GENDER AND HEALTH-SEEKING BEHAVIOURS: SOCIOECONOMIC AND CULTURAL DETERMINANTS OF DELAYED PROSTATE CANCER DETECTION IN SENGEREMA, TANZANIA

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Abstract

Delayed prostate cancer detection is on the rise in Tanzania, intensifying the existing cancer burden despite the availability of screening services capable of identifying the disease in its different stages. The delay remains a pressing public health challenge, as it demands advanced systemic therapies that are currently unavailable in the country, making treatment more difficult and often resulting in poorer outcomes, including death. This study explored socioeconomic and cultural determinants for the delayed prostate cancer detection in Sengerema District, Tanzania. It employed a phenomenological research design to capture the essence of lived experiences through in-depth interviews conducted between March and May 2023 with 25 purposively and conveniently sampled participants, including patients undergoing treatment, their spouses, and both traditional and biomedical practitioners. Data were analyzed thematically, guided by Braun and Clarke's six-phase framework; and five themes emerged: Beliefs in witchcraft; Fatalistic perceptions; Prioritizing gender roles; Stigmatized

disease; and Communication barrier. These findings highlight that while access to screening services could substantially improve outcomes through early detection, meaningful change requires addressing gender socialization and masculinity ideologies that influence men's health-seeking behaviours, alongside improving cultural sensitivity in health communication and expanding affordable diagnostic and treatment services.

***Keywords**: Prostate Cancer, Delayed detection, health-seeking behaviour.*

1.0 INTRODUCTION

Prostate cancer (PCa) is a global growing public health concern ranking as the second most frequently diagnosed malignancy among men and the fifth leading cause of male cancer deaths, with an estimated 1.4 million new cases and 375,304 deaths in 2020 (Benedict et al., 2023; Wang et al., 2022). Projections suggest a dramatic increase to nearly 2.3 million new cases and 740,000 deaths by 2040, largely due to population growth and ageing (Culp et al., 2020). While PCa is a global concern, the burden is unevenly distributed, with low- and middle-income countries (LMICs) disproportionately affected (Odedina et al., 2008). In Africa, the proportion of new cases rose from 15% in 1970 to 56% in 2008 and is projected to reach 70% by 2030 (Ramaliba et al., 2022). Evidence indicates that men of African descent are more than twice as likely to be diagnosed with and die from PCa compared to other ethnic groups, presenting at a younger age and with more aggressive forms of the disease (Bugoye et al., 2019; Vapiwala et al., 2021). In East Africa, PCa accounts for 9% of all cancer cases and 8.5% of male cancer deaths annually (Adibe et al., 2017).

Like in other developing countries, PCa is a growing public health concern in Tanzania, where delayed detection continues to strain an already overburdened healthcare system (Ferlay et al., 2024; Katabalo et al., 2022). Despite the availability of screening services capable of identifying the disease in its early and more treatable stages, late presentation remains persistent, leading to poorer treatment outcomes and higher mortality (Adeloye et al., 2016). In Tanzania, the PCa ranks second among new cases (10.7%) and third in cancer mortality (9.4%) across both sexes (Ferlay et al., 2024). Studies report a high

prevalence of advanced, high-grade prostate cancer at diagnosis, nearly half of patients in some cohorts (Katabalo et al., 2022), and among top three causes of cancer mortality between 2006 and 2015 (Mboera et al., 2018). While biomedical and clinical aspects are well documented (Assefa et al., 2022; Benedict et al., 2022; Bugoye et al., 2019), there remains a gap in understanding the socioeconomic and cultural dimensions that influence men's health-seeking behaviour, particularly in low-resource settings. Gendered norms, cultural beliefs about masculinity, and perceptions of illness can shape decisions about when and where to seek care, while economic status, education, and geographic access, could further complicate timely health service utilization.

Existing literature acknowledges the complex interplay of these factors (Kahissay et al., 2017; Mbugua et al., 2021), yet several gaps remain. First, little is known about how specific cultural beliefs and explanatory models of illness influence PCa screening behaviour in Tanzania. Second, logistical and structural barriers, such as distance to facilities, transportation constraints, and clinic operating hours, are underexplored in relation to socioeconomic status. Third, healthcare provider communication and potential biases in discussing screening with men from different cultural backgrounds have not been sufficiently examined, despite evidence that these influence patient trust, compliance, and perceptions of care quality (Shaikh & Hatcher, 2005). These gaps suggest that health-seeking behaviour is not only a matter of service availability, but also of social meaning, identity, and power relations embedded in gender norms.

