Augusta M Villanueva, PhD

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PERSONAL STATEMENT

1. Overview

My definition of scholarship follows that espoused by the late Ernest Boyer, American educator and president of the Carnegie Foundation for the Advancement of Teaching: "The scholarship of engagement means connecting the rich resources of the university to our most pressing social, civic, and ethical problems, to our children, to our schools, to our teachers and to our cities." It is in this light that since co-developing the blueprint for the establishment of the School of Public Health (SPH) in 1994, my teaching, research, practice, and service have sought to create opportunities designed to advance students' competencies while instilling in them a sense of engagement and advocacy on behalf of vulnerable and marginalized populations.

At the time that I was asked to co-develop the SPH's blueprint, no extant school of public health—domestically or internationally—relied principally upon problem-based learning (PBL) pedagogy or community-based learning. The city's public health challenges, and the imperative to train future public health professionals in interdisciplinary teams, convinced me of the need to advocate for adoption of a PBL curriculum including community-based experiential learning.

Below, I provide a synopsis regarding my research, teaching, practice and service on behalf of the SPH, as well as how I have contributed to the advancement of its mission. Additionally, I will discuss my work's contributions to the communities served by the SPH, to the field of public health as well as future directions in my role as faculty.

2. Research: Foci, Dissemination, Grant Submissions

My research orientation builds on the evidence provided by successful community-institutional partnerships linked to effective prevention science as well as service-learning.[i] In this regard, Seifer has identified key factors that can facilitate and impede successful community-institutional partnerships and outcomes, as well as strategies for building community and institutional capacity for participatory approaches to prevention research. The research I have undertaken has sought to embody partnerships with institutions committed to the vulnerable and marginalized.

Service-learning, [ii] and community-based participatory research (CBPR), [iii] are two major methodologies for community-academic partnerships that serve as the focus of my scholarship. CBPR received the endorsement of the Institute of Medicine in 2002, and constitutes a core competency in academic public health education.[iv] Additionally, I

have expertise in cultural competency, community-based experiential education, PBL, collaborative learning, and adult learning.

Community-academic partnerships that I have nurtured embody prevention as well as the recognition of local assets, as opposed to an emphasis on only needs and problems, in seeking solutions. Ongoing collaborations that I have fostered on behalf of the SPH are reflective of successful partnerships that can pave the way, for example, to prevention, harm minimization, and health promotion among many other equally important outcomes. The partner agencies I collaborate with include a wide array of populations, public health issues, and environments. The core of my collaborations is the advancement of prevention. I have worked with at-risk youth, incarcerated women and girls, middle school children, and individuals affected by HIV/AIDS, among others.

Truant and Adjudicated Youth

My earlier research in prevention focused on early intervention with a cohort of truant and adjudicated African American and Latino youth between the ages of 13-18 in Philadelphia (2002 – 2004). This research heightened my awareness about the co-mingling of risk behaviors affecting youth within specific socio-environmental and ethno-cultural contexts, the developmental trajectory between early risk behaviors and chronic diseases, the difficulties with mounting behavioral interventions with at-risk youth of color, and the challenges of conducting intervention research. I learned that researchers must ensure inclusion of the youths' familial and/or social network because of the indelible role these can have on social cohesion. This is particularly salient within African Americans and Latinos given their close familial and social-relational contexts.

Two peer-refereed articles have been published based on my research on these youths (See Tab 2 - Sample of Peer Reviewed Articles). The first of these is focused on an assessment of the violence-related factors among truant boys as well as comparisons between truant and dependent boys from those considered delinquents. Absence of a caring adult was pervasive among all and highest among delinquents, reflecting a critically important void. Thus, forming close relationships with adult role models can be critical in reducing their susceptibility to violence. The second article relied on vignettes about significant women in the boys' lives (mother, sisters) to document their relational patterns as well as challenges they faced forming attachments. The indelible mark left by the violence experienced is evident in their relationships with women who are significant in their lives.

Cancer and Disparities in Mortality in Underserved and Vulnerable Populations

My experience conducting intervention research with Latino youth greatly facilitated my ability to address the magnitude of cancer and the stark disparities in mortality among the same ethnic group statewide. Since 2008, I have served as co-investigator of an evaluation of the Pennsylvania Cancer Education Network,

Commonwealth of Pennsylvania, and Centers for Disease Control & Prevention. My research has focused on the analysis and improvement of cancer education for underserved vulnerable minority groups participating in projects associated with the Pennsylvania Cancer Prevention and Control Division supportive of Act 33 and the Pennsylvania Cancer Control Plan. To date, my analysis has centered on the outcomes derived by Latino populations relative to cancer prevention through early detection and intervention statewide. To effectively educate vulnerable groups, intervention strategies and evidence-based strategies were merged with principles of multicultural competence, stages of change, and health literacy. Analysis is ongoing and two manuscripts are emerging regarding the lessons learned through early detection and intervention among Latinos in Philadelphia County, as well as the inherent strengths of the lay health advisor model within the context of reaching Latinos and other ethnic minorities at risk for cancer across the Commonwealth of Pennsylvania (See Tab 2 - Sample of Manuscripts in Preparation). These manuscripts will be submitted to the *American Journal of Public Health* on or before December 15, 2010, in response to a Call for Papers for a theme issue devoted to community health workers and public health.

Community-based Experiential Education in Public Health

Outcomes derived from the community-based experiential education of public health students is another important area of research for me given my commitment to community-academic partnerships that advance prevention science. Since 2006, I have led the collection and analysis of quantitative and qualitative data derived from students' service-learning experiences, including preceptors' feedback. This has resulted in seven presentations relative to my research on community-based learning and service-learning at refereed national conferences. Currently, I am completing a manuscript entitled, 'What is Learned from a First-Year Master of Public Health Community-based Practicum,' developed in response to our research being selected among more than 180 abstract submissions to the *Journal of Public Health Management and Practice* (theme issue devoted to teaching and learning in the community to be published in 2011. The deadline for submission of this manuscript is October 29, 2010. (See Tab 2: Sample Publications: Manuscripts in Preparation).

