Lessons Learned From a Decade of Focused Recruitment and Training to Develop Minority Public Health Professionals

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From 1999 to 2009, the Eliminating Health Disparities Pre-doctoral Fellowship Program provided specialized education and mentoring to African American graduate students in public health. Fellows received a public health degree, coursework in understanding and eliminating health disparities, experiential learning, mentored research, and professional network building with African American role models. We describe successful strategies for recruiting and training fellows and make 5 recommendations for those seeking to increase workforce diversity in public health: (1) build a community of minority students, not a string of individual recruits; (2) reward mentoring; (3) provide a diverse set of role models and mentors; (4) dedicate staffing to assure a student-centered approach; and, (5) commit to training students with varying levels of academic refinement. (Am J Public Health. 2011;101:S188–S195. doi:10.2105/AJPH.2011.300122)

Increasing minority participation in public health careers and graduate education programs is a priority for many organizations and disciplines and essential for achieving greater success in eliminating health disparities that exist among populations. Although racial and ethnic minority groups account for over 30% of the United States population (increasing to nearly 50% by 2050), they are a far smaller proportion of the total workforce in health professions.11 A diverse workforce of health professionals can play an important role in eliminating racial health disparities.12-14 Racial and ethnic minority health care professionals were more likely than their White peers to serve patients of color, indigent patients, and work in medically underserved communities.15,16 In addition, patients from minority groups were more likely to report receiving preventive care, needed medical care, and greater satisfaction with care from health care professionals that shared their racial/ethnic background.17-19 This may be based on comparatively negative experiences patients had with nonracially/ethnically concordant providers, or the expectation that experiences of disrespect in other aspects of society will occur with members of the medical community.20

In particular, African Americans have been underrepresented in health professions and the graduate education programs that led to these professions.21,22 In 2008, African American doctoral degree recipients represented only 7% of all doctoral degrees earned from United States universities; that proportion was even lower in many science fields. African Americans represented 6.2% of doctoral degrees in social science, 4.5% in life science, 3.8% in engineering, and 3.2% in physical science.22 Compared with White doctoral students across all fields of study, African American doctoral students graduated with a greater debt load, were less likely to report teaching and research assistantships as a primary source of educational support, and were more likely to rely on their own financial resources.22

Certain minority-focused programs showed promise for increasing participation in public health graduate studies,23 and Schools of Public Health have made great strides increasing minority enrollment in recent decades. However, these gains have stagnated somewhat among African American students. From 2001 to 2007, African American graduate student enrollment changed little, from 12% to 11%.24-31 The proportion of these students earning doctoral degrees was lower. In 2008, member institutions of the Association of Schools of Public Health awarded 9% of doctoral degrees to African American students. African Americans were especially underrepresented among tenured faculty members at Schools of Public Health. In 2008, only 46 of 1431 (3%) tenured faculty members in United States Schools of Public Health were African Americans.32 Improvements in both areas are needed to develop a well-trained and diverse next generation of public health professionals to help improve the health of all populations and address the complex challenge of eliminating health disparities.

To help meet this need, we created the Eliminating Health Disparities Pre-Doctoral Fellowship Program (hereafter “program”) for African American graduate students in public health. Established in 1999 and funded first by the Centers for Disease Control and Prevention’s Prevention Research Centers Program and later the National Cancer Institute, the program trained 33 fellows in the last decade. The purpose of this article was twofold: (1) to describe core program elements, the approach to recruiting, selecting and placing fellows, and key responsibilities of program leaders; and
(2) to present 5 lessons learned from 10 years of experience. We hope that sharing our approach, successes, and challenges will help other institutions continue or build momentum in their efforts to develop a diverse public health workforce for the future.

**ELIMINATING HEALTH DISPARITIES PRE-DOCTORAL FELLOWSHIP PROGRAM**

The Eliminating Health Disparities Program prepared African American predoctoral students in public health to understand and conduct applied prevention research in community settings, with a focus on improving health in low-income minority populations. To accomplish this, we designed a multifaceted education program that provided fellows with: (1) a master’s or doctoral education in public health; (2) specialized coursework in understanding and eliminating health disparities; (3) mentored experiential learning; (4) mentored independent research; and (5) professional network building with local and national African American role models.

