What are the barriers preventing Black men from accessing prostate cancer treatment?

Date: June 2026

Contributors: Alexandra Naranjo[1], Abel Tesfai[1], Ellie Blake[1], Harris Wong[1], and Natalia Norori[1]

1 Data & Evidence, Prostate Cancer UK

PROSTATE CANCER UK

Contents

Summary

A 2020 report from the National Cancer Auditing Collaborating Centre's National Prostate Cancer Audit has reported that Black men are less likely to receive potential curative treatment than white men, and that Black ethnicity is associated with undertreatment[1]. Because undertreatment can adversely affect cancer outcomes, it is imperative to understand the barriers to treatment that Black men face. The understanding and characterisation of the barriers to accessing treatment for Black men is fundamental to dismantling health inequalities and ensuring that all men receive a similar standard of care.

This literature review aims to identify treatment access barriers experienced by Black men and was not limited to UK studies due to paucity of research in UK setting. A search strategy formed around this research question was conducted using MeSH terms and keywords on PubMed, which returned 154 articles; 17 met the inclusion criteria and were included in this review. Major themes of barriers to treatment access for Black men include socioeconomic factors, mistrust in the medical community, lack of knowledge, communication, and/or outreach, as well as the limited inclusion of Black men in research and diagnosis.

Introduction

It is understood that although Black men experience a higher incidence and mortality from prostate cancer than white men, it appears that they do not have worse prostate cancer outcomes if there is equitable access to care [2-4]. This is corroborated by a multiple-cohort study including data from 306,100 US patients with prostate cancer within 3 different cohorts- Surveillance, Epidemiology, and End Results (SEER) database, National Cancer Institute-sponsored clinical trials, and Veterans Affairs health system [2-4]. The analysis showed that after adjustment to access to care and standardised treatment, being of Black race was not associated with inferior stage-for-stage prostate cancer-specific mortality in nonmetastatic prostate cancer [5].

This research emphasises the importance of providing equitable access to care to all to improve prostate cancer outcomes. However, the reality is that disparities in treatment access exist. Many studies have found that Black people are less likely to receive treatment for localised prostate cancer [6, 7]. An example of this comes from Moses et al., 2016, who evaluated the SEER database and identified that 327,636 men diagnosed with clinically localized prostate cancer from 2004-2011, of which 14% were African American, showed that African American and Hispanic men were less likely to receive treatment compared to white men (odds ratio [OR] 0.73, 95% CI 0.71–0.75, and OR 0.95, 95% CI 0.92–0.98, respectively) [7]. In fact, failure to meet the standard of care for Black men has been reported across all disease risk strata, with reported stepwise decrease in odds of curative treatment in Black men, compared to their white counterparts, across increasing risk categories [8].

Despite these worrying statistics, there is a lack of research into the barriers preventing Black men from accessing prostate cancer treatment. Some evidence suggests that treatment disparities tend to dissipate when treated in equal access settings such as Veterans Affairs [9]. Indeed, racial disparities in all-cause mortality were reported in a community health care cohort representing a non-equal care access setting, but not in an equal access setting Veterans Affairs cohort, according to a study by Wadhwa et al., 2024 [10]. However, other evidence suggests that even after adjusting for residential, provider, and hospital location factors, substantial disparities in prostate cancer care still exist [6]. For this reason, it is important to understand why disparities in guideline-concordant treatment exist, and to what extent they are explained by treatment access challenges. This information will help provide a basis of understanding why Black men are undertreated for prostate cancer.