A qualitative study I conducted in 2009 as part of a written class assignment I incorporated into PBHL 550 (Community-based Prevention Practice) has enabled me to develop and submit a manuscript to *Health Promotion Practice* focused on preparing students to work with communities. First-year public health students (n=70) enrolled in a class that includes a 120-hour community-based practicum responded to a two-part written assignment after viewing two parts of the documentary series, *Unnatural Causes*. Its themes and written assignments, and safe learning environment created by instruction combining Problem-based Learning and lectures allowed students to share their reflections identifying factors influencing their selection of a public health career; examination and awareness of differences in health status across populations; proposals for advancing public health, as well as the relationship between one's ability to walk in

another person's shoes and effective public health practice (See Tab 2: Manuscripts Under Review; also, please see Tab 3: Samples of Course Assignments). Students' ability to work effectively and sensitively in communities is a key competency that public health professionals need to master given extant health disparities across populations.

In my role as course director of Community-based Prevention Practice, I have had the opportunity to gain expertise in the design of applied learning opportunities. In 2007, my research and practice in designing and evaluating community-based practicum experiences in graduate public health education enabled me to join the Association of Schools of Public Health's editorial team responsible for writing the fourth and final monograph of the Demonstrating Excellence in Practice Series (*Demonstrating excellence in the scholarship of practice-based service for public health, 2009*.) [See Tab 2: Sample of Peer Reviewed Articles, as well as Sample Publication of Monograph]

As a result of my research experience in community-based learning in graduate public health education, I have also been invited to speak with national audiences in the field. For example, in December of 2009, I was asked to make a presentation before the Behavioral and Social Sciences Council of the Association of Schools of Public Health on innovations in service-learning, and how to assess and evaluate student practice experiences. Similarly, I have conducted workshops attended by national audiences such as the Health Disparities Service Learning Collaborative (2008), an initiative developed by Community-Campus Partnerships for Health and funded by the US Centers for Disease Control and Prevention (CDC). Opportunities such as these have provided opportunities to showcase my research on community-based experiential learning, as well as describe the evolution of the SPH's partnerships linking its faculty and students with community-based agencies.

Resilience and Vulnerability Factors Among Local LGBTQI Youth of Color

In 2009, my concern for young people, especially the vulnerable and at risk, led me to initiate conversations with local executive directors and program staff of agencies serving lesbian, gay, bisexual, transgender, questioning and intersex (LGBTQI) youth. Over the course of approximately nine months, I attained a wealth of knowledge from these leaders and their staff relative to the plight of youth who seek their services, and who often are segmented from family and unable to take care of themselves. Our commitment to at-risk youth fostered the development of a consortium that collaboratively developed and submitted an R21 grant proposal (Exploratory / Developmental Research) application to the National Institute of Child Health and Human Development of the National Institutes of Health in September 2010 (See Tab 2: Sample of R21 NIH Grant Submission). My efforts will capitalize on the resources of the Program for Lesbian, Gay, Bisexual & Transgender (LGBT) Health Research, housed in the school's Department of Community Health and Prevention.

This collaborative research proposal adds to the small but growing scholarly knowledge about HIV prevention efforts conducted by the African American and Latino dominated House and Ballroom Communities (HBC) across the US. Current research focuses largely on issues of adult Men who have Sex with Men (MSM) in the HBC of New York, Chicago, Los Angeles and Detroit. Yet the vibrant Philadelphia HBC remains mostly unexamined up to now. The Drexel Program for Lesbian, Gay, Bisexual and Transgender (LGBT) Health aims to fill the gaps in our knowledge by way of a community-based participatory research project assessing HIV prevention and health promotion carried out in the local HBC. As our initial explorations among key stakeholders - "House Mothers and Fathers" - suggests that a clear majority of HBC participants are gender-atypical youth rather than MSM, our study focuses on the HBC as a locus of social cohesion bridging a wide spectrum of racial minority youth. While the HIV/AIDS epidemic still disproportionately impacts racial/ethnic minorities, the CDC estimate that adolescents account for one-third to one-half of all new HIV infections in the US. Thus, HBC youth are seen to be among the highest at risk for HIV vulnerability. Along with many House Mothers/Fathers, they are also often associated with one or more partnering community health agencies: Attic Youth Center, YHEP, Colours, GALAEI and Trans Information Project (TIP).

As scientific literature documents extensive health disparities affecting these populations, our aim is to elaborate explanations for the causes and effects of specific disparities identified by HBC participants themselves. In focus groups comprised of House Mothers/ Fathers and LGBTI youth aged 13 - 24, our community-based participatory research (CBPR) investigation explores commonalities and distinctions of experience and background among HBC participants across race, ethnicity, age, gender and gender identity. A select subset of the youth will also take part in Cognitive Interviews to provide substantive significance to focus group data. Finally, 20 youth participants will take part in a mentored *Photovoice* project focusing on vulnerabilities as well as resiliencies demonstrated by these youths, to elucidate positive aspects of their environments as well as challenges they may identify as contexts for high-risk behaviors. We will apply epidemiological methods to elucidate statistical significance and assure inferential strength in our qualitative findings. Our analysis employs concepts and models from the behavioral and social sciences focusing on prevention strategies, health promotion and public policy.

The focus of my research on LGBTQI youth and, particularly, youth of color is driven by the belief that the HBC is by all accounts much more than just a venue for socializing, fantasy fulfillment, dance competition or research. The rewards and challenges it presents are extensive and complex. Defined by a system of fairly rigid to informal yet close-knit social units modeled on family roles and relationships known as "houses," the HBC draws in African American, Latino, and working class LGBTQI youth with enticements of support and affirmation often lacking in their biological families. Histories of traumatic familial rejection and estrangements are common among HBC youth, and most often attributed to hostile reactions of their families-of-origin upon the

emergence of atypical gender identities and sexual orientations among them. Some are homeless in every sense save for the shelter found in the HBC (House Mothers/Fathers sometimes offer housing opportunities to the HBC youth - but not always).

