

Prostate Cancer Ambassadors: Process and Outcomes of a Prostate Cancer Informed Decision-Making Training Program

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Abstract

African American men bear a higher burden of prostate cancer than Caucasian men, but knowledge about how to make an informed decision about prostate cancer screening is limited. A lay health advisor model was used to train “Prostate Cancer Ambassadors” on prostate cancer risk and symptoms, how to make an informed decision for prostate-specific antigen screening, and how to deliver the information to members of their community. Training consisted of two, 6-hour interactive sessions and was implemented in three predominantly African American communities over an 8-month period between 2013 and 2014. Following training, Ambassadors committed to contacting at least 10 people within 3 months using a toolkit composed of wallet-sized informational cards for distribution, a slide presentation, and a flip chart. Thirty-two Ambassadors were trained, with more than half being females (59%) and half reporting a family history of prostate cancer. Prostate cancer knowledge improved significantly among Ambassadors ($p \leq .0001$). Self-efficacy improved significantly for performing outreach tasks ($p < .0001$), and among women in helping a loved one with making an informed decision ($p = .005$). There was also an improvement in collective efficacy in team members ($p = .0003$). Twenty-nine of the Ambassadors fulfilled their commitment to reach at least 10 people (average number of contacts per Ambassador was 11). In total, 355 individuals were reached with the prostate cancer information. The Ambassador training program proved successful in training Ambassadors to reach communities about prostate cancer and how to make an informed decision about screening.

Keywords

men of color, prostate cancer, PSA testing, health awareness, lay health advisor

Introduction

Prostate cancer is a sizeable threat to the health and well-being of men living in the United States, and African American men suffer at a disproportionately higher rate compared with their Caucasian counterparts (American Cancer Society, 2014). Prostate cancer occurs most frequently in older men, but it occurs at an earlier age in African Americans; the differences in tumor type and disease aggressiveness or progression between Caucasian and African American men may drive the disparity (Powell, Bock, Ruterbusch, & Sakr, 2010; Roberts, 2014). Education is important in bringing people into the cancer care continuum, which begins with prevention and screening. Participatory approaches to educating individuals and communities about prostate cancer and informed decision making (IDM) about screening may be an important step in addressing cancer disparities.

In spite of their increased risk for prostate cancer compared with Caucasians, not all African American men choose to be screened. Empirical literature identifies trouble navigating the health care system as a significant barrier to screening (Lee, Consedine, Gonzales, & Spencer, 2012). Lack of access to health care, socioeconomic status, inadequate knowledge about the procedure, fear of what tests might show, poor patient–provider communication, embarrassment, and distrust of the medical

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profession are other identified barriers (Hunter, Vines, & Carlisle, 2015; Oliver, Grindel, DeCoster, Ford, & Martin, 2011; Reynolds, 2008).

The decision to screen is not simple. When the U.S. Preventive Services Task Force released a recommendation against prostate-specific antigen (PSA) screening for men of any age (Moyer, 2012), others objected on the basis that the science on which the recommendation was based was methodologically flawed and not powered properly to allow conclusions to be drawn about African American men (Slomski, 2011).

The U.S. Preventive Services Task Force defines IDM as “an individual’s overall process of gathering relevant health information from both [his] clinician and from other clinical and nonclinical sources, with or without independent clarification of values” (Sheridan, Harris, & Woolf, 2004). A man engages in IDM when he weighs the pros and cons of PSA screening and makes decisions that are appropriate for him based on scientific facts, personal and familial health history, personal beliefs, and input from his loved ones and physician (Centers for Disease Control and Prevention, 2013). IDM about screening for prostate cancer is a critical tool for all men, and its tenets are especially germane to African American men because of their increased risk for the disease. IDM involves assessing one’s risk for prostate cancer; understanding the risks, benefits, and alternatives to screening; participating in making the decision to be screened; and making a decision that is consistent with one’s own values and desires (Centers for Disease Control and Prevention, 2013).