Methods, search strategy, and rationale

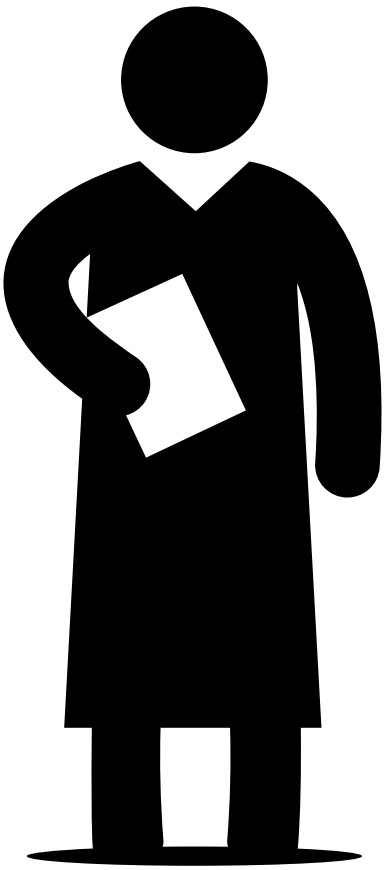
A structured literature review was conducted using PubMed. The search strategy followed Population, Intervention, Comparator and Outcome framework and utilised standardised Medical Subject Headings used to index literature in PubMed to facilitate searching in PubMed.

Keywords used to describe the population of interest include “Black People “and "Black or African American”, and “prostatic neoplasms”. Keywords used to describe the intervention include “treatment”, “radical treatment", "radical therapy", and "therapy”. Keywords used to describe the outcome, namely treatment access and lack thereof, include "Health Services Accessibility", "Health care quality, access, and evaluation”, and “undertreatment”. The search excluded metastatic or advanced prostate cancer, as these were outside the scope of the review. Inclusion criteria included a focus on Black men, non-metastatic prostate cancer, treatment access, and papers published between 2020 and 2026. This time frame was selected as we wanted to understand the treatment access barriers within the modern context of using MRI in the diagnostic and treatment pathway. Exclusion criteria included any studies that did not meet the inclusion criteria or did not specifically address treatment access or undertreatment. The number of papers that met the requirements for this search strategy was limited, and among them, there were no studies that were conducted from the UK. Due to the small number of studies that met the criteria, the studies were not limited to equal access care settings in the United States such as Veterans Affairs or Medicare.

Results

On PubMed, the search strategy yielded 577 results. Of these 577 results, only 154 met the criteria of being published between 2020 and 2026. These 154 articles were imported on Rayyan, where each article was reviewed individually for relevance to the research question. Of these 154 articles, 23 articles met the inclusion/ exclusion criteria after review on screening tool Rayyan. Of these 23 articles, 6 were excluded due to a lack of access. Of the remaining 17 articles, 6 were qualitative or retrospective cohort studies, and 11 were literature reviews. All the articles report on data from the US.

A few key themes were identified from the evidence synthesis. Socioeconomic factors arose as a considerable barrier, including factors such as insurance coverage, differences in healthcare providers, and geographical location. Medical mistrust amongst the Black community also emerged as a barrier, emphasised by the lack of representation of Black clinicians. Issues on knowledge and communication included miscommunication between clinician and patient, and lack of knowledge among the Black community about prostate cancer information, as well as lack of knowledge amongst healthcare providers. Lastly, the lack of representation of Black men in clinical trials was identified as a barrier, limiting access to novel and emerging therapies and reducing the applicability of clinical trial findings to this population.



Discussion

Theme 1: Socioeconomic Factors

Many studies reported that socioeconomic factors created healthcare disparities in prostate cancer care for Black men [6, 8, 11-14]. Some of the socioeconomic factors that may prevent Black men from accessing treatment include housing, transportation, occupation, education, health insurance, and cost of care [15].

When compared to white patients, African American patients seem to be more concerned about the financial burden of cancer treatment, and are more likely to be uninsured [8m, 14]. This was reflected in a qualitative study by Wallington et al., 2025 which conducted focus groups with 29 Black men, reporting a trend of concerns about the price of healthcare and limited access to insurance [11]. We also know that uninsured patients access treatment with more difficulty, as shown by an analysis of over 138,000 patients with nonmetastatic high-risk prostate cancer, which showed minority and uninsured patients were less likely to receive definitive therapy [8]. A geographic factor that can also be linked to socioeconomic status is travel distance. The travel distance to a medical facility can potentially limit Black patient's treatment access. A cross-sectional analysis of 2,136 men in Philadelphia showed that Black men reported longer travel time to the clinic than white men [12].