These youths are subject to greater than the nominal effects of health disparities facing socioeconomically disadvantaged and racial/ethnic minorities, including higher rates of HIV infection, less access to treatment and disinclination to test for HIV or to seek treatment for asymptomatic health conditions. Though the HBC has reportedly integrated HIV awareness and prevention efforts in a number of HBC contexts, including Ball themes and House philosophies, these continuing disparities suggest a measure of inefficacy in current prevention efforts targeting HBC youth. Yet we have little evidential basis to determine whether these disparities are equivalent in measure to those affecting all marginal groups at risk for HIV. The issues are compounded by the problematic classification of "Men who have Sex with Men (MSM)" in HIV research: a designation of adult behaviors and motivations that should, by logic and reason, exclude most youth and transgender people but often rather conflates divergent issues of various identifiable at-risk groups. This alone presents significant challenges to any competent youth-focused examination of prevention efforts in the HBC and elsewhere.

Thus, whether my research involves truant and adjudicated youth, or Latinos exhibiting more advanced stage of cancer when diagnosed and often also lack access to treatment and thus remain underground, or at-risk LGBTQI youth of color, my focus is on better understanding the resilience factors and vulnerabilities faced by hard-to-reach populations in order to design programs that are responsive to their needs. For example, much of the research funded on HBC has focused on MSM's with limited attention given to youth. The data suggest that black/African American adolescents who make up only seven percent of the 13-to-19 year-old US population account for 72% of all adolescent HIV/AIDS diagnoses. In June 2010, the CDC reported that most new infections among black MSM occur among young black MSM, and that there are more new HIV infections among young black MSM aged 13-29 than among any other age and racial group of MSM.[v] Thus, a major goal of this study is to build a solid knowledge base about Ball attendees who are gender-variant youth of color. That majority is made up of various categories of identity including Butch Queens, Fem Women, Fem Queens and Trans Men (few MSM – though these categories are often integrated and labeled MSM for convenience). Enhancing our understanding of the identity formation among these youths is essential to our ability in designing future interventions that will achieve risk reduction and the transmission of HIV in these communities.

Having devoted my academic career to building and sustaining long-term community-academic partnerships premised on trust and collaboration, my research reflects an engaged scholarship model supportive of social justice and social change on behalf of vulnerable and marginalized populations. My scholarship is therefore inclusive, collaborative, and problem posing, and designed to capitalize on the strengths of faculty to address public health needs while engaging with community partners about their

concerns. Implicit in this model is the stature of higher education institutions committed to effecting change by engaging or serving to broker relationships with key stakeholders on behalf of communities. Ultimately, my work seeks to enhance academic public health education and research to effect greater benefit on behalf of communities while enhancing their influence on higher education institutions.

Future Directions

Capitalizing on my research with a local consortium of agencies serving LGBTQI youth of color relative to the sexual transmission of HIV and other STDs in and across various subgroups, and Latino populations who increasingly exhibit more advanced stage of cancer when diagnosed including a lack of access to treatment, two main foci have emerged that will enable me to continue advancing research on behalf of populations that are vulnerable and marginalized. First, I intend to advance future findings of my R21 study to inform the development of an LGBTQI-focused health-promoting R01 intervention to benefit young racial and ethnic minorities. This research is consistent with the policies of the Demographic & Behavioral Sciences Branch (DBSB) of the National Institute of Child Health & Human Development (NICHD) which promote a population-based perspective on the HIV epidemic, examining shared norms, values and beliefs, as well as demographic, social, and behavioral aspects of the sexual transmission of HIV and other STDs in and across various subpopulations.

My previously described research addressing the magnitude of cancer and stark disparities in mortality among Latino in Pennsylvania has recently positioned me to co-develop a grant proposal to improve communication about modifiable risk factors with young Latinas and/or Hispanics at risk for breast cancer disparities. In collaboration with Dr. Ann Klassen, Associate Dean for Research at the SPH, we have been invited to resubmit an investigator-initiated research grant proposal to the Susan G Komen Foundation for the Cure designed to explore and contrast media, stakeholder/audience, and clinician views on how to address modifiable risk factors for breast cancer among younger women in low resource populations (November 2010). Specifically, I will be facilitating between 8-10 focus groups comprised of Latinas as well as conducting in-depth one-on-one interviews with approximately 20 of them.

I also plan to continue my research pertaining to community-academic partnerships designed to advance the health and well being of communities (principally, ethnic and racial minorities who are at risk and/or vulnerable) as well as the professional development of public health students resulting from their work in communities. My scholarly contributions will be through publications derived from the analysis of the objectives initially set out by the collaborators as well as outcomes attained by all (partners; populations served; and students. I am equally invested in assessesing the longitudinal impact of service-learning on communities, students and faculty. Similarly, I will also aim to develop products of practical use to the populations being served (e.g., program design; technical assistance; staff training; evaluation). Thus,

it is my intention to continue investigating and concretely addressing ways in which the health and well-being of vulnerable and marginalized populations can be promoted, while enhancing the competencies of future public health professionals.

3. Education: Teaching Philosophy, Teaching Responsibilities and Mentoring

Teaching Philosophy and Conceptual Framework for Teaching

My approach to teaching is founded on the principles of Paulo Freire, a 20th century Brazilian educator known for his understanding that education has a socio-political context.[vi] Freire's ideas call for the creation of a society free of exploitation where, especially vulnerable populations take an active role in the world by achieving literacy. For Freire, learning is enhanced in the context of organic group processes (co-learners) and application, as well as through dialogue, critical thinking, reflection, and action. Listening is critical to fostering genuine dialogue, as is one's capacity reflecting about what is being said. The iterative nature of the noted steps in this cycle empowers learners, informs future action, and can also prepare people working together to address increasingly more complex tasks. In the words of Freire, education gives us the opportunity to achieve self and community transformation.

