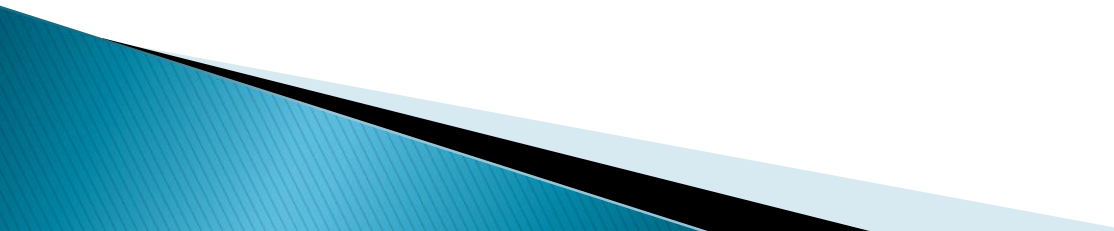


African American and Afro-Caribbean American Men's Prostate Health Knowledge and Beliefs

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
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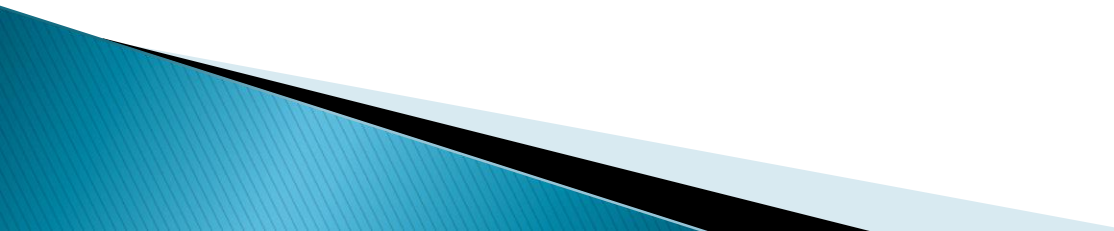
Study Purpose/ Research Questions

- ▶ 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

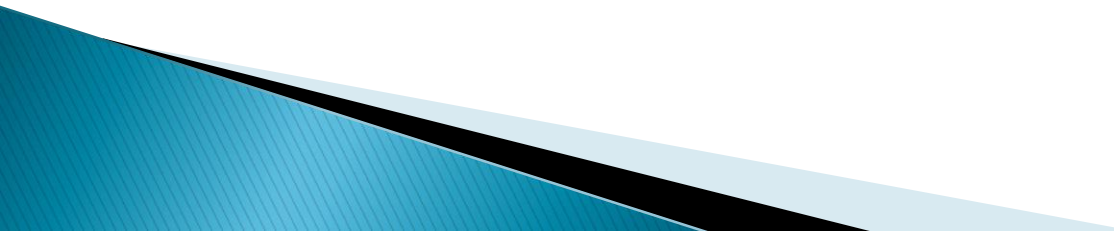
Health Belief Model (HBM)

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

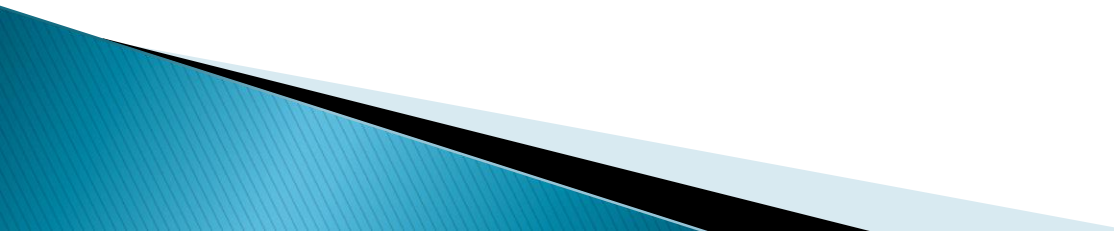
Literature Review

- ▶ Screening: properties, importance, controversy, perceived barriers
 - ▶ Culture
 - ▶ Cost
 - ▶ Spiritual well-being and faith-based medical partnerships
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Methods: Setting/Sample

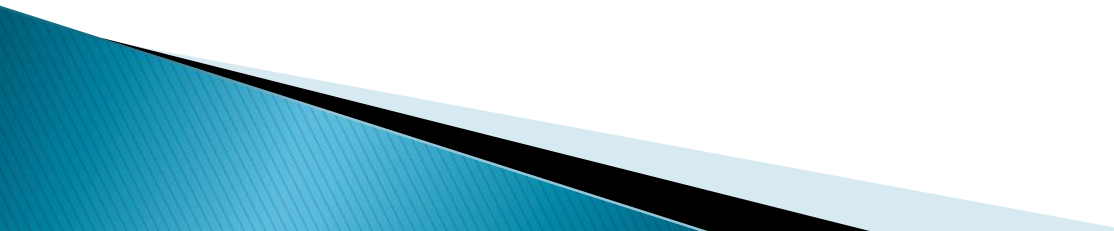
- ▶ Non-Experimental, Mixed Methods: focus group and survey
 - ▶ Congregational Health Alliance Ministry Program (CHAMP)
 - ▶ AA and ACA in this research context
 - ▶ Inclusion criteria: AA or ACA, English, over 21, born male (at least part of prostate), willing
 - ▶ Exclusion Criteria
 - ▶ Power Analysis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