A key study showing how socioeconomic factors affect treatment access is presented by Hammarlund et al., 2025. This was a retrospective cohort study evaluating over 17,000 patients with prostate cancer within the SEER database, which found that Black men were more likely to receive care at large hospitals (>440 beds) and hospitals serving minorities (where >33% are Black or American Indian/ Alaska Native) when compared to White men. Black men were also less likely to receive care from hospitals that were among the 90th percentile of high surgical volumes for radical prostatectomies. In addition, the top 20 most common postal codes for Black and white men differed in that the postal codes of white men were less densely populated and outside of cities, whereas the top 20 postal codes for Black men were densely populated areas within major cities such as Detroit or Atlanta, which tended to have lower average income [6]. A regression analysis with fixed effects was undertaken to adjust for hospital, clinician, and postal codes. A bootstrapped test of the changes in estimates showed that including location-based fixed effects decreased the treatment inequity from 6.04 percentage points to 3.28 percentage points, which represented a marginally significant change ($p<0.01$). This means that racial differences in treatment are multifactorial and despite geographical location of men accounting for a statistically significant portion of the inequity, it did not explain all the inequity that was present [6]. Therefore, socioeconomic factors are not completely at fault for the racial disparities in treatment.

Whilst socioeconomic factors may not account for all the disparities in treatment access, it has been observed that the hospital where they receive care is important for Black men seeking care. A study by Labban et al., 2024, determined from interviewing 25 hospital representatives and representatives for grassroots organisations providing prostate cancer education in Massachusetts that Black patients tend to seek safety net hospitals because of the many services they provide, including patient navigators, interpreters, social workers and transportation support [13]. Indeed, hospitals that historically were attended by wealthier and white populations noted that their hospital demographics were not representative of the racial diversity of their community. In fact, Black men may be willing to take on burdens associated with transportation to attend other hospitals, out of feelings of mistrust, not belonging, and not seeing diverse clinicians [13].

As such, healthcare providers and institutions have much room for improvement. A semi-structured interview study by Anderson et al., 2025 engaging with 15 Black participants reported their challenges in prostate cancer care, including medication delays and patients seeing multiple healthcare providers, which had an impact on patients' understanding [16]. Black men also reported bias in the healthcare system at large, in the form of healthcare providers judging patients' insurance provider or type [11]. Anderson et al., 2025 reported examples of past negative experiences that the participants endured,

including high turnover of clinicians, miscommunication, dismissive clinicians, and overworked staff. Several of the interviewees reported the need to conduct their own research to support the information communicated by their clinicians [16].

Theme 2: Medical Mistrust

Overwhelmingly, the evidence base attributed treatment disparities to the Black community's mistrust of the medical community [9, 11, 12, 14, 17]. The Black community experiences medical mistrust because of a long line of historical instances of medical mistreatment [12]. This theme has also been found in a UK context. A qualitative study using semi-structured interviews with Black men in the UK identified a trend of mistrust in medicine due to the historical and ongoing racism they have experienced and unethical acts against the Black community throughout time. This mistrust in the medical community has widespread implications and may affect Black men by instilling fear of hospitals, clinical trial participation, and distrust with clinicians [18]. Factors such as ineffective communication between healthcare providers (including healthcare professionals) and patients and the lack of Black clinicians continue to contribute to mistrust in the healthcare system [12, 14, 17]. Indeed, there has been a lack of Black clinicians, as emphasised by the fact that in 2019 Black men made up 13.4% of the US population, but only 6.2% medical graduates and 5% of active clinicians [12].The UK shows a similar pattern, with only 8% of junior doctors and 3% of consultants being of Black ethnicity in 2021 [19]. The lack of ethnic representation has also been seen in UK conferences and scientific meetings. The British Association of Urological Surgeons (BAUS) show that BAUS annual meetings have underrepresented ethnic minorities from programmes in between 2009-2021. However, representation of Black people within the clinical workforce is pivotal for good quality of care, as reported by focus groups with Black men and evidence showing that diversity in clinicians has been reported to improve quality of care and doctor-patient relationships [20].

