TITLE PAGE

Title: A constructivist grounded theory study on decision-making for treatment choice among Black African and Black Caribbean prostate cancer survivors

Short title: Treatment Decision-Making by Black men with Prostate Cancer

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ETHICS APPROVAL

The study was approved by the Ulster University Research Ethics Committee (REC/16/0079) and the Health Research Authority (17/YH/0027). The study was conducted in line with the principles of the Declaration of Helsinki. Written informed consent was received from each study participant prior to being interviewed

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DATA AVAILABILITY STATEMENT

The datasets generated during and/or analysed during the current study are not publicly available due to privacy or ethical restrictions but are available upon reasonable request from Ulster University Repository.

CONFLICT OF INTEREST

The authors have no conflicts of interest to declare that are relevant to the content of this article.

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ABSTRACT

Objective: Despite Black African (BA) and Black Caribbean (BC) men having a disproportionately high-risk (1 in 4) of developing prostate cancer (CaP), there is limited understanding of their decision-making for treatment choice. This study explored decision-making for treatment choice among BA/BC men treated for CaP.

Design: Using constructivist grounded theory, face-to-face, Skype and telephone interviews were conducted with 25 Black men (8 BA, 17 BC) recruited in England between October 2016 and March 2018. Data were analysed using constant comparison until saturation was achieved.

Results: Data analysis yielded three broad categories: ‘coming to terms with the prostate cancer diagnosis’, ‘getting empowerment through information-seeking’ and ‘choosing a treatment option’. Priority for survival substantially motivated BA/BC men to take up radical treatment for their CaP. However, decision-making for a particular treatment option was a more complex process which was shaped by an intersection between biological, behavioural, medical, personal and cultural factors.

Conclusions: Healthcare providers need to consider the complexity of decision-making process for CaP treatment among BA/BC men, and tailor cancer care services to reflect cultural sensitivity and person-centredness. This could potentially minimise treatment decision regrets and improve men’s psychological wellbeing along the CaP survivorship pathway.

Keywords: Prostate cancer, Black African, Black Caribbean, treatment decision-making, grounded theory, qualitative research

INTRODUCTION

Prostate cancer (CaP) has been recognised as one of the most treatable forms of cancer, having high survival rates (Cancer Research UK [CRUK] 2020). The National Institute for Health and Care Excellence's (NICE) guidelines (2019) highlight disease stage and patient age as key considerations when making treatment recommendations for men diagnosed with CaP. However, the current lack of 'gold standard' treatment for CaP makes decision-making for treatment choice even more difficult for affected men. This is because treatment type has been recognised as an important predictor of chronic side-effects (such as sexual dysfunction, incontinence issues, and fatigue) (van Tol Geerdink et al 2013) which substantially impact on men's post treatment quality of life and psychosocial well-being (McCaughan et al. 2015; Bamidele et al. 2017). Decision-making for CaP treatment may be particularly challenging for Black African (BA) and Black Caribbean (BC) men due to their disproportionately high risk (1 in 4) of being diagnosed with an aggressive form of the disease at a younger age and in more advanced stages (Prostate Cancer UK [PCUK] 2016). However, this is a poorly understood phenomenon due to a dearth of research on the topic. This is worthy of investigation particularly noting the influence of cultural context in how men respond to and experience CaP (Nanton and Dale 2011).

Different theories have been postulated to help understand treatment decision-making in healthcare, one of which is the concept of shared decision-making (SDM) - a collaborative process between the patient and clinician to mutually make decisions that are best for the patient's care (Charles 1997; Truglio-Londrigan and Slyer 2018). SDM has been associated with improved patient satisfaction (National Health Service [NHS] 2021) and management of power dynamics in patient-provider relationship without compromising on patient autonomy or clinician's expertise (Charles et al. 1997). An intersection between different treatment options (each having its pros and cons), long-term impact of treatment side-effects on men's quality of life and intimate relationship, and differences in socio-cultural contexts, suggest the need to consider SDM in clinical consultations with BA and BC men diagnosed with CaP. Moreover, patient participation in treatment decision-making is now regarded as an ethical issue as informed consent and patient autonomy are considered important elements of the patient-provider communication (NHS 2019). However, it is unclear if and/or how SDM is applied to treatment decision-making among BA and BC men diagnosed with CaP as this phenomenon is currently underexplored.