The empirical literature is rich with examples of how IDM has been used to help men make decisions about PSA screening. In a recent article published in *American Journal of Men’s Health*, researchers reported that men who have previously had a PSA test were able to make decisions about having another one more easily than men who had never experienced a PSA test. The authors also reported that, for fully 85% of participants, physicians had recommended having a PSA test when the participants broached the subject. This study was part of a larger program in which barbers helped advise their clients about having a conversation related to PSA testing with their physicians (Luque, Ross, & Gwede, 2016). Another study, which focused on first-degree relatives of prostate cancer survivors, reported that using a decision aid booklet and DVD helped participants increase their confidence in their ability to make an informed decision and improve their knowledge about prostate cancer (Davis et al., 2014). There is mixed evidence concerning whether, given up-to-date, scientifically sound information about implications of the PSA test, men are more likely to choose to undergo screening. In a sample of men aged 50 to 75 years, one study reported that subjects participating in an online IDM intervention were less likely to obtain a

PSA test than those who did not receive the IDM intervention (Evans et al., 2010).

Traditional methods for spreading information about a health-related cause have included media campaigns, rallies, brochures distributed in clinics, and talks given at churches and other gathering places. The Lay Health Advisor (LHA) model involves individuals who the community considers natural leaders, people to whom others often turn for advice and guidance (Altpeter, Earp, Bishop, & Eng, 1999). LHAs frequently have large social networks and are thus perfectly positioned to help share health messages with others in those networks (Altpeter et al., 1999). Through training, LHAs gain skills, such as organizing community groups and speaking publicly, to help empower their communities for better health and to build capacity for advocacy (Mock, Nguyen, Nguyen, Bui-Tong, & McPhee, 2006). A need exists for developing educational strategies for LHAs to use in raising awareness about prostate cancer in vulnerable communities.

LHAs have also been leveraged to raise awareness and improve IDM skills for prostate cancer screening. Luque et al. (2011) disseminated prostate cancer information through barber shops in an African American community. The barber volunteers underwent a 10-hour, interactive skill-building training session to learn how to share the information with clients, and the program resulted in an increase in self-reported knowledge about prostate cancer and intention to talk to a doctor about screening (Luque et al., 2010; Luque et al., 2011). In other studies, Wray, Vijaykumar, Jupka, Zellin, and Shahid (2011) used a community-based participatory research approach to develop a curriculum for educating African American men in St. Louis, Missouri, about prostate cancer and IDM for PSA screening. The program was delivered to communities using peer educators who had themselves survived prostate cancer or by health educators, and their approach resulted in improvements in prostate cancer knowledge and decisional self-efficacy and decreased barriers to screening (Wray et al., 2011). Further investigation demonstrated that peer educators who had themselves survived prostate cancer had greater appeal than the health educators did (Vijaykumar, Wray, Jupka, Clarke, & Shahid, 2013).

In a recent study, Holt et al. (2015) implemented a church-based program called M-PACT, which consisted of four workshops administered by LHAs, to promote IDM for prostate cancer screening among African American men. The researchers tested whether the educational program for promoting IDM could satisfactorily be implemented by both (a) a group of all-male LHAs and (b) a mixed group of male and female LHAs. Both groups were successful in moving men forward on the stages of decision making, but only the mixed-sex group maintained these changes over time, indicating some utility for

the inclusion of women in IDM programs for African American men (Holt et al., 2015).

In another church-based study, guided by the Health Belief Model, African American men were recruited through seven churches via announcements, church bulletins, and posters. A male, African American community health educator (CHE) led a one-time, 30- to 60-minute session in which he shared information about prostate cancer and helped men identify or clarify their own ideas and values about the pros and cons of prostate cancer screening. Preintervention and postintervention tests revealed significant changes in knowledge and decision self-efficacy following participation in the program (Drake, Shelton, Gilligan, & Allen, 2010).