As part of the fellowship application process, students had to be accepted into a graduate degree program at the Saint Louis University School of Public Health (i.e., behavioral science, epidemiology, biostatistics, environmental and occupational health, public health administration, or public health policy). In addition to coursework required of all students, fellows had to complete 2 separate 3-credit hour courses: Understanding Health Disparities and Eliminating Health Disparities. These courses were developed specifically for the program, although students not involved in the program could and did enroll. The first course described specific health disparities, examined conditions associated with those disparities, and identified the most affected populations. Particular emphasis was given to understanding systemic factors that contributed to disparities. The second course built on this knowledge and explored existing evidence and potential strategies to eliminate disparities. Particular emphasis was given to multifaceted, multilevel interventions. These courses were completed during a fellow’s 1st and 2nd semesters, respectively.

Fellows also completed multiple faculty-mentored research experiences in health disparities. The first of these was completed as an existing research project. Fellows selected from a menu of approved projects that addressed health disparities and were led by 1 or more senior faculty members who had completed a fellowship orientation, expressed willingness to serve as a mentor, and agreed to complete planning and evaluation documents regarding the fellow’s research. For each of these research experiences, fellows were required to identify specific learning objectives, responsibilities of the fellow and mentor, and a scholarly product to be completed (e.g., manuscript, presentation, poster). Fellows completed these research experiences during the first 12 months of the program. During their 2nd year in the program, fellows also developed and carried out an independent research project with guidance from a faculty mentor.

Fellows also built a network of professional contacts and met potential career role models. To facilitate this, we established the Eliminating Health Disparities Seminar Series and invited national and local presenters to share their work in formal presentations and meet informally with fellows to answer questions and give advice about career paths and trajectories. In all, 26 African American professionals engaged in health disparities work participated in this series. They included men and women at all career stages, from different disciplinary backgrounds, and with varying degrees of focus on research, education, or practice.

**Recruiting Efforts**

Faculty and staff from the program and from the School’s Office of Admissions recruited potential applicants. Recruitment occurred nationally at career fairs, professional meetings, historically Black colleges and universities, other universities with large populations of African American students, and through personal contacts and presentations by program faculty. Locally, recruitment occurred through area universities and at open house events for prospective students. Program and application materials were also available online through a website. Links to the site and references to the program were established with government health agencies, public health associations, and historically Black colleges and universities.

Names and contact information were gathered from prospective applicants, who were then contacted personally by the program coordinator to discuss the program and encourage and assist with applications. Applications included educational transcripts, standardized test scores, 3 letters of support, and essay responses to questions about personal goals, health disparities, and minority health. From 1999 to 2009, we received over 200 program inquiries and 149 applications from prospective fellows in 22 states. Of these, 52% came from students or former students at historically Black colleges and universities (21% public, 31% private), and 48% came from other institutions (28% public, 20% private). Applicants were disproportionately women (80%). All applications were reviewed by at least 3 members of the program faculty, and evaluated using a standardized scoring system. Previous educational experience, including difficulty of coursework, performance in courses related to public health studies, trajectory of performance over time, and grade point average (GPA) accounted for 36% of the score. Standardized test scores and essay responses each accounted for 28% of the score. Letters of recommendation accounted for the remaining 8%. Based on reviewer scores and discussion, finalists were identified and invited to St. Louis for a 3-day on-site visit and interview, paid for by the program. In all, 52 applicants were selected for a visit (about 7 per year), and 50 (97%) accepted.