This mistrust can negatively impact patient outcomes, including potentially delaying care, giving rise to misconceptions about disease severity, and driving forward ineffective shared decision-making [12, 17]. Medical mistrust is seemingly responsible for many fears and anxieties within the Black community. In a semi-structured interview study of 15 Black men with prostate cancer, researchers found that almost half of the participants believed that healthcare organisations concealed mistakes, with a smaller number of these men believing that these organisations deceived patients and one third of these participants believed organisations carried out harmful experiments without patient consent [16]. Labban et al., 2024 showed that Black men are willing to go to lengths to avoid going to hospitals that were typically more attended to by white people, by undertaking a longer commute and by consequence, accepting the costs and time resources that come with travelling further away [13].

Theme 3: Issues in Knowledge and Communication

Lack of Knowledge

Another barrier to accessing Prostate-Specific Antigen (PSA) testing or treatment comes from a lack of knowledge in prostate cancer care. Current literature indicates a lack of knowledge about prostate cancer among Black men [3, 11, 14]. Interestingly, lack of knowledge can be caused by poor patient and provider communication, indicating an intersection of multiple determinants of disparity [9]. This lack of knowledge has also been reflected in semi-structured interview studies with Black men, which show that most of the 15 participants had minimal knowledge about prostate cancer before they themselves or a loved one got diagnosed with prostate cancer. These participants reported challenges in acquiring information, which led them to support their understanding of prostate cancer care by conducting their own research. Many expressed that they could have been more proactive in monitoring their prostate health, presumably if they had had more information accessible to them [16].

An example of how lack of knowledge can translate to poor cancer outcomes, and how different information can give rise to different choices, comes from a study which found that Black men were more likely to underestimate the severity of their diagnosis, and twice as likely to factor in time of treatment and recovery in their decision to pursue treatment when compared to white men [14, 21]. Black men have also been found to have a higher likelihood of decision regret, or less satisfaction, after treatment than white men [4, 21].

Communication

Another potential barrier for Black men is the way health information and healthcare awareness are communicated to them. For this reason, it is also important to understand who is best placed to deliver healthcare information to the Black community, and in what format. A retrospective analysis of 1308 Black men reported that decisions on prostate cancer heavily relied on information from community members, family, and interpersonal sources such as barbers or pastors [12]. Not only are family members seen as sources of information, but also as a source of support. A semi-structured interview study involving 15 Black participants by Anderson et al., 2025, identified that interviewees reported family members offered prostate cancer patients emotional support as well as company to treatment appointments [16].

It also appears that Black men benefit from speaking about their prostate cancer with their peers. A mixed-methods study evaluating questionnaires and focus group insight from 11 Black prostate cancer survivors in the Southeastern area of the U.S. found that among focus groups of Black men, participants seemed to enjoy discussing treatment options and side effects with each other. The authors mention these men seemingly gaining comfort in sharing experiences among one another. Other interesting findings from this study are that men reported increased health communications within their families and communities among recent generations [22]. These findings could potentially reflect the idea that Black men prefer to discuss sensitive health topics, such as sexuality and prostate cancer, with other Black men experiencing the disease [22].

Women and spouses have also been found to play a pivotal role in Black men's prostate cancer knowledge, by the role they play in encouraging their husbands and family members to pursue PSA testing or treatment accordingly [3]. A mixed method study by Dickey et al., 2020, which conducted focus groups and questionnaires with 11 Black prostate cancer survivors also found this trend to be true, with mothers reported as the primary person responsible for health communications within the family[22]. Another qualitative study, conducting a focus group interviewing 29 Black men, also identified this theme, with Black men saying that they trust and rely on information from family and friends, particularly those in healthcare [11]. Family in healthcare and Black first-degree male relatives have potential in raising awareness and knowledge within the Black community [11, 22]. Because we know that ineffective communication between healthcare providers and patients is a source of medical mistrust and a barrier to treatment access, it may be useful to translate these findings by implementing health information or health awareness campaigns or outreach programmes that are specifically tailored to the Black community's focus on family and community.

In fact, community outreach programmes have already shown to improve the community's knowledge of prostate cancer care. An example of this comes from the National Coalition of 100 Black Women Prince William County, which found that 80% of the 438 participants reported having a conversation about PSA testing with their clinician 3 months after the education event [3].