As the table shown below makes clear, Freire's problem-posing approach to learning complements the SPH's use of problem-based learning (PBL) pedagogy as well as being equally responsive to the challenges posed by public health practice. Learning is by nature reciprocal, allowing teacher and student to engage in dialogue and to make use of the power of critical reflection. This helps my students assess their beliefs and newly acquired knowledge, test concepts in applied settings, and often challenges their assumptions. Similarly, it is also the process of critical reflection that informs my students' future actions, helps them redefine problems from a different perspective, and fosters change in their own thinking and behavior.

Conceptual Framework for Teaching[vii]	
Banking Approach	**Freire's Problem-Posing Approach**
Teacher seen as possessing all essential information.	Facilitator provides a framework for thinking; creative, active participants consider a common problem and potential solutions
Pupils seen as "empty vessels" who need to be filled with knowledge.	Facilitator raises questions: Why? How? Who? When? What?
Teacher-centered education	Participants are active, describing, analyzing, suggesting, deciding, and planning.
Pupils absorb passively	Listening – dialogue – action has the potential to promote further growth and action.

In my classes, I try to listen for students' generative themes as a starting point for organizing and developing our sessions. Freire's 'problem-posing' method of dialogue assumes that societal problems require short and long term strategies for change as well as multiple interventions. This is also true for public health practice. My role, therefore, is to empower my students by helping them crystallize the core issues they have identified, ask questions about the root causes, and elicit responses regarding the necessary strategies for action and/or change. After applying their ideas, we dialogue about our successes and shortcomings, and later plan future strategies.

My teaching philosophy is grounded on the assumption that globalization is challenging us to consider the impact of everyday acts on people we do not yet know. The courses I teach incorporate a brief introduction to explain and apply core concepts and methods, combined with their application to challenges posed in public health practice. My classes include collaborative approaches focused on macro-societal issues to engage students in defining venues that will lead them to master and apply content knowledge, test assumptions, and assess intended and unintended outcomes. The materials and activities comprising the courses I teach principally include group problem solving, case study analyses, community health and prevention journals, and community-based research projects among others.

I always begin class by acknowledging the reciprocity of the learning process, and the value of students' own knowledge bases and life experiences. This is intended to provide them with validation, equality, safety, and trust. Additionally, I remind them that they will learn from their peers as much or more than from their instructor so that early on they will discern that I am not the only knowledgeable participant in their learning process. As their teacher, it is my hope that I will help them 'learn how to learn' by facilitating and supporting their learning in the context of their own experience. Similarly, I ask them to define and assume ownership regarding group assignments, including the appropriate division of labor required for their successful completion. Students define the sequence of activities in each class, and partake in both leader and participant roles. Students assess each class meeting by reviewing what worked well that warrants continued use as well as offering suggestions for adjustments of activities intended to enhance future learning processes.

Teaching Responsibilities

My teaching at the SPH began in 1996, and has focused on developing competencies that enable students to engage in community outreach and prevention research and practice with sensitivity and humility; that is, to learn how to work with communities respectfully while acknowledging the influence of sociocultural, ethnic, linguistic, and diversity factors among others. As noted in the preceding, service-learning, and community-based participatory research (CBPR), are two major methodologies for community-academic partnerships that equally inform my teaching. Additionally, my students also benefit from my expertise in cultural competency,

community-based experiential education, PBL, collaborative learning, and adult learning.

My most significant contribution to students' development bridges theoretical and applied learning by assessing the role of contextual influences when collaborating with populations of diverse cultural, ethnic, and linguistic origin among other markers, given the dynamic nature of social, economic and demographic variables affecting their lives. Students' learning is further enhanced when they self-assess their assumptions, biases and suppositions in the context of interactions with populations that often, are different from them. With guidance from community-based public health preceptors and faculty, the experiential learning opportunities we have jointly developed facilitate integration of knowledge gained in the classroom and its application in the 'real world.' Similarly, these opportunities provide teachable moments when they 'learn by doing' while engaging with service providers and program participants.

Since the SPH's inception, I have taught 47 classes in the full-time and executive MPH programs, and worked one-on-one with approximately 500 students. Currently, I teach all full-time MPH students as well as doctoral students in the Doctor of Public Health program (DrPH) in community health and prevention. I have had the privilege of serving as faculty supervisor to more than 40 MPH and one DrPH graduates in community health and prevention. I am also serving in the same capacity three doctoral and seven master's level students. Within my department, I have served as a member of one graduate's doctoral dissertation committee, and currently serve in that capacity on four additional committees.

Between 1995-2003, I built the SPH's infrastructure for experiential learning by identifying and nurturing responsive community-based partners and public health preceptors one at a time. During the same period, I also developed approximately 30 educational site visits and resource sessions annually in support of the MPH curriculum. Following these, I also facilitated hour-long structured reflection sessions with students to help them apply knowledge in context. The SPH's infrastructure for community-based learning currently includes approximately 250 partner organizations regionally.

I taught the SPH's executive MPH program students between 1999 and 2005, and continue one-on-one involvement with at least six such students annually advising them in the development of their culminating paper. MPH courses I have taught include: introduction to public health, prevention principles and practices, community-based prevention practice, program planning and evaluation, and multicultural competence in community health and prevention. At the doctoral level, I have taught: theory and practice of community health and prevention, needs assessment, practicum, and community-based participatory research (See Tab 3: Course Evaluations).

