

Health Is Power, and Health Is Wealth: Understanding the Motivators and Barriers of African American/Black Male Immigrants With Gastrointestinal Conditions

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Abstract

The digestive health of African American/Black male immigrants in the United States has not been previously studied. Much of what is known about gastrointestinal (GI) concerns in this population is based on studies conducted on the overall Black American population. The purpose of this narrative study was to understand how African American/Black male immigrants with GI concerns navigated their GI condition. Fifteen African American/Black male immigrants from various cities in the United States participated in two remote focus groups to discover what motivates them to take control of their illness. Narrative analysis was used to analyze the qualitative data. Most men, 47% ($n = 7$), did not have health insurance, and 67% ($n = 10$) reported their income was less than US\$52,000. The themes identified were: (1) lack of knowledge of GI, (2) denial of initial diagnosis, (3) self-discipline, (4) positive provider interactions, (5) health as a priority, and (6) advice to other African American/Black male immigrants experiencing GI. A strengths-based approach is necessary for describing the health-seeking behaviors among African American/Black male immigrants.

Keywords

African American/Black male immigrants, gastrointestinal concerns, strengths approach, health-seeking behaviors

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Introduction

Digestive conditions are defined as any health problem in the gastrointestinal tract. The conditions can be very serious or mild, but some common symptoms include constipation, vomiting, bloating, and heartburn. In the United States, digestive diseases affect 60 to 70 million Americans yearly (Digestive Diseases Statistics for the United States, 2022). These conditions are a significant source of morbidity, mortality, and hospitalization admissions in the United States (Almario et al., 2018). Data from 2004 revealed that digestive conditions resulted in 4.6 million hospitalizations, 72 million ambulatory care visits, and 236,000 deaths (Peery et al., 2012). In 2009, 245,921 deaths were attributable to underlying digestive causes. In 2010, hospitalizations due to digestive conditions were 21.7 million, a substantial increase from 2004 (Digestive

Diseases Statistics for the United States, 2022). Digestive conditions present clear challenges to adults and are a significant source of burden. This burden becomes even more noticeable when looking at race and ethnicity.

The prevalence rate of irritable bowel syndrome (IBS) among Americans is 3% to 20% (Wigington et al., 2005). The symptoms associated with IBS, including cramping, pain, and bloating, are troublesome because they are linked to adverse quality of life, work productivity, and activity effects (Trindade et al., 2022). Peptic ulcer disease

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(PUD) is another common digestive condition with an incidence rate of 500,000 cases annually and a prevalence rate of 10% to 12% (Baghianimoghadam et al., 2011). A long-life risk is associated with PUD, in which about 5% to 10% of people suffer from this condition. This is especially relevant considering the many health complications associated with PUD, such as bleeding, perforation, and gastric obstructions, do not have excellent outcomes (Narayanan, 2018).

Examining digestive conditions by race and ethnicity reveals interesting trends. The impact of race and ethnicity on digestive disorders focuses on specific diseases such as IBS, gastric cancer, and helicobacter pylori infection. Other digestive conditions are poorly studied (Parkman et al., 2019). Historically, studies have reported that White populations were more likely to experience IBS than other racial and ethnic groups, such as African American/Black populations (Ahmed et al., 2021; Sandler, 1990; Wigington et al., 2005). However, empirical studies from 2016 to 2022 reveal that IBS is increasing among African American/Black populations (Afzali & Cross, 2016; Ahmed et al., 2021; Aniwani et al., 2019; Anyane-Yeboah et al., 2022). Another study indicated that African Americans and Black Americans have the highest rates for several cancers, including gastric and small bowel cancers (Ashktorab et al., 2017). Research is shifting, and trends show increased digestive conditions in African American/Black populations. One study examined digestive cancers across race and sex and presented troubling findings among African American and Black men. For example, the incidence rate of stomach (gastric) cancer in African American and Black men was 13.6 per 100,000, which was 1.5 higher than in non-Hispanic white men (8.2 per 100,000) (Ashktorab et al., 2017). Mortality due to stomach cancer showed similar trends; African Americans and Black Americans' mortality rates were 2.5 times higher than non-Hispanic white men (Ashktorab et al., 2017). This is concerning because stomach cancer is the world's fourth most common malignancy. It also highlights an even greater need to study the digestive health of Black male immigrants since much of the information on their health largely depends on the general population of African American and Black men.