While it only occurs in men, prostate cancer is not only a man's disease. Women can play an important role in helping their loved ones enter and navigate the health care system. In a recent qualitative study, Hunter et al. (2015) reported that men appreciate their wives' ability to help them come to terms with topics that make them uncomfortable, such as the need for maintaining their prostate health. Women are seen as being able to influence their loved ones to go to the doctor in the first place and, once there, obtain preventative care. Wives and female loved ones help in the IDM process because they can present information in ways that are less threatening than it might be to hear the same information from a doctor or another man and help their partners think through consequences and alternatives (Hunter et al., 2015).

The Carolina Community Network Center to Reduce Cancer Health Disparities (CCN), whose mission is to reduce cancer health disparities using community engaging approaches, leveraged the support of its Community Health Educator (CHE) and community partners to implement the Prostate Cancer Ambassadors Informed Decision-Making training program. The purpose of this article is to describe the process for implementing the Prostate Cancer Ambassadors Informed Decision-Making training program for community members; to present the pretraining and posttraining outcomes; and to describe the Ambassadors' delivery outcomes of the prostate cancer information by the Ambassadors in their communities. The institutional review board at the University of North Carolina at Chapel Hill approved this research study.

Method

The present study used a single group, pretest–posttest design to assess the training and outreach outcomes of the Prostate Cancer Ambassador Informed Decision-Making training program, whereby the curriculum utilizes principles of adult learning theory (e.g., Knowles, Holton, &

Swanson, 2015), which informed the interactive manner in which material was presented to the Ambassadors, and social cognitive theory (e.g., Bandura, 1986), which emphasized building self-efficacy for presenting the material to the community. The details of the development of the training program and its curriculum have been fully described elsewhere (Vines et al., 2015). The original training was developed for African Americans by African American community leaders, though it was refined by a multiethnic team of researchers and community members. It featured updated statistics regarding prostate cancer among African American men in the county, state, and nation. It also had vignettes, information about health disparities, and a debate, all of which framed important information to be relevant to African Americans. Finally, the trainings were implemented with African American community partners, including community organizations and churches.

Briefly, the curriculum included information about how to assess risk for prostate cancer based on personal and familial history, presented the latest science and statistics related to prostate cancer, provided a module that described the role of an Ambassador, detailed how women can also play a role in promoting men's prostate health, outlined steps to making an informed decision, allowed for detailed study of the pros and cons of the PSA test, and featured "mock" outreach sessions that included role-plays of conversations about screening using a toolkit that included IDM aids (Table 1).

Recruitment of Prostate Cancer Ambassadors

The CCN's CHE, certified with master's level training, worked with the center's community partners to identify and establish three training sites in the community for the Ambassadors training program. The community partners were also instrumental in boosting the training's credibility because of their community influence. Two of the three sites recruited were churches, and the third was a community-based organization. One church was a long-standing CCN community partner. A leader of the second church had participated in an event sponsored by the CCN and subsequently expressed interest in addressing cancer health disparities in his community. The community-based organization had volunteers who had been previously trained as LHAs for other chronic diseases.

The leaders of the training sites assisted the CHE by promoting the goals of the program, identifying potential Ambassadors, preparing the training space, and handling the sessions' logistics. Each training site was asked to identify and recruit 8 to 10 volunteers who exhibited the qualities of a LHA: people to whom members of the community turn for guidance; who have warm, engaging

Table 1. Prostate Cancer Ambassadors Training Program Curriculum.

Unit	Topic
Day 1	
1	Introduction to the Prostate Cancer Ambassador (LHA) model
2	Prostate cancer incidence, trends, and risk factors
3	Biology of the prostate; cancer biology
4	Cancer risk reduction and treatment
5	Screening and informed decision making
Day 2	
6	Practical skills for being an Ambassador
7	Hands-on toolkit practice
8	Barriers to health care utilization; the role of women
9	Project logistics

Note. LHA = lay health advisor.

personalities; and who possess large social networks (Altpeter et al., 1999). Ambassadors had to be adult men or women (aged at least 18 years), and they were required to read, write, and speak fluent English. There were no requirements regarding race, ethnicity, or cancer history. Sites were given up to 4 weeks to recruit members of their community to become Ambassadors. The volunteers could come from within or outside the organization. Recruitment letters and flyers were provided to the training sites to aid in promoting participation in the training. Organizations that served as training sites received compensation for their assistance and use of their facilities.