Curriculum Development and Innovation

In 2004, the time-intensive teaching of the community health and prevention curriculum prompted me to explore options to expand the size of small learning groups without compromising the students' education. While reviewing the work of Rangachari,[viii] it became apparent that the size of students' learning groups could be expanded to 13-15 each while making continuous use of problem-posing situations as starting points for students' inquiry, the framing of learning tasks to guide the search process, synthesis, and integration of information. As a result, faculty facilitators have assumed a more active role during the brainstorming phase of the learning process to ensure ideas raised are captured, as well as demanding greater vigilance of themselves and their students during the definition of learning tasks. Thus, the reasons making PBL particularly suitable for academic public health education – student-centered, self-directed, active learning – remain intact.

During the 2010-2011 academic year, my teaching spans two required courses in the MPH program as well as two other required offerings in the DrPH program. I teach Prevention Principles and Practices (PBHL 540), and Community-based Prevention Practice (PBHL 550). Between 2003-2010, I served as course director for the latter (See Tab 3: Syllabus for PBHL 550). In this capacity, I designed and provided oversight for a required 120-hour community-based practicum for first-year students including periodic consultation with preceptors (See Tab 3: Samples of Community-based Learning). As can be seen by reviewing the abstracts developed by these students, there is a wide range of community-based experiences available to them. Additionally, I also provided oversight for students' placements across governmental, health systems and not-for-profit agencies regionally. I have also designed and provide oversight for an MPH course dedicated to Multicultural Competence in Community Health and Prevention (PBHL 670) [See Tab 3: Syllabus for PBHL 670] as well as a doctoral course focused on Community-based Participatory Research (PBHL 814) [See Tab 3: Syllabus for PBHL 814]. These courses enable me to provide expertise in developing and sustaining community-academic partnerships for health, fostering student engagement in chronic disease prevention among ethnic minority communities, as well as in designing and implementing prevention practices supportive of at-risk minority youth and other vulnerable groups.

I incorporate into my teaching group problem solving by asking students to assess a substantive public health problem of macro-societal impact as a means of fostering their assessment across systems, and use of an interdisciplinary perspective. For example, in my classes I have asked students to critique major case studies, such as the aftermath of the 9/11 and Katrina Hurricane disasters, from a public health perspective. Each student takes an area critical in each of the noted events (e.g. environmental and occupational health, communications, displacement of populations, access to needed services, etc.) and assesses responses within the selected field as well as within and across a systems framework. This group assignment challenges them to

explore the implications of public health interventions for prevention and policy within a health disparities context. Student-directed learning is promoted through in-class discussions and self-reflection to enable each individual to identify topics consistent with their professional aspirations.

As a final assignment, students are asked to integrate the knowledge and skills gained through the mid-course group exercise, class readings and discussion to critique a macro-societal public health dilemma including an oral presentation. This integrative assignment is done individually, and includes an assessment of interventions at two levels: societal (population level) and individual (community/neighborhood) to ensure maximization of public health and human rights. The case study analysis assignments teach the students about the complexity of the public health system, the need for systems integration and interdisciplinary collaboration, as well as the tension balancing public and private rights.

Students' individual final projects serve to assess performance in a summative manner, while mid-point assessments enable me to ascertain which learning objectives have already been mastered, and gaps in knowledge and application. I aim to evaluate how well the students defined the problem area selected, its importance, and whether it was framed within a sufficiently wide macro-societal context. I also gauge students' knowledge of best practices, capacity generating recommendations, and rationale for a proposed course of action including implementation and evaluation considerations. Students are also evaluated on the clarity of their presentation, depth of research and analysis, and capacity responding to questions from peers and instructor. The final class session also includes the course's evaluation.

Another learning tool I have incorporated into a course on Multicultural Competence in Community Health and Prevention (PBHL 670) is a self-assessment assignment designed to enhance students' self-discovery (i.e. better understanding of why, how, who, when, and what determinants help explain one's thinking and behavior) (See Tab 3: Samples of Course Assignments). This assignment has been very useful in my assessment of students. Through the use and application of material introduced in readings and discussions, this self-assessment exercise serves students to understand how the dimensions that define them as individuals may influence their roles as future public health professionals. Students' projects are evaluated based upon their use and application of concepts learned in class, and the depth of reflective capacity identifying and articulating their own significant markers (i.e. antecedents; representative behavior settings and scripts; beliefs, values, worldviews; visible cultural persona; preferred patterns of speaking and relating to others; personality patterns; cultural dimension mapping; and summary statement). Following this reflective assignment, they also prepare a critique of a public health problem that, in their view, is defined through a cultural prism (See Tab 3: Sample of Course Assignments). Thus, in this and other courses I use mixed methods including quantitative and qualitative approaches provided by the student and teacher as a means of assessing learning outcomes. In courses such

as Community Assessment (PBHL 550), I also include the feedback provided by community-based preceptors with whom I jointly assess students' performance.

The course I teach on community-based participatory research (PBHL 814) also enables me to assess how doctoral students are including communities in their research endeavors. As part of this course, students are expected to interact with a community that they are already working with, or establish contact with a new community. For example, students interact with a given community agency or group regularly by observing, listening, dialoging, and often facilitating meetings designed to address environmental concerns that local health departments are eager to receive. Throughout these interactions, students become aware how CBPR principles come to life. In other instances, they find that their community experiences contradict some of the ideas presented through class readings. Moreover, students have the opportunity to self-assess in the context of working with and in the community. Reflections derived from their community experience and those with whom they have interacted are included in their journals and constitute a requisite component. At the end of the academic quarter, students review their journal entries to assess the extent of their learning, and design plans for their continued education regarding community health and prevention.