This article will refer to Black male immigrants as African American/Black male immigrants. This describes the population's origin and also their current racial identity. The health of African American/Black male immigrants in the United States is understudied (Omenka et al., 2020; Vinneau-Palarino, 2021). We know little about the health care experiences among African American/Black male immigrants, particularly as it impacts their digestive health. Much that is known is based on studies conducted

on the overall African American populations in the United States, which lumps Africans, Caribbeans, and Black Americans together (Omenka et al., 2020). This dismisses cultural nuisances (Adekeye et al., 2018) and does not consider that African American/Black male immigrants may have different health beliefs, actions, and outcomes (Omenka et al., 2020).

Considering the burden of digestive conditions on the United States adult population, it is necessary to understand the experience of digestive disorders in African American/Black male immigrants. In understanding their digestive health conditions, there is an opportunity to view their experience through a strengthened lens. Using the strengths perspective can introduce new knowledge and solutions to this field of research while also empowering this community to share their background and experiences dealing with their digestive conditions. This is important, primarily since, to our knowledge, no research exists on this specific population, and research on similar ethnic groups is limited.

The purpose of this study is (a) to understand the unique experiences of African American/Black male immigrants with digestive conditions, (b) to describe the promoters that contributed to their health, and (c) to explore potential digestive health recommendations for other Black men.

Strength Perspective Approach. The majority of African American/Black men's research focuses on the disparities and health problems impacting this population. A deficiency model highlights issues and failures and focuses on the gaps in our knowledge of the intended target population (Mollard et al., 2020). This study will focus on the strengths of African American/Black male immigrants and the promoters of their digestive issues and health. Typically, the strengths perspective is used in social work and other social science fields (Joseph et al., 2022). However, this study will apply this model to public health. A strengths perspective can help African American/Black male immigrants identify the assets currently available to promote better health outcomes. The model also allows for a deeper understanding of African American/Black male immigrants with digestive conditions as a population. This provides a starting place to build on the resources and tools they possess to cultivate long-lasting health changes for their overall well-being. Looking at this population holistically is a unique opportunity to impact the literature by highlighting the facilitators, motivators, and solutions to address barriers to health facing this population.

The strength perspective focuses on the skills, attributes, and values of individuals and communities instead of fixating on the problems associated with their current issues (Joseph et al., 2022). The primary assumption is

that individuals, groups, and so on, have self-discipline that can be used for positive changes and problem-solving (Joseph et al., 2022). This theory does not ignore the struggles or problems at hand but instead uses them as opportunities to find solutions to change the circumstances (Joseph et al., 2022). Focusing on their strengths empowers the individual to understand their internal assets for health promotion. This allows individuals to take concrete action to better their health and circumstances. In addition, this perspective moves away from the deficit model and toward strengths to improve health outcomes.

Methods

This narrative study describes the men's unique behaviors, influences, and the retelling of their digestive conditions (Moen, 2006). For this study, the narratives highlight the experiences of African American/Black male immigrants with digestive issues. Having this experience told from their perspective means the individual's thoughts, feelings, and reactions are gathered at that moment. This reveals what is happening around and within them and how they interpret their GI condition. The main objective was to discover what encourages and motivates African American/Black male immigrants to take control of their illness by sharing their experiences with digestive health. A Rutgers University Institutional Review Board approved this study.

Sampling and Recruitment Techniques

The sampling method used for this study is purposive sampling. Flyers and advertisements of the study were posted to different GI Facebook groups and African American/Black men-only Facebook groups, were also distributed to colleagues, and posted in the area hospitals. The inclusion criteria were: African American/Black male immigrants, 30 to 55, experienced digestive issues (IBS, ulcer, etc.), and lives in the United States. Eighteen African American/Black male immigrants contacted the researcher via social media and email to participate in the study. Two men were excluded from the study because they did not live in the United States, and one individual did not respond to follow-up emails. Fifteen African American/Black male immigrants enrolled in the study and participated in the focus group meetings. All participants in the focus group meetings verified that they had seen the flyer on Facebook.

Data Collection

Per the flyer's instructions, each participant emailed the facilitator about their interest in the study. Participants were given an initial date and time to review the

eligibility process in the response. Once the date and time were confirmed via email, participants were sent a Health Insurance Portability and Accountability Act (HIPPA)-compliant Zoom link. Every participant was provided with the informed consent documents before the meeting. One reminder was sent to each participant. Participants were selected sequentially, meaning those who emailed first received an eligibility meeting until the desired number of participants was reached.