It is particularly important to understand the basic social processes involved in BA and BC men's decision-making for CaP treatment, including what treatment choices they make, how and why they make those decisions. Such insights will be useful to inform policy and practice for culturally-sensitive CaP care for this high-risk but underserved populations. Therefore, this study explored treatment decision-making among BA and BC men as influenced by a CaP illness diagnosis and a unique socio-cultural context. The paper reports men's data from a larger study which explored the experiences and psychosocial needs and how best to address them after CaP treatment for BA/BC men and their partners.

METHODS

Study design

Constructivist grounded theory design (Charmaz 2014) facilitated co-construction of knowledge with study participants to understand the research phenomenon. Convenience and snowball sampling were first used to identify and access men who provided the initial data (Charmaz 2014). Between October 2016 and March 2018, eligible men were recruited in England through three NHS Trusts, a prostate support group, colleagues within the researchers' network and referral from research participants who already participated in the study (snowball sampling). Men were included if they: were of BA or BC ethnic origin, had undergone treatment for CaP at least three months prior to participating in the study, resident in the UK and able to speak, read or understand English Language. BA and BC men with CaP on palliative care were excluded, as their experiences were perceived to be beyond the scope of the study. Detailed discussion of recruitment for the study is reported elsewhere (Bamidele et al. 2018). Theoretical sampling was subsequently used to explore preliminary findings which emerged from the analysis of the initial data, in subsequent interviews until saturation was achieved (when the study phenomenon was conceptually understood and no further data was required) (Foley and Timonen 2015). The study is reported following the Consolidated Criteria for Reporting Qualitative Research (COREQ)'s guidelines (Tong et al. 2007).

Data collection

Eligible men who consented were interviewed between October 2016 and March 2018 either in their homes, via telephone or by Skype. The interviews lasted between 30-90 minutes, were audio-recorded, and were conducted by the first author (a BA woman in her mid-thirties with no prior relationship with the men). To guide the interviews, a semi-structured topic guide with open ended questions was initially developed from the literature and the research aim. The topic guide was iteratively modified as informed by emerging concepts from initial interviews with the men (theoretical sampling). Sample open-ended questions on the topic guide broadly included: men's experience of their CaP diagnosis and treatment, decision-making process for treatment type, and men's reasons for the treatment type they had for their CaP. Necessary data protection measures and ethical considerations were observed in line with institutional policy (X University) and principles of the Declaration of Helsinki (World Health Organisation [WHO] 2018). Participants' transcripts were anonymised (using a pseudonym) to ensure confidentiality.

Ethics approval

The study was approved by the X University Research Ethics Committee (X) and the Health Research Authority (X). The study was conducted in line with the principles of the Declaration of Helsinki. Written informed consent was received from each study participant prior to being interviewed

Data analysis

Interview recordings were transcribed verbatim and uploaded onto Nvivo 11 software for effective management and organisation. Data was analysed using the constant comparison approach which involved iteratively comparing codes in the data with each other and with further data until the research phenomenon was conceptually understood and no further data was required (Charmaz 2014) (theoretical saturation). Initial coding of the first few interviews using gerunds (action words which indicate the basic social processes in the data) in participants' narratives helped to identify gaps, which were explored further in subsequent interviews. This was followed by focused coding in which relationships, similarities and differences between emerging concepts were iteratively explored and compared with new data, to probe the basic social processes involved in the men's decision-making for CaP treatment within their context. Lastly, theoretical coding enabled the grouping of similar concepts into categories, which were compared with each other and explored with additional data until saturation was achieved. Both authors analysed the data and differences in opinion were resolved through discussion. Reflexive and analytical memos were kept to enhance theoretical sensitivity. Theoretical sampling facilitated the validation of the researchers' interpretation of emerging categories from participants to ensure trustworthiness (Charmaz 2014).