My syllabi incorporate course description including an overview, objectives, teaching methods, evaluation, and required and recommended readings. I note how grades are derived from each class component, a description of group and individual assignments including criteria guiding the grading of each assignment, and deadlines for submission. Similarly, a course schedule outlines each class session's topic, and required and/or recommended reading for each week. All told, I seek to instill in students reflection and analysis about the competencies being mastered, those they still need to attain as well as to self-assess regarding their beliefs, values, and assumptions. I challenge them to examine the root causes that help to explain today's community health dilemmas, and assist with their development as competent and sensitive public health professionals working towards the eradication of health disparities.

Mentoring of Students

My commitment as an educator extends to training the next generation of public health researchers and practitioners dedicated to working with vulnerable and marginalized populations and the eradication of health disparities. Since 2008, I have engaged seven MPH students and one MS student in biostatistics to assist with my research on: a) student-, preceptor- and community-related outcomes derived from the SPH's community-based experiential learning; b) cancer prevention through early detection and intervention among Latino populations; and c) vulnerability and resilience factors among lesbian, gay, bisexual, transgender, questioning and intersex (LGBTQI) youth of color under the age of 24.

In the spring 2010, a first-year MPH student approached me to develop his practicum with a focus on my research on vulnerability and resilience factors among

LGBTQI youth of color. In addition to providing a review of the extant literature on this population, this student interviewed leaders of five local community-based agencies serving the majority of Philadelphia's LGBTQI youth of color under the age of 24. In addition to acquiring new knowledge, this student gained qualitative research skills by transcribing, and synthesizing the salient findings emerging from these discussions.

A second-year community health and prevention MPH student with expertise on LGBTQI health also expressed interest in serving as my research assistant in the summer of 2010 (15 hours per week), and continues doing so now (10 hours per week). This student is providing assistance on a project focused on vulnerability and resilience factors among LGBTQI youth of color under the age of 24, including the House Ball Community (HBC) in Philadelphia. In the summer of 2010, this student helped craft sections of an R21 grant application (Exploratory/Developmental Research), submitted to the National Institute of Child Health and Human Development of the National Institutes of Health in September of 2010. As part of this project, I have assembled a consortium, including leaders and staff of five local agencies serving LGBTQI youth. This same student was also able to observe the scope of the consortium's collaboration, interact with its members, attend planning meetings, and is learning first-hand how community-based participatory approaches linking community representatives and academics can be implemented.

Consistent with Drexel University's goals of "promoting a culture of research and scholarship" (objective 2), and "promoting a culture of student engagement" (objective 4), I am also capitalizing on my research on cancer prevention through early detection and intervention, funded by the Pennsylvania Department of Health through the Pennsylvania Cancer Education Network, to train MPH students to conduct and analyze cancer prevention research. During the academic year 2009-2010, two CHP students served as research assistants on this study for approximately ten hours per week. In the spring of 2010, one of these students selected my research to develop her first-year practicum, and devoted more than 120 hours to the conduct of bibliographic research, data analysis, and field research. Additionally, she was a participant observer in several health education sessions designed for Latino populations conducted by Philadelphia Department of Health staff. During the summer of 2010, this same student served as a research assistant for approximately 15 hours per week, and developed a manuscript focused on the adoption of lay health advisors in reaching especially vulnerable populations who are predominantly Latino and at risk for cancer. As noted in the preceding section devoted to my research, this manuscript will be submitted to the *American Journal of Public Health* in response to a Call for Papers devoted to a theme issue on community health workers and public health (12/15/10).

All told, my teaching aims to challenge students to think through the multidimensional implications of their community-engaged work, facilitates their interaction with marginalized communities often different from their own, and engages them in structured reflective discussion regarding how their own status in society is

bound to impact their research and practice experiences. Similarly, my teaching also integrates members of the community as well as community-based preceptors into the learning experience as well as encouraging students to engage in this reciprocal process and benefit from its inherent strengths.

Future Directions

LGBTQI populations experience barriers accessing services, and are often underserved due to reasons including societal stigma, isolation, and the absence of supportive health and human services networks. Capitalizing on the work on LGBTQI youth of color that facilitated my submission of an R21 in September 2010, I am collaborating with the Goodwin School of Professional Studies to develop and implement an on-line, three 4-hour course primer devoted to LGBTQI health advocacy in early 2011. Its aims are to empower students with the knowledge, skills and attitudes needed to more effectively serve LGBTQI populations as well as to sharpen their advocacy skills on behalf of the same groups.

This course is intended to reach consumers, front line staff, volunteers, consultants, board members and/or advocates within agencies serving LGBTQI populations to encourage increasing awareness of the concerns of all gender and sexual minorities. The course will expand upon concepts in LGBTQI cultural competency especially needed among individuals serving in an advocacy capacity. Health-related institutions including hospitals, physician offices, clinics and care centers, in particular, are environments where issues pertaining to LGBTQI patients, clients, and providers intersect. The course will therefore address concerns affecting consumers as well as LGBTQI practitioners, staff, and advocates and, especially, the treatment of access and equity issues and other disparities identified as detrimental to LGBTQI groups and/or populations. All told, this initiative aims to provide its participants with a set of essential competencies designed to ensure the provision of accessible, respectful, and safe health and human services for all gender and sexual minorities.

4. Service

School-related Service

My service ethos and commitment to promoting academic public health education within the institution can be traced to 1994, when I was asked to co-develop a blueprint for the establishment of what today is Drexel University's School of Public Health.[ix] Given the opportunity to develop a school *de novo*, a national advisory board recommended that in order to make a difference, its design needed to reflect collaboration with community partners in response to the inherent health disparities in the region. Thus, I advocated implementing community-based experiential education premised on service-learning and community-academic partnerships for health. Today, these are signature features distinguishing the SPH as a national leader in academic

public health education. Thanks to our collaborations with community-based partners, the per capita MPH graduate contribution to service in the region surpasses 500 hours. At the time of the SPH's inception, I also co-developed a grant proposal funded by the Pew Charitable Trusts ($300,000) in support of developing a community-academic partnership in North Philadelphia's 11th Street Corridor.