Ambassador Training

The Prostate Cancer Ambassador Informed Decision-Making training program was designed to be implemented over a 2-day training period for a total of 12 hours (Vines et al., 2015). A community partner with a history of grassroots community education efforts co-facilitated the sessions with the CHE and doctoral student. Training Day 1 was an intense “academic” session with information about the anatomy of the prostate, statistics about prostate cancer, and screening practices. Day 2 focused on practical skill building and teamwork. Some groups preferred to have 1 to 2 weeks between sessions, whereas others preferred to have them back-to-back. For all training sessions, lunch was provided. All trainees provided informed consent at the outset of the training. Implementation of the training did not differ by group.

At the end of training, each Ambassador received a modest monetary token of appreciation for their time spent in training, a certificate of completion, a cohort photograph, and a training toolkit. The toolkit contained a set

of presentation tools derived from the training curriculum that included distributable, wallet-sized cards showing the steps involved in making an informed decision about PSA screening; a slide presentation for speaking formally to larger audiences; materials for keeping track of outreach contacts; and a tabletop flip chart for sharing the steps of IDM with small groups of individuals.

Assessment of the Ambassador Training

The goal was to assess changes in knowledge, decisional self-efficacy, collective efficacy, and outcome expectations for delivering the information using pretraining and posttraining questionnaires that were administered at baseline (beginning of Day 1 training) and at the end of the second day of training.

The current self-efficacy scale for making an informed decision was based on O’Connor’s (1995) Decision Self-Efficacy Scale. This scale has strong internal consistency (Cronbach’s alpha = .78-.84) and discriminant validity ($p = .000-.037$; Bunn & O’Connor, 1995). In men, the team assessed self-efficacy for making an informed decision (11 items), and in women, self-efficacy for helping a loved one make an informed decision was assessed (12 items).

The eight self-efficacy for outreach items and seven collective efficacy items loosely followed Bandura’s (2006) guidelines for creating self-efficacy scales—specifically, the scales created were unipolar (going in one direction from 0 to 2 rather than having positive and negative options like a Likert-type scale would) with 3-point response options (*not at all confident*, *somewhat confident*, and *very confident*), and separate items measured the behaviors around which the team wanted to build self-efficacy in the Ambassadors.

In assessing outcome expectations, there were five items with the response options of *strongly disagree*, *disagree*, *agree*, and *strongly agree*. A sample item was, *I will be able to speak confidently and calm my nerves*. There were 25 knowledge questions derived from the key points and content in the curriculum. For example, participants were asked to respond “True” or “False” to “Prostate cancer is the most common cancer in men.” Ambassadors were expected to score 80% or better on the final assessment questionnaire to “graduate” from the program. The pretest and posttest questionnaire data were analyzed using Wilcoxon signed-rank tests on the differences between the paired means. Statistical analysis was conducted in SAS version 9.3 (SAS Institute, Cary, North Carolina), and alpha was set to .05 for all analyses.

Last, to better understand how participants felt about the training, open-ended questions were included. These items asked the Ambassadors to provide feedback about their experiences during the training, the usefulness of

the interactive activities used, and areas that could be improved.

