Nigerian men who are at a higher risk of being diagnosed at fatal or advanced stage of cancer. With older age as a significant risk factor for cancer development such as prostate cancer in men, this study explored factors that influence cancer detection behavior among aging Nigerian men. Specifically, we examined possible predictors of current and future intentions to engage in early cancer detection behaviors among Nigerian men. Participants (N=143), with a mean age of 44.73 (SD = 6.15), responded to measures assessing health (cancer detection behaviors), social (masculinity, self-esteem, attachment), and psychological (active coping) factors. Demographic and ecological questions were also included in the survey. Results revealed that education, masculinity, and anxious attachment were significant predictors of current cancer detection behavior. Education, masculinity, and anxious attachment also predicted future cancer screening intentions. We discuss the implication of result for health policy, health education and cancer prevention interventions for Nigerian men and for the global campaign for early cancer detection.

RACE AND EDUCATIONAL DISPARITIES IN ADVANCE DIRECTIVE COMPLETION: ENCOURAGING TRENDS IN THE UNITED STATES

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Advance directives (AD) help to ensure patients' wishes are honored and contribute to improved end-of- life care. Race and education disparities in advance directive completion have been extensively documented. This study examined five waves of U.S. Health and Retirement Study exit survey data (N = 7,067) to examine to what extent these disparities have expanded or diminished over the past decade. Overall, advance directive completion increased from about 63% among participants who died in 2005-06 to about 73% among those whose deaths occurred between 2015 and 2016. Non-Hispanic whites were almost four times as likely to have advance directives compared to Hispanics or African Americans across this time period (OR=3.90. p<.0001). However, the growth rate in advance directive completion among non-Hispanic whites was significantly slower than for non-whites (OR=.90, p<.01). Compared to those with a high school education or less, those with some college (OR=1.67, p<.0001) and those with at least a college degree (OR=2.02, p<.0001) were significantly more likely to have advance directives across the time period. There were no significant differences in growth rates of advance directive completion for the different educational categories. These results suggest that educational disparities in advance directive completion are fairly stable, but that race disparities may be diminishing.

RACIAL OR ETHNIC AND MULTIMORBIDITY DIFFERENCES IN FUNCTIONAL LIMITATION TRAJECTORIES AMONG OLDER AMERICANS

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Racial/ethnic minority groups in the U.S. are at risk for greater co-existing chronic disease (multimorbidity) burden and experience greater functional limitations relative to non-Hispanic white peers. To target programs designed to preserve functional independence, this study aims to identify temporal trends of functional limitation among race/ethnic groups and within the context of multimorbidity. Data from the Health & Retirement Study (2000-2014, N=16,959, 65 years of age and older, community-dwelling adults) were used in generalized estimating equation (GEE) models to assess changes in functional limitations over time (combined activities of daily living [ADL] and instrumental activities of daily living [IADL], range 0-11). Models were adjusted for race/ethnicity (non-Hispanic black, Hispanic, non-Hispanic white), self-reported chronic disease categories (no/one, ≥2 somatic, somatic-depression; of arthritis, cancer, diabetes, heart disease, high depressive symptoms [CES-D8≥4], hypertension, lung disease, stroke), age at baseline, sex, body-mass index, education, partnered, net worth, and time. In adjusted GEE models, Hispanic and black respondents experience 1.4 times greater counts of functional limitations, respectively, relative to white respondents (incidence rate ratio [IRR]= 1.4, 95% CI[1.17, 1.66], IRR=1.4, CI[1.26, 1.61]); however, temporal trends were similar. With regard to multimorbidity categories, somatic or somatic-depression multimorbidity were each associated with 2.2 or 3.5 times greater functional limitations, respectively, relative to having no/one condition (IRR=2.2, CI[2.06, 2.39], IRR=3.5, CI[3.18, 3.74]). There are marked differences in functional limitation levels between minority ethnic and white groups, as well as among chronic disease combination groups, suggesting the need to intervene in middle-age to reduce disparities.

SELF-RATED HEALTH STATUS AS A PREDICTOR OF EXECUTIVE FUNCTION IN OLDER LATINOS

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Latinos have high risk of Alzheimer's disease and related dementias (ADRD). Self-rated health (SRH) has been used to predict cognitive decline. Early detection of executive function changes may help identify those at higher risk of cognitive decline. The purpose of this study was to examine the relationship between SRH and executive function in Latinos. Latinos (N=333, 84.4% female, Mage= 64.9 ± 7.08) from the BAILA randomized controlled trial self-rated their health as 1) poor/fair, 2) good, and 3) very good/excellent. Executive function was assessed by the Trail-making B, Verbal Fluency, Stroop C & CW, and the Digit Modality tests and stratified by SRH. One-way analysis of variance showed that the effect of SRH was significant for Trails B, F(2,298)=4.01, p=.019 and Stroop CW, F(2,298)=3.07, p=.048. Tukey's test indicated that participants who rated their health as fair/poor took longer to complete Trails B (M=196.78±83.0 seconds) compared