The persistent late presentation of PCa in Tanzania is a big concern with up to 80% of cases diagnosed at advanced stages, leaving palliative care as the main option (Makene et al., 2022). Advanced-stage diagnosis reduces survival chances (Bugoye et al., 2019; Gunda et al., 2018; Lyimo et al., 2020) and profoundly impacts quality of life, often leading to pain, functional decline, and psychological distress (Hanna et al., 2020). Screening uptake remains critically low between 0% and 15% across Africa (Bugoye et al., 2019; Makungu & Mweya, 2023) and incidental diagnosis of advanced PCa among men treated for unrelated urinary complaints underscores the underutilization of available services (Bugoye et al., 2019).

To address these knowledge gaps, this study applies Kleinman et al.'s (1978) explanatory model of illness to explore how men interpret and respond to symptoms, and Courtenay's (2000) theory of gender and health to examine how masculinity ideologies shape health-seeking behaviours. This study explores socioeconomic and cultural determinants for delayed prostate cancer detection in Sengerema District, Tanzania. It specifically, examines how cultural beliefs and gender socialization influence men's interpretations of prostate cancer symptoms; analyses the role of socioeconomic status in shaping access to and utilization of screening services; and assesses how interactions with healthcare providers affect decisions about seeking timely medical care.

The central research questions guiding the study are: How do socioeconomic and cultural factors influence health-seeking behaviours for prostate cancer among men in Sengerema? In what ways do gender norms shape these behaviours? And how do interactions between patients and healthcare providers affect

the timing of prostate cancer detection? By situating these questions within a dual theoretical framework, this study provides an integrated perspective that can inform culturally responsive, gender-sensitive public health strategies aimed at promoting early detection and improving prostate cancer outcomes in Tanzania.

2.0 METHODS

2.1 Research Design

This study adopted a phenomenological design, to explore the lived experiences and perceptions of men undergoing treatment, their spouses, and healthcare providers including both traditional and biomedical practitioners, regarding prostate cancer detection and care. A phenomenological design was deemed appropriate because it enables in-depth understanding of how participants interpret their health experiences within their sociocultural contexts, aligning with the study's aim of exploring the intersection of gender, socioeconomic factors, and cultural norms in health-seeking behaviour (Creswell & Poth, 2018). This approach is consistent with Arthur Kleinman's explanatory model (EM) of illness and Courtenay's theory of gender and health guiding the study, both emphasizing subjective interpretations of illness and socially constructed health behaviours.

2.2 Study Setting

This study was conducted in Sengerema District in Mwanza Region of Tanzania. This Region was selected due to its high incidence of advanced and aggressive prostate cancer cases, which frequently lead to prostate cancer–related deaths (Gunda et al., 2018; Katabalo et al., 2022). Additionally, using Mwanza

Cancer Registry data for 2016–2019, the African Cancer Registry Network (2020) reports that prostate cancer ranked first among cancers affecting men in the region. The referral system, together with the study scope and patterns of healthcare access, justifies the selection of Sengerema District and the interviewing of patients at Bugando Medical Centre (BMC), despite the centre being located outside the district.

2.3 Sampling Techniques and Samples Size

The study used purposive and convenient sampling techniques. Purposive sampling technique was employed to ensure the inclusion of participants with relevant, diverse, and information-rich experiences of the PCa care. This included men diagnosed with prostate cancer and receiving treatment at Bugando Medical Center, their spouses, and healthcare practitioners (Biomedical practitioners and Traditional healers (TH). Convenience sampling was used within the purposive framework to reach participants during times and locations that were logistically feasible, such as consultation hours at Bugando Medical Center for patients and doctors, and home settings for spouses. The total sample comprised 25 participants as determined by data saturation.

2.4 Data Collection and Analysis

Data were collected between March and May 2023 through in-depth interviews (IDIs) and non-participant field observations. IDIs served as the primary method, allowing participants to share detailed narratives of their journey to prostate cancer detection and care. Conducted in Kiswahili to ensure comfort and fluency, interviews were audio-recorded, transcribed verbatim, and later translated into English and

guided by the study's theoretical frameworks to capture cultural beliefs, gender norms, and structural barriers to early detection. Field observations at Bugando Medical Center's cancer unit documented care procedures, waiting times, patient flow, and patient–provider interactions, offering contextual insights that complemented interview data. Data were thematically analysed using Braun and Clarke's (2006) six-phase framework, supported by NVivo 12 software for data organisation. Themes were developed inductively, reviewed, refined, and interpreted through Kleinman's explanatory model and Courtenay's theory to explore the interplay of illness perceptions, masculinity norms, and socioeconomic realities in shaping health-seeking behaviour.