Ambassadors' Outreach

On the final day of training (Day 2), Ambassadors committed to making at least 10 contacts over a 3-month follow-up period. They were reminded to leverage their personal social networks (i.e., families and friends, acquaintances at church and other social events, and their partners) and use the toolkit to share information on prostate cancer and IDM for prostate cancer screening. Ambassadors could reach the goal of 10 contacts in teams (e.g., if two Ambassadors contacted six people together, it counted as six contacts for each Ambassador). Ambassadors could also hold group sessions to share the information. They were instructed to keep a record of their contacts using the contact form provided to them in their toolkit. The form included details such as the type of contact made (i.e., face-to-face, telephone, or group setting) and the educational tool used to convey the information on IDM (e.g., tabletop flip chart, slide presentation, or wallet card).

Ambassadors' Outreach Tracking and Follow-Up

The CHE provided ongoing post-training support to the Ambassadors and monitored their outreach efforts. The CHE was responsible for troubleshooting questions from the Ambassadors, replenishing toolkit supplies, and collecting outreach data from the Ambassadors during telephone check-ins that occurred every 3 weeks.

Ambassadors were asked to collect contact information (with permission) from individuals willing to offer feedback about their interaction with the Ambassador and the information presented. For those who did not feel comfortable asking directly for contact information, the project's community partners suggested providing the Ambassadors with a card containing the CHE's contact information. The Ambassador would then share a card with the community member(s) reached and ask him or her to call the phone number to share their feedback on information and/or to ask further questions. Participants who provided feedback on information received from the Ambassador were eligible to receive a small gift in the form of a spiral notebook and pen.

The CHE also held a phone conversation with each Ambassador toward the end of the project (~4 months), at which time she collected anecdotes and documented the unique things they did as part of their outreach. Ambassadors also provided the CHE with information from their contacts, including date of contact, type of contact, method info

Table 2. Characteristics of the Prostate Cancer Ambassadors, $n = 32$.

Characteristic	Participants, n (%)
Self-reported race/ethnicity	
African American	30 (94%)
American Indian	1 (3%)
Caucasian	1 (3%)
Sex	
Female	19 (59%)
Male	13 (41%)
Yes to ANY history of prostate cancer in immediate family (brother, father, grandfather, uncle, cousin, or son)	16 (50%)
Yes to ever had ANY screening for prostate cancer ($n = 13$ men)	9 (69%)
Yes to having a personal history of prostate cancer ($n = 13$ men)	0 (0%)

shared, number contacted, phone numbers collected, and general comments/summary of events.

Results

The training sessions across the three sites yielded 32 Ambassadors (Table 2). Thirty (94%) of the Ambassadors were African American; the other two were American Indian and Caucasian, respectively. Nineteen (59%) of the Ambassadors were female. The ages of the Ambassadors ranged from 32 to 74 years, with a mean age of 52 years. Of the men, none reported a present or past diagnosis of prostate cancer, and 9 of the 13 men (69%) had ever experienced any kind of screening test for prostate cancer. Among all Ambassadors, half ($n = 16$) reported a family history of the disease.

Change in Ambassadors' Knowledge and Self-Efficacy

All Ambassadors demonstrated a significant increase in knowledge from baseline to posttraining by earning 80% or better on the final assessment ($S[31] = 251$, $p < .0001$; Table 3). Change in self-efficacy for making an informed decision about prostate cancer screening did not reach statistical significance for men ($S[12] = 11$, $p = .1563$), while change in self-efficacy for helping a loved one make an informed decision was significant for women ($S[18] = 34$, $p = .0049$). There was significant increase in self-efficacy for performing outreach tasks ($S[31] = 236$, $p < .0001$) and collective efficacy in team members for performing outreach tasks ($S[31] = 70.5$, $p = .0003$). Similarly, outcome expectations for completing outreach

Table 3. Change in Knowledge, Self-Efficacy, and Outcome Expectations Following Training, $n = 32$.

