Health Beliefs and Prostate Screening Practice among Trinidadian Men

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ABSTRACT

Background: Prostate cancer is the leading cause of cancer in Trinidad and Tobago. The disease is typically detected in the late stages due to low screening levels. In the later stages of the illness, treatment is associated with considerable morbidity and mortality. The purpose of this study was to determine the factors that act as barriers and facilitators to screening practice among Trinidadian men.

Methods: This phenomenological study utilized in-depth interviews to examine the health beliefs of a group of Trinidadian men regarding prostate cancer screening. Data were analyzed using interpretative phenomenological analysis. Triangulation and member checks were utilized to enhance the trustworthiness and credibility of the data.

Results: The findings, which were discussed using the lens of the Health Belief Model, suggest that the three main barriers to routine screening was a dislike for seeking medical attention, an aversion to the digital rectal examination, and a fear of impotence. Advice from a healthcare professional, encouragement of a spouse and faith in God were the three main facilitators to screening.

Conclusion: Since the results of this study cannot be generalized, it is recommended that the information gained be used to develop a study which can be conducted among a wider subset of the population.

Key Words: prostate cancer screening, health beliefs

Introduction

Prostate cancer is the second most common cancer in men worldwide, with a lifetime prevalence of 17 percent (Wilbur, 2009). It is the leading cause of cancer deaths in Trinidad and Tobago (Cancer Registry, 2003). The literature has consistently confirmed that men of African descent are at much higher risk of developing prostate cancer than men from other ethnicities (Smith, Cokkinides & Eyre, 2005).

In Trinidad the disease is typically detected in the late stages and is more common among men of African descent than in East Indian or Caucasian men (Goetz et al., 1997). The pattern of late detection seems to suggest that men do not typically participate in routine screening for prostate cancer. Late diagnosis and treatment of prostate cancer is associated with urinary incontinence, erectile dysfunction, bowel dysfunction and pain from metastases to the spine, hip, ribs and other organ systems (Porth, 2005). It must be noted that in both males and females, evidence based prevention programmes and early detection can have a significant impact on the incidence and mortality for the majority cancers (WHO 2015).
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The purpose of this study is to determine the possible issues that may be associated with low prostate screening practice among Trinidadian men. Specifically, this study will examine the beliefs that healthy men hold about prostate cancer and the factors that act as barriers or facilitators to screening practice.

Research Questions:
1. What are men’s beliefs about prostate cancer?
2. What are the main barriers that prevent men from undergoing routine prostate cancer screening?
3. What are the factors that enable men to undergo routine prostate cancer screening?

Conceptual Framework
The constructs of the Health Belief Model were used to guide the development of interview questions and also in the discussion of findings. The Health Belief Model is a conceptual framework that has been widely used “to explain change and maintenance of health-related behaviors and as a guiding framework for health behavior interventions” (Janz, Champion & Strecher, 2002, p. 45).

Barriers to Screening
The literature has identified aversion to the digital rectal examination (DRE), lack of knowledge about the disease and screening methods, and fear of relinquishing control as barriers to screening. (Forrester-Anderson, 2005; Gelfand, Parzuchowski, Cort & Powell, 1995; Parchment, 2004; Shelton, Weinrich & Reynolds, 1999).

Gelfand et al., (1995) found that men from higher income brackets and well educated older men were more receptive to having a DRE than their younger less educated counterparts in lower income brackets. Woods, Montgomery, and Herring (2004), who conducted a longitudinal study to explore prostate cancer screening behavior among 277 black men, reported that although respondents were willing to have the DRE, they disliked the examination, associated it with homosexual tendencies and generally found it to be embarrassing.

In contrast, both Hooper (1998) and Greenwood, Paul and Holder-Nevins (2001) who studied men living on the island of Jamaica, found that there was a moderately positive attitude to the digital rectal examination Hooper (1998). Greenwood, Paul and Holder-Nevins (2001) reported that embarrassment about having the digital rectal exam did not appear to negate screening decisions.

Lack of knowledge regarding the need for screening was cited by Shelton, Weinrich and Reynolds (1999) as the primary barrier to being screened for prostate cancer. Lack of knowledge can lead to fear and an increase in the likelihood that an individual may choose not to access information on prevention (Woods et al., 2004). In a study of Jamaican men regarding their knowledge, attitude and beliefs about prostate cancer, Hooper (1998) found that more
than half the men surveyed lacked knowledge about risk factors, signs and symptoms of disease, screening methods and treatment options.

