


African Immigrant Health: Prostate Cancer Attitudes, Perceptions, and Barriers

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Abstract

Prostate cancer (PCa) is the second leading cause of cancer-related death among Black men who present with higher incidence, mortality, and survival compared to other racial groups. African immigrant men, however, are underrepresented in PCa research and thus this research sought to address that gap. This study applied a social determinants of health framework to understand the knowledge, perceptions, and behavioral tendencies regarding PCa in African immigrants. African immigrant men and women residing in different parts of the country (California, Texas, Colorado, Oklahoma, and Florida) from various faith-based organizations, African community groups, and social groups were recruited to participate in key informant interviews ($n = 10$) and two focus groups ($n = 23$). Four themes were identified in this study: (a) PCa knowledge and attitudes—while knowledge is very limited, perceptions about prostate health are very strong; (b) culture and gender identity strongly influence African health beliefs; (c) preservation of manhood; and (d) psychosocial stressors (e.g., financial, racial, immigration, lack of community, and negative perceptions of invasiveness of screening) are factors that play a major role in the overall health of African immigrant men. The results of this qualitative study unveiled perceptions, attitudes, beliefs, and knowledge of PCa among African immigrants that should inform the planning, development, and implementation of preventive programs to promote men's health and PCa awareness.

Keywords

prostate cancer, African immigrant men, knowledge, psychosocial stressors, culture

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Prostate cancer (PCa) is the most prevalent noncutaneous cancer in men worldwide (Cancer Facts & Figures 2020, 2020). Although on average, one in nine men will develop PCa in their lifetime, among Black men in America this risk is one in four (Cancer Facts & Figures 2020, 2020). Black men also develop PCa at a younger age, are more likely to advance to a higher grade/metastatic state before clinical diagnosis, tend to have a more aggressive disease, and die at a higher rate than any other ethnic group (Tsodikov et al., 2017). This disproportionately high incidence, mortality, and disease presentation (Keavey & Thompson, 2018) is believed to stem from a complex set of dimensions including behaviors and attitudes (Blocker et al., 2006), and clinical (Sarma et al., 2002; Stephenson, 2002), biological (Hjelmborg et al., 2014; Mucci et al., 2016), and socioeconomic factors (Tewari et al., 2009).

While many studies (Bensen et al., 2013; Faisal et al., 2016; Odedina, Akinremi, et al., 2009) have sought to understand this PCa disparity among Black men, most

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have focused on African American men, and a few on Afro-Caribbean men, with only limited studies exploring these issues with African immigrant men (Odedina et al., 2011; Odedina, Yu, et al., 2009).

African immigrants, although a relatively small ethnic minority group in the United States, are the fastest growing immigrant population (Anderson, 2017). However, despite their growth, public health studies focusing on African immigrant health is limited and when it comes to cancer research, they are grossly underrepresented (Venters & Gany, 2011). Additionally, in PCa research, Black health research, and surveillance reports, African immigrants tend to be lumped together with African Americans or Afro-Caribbeans, concealing the true African data patterns under the assumption that all Black populations in the United States are the same (Blanas et al., 2013; Woods et al., 2004). With the low rates and concealment of African immigrant-specific results, it is difficult to ascertain if the rates, attitudes, and perceptions associated with PCa are the same in the different subgroups of Black men.

The theory of social determinants of health (SDoH) posits that the health of people and communities is influenced by social and economic factors (Asare et al., 2017). These factors—or the conditions in which people are born, grow, live, work, and age—can positively or negatively affect an individual's attitudes and perceptions with any health issue, in this case, those associated with PCa. The SDoH framework argues that political, economic, and social mechanisms give rise to a set of socioeconomic positions, whereby positions are stratified based on income, education, occupation, race/ethnicity, gender, and other factors (WHO, 2010). These socioeconomic positions collectively shape specific determinants of health which are reflective of people's place within social hierarchies, are based on their respective social status, as well as individual's experienced differences in exposures and vulnerabilities to health-compromising conditions (Asare et al., 2017; WHO, 2010). Moreover, based on the SDoH framework, conditions like PCa itself can also reverse or feedback to affect the functioning of an individual's social, economic, and political institutions because all of the constructs in the SDoH framework are interrelated (WHO, 2010). SDoH contribute substantially to creating and perpetuating health inequities which in turn impact health differences in a population (Embrett & Randall, 2014). Thus, to improve health and reduce disparities in health and health care, it's been proposed that addressing SDoH is crucial; by improving the conditions of daily life and tackling the inequitable distribution of power, money, and resources, we can positively impact the health of many (Marmot et al., 2008).

