



Annals of Nursing and Clinical Medicine

DOI: 10.5281/zenodo.21842929 | ISSN: 3141-643X | Volume: 1 | Issue: 2 | 2026

Knowledge, Practice, and Barriers Relating to Prostate Cancer Screening Among Male Undergraduate Students at Edo State University, Iyamho, Nigeria

Obataze J. Akpoyovwere^{1,*}, Gabriella Oghenevwede Igbru¹

¹Department of Nursing Science, Faculty of Applied Health Sciences, Edo State University, Iyamho, Edo State, Nigeria

*Corresponding Author: akpoyovwere.obataze@edouniversity.edu.ng

Abstract

Prostate cancer remains an important cause of cancer-related morbidity and mortality among men, while late presentation continues to undermine early detection and treatment outcomes in many low- and middle-income settings. Although most male university students are younger than the age at which routine prostate cancer screening is generally discussed, knowledge acquired in early adulthood may influence future health-seeking behaviour, risk perception, peer communication, and family health decisions. This study assessed knowledge, reported practice, and perceived barriers relating to prostate examination and prostate cancer screening among male undergraduate students at Edo State University, Iyamho, Nigeria. A descriptive cross-sectional survey was conducted among 200 male undergraduates selected from a target population of 2,169 students using simple random sampling. Data were collected using a researcher-developed structured questionnaire and analysed with SPSS version 25 using frequencies, percentages, and mean scores. The grand mean for knowledge was 2.44, below the predefined criterion mean of 2.50, indicating inadequate knowledge. Only 35% of respondents identified digital rectal examination as being related to prostate examination and 38% recognized the examination position described in the questionnaire. Screening-related practice was also low: 25% reported ever performing what the original questionnaire termed self-prostate examination, 22% reported ever having or performing digital rectal examination, 22.5% reported current practice, 20% routine practice, and 21% previous prostate examination or screening by a nurse or physician. Feeling healthy or having no symptoms was the most frequently reported barrier

(37%), followed by discomfort with the examination (24%), discomfort with body exposure (15%), embarrassment (14%), and being too busy (10%). The findings reveal important gaps in prostate cancer literacy and preventive health orientation among the respondents. University-based health promotion should therefore emphasize accurate information on prostate cancer risk, the distinction between symptoms and preventive assessment, evidence-based screening pathways, and the importance of professional clinical evaluation rather than unsupervised self-examination.

Keywords: prostate cancer; prostate cancer screening; knowledge; screening practice; barriers; male undergraduates; Nigeria.

1. Introduction

Prostate cancer is one of the most frequently diagnosed malignancies among men and remains a major contributor to cancer-related morbidity and mortality worldwide [6, 7]. Its public-health importance extends beyond incidence alone because prognosis is strongly influenced by stage at diagnosis, access to diagnostic services, treatment availability, and the timeliness of health-seeking behaviour. In many low- and middle-income countries, particularly in sub-Saharan Africa, a substantial proportion of men present only after symptoms have become troublesome or disease has advanced, thereby narrowing opportunities for curative treatment and increasing the clinical, social, and economic burden of care [9, 11, 12].

The Nigerian context reflects many of these challenges. Available studies have repeatedly identified poor awareness, misconceptions about prostate cancer, limited use of screening services, financial constraints, inadequate access to diagnostic facilities, and delayed presentation as barriers to early detection [1, 12, 15]. Such barriers are important because early prostate cancer may be asymptomatic. Men who equate the absence of symptoms with the absence of risk may therefore be less likely to seek reliable information, discuss their risk with a healthcare professional, or participate in clinically appropriate assessment when indicated.

Prostate cancer screening and early-detection discussions commonly involve prostate-specific antigen (PSA) testing and clinical assessment, including digital rectal examination (DRE) in selected circumstances [14, 16]. These procedures are screening or assessment tools rather than definitive diagnostic tests; suspicious findings may require further evaluation and histopathological confirmation. Their use must therefore be interpreted in relation to age, family history, symptoms, individual risk, potential benefits and harms, and professional clinical guidance. This distinction is especially important in health education because inaccurate messages can produce either unnecessary anxiety or false reassurance.