However, it is also important to note that there are challenges in setting up outreach programmes that can successfully connect with the Black community whilst also sharing crucial health information. Labban et al., 2024, who interviewed 25 hospital representatives and representatives from grassroots organisations in Massachusetts, found that although all participants agreed community outreach was valuable in preventing healthcare inequities, they found it challenging to bridge the gap between healthcare providers, academia, and the community [13].

Healthcare Provider's Lack of Knowledge and Cultural Sensitivity

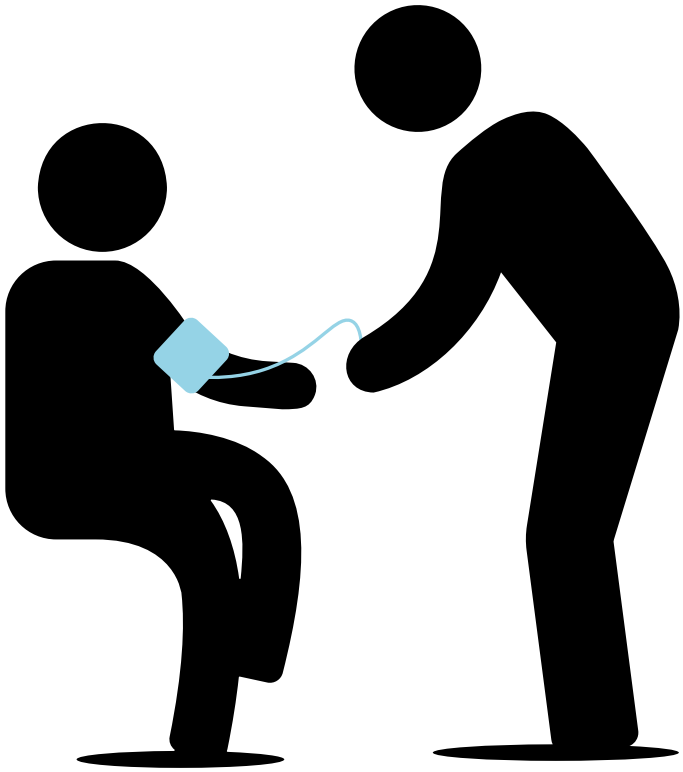
It is not only a lack of knowledge on the patient's behalf that contributes to disparities, but a lack of knowledge and cultural sensitivity from the healthcare providers as well. A qualitative study by Labban et al., 2024, interviewing hospital stakeholders and representatives from grassroots organisations dedicated to prostate cancer education, discovered that half of their interview participants were not aware of treatment access disparities within their city of Massachusetts [13]. It was observed that those from grassroots organisations, as compared to hospital representatives, were more aware of treatment disparities at a more local level [13]. The importance of grassroots work for the Black community has been found in UK-based studies as well. Ettehad et al., 2025 found that community and religious leaders were critical for facilitating open discussions, dispelling misconceptions, and promoting peer support. Community and partner support were fundamental sources of both practical and psychosocial support, especially when medical mistrust is an issue [18]. Labban et al., 2024 also reported that the frequent changes in screening (PSA testing) guideline recommendations regarding age and race contributed to both patient and primary care providers' confusion [13]. Another issue on provider awareness is the reported uncertainty on how metrics relating to patient satisfaction and access to care are measured by institutions, how to access this information, and who is responsible for the collection of these metrics. Healthcare providers were unaware of their role in promoting care access [13]. This difficulty has been reported in other studies, with one qualitative focus group study suggesting updating and tailoring national guidelines for Black men [11].

In the UK, Black men face barriers to healthcare that include a lack of health knowledge and cultural insensitivity. A systematic review by Bamidele et al., 2017 highlighted a need for cultural sensitivity in healthcare due to the healthcare professionals' stereotyping of Black men as 'secretive and reluctant to seek treatment' and Black men's perception of discussing sexual issues as taboo. Implementing culturally sensitive healthcare to the Black community can take many forms, such as having Black healthcare professionals, facilitating community peer support, and providing faith-based interventions [23, 24]. Thus, cultural insensitivity in healthcare systems may be a contributing factor to disparities in treatment access and uptake.