3.0 RESULTS AND DISCUSSIONS

Table1: ***Demographic characteristics of the Participants(N=25)***

Participants' Characteristics	Male	Female	Total
Age			Mean 56 years (range 39-80)
Marital Status			
Married	16	9	25(100%)
Single	0	0	0(0%)
Widowed	0	0	0(0%)
Number of Children			Mean 4(range 1 - 8)
Educational level			
University degree	2	0	2(8%)
High school	0	0	0(0%)
Secondary school	6	0	6(24%)
Primary education	6	5	11(44%)
Informal education	2	4	6(24%)
Occupation			
Farmer/peasantry	7	3	10(40%)
Fishing	4	0	4(16%)

Home maker	0	6	6(24%)
Primary school teacher	1	0	1(4%)
Medical practitioner (modern and traditional)	4	0	4(16%)
Time from symptom onset to PC detection (delay indicator)			Mean 12 months (range 6 – 24)

Source: Research findings 2023.

The demographic profile of the study participants was a good predictor of knowledge and awareness about prostate cancer. The study discovered low levels of knowledge and awareness about prostate cancer, attributed to illiteracy, old age, lower income levels, and being self-employed. This contributed to poor intentions to adopting screening habits as patients believed were not at risk, had financial constraints, and had no symptoms. These findings are in line with the reviewed literature, which associate high levels of awareness with a relatively younger age, higher income, being a government employee, having poor health, and being well educated (James et al., 2017; Maladze et al., 2023). These factors were also positively linked to higher intention of utilising modern healthcare services (Assefa et al., 2022; Bugoye et al., 2019).

It is argued that a number of sociodemographic factors can influence patients' pathways to healthcare including age, education, past information (Engeda et al., 2016; Sun et al., 2013). According to Engeda et al. (2016), persons with higher educational levels have better understandings of how diseases work, are more likely to have access to diagnosis and treatment choices, and are less likely to put off seeking medical attention. Contrary, a study by Islam and Begum (2020) discovered that there was no significant correlation between the importance of selecting health care and other criteria like education, even

though some researchers used different techniques and had different results.

The study further found that the main sources of health information were friends/family and news from radios and television. This was contrary to past studies that revealed internet and healthcare providers as main and trusted source of health information (Adeloye et al., 2016; Alduraywish et al., 2020; Morlando et al., 2017). For example, doctors were completely trusted for medical information by more than half of the population in a study conducted in Saudi Arabia (Alduraywish et al., 2020). The observed difference may be attributed to contextual and demographic factors including limited internet access, high data costs, and low digital literacy, particularly in rural and peri-urban Tanzania, which constrain reliance on online sources. In such settings, culturally embedded trust in friends, family, and widely accessible media channels like radio and television often outweighs dependence on healthcare providers or internet-based platforms. Still, it has been argued that clinical outcomes are fundamentally influenced by the doctor-patient connection, which helps to both promote positive outcomes and prevent negative ones. This finding is in line with the explanatory model which asserts that a consensual relationship in which the patient knowingly seeks the physician's assistance and in which the physician knowingly accepts the person as a patient, entails the doctor-patient relationship (Kleinman, 1980).

Additionally, evaluating the doctor's willingness to involve the patient in decision-making, provide informational programme, and enquire about the patient's explanatory model of illness, was another way of measuring the quality of communication

between a doctor and patient. Unfortunately, patients in the current study reported to have lacked enough time to enquire information from their doctors. Even doctors themselves reported to have been attending to too many patients in a single day, which provided limited consultation time. The following quotes depict such experiences:

> *"……. It is not possible to ask for your illness clarification because they are busy attending to the patients, if you ask them questions, he will tell you that he has patients waiting for him outside, so I should focus on the treatment he is prescribing, and wait to get better. Truthfully, I don't know much about this illness"* ***(IDI, 68 years, Patient, Busisi, 05/04/2023)***

An oncologist added

> *"……. we attend too many patients, and many of them are late, on average we attend between 40 and 50 patients everyday"* ***(IDI, 48 years, Oncologist-BMC, 07/04/2023)***

These narratives reveal that limited consultation time, driven by high patient loads and staff shortages, restricts opportunities for patients to discuss their illness, clarify treatment, or share their own explanatory models of disease. From Kleinman's perspective, lack of dialogue prevents physicians from understanding patients' culturally rooted illness interpretations, potentially weakening adherence and trust (Kleinman et al., 1978). Courtenay's theory further suggests that men, already inclined to minimise help-seeking and health discussions due to prevailing masculinity norms, may be disproportionately affected when clinical encounters do not actively invite their participation. The convergence of overburdened oncology

services, systemic underfunding, and drug procurement challenges (Musoke et al., 2014) not only constrains the quality of patient–provider communication but also reinforces structural and gender-related barriers to timely and effective cancer care.