During the eligibility meeting, the participants' age, race, and digestive condition status were confirmed to ensure they fit the inclusion criteria. This information was documented in a password-protected Excel file. The consent form was displayed and read verbatim to participants with periodic breaks to ensure they followed along. They were asked to consent verbally; the consent form was marked with their initials and stored in a secure folder. Participants were then emailed a copy of the consent form and asked to confirm they had received it.

Once participants were enrolled in the study, they selected their desired date for the focus group meeting. A follow-up email was sent to participants to confirm their residence in the United States and the focus group date and time. A secure Zoom link was sent to each participant afterward. Reminders were sent every week leading up to the focus group meeting with a personalized greeting, a secure Zoom link, and a request for confirmation that the email was received. Participants were free to email with any questions and concerns during this period.

Demographic data, such as income, health insurance status, marital status, United States residence, and race/ethnicity, was collected from the eligible participants. Participants were emailed the demographic form after completing the focus group session. The chat function on Zoom was utilized and monitored in both focus group meetings to allow for additional conversations. This tool was helpful, and the participants preferred using the chat function. After the demographic forms were filled out and verified, the participants were emailed a US\$25 Amazon electronic gift card. A follow-up email was sent two days after the electronic gift cards were delivered to ensure participants received them.

Focus Group Protocol

This focus group protocol was field-tested and reviewed by the co-facilitator. The interview protocol included an introduction of the primary facilitator, the purpose statement, a description of the study, and informed consent. The informed consent highlighted the confidentiality language, the ability of the participant to withdraw at any time, and the recording procedures.

The focus group questions covered the following topics: (a) Background, focused on understanding their upbringing and experiences as Black men in the United States; (b) Health Problems, which focused on identifying their digestive condition, symptoms, pain, and experience with the condition; (c) Medical Settings, asked questions about their experiences with their medical provider, and their relationships with their provider; (d) Health-seeking Behaviors, focused on seeking care and whether health was a priority (e) Masculinity, focused on perceived manhood and its connections to connects to digestive health; (f) Barriers discussed challenges to obtaining care and influences to seeking care; and (g) Solutions, this section focused on recommendations on dealing with digestive conditions.

First Focus Group Meeting

The first focus group meeting was scheduled for October 15, 2022, and lasted over 90 minutes. Both facilitators met 15 minutes before the initial focus group meeting to discuss the focus group interview protocol and to confirm recording and sound capabilities. Participants were given a 5-minute grace period, and the facilitators reconfirmed their consent to participate. Most of the study participants did not turn on their cameras, which impacted the quality of the focus group discussions. The protocol was modified to increase engagement and participation, requiring participants to turn on their cameras at the second focus group. Study participants were notified of this change. All but one participant agreed to continue. Eventually, this participant decided to rejoin the study.

Second Focus Group Meeting

The second focus group meeting was held on November 12, 2022, and was also 90 minutes long. There was more participation and engagement in focus group two because all cameras were turned on. Having their cameras turned on improved engagement, leading to accountability and increased trust between study participants and facilitators. The Zoom chat was used a lot more during this focus group.

Qualitative Analysis

The focus group audio was transcribed verbatim on NVivo and manually reviewed by the facilitators by simultaneously listening to the recording and editing the transcript. The focus group transcript, Zoom chats, and memos were uploaded to NVivo for qualitative data management and analysis. The protocol and memos that each facilitator wrote about produced an initial list of

first-level codes. The coding process started manually, utilizing line-by-line and open coding. NVivo was used afterward for further coding and analysis. A word frequency query was run on NVivo to determine the salient words that appeared in the transcript. However, this proved to be inefficient in producing more initial codes. Thus, further line-by-line coding was necessary to extract more codes, which were then uploaded to NVivo. Many qualitative researchers find that human coders can detect subtle and contextualized themes that are often of interest in the analysis, even with the advancement of computational techniques that use computers to code via keywords (Beresford et al., 2022). Thus, coding by hand proved to be more efficient.

Chunking is often used on interrelated chunks of text to answer a research question (Roberts et al., 2019). This study used chunking to connect and flush out the related texts and ideas between the two focus group meetings, transcripts, Zoom chats, and memos. This helped to categorize the data, and salient codes started to appear more, creating the second-level codes. The primary codes were adjusted and changed as the transcript, Zoom chats, and memos were reviewed further. After diving deeper into the data, all codes were finalized in NVivo, and a codebook was developed. The codebook had five primary codes with nine secondary-level codes. Table 1 describes the codebook.