To address SDoH, however, it is important to understand the psychological processes that influence behavior. For

instance, among African American men, understanding the impact medical mistrust has on PCa has led to interventions to promote better health (Allen et al., 2007; Forrester-Anderson, 2005). Among Afro-Caribbean men with PCa, understanding the diversity of experiences influenced by a wide array of personal and societal factors provided an opportunity for interventions that took into account the heterogeneity of diverse experiences when addressing PCa (Gray et al., 2005).

Therefore, in order to supplement current literature and to understand African immigrants' attitudes and perceptions associated with PCa, this study applied a SDoH framework to understand the knowledge, perceptions, and attitudes associated with PCa and how these might influence behavioral tendencies relating to preventive screening and treatment for PCa.

Methods

Sampling and Recruitment

This study used a grounded theory methodology in the gathering and analysis of data (Charmaz & Belgrave, 2015). African immigrant men and women residing in different parts of the country (California, Texas, Colorado, Oklahoma, and Florida) from various faith-based organizations, African community groups, and social groups were recruited to participate in key informant interviews and focus groups. Recruitment strategies included church announcements, community groups, African Facebook communities, and word of mouth. Recruitment was conducted by an African immigrant health professional who partnered with the site leaders to create and distribute flyers and explain the study at townhall forums within the various organization. Participants who met the established criteria of age (18 years and older) were either African immigrant males and/or the spouse/partners of an African immigrant male, and who were willing and available, were accepted in the study. In order to maximize credibility, dependability, and confirmability of the findings, a data triangulation methodology was used with the inclusion of multiple source participants (i.e., female partners of the target men) and multiple qualitative methodologies (focus groups and key informant interviews; Guba, 1981; Lambert & Loiselle, 2008; Shenton, 2004). To seek triangulation on the deeply personal and often relational issues surrounding PCA and related screening behaviors, we decided to gather data from both men and women to allow women's views about how they see their partners' perceptions on these issues as a means of further validating the information (Wilson, 2014). Including multiple sources to seek triangulation has been argued (Denzin, 2017) as an important strategy to seek validity though convergence (Patton, 1999) in qualitative research methodology,

because each source and type of methodology reveals a different aspect of reality which increases the rigor (Patton, 2002), trustworthiness (Guba, 1981), and comprehensiveness (Pope & Mays, 2000) of the study. The institutional review board at Loma Linda University approved the study protocol prior to implementation.

Data Collection Procedures

The interview and focus groups were conducted in conference or break rooms at churches and participants' homes. Prior to the discussion, each participant completed a consent form and once consented, a short demographic questionnaire, which asked for age, marital status, education, PCa family history, and PCa screening information. Two focus groups and 10 key and general informant interviews were conducted. A 16-item semistructured outline was used as a starting point to guide the discussion. The items included, but were not limited to, the following questions: What does health mean to you as an African male? Or what does health mean to African men? What are some of the issues that are important to you in terms of men's health? Describe how men talk about prostate cancer. What have you heard about how African men deal with a diagnosis of prostate cancer? Do you feel that beliefs men hold about life and health in general affect the way they deal with prostate cancer screening? For each question, probes would then be used by the interviewer to delve more deeply into the responses and explore them further as the interview progressed.

The interview outlines were pilot-tested for content, relevance, and clarity, and modified prior to the start of the study. Each discussion was conducted by qualitatively trained interviewers (two African immigrant MD/MPH and a social policy PhD candidate), lasted 1.5–2 hr, and was audio-recorded to ensure accurate transcription. Summary field notes were also completed by the interviewers/facilitators after each appointment. In addition, we had a reporting back forum with 30 persons (male and female) we used to both share information as well as to member-check our findings and assumptions.

Qualitative Data Analysis

Descriptive statistics were used to present the demographic characteristics of the participant sample. Following the discussion, audio recordings were transcribed verbatim and double-checked for accuracy by comparing the recordings and the transcripts in a second and third reading. Focus groups, field notes, and key informant interviews were coded line by line independently by two coders, according to grounded theory methods of analysis (Charmaz & Belgrave, 2015). Once the initial emergent coding was completed, a final codebook was derived in a

Table 1. Demographic Characteristics ($n = 33$).