The distinguishing feature of the on-site interviews was that all finalists attended together as a group. They met at a welcoming reception attended by all program faculty and staff and other faculty, deans, and students from the School of Public Health. They then participated in an orientation to the fellowship program that included remarks and challenges from the University Provost, the Dean of the Graduate School, and a visiting health disparities scholar, typically a prominent African American public health professional. They were divided into groups based on the specific degree they sought, and learned curricular details and requirements from a faculty member within that department. They had one-on-one interviews with at least 3 faculty members, each of whom had been designated to ask specific questions prepared by program staff.
They attended a presentation on health disparities by the visiting public health professional, and had lunch with him or her. Finally, they met with current and past fellows to hear about their experiences in the program.

Selection Process
Immediately after the on-site interviews, the program faculty met and discussed each finalist in detail. Candidates were rated on academic and practice-related skills and experience, leadership potential, and commitment to public health and health disparities. Consideration was also given to constructing a cohort for that year that was diverse in disciplinary background, applicant gender, and type of public health degree sought. Candidates were ranked, and offers were extended to as many highly rated candidates as could be supported. Qualified applicants for whom funding was not available were designated as alternates. Nearly all applicants not selected for the fellowship were still admitted to the school, and many of them enrolled.

All offers were for a 2-year fellowship and included an 85% tuition scholarship (provided by the Graduate School and School of Public Health), a book allowance each semester, travel to 1 professional meeting per year, a monthly stipend, and health insurance. The value of this package was approximately $29,000 per fellow, per year. In all, initial fellowship offers were made to 33 applicants, of whom 27 (82%) accepted and matriculated. Available slots were filled with alternate candidates. Cohorts ranged in size from 3 to 6 fellows per year.

Program Management
The Eliminating Health Disparities Program had dedicated leadership from faculty and staff. The director and 5 faculty members from diverse disciplines each dedicated 0.05–0.10 full-time equivalency to the program. These faculty members were actively engaged in health disparities research and involved in all aspects of the program—from recruiting, interviewing, and evaluating applicants, to teaching health disparities coursework and mentoring fellows. The program also had a full-time master’s level coordinator who led all day-to-day operations. The coordinator planned and implemented recruitment efforts, administered the application process, matched fellows and faculty in mentored research experiences, scheduled and arranged visits from health disparities professionals locally and nationally, monitored fellows’ progress and helped them navigate and meet program requirements, obtained faculty evaluations of fellows’ performance, and assessed fellows’ self-reported experiences in the program. The coordinator was also the program’s primary liaison to the school and university for administrative issues and the first point of contact for fellows when they had questions or concerns about the program.

Outputs and Placement
Of the 33 fellows, 32 earned a master’s degree and 1 earned a PhD in the program. Through November 2010, 22 fellows (67%) published at least 1 article in a peer-reviewed scientific journal, and 15 of these published multiple articles. Collectively, fellows published 66 scientific articles that have been cited 825 times. For comparison, we drew a random sample of 33 nonfellowship students from the Saint Louis University School of Public Health, stratified to match our fellows in graduation year and degree earned. Among the comparison students, 16 of 33 (48%) published at least 1 article and 10 of these published multiple articles. Collectively, comparison students published 52 articles that have been cited 669 times.

Nearly all fellows (94%; n = 31) are currently doing work or pursuing further studies directly related to public health and/or health disparities. Many have gone on to pursue doctoral education, medical training, or postdoctoral fellowships (n = 10). Others accepted positions with the US Centers for Disease Control and Prevention (CDC) or the National Cancer Institute (n = 10), including 3 who earned spots in CDC’s Epidemic Intelligence Service, Public Health Prevention Service, and Public Health Apprentice Program. Some are working in academic (n = 6) and nonacademic (n = 6) health research settings, in community health organizations (n = 4; e.g., Federally Qualified Health Centers, community hospitals, local health departments), or state and national health foundations (n = 2). They are working or continuing their training in 12 states, at organizations including American Red Cross, CDC, Kaiser Family Foundation, Mayo Clinic, M.D. Anderson Cancer Center, National Cancer Institute, Siteman Cancer Center, and at universities, including Harvard, Penn State, Washington, and Wisconsin.