Beliefs in witchcraft

Belief in witchcraft strongly influenced participants' understanding of illness and treatment choices, leading many to attribute prostate cancer to curses or evil spirits and seek help first from *Mfumu* (traditional healers) rather than biomedical facilities, which contributed to delayed diagnosis and treatment. One participant mentioned;

> *"……. such illnesses are not for the hospital, they can only be treated here, the disease will not be visible to the doctors at the hospital, when you have been bewitched* ***(IDI, 71 years, TH, Busisi, 07/05/2023)"***

Through the lens of Kleinman's explanatory model, such beliefs shape patients' aetiological interpretations, leading them to perceive cancer as the result of curses or evil spirits, thus prioritising traditional and spiritual healing over biomedical care. Consistent with findings from other African contexts, including Nigeria, where a wide range of illnesses are attributed to witchcraft (Agbanusi, 2016), participants in this study often sought care from *Mfumu* (traditional healers) before visiting hospitals. Courtenay (2000) theory further suggests that gender norms may reinforce this pathway, as men's preference for culturally familiar, non-intrusive care can align with masculinity ideals that resist early biomedical engagement. However, patients later expressed regret for the delays caused by reliance on traditional healers, citing wasted time and money on

ineffective treatments. This pattern underscores how culturally embedded explanatory models, when combined with structural barriers, can perpetuate late-stage presentation and poor cancer outcomes. Culturally embedded explanatory models are further depicted in the following story;

> *"……. I am a proud African man who, like many of our ancestors, placed great trust in our traditional healing practices. I made the difficult decision to consult a traditional healer instead of a medical practitioner. With hope in my heart and faith in the power of natural remedies, I embarked on a journey that would ultimately lead to an unfortunate late diagnosis at the hospital* ***(IDI, 70 years, patient, Ibisabageni, 05/05/2023).***

The quotation illustrates the deep trust placed in traditional healing practices, reflecting how culturally embedded beliefs continue to shape health-seeking behaviour. From the perspective of Kleinman's explanatory model, patients interpret illness through culturally grounded frameworks, intertwining of traditional religion and healing practices, leading them to prioritise traditional remedies over biomedical care. Courtenay's theory of gender and men's health further advocates that masculinity norms which valorise self-reliance and adherence to cultural identity, may reinforce men's preference for familiar, socially sanctioned treatments. This dual influence of culture and gender contributes directly to delayed prostate cancer detection, as men may postpone biomedical consultation until symptoms become severe, resulting in late-stage diagnosis and reduced treatment efficacy. Historical continuity of traditional healing practices, even after colonial and Western influences (Mokgobi, 2014), explains the persistence of these behaviours,

highlighting the need for culturally sensitive interventions that integrate men's explanatory models into early detection strategies. Another participant added;

> *"…… the traditional healer, with his vast knowledge of herbs and ancient healing techniques, assured me that his remedies would cure my cancer. But also, I sought medical help at a hospital, where I was met with "grave news"* ***(IDI, 68 years, patient, Busisi, 05/04/2023).***

The quotation illustrates the dual reliance on traditional and biomedical therapies, where the patient initially trusted the traditional healer's remedies but ultimately received *"grave news"* at the hospital, reflecting late-stage metastasis. Kleinman's explanatory model helps explain this pattern, as patients' culturally rooted illness interpretations, here influenced by beliefs in witchcraft and supernatural causation, guide initial treatment choices, delaying engagement with biomedical care (Mirambo, 2004). Courtenay's theory further suggests that masculinity norms may reinforce men's adherence to culturally sanctioned treatments, including traditional medicine, which is intertwined with identity and social values (Mirambo, 2004). The concurrent use of medicinal plants and modern medicine documented elsewhere in Africa (El-Seedi et al., 2013; Kabbaj et al., 2012) illustrates how these practices, while culturally meaningful, can contribute to delayed diagnosis and limit the effectiveness of curative therapies. The unreliability of traditional medicine was discovered in this study; -