Theme 4: Limited Inclusion of Black men in Research & Diagnosis

Underrepresentation in Clinical Trials

One barrier to treatment access is the lack of representation of Black men within clinical trials. The impact of the underrepresentation of Black men in clinical trials is twofold. [1] The lack of Black men represented in clinical trials reduces evidence to support clinical use, and [2] prevents Black men receiving novel therapeutics through the trials [9, 15, 17, 25]. The impact of having little to no data on treatment metrics within the Black community can be potentially harmful for Black men, as treatment effectiveness or safety may be different across different populations and remain insufficiently studied. This evidence gap may contribute to uncertainty in clinical decision-making. An example of where the underrepresentation of Black men in clinical trials can result in potential undertreatment is shown by the example within precision oncology. Clinical trials in the field of precision oncology, which entails targeting specific genetic biomarkers that predispose



men to prostate cancer, have consistently underrepresented Black men. As a result, biomarkers and risk stratification tools have been insufficiently evaluated in Black men, limiting the generalisability of results [25].

To complicate matters further, there are also barriers to the enrolment of Black men into clinical trials. Barriers to trial participation may be related to type of work and lack of autonomy (inability to take time off work) as well as travel costs. Some of these barriers may be offset by funding to promote inclusion of Black men, but the lack of funding in trials to widen the pool of participants is also an issue. The lack of both awareness of and opportunity to take part in trials may also inadvertently contribute to barriers to treatment access. Additionally, there are sometimes clinical trial eligibility criteria excluding men with comorbidities (which affects Black men more than white men), lack of funding to promote inclusion of Black men in trials, and a lack of participant and/or provider awareness of trials to participate in [17, 25]. The way in which lack of trial participation functions as a barrier to accessing treatments has yet to be fully realised but may be a contributing factor to limited access and use of the latest treatment modalities across the prostate cancer continuum.

Fear of Side Effects

Crocerossa et al., 2022 theorise that the fear of side effects, particularly sexual dysfunction, may contribute to the decision among African American men to forego radical treatment [14]. This is highlighted by a study by Polienski et al., which evaluated the racial differences in health-related quality of life after prostate cancer treatment. The study evaluated 1006 men (of which 22% were Black) diagnosed with prostate cancer between 2007-2017 found that African American men had more sexual bother (p=0.024) after radical prostatectomy than non- African American men [14, 26]. Therefore, if Black men have a higher likelihood of developing side effects of treatment, this could also be considered a deterrent for pursuing radical treatment options.

Prostate Cancer UK Focus Group Findings

Prostate Cancer UK conducted two focus groups with Black men diagnosed with prostate cancer from 2015 onwards to understand their personal experiences of care on the NHS and explore potential reasons for undertreatment. A theme that emerged from this focus group was that although men said that their diagnosis/ prognosis was explained, they only understood some information. Some men said they either didn't fully understand or did not understand their treatment options. This supports the theme of 'lack of knowledge' as a barrier identified in the literature review. Themes of barriers to treatment found from the focus group discussions included economics, lack of communication around cancer, mistrust and taboo, masculinity, and fear of erectile dysfunction.

Conclusion

To summarise, the disparities in prostate cancer treatment experienced by Black men, which result in the Black community being undertreated, are caused by a complex and multifaceted interplay of factors. In this review, we were able to categorise the treatment access barriers into four sections: socioeconomic factors, medical mistrust, issues in knowledge and communication, and lack of inclusion of Black men in research. One of the most prominent themes underlying this literature review is the need to tailor and update prostate cancer care guidelines and policies to meet the needs of Black men. Because studies have shown that Black men prefer to share their experiences of prostate cancer with other Black men, future initiatives to enable treatment access to the Black community should consider the representation of Black men within the clinical workforce and community outreach programmes, which would facilitate peer support and the sharing of healthcare information.

Limitations of the review and future steps

More research is needed to be able to provide a robust picture of why barriers exist for Black men in treatment access and in undertreatment, specifically. The studies from which the evidence is synthesised have key limitations. Because the keyword 'undertreatment' rendered very few results on PubMed in the context of prostate cancer in Black men, this literature review has focused on treatment access barriers instead. We hope that the barriers to 'treatment access' are similar, if not identical, to the factors underlying 'undertreatment', although we recognise these are different concerns. According to the National Prostate Cancer Audit in the UK, 'undertreatment' is defined as men with high-risk or locally advanced disease (defined as Cambridge Prognostic Groups 4 or 5 or nodal disease (N1) prostate cancer) who do not receive radical treatment. We understand that Black men are associated with undertreatment, in accordance with a short report written by the NPCA in 2020.