Traditionally, men have been socialized to see themselves as independent, strong and invincible. They are socialized to be in control and to fear being controlled, particularly by other men (Volbrecht, 2002). This belief in their invincibility can negatively affect men’s willingness to seek help for health related problems. Webb, Kronheim, Williams and Hartman (2006) found that African American men associated prostate cancer screening with feelings of vulnerability and compromised manhood, beliefs which resulted in low screening behavior.

**Facilitators to Screening**

Advice from a healthcare professional, the support of a spouse or significant others as well as the support of a faith based community, have all been identified as facilitators to screening (Blocker et al., 2006; Eyre & Feldman, 1998; Webb, Kronheim, Williams and Hartman, 2006; Weinrich, Reynolds, Tingen, & Starr, 2000).

Physicians and healthcare professionals who provide information about risk factors, the severity of the disease as well as the benefits and availability of screening, greatly influence men’s decision to engage in screening. Weinrich (2006) found that the influence of physicians was the strongest predictor for screening practice (cited in Reynolds, 2008). Webb, Kronheim, Williams and Hartman (2006) concluded that fostering positive relationships between the physician/healthcare provider and at risk men could improve dialogue and lead to shared decision-making regarding early detection and screening for prostate cancer.

In addition to the influence of physicians, Webb et al., (2006) reported that men’s ‘female significant other’ as well as the church had a significant impact on screening behavior.

**Health Beliefs**

The Health Belief Model (HBM) (Janz & Becker, 1984) has been used by several researchers (e.g. Adjei, 2006; Kleier, 2004; Pierce, Chadiha, Vargas & Mosley, 2003) to determine the possible reasons for low prostate cancer screening practice among African American men. The model, which attempts to explain and predict individual motivation to engage in health promoting / health protecting behaviors, includes the constructs of perceived susceptibility to the disease, perceived severity of the disease, and the perceived benefits of the behavior.

**Perceived Severity**

The HBM postulates that an individuals’ belief in the severity/ seriousness of developing a disease or its sequelae has an impact on the decision to take preventative action. Albaugh and Danaher Hacker (2008) as well as Hegleson
and Lepore (2004) argued that since many treatments for late stage prostate cancer can result in erectile dysfunction they have the potential to negatively affect men’s self-image. In her study of 305 African American, Trinidadian and Jamaican men, Adjei (2006) found that participants associated prostate cancer with incontinence and/or impotence. Jenkins et al., (2004) found that black men believed that having a firm erection was necessary for the enjoyment of sexual relations with a partner and were therefore more emotionally affected by sexual dysfunction following prostate cancer treatments than men of other ethnicities.

Gray, Fergus and Fitch (2005) found that Afro-Caribbean men were unwilling to seek medical intervention for anything that might negatively affect their sexual functioning.

Perceived Susceptibility

Men’s beliefs regarding their risk of developing prostate cancer has an impact on their decision to engage in screening. Research has consistently shown that demographic and lifestyle factors such as age, race and ethnicity, family history, and diet are known risk factors to developing prostate cancer (Porth, 2005; Plowden, 1999). Smith, DeHaven, Grundig and Wilson (1997), who conducted a study of 556 African American men over the age of forty, found that their knowledge about the risk factors for prostate cancer was limited. Low income men and men of low educational backgrounds were less knowledgeable about risk factors than men who had a regular physician or who had a close friend or family member diagnosed with the disease. Limited knowledge about risk factors affected perception of risk and decision to engage in screening.

Perceived Benefits

According to the HBM persons will engage in health promoting/protecting behaviors if they believe that the prescribed activity, in this case a screening test, will result in either the prevention or early detection of the disease. Adjei (2006) found that the men in her study had lower levels of perceived benefits for engaging in prostate cancer screening than men of European descent.

Tingen, Weinrich, Heydt, Boyd and Weinrich (1998), found that men who perceived high benefits to screening and early treatment were more likely to engage in prostate cancer screening than men who perceived low benefits. The study also revealed that younger men and Caucasian men had higher perceived benefits than older men and men of African descent.

Methodology

A qualitative design was utilized for the study. Purposive sampling was used to select a sample of five men, 40 years of age or older, who possessed knowledge or experience of prostate cancer screening, and had no previous personal history of prostate cancer. Participants were recruited through professional and church contacts, via referral from other participants in
the study, and from amongst the residents of a small rural village. Pseudonyms were used for the five participants who were interviewed. Three of the men, Richard, a married 48 year old taxi driver with two teenage daughters, Wesley, a 52 year old Joiner who remained celibate until marriage, and Anton a 47 year old, twice married Trade Unionist were of African descent. The other two participants, Charles, a divorced 46 year old Counselor and Paul a 48 year old Prison Welfare Officer, were of mixed (Afro/Indo Trinidadian) descent.