Although the fellows deserve all credit for earning these positions, the program helped them learn about and prepare for these opportunities. Announcements for jobs, fellowships, and other training programs were collected and routinely shared with all program fellows, including alumni. We conducted 3 job skills seminars for each cohort, focusing separately on developing resumes, interviewing, and networking. Fellows attended a professional meeting each year where they learned about career opportunities and job openings. Visiting career role models were specifically asked to talk to the fellows about their own career path after graduation. Finally, program faculty, staff, and mentors were proactive and strong advocates for fellows as they pursued postgraduate positions.

LESSONS LEARNED
Reflecting on program activities over the last decade and the results of those efforts, we identified 5 lessons learned. In some cases, these were things we did right that proved to be keys to success. In other cases, they were the result of trial and error, adapting the program as we learned what worked well and what did not. In the final case, these were observations about trends in minority recruitment and training that have broader implications for programs like ours. Although these lessons are presented in the specific context of minority recruitment and training, some of them may be applied more generally to training and mentoring programs.

Build a Community of Minority Students
From the outset, we sought to establish a clear and positive identity for the program and the students who were part of it. Two key values were central to this identity. First was the notion that students in the program were part of something bigger than their personal education—a collective experience among a peer group of other African American students working toward a grand challenge—eliminating health disparities. Second was assuring institution-wide recognition that
Students in the program met the same admission standards as those outside the program, and had additional fellowship requirements. This approach helped avoid the stigmatization students could experience when participating in programs designed to improve workforce diversity by focusing on specific racial or ethnic groups. This positive and collective identity was reinforced in at least 5 specific ways, some planned and some organic.

**Group-based recruitment.** Strategies that facilitated academic belonging and social support improved retention and graduation rates among African American students. We applied this evidence to our recruitment efforts, such that all finalists being considered for a fellowship were brought to campus together for a 3-day interview and orientation process. We were very transparent that we were recruiting a cohort of students that would come into the program together. The students spent extensive time together over the 3 days, in professional and social situations, with and without faculty present. Invariably, candidates exchanged contact information at the end of the visit and many friendships were formed.

**Alumni involvement.** Graduates of the program and current program fellows played an active role in socializing new fellows. This took many forms. During recruitment of new fellows, program alumni helped describe the program and its benefits and current fellows served on discussion panels and as escorts to the recruits. Program alumni returned as early career professionals to share their job experiences with current fellows. Fellows provided mutual support across cohorts by attending major reports and presentations from other fellows. In short, the fellows from past cohorts were highly visible and involved in the program.

**Information sharing.** We developed an electronic newsletter for the program and distributed it quarterly to all past and current fellows, faculty, and stakeholders. It provided health disparities news and information, interviews on mentoring conducted with the program’s seminar series speakers, and professional and personal updates on past and current fellows. In particular, this latter feature of the newsletter was valuable in helping fellows maintain contact with one another over time, and for presenting varied career trajectories. These updates also fostered a sense of pride and created positive peer pressure by sharing scholarly productivity and accomplishments. In the 8th year of the program, the fellows created a listserv to aid communication among current students and alumni.

**Forming a student organization.** In 2001, fellows reinforced the sense of community by establishing a student organization, the Multicultural Public Health Student Association. This group was founded and initially led by 1 of our fellows, became formally sanctioned as an official student organization by the school and university, and attracted wide membership from across the School of Public Health, including both minority and nonminority students who were not involved in the program. The fellows created the association to increase involvement of other students in health disparities concerns, and to give an organizational voice to health disparities outside the program. The association convened public health community service activities consistent with the program’s mission.

**Building traditions of celebration.** We made a point of collectively celebrating program milestones achieved by each cohort. Social events and ceremonies were held at the beginning and end of each academic year, upon completion of major program requirements, during recruitment of new fellows, and at commencement. These events were attended by program faculty, staff, and fellows, and emphasized the progress of the cohort or group through the program.