> *"…… By relying solely on traditional remedies, I had inadvertently delayed my diagnosis, allowing the*

> *cancer to progress unchecked. Traditional healing can play a valuable role in maintaining overall well-being, but when it comes to life-threatening diseases, we must not ignore the advancements of modern medicine* ***(IDI, 60 years, patient, Busisi, 14/05/2023).***

This narrative highlight how reliance on traditional remedies contributed to delayed diagnosis, allowing the cancer to progress unchecked. Although prostate cancer often progresses slowly and early symptoms may be mild (Bugoye et al., 2019), extended use of herbal and traditional therapies can make disease advancement to stages where symptoms become severe and harder to manage. From Kleinman's explanatory model, patients' cultural beliefs, illness attributions, and expressions of suffering shape how symptoms are perceived and reported in clinical contexts, influencing the timing of biomedical consultation (Kleinman et al., 1978). Coupled with masculinity norms outlined in Courtenay's theory, which may discourage men from seeking formal care early, the culturally embedded behaviours contribute directly to late-stage presentation and reduce opportunities for effective treatment.

Perceptions of fatalism

Belief in fatalism, viewing health outcomes as predetermined by fate or a higher power, deterred some patients from seeking cancer care. Fear of confirming a cancer diagnosis led them to avoid hospitals, as they preferred to evade anxiety and worry. Aligned with beliefs in witchcraft, these patients perceived their health as beyond personal control, determined by fate or divine forces. One participant had this to say:

> *"……. Every time I thought about coming to the hospital, I remembered how people used to say back in the village. They used to say that everyone who went to the hospital with cancer never returned alive and that they had seen people going to Bugando who never returned alive and so, it was better for me to see a traditional healer, that way you will prolong your life* ***(IDI, 65 years, patient, Busisi, 13/03/2023).***

The extract illustrates how mistrust in the biomedical system, reinforced by communal narratives, can shape men's health-seeking behaviours. According to Kleinman's explanatory model, patients interpret illness and treatment outcomes through culturally informed frameworks, including familial experiences and communal beliefs, which influence the perceived efficacy and risks of biomedical care. Courtenay's theory of gender and men's health further suggests that masculinity norms, emphasizing self-reliance, endurance, and adherence to socially sanctioned behaviours, may reinforce avoidance of hospital care in favour of traditional healing.

Fatalistic beliefs, wherein health outcomes are seen as predetermined or beyond individual control, compounded by myths about invasive tests and treatment, contributed to delayed engagement with biomedical pathways (Wachira et al., 2018). Unlike findings from the U.S., where some fatalistic beliefs were associated with higher screening uptake (Benedict et al., 2022), in this study, high fatalistic views correlated with low prostate cancer screening and late-stage presentation, highlighting the critical role of cultural and gendered frameworks in delaying timely diagnosis. The medical doctor

however, had an opinion on what could possibly make patients fear;

> *"……. unfortunately, enough, here at the hospital treatments can take up to two years or more, but for them (traditional healers), they will tell you to take their medicine for three months and completely get cured. Nobody like to take drugs for that long at the hospital, thus, when a patient hears of this option, their hopes would be renewed and they will be more likely to opt for it instead of coming to the hospital* ***(IDI, 48 years, Oncologist, BMC, 07/04/2023).***

The oncologist's observation highlights how the perceived complexity and duration of hospital-based treatment can drive patients toward traditional healers, who promise quicker, simpler remedies. Kleinman's explanatory model explains this preference as rooted in culturally informed understandings of illness, treatment expectations, and acceptable timelines for healing. Courtenay's theory further suggests that masculinity norms, emphasizing self-reliance and avoidance of prolonged medical intervention, may reinforce these choices. Similar findings from rural Kenya show that fatalistic or pessimistic beliefs about prostate cancer, including the perception that no effective treatment exists, can influence care-seeking behaviours (Mutua et al., 2017; Wachira et al., 2018). Compensatory control mechanisms, expressed through ritualistic, religious, and superstitious practices, provide patients with a sense of agency in confronting illness (Kay et al., 2009; Willard et al., 2024). Collectively, these factors contribute to delayed hospital presentation and late-stage prostate cancer detection, as men

may prioritise culturally and psychologically comforting alternatives over biomedical care.