**Data Collection Strategy and Procedure**

Semi structured in-depth interviews, of between 45-60 minutes, were used to determine how participants beliefs regarding prostate cancer influenced their decision to undergo routine screening. Interview questions were developed under the headings facilitators (cues to action), barriers, and health beliefs. The Knowledge of Prostate Cancer Screening (KPCS) Scale (Weinrich, Reynolds, Tingen & Starr, 2004) was used as guide to question development. The wording of questions were slightly modified during the interviews to ensure that each participant had a similar understanding of the question. Oppenheim (1992) refers to this as *stimulus equivalence*, where the researcher attempts to ensure that the interview questions are understood in the same way by each participant (cited in Cohen, Manion & Morrison, 2000).

**Data Analysis Technique**

The study yielded rich textual data, which were analyzed using Interpretative Phenomenological Analysis (IPA). Tape-recorded interviews were transcribed no later than one day following my meeting with participants. All transcripts were re-read once while listening to the recordings to ensure congruity between the spoken and the typewritten word. This iterative process increased familiarity with the text and allowed the taking of notes of first impressions as well as recollections about the interview experience itself. Re-reading of each transcript allowed a better understanding of each participant and their unique life story.

Each interview transcript was analyzed individually before moving on to subsequent ones. Once the transcript had been read a number of times, notes on my initial impressions of the text were made I then returned to the beginning of the transcript and used the right margin to transform these initial notes into concise phrases and emerging themes. The skill at this stage was “finding expressions which are high level enough to allow theoretical connections within and across cases but which are still grounded in the particularity of the specific thing said” (Smith & Osborn, 2008; p. 68). Themes were repeated wherever they reoccurred in the script.

A table of themes ordered as they appeared in the narratives was then drawn up. Themes were examined more closely and similar
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ones clustered together. Transcripts were re-read to compare these themes with the original transcript thereby ensuring that they reflected the participant’s words. Original words or phrase which supported each theme were also included.

Each cluster of themes was given a name (superordinate theme) and a final table of coherently ordered themes was then drawn up. Once completed the transcript was set aside and each subsequent case analyzed with an open mind in a similar fashion. Cases were then examined to locate areas of convergence and divergence. A final master table of themes was then drawn up. Earlier transcripts were then reviewed in light these final themes.

Trustworthiness of the Data

When participants lose control over how their narratives are interpreted and generalized upon, they are losing risk over their identity (Gonzalez–Perez, 2007). To enhance the trustworthiness and credibility of the data, triangulation and participant checks were incorporated into the data collection and analyses procedures. With participant checks, each participant was allowed to read his interview transcript to verify that the words contained therein were his words. All five men agreed that the transcribed notes were an accurate representation of his ideas and beliefs. As an additional measure the coded interview transcripts were shared with two healthcare professionals with research experience. The initial codes and themes were reviewed by these analysts and discussed with the researcher before final themes were generated. Patton, (1999) described this as analyst triangulation, one of four methods that could be utilized by qualitative researchers to verify and validate findings.

Data Analysis and Interpretation

Research Question 1: What are men’s beliefs about prostate cancer?

Perceived susceptibility

The HBM suggests that persons evaluate the severity of a health threat and whether they are personally susceptible (at risk) to that threat before they decide to take preemptive action. Sexual promiscuity, ethnicity, age and diet were the four main risk factors that were identified by the interviewees.

a) Sexual Promiscuity

Four of the five participants linked susceptibility of prostate cancer to sexual promiscuity. They believed that men who had multiple sexual partners were at greater risk than monogamous men.

Current literature does not recognize a causal link between sexual promiscuity and prostate cancer. The genesis of these beliefs, which was so widely held among participants in the study, needs to be explored and refuted given that their perception of personal risk hinged strongly on this belief.

b) Ethnicity
All of the four men who identified ethnicity as a risk factor for prostate cancer agree that men of African descent are at greater risk than men of other ethnicities. The majority of participants who were of African descent, however saw themselves as being at low risk despite their ethnicity. These findings are similar to those of Myers et al., (1996), who found that although participants (African American men) agreed that the risk for prostate cancer was high for men of African descent, they generally believed that their personal risk was low.

c) Age

All respondents identified age as a risk factor for developing prostate cancer. Four of them believed that annual testing should begin at age 40 or 45. However, in spite of having uniformly identified age as a risk factor, only one of the men participated in the routine annual screening recommended by their physician. Their pattern of testing seems to suggest that knowledge alone does not change behavior.