**Reward Mentoring**

Because mentored research was such a critical aspect of the program, we aimed to make it easy and highly attractive for faculty to participate. First, we identified 3 valued resources for faculty—high-quality students, money, and time—and provided each as incentives for mentoring. A faculty member who mentored 1 of the program fellows added a bright graduate student to his or her project team (i.e., quality student), at no cost to them (i.e., money), and received up to 5% salary support during the mentoring period to assure protection for this activity (i.e., time).

Second, we structured the mentoring process to maximize its appeal to faculty members. To assure that mentors focused their time on research and not administrative tasks associated with the program, the program coordinator was highly involved in facilitating initial mentoring agreements, progress reports, and performance evaluations. In addition, the requirements of mentored research experiences were designed to be attractive to faculty. Most of these experiences had scholarly products like manuscripts, conference presentations, or posters as endpoints. Achieving these goals benefited not just the fellows, but also the faculty members, who were usually coauthors on their work.

As the program matured and the benefits of being a mentor to program fellows became more widely recognized, there was increased competition among faculty members to attract fellows to their projects. More faculty members submitted health disparity projects as candidates for mentored research. They recruited and lobbied for specific fellows seen as a good fit for their work. Faculty members tried to make their projects more attractive to fellows by offering to pay for additional hours working with their teams. In short, this approach created a genuine demand for program fellows to mentor.

**Provide a Diverse Set of Role Models and Mentors**

Initially, all of the public health and health disparities career role models brought in to talk with the students were highly accomplished senior leaders. It was important for the fellows to meet African American men and women in high-level positions to give them a sense of what they could do in their professional lives. Although the fellows benefited from interacting with the senior scholars and hearing about their career paths and work, there was a huge gap between the scholars and the fellows in both chronological age and public health experience. For example, the program once hosted former US Surgeon General David Satcher, who led a discussion panel with 1st and 2nd year master’s level fellows. The fellows respected the senior scholars deeply, but sometimes found it difficult to process or integrate a senior scholar’s current responsibilities within their own much more limited experiences. The large gap between the scholar’s position and their own made some fellows hesitant to ask questions and interact with the senior scholars.
The fellows requested that the program invite more early career scientists to present in the seminar series. They also requested that the program invite a greater variety of public health professionals, in particular those working outside academia, in public health practice, and in local settings. Based on these requests, the role model component of the program was broadened to include African American professionals at all career stages: (1) recent graduates, early career, and senior leaders; (2) in research and practice; (3) from academic, government, and private settings; and (4) working in public health and health disparities at the local and national level. Finally, we also changed the process for selecting professional role models. At the beginning of each academic year, we identified a range of professionals who met these criteria and created a brief biosketch about each. We then provided this information to fellows, who ranked the candidates in order of interest. These preferences were weighted heavily in selecting each year’s professional role models. Most recently, students were encouraged to nominate their own candidates.

We built on fellows’ interest in diverse role models to also encourage them to develop a diverse team of mentors. Many did not realize they could have more than 1 mentor, and had not thought about how a team approach might better serve their needs. As others have recommended, our program fellows were encouraged to develop relationships with multiple junior and senior faculty, academic and non-academic public health professionals, African Americans, and those from other racial and ethnic groups, and around substantive areas of interest, methodological skills, and career counseling. Nearly all of the professional role models who visited the program reinforced this advice, sharing with fellows their own experience of turning to different mentors for different needs.

**Dedicate Staffing to Assure a Student-Centric Approach**

Assuring a positive learning experience for fellows requires a program to be operationally well organized and highly coordinated, and to have processes and people in place to make sure needs and concerns are heard and addressed. In our program, having a dedicated, full-time coordinator was essential to realizing this goal.

In addition to the administrative responsibilities described previously, the coordinator had 3 responsibilities directly related to enhancing fellows’ experience: accessibility, advocacy and assistance, and support. First, we wanted to assure fellows easy access to a program representative at all times. We (and fellows) learned early on that most faculty members had schedules that precluded extensive availability for impromptu meetings to address administrative issues in a timely manner. However, the coordinator—the only staff or faculty member dedicated full-time to the program—filled this need and faculty members could focus on academic and research mentoring. After 2 years, we moved the coordinator’s office immediately adjacent to the fellows’ workspace. Fellows appreciated having a program representative who was regularly available, and interacted with the coordinator daily about a wide variety of issues.