Analytical Plan

Narrative analysis was used as the analytical approach for this study. This allowed for a deeper understanding of the data and the participants' experiences. All codes were exported from NVivo with their subsequent quotes. A list of possible themes was created by noting reoccurring categories. The themes identified were: (1) lack of knowledge of GI, (2) denial of initial diagnosis, (3) self-discipline, (4) positive provider interactions, (5) health as a priority, and (6) advice to other African American/Black male immigrants experiencing GI.

A word frequency query was used in NVivo to identify the reoccurring symptoms participants experienced, further supporting a strength approach. Pain was the most frequent symptom that affected participants. Table 2 describes the GI Symptoms.

Findings

Fifteen men participated in the focus group meetings; the first group consisted of seven men and the second group of eight men. The men were between the ages of 30-45, with 33% ($n = 5$) of the participants being 33. They self-identified as African American, even though most participants expressed being born outside the United States and

Table 1. Codebook

First code	Second code	Third code	Fourth code	Inclusion	Exclusion	Examples
GI	Initial onset Health impact	Diagnosis Feelings Symptoms Lack of knowledge	Pain	Experiences with GI, impact on health, symptoms, feelings about GI issue, initial on-set, and pain.	No mention of GI health issues	"I have been suffering from stomach pain which I know it's ulcer."
Recommendations	How to deal with GI issues Encouragement	Dos and Don'ts		Recommendations and suggestions on how other Black men can deal with GI.	No mention of recommendations.	"Keep constant reach to their doctors know, who can actually help them. That is very important."
Background	Being a Black man today			Discussions about the experiences of being a Black man, transitioning from boy to adult	No discussion of the experience of being a Black man.	"Being a Black man in this country its, basically its . . . it's an experience of confliction like I used to say."
Health Behaviors	Lifestyle changes Health prioritization (they take action to manage their condition)	Diet restrictions and changes Taking medications		Any discussion of behaviors that are beneficial to one's health. Any discussion around diet, medication, self-management, and care.	No discussion of behaviors that are beneficial to one's health. No discussion of diet, medication, self-management, and care.	"I would only go to the doctor if I had to. For like physicals and stuff."
Doctors	Patient provider relationships Patient provider interactions	Support		Any discussion of providers being supportive and exceeding expectations. Any discussion of personal relationships with providers and how this impacted their feelings about their health.	No discussion of providers being supported. No discussion of personal relationships with providers.	"Yes, I feel like I'm really close with my doctor. . . so he really supported me and just made me realize that it's not. It's not a new thing."

Note. GI = gastrointestinal.

Table 2. Frequent GI Symptoms Described by Participants

Symptoms	Frequency in codes
Pain	38
Constipation	9
Abdominal Cramps	8
Heart Burns/Acid Burn	6
Belching	5
Bloating	2
Vomiting	2

of a different cultural backgrounds. Approximately 54% of the men were single ($n = 7$), and 47% had no health insurance ($n = 6$). This is interesting, considering the men noted frequent visits and engagement with their physicians. Most participants (67%, $n = 10$) reported their income was less than US\$52,000. Finally, the men were spread across the United States, from California, Washington, Michigan, Massachusetts to New York.

Table 2 describes the participants' symptoms. The two symptoms described the most by participants were pain and constipation. These symptoms affected the participants' daily lives and caused them much grief. One participant described how severe the pain was for him,

It was very tough. It was very tough for me then. It was accompanied by a lot of pain, a lot of pain. [33 years old from California].

Another participant mentioned how constipation had been affecting him for a while,

They said I had a word flatulence; it's accompanied by constipation. . . . And I feel it's affected me to some extent. [32 years old, Washington].

These two symptoms impacted the men's daily lives. The study's findings reveal that the stages of strength begin with noticing pain but not being able to understand the root cause of the pain to identify potential solutions with guidance from their healthcare provider.

The strength stage is a process that begins with the following: (1) a lack of knowledge of GI, where the participants did not know or understand their symptoms. The next stage focused on (2) denial of initial diagnosis, where the participants could not come to terms with their condition. After the pain becomes unbearable, participants decide to take control of their health using (3) self-discipline. In addition, healthcare staff provides the medical intervention necessary to address their condition, leading to (4) positive healthcare provider interactions. This results in actionable steps to managing their GI and having them (5) prioritize health. Finally, after this

experience, participants shared solutions, enabling them to provide (6) advice to other African American/Black male immigrants experiencing GI.