Prioritising gender roles

Traditional gender norms positioned men as strong, authoritative providers responsible for their families' economic welfare and decision-making, while women were expected to offer emotional support and uphold domestic roles. In this study, some men delayed medical consultations due to limited finances, prioritising family needs over hospital expenses, reflecting the pressures of maintaining their role as sole breadwinners. Women, in turn, were expected not to challenge these decisions, reinforcing gender dynamics that contributed to postponed healthcare-seeking. One patient said;

> *"……. can you go to the hospital to get treated while your family is going to bed with empty stomachs? What will they think of you ……. you as a head of the family?* ***(IDI, 68 years, patient, Busisi, 05/04/2023).***

The quotation highlights how traditional gender norms and economic constraints interact to delay men's engagement with prostate cancer care. Kleinman's explanatory model helps to explain that men interpret illness and treatment decisions not only through biomedical frameworks but also within culturally embedded social expectations. Courtenay's theory of gender and men's health further indicate that masculinity norms emphasising the male role as provider and protector, may lead men to prioritise family welfare over personal health. Economic limitations, including low income and travel costs to medical facilities, reinforce these patterns, making hospital visits financially and socially challenging. As a result, men may delay

screening and treatment, contributing to late-stage prostate cancer detection. Social sanctions or stigma for failing to conform to gendered expectations (Gonalons-Pons & Gangl, 2021) may further discourage timely healthcare-seeking, highlighting how intertwined economic, cultural, and gendered factors shape health behaviours in this context. Additional costs associated with taking time off work for cancer treatment or screening also posed a significant financial burden especially when individuals were the primary breadwinners for their families.

> *" ……. we were complaining about the costs of the drugs…. And one nurse said that the cost was reasonable, and we should be thankful that we even get radiation therapy for free. Because one session is a hundred thousand ..... and we have to get it every day for a couple of months. Those with health insurance are usually charged a half of the amount, but for us (without health insurance) it is entirely free* ***(IDI, 58 years, patient, Ibisabageni, 16/04/2023).***

The above quotation demonstrates the steps taken by the government to make treatments accessible by cutting down the costs, and making radiotherapy free of charge. Patients expressed how impossible it could have been if they had to pay for it every time they needed it. Data gathered from different patients revealed that radiation therapy previously costed one hundred thousand shillings (100,000) for a single session and one had to have multiple sessions a week for a couple of months.

Lack of health insurance emerged as a major economic barrier to early detection. From a health equity perspective, this reflects structural determinants of health, where the absence of financial risk protection disproportionately affects low-income men (Asfaw et al., 2018). Courtenay theory of gender and men's health suggests that even when men are aware of screening benefits, financial barriers intersect with masculine ideals of self-reliance, limiting timely health-seeking. In rural areas, shortage of oncology specialists compounds the delay, with limited referral capacity from primary hospitals. Consistent with the Foundation for Cancer Care in Tanzania (2015), patients with private or public insurance reached diagnosis and treatment faster than uninsured patients. The findings imply that without policy interventions to expand insurance coverage and rural oncology capacity, men will continue to present with advanced disease, reducing survival chances and increasing preventable prostate cancer mortality. One participant had this to say

> *"……. without health insurance, many men in Tanzania simply cannot afford to undergo regular prostate cancer screening, because they have to pay for it. In a long run, this means that will not be able to catch the disease early, when it is most treatable. As a result, many men in Tanzania are dying from prostate cancer unnecessarily. Even men who are aware of the importance of screening may not be able to access services due to high out-of-pocket costs. In Tanzania, the cost of a prostate cancer screening can be up to 10% of a regular person's monthly income, making it prohibitive for many men. In addition, there is a severe shortage of healthcare providers in Tanzania, particularly in rural areas, making it difficult for men to access screening services*

> *even if they can afford them."* ***(IDI, 55 years, Oncologist, BMC, 06/04/2023).***

Affirming masculinities

Likewise, patients reported to have come from cultural background that did not allow talking about men health issues publicly, especially those related to reproductive health, as it was considered a taboo. Neither were they comfortable to discuss their health status with family members as it was traditionally unacceptable. Since there is no uniform set of expectation for masculinity (Connor et al., 2021), this was the prevailing code within such a society that put pressure on and generated expectations around men, with implications for women, children, and society as a whole. One patient had the following to say;

> *"…….. It is forbidden for a man of the house to discuss his problems with family members, such personal issues are to be kept a secret, the family will think that their father is weak, eeh! men are not supposed to be weak and that is how I even train my boy children. If they have issue in their personal life, they have to deal with it without telling anyone. We do not want anyone despising us considering us weak or vulnerable* ***(IDI, 72 years, patient, Ibisabageni, 05/05/2023).***