Second, the coordinator served as an advocate for the fellows to program faculty and mentors. When fellows had a question or concern about some aspect of the program (e.g., inviting career role models), they often went to the coordinator first, who then raised the issue with program faculty. This worked well, because unlike the fellows and faculty members, the coordinator was always present and therefore available to both groups.

Finally, but most importantly, the coordinator provided a wide range of assistance and support to fellows. This started early on by providing assistance in the application and interview process, and continued after admission with help navigating program requirements. Although it aimed to be proactive (and in many cases followed a detailed timeline), the coordinator often solved emerging problems for the fellows. These included issues related to the program (e.g., challenges in a course or research experience), but also many that were unrelated (e.g., family or personal issues). The coordinator was known and trusted as someone who was dedicated to the fellows, listened to their concerns, ideas and opinions, and got things done on their behalf.

Our program had 3 different coordinators during its first 10 years, but they shared several important qualities. All held graduate degrees in public health, therefore giving them the content expertise the fellows were seeking to acquire. All were empathetic, but also strong. They were good listeners who genuinely cared about the fellows, but stood firm and were not afraid to deliver honest, if unpopular feedback. They were trusted and well liked, but also respected. Finally, they were relatively close in age and (in 2 cases) African American. Factors such as perceived similarity (i.e., by age and race) and liking build trust, which when combined with expertise (i.e., by public health training) enhanced perceived credibility.\(^{36,37}\) The program had outstanding success retaining fellows (32 of 33 original fellows completed the program; 97%), and the coordinators were a primary reason for this.

**Commit to Training Students With Varying Levels of Academic Refinement**

During a decade in which “eliminating health disparities” was 1 of 2 overarching goals for improving population health in the United States,\(^ {38}\) many universities redoubled their efforts to attract and train a more diverse student population to help address the problem. From 1996 to 2005, multiple schools of public health and medicine participated in the Health Professions Partnership Initiative (HPPI), funded by the Robert Wood Johnson Foundation and W.K. Kellogg Foundation, with the goal of addressing minority underrepresentation in medical schools. These programs produced several successful models for strengthening the pipeline of minority practitioners and most continued their efforts after funding.\(^ {39}\)

In 2005, the W.K. Kellogg Foundation hosted a conference exploring the role of Schools of Public Health in eliminating racial and ethnic health disparities. Participants included delegates from the Association of Schools of Public Health, who responded with the 2008 report, “Schools of Public Health Goals Toward Eliminating Racial and Ethnic Health Disparities.”\(^ {40}\) A major recommendation of the report was to increase the number of racial and ethnic minority students enrolled in schools and graduate programs of public health.\(^ {40}\)

For public health as a field, it is critically important that we succeed in attracting talented individuals from all racial and ethnic population groups. As described in the “Introduction,” there is evidence to suggest we are making progress. However, from the perspective of any individual institution, the increasing...
number of workforce diversity efforts means much greater competition for the current pool of prospective minority students, especially those who score highly on conventional indicators of academic ability (e.g., GPA, standardized tests). In our program, there was a dramatic change in the number of competing offers such students received from 1999 to 2009. However as Grumbach et al. cautioned, competition and success in recruiting a larger share of the same limited pool of students is a zero sum game. Public health also needs an expanded pool.

One way to achieve this is by committing to develop the knowledge and skills of promising minority students whose academic pedigrees might usually attract less attention in the application process. So-called “whole file” reviews of applicants rely less on GPA and standardized test scores, and have been part of successful workforce diversity efforts in health professions. In our program, key variables in the whole file approach included steady improvement over time in concentration-specific coursework, and evidence from essays, interviews, and observation that an applicant had critical thinking and problem solving skills, understood research, and had a strong interest in the program’s research rotations, coursework, and professional development activities. Studies that evaluated the success of students in programs designed to increase diversity in science, technology, and health professions have suggested that students with adequate academic preparation can thrive when supplemented with focused programs. We need, as Malcolm Gladwell described, public health programs that produce treatment effects, that is, improvements resulting from educational efforts, not just selection effects.