The original questionnaire used in this study repeatedly employed the term “self-prostate examination.” That wording is retained when reporting the original variables but should not be interpreted as a recommendation for men to perform unsupervised DRE. DRE is conventionally a clinician-performed examination, and the literature cited in the source manuscript indicates that untrained self-examination may be inaccurate, uncomfortable, potentially harmful, and incapable of replacing professional evaluation [2, 5]. The present article therefore interprets the questionnaire responses within the broader concept of prostate cancer awareness, prostate examination knowledge, and screening-related health behaviour.

Knowledge is an important determinant of preventive behaviour. Individuals who understand disease risk, recognize the purpose of screening, and know where appropriate services can be

obtained are better positioned to make informed health decisions. Conversely, poor knowledge may interact with low perceived susceptibility, embarrassment, discomfort, fear, and competing demands to delay preventive action. Previous studies in Ghana, Kenya, Tanzania, Zambia, and Nigeria have documented important deficiencies in prostate cancer awareness and screening uptake among adult men [3, 7, 8, 10, 15]. However, much of this evidence has focused on middle-aged and older men, healthcare users, workers, or community-based adult populations.

Male university students represent a different but relevant population. Most are below conventional screening ages, yet the university period is a formative stage during which health beliefs, preventive attitudes, and information-seeking patterns are developed. Students may also become future professionals, partners, fathers, caregivers, and peer educators whose knowledge can influence wider family and community health practices. Examining prostate cancer literacy in this population is therefore useful not because young men should be routinely screened, but because misconceptions established during early adulthood may persist into later life.

The Health Belief Model provides a useful conceptual lens for understanding this issue. Preventive action is influenced by perceived susceptibility to disease, perceived severity, perceived benefits of action, perceived barriers, cues to action, and confidence in one's ability to respond appropriately. In the context of prostate cancer, a young man who feels healthy may perceive little personal susceptibility, while embarrassment or discomfort may further reduce interest in screening information. Conversely, credible health education and contact with healthcare professionals may act as cues to action and improve future readiness to engage in appropriate screening discussions.

Despite the recognized burden of prostate cancer in African populations, there is limited published evidence describing how male undergraduate students understand prostate examination and prostate cancer screening, particularly within Nigerian universities. This study therefore assessed the level of knowledge, reported practice, and perceived barriers relating to prostate examination and prostate cancer screening among male undergraduate students at Edo State University, Iyamho, Nigeria. The findings are intended to provide baseline evidence for age-appropriate men's health education and future research on preventive health behaviour among young adult males.

2. Methods

2.1. Study design and setting

A descriptive cross-sectional survey design was adopted because the study sought to describe existing knowledge, reported practices, and perceived barriers at a defined point in time without manipulating the study environment. The research was conducted at Edo State University, Iyamho, Edo State, Nigeria. The university comprises students drawn from health-related and non-health-related disciplines, providing an appropriate setting for examining variation in exposure to men's health information across a heterogeneous undergraduate population.

2.2. Study population

The target population comprised 2,169 male undergraduate students enrolled in the university at the time of the study. The source study included students from different years of study and from the Faculties of Engineering, Science, Arts, Management and Social Sciences, Clinical Sciences,

2.3. Sample size determination

The sample size was estimated using Yamane's formula:

$$n = \frac{N}{1 + N(e^2)}, \quad (1)$$

where n represents the required sample size, $N = 2169$ the target population, and $e = 0.07$ the selected precision level. Substitution yielded an initial sample of approximately 187 participants. An allowance of approximately 7% was then made for possible non-response or attrition, producing a final target sample of 200 respondents. The reported analysis was based on 200 completed responses.