Further, it can be argued in light of the theory of gender and health (Courtenay, 2000) that, health-related beliefs and behaviours including fears, serve as markers of femininity and masculinity. In this regard, the only thing that was discovered to push men to open up was the severity of symptoms and how it

affected their social and personal life, as indicated by words of one participant; -

> *"……when symptoms returned, I felt like dying so, I told my wife and she suggested I see a medical doctor. I wish I told her earlier because my symptoms are improving every day since I started treatment at Bugando."* ***(IDI, 65 years, patient, Ibisabageni, 13/03/2023).***

The reluctance to disclose symptoms was aligning with Courtenay (2000) theory of gender and men's health, which posits that masculine norms often discourage men from acknowledging vulnerability, leading to delayed care-seeking. In this study, stigma surrounding male-specific illnesses such as prostate cancer, compounded by the expectation to endure pain silently, contributed to concealment of symptoms. The health belief model further explains that low perceived susceptibility, amplified by poor awareness, reduces the likelihood of early screening (Bugoye et al., 2019). As a result, participants often failed to recognise warning signs or act promptly, increasing the likelihood of late-stage presentation. These findings imply that dismantling societal stigma and promoting open discourse about men's health could improve early detection rates, reduce the need for aggressive interventions such as surgery, and ultimately lower prostate cancer mortality. One medical practitioner had an opinion on such male's sternness to open up;

> *"…….. we Africans, we never cry, especially men ……. we rarely cry in public. That is also a problem to us, in short, we cannot accept or admit weakness, though unknowingly, it delays to get services which can be beneficial to us. But also, if the father is the breadweaner*

> *at home, cancer treatments bring impacts on the family's economy, so many will choose to stay home because their families depend on them, though in this process the disease is advancing."* ***(IDI, 48 years, Oncologist, BMC, 07/04/2023)***

Studies in gender-role socialisation share these assertions, depicting men who adhere to the traditional male gender role may have unfavourable attitudes toward seeking help (Hoyt et al., 2013; Wahto & Swift, 2016). Given that the person seeking support is dependent on the one providing it, asking for help implies and, in certain cases, even necessitates a feeling of vulnerability (Lee & Owens, 2002). In this regard, asking for aid is contrary to the masculine gender role, and as a result, seeking healthcare may be avoided due to gender-role conflict. Hoyt et al. (2013) discovered a correlation between certain aspects of masculinity, restrictive gender roles, poorer physical and psychological results in men who have cancer. Various studies on men's and psychological issues comprehends the previous assertions (Kanbarkar & Chandrika, 2017; Sileo & Kershaw, 2020). For example, Kanbarkar and Chandrika (2017) found that men were continuously less likely than women of all ages to seek help for health problems. Furthermore, Sileo and Kershaw (2020) revealed that lower levels of openness to acknowledging health concerns are a contributing factor to gender-specific attitudes, such as males' unfavourable attitudes toward getting treatment.

Prostate cancer as stigmatised disease

Stigma around prostate cancer originated from patients' own feelings of shame and embarrassment, thus, hindering their willingness to seek medical care. It was further indicated that

this self-stigma was reinforced by cultural and societal norms that discouraged men from discussing health issues, thereby limiting their engagement with preventative and treatment services. For example, men felt a pressure to be stoic and not show vulnerability, something which made it difficult for them to discuss their health concerns as observed in the following narratives;

> *"……. It was like admitting that I was at risk, was somehow a sign of failure. So, the thought of going in for a screening and having to admit that my health might be in jeopardy – it was just too much to bear. I felt like it would be a sign that I was not living up to the expectations of what a man should be. And it's not just the judgment from others that worried me – it was the way it would make me feel about myself. I'd rather just ignored the possibility altogether than face up to that reality* ***(IDI, 64 years, patient, Busisi, 18/03/2023)****.*

This particular participant described avoiding screening because acknowledging potential illness felt like a personal failure, conflicting with expectations of masculinity. This reflects internalized stigma (Goffman, 1963), where self-perceptions, rather than overt discrimination, deter help-seeking. Such stigma heightens stress, limits coping capacity, and worsens psychosocial distress, contributing to delays in detection. Cancer-related stigma, experienced by 13–80% of individuals, is often tied to associations with death, altered body image, social isolation, guilt, and blame (Buote et al., 2020). In this study, prostate cancer's physical and emotional side effects, particularly incontinence and erectile dysfunction (ED), emerged as "invisible stigmas" that challenge male identity.

