than half of those respondents said those services were related to medications for diagnosis of a chronic disease or for pharmacy services. While there are some community education talks for health-related subjects called *charlas,* attendance is low. 70% of respondents have heard of these presentations but less than 50% of those attended. Further, the topics of these talks may not serve to address the issues related to existing chronic disease enough to promote prevention of advancement of disease. Finally, it appears that most of the education and community programming is developed and implemented by individuals with only a slightly higher-level of education then most community members, while

others have had health promotion training. This may not be adequate training and guidance for healthy lifestyle changes and long-term improvement of quality of life.

Those surveyed do not know how many people leave or enter the community from other places, but they are aware of the flow of their own relatives who leave and then return. The most informed reason to leave the community was to seek a better life through employment opportunities. Many said their neighbors are very helpful, especially if someone has a death in the family.

Creighton Student Learning

Even though the PUCMM and Creighton students are from different cultures, both groups did share some characteristics that could have contributed to a difficult immersion. All came from families with homes and what most would call more than just the necessities of life (i.e., food, clothing, shelter). They appeared to be students of privilege who all had electronic devices, were graduates of or soon to be graduates of an institution of higher learning. They would be entering professions that would most likely provide long-term financial stability.

What the students encountered on this immersion was not what they were accustomed to. Host community members and their families live in two rooms or very small homes made of wood with aluminum roofs. Windows had shutters but no screens allowing insects and animals access. Only the home of the community leader and his family had indoor plumbing. This plumbing still required bucket bathing from a water barrel in the bathroom. There was little to no electricity and certainly no telephone cells and internet. The roads were not paved and, in fact, were quite treacherous with large rocks, dirt and holes to be navigated. Students traveled on foot, in heat and humidity to homes with no fans nor air conditioning. While food was scarce for our host families and residents, many if not all of the residents offered a

warm welcome to their homes, cooked what little food they had to offer and shared laughs and stories as they hosted the students.

To capture knowledge, attitudes and beliefs of the Creighton students participating in the project, a pre-trip and post-trip survey were administered. This survey was a 7 – item survey that collected some demographic information. There were 8 respondents (1 for each Creighton student). 1 respondent who identified as male and 7 who identified as female. 2 were graduate students from the School of Medicine the other 6 were from the College of Arts & Sciences. Students represented various programs like nursing, medical anthropology, pre-dentistry and Spanish making this an interdisciplinary approach to community health.

Students were asked questions about any previous experience with a CHNA, including development of an instrument, philosophy of community engagement, how to serve the needs of other people using a CHNA, an understanding of what influences health behavior and how to navigate cultural differences while being culturally sensitive. 71% of the students were bi-lingual with the remaining self-reporting as "somewhat" bi-lingual.

Results indicate that students learned how to listen more closely to what is being said by someone, how to pay attention to the needs of the community as reported by the members of the community, and not by what they think the community needs. As one student reported "community members can provide their input and be heard to create a sense of self-agency within the community itself." All the students reported that this project "has increased my appreciation for interdisciplinary collaboration and my awareness of community strengths and weaknesses." In some way, all students reported the project has changed their lives. One student reported "It has strengthened my relationship with God, and I met so many people who inspire me to be a better version of myself." The students valued more than just the skills learned

for how to interact with people and community stakeholders and to conduct a needs assessment. They also related everything they did to this recurrent theme: "I learned more than I ever imagined possible, it has changed the way that I view healthcare and my role as a future [physician], and I am excited to begin to see more of the results that come of this project."

Conclusion

As a Catholic and Jesuit Institution, Creighton University not only has the responsibility to serve others, but within that service to reach out specially to serve the poor and marginalized. "The principle of the universal destination of goods requires that the poor, the marginalized and in all cases those whose living conditions interfere with their proper growth should be the focus of particular concern."[19] Making this preferential option for the poor is necessary in underserved communities in the Dominican Republic who are visited by Creighton medical teams, dental teams, OT/PT groups, undergraduate semester programs as well as many others who immerse and try to learn with and from these people. A thorough CHNA makes possible a concrete option for the poor in three ways. First, it helps identify agency or lack of agency within a community; second, it helps identify those who both possess and lack social capital; and third, it helps identify vulnerable populations.

Community agency is the capacity for a community to actualize its own vision and goals. This agency must be present for any external intervention to be sustainable and transformative. This perspective on a community argues that "people should not be considered merely as an object of socio-environmental influences, but [that] they contribute, by strategies for collective action, to determine actively [a]more satisfactory condition of health."[20] Agency, both personal and communal, can be evaluated through questions related to the ability of a community to achieve its own vision and goals. The team included questions directly asking about: what people are

proud of in the community, whether they work, how often they work and for what salary, where they go if they need medical care, how often they visit a health professional, how they understand themselves as healthy or not, how they cook, what kind of food they prefer and whether they have enough, whether they actively practice a religious faith, whether community meetings are offered and whether they attend, and finally whether they are interested in being part of a new future of possible health care services. One can gauge agency through the answers to these questions insofar as they reveal whether people act upon their own reality or remain passive and unengaged. From a public health perspective, residents of a community who are self-aware of their bodies and proactive in seeking better health are "healthier" than residents who only seek medical care for the onset of problems.