Theme 1: Lack of Knowledge of GI

Lack of knowledge of GI describes the participants' uncertainty with their initial symptoms. This is where the problem began, and without digestive health knowledge, the participants did not know how to seek or ask for help. One participant described the first time getting sick and not understanding the origin of his issue. He describes it as "my first time getting sick was really tough for me. I found it difficult to stand straight due to the abdominal pain, which lasted for hours. I really didn't know what caused it." [30 years old, New York]. This sense of uncertainty led him to deal with the initial symptoms for hours because he did not know what to do next. Another participant, age 30 and from New York, describes a similar experience:

So, the first time I noticed that was it . . . I was 16, and I feel fairly pain in my stomach, and I was . . . I was not comfortable for a long period of time. I was . . . I couldn't even stand up properly.

This experience was common among other participants, who were unsure how to deal with the initial symptoms. Family can reinforce this feeling. For example, a 33-year-old participant from California noted the following:

OK, so we . . . at first I . . . I tend to react whenever I eat certain foods and dairy products like milk and ice cream. So, I think my parents neglected it then. Maybe they just thought, OK, you'll get better.

Lacked knowledge was a consistent theme that the men shared. They did not know what was happening to them and why they were getting sick in the first place. This was the beginning of their story, beginning with having pain. One participant, age 33 years old from California, laid in bed all day in pain until his mom took him to the hospital. He received his diagnosis after visiting the emergency room, but not until after dealing with the symptoms for some time.

Theme 2: Denial of Initial Diagnosis

After their diagnosis comes denial. Denial of initial diagnosis describes how the participants ignored their condition because they did not want to come to terms with it. Acknowledging their situation meant they would have to change and were not ready. One participant, aged 31

years, from California, described being young and wanting to live freely. For example,

. . . when you first started, you know, in my teen years. The pain was excruciating. Like I said, I'm also rebellious, so I didn't care about the pain. I just wanted to live life.

Similarly, another participant, age 35 years from Michigan, discussed being young, continuing to eat unhealthily, and experiencing many consequences,

. . . yes, so when I was young, I consumed a lot of sugar, and a lot of chocolate and my experiences getting . . . has really been bad because I've been suffering from some.

In addition, participants ignored their symptoms and continued with their lives, For instance, the 45 years old from Massachusetts,

Maybe I'll just wake up with pain in my abdomen and but I just shrug it off. Maybe it was something I ate for dinner or something I ate that didn't sit right.

Feelings of denial are normal when change is inevitable, and these men's initial attitudes and actions clearly show they were not ready to acknowledge their conditions. The study participants refused to change their lifestyles. This can be a barrier because symptoms will worsen, as the participants talked about persisting pain, the pain forced them to consider another alternative.

Theme 3: Self-Discipline

Self-discipline was the focal point of change the participants used to modify their eating and dietary habits. Because of extreme pain, the men decided to find another way and take control. While the men had varying approaches to better their health, it was done for the same reason: to live and avoid the feeling of pain. Some participants decided to set boundaries, while others chose to accept it. For example, one participant age 31 from California indicated,

. . . but now that I am an adult, I look at it, I just feel like it's I don't know. I just accept it as fate.

Similarly, another participant, age 33, also from California stated:

I mentioned previously that these the earlier you . . . What's it called? You tend to come to peace with yourself. Okay, this is who I am, this is what is going on. So, I've accepted the condition as part of me.

For these men, accepting their condition was their way to avoid the pain and finally start living life differently. Other participants took a different route and set rules and restrictions for themselves. One participant, age 31 from California, said:

. . . but now I know better and I'm older. So, I really want to live in this life. So, I tend to set rules for myself, and I follow these rules.

While these men took different paths to take control of their health, they all displayed self-discipline. They began to value their lives and well-being, which is an essential next step, and these approaches were encouraged by healthcare providers.

Theme 4: Positive Provider Interactions

Positive provider interactions are the supportive relationships participants established with their doctors. Providers encouraged the men to continue their journey and to take control of their GI. For instance, one participant, age 30, from New York, talked about a conversation with his provider and how it changed his outlook on his condition. He says,

He made me realize there are many people with the same condition, and I shouldn't feel it is strange because I do not know about it or I don't know people with it. He told me that he has a son that has the same thing and that I could go through it, and it was not that difficult. That encouraged me that ok I am not in this alone.