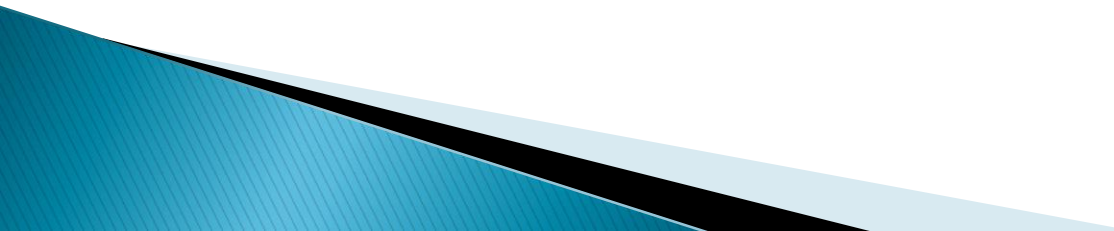
- ▶ Institutional Review Board (IRB)
 - ▶ Recruitment
 - ▶ Informed Consent
 - ▶ Focus group and Surveys
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Methods: Procedures continued

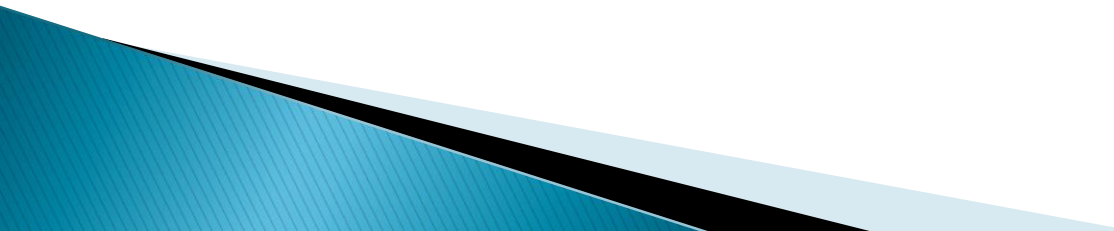
▶ Data Collection

- 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)
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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
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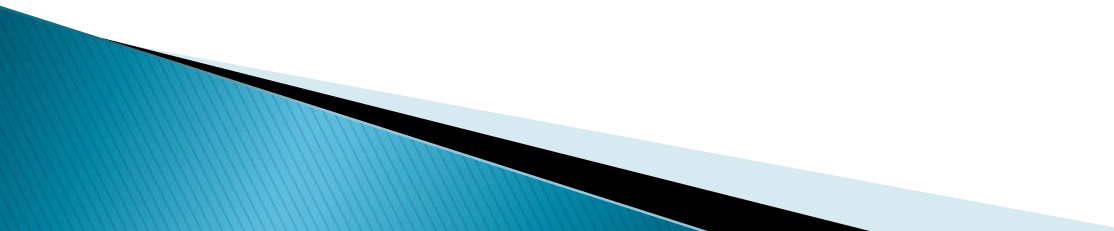
Findings: Focus Group

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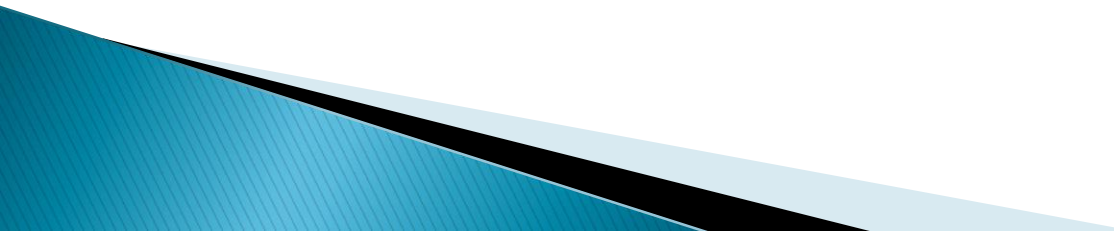
Findings: Survey