2.4. Sampling procedure

Simple random sampling was reported as the sampling technique. The rationale was to provide eligible male undergraduates an equal opportunity of selection and to reduce systematic selection by the researcher. The source manuscript did not provide further detail on the construction of the sampling frame or the specific randomization procedure; consequently, no additional procedure is inferred here.

2.5. Instrument and study variables

Data were collected with a researcher-developed structured questionnaire informed by the objectives of the study and the literature reviewed in the original manuscript. The instrument contained sections on socio-demographic characteristics, knowledge relating to prostate examination, reported examination or screening-related practice, and factors influencing practice. Knowledge items were rated on a four-point Likert scale ranging from strongly agree to strongly disagree. Practice items were recorded mainly as yes/no responses, while the barrier section asked respondents to identify factors that affected their practice.

The primary descriptive outcomes used in this article were the grand mean knowledge score, selected item-level knowledge percentages explicitly reported in the source manuscript, frequencies and percentages of screening-related practices, and frequencies and percentages of reported barriers. Because the original manuscript did not provide complete item-level knowledge frequencies, psychometric indices, or inferential statistics, these were not reconstructed or estimated.

2.6. Data collection procedure

The questionnaire was administered face-to-face. According to the source manuscript, an introductory letter was obtained from the Department of Nursing Science and permission was sought through the university administrative/ethical process before data collection. The purpose of the study was explained to prospective respondents and participation was voluntary. Questionnaires were administered by the researcher with assistance and retrieved after completion. Data collection reportedly took place over approximately one month.

2.7. Data management and analysis

Completed questionnaires were coded and analysed using SPSS version 25. Descriptive statistics were used because the stated study objectives focused on levels of knowledge, patterns of practice, and perceived barriers. Categorical variables were summarized using frequencies and percentages, whereas the knowledge scale was summarized using mean scores. A criterion mean of 2.50 was predefined in the original study; a grand mean below this threshold was interpreted as poor knowledge. No inferential analyses were reported in the source manuscript, and none were generated for this article because individual-level raw data were not available.

2.8. Ethical considerations

The source manuscript states that permission or ethical approval was obtained through the university's administrative/ethical process before data collection. Respondents were informed about the purpose of the research, confidentiality, voluntary participation, and their freedom not to participate. A formal ethics committee name and approval number were not provided in the source document; therefore, none is invented or reported here. These details should be inserted by the authors before final journal submission if available.

3. Results

3.1. Socio-demographic characteristics

A total of 200 male undergraduate students were included in the reported analysis. Nearly half (46.5%) were aged 20–24 years, 33.0% were aged 25–29 years, 15.5% were aged 30 years or older, and 5.0% were younger than 20 years. Seventy percent identified as Christian and 30% as Muslim. Respondents were distributed across all years of study and across seven faculties (Table 1).

Table 1: Socio-demographic characteristics of respondents ($N = 200$)

Characteristic	n	%
<i>Age group</i>		
< 20 years	10	5.0
20–24 years	93	46.5
25–29 years	66	33.0
30 years and above	31	15.5
<i>Religion</i>		
Christian	140	70.0
Muslim	60	30.0
<i>Year of study</i>		
Year 1	45	22.5
Year 2	50	25.0
Year 3	50	25.0
Year 4	55	27.5
<i>Faculty</i>		
Engineering	40	20.0
Science	38	19.0
Arts, Management and Social Sciences	34	17.0
Clinical Sciences	28	14.0
Applied Health Sciences	22	11.0
Basic Medical Sciences	20	10.0
Law	18	9.0

3.2. Knowledge relating to prostate examination

The original analysis reported a grand mean of 2.44 for the knowledge scale, below the predefined criterion mean of 2.50. On this basis, overall knowledge was classified as poor. Among specific results explicitly reported in the source manuscript, 35% of respondents recognized DRE as related to prostate examination, and 38% identified the described body position associated with the questionnaire's examination procedure (Table 2). Item-level frequencies for the remaining knowledge statements were not provided in the source manuscript and were therefore not reconstructed.