The qualitative studies included in this literature review provide valuable insights through self-reported outcomes but are based on very small sample sizes of interviewees or focus group members.
All studies are within a U.S. context, which has limited generalisability to a UK healthcare context, due to differences in healthcare systems. In addition, although all articles that were published outside of 2020-2025 were excluded, there are some retrospective cohort studies which included the evaluation of patients diagnosed in the early 2000s.

Currently, the evidence base is limited and more heavily weighted towards US specific healthcare setting. This means that there is a need for UK-based qualitative studies investigating undertreatment in Black men to fully understand why this is occurring in NHS context.

References

1. National Prostate Cancer Audit. Variation in the Treatment of Men with high-risk/ locally advanced prostate cancer in England [Internet]. 2020 Oct. Available from: https://www.natcan.org.uk/reports/npca-short-report-2020/

2. Chowdhury-Paulino IM, Ericsson C, Vince R, Spratt DE, George DJ, Mucci LA. Racial disparities in prostate cancer among black men: epidemiology and outcomes. Prostate Cancer and Prostatic Diseases. 2021 Sep 2;

3. Carthon B, Sibold HC, Blee S, D. Pentz R. Prostate Cancer: Community Education and Disparities in Diagnosis and Treatment. The Oncologist. 2021 Mar 22;26(7):537–48.

4. Matthieu Vermeille, Koster KL, Benzaquen D, Champion A, Taussky D, Kaulanjan K, et al. A Literature Review of Racial Disparities in Prostate Cancer Research. Current Oncology. 2023 Nov 12;30(11):9886–94.

5. Dess RT, Hartman HE, Mahal BA, Soni PD, Jackson WC, Cooperberg MR, et al. Association of Black Race With Prostate Cancer-Specific and Other-Cause Mortality. JAMA Oncology. 2019 Jul 1;5(7):975.

6. Hammarlund N, Holt SK, Etzioni R, Morehead D, Lee JR, Wolff EM, et al. The association of where patients with prostate cancer live and receive care on racial treatment inequities. Journal of the National Cancer Institute [Internet]. 2025 Apr 1;117(4):713–8. Available from: https://pubmed-ncbi-nlm-nih-gov.knowledge.idm.oclc.org/39565920/

7. Moses KA, Orom H, Brasel A, Gaddy J, Underwood W. Racial/Ethnic Disparity in Treatment for Prostate Cancer: Does Cancer Severity Matter? Urology. 2017 Jan;99:76–83.

8. Vince RA, Jamieson S, Mahal B, Underwood W. Examining the Racial Disparities in Prostate Cancer. Urology. 2022 May;163:107–11

9. Murphy A, Cottrell-Daniels CC, Awasthi S, Katende E, Park JY, Denis J, et al. Understanding and Addressing Prostate Cancer Disparities in Diagnosis, Treatment, and Outcomes Among Black Men. Cancer Control. 2024 Jan 1;31.

10. Wadhwa A, Roscoe C, Duran EA, Kwan L, Haroldsen CL, Shelton JB, et al. Neighborhood Deprivation, Race and Ethnicity, and Prostate Cancer Outcomes Across California Health Care Systems. JAMA network open. 2024 Mar 19;7(3):e242852–2.

11. Wallington SF, Bennett K, Ford ME, Moultrie L, Slan M, Tucker-Seeley RD. Exploring the Vision of an Equitable Prostate Cancer Care Delivery System: Perspectives of Black Men in Charleston, South Carolina. American Journal of Men s Health. 2025 May 1;19(3).

12. Lillard JW, Moses KA, Mahal BA, George DJ. Racial disparities in Black men with prostate cancer: A literature review. Cancer. 2022 Nov 1;128(21):3787–95.