Although not explicitly identified as “lessons,” our efforts benefited greatly from strong and supportive leadership (within the program, school, and university), significant financial resources (from grants, university contributions), and continuity of key personnel (faculty and staff) involved in the program.

CONCLUSION

With a plan, resources, institutional support, and a committed team of faculty and staff, we attracted, trained, and placed African American graduate students in public health practice and research careers addressing health disparities. At other institutions, efforts to achieve similar goals used different approaches (e.g., intensive summer institutes, partnerships with other educational systems), emphasized different aspects of the challenge (e.g., enhancing performance on admission tests), and targeted students at different career stages (e.g., undergraduates, postdoctoral fellows). The descriptive nature of most evaluations of these programs and the programs’ varying objectives makes it difficult to compare results across approaches. It is more useful to examine what these apparently successful programs share in common.

Consistent with our experience, the success of others’ efforts has been attributed to institutional commitment to diversity, including having and involving a diverse faculty, building partnerships for recruiting, training and placement, using more comprehensive review processes for admissions, providing student support that addressed academic, administrative, and personal needs from application and enrollment through retention and placement, and providing students with networking opportunities and exposure to public health leaders. These would seem to be foundational building blocks for any School of Public Health undertaking workforce diversity initiatives.

At least 2 aspects of our approach were somewhat unique among currently reported efforts. First was the attempt to make mentoring more attractive to faculty members by directly addressing issues of cost, time, and scholarly productivity. Second was the commitment to building a vibrant community of minority students focused on eliminating health disparities. It was clear that our fellows learned not only from faculty and visiting scholars, but also from each other’s cognitive, research, and practice skills. This type of cooperative or “jigsaw” learning depended on shared common goals and mutual interdependence, both of which were heightened when students formed a community. Building communities of minority students has been recommended as a diversity-enhancing strategy in other disciplines. Importantly, this “community” was not isolated or exclusionary. Fellows were fully integrated in their graduate programs, took the same coursework, attended the same social events, and adhered to the same policies and procedures as other students.

The program also experienced some challenges. Despite our efforts to achieve gender balance in the program, only 6 of 33 fellows were men. Some of the factors contributing to this gender gap are well known. About twice as many African American women as men earn bachelor’s degrees each year and interest in health majors is even more disproportionate (3:1) in favor of women. Finding ways to attract more African American men to public health professions addressing health disparities is critical. African American men typically have worse health status than African American women, and have some of the greatest disparities of any demographically defined group. Our program was not unique in experiencing these challenges, but nor was it unique in solving them. All our dedicated staff members were women, and there were fewer opportunities for placements that focused on men’s health. The relative absence of male fellows also meant there was seldom a critical mass of men to provide a gender-specific sense of community as was available to women fellows. Any of these factors could have inadvertently discouraged men from participating. Future efforts should seek out strong partnerships with groups and institutions noted for their work with African American men, such as 100 Black Men.

We also observed that some students outside the Program had misconceptions about it. Some believed that fellows had it easier or received more advantages than other students. They did not realize that fellows had additional research and coursework requirements. Some did not understand that they, too, could enroll in the health disparities coursework. Some White students felt it was unfair to have a program just for African Americans. Although these comments were not common, they should be anticipated and addressed. They could have been prevented by doing a better job communicating about the program within the school.

To “scale up” what we learned from the Eliminating Health Disparities Program, a substantial commitment and focused efforts are needed. Analogous to initiatives to improve health care delivery, changes must address structural (e.g., financial resources, diverse faculty), process (e.g., admissions, mentoring), and outcome (e.g., tracking and documenting career outcomes).
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Human Participant Protection

Institutional review board approval was not needed.

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