- ▶ 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

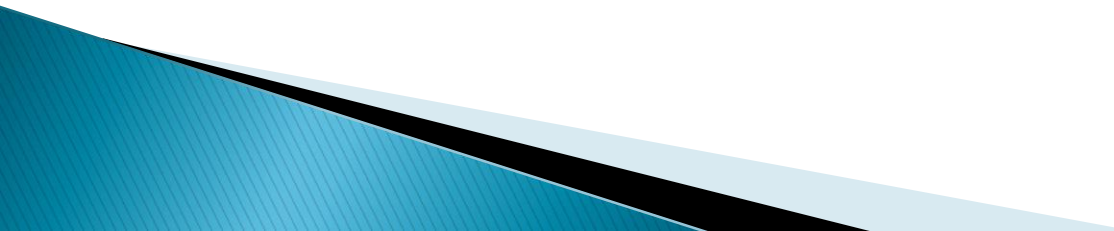
Findings: Prostate Knowledge

- ▶ 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
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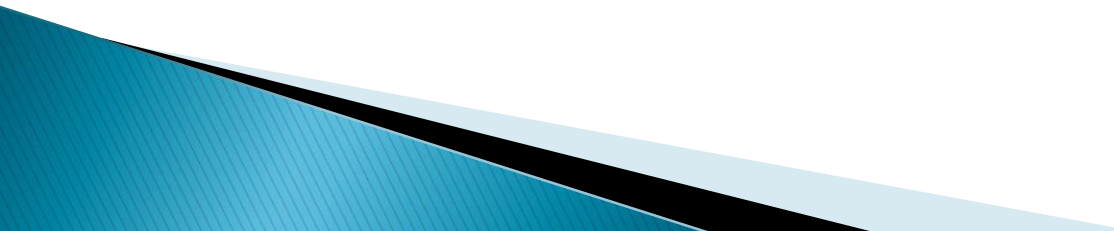
Findings: Decision Making

- ▶ 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
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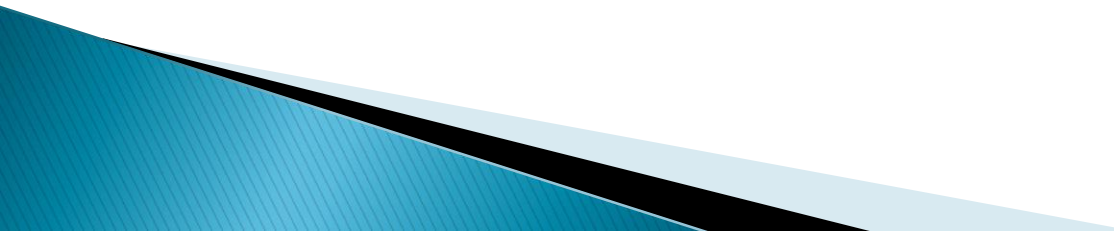
Findings: Barriers

- ▶ 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
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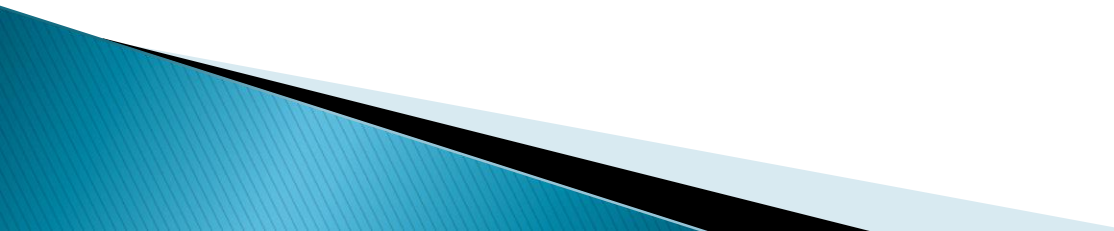
Findings: Beliefs

- ▶ 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
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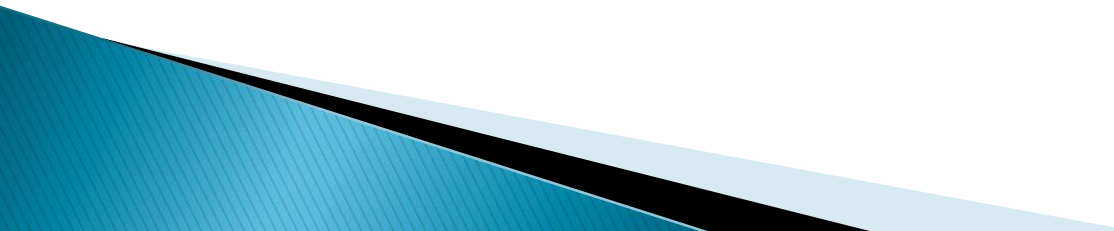
Findings: Cost

- ▶ 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
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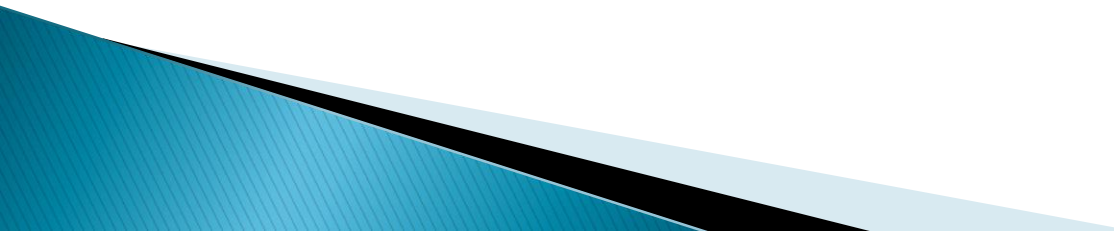
Limitations

- ▶ 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
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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
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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