Outcome measure	Possible points	Pretest mean (% correct)	Posttest mean (% correct)	Wilcoxon signed-rank test statistic	p
Knowledge	25	16.06 (64)	20.72 (83)	254	<.0001
Self-efficacy for making informed decision (men only)	22	18.92 (86)	20.33 (92)	11	.1563
Self-efficacy for helping a loved one make an informed decision (women only)	24	19.06 (79)	23.18 (97)	34	.0049
Self-efficacy for performing outreach tasks	24	12.62 (53)	22.22 (93)	236	<.0001
Collective efficacy in team members for performing outreach tasks	14	11.57 (83)	13.37 (96)	70.5	.0003
Outcome expectations for presenting information	15	13.25 (88)	14.16 (94)	36.5	.0206

tasks improved significantly from pretest to posttest ($S[31] = 36.5, p = .0206$).

Tracking Prostate Cancer Ambassadors' Outreach Efforts

Of the 32 Prostate Cancer Ambassadors, 29 (91%) reported having at least one contact in which information about IDM was relayed to at least one person (Table 4). The total reported contacts by the 29 Ambassadors were 355. The average number of contacts per Ambassador was 11 (range: 0–45). Nineteen Ambassadors (59%) reached the project goal of 10 contacts. Among the three Ambassadors who did not make any contacts, two were unable to fulfill their commitments to the project within the designated time frame due to medical reasons. The CHE was unable to reach the third Ambassador.

The types of interactions, toolkit material(s) used, and locations for community contact varied across the 29 Ambassadors who made contacts (Table 4). Most Ambassadors (25 out of 29, or 86%) had one-on-one interactions, and a dozen (41%) of them had group interactions. Only two Ambassadors (7%) used the PowerPoint presentation slides, while seven (24%) used the flip chart. In total, 125 wallet cards were given out. Contacts occurred in barbershops, churches (e.g., through health fairs and men's ministries), family gatherings, places of business, and a housing community.

There were many occasions that required the Ambassadors to problem-solve to get their message to the community. At times, when an Ambassador sensed that men may not be comfortable with the subject, he would ease tensions with a little humor. When Ambassadors had challenges making contacts on their own, they would partner with other Ambassadors. Another Ambassador, having trouble making contacts with friends and coworkers, spoke

Table 4. Prostate Cancer Ambassadors' Outreach Outcomes, $n = 29$.^a

Criterion	Number of Ambassadors (%)	Number of contacts ^b
Fulfilled commitment of 10 contacts	19 (59%)	
Made at least one contact	29 (91%)	
Enrollment per training site		
Training Site A: Church	12 (38%)	107 (8.9)
Training Site B: Community organization	12 (38%)	185 (15.4)
Training Site C: Church	8 (25%)	63 (7.9)
Type of contact made (options not mutually exclusive)		
One-on-one	25 (86%)	
Group with at least two community members	12 (41%)	
Toolkit materials used in encounter (options not mutually exclusive)		
Microsoft PowerPoint presentation	2 (7%)	
Tabletop flip chart	7 (24%)	
Wallet card on informed decision making (out of 160 given to Ambassadors)	125 (78%)	

^aOf the 32 Ambassadors, 1 Ambassador was lost to follow-up and 2 became unable to conduct outreach for medical reasons. ^bThe numbers in parentheses represent the average number of persons contacted by the Ambassadors at each site.

with family members. Anticipating discussing issues of prostate health in front of a female Ambassador might be uncomfortable, a male and female Ambassador teamed to conduct a presentation. After providing the information, the team asked if there was any discussion that the group would like to have without the female present. The female

Ambassador left the room to allow continuation of the discussion.

When the CHE conducted follow-up with the Ambassadors by telephone, she learned that some tailored their outreach by distributing handouts of the presentation slides handouts or providing small notebooks for their contacts to use to record questions for their doctors.

Discussion

Thirty-two Ambassadors across three training sites were trained to share information about prostate cancer risk, symptoms, and how to make an informed decision about prostate cancer screening, and 19 (59%) fulfilled their commitment of reaching 10 individuals in their community. Despite the small sample size, the Ambassadors collectively were able to reach 355 people in their communities. The Ambassadors came from a general community audience, whereas other studies have used trained barbers or individuals with a personal history of prostate cancer (Luque et al., 2010, Luque et al., 2011; Vijaykumar et al., 2013; Wray et al., 2011). Regardless of the vocation of the person trained to deliver the prostate cancer information, the findings reported here are consistent with the other studies in identifying a benefit in using LHAs for prostate cancer education.