	Percentage
Age	
20–25	4.3%
26–30	8.7%
31–35	4.3%
36–40	26.1%
41–50	21.7%
51 and older	34.8%
Gender	
Male	54.5%
Female	45.5%
Marital status	
Never married	13.0%
Married	78.3%
In cohabiting relationship	-
Divorced/separated	8.6%
Widowed	-
Education level	
High school	-
Associate degree	-
College degree	65.2%
Master's degree	21.7%
Beyond master's degree	13.0%
Family history	
No	91.3%
Yes	8.7%
Health insurance	
No	73.9%
Yes	26.1%

facilitated discussion by the coders with a third (senior) investigator reviewing any discordant codes, to arrive at a shared language for codes. All transcripts were then coded using this final codebook, and quotations aligned with emergent codes were then abstracted from the transcripts and clustered (hierarchical coding), making the process of the theme development emergent. They were subsequently grouped in themes. These concepts were then further developed and validated through constant comparison with the most relevant concepts being integrated to expand the SDoH framework to fit the African immigrant men perspective.

Results

Table 1 shows the demographic information gathered. A total of 33 participants were part of the study: 18 men and 15 women. The majority (82.6%) of participants were 36 years and older, most were married (78.3%), and all had a college education or more. Only 8.7% reported knowing of a family history of PCa and 73.9% had health insurance. Four themes were identified in this study: (a)

PCa knowledge and attitudes—while knowledge is very limited, perceptions about prostate health are very strong; (b) *culture and gender identity* strongly influence African health beliefs; (c) *preservation of manhood*; and (d) *psychosocial stressors* (e.g., financial, racial, immigration, lack of community, and negative perceptions of invasiveness of screening) are factors that play a major role in the overall health of men.

Theme 1: PCa Knowledge and Attitudes—While Knowledge Is Very Limited, Perceptions About Prostate Health Are Very Strong

All participants in the informant interviews and focus groups, regardless of age and gender, identified knowledge about PCa as being very limited.

“I don't even know what prostate is, is it a part of the body?”—Nigerian man, 24 years

“They have some knowledge, I don't think they have enough”—Kenyan woman, 62 years

“I personally, as a physician, it's not something that you know. . .the recommendation is like C grade. So, if I myself, don't have that information, how much more is someone who is not in the medical profession.”—Ghanaian man, 40 years.

“If the awareness was like breast cancer, I'm sure a lot of people would have heard about it”—Nigerian man, 26 years

While all respondents agreed that knowledge about PCa and its prevention was very limited in their community, they stated that even when some had knowledge, it went mainly unchecked for accuracy, influencing perceptions around PCa and creating an additional attitudinal layer that interferes with seeking more information or translating knowledge into action. Attitudes about male performance seem to override men's willingness to seek accurate information as any challenges related to prostate health were equated with an inability to perform as a man.

“Prostate cancer affects their manhood. . .they believe they have erectile dysfunction (ED). Or rather if they talked about it, everybody would think they have ED. Everybody believes it and so the men don't want to talk about it. They don't want people to think, even if they don't have.”—Kenyan woman, 62 years

“Men fear the stigma around it and the community's perception around masculinity. Prostate cancer would diminish a lot of men's sense of manhood in many African contexts”—Kenyan man, 30 years

Theme 2: Culture and Gender Identity Strongly Influence African Health Beliefs

Health is “based on a) teaching from family a) an early age which could include tradition[al] family beliefs, health inheritance challenges, and bad omen beliefs. And b) fear and beliefs about witch craft”—Kenyan man 55 years

“The spiritual. You know we Africans we are very spiritual negatively sometimes, so the spiritual plays a lot of role in that cloud around that prostate cancer thing because most people feel that most sickness, sickness is from the devil or from evil people, so they will think that prostate cancer is from someone, or maybe an enemy, they poisoned him or I don't know”—Nigerian woman, 36 years

“when it comes to prostate cancer and general illness it's an offshoot of the way we express our faith. one of the things that is killing Africans and by extension African men is the culture, it's the way of life because culture is one of the most difficult things to change. . .it's the way people have believed”—Nigerian man, 36 years

Socially constructed models of masculinity can have deleterious health consequences for men especially in the African context where being a man means never talking about or showing weakness. This was identified as an influencer of health in 8 of 10 interviews and in both focus groups. Moreover, in a follow-up discussion reporting results back for member-checking, all men stressed that being a man meant to be there and provide, and not to worry about one's personal health, leaving even highly educated men uninformed about men's health, as it was not seen as a priority.