My service to the SPH has also included the development and analysis of data required for accreditation self-study documents submitted to the Council on Education for Public Health, the national accreditation body for schools of public health (2003 and 2006 respectively). In this context, I have been responsible for compiling data relative to the outcomes derived from students' community-based experiential learning, including preceptors' feedback.

I have also served as the school's chairperson of the Educational Coordinating Committee (ECC) since 2005. In this multifaceted role, I provide oversight on issues that crosscut the SPH's departments, including interaction with the Faculty when developing and/or restructuring programs. Between 2005-2008, my concurrent service as ECC chairperson and SPH representative to the Faculty Senate (including its subcommittee on academic affairs) enabled me to expedite approval of academic programs mandated by the SPH's accreditation requirements as well as other noteworthy expansions of institutional significance. These included: 1) two Doctor of Public Health (DrPH) degree programs in community health and prevention, and health policy and social justice respectively; 2) PhD program in epidemiology and biostatistics; 3) five distinct academic concentrations in community health & prevention, environmental & occupational health, epidemiology & biostatistics, and health management and policy; 4) curricular conversion from academic semesters to quarters; 5) Master of Science degree program in Biostatistics; 6) certificate in epidemiological and biostatistical principles and methods for public health in the 21st century; and 7) executive MPH program in Sacramento, CA.

Department-related Service

In January 2006, I provided oversight to two faculty search processes that culminated in the hiring of Dr. Lisa Bowleg and Dr. Randall Sell to the CHP Department later that fall. Eight candidates were interviewed for these positions. As part of this process, I contacted and screened all candidates, and scheduled visits by the top four to the SPH and Drexel University. The top two candidates were invited for second visits. I also followed up with their references as appropriate, and forwarded recommendations to the SPH's Dean.

Since 2007, I have served as MPH curriculum director within my department, and thus am responsible for planning and managing the implementation and assessment of its coursework. In collaboration with a faculty subcommittee, I conduct periodic assessments including the restructuring of learning objectives and various other curricular components consistent with guidelines advanced by the Association of

Schools of Public Health and other national groups committed to academic public health education. I also review and approve all student academic major requests, assign students a faculty advisor, and review and approve all student research proposals submitted to the Institutional Review Board. I also ensure appropriate faculty coverage to meet curricular demands, including identifying and recruiting adjunct faculty as appropriate. I also facilitate students' annual review of competencies in preparation for two national credentialing examinations (National Board of Public Health Examiners, and Certified Health Education Specialist). Lastly, I seek to ensure that the experiential needs of second-year CHP concentration students are appropriately matched relative to the selection of community-based sites and preceptors.

Early in the 2009-2010 academic year, Dr. Marla Gold, the SPH's Dean appointed me to a SPH faculty search committee convened to identify a leader for my department (Community Health and Prevention, CHP). In my role as CHP representative within a five-member search committee, I screened 25 candidates, as well as interviewing five of them in the context of visits to our campus. Additionally, I participated in subsequent two-day visits extended to the top three candidates. My participation in this faculty search committee is ongoing given that the candidate that was extended an offer did not accept it. My service to this search committee has been extended through the 2010-2011 academic year.

University-related Service

My service on the Faculty Senate and its subcommittee on academic affairs (2005-2008) stands as an important learning experience given that it provided me the opportunity to review and assess program proposals designed by various schools and colleges within Drexel University. More important, my ability to review and assess program proposals enabled me to appreciate the richness extant across the campus. It also afforded me the time to share program plans in public health education, and to receive invaluable input from my peers across the university.

Since 2009, I have also served as a member of the steering committee of Drexel University's Intercultural Engagement and Diversity Initiative, designed to promote equality among faculty, staff and students. In this role, I have been privileged to facilitate focus groups on issues pertaining to campus-wide diversity concerns, as well as facilitating a discussion inclusive of faculty and staff based on Beverly Tatum's book on the development of racial identity, *Why Are All the Black Kids Sitting Together in the Cafeteria?* In 2010, I was invited to serve as co-chair of a university-wide faculty committee created to solicit feedback from their peers on pressing diversity concerns.

National Service

I have always maintained a commitment to service opportunities that enable me to contribute my experience and expertise in community-based learning, as well as in

building effective community-academic partnerships for effective public health practice nationally. These have included editorial review roles in six national journals; research grant and fellowship grant reviews sponsored by the National Institutes of Health, the US Department of Health and Human Services, as well as the Association of Schools of Public Health (ASPH). Since 2005, I have also worked closely with the ASPH, including collaborations such as the Master's degree in public health core competency development project (leadership workgroup), as well as currently serving as a member of its public health practice coordinator's council. Between 2007-2009, I was also a member of the ASPH's editorial team responsible for writing one of the monographs within the Demonstrating Excellence in Practice series (*Demonstrating excellence in the scholarship of practice-based service for public health*).

5. Contributions to the Community and Public Health Practice

As previously stated, my definition of engaged scholarship reflects genuine community engaged education, research, practice and service that extends beyond theoretical application. It must embody an approach that reflects a commitment to the public good and to social justice, as well as always including communities as active participants of their destiny. It is the values reflected in our approach when working with community partners, and the concrete outcomes of our actions that define our commitment to community-engaged work.

I have established lasting partnerships with agencies in the Philadelphia region focusing on the needs of those who are vulnerable and marginalized. Whether working with Planned Parenthood Southeastern Pennsylvania or Congreso de Latinos Unidos, Inc., to empower at-risk youth, I view collaboration with community partners as indispensable to the goal of giving a voice to historically marginalized populations. My efforts have been devoted to developing tools that enhance funding opportunities, improving their programs and data collection methods, as well as relying on the social capital inherent in the expertise of community residents.