RESULTS

Overview

Theoretical saturation was achieved after 25 interviews with 8 BA and 17 BC men. Men were aged between 50 and 88 years old with an average age of 65 years. Length of time since treated for CaP ranged from 5 months to over 5 years. Treatment type included surgery (including robotic surgery (n=7), radiotherapy with hormone treatment (n=7), brachytherapy (n=5), surgery with radiotherapy (n=3), hormone treatment with chemotherapy (n=1), hormone treatment with cryotherapy (n=1) and cyberknife (n=1). Most of the men (n=19) were in long-term (> ten years) marital relationship with their partners. Others had unmarried partners (n=3), were single (n=1), widowed (n=1) or did not specify their marital status (n=1). Men were educated to at least secondary school (n= 13), graduate (n=5) or post graduate (n=5) levels. Nearly all the men had been resident in the United Kingdom (UK) for over 20 years (n=23) and they were mostly either in paid employment (n=10) or retired (n=11) with a few men being self-employed (n=3). Analysis of interview data yielded seven descriptive themes which were analytically aggregated into three broad categories: '*coming to terms with the prostate cancer diagnosis', 'getting empowerment through information-seeking',* and *'choosing a treatment option'.*

Category one: Coming to terms with the prostate cancer diagnosis

Many of the men admitted some difficulty in coming to terms with their CaP diagnosis. Although they were aware of their own risk because of a previous family history of CaP or via information received from other sources (e.g. media programmes), men expressed feelings of shock when they were diagnosed with CaP. Many reported being psychologically distressed because they associated CaP diagnosis with imminent death, had uncertainties around the implications of being diagnosed and were concerned about the potential wider impact of the CaP diagnosis on their dependent family's welfare due to their role as the main breadwinner for their family:

> *…I was scared erm I'm a very practical man erm and I'm also the breadwinner, so my family is very reliant on me in terms of you know financial well-being…I was scared for them I was saying then how do I make provisions for them, what's the next steps... (Mr Chris, BC, 51)*

Men's fear of cancer fatality was allayed after learning through personal research, discussion with doctors and experienced colleagues, that CaP is a treatable type of cancer. A few men reported feelings of inner peace which stemmed from their religious faith that God will "*get things sorted*" for them.

Category two: Getting empowerment through information-seeking

While most of the participants promptly took up active treatment as their priority was to stop the CaP from progressing, a few delayed treatment decisions. Prior to deciding on treatment recommendations from their doctor, men highlighted they were proactive in seeking additional information through personal research to understand the side-effects of available treatment options. Personal research included consultation with peers who had undergone a similar CaP experience, a clinician friend/family member and online search:

> *…so they (medical team) gave me all the options of cure, so I told them I need time to you know go through, I took about two weeks and made my research on the internet, going to libraries, talking to a few friends who are doctors, you know, I gathered as much information as I can and then I sat down and I analysed the situation, analysed the side-effects of all the treatment and none of them was equally suitable, but at least I could get close to the brachytherapy… (Mr Dave, BA, 62)*

Differences were reported in men's attitude towards seeking online information. While some reported online platforms such as Google as their first port of call for medical information, others were reluctant to go online because of concerns around the credibility of information accessed via this source. For such men, their primary source of information were their doctors and peers who had undergone a similar CaP journey.

Category three: Choosing a treatment option

Men whose CaP was localised at diagnosis recalled they had wider treatment options. However, they highlighted that decision-making to choose a particular treatment option was more difficult for them. This category is reported under four themes: '*prioritising survival from the prostate cancer', 'reluctance to lose a significant body part and function', 'medical treatment as a last resort'* and *'prioritising masculine responsibilities to the family over own cancer treatment'.*

Prioritising survival from the prostate cancer

Priority for survival informed many of the men's promptness to take up medical treatment. Although they received guidance from their doctors, did personal research and discussed with partners and peers (CaP survivors), men noted that they had the autonomy to make the final decision on which treatment option to take. Being alive and reducing the risk of cancer reoccurrence informed some men's choice for radical prostatectomy (including, robotic surgery). Men reported that although they were aware this could lead to a loss of their sexual potency and function, their immediate priority was survival as they took consolation in having had all the children they wanted prior to the CaP diagnosis:

> *…when it was diagnosed as prostate cancer, my consultant then said what do you want to do you've got only a number of options and I said to him look, listen I've had all the children that I'm gonna have, I want it out and he said well you know we could do brachytherapy, we can put you on hormone, I said no , I said I'm done (authoritatively) I said we're gonna go for, ahm we're gonna go for the prostatectomy I've researched it, I've done a far bit of research by now ah and I said we'll go for the Da Vinci ok fine…(Mr Ben, BA, 50)*

For a few of the men with more aggressive and advanced cancers, they admitted their treatment options were more limited and they decided to go with their doctor's recommendation for more intensive treatment including hormone therapy.