“as men, we. . .[have] the natural inclination to be a provider. You don't prioritize yourself so maybe because of that you just feel that if others are doing well then I'm happy”—Nigerian man, 36 years

“if somebody as a man, if they find you crying pain they will tell you, you are being a woman. So African men always toughen themselves up. And sometimes when sick, instead of them seeking treatment either traditionally or going to the doctor, they will feel like they want to tough it out”—Ghanaian man, 40 years

“Africans. . .we don't talk too much about our health and then men, most especially, they don't talk too much about their health because they feel it reduces their manhood or masculinity, or their ego”—Nigerian woman, 36 years

The two main PCa tests available are Prostate Specific Antigen (PSA) test and Digital Rectum Examination (DRE). The PSA test, as a blood test, is less invasive;

however, it is not the most reliable test especially for a group of people with high susceptibility. The PSA test is prone to give more false positives and false negatives and although helpful in some cases, it isn't the most reliable (Ciatto, 2003; Ilic et al., 2013). The DRE, however, has an increased ability to capture clinically significant PCa, but is very invasive (Cui et al., 2016). As a result of such invasiveness, studies (Blocker et al., 2006; Winterich et al., 2009) have shown that most African American men opted for the PSA rather than the DRE and this was no different for African immigrant men. In addition to psychosocial stressors being barriers, the DRE was found to deter men from screening.

"They have to put their hands in there to check and I think that's another thing that makes the men not want to go"—Nigerian woman, 36 years

"A normal man would not go for that thing [digital rectal exam]"—Nigerian man, 26 years

"I have never got screened because personally I am uncomfortable with the idea of a prostate exam and don't believe I am particularly at risk"—Kenyan man, 30 years

"The digital rectal stuff, no way. Personally, maybe I'd rather just do the blood and say okay, pull whatever blood you want to pull and go do whatever you want to do. But normally, men would not go for the digital rectal exam easily but for the blood sample, it's going to be oh just take the blood and just give the report and the analysis and everything. I think a man would rather do that [PSA] than go for the other one [DRE]"—Nigerian man, 36 years

Theme 3: Preservation of Manhood

Another significant theme found among African immigrant men was impotency as a result of PCa treatment. While many hesitated to even bring it up, half of the participants believed that PCa and its treatment would diminish a man's sense of manhood and that this would be worse than dying.

"men fear death and losing their manhood. It is like walking on the street without clothes. It makes men feel less human and very useless. And when it comes to sex, they feel equivalent to an object"—Kenyan man, 55 years

"most men would rather die, African men ooo, ok Nigerian men would rather die. Die a slow painful death than lose their manhood. Because you know, African men, they hold on to this manhood thing, it's like their life. If you take it away from them they are dead. So most of them would prefer leaving the cancer and dying with the sickness than to give up that aspect of their life"—Nigerian woman, 36 years

Theme 4: Psychosocial Stressors Such as Financial, Racial, Immigration, Lack of Community, and Negative Perceptions of Invasiveness of Screening Are Factors That Play a Major Role in the Overall Health of Men

Even if an African immigrant man perceives that PCa is threatening and believes that a particular action (screening or treatment) will effectively reduce the threat, there are still barriers that prevent them from engaging in preventive or treatment-seeking behaviors. Within the African population, income, race/ethnicity, immigration, and lack of community were identified as key structural factors and mentioned among nearly all of our participants.

Income and Insurance. Many of our participants noted that, as immigrants, their responsibility is to build a better future for their families and that this is where income was to go. Again, in our follow-up discussions, many noted forgoing health insurance as they were building business to support their families—so why "dig" for problems. This is further validated by the fact that while all our respondents had a college degree or above and were employed, three quarters had no health insurance making them hesitant to even "find out" about health challenges and turning to traditional herbal methods when problems arise as these are both more familiar and affordable.

"Sometimes it's not just that people don't want to go for medical stuff, it's the attendant cost. Even if it's [Prostate cancer] detected early, the cost of surgery, chemo and everything is high"—Nigerian man, 36 years

"People kind of result to herbal medicine and all that for treatment because its cost effective"—Ghanaian man, 40 years

"if you go to other places around other cities all over the U.S. where you have lots of African population, you realize that it's not that people don't want to seek treatment, but they don't have insurance. Some people it's not about having access to insurance but probably they don't even have documents"—Ghanaian man, 40 years

Race/Ethnicity. The concept of race was a challenging dilemma for our respondents who come from a context where the norm was being Black. They quickly learned, however, that in the United States they are less seen for their immigrant values of hard work and wanting to build a life for their families than for their skin color and the negative stereotypes it represents.