A unique feature of the present study was the inclusion of female Ambassadors. In a qualitative study about the community's beliefs and myths about prostate cancer, African American women were believed to have an integral role in helping men obtain prostate-related health care (Hunter et al., 2015). Furthermore, Holt et al. (2015) identified that female LHAs who partnered with men were acceptable and effective in sharing prostate cancer information through the African American church. Although the training curriculum was delivered equally to the male and female Ambassadors, it is interesting to note that the majority of Ambassadors were female, and their self-efficacy to share information on prostate cancer IDM improved from baseline. However, further research is needed to elucidate whether men who encountered female Ambassadors responded any differently in terms of health or screening behaviors compared with those who encountered male Ambassadors.

The improvement in Ambassadors' knowledge and self-efficacy cannot be assumed to be solely the result of the curriculum. Prostate cancer information could have been seen by the Ambassadors on the news or the Internet, but this would have enhanced their understanding of the materials. Furthermore, there were no major news stories about prostate cancer that broke during the training time frames that would have influenced the uptake of the training information. It is also important to note that the

Ambassadors were able to take their training binder home to review the covered materials. They were also permitted to be in communication with other Ambassadors about the materials.

Overall, there were positive changes in self-efficacy and collective efficacy, but it was interesting that a significant change in self-efficacy for making an informed decision about prostate cancer screening was not present for men. This finding could be due to a ceiling effect; the men already had high self-efficacy for making an informed decision about prostate cancer screening when they came to the trainings. The present study also saw significant improvements in self-efficacy for performing outreach tasks; this finding was expected given that the curriculum which was designed using adult learning strategies that included role-play and other interactive activities, as recommended by adult learning theory (Knowles et al., 2015).

The results reflect the reach of the Ambassadors' training in terms of the number of people reached directly, but they do not reflect the extent to which the information on prostate cancer risks, signs/symptoms, and the steps in the IDM process resonated among the individuals reached or the larger community, despite CHE efforts to collect these data during the 3-month follow-up period. Likewise, the actual number of men reached by the Ambassadors' efforts who subsequently engaged their doctors in conversation about prostate cancer and screening is unknown.

A lesson learned and one that future research should consider is the inclusion of a training module on evaluation. Just as it is important to educate the community about research for the purpose of improving research study participation, similar emphasis should be on educating the community about the importance and value of collecting evaluation data to demonstrate the impact of LHAs. Other lessons learned included (a) it helps having multiple strategies to share the information to match available time, recipient, and comfort level of Ambassador; (b) it also helps have other Ambassadors to team with and share information; and (c) Ambassadors appreciated having visuals, whether it was the wallet cards, the presentations, or demonstrations learned in training. Moreover, future studies should be structured in such a way as to allow for collection of follow-up data demonstrating whether Ambassadors used their new IDM skills to make a decision about prostate cancer screening.

Implications for Practice

The role of community partners in the implementation of the Prostate Cancer Ambassador program proved beneficial to the successful recruitment of training sites, engagement of the leadership at those sites which improved the recruitment of Ambassadors, and the promotion of the

program. The project also demonstrated that women can be influential in the dissemination of men's health information. Flexibility and consideration of requests made by the training sites were essential. For instance, while the training was designed to be implemented over 2 days, one host site requested that there be 2 weeks between training sessions; the other two host sites wanted the sessions to be held on consecutive days. The toolkit provided the Ambassadors with flexibility such that they were able to draw from a variety of tools to use for sharing information and to be responsive in any context. Thus, prostate cancer LHA training programs are effective in disseminating health information, especially when the program includes interactive activities for learning how to share information, flexibility, and the active involvement of community in the research and training process.

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