My commitment to community-academic partnerships is reflected in the engagement in which I partake when working with colleagues representing community-based organizations. For example, the range of agencies and projects comprising our consortium of partners working with LGBTQI youth makes this point evident. These include: the Attic Youth Center and YHEP: the Youth Health Empowerment Project of Philadelphia Fight, Inc., the two largest nonprofit LGBTQI health/social service organizations sponsoring youth programs for African Americans and Latinos (respectively: Colours Organization, Inc. and GALAEI: the Gay & Lesbian Latino AIDS Education Initiative) and the major health/social service organization serving the city's Transgender adults and youth, TIP: the Trans Information Project (an initiative of Prevention Point Philadelphia). These partners embody the commitment and engagement needed to work in tandem regardless of their organizational affiliation. They will assist in the design and dissemination of strategies that have proven beneficial

in reaching out and engaging LGBTQI youth that currently do not always enter the healthcare system.

Implicit in my work with community partners is my being accountable to them in the context of our collaborative research so that it will mirror the social justice goals inherent in our mutually developed research agenda. For example, as part of the LGBTQI agency consortium I helped to create, we have integrated their clients and staff so that they will have a central role in identifying the research problem as well as its process. Having a deeper understanding of how certain factors such as one's structural and sociocultural context influence sexual identity formation and, in turn, risky sexual behaviors among the gender-variant youth of color served by our community partner agencies would be a significant contribution to public health practice, and to the populations themselves. It could also inform prevention interventions, and may actually even begin to lift some of the stigma attached to these subgroups.

The SPH's mission to "identify the societal conditions required for people to be healthy, and to advance practices that improve the health of vulnerable populations," is consistent with my orientation to make a difference in people's lives and to honor each person's dignity. By facilitating their own empowerment, they are more likely to learn how to advocate for themselves. Equally important is to share the knowledge gained about LGBTQI populations with health care providers so that they, in turn, can gain knowledge and thus be more comfortable in the delivery of services to groups that are often stigmatized or segmented.

Service to community-based agencies in the region is personally important and gratifying to me. I currently serve on the boards of Safeguards, MANNA, and Essential Elements. Equally important has been my work with the Philadelphia Department of Public Health throughout my years at the SPH. Much has been given to me by many great role models I have been privileged to work with in Philadelphia.

My work at the SPH is personally important, as are colleagues within my department and elsewhere within the institution. I have been privileged to make contributions to its philosophy and mission as well as having played a key role in its institutional development. The opportunity to have a seminal role in the development of a school recognized for its ability to engage faculty and students in public health practice including the lives of everyday people, has taught me about the reciprocal value of advancing community-academic partnerships built on social justice, prevention and health promotion within an equally committed university culture of research, scholarship and student engagement.

Two individuals are especially deserving of my gratitude in my role as faculty at the SPH. Dr. Lisa Ulmer, my department's chairperson, has provided me with wholehearted support. I am also grateful to the school's Dean, Dr. Marla Gold, for her leadership and commitment to ensuring that our work as faculty always incorporates

policy and advocacy perspectives on behalf of vulnerable populations. I appreciate all the opportunities that the University has afforded me, and that enable me to enhance my role as an educator, researcher, colleague and citizen. I am therefore honored to submit my dossier for consideration for tenure at this time.

REFERENCES

[i] Seifer S. Examining community-institutional partnerships for prevention research. Project fact sheet. Retrieved from http://depts.washington.edu/ccph/pdf_files/Project%20Fact%20Sheet%20Apr%2006.pdf on September 3, 2010; and Aaronson KR (2006). How prevention science can inform service-learning research. *International Journal of Teaching and Learning in Higher Education*, 18, 5-16.

[ii] According to Seifer (1998), "Service-learning is a structured learning experience combining community service with preparation and reflection. Students engaged in service-learning provide community service in response to community-identified concerns and learn about the context in which the service is provided, the link between their service and academic coursework, and their civic roles. Service-learning aims to include both service and learning objectives; emphasizes concrete community concerns, social determinants of health, reciprocity, reflective practice, and civic engagement." (Seifer SD. Service-learning: Community-campus partnerships for health professions education. *Academic Medicine*, 73, 273-277).

[iii] Community-based participatory research is a partnership approach to research that equitably involves community members, organizational representatives, and researchers in all aspects of the process, and where all partners contribute expertise and share responsibility and ownership to enhance understanding of a given phenomenon, as well as to integrate the knowledge gained with concrete action to improve the health and well-being of community members. (Israel B, Schulz A, Parker E and Becker A (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, 19, 173-202).

[iv] Gebbie K, Rosenstock L and Hernandez L (2003). *Who will keep the public healthy? Educating health professionals for the 21st century*. Washington, DC: National Academy Press.

[v] CDC Fact Sheet: HIV and AIDS among gay and bisexual men, June 2010. Retrieved from http://www.cdc.gov/nchhstp/newsroom/docs/FastFacts-MSM-FINAL508COMP.pdf on September 3, 2010.

[vi] Freire P (1993). The pedagogy of the oppressed. New York, NY: The Continuum Publishing Company, pp. 68-105.

[vii] Freire P (1993). The pedagogy of the oppressed. New York, NY: The Continuum Publishing Company, pp. 52-67.

[viii] Rangachari PK (1996). Twenty up: Problem-based learning with a large group. In: *Bringing Problem-based learning to higher education*, ed. L Wilkerson & WH Giljselaers. *New Directions for Teaching and Learning* 68, 63-71.

[ix] Medical College of Pennsylvania and Hahnemann University. Pre-proposal for the establishment of the Medical College of Pennsylvania and Hahnemann University School of Public Health, submitted to the Pennsylvania Department of Education. Philadelphia, PA: July 1, 1994; and Medical College of Pennsylvania and Hahnemann University. Proposal for the establishment of the Medical College of Pennsylvania and Hahnemann University School of Public Health, submitted to the Pennsylvania Department of Education. Philadelphia, PA: June 1, 1995.