"I've been tense. . . I am not comfortable moving around because of what might happen to me as a Black man in America"—Nigerian man, 26 years

"Africans automatically become Black when they come to America. And to be Black in America is not safe, especially a Black man"—Kenyan woman, 51 years

Immigration. For most participants, legal status was mentioned as being a barrier to most things in life when on a visa, but a relief once they attained permanent residency or naturalization.

"It's like when you are an immigrant and you come here, some people have extensive education back home in Africa but when you come here, you can't use it. Most of the time they spend time at work. Working two jobs"—Ghanaian man, 40 years

"Someone's immigration status determines, if they can work, go to school, go back home [Africa] to visit family or even come back once you have travelled. Your immigration status affects everything. You could be here on a student visa and prevented to work, and so you can't afford food or pay bills, or you can be on another type of visa that restricts other aspects and it just makes life hard. When my family was on a visa, my daughter couldn't apply for student aid for college, and if she couldn't go to college then her life has been changed. And so you see, how one thing can end up affecting an entire trajectory of your life."—Kenyan woman, 51 years

Community. Being part of a community can have a positive effect on mental health and one's emotional well-being. Community provides a sense of belonging and social connectedness and is a good resource for navigating life. A lack of it therefore can negatively affect one's health. Our respondents spoke about community and how the loss of it affected their lives.

"I mean, [in Ghana] if you don't have food on the table I can just go to my next door neighbor or go to my aunty or my dad or just family. . . somebody will at least help you, give you something. But here, the case is that sometimes people find that they don't know anyone"—Ghanaian man, 45 years

"When you don't have good community, you have bad health. Back home I had good health because I was surrounded by people. Here all we do is work, work, work. The only place you get to see people is in church and that time is short too."—Ghanaian woman, 55 years

Discussion

The aim of this study was to better understand the perceptions, attitudes, and beliefs surrounding PCa in African immigrant men, a highly vulnerable subpopulation using the SDoH framework. This study first identified that in

this subset of African immigrant men, perception of health is strongly rooted in their cultural and masculine identity. Cultural beliefs are powerful forces that affect one's social, structural, and psychological being (Hernandez & Blazer, 2006). In the African context, they are the root of everything in life and therefore are powerful forces that affect health (Otiso, 2006). We found this to be the case across all interviews we conducted with participants, who described to us that their perceptions of health were closely tied in their traditional cultural identity, and included traditional animistic religious beliefs that coexist with men's Christian identity, such as the role of witchcraft and attributions of a diagnosis being related to interpersonal conflict as a root cause of illness. Further, when it came to PCa, these beliefs were intertwined with traditional roles of maleness and affected openness by the men to become active on behalf of their own health. Interestingly, these beliefs crossed all ages and were validated by female partners who were interviewed for triangulation. Cultural beliefs rooted in the spiritual realm, along with the African masculine identity to never show pain or weakness, played a role in these men's avoidance to seeking health care especially with regard to PCa. This greatly disadvantages them and points to the need for public health research that is cultural and gender sensitive to men's lives and masculinities in relation to health and illness (Griffith et al., 2012).

Second, although PCa knowledge was found to be low among African immigrant men, the little knowledge that existed about prevention and treatment were often inaccurate. Perceptions associated with PCa such as erectile dysfunction or loss of manhood prevented men from screening and seeking treatment. These perceptions, which are tied with how the community will perceive them, supports literature in the fact that they influence their behavior when it comes to PCa (Ferguson & Bargh, 2004). The fact that the DRE is an important part of PCa screening does not help in this respect. Having someone other than a sexual partner engage with their genitals is seen as unnatural, and a challenge to their African male role. Our respondents had strong feelings about not wanting anyone to perform a rectal exam, no matter how critical it may be to their health. Cultural beliefs about causality and an expectation that things that are supposed to happen will happen coupled with strong male gendered expectations further hinder African men's active engagement on PCa prevention, leading many to not even wanting to find out more. Even when we reported back on our finding and gave more information about the PCa risks African men face, many were exceedingly uncomfortable. Although once we started the conversation, everyone was highly engaged and had many follow-up questions, and while comments about male performance continued to enter the conversation, all felt that the choices for them were tough

as they noted that the very reasons for them being immigrants was to take care of their families and that illness would negatively affect and undermine this responsibility. This dilemma came across for all ages and genders with women getting clearly frustrated with their partners. Indeed, even after learning about the risk, African immigrant men continued to state they would rather opt out of the DRE as they saw it as a threat to their manhood.