Table 2: Selected reported indicators of knowledge

Indicator	Reported value
Recognized DRE as related to prostate examination	35.0%
Recognized the described examination position	38.0%
Grand mean for knowledge scale	2.44
Criterion mean used in the original study	2.50
Overall interpretation	Poor knowledge

3.3. Reported practice

Reported engagement with prostate examination and screening-related activities was low (Table 3). One quarter of respondents reported ever performing what the original questionnaire termed self-prostate examination, while 22% reported ever having a DRE. Only 22.5% reported current practice and 20% routine practice. Twenty-one percent reported having previously undergone prostate examination or screening by a nurse or physician.

Table 3: Reported prostate examination and screening-related practice ($N = 200$)

Practice item	Yes		No	
	n	%	n	%
Ever performed “self-prostate examination”	50	25.0	150	75.0
Ever had/performed DRE	44	22.0	156	78.0
Currently practising “self-prostate examination”	45	22.5	155	77.5
Engages in routine practice	40	20.0	160	80.0
Previously examined/screened by a nurse or physician	42	21.0	158	79.0

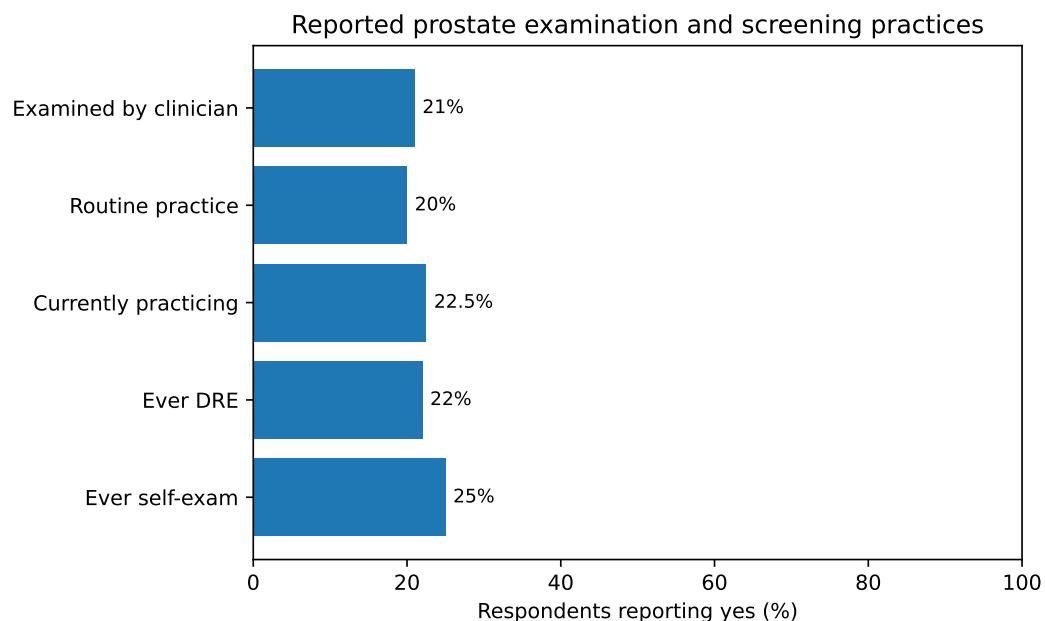


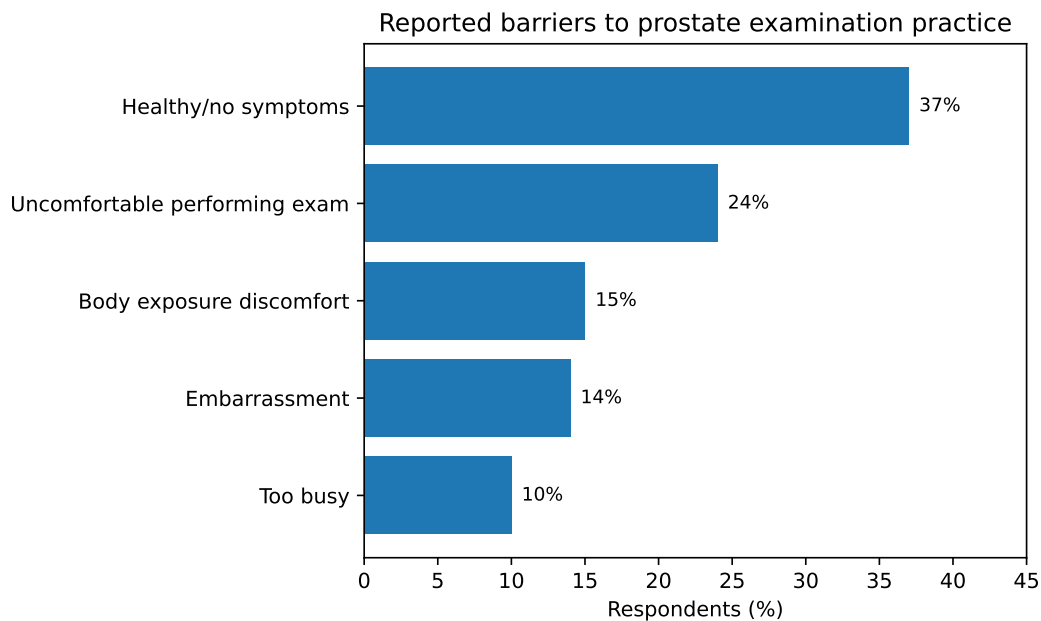
Figure 1: Percentage of respondents reporting selected prostate examination and screening-related practices.

3.4. Barriers influencing practice

The most frequently reported factor was feeling healthy or having no symptoms (37%). Discomfort with performing the examination was reported by 24%, discomfort with body exposure by 15%, embarrassment by 14%, and being too busy by 10% (Table 4; Figure 2).

Table 4: Reported factors influencing practice ($N = 200$)

Factor	n	%
Feeling healthy / absence of symptoms	74	37.0
Feeling uncomfortable performing the examination	48	24.0
Uncomfortable with body exposure	30	15.0
Embarrassment about touching/examining the body	28	14.0
Being too busy	20	10.0

