African American and Afro-Caribbean American Men's Prostate Health Knowledge and Beliefs

Cora Yoose, PhD, FNP-BC

Significance: Prostate Cancer

- Highest diagnosed (non-skin)
- Prevalence one out of six
- 2010 direct cost over $12 billion
- African American (AA) and Afro-Caribbean American men (ACA):
  - 70% higher incidence rate
  - More than twice the mortality rate

Study Purpose/ Research Questions

- Better understand significance by testing relationship between ethnicity (AA versus ACA men) and
  - Knowledge of prostate health
  - Conflict in decision prostate screening
  - Influencing factors barriers and beliefs

Health Belief Model (HBM)

- Theoretical constructs
  - Knowledge
  - Self-efficacy (measured as decisional conflict)
  - Perceived barriers
- Modifying variable of ethnicity
- Others: spiritual well-being and perceived cost

Literature Review

- Screening: properties, importance, controversy, perceived barriers
- Culture
- Cost
- Spiritual well-being and faith-based medical partnerships

Methods: Setting/Sample

- Non-Experimental, Mixed Methods: focus group and survey
- Congregational Health Alliance Ministry Program (CHAMP)
- AA and ACA in this research context
- Inclusion criteria: AA or ACA, English, over 21, born male (at least part of prostate), willing
- Exclusion Criteria
- Power Analysis

Methods: Procedures

- Institutional Review Board (IRB)
- Recruitment
- Informed Consent
- Focus group and Surveys

Methods: Procedures continued

- Data Collection
  - Demographic Questionnaire
  - Personal/Family Health History Questionnaire
  - Prostate Knowledge Scale
  - Decisional Conflict Scale
  - Perceived Barriers Survey
  - Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being, a modified version for non-illness (FACIT-Sp Non-Illness)

Methods: Procedures continued

- Data Management: REDCap and SPSS
- Data Analysis: ($p < 0.05$)
  - descriptive univariate: independent and dependent
  - t-tests: Age, Prostate Knowledge Scale, Decisional Conflict Scale, FACIT-Sp Non-Illness scale
  - chi-square tests: Demographic Questionnaire (not age), Personal and Family Health History Questionnaire
  - Mann-Whitney U Test: Perceived Barriers Survey

Findings: Focus Group

- Sample: (n=8), ages 40–70, M=53.8 (10.3)
- All directions clear
- All questions raised awareness
- No change suggested

Findings: Survey

- Sample: (*n*=113), ages 23-93, *M*=59.5 (16.4)
  - AA (*n*=49) *M*=53.4 (16.1)
  - ACA (*n=38*) *M*=61.2 (16.2)
- Most no family history, had DRE and a PSA test, never had urinary symptoms
- Age statistically significant

Findings: Prostate Knowledge

- Low total, symptoms, and screening
- None statistically significant
- Both ethnicities highest screening
- Highest and lowest questions dealt with urinary symptoms
- HBM: Knowledge was low, but screening practice was high

Findings: Decision Making

- High willingness participate PSA test
  AA (85.1%) ACA (77.8%)
- Conflict regarding PSA test low both ethnicities (total, uncertainty, informed, values, support)
- None statistically significant
- Support subscore lowest and closest to equal
- HBM: High self-efficacy, low conflict, high willingness participate PSA test

Findings: Barriers

- AA (structural/societal) “Doctor did not tell me I needed it” at 6.6 (*n*=39), “Can’t afford it”, “Dislike or fear of doctors”, mixed recommendations, distrust doctors
- ACA (personal) “Exam is embarrassing" at 6.1 (*n*=24), “Exam is uncomfortable”, fear, pain
- Practically, not statistically significant
- HBM if perceived benefits outweigh; high perceived barriers can prevent or delay screening; high perceived barriers, low screening

Findings: Beliefs

- AA and ACA high total, meaning, peace, and faith
- None statistically significant
- HBM: spiritual well-being related to knowledge and self-efficacy
- Community churches
- Faith-based medical partnerships
- Healthy People 2020
- Religion statistically, but not practically significant

Findings: Cost

- HBM: knowledge increases and perceived barriers decrease, perceived cost decreases
- Perceived Barriers: “Can’t afford it, “No insurance”
- Affordable Care Act
- Less expensive to manage when detected early

Limitations

- Self-reported data and convenience samples
- Focus group
- All attended church
- Country of origin
- Clarity religion and Perceived Barriers Survey
- Decisional Conflict Scale PSA only
- Culture
- Missing data

Implications

- HBM: fill some gaps knowledge, self-efficacy, perceived barriers, and spiritual well-being
- Nursing knowledge and practice
- Future educational programs
- Better care and resources, money saved, decrease disparity
- Faith-based medical partnerships
- Healthy People 2020 goal

Future Research

- Program of Research influence culture and educational programs
- Perceived barriers
- HBM: perceived susceptibility, perceived severity, perceived cost, perceived benefits, cues to action
- Influence of culture
- Other ethnicities and settings

Conclusion

Study results indicated there was not a relationship between ethnicity (AA versus ACA men) and

- Level of knowledge of prostate health
- Informed decision making
- Spiritual well-being
- Barriers to screening