Because ED is concealed from others yet deeply tied to masculinity, it can intensify feelings of humiliation and inhibit disclosure (Larkin et al., 2022). These findings suggest that unaddressed internalized stigma and its masculine identity implications may significantly delay prostate cancer detection and treatment engagement.

Communication barrier

Patients in rural Sengerema faced significant communication barriers with healthcare providers, primarily due to language differences between the local Sukuma language and Swahili. These barriers hindered effective information exchange, leaving patients feeling uninformed, frustrated, and helpless. Communication barriers increased the risk of misunderstandings, misinterpretation of diagnoses, and difficulties in explaining medication use or side effects, ultimately impeding timely diagnosis and treatment of prostate cancer.

> *"……. but many of the healthcare workers only speak Swahili, which made it difficult for me to explain my symptoms and understand their recommendations, I can understand Swahili but I am not that fluent* ***(IDI, 70 years, patient, Ibisabageni, 05/05/2023).***

Another patient added; -

> *"……. I had to bring someone with me to the hospital to translate. This situation created a sense of fear and frustration when seeking medical attention because I was not sure if I was understood or if I was understanding the healthcare provider's instructions correctly"* ***(IDI, 72 years, patient, Bisisi, 04/04/2023).***

As illustrated by the patient account, language mismatches created feelings of fear, frustration, and uncertainty, hence, necessitating reliance on interpreters. These barriers led to misunderstandings, poor treatment adherence, avoidable medical errors, prolonged hospital stays, weakened therapeutic relationships, and reduced satisfaction with care. Similar findings have been reported elsewhere, linking communication difficulties to lower quality of care, diminished patient safety, and preference for traditional healers who share the patient's language (Al Shamsi et al., 2020; Matovelo et al., 2021; Olani et al., 2023). Language barriers in prostate cancer care proved to disrupts the negotiation of a shared understanding of illness between men and healthcare providers, as explained by Kleinman's Explanatory Model. This misalignment fosters uncertainty, erodes trust, and drives some men to seek traditional healers who communicate in their language and validate culturally grounded illness beliefs. The Theory of Gender and Men's Health shows how masculine norms could compound this problem, men may avoid seeking clarification, disengage from care, or shun interpreters to protect their sense of control and avoid perceived vulnerability. These barriers not only reduce treatment adherence and satisfaction but also contribute to delayed prostate cancer detection by discouraging early biomedical screening and limiting accurate symptom disclosure.

4.0 CONCLUSION

This study highlights that prostate cancer detection and care in Sengerema, Tanzania, are shaped by interplay of sociodemographic factors, culturally embedded beliefs, gender norms, and systemic health constraints. Low awareness and knowledge, reinforced by illiteracy, older age, and low income, limited screening uptake, while beliefs in witchcraft, fatalism, and traditional healing guided initial health-seeking decisions. Masculinity norms emphasizing self-reliance and economic provision, combined with stigma around male reproductive health, further delayed engagement with biomedical care. Structural barriers, including high patient loads, limited consultation time, language mismatches, and financial constraints, compounded these delays, resulting in late-stage diagnosis and poorer outcomes. These findings underscore the importance of integrating culturally sensitive approaches and gender-aware strategies in prostate cancer prevention and care.

5.0 RECOMMENDATIONS

To improve early detection and treatment, culturally tailored health education campaigns should be implemented using local languages and trusted community channels, while fostering collaboration with traditional healers to encourage timely referrals. Gender-responsive interventions that challenge harmful masculinity norms and reduce stigma are essential, alongside strengthened patient–provider communication through multilingual staff and culturally competent dialogue. Expanding health insurance coverage, mobile screening units, and oncology staffing can address financial and structural barriers, thus, ensuring equitable access. Collectively, these strategies can

bridge cultural, gendered, and systemic gaps, promoting timely prostate cancer care and improved outcomes for men in rural Tanzania.

Ethical Considerations and Consent

Ethical approval for this study was obtained from the Catholic University of Health and Allied Sciences (CUHAS) with certificate No. AB3/12(B). Permission to conduct the study at BMC and in the selected wards was secured from the relevant local authorities. Written informed consent was obtained from all participants prior to participation. To ensure confidentiality, all identifying details were removed from transcripts.

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Disclosure statement

The author reports no potential conflict of interest.

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