This participant's supportive relationship with his provider encouraged them to stick to the course with his medical treatment and not give up. Another participant, age 45, from Massachusetts, shared a similar experience with his doctor that changed his attitude about his condition. He stated:

I feel like I'm really close with my doctor. He is like a handyman who cares for me and my wife. So, he really supports me and just made me realize that it's not . . . It's not a new thing. It's not . . . It's not the end of the world.

His provider helped him realize that his GI does not need to take over his life. His provider would also check on him and ensure he followed his recommendations. He goes on to say the following:

So, he tries as much as possible to calm me down, calls me, and ensures that I get reports. And ask if I'm making progress, are the medications working, and even when I . . .

when I dial back a little on the medications when I don't really like it . . . He comes back and says to keep using it.

Family doctors were an exciting level of support discovered among the participants. A few participants discussed having a family doctor who treated and supported them for 20+ years. For example, one participant, age 31, from California, discussed how his family doctor had seen him through the different stages of his condition. His doctor has supported him in his journey. He states:

My experience with the doctor has always been good. So, this one is my doctor cause, a, it's like family friend. So, I've known this doctor since When I was a kid. It was probably my mom's friend, and we have taken him as the family doctor. So, he was the one responsible for taking care of me since my teenage years, giving me in treatment and giving me advices and tips on how to avoid the pains over the years. And I still go to him to now.

Provider relationships were the reinforcement participants needed to keep going. Participants could lean on their doctors and develop a bond that encourages them to change their eating habits, revealing a vital bedside manner between provider and patient.

Theme 5: Prioritize Health

“Do's and Don'ts,” Through all the adverse experiences, participants were able to find comfort and strength in being able to control their GI condition and lessen the pain. Prioritizing health is the next actionable strategy participants took to maintain their health. This includes making intentional decisions about their lifestyle, eating habits, physical habits, and so on, to manage their GI condition and reduce the pain. As one participant noted, “Health is wealth.” Another participant, age 45 from Massachusetts, changed his entire lifestyle, including limiting traveling to manage GI:

Actually, really compromised my meals and diet again, just to accommodate this changing mood . . . From my diet options to my day-to-day lifestyle. Most days I don't like to travel because of this thing, because it could eat you anytime, and anywhere. So, I don't like to travel.

Another participant, age 35 from Michigan, makes sure he keeps his appointments with his physician:

I feel working on my health has been my top priority. So that is why I tend not to miss appointments with my doctor, usually when I'm having or experiencing some challenges.

Finally, another participant, age 34, from New Jersey, discussed taking a break from work to focus on his health

and manage it. He said, “*In a few months, I even had to take some breaks of work. Just try to relax and focus on myself and my health and my mental and on my own thoughts.*”

Prioritizing health is never easy, but these men took on the challenge of changing their lifestyles and daily routines.

Theme 6: Advice to Other African American/Black Male Immigrants Experiencing GI

The stages of strength led them to find solutions, helping them provide solid advice to other men dealing with GI conditions. Participants gave actionable ways other African American/Black male immigrants could adjust and manage their GI and how to stay healthy. One common solution was seeking medical attention immediately and following the physician's advice. For example, a 33-year-old participant from California said, “*listen to the doctor. Do what the doctor asks you. What you need, what you should eat, you eat, and things You should not eat.*”

Receiving the advice and attention of medical professionals is vital for digestive conditions and has been helpful for them. Another recommendation was to avoid provoking agents, essentially changing your habits. One participant said,

I believe that Black men that have this issue should just, you know, should just stay away from things. You know things that will provoke the . . . the issue. [33 years old, California].

The participants also shared bits of encouragement and support and wanted other African-American/Black male immigrants to know. Such as, “*and I would tell them not to give up though. It started so; some are born with it, some are not born with it, so eventually miracles might happen.*” [35 years old, MI].

These suggestions are important because no one knows how to deal with a condition more than those with lived experience. The way these men gave recommendations shows they are experts in their GI and have found actionable steps that can be helpful to others. More importantly, they have found ways to help themselves feel better.

Discussion

The findings in this study suggest that African American/Black immigrant men may have more facilitators that encourage them to take control of their health. More specifically, these facilitators are positive provider relationships, self-discipline, and their decision to prioritize their health. Positive provider relationships reveal the

importance of emphasizing personal relationships, which can help shift patient attitudes about their conditions. Participants mainly described not feeling alone and realizing their GI does not control their lives.