**Figure 2:** Reported barriers influencing prostate examination practice.

4. Discussion

This study provides evidence of important gaps in knowledge and screening-related health behaviour among male undergraduate students at Edo State University, Iyamho. The overall knowledge mean of 2.44 fell below the study's predefined criterion mean of 2.50, and only 35% of respondents identified DRE as being related to prostate examination. Although the difference between the grand mean and the cut-off is numerically small, the pattern of item-level findings reported in the source manuscript supports the interpretation that many respondents lacked clear and clinically accurate knowledge of prostate examination and screening concepts.

The finding is consistent with evidence from other African settings where knowledge of prostate cancer and its screening methods has frequently been suboptimal. Asare and Ackumey reported limited awareness of screening options among male teachers in Ghana, while Taofiq and colleagues documented poor prostate cancer knowledge and screening practices among men in Sokoto, Nigeria [3, 15]. Similar concerns have been reported in Kenya and Tanzania [7, 10]. These comparisons suggest that knowledge deficits are not confined to a single occupational or geographic group, although differences in age structure, educational background, access to healthcare, and study instruments make direct numerical comparison inappropriate.

The relatively young age profile of the present sample is central to interpretation. Nearly half of the respondents were aged 20–24 years, and only 15.5% were aged 30 years or older. Most participants were therefore below the age at which prostate cancer screening is commonly considered. Low screening uptake in this group should not automatically be interpreted as failure to comply with screening recommendations. Rather, the more relevant concern is whether students possