RESULTS

The 2011 HDSIP pre-survey was completed by 41 students and the post-survey by 48 students. When asked which health disparities they were interested in knowing more about, the majority were U.S.-born citizens; however, 24.4% were immigrants to the U.S., having migrated between one month to 12 years from the date of participation in the program. This was similar to post-survey results from 2010, which indicated 35.5% of the students were immigrants to the U.S., which reflects the demographics of East Flatbush/Flatbush, Brooklyn, NY.

Participants of the program were also asked what the primary language spoken in their households were. 58.5% of the students responding to the post-survey in 2011 indicated English as the primary language spoken at home; however, 24.4% indicated English was NOT the primary language spoken in their household. Instead, they listed Haitian Creole (Kreyol), Punjabi and Chinese, among others, as the primary language in their households. This finding was also consistent with data from post-survey conducted in 2010, where 25.2% of the students in HDSIP indicated English was NOT the primary language spoken in their household.

In the HDSIP post-survey (2011), students were also asked whether attending the program resulted in their being more inclined to exercise, eat healthier and/or encourage their family members to do the same (CHART 1).

DISCUSSION AND CONCLUSION

There was a strong response rate (95.9%) to the survey distributed to parents of students who participated in the program. This may be attributed to the fact that parents were not given the opportunity to participate in the program and their children’s exposure to health disparities curriculum. Under-represented communities, where English may not be the primary language spoken, encounter challenges to accessing quality healthcare. Parents may rely on their children, often born or formally educated in the U.S., to deliver culturally-competent messages to their constituents in a culturally competent manner. Many of the students shared information with their parents’ perception of the students participating in the program through their children’s exposure to the health disparities curriculum.

REFERENCES


Barr, B., Stangl, S. P., Wasant (2005). Listening to patients: Cultural and linguistic barriers to health care access. 37 (3) 199-204


METHODS (CONTINUED)

Three days per week, students participated in morning didactic and skill-building sessions at the SUNY Downstate Medical Center and, on afternoons, engaged in research projects of interest to, and supported by participating community-based Organizations (CBOs).

Pre and post-surveys were administered to the students participating in the program to measure changes in knowledge and/or awareness of health disparities, interest in advocacy and in pursuing a career related to health and specifically, minority health. In 2011, an additional assessment tool was developed to gauge parents’ perception of the program and their children’s exposure to the health disparities curriculum.

This assessment tool was developed as an online survey, to be completed anonymously (to ensure confidentiality) and distributed electronically via Survey Monkey.

The post-assessment was distributed after students had completed the program, and remained open for data collection for nine weeks after program completion. Parents of students participating in the program were asked to provide an active e-mail address and were followed-up weekly by program staff.

METHODS

The forty-nine participants of the HDSIP (2011) comprised of students in grades 10-12, from eleven Brooklyn-based high schools, and who were actively enrolled in the HSA. The curriculum facilitated during the summer internship program was developed with input from various organizations represented on the Community Advisory Board of the Center’s Community Engagement core.

The curriculum was originally implemented in 2010 and revised based on students’ feedback before being re-implemented in 2011. Core courses and training provided over the four weeks of the program included an overview of health disparities and social determinants of health, and topics such as HIV/AIDS, cardiovascular disease, mental health and environmental justice, viewed through the lens of social determinants of health.

RESULTS

There was a strong response rate (95.9%) to the survey distributed to parents of students who participated in the program. This may be attributed to the fact that parents were not given the opportunity to participate in the program and their children’s exposure to health disparities curriculum. Under-represented communities, where English may not be the primary language spoken, encounter challenges to accessing quality healthcare. Parents may rely on their children, often born or formally educated in the U.S., to deliver culturally-competent messages to their constituents in a culturally competent manner. Many of the students shared information with their parents’ perception of the students participating in the program through their children’s exposure to the health disparities curriculum.

REFERENCES


Barr, B., Stangl, S. P., Wasant (2005). Listening to patients: Cultural and linguistic barriers to health care access. 37 (3) 199-204


METHODS (CONTINUED)

Three days per week, students participated in morning didactic and skill-building sessions at the SUNY Downstate Medical Center and, on afternoons, engaged in research projects of interest to, and supported by participating community-based Organizations (CBOs).

Pre and post-surveys were administered to the students participating in the program to measure changes in knowledge and/or awareness of health disparities, interest in advocacy and in pursuing a career related to health and specifically, minority health. In 2011, an additional assessment tool was developed to gauge parents’ perception of the program and their children’s exposure to the health disparities curriculum.

This assessment tool was developed as an online survey, to be completed anonymously (to ensure confidentiality) and distributed electronically via Survey Monkey.

The post-assessment was distributed after students had completed the program, and remained open for data collection for nine weeks after program completion. Parents of students participating in the program were asked to provide an active e-mail address and were followed-up weekly by program staff.

METHODS

The forty-nine participants of the HDSIP (2011) comprised of students in grades 10-12, from eleven Brooklyn-based high schools, and who were actively enrolled in the HSA. The curriculum facilitated during the summer internship program was developed with input from various organizations represented on the Community Advisory Board of the Center’s Community Engagement core.

The curriculum was originally implemented in 2010 and revised based on students’ feedback before being re-implemented in 2011. Core courses and training provided over the four weeks of the program included an overview of health disparities and social determinants of health, and topics such as HIV/AIDS, cardiovascular disease, mental health and environmental justice, viewed through the lens of social determinants of health.