An unexpected finding was the use of family doctors. For instance, a few participants discussed having a doctor for 20+ years since they were young. Other participants spoke about consistently using the same doctor since diagnosis. However, there is limited scientific literature on prosocial behaviors among African-American/Black men, especially in American/Black male immigrants seeking health care treatment. Studies have reported that, in general, Black men have less access to health services (Ravenell et al., 2008; Stewart et al., 2019). A study conducted by Hammond (2010) found that Black men who experienced recent negative interactions in a healthcare organization were treated differently by providers due to their race.

Another study reported that African American/Black men are less likely than White men to report having annual physical check-ups (Barber et al., 1998). The existing body of research corroborates the observations that Black males [not African American/Black male immigrants] are more likely to postpone medical treatment and forgo routine check-ups, as indicated by Gilbert et al. (2016) and Ashton et al. (2003). Additional evidence suggests a trend of underutilization of primary care services among Black males (Ravenell et al., 2008; Stewart et al., 2019) and a need to study the health-seeking behaviors of African American/Black male immigrants with GI.

In this study, American/Black male immigrants had self-discipline, prioritized their health, and had the strength and skills to make positive changes to address their GI condition. This is shown by understanding their “dos and don’ts,” such as not traveling when unwell and setting up appropriate eating schedules. It is unknown whether maturity and being older played an essential role in their health-seeking behaviors. Stewart et al. (2019) found that as African American/Black men aged and matured, there was a push toward health promotion activities. Future research should identify the driving factors encouraging prosocial and health promotion behaviors among African American/Black male immigrants.

Furthermore, this study demonstrated that African American/Black male immigrants want to be healthy and have to make the necessary decisions to maintain their health, but studies on this phenomenon are limited. This qualitative project contributes to the gap in our knowledge by exploring the strengths and healthy facilitators in African American/Black male immigrants.

The primary barriers discussed in this study occurred early in the learning about their GI. The two main barriers are lack of GI knowledge and denial of diagnosis. These barriers started when they first experienced GI; many of the participants ignored their medication regimens, ate

recklessly, and neglected symptoms. The men in this study described lacking the appropriate information to recognize disease signs and symptoms, how to change certain behaviors, and where to locate much-needed resources (Ravenell et al., 2008).

It was common for the men not to understand their GI symptoms; most did not know how to ask for help. For example, one participant laid in bed in extreme pain until his mom took him to the hospital. There is a need for health information and education strategies that describe the signs and symptoms of GI that can reach African American/Black male immigrants. Furthermore, denial of diagnosis was absent in the existing scientific literature (Ravenell et al., 2008), providing a unique opportunity to examine this barrier. Despite those barriers, African American/Black male immigrants were eager to prioritize their health and reduce the pain of GI symptoms.

An important theme was their advice to other African American/Black male immigrants with similar conditions. The study participants curated them as a result of their situation. Common recommendations were seeking immediate medical attention, adhering to provider suggestions, and avoiding provoking agents. This advice may encourage others to find immediate relief rather than having the pain linger for a long time.

Future Research

Public health and medicine need to consider the strengths of the African American/Black male immigrants rather than focusing on the deficiencies and limitations of this population. The current empirical evidence rarely focuses on the lived experience of African American/Black male immigrants; their health-seeking behaviors and attitudes toward GI should be considered in future research.

Limitations

Given that there is little to no literature on this phenomenon, the literature used should be carefully considered. It should be acknowledged that much of the current studies refer to Black Americans, those born in the United States.

In addition, the two focus group meetings were conducted differently. Participants did not have their cameras on during the first focus group meeting, while the second meeting required the men to turn on their cameras. Requesting the study participants to turn on their cameras might have helped build rapport and trust between each other and the facilitators.

Conclusion

This study highlighted essential facilitators that contributed to the health of African American/Black

male immigrants. Self-discipline and health prioritization demonstrate African American/Black male immigrant's conscious decisions toward health promotion. That being said, African American/Black male immigrants already possess several strengths that contribute to their resilience. This was rooted in their desire to reduce or lessen the initial pain experienced with having GI. This is further revealed as they provided suggestions to other men with GI conditions, such as finding a provider, avoiding gastric foods, and accepting their condition. The ability to take control of GI highlights the need to move away from the deficiency model and toward a strength-based approach, particularly for African American/Black male immigrants.

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