Reluctance to lose a 'significant' body part and function

Other men admitted that although surviving the CaP was important to them, they were equally concerned about the risk of losing a significant body part (the prostate) and function through radical prostatectomy. Men noted that because of its centrality to their masculine identity, surgical removal of the prostate would make them feel incomplete as a man. They reiterated a need to preserve their sexual and urinary functions (as much as possible) as these were described as crucial to their masculine self-image. Some men who opted for brachytherapy added their decision was motivated by preference for a "*less invasive procedure with minimal urinary problems"*, minimal and convenient travel to and from hospital for treatment, and the need for a speedy recovery, which would enable them return quickly to their normal routine lives post treatment:

> *…so looking at all the options, the one that was less invasive and also can get you back to your fit quickly was the brachytherapy… (Mr Gary, BA, 66)*

Medical treatment as a last resort

A few of the men reported delaying medical treatment because they were trying traditional remedies (for example herbs) as a first option, and only considered medical treatment as a last resort. This was mostly motivated by the men’s desire to recover naturally in order to prolong their lives without having to undergo medical procedures, which they perceived as an invasion on their bodies and ‘*synthetic*’:

> *…I was also in touch with an herbalist. I’m still in touch with him to tell you the truth and I thought well you know maybe I can use natural medicines to cure myself you know so I then decided to get in touch with him and other people from his kind and erm to see if I can use natural means to change my diet and you know to really make a difference…I was opting for it because I thought to myself maybe there is a connection to a longer life a natural life with herbs instead of synthetic drugs and especially with radiotherapy …. (Mr Jim BC, 69)*

Some men who had also initially delayed treatment for religious reasons noted that they only took up medical treatment after their pastors advised them that medical treatment could be a route to the divine healing the men desired. For these men, they admitted the CaP had progressed by the time they decided to commence medical treatment which meant they had very limited options and had to go with radiotherapy with hormone treatment as recommended by their doctor.

Prioritising masculine responsibilities to the family over own cancer treatment

Men expressed a personal obligation to prioritise their responsibilities to nuclear and extended families over taking up or continuing treatment for their CaP. Such sense of obligation was expressed within the context of their masculine duty to lead important family functions, for example, the funeral of a deceased parent in their home country. The priority to ‘*get back to their feet quickly*’, in order to resume their active work lives and continue their breadwinning role for their dependent families further influenced men’s decisions for treatment type. They recounted the psychological impact of treatment-induced restrictions on their work lives. For example, one man described his inability to resume work because of his CaP treatment as ‘*’mentally-destroying’’*, to the extent that he contemplated coming off his treatment schedule regardless of the potentially fatal consequences this might have on him:

> *…and the oncologist spoke to me and said if “you come off this (treatment) you will die”, and my words to him was if I don’t I will die, you need to understand my mental state right now … if you do not work something out for me, I am coming off, there is nothing you can do for me or anybody can do I am coming off, I know the consequences but if I don’t, I’m gonna die so you have to understand where I am at, I need to earn my money, I need to be there for my family, I need to be able to provide for my family…I have to as a man look to my family ok I have to, …, if I am not able to turn around and have that ability to provide for myself then mentally it is destroying me, it will destroy me… (Mr Nelson, BC, 50)*

DISCUSSION

The aim of this article was to report on decision-making for treatment choice among BA and BC men treated for CaP as influenced by the illness diagnosis and a unique socio-cultural context. Study findings showed that similar to evidence from studies related to Caucasian and African American (AA) men (Moses et al 2010; Gordon et al. 2019; Owens et al. 2019), priority for survival and getting rid of the cancer were key motivators for BA and BC men in this study to take up active treatment for their CaP.

However, decision-making for choosing a particular treatment type over another was a more complex process. The differences observed in BA and BC men's preferences in this study were influenced by an interplay of biological (e.g. cancer stage at diagnosis), behavioural (e.g. preference for divine healing and traditional remedies), medical (e.g. invasiveness of treatment procedure and promptness of recovery), personal (e.g. self-perception of masculine body image) and cultural (e.g. prioritisation of masculine responsibilities to the family) factors. This mirrors similar findings from Mead et al. (2013) which highlight that decision-making for cancer care among ethnic minority patients is not a straightforward process but substantially shaped by influences from the patient, their healthcare providers, and wider socio-cultural community. A conceptual model of the treatment decision-making process among participants in this study is presented in Figure 1.