This finding suggests a need for further strategies to reinforce the importance of routine screening after age 40 for early detection of prostate cancer. According to Smeltzer and Bare (2004), age is the most important risk factor for prostate cancer with the incidence of the disease increasing rapidly after the age of 50.

d) Diet

Three participants identified dietary practices as risk or protective factors for prostate cancer. According to one participant (Charles); East Indian men have a lower incidence of prostate cancer than Afro Trinidadian men because of the consumption of tomatoes and hot peppers.

According to Bunker et al., (2002) the regular consumption of tomato choka, a cooked salsa, is one dietary factor that is hypothesized to reduce prostate cancer risk among Asian Indians in Trinidad. Preliminary research by Giovannucci, Rimm, Liu, Stampfer and Willett (2002), confirm that lycopene, a carotenoid from tomatoes, is associated with reduced risk of prostate cancer. According to Mori et al., (2006), capsaicin, a component of hot peppers, inhibits the growth of malignant prostatic cancer cells.

Charles on the other hand, linked higher risk of prostate cancer to consumption of a high fat diet. Studies such as the one done by Vykhovanets, Shankar, Vykhovanets, Shukla, & Gupta (2010), confirm that a high fat diet causes proliferation, inflammation, and oxidative stress that can lead to benign prostatic hyperplasia, prostatitis, and cancer of the prostate.

**Perceived Severity**

The HBM proposes that in addition to perceived susceptibility, one's beliefs and attitudes about the seriousness of a particular illness and its sequelae, can influence the decision to seek treatment or engage in health protecting behaviors. All participants in the study expressed the belief that prostate cancer was a serious illness because a cancer diagnosis, wherever in the body it develops, can result in death. One participant (Wesley) puts it this way:
“It serious. Cancer, wherever it is in the body is a serious thing. With prostate cancer d stoppage of water and d impotence make it real frightening for men on ah whole.”

Christ (1989) suggested that a diagnosis of cancer, because it is often perceived as uncontrollable, can create a sense of fatalism among individuals so diagnosed. Fatalism and pessimism can lead to fear and inaction.

All five participants considered prostate cancer to be a serious illness because it could lead to death, incontinence and impotence. Although all of them were at risk for developing the disease due to ethnicity, age and family history, three of the participants (Richard, Wesley and Paul) considered themselves to be at low risk. They failed to acknowledge the importance of age and ethnicity in the development of prostate cancer, maintaining that since they were not sexually promiscuous and were otherwise healthy, they were safe.

It appears that the biggest risk for developing prostate cancer identified by these men was sexual promiscuity, and since all of them claimed to be monogamous, their perception of personal susceptibility was low. As a result, none of these men considered it necessary to follow the recommendations of their personal physician to test every year. Each of them did the test to establish their status, and once the results came back negative, they were content to put off future testing for 2 to 4 years at a time.

These results concur with that of Clarke–Tasker (2002), who also found that while respondents acknowledged the severity of prostate cancer, 53.2 % did not believe that they were at risk. An additional concern in this study was the fact that although Richard and Anton had a family history of prostate cancer, they were unaware that this doubled their personal risk of contracting the disease (Smeltzer & Bare, 2004).

Perceived Benefit of Action

This refers to a person’s assessment of the positive outcome of engaging in the recommended health protecting action. The HBM suggests that if a person believes that he is susceptible to a severe illness, and that the recommended action will either prevent or help detect the illness, he is more likely to perform the activity. All participants believed that participating in screening was necessary for early detection of prostate cancer.

Once the test results were negative however, the men became complacent and did not follow recommendations for annual testing. This absolute faith in the efficacy of the tests in detecting cancer highlights the need not only for men to be educated about the need to combine PSA testing with the DRE, but also to address issues surrounding perceived susceptibility and risk.

Wilbur (2009) examined the limitations of the PSA test and reported that it had a high false negative rate – at least 15 to 38 %. This
means that a man may have a PSA reading of <4nm, considered a normal reading, and still have prostate cancer. It is therefore imperative that the need to combine PSA testing with the DRE be emphasized to at risk men.

Research Question 2: What are the main barriers that prevent men from undergoing routine prostate cancer screening?