13. Labban M, Stone BV, Steele GL, Salinas KE, Agudile E, Katz MH, et al. A qualitative approach to understanding the drivers of unequal receipt of definitive therapy for Black men with prostate cancer in Massachusetts. Cancer [Internet]. 2024 Autumn;130 Suppl 20:3590–601. Available from: https://pubmed.ncbi.nlm.nih.gov/38837334/

14. Crocerossa F, Mir MC. Racial disparities in treatment patterns for localized prostate cancer in an equal access system: What are we missing? Prostate Cancer and Prostatic Diseases. 2022 Nov 15;

15. Johnson JR, Mavingire N, Woods-Burnham L, Walker M, Lewis D, Hooker SE, et al. The complex interplay of modifiable risk factors affecting prostate cancer disparities in African American men. Nature reviews Urology. 2024 Feb 2;

16. Anderson A, Choudhury MC, Savaski SM, Krane LS. Barriers and Facilitators of Shared Decision Making in Prostate Cancer Treatment Among African American Men. The Journal of the American Board of Family Medicine. 2025 Mar 1;38(2):302–11.

17. Cobbs C, Chesnut GT, Shafi AA. Understanding Racial Disparities in Prostate Cancer: A Multifaceted Approach. Cancer Medicine [Internet]. 2025 May 30;14(11). Available from: https://pmc.ncbi.nlm.nih.gov/articles/PMC12123386/

18. Ettehad D, Mohammed H, Bailey JV, Schloss D, Walters K, Samuel, et al. Barriers and facilitators to prostate cancer healthcare in Black men in the UK: from diagnosis to survivorship. Journal of Cancer Survivorship. 2025 Dec 27;

19. Institute for Fiscal Studies. Ethnic diversity of NHS Doctors [Internet]. 2024 Jan. Available from: https://ifs.org.uk/publications/ethnic-diversity-nhs-doctors

20. Massella V, Sinha M, Pietropaolo A, Geraghty R, Cresswell MJ, Philip J, et al. Ethnic and gender trends at the annual British Association of Urological Surgeons (BAUS) meeting: A review of BAUS programmes over a 13-year period (2009–2021). Journal of Clinical Urology. 2022 Jul 15;16(3):181–9.

21. Nyame YA, Cooperberg MR, Cumberbatch MG, Eggener SE, Etzioni R, Gomez SL, et al. Deconstructing, Addressing, and Eliminating Racial and Ethnic Inequities in Prostate Cancer Care. European Urology [Internet]. 2022 Oct 1;82(4):341–51. Available from: https://www.sciencedirect. com/science/article/pii/S0302283822016773

22. Dickey SL, Matthews C, Millender E. An Exploration of Precancer and Post-Cancer Diagnosis and Health Communication Among African American Prostate Cancer Survivors and Their Families. American Journal of Men's Health. 2020 May;14(3):155798832092720.

23. Bamidele O, McGarvey H, Lagan BM, Ali N, Chinegwundoh MBE F, Parahoo K, et al. Life after prostate cancer: A systematic literature review and thematic synthesis of the post-treatment experiences of Black African and Black Caribbean men. European Journal of Cancer Care. 2017 Oct 16;27(1):e12784.

24. Bamidele O, Greenley S, Onyinye Ukoha-Kalu B, Titus OF, Nanton V. A Scoping Review of Stigma Related to Prostate Cancer in Black Men. Journal of racial and ethnic health disparities. 2024 Jul 9; 12 (4): 2521-2559

25. Esdaille AR, Ibilibor C, Holmes A, Palmer NR, Murphy AB. Access and Representation: A Narrative Review of the Disparities in Access to Clinical Trials and Precision Oncology in Black men with Prostate Cancer. Urology [Internet]. 2022 May 1 [cited 2023 Sep 25];163:90–8. Available from: https://www.sciencedirect.com/science/article/pii/S0090429521008931

26. Posielski NM, Santosh Shanmuga, Ho O, Jiang J, Elsamanoudi S, Speir R, et al. The effect of race on treatment patterns and subsequent health-related quality of life outcomes in men undergoing treatment for localized prostate cancer. Prostate Cancer and Prostatic Diseases. 2022 Nov 10;26(2):415–20.