Second, a thorough CHNA can evaluate who can access social capital. "Social capital refers to the features of social organization that facilitate coordination and cooperation for mutual or individual benefit."[21] Residents of the rural communities we surveyed who lacked food, a safe environment to sleep or work, or were not connected to any of the health services offered in their community clearly lacked social capital. Sometimes this was evident through the process of physically walking around and listening to conversations related to the questionnaire delivered. For example, often Haitian immigrants were referred to negatively, rarely volunteered to participate and did not speak Spanish. Additionally, Haitians lived in their own sub-communities within a village. This was confirmed during the environmental scan when the team walked throughout the entire village. Underserved or marginalized individuals or groups often suffer from a lack of social capital. This lack of social capital can be remedied by connecting these individuals and groups to people and organizations who can bring them into activities and networks that benefit them.

Finally, those individuals and sub-groups who struggle for agency and lack social capital are often the most vulnerable members of a community. They are children, the elderly who live alone and those who inhabit stigmatized populations (racial and cultural minorities, those who suffer from untreated mental health problems, the physically disabled, etc.). A CHNA can help identify these individuals and groups by focusing analysis on questions and answers related to agency and social capital. Something as simple as observing how people in a community respond to someone experiencing addiction to alcohol can be instructive.

The Creighton team created instruments for understanding the health of communities served by CESI. With that understanding, CESI staff can move resources and programs toward those individuals and groups most in need. This has been done as a university that has employed the talents of its faculty, staff and students for research and investigation and put these at the service of marginalized and underserved communities in the Dominican Republic. In this manner we are a Jesuit University making an option for the poor.

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[1] Arturo Sosa, S.J., *Universal Apostolic Preferences of the Society of Jesus, 2019-2029*, accessed at https://jesuits.global/en/uap on April 2, 2019.

[2] Sosa, *Universal Apostolic Preferences of the Society of Jesus, 2019-2029*, accessed at https://jesuits.global/en/uap on April 2, 2019, p. 3.

[3] Bernard Turnock, *Public health: What it is and how it works*, 6th edition, (New York, NY: Jones and Bartlett, 2015), p.153.

[4] The acronym **CESI** is used to refer to the *Centro para Educación y Salud Integral*, a Mission in the Dominican Republic staffed by Dominicans. The acronym **ILAC** stands for the *Institute for Latin American Concern* and will be used to refer to the Creighton office in Omaha, NE that partners with CESI.

[5] Creighton student participants included: Ms. McCall Bromelkamp—CCAS; Ms. Caroline Byrne—CCAS; Ms. Brooke Gensler—School of Medicine; Ms. Yesi Morales—CCAS; Mr. Cooper Nagaki—

School of Medicine; Ms. Abigail Rudigier—CON; Ms. Emily Schaefer—CON; Ms. Jenna Vrable—CCAS.

[6] https://www.cdc.gov/socialdeterminants/index.htm January 2018.

[7] Society of Jesus, Social Justice and Ecology Secretariat, *Promotio Iustitiae*, No. 120 2014/2015, 3.1.

[8] John Kretzmann and John Mcknight, *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets* (1993, ACTA).

[9] Amerson, R. (2014) Research-Based Recommendations for Implementing International Service-Learning, *Journal of Professional Nursing*, Vol. 30, No. 2 (March/April), 175-179.

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[10] The groups divided along the following lines: Focus Group Instrument: Yesi Morales, Cooper Nagaki; Interview Instrument: Jenna Vrable, Emily Schaefer; Physical Scan Instrument: McCall Bromelkamp, Caroline Byrne; Questionnaire Instrument: Abby Rudigier, Brooke Gensler.

[11] These principles are taken from and further developed in Thomas Kelly, "Mission Trips, Culture and Causality: A Proposal to Re-Think How North Americans Religiously Engage the World," *Journal of Religion and Society*, (2018) *Supplement 16*, ISSN 1941—8450.

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[13] Social Justice & Ecology Secretariat: 2015, 3.1.2.

[14] Newton & Early, xiii; Social Justice & Ecology Secretariat: 2015, 3.1.3.

[15] Social Justice & Ecology Secretariat: 2015, 3.1.4; Reisch:2011, 98.

[16] Social Justice & Ecology Secretariat: 2015, 3.1.5.

[17] *Machismo* can be understood as a strong and aggressive male dominance in the socio-cultural makeup of a society.

[18] Centers for Disease Control and Prevention, *About Diabetes*, 2017, Downloaded from: https://www.cdc.gov/diabetes/basics/diabetes.html, May 9, 2019.

[19] Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, Libereria Editrice Vaticana, 2017, p. 79.

[20] Capone & Petrillo, 2011.

[21] R. Leenders, "Social Capital," in the *Encyclopedia of Social Network Analysis and Mining*, (Spring New York, 2018) p. 1759.