<<Insert Figure 1 here>>

Men in this study reported prioritising their leadership (e.g. travelling to home country to lead important family functions) and breadwinning responsibilities to their dependent families over their CaP treatment. Some were also reluctant to lose a significant body part (prostate) in order to preserve their reproductive ability. These highlight the centrality of culturally informed masculinity ideals to the CaP illness experience and treatment decision-making of BA and BC men. Core values of masculinity within the BA/BC cultural context include independence, leadership (Kolawole et al. 2012), sexual virility/fertility (Odimegwu and Somefun 2017), breadwinning and dominance (Owens et al. 2019) and these seemed to have substantially influenced men's decision-making for CaP treatment in this study. Evidence from previous studies further showed that masculinity beliefs predict Black men's help-seeking for CaP diagnosis (Seymour-Smith et al. 2016) and posttreatment psychosocial functioning (Campbell et al. 2012). Men's perception of medical treatment as 'synthetic' and preference for natural healing through traditional remedies or divine healing resonates with current evidence on the influence of religious faith (Zhang et al. 2013; Rivas et al. 2016) and traditional remedies (Nanton and Dale 2011) on how Black men respond to and cope with a CaP diagnosis. This highlights the need for HCPs to be open-minded and confident to discuss traditional remedies and spiritual beliefs with BA and BC men during clinical consultations for CaP treatment.

Prior to making treatment choices, men in this study proactively did their personal research to be well informed of the pros and cons of available treatment options. Besides prioritising survival, men highlighted preference for a treatment type that would allow them to regain their physical fitness and resume their work lives as soon as possible posttreatment. Contrary to findings from Sidana et al. (2012) who identified ‘doctor’s recommendation’ as the most influential factor in their study participants’ decision for radical treatment, men in the current study (especially the younger ones) reported a more independent attitude towards treatment decision-making following a CaP diagnosis. Evidence highlights an intersection between age and the enactment of masculine ideals in which younger men (<65s) are perceived as exhibiting greater self-reliance (Shim et al. 2015) and independent decision-making (1.68 times higher) for CaP treatment (Song et al. 2013) compared with older men. This has particular implications for Black men who, on average, are 5.1 years younger than white men, when diagnosed with CaP (Metcalfe et al. 2008). Thus, they are affected with CaP at the most productive stage of their lives and understandably may have higher concerns regarding their posttreatment work lives compared with their White colleagues (Owens et al. 2019). While work has been identified as an important coping strategy for BA/BC men living with prostate cancer (Bamidele 2019), it is particularly worthy to note that socio-economic reasons (desire for ‘greener pastures’) is an important motivating factor for this ethnic population’s immigration to the UK (Brown 2014). Therefore, the men’s priority consideration for a treatment type with minimal impact on their work lives cannot be underrated. There are further suggestions from the literature that younger AA men are more likely to experience treatment decisional regret compared with older men, mostly attributed to the impact of side effects on their intimate relationship and work lives (Morris et al. 2015).

While some elements of SDM seemed evident in this study (e.g. men comparing doctor’s treatment recommendation with findings from their personal research before making a decision), evidence suggest the existence of some power imbalance in patient-doctor communication as some participants narrated insisting on a particular treatment type based on their personal priorities. There are suggestions that mistrust and perceived racial discrimination impact on patient-provider interactions, access to care, patient satisfaction, and SDM for Black men diagnosed with CaP (Moore et al. 2013). In contrast, a more recent study by Owens et al. (2019) reported their AA study participants had high levels of trust in their HCPs which enabled them to discuss treatment options and make informed choices. This seemed to resonate with UK Black men in the current study as they were generally positive about their interactions with their doctors to discuss treatment options. Without undermining the doctor's professional expertise particularly where a life-defining illness such as CaP is concerned, evidence from the current and earlier mentioned studies suggest that there is no 'one size fits all' approach to the application of SDM as this is often determined by context (e.g. patient demographics, family circumstances, personal preferences).

Unsurprisingly, cost of medical treatment did not influence men's decision-making in this study, possibly because all the participants were resident in England where they had access to subsidised cancer care through the NHS. This is in contrast to evidence related to US Black men (AA) which highlighted cost of healthcare as a determining factor in decision-making for cancer treatment (Xanthos et al. 2010). Gordon et al (2019) corroborated that AA men significantly prioritised treatment and recovery time ($P<.001$), ($P<.001$), healthcare cost ($P<.001$) and impact of treatment on daily activities ($P <.001$) when making treatment decisions for a CaP diagnosis. These highlight that regardless of a shared racial origin, differences continue to exist (Livingston et al. 2013) in Black men's priority concerns for CaP treatment choice, as shaped by their context and unique demographical structure (e.g. age, country of residence, healthcare system). This should be duly considered in cancer care delivery for this population

Implications

It is essential to recognise the complexity and multifacetedness of factors which influence decision-making for CaP treatment among UK-based BA and BC men. Therefore, HCPs need to avoid stereotyping the attitude of this patient population towards CaP treatment as predominantly driven by a masculine priority to preserve sexual function. For example, men considered their ability to return to work quickly and continue their breadwinning obligation to their dependent families when making treatment decisions. HCPs need to be aware of and sensitive to these diverse dilemmas which BA and BC men experience when diagnosed with CaP and show empathy and cultural sensitivity when discussing treatment options with them. Further consideration should also be given to BA and BC men's self-driven approach to decision-making as influenced by their personal priorities, masculinity ideologies and the implications of CaP treatment side-effects for their physical and psychosocial wellbeing. Hence, HCPs need to be dynamic in their approach to CaP care for this patient population by prioritising men's choices, but with professional guidance and support (NHS England 2017).

The primary avenues BA and BC men consult for advice (such as peers, religious leaders) should also be recognised and strengthened with up-to-date medical guidelines on CaP treatment. To demonstrate cultural sensitivity, HCPs should work collaboratively with religious leaders, peer champions and traditional remedy providers to educate BA and BC men on the pros and cons of delaying medical treatment for a potentially fatal illness such as CaP cancer and support them to make informed treatment decisions (Baruth et al. 2013; Bowie et al. 2017; Bamidele 2019). This could potentially help to dispel men's concerns around perceived syntheticity of medical treatment and improve their prompt uptake of active treatment following a CaP diagnosis.

The difference observed in men's attitude towards seeking information online is also worthy of attention. While some men proactively sought information online, others perceived online information as lacking sufficient credibility to guide them in their decision-making. With the increasing digitalisation of healthcare and support services (including cancer care) which has been further advanced by the COVID-19 pandemic (NHS 2020), more patients now turn online to seek cancer information (Chua et al. 2018). This suggest that as soon as a CaP diagnosis is confirmed and at the start of treatment discussions, HCPs should signpost men to credible websites where they can check for further information relating to treatment options. To address men's credibility concerns, HCPs also need to be available to answer men's questions where and when required (Bamidele 2019).

Limitations and directions for future research

This study makes new contribution to knowledge by using rigorous qualitative methods to unravel contextual and conceptual insights into an underexplored but important research topic. The available studies which have explored this phenomenon are predominantly on AA men (e.g. Moore et al. 2013; Bowie et al. 2017; Owens et al. 2019) with a dearth of studies focused on UK Black men. The current study addresses this gap in the evidence base. However, it is not without its limitations. The small sample of 25 BA and BC men who were all recruited in England limits the generalisability of study findings to a wider population of Black men. Using convenience and snowball sampling strategies might have led to the inclusion of men who are already motivated towards help-seeking and may have contributed to the rather ‘positive views’ of men in this study. Whilst the majority of the men had partners, it is unclear how much they involved their partners in treatment decision-making. This is worthy of investigation in future studies, especially noting the implications of treatment side-effects for couple’s psychosocial and psychosexual wellbeing.

Conclusion

This is the first study (to the best of our knowledge) which addresses an important research gap and provides useful insights to enhance current limited understanding of the decision-making process for treatment choice among UK BA and BC men with CaP. Findings showed there are wider factors (beyond preservation of sexual function) which influence decision-making for CaP treatment among BA and BC men. An understanding of this could help avoid stereotyping in healthcare delivery and enhance cultural sensitivity in patient-provider communication when discussing treatment options with this patient population. It is also important to recognise and strengthen BA and BC men’s sources of information, and socio-cultural influences (e.g. peers and religious leaders) through collaborative partnerships. This could potentially help to enhance treatment decision-making, prevent decision regrets and improve BA and BC men’s psychological well-being and quality of life along the CaP survivorship pathway.

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Figure 1

A conceptual model of the treatment-decision making process among Black African and Black Caribbean prostate cancer survivors