Title:
Increasing BRCA Screening in Eligible Orthodox Jewish Women

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barriers, brca screening and jewish

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Abstract Summary:
Ashkenazi Jewish women have a higher risk of being BRCA carriers, which increases the likelihood of developing breast cancer. This study will provide a mailed educational intervention to self-selected Orthodox Jewish participants and evaluate their intent to test after their receipt of more information.

Learning Activity:

| LEARNING OBJECTIVES | EXPANDED CONTENT OUTLINE |
understand the barriers which preclude many Orthodox Jewish women from seeking out BRCA screening

information on cultural and knowledge barriers which exist in the Orthodox Jewish communities will be presented, as well as how these barriers relate to health care and cancer screenings

understand the risks associated with BRCA screening specifically as it relates to Ashkenazi Jewish women

epidemiology on prevalence and incidence of BRCA mutations as it relates to Ashkenazi Jewish women will be presented

Abstract Text:

Hereditary breast or ovarian cancer (HBOC) has high rates in the Ashkenazi Jewish community. Women of Ashkenazi Jewish descent have a tenfold increase in carrying the BRCA mutation: 1 in 40 Ashkenazi Jewish women carry the mutation, while in the general population the ratio is 1 in 400. The BRCA gene protects tumor growth, and mutations are associated with an 80% likelihood of developing breast cancer, 60% likelihood of ovarian cancer, and increased risks of melanoma, colon cancers and pancreatic cancers. The average BRCA-related breast cancer occurs during a woman’s 4th decade, compared to higher ages in non-hereditary cancers. The morbidity and mortality data on breast cancer are well documented. In the US, the number of carriers of BRCA mutations is estimated to be between 250,000 and 415,000. Approximately 57,000 of these women are thought to be of Ashkenazi Jewish background, and only 35% have been tested for the mutation.

Prior research suggests that tailored client interventions are an effective method for increasing cancer screening when compared to reminders that do not have health information in them. The Health Belief Model (HBM) was developed in the 1950’s as one of the first theories of health behavior to understand and improve the health behaviors of the public. The model considers the individual’s personal perceptions of risk (susceptibility), seriousness, cues to action, benefits and barriers. Taken together, these constructs may help predict an individual’s health behaviors.

This intervention was selected due to the strength of the evidence which included systematic reviews and randomized controlled trials. Although many studies have demonstrated the efficacy of using tailored interventions to increase health screenings, and the utility of the HBM, neither of these methods have been used to address BRCA screenings in the specific population of Orthodox Jewish women.

The goal of this proposal is to increase uptake of BRCA screening among high-risk women in Orthodox Jewish communities. The key outcome to be measured would be self-reported intent to test, or self-reported outreach to genetics counselors. Two weeks following the mailed intervention, participants will be contacted by this DNP student on the phone and asked about their current intent to test. It is hypothesized that the intervention will increase the likelihood that the participants will consider genetic screening for the BRCA mutation. A second outcome will be self-reported outreach to genetic services.

This would be the first study of its kind to examine health beliefs among Orthodox Jewish women related to genetic cancer screening, and to provide an intervention to increase knowledge as well as screening rates.

Forty participants were recruited. After they contacted this DNP student and expressed their desire to join the study, they were mailed a packet which included the informed consent and adapted Health Belief Model questionnaire. The responses and informed consents were received by the PI and the participants will soon be sent an educational brochure containing common concerns related to genetic testing for
cancer, as well as information regarding the BRCA mutation. The pamphlet will include a sign up sheet from Sharsheret, in case the participant decides to contact Sharsheret to learn more.

Two weeks after they received their brochure, the participants will be followed up with a phone call by this researcher to ask about their intent to test using a five-point Likert scale. Following this phone call, participants will be mailed a Visa gift card and thanked for their participation.

This intervention accommodates the women’s need for privacy and confidentiality, while addressing common barriers related to genetic testing for cancer. The research has demonstrated that using both, the Health Belief Model, and tailored interventions, have been effective in predicting and improving health outcomes in a variety of populations and circumstances. Potential outcomes may result in increased uptake of BRCA screening among eligible women in this community, and achievement in better overall health. Finally, the data from this project may provide future researchers with more information regarding how women in this vulnerable population feel about culturally sensitive health screenings.