The HBM suggests that a person’s decision to engage in health protecting behavior is influenced by intrinsic and extrinsic factors that negatively affect motivation. Several factors that could act as barriers to screening practice emerged during the study. Negative attitude towards the DRE, dislike for seeking medical advice, fear of impotence, and lack of support at home, were the main barriers identified by participants.

**Digital Rectal Exam (DRE)**

With the exception of Anton, all participants expressed the view that the DRE was painful, embarrassing and emasculating. Charles, who had a DRE as well as a rectal ultrasound, states:

“The blood test was ok, but the ultrasound and DRE were very distressing. The ultrasound was painful because I could not relax – they send this young girl who was barely out of school to do it. I was tense throughout that ordeal. I don't think I will ever do that again.”

Although having the tests performed by a young woman was a source of added distress for Charles, Wesley, who had a DRE done by a male GP, was equally distressed:

“For ah man to push his finger up your bottom is not ah nice thing. In our society is taboo. Is ah kind of homosexual thing nah. No real man will feel comfortable to have ah next man do that to them.”

The homosexual theme is borne out by Paul who believes that most men will have a problem with the DRE “unless they homosexual...that rectal exam strip you of your manhood”.

These findings corroborate with those of Woods et al., (2004), who also reported homosexual fears and embarrassment among men having the DRE. Battle and Bennet (2000) agreed that African American men were more likely than white men to refuse DRE because they believed that anything inserted in the rectum was suggestive of homosexual behavior. Agho and Lewis (2001) also found that African American men were less likely than their Caucasian counterparts to engage in prostate cancer screening because of an underlying fear that manipulating the prostate could interfere with their virility.

**Dislike for Seeking Medical Advice**

All of the interviewees expressed a dislike for visiting a doctor unless they were
seriously ill. Most of them viewed frequent visits to the doctor as a sign of weakness.

As a result of this aversion to making routine doctor’s visits, Charles delayed visiting his doctor until he started to experience genitourinary symptoms which were later identified as prostatitis.

Griffiths (1992) posited that in general, men were less likely than women to seek medical advice when they were ill and often preferred to tough it out instead. In their study of physician’s perspective on the help seeking behavior of men, Tudiver and Talbot (1999) reported similar findings. Their study results showed that traditional social roles which equate manhood with a sense of immunity and immortality, made it difficult for men to easily relinquish control and seek help.

In describing the experience of visiting a physician to have a DRE done Paul argued that:

“All your life you are a man and then for twenty minutes, when you lying on that table, someone else is the man and you have to humble yourself.”

His words echo those of Johnson (1997) who contended that men feared being controlled especially by other men. Seeking help for health issues is therefore seen as an admission of vulnerability that was unacceptable in a ‘real man’.

**Fear of Impotence**

Fear of impotence was identified by most of the men as a major barrier to screening. The inability to perform sexually was equated to a loss of one’s masculinity. Wesley expressed the view that for many men there was an added fear of being ridiculed if the problem became public knowledge.

“…from ah Afrocentric view sexuality is ah really big thing with us. If ah man can’t handle his business in d bedroom and d neighbors find out is trouble. They will laugh at him – ‘dat man have no stand’ or ‘he is ah soft man.’”

This type of ‘picong’ can further fuel an already strong reluctance by men to participate in routine screening.

Most of the respondents believed that men of African descent more so than other men, equated sexual prowess with manliness. To them this preoccupation with sex translated into a reluctance to acknowledge any disease process that may threaten a man’s ability to perform sexually. Richard believes that this fear of impotence is tied a preoccupation of creole men with their penises. He says:

“They talk about it as if is ah separate person – ’d boy get mih in trouble.’ Is like they have no control so they jumping all over the place (being unfaithful) and have to buy punch and Viagra and all kinda thing to keep d boy working good.”

The power and importance given to the penis as a symbol of black masculinity is not
unique to the local context. Henry (2004) and Lester and Goggin (1999) also found that the movie and the music industry in the United States have fed these hyper masculine myths centered around preoccupation with the penis.

These beliefs lead to a heightened fear of screening. Boehmer and Clark (2001) identified fear of sexual dysfunction as a significant barrier to screening among African American men in their study.

**Lack of Social Support**

Two of the interviewees indicated that lack of a supportive environment could deter some men from engaging in screening. The possibility of having to face a serious illness alone can be very daunting prospect for anyone; more so for a man with no family to care for him. Charles believes that:

“....unless a man has a really strong faith in God and a good support system at home he may not feel confident enough to have such a test. A man with no support system will not go because of fear;”

Richard believes that lack of support at home is a big issue for a large number of Afro Trinidadian men because they have not taken time to build lasting monogamous relationships with women, preferring instead to remain single and play the field.