The third theme identified that psychosocial stressors such as finances, access to health insurance, the effects of race/ethnicity, immigration, and lack of community/isolation generate and reinforce barriers in the society that negatively affect the respondents' health in regard to PCa. Despite high levels of education, many still work hard to establish themselves financially. Few (<26%) had health insurance and many did not want to know or turned to traditional methods of dealing with health challenges. No one would even consider getting public assistance to gain access to health care. As immigrants, not being a burden to family members was of utmost importance to all. This was especially important to them as they realized that in the United States, they are now seen as "Black" and the negative perceptions of Black men in America are also placed on African immigrant men. Though many were at first hesitant to talk about this, the issue of race and their standing as Black men in the United States, combined with lack of community support and isolation, was seen as very deleterious to their health.

A crucial aspect that this study identified was the intersectionality of the African immigrant men experience. W.E.B. Du Bois coined the term "double consciousness" to describe an individual whose identity is divided into two facets, being American and being Black. Du Bois argued that "one feels his two-ness, an American, a Negro; two souls, two thoughts, two unreconciled strivings; two warring deals in one dark body, whose dogged strength alone keeps it from being torn asunder" (Du Bois, 1903). What the present study revealed is that African immigrant men experience a triple consciousness, being an African male, an immigrant, and Black male in America with all the prejudices that come with each. In our study, African men argued that they are defined by their cultural beliefs—a very complex spirituality left to them by their ancestors that they carry with them regardless of the pressures of expected assimilation and social conformity placed upon them. Their culture was defined as a way of life. This way of life combined with the African perspective of masculinity intersect to affect health behaviors and health outcomes of African men. Being an immigrant in America surrounded by the anti-immigration rhetoric, in addition to being a Black man in America adds barriers and complexity that only the African immigrant man experiences. The fact that they then also learn that others often simply see them as

Black men—an inherent threat—adds further layers of stress.

The intersectionality of these three factors adds complexity to the lived experiences of African immigrant men. In this respect, though they share many similarities, and are often seen as one and the same, African immigrant men in the United States experience the world very differently than African American men (who lack the cultural ties, the African perspective of masculinity, and immigration implication), and Caribbean American men (who also lack similar cultural ties and perception of African masculinity). In regard to PCa, this intersectionality plays a key role in their health because it affects the resources allotted to them, the type of information available that would be relevant to them, and health professionals who often do not understand their perspective or even see them as culturally the same as all other Black men in the United States.

Given that rates of PCa are high in all groups of Black men in the United States, including African immigrant men, one of the fastest growing immigrant groups, preventive interventions aimed at increasing screening behavior among African immigrants should take these intersectional struggles into account and aim to address this complexity of overall low levels of knowledge, complex cultural beliefs, lack of community support, and strong gender-cultural barriers. With so many Africans migrating to the United States, their lives are being shaped both by the social determinants in their homelands as well as by their new destination country. Taking these into consideration when attempting to reach African men in regard to prevention and treatment for PCa, a cancer already burdened by male gender roles, is critical.

Moreover, as immigrants, the additional challenges that come with this role according to the SDoH require the additional barriers inherent in this to be addressed and not to simply treat all Black men as one homogenous group. Subgroup differences matter, and if substantive changes in African immigrant health are to be achieved, then immigration has to be treated as a health determinant (Castañeda et al., 2015).

Implications

The results of this study unveiled perceptions, attitudes, beliefs, and knowledge of PCa among African immigrant men and women, which should inform the planning, development, and implementation of preventive programs to promote men's health and PCa awareness. In attempting to improve screening rates and reduce morbidity and mortality of PCa, issues specific to the African immigrant population must be addressed. Many of the participants brought up the psychosocial stressors experienced by all immigrants and racism experienced by

Black men especially in the United States and how the intersectionality of both devalues the African immigrant life. The culture, experience, and beliefs of African immigrant men must be considered when assessing both the content of a public health message and the intent of the messenger.

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Supplemental Material

Supplemental material for this article is available online.

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