“...once you build a relationship with one person over d years, you face d realities of life together. She will quicker understand that ‘look he sick and cyah give me sex no more.’ With ah outside thing d focus of d relationship is sex, so when something go wrong with d boy (his penis) relationship done and you are alone with nobody to see bout you.”

In a case study of a man who was living with prostate cancer, Pierce (1999) found that his subject drew strength from his family, especially his praying mother, to cope with his illness.

**Research Question 3: What are the factors (cues to action) that enable men to undergo routine prostate cancer screening?**

Referred to in this study as facilitators, cues to action are internal and external factors that spur an individual on to action. Specific to this study, facilitators are those factors that enable men to participate in prostate cancer screening.

Advice from a healthcare professional, encouragement of a spouse or female friend, knowing someone with the condition, faith in God, knowledge of screening tests and a positive attitude towards health, were the main facilitators that emerged from this study.

**Advice from Healthcare Professional**

Four out of the five participants in this study had their original prostate examination following advice from a doctor in three cases,
and a nurse in the other. In his study of a cohort of Jamaican and Haitian men living in the United States, Kleier (2004) reported that both groups of men identified doctors and nurses as their main source of health related information.

The role of healthcare professionals in disseminating health promotion advice to persons cannot be overemphasized. Doctors and nurses are uniquely positioned to teach and counsel men about prostate cancer, screening options and treatment modalities.

**Encouragement of a Spouse or Female Friend**

Most of the men in this study believed that a man’s wife or female significant other played a pivotal role in encouraging them to seek medical help. Wesley admitted that:

“Most times ah man end up by doctor is he wife who carry him. We not going just so, thing have to be real bad. Is my wife who make me conscious of myself. Is because of she I start doing my little facial at home...”

The role of wives in encouraging men to visit their physician was reported in studies conducted by Parchment (2004), as well as Kleier (2004). Similarly, Tudiver and Talbot (1999) found that while men rarely sought support for their health concerns, when support was sought, it was generally initiated by a female partner. Almost all of the respondents in the study agreed that the influence of partners was critical in men’s decision to seek medical help.

The issue of encouragement from a spouse or female friend is tied to the barriers – lack of a supportive environment and dislike for visiting physicians. Spouses not only encourage men to seek medical attention, they also promote self-care and provide a supportive environment if a man does become ill.

In a study which explored the effects of prostate cancer on 168 couples Volk et al., (2004) found that wives were less distressed over impotence than their spouses and admitted that they would sacrifice sexual relations for their spouse’s longevity. This type of unconditional support could give a man the confidence to test and to face a positive diagnosis.

**Faith in God**

Charles felt that “unless a man has a really strong faith in God...he may not feel confident enough to have such a [prostate examination] test.” Both Richard and Wesley admitted that they obtained some of their information about prostate cancer from health education seminars organized by their respective churches.

Parchment (2004) found that churches played an important role in disseminating health education and information to their membership. Similarly, in their study of the health beliefs of African American men in 2002, Lambert, Bell and Newton found that having faith in God...
encouraged men to participate in health promoting activities such as prostate cancer screening (cited in Kendrick, 2010).

Membership in a local church can afford access not only to relevant health related information, as in the case of Wesley and Richard, but the members of the church can function as a quasifamily to men with prostate cancer (Pierce, 1999).

**Summary**

While the men in the study universally agreed that prostate cancer is a serious illness and that routine screening can lead to early detection, four out of the five participants failed to follow recommendations regarding annual screening. Participants identified age, ethnicity, diet and sexual promiscuity as risk factors to prostate cancer. Of these factors, sexual promiscuity emerged as the main risk in the minds of the participants. Since all of the men described themselves as monogamous, they underestimated their personal risk for developing the disease and failed to screen routinely. These findings suggest that perceived susceptibility rather than perceived severity was the greater predictor of screening behavior among participants.

**Recommendations**

This qualitative study sought to gain preliminary insight into the health beliefs regarding prostate cancer and prostate cancer screening by interviewing five men of Afro-Trinidadian and mixed descent. Although the study generated some interesting insights, the results cannot be generalized to the entire population. It is therefore recommended that the information gained be used to develop a larger study which can be administered to a wider subset of the population to gain a better understanding of Trinidadian men’s views on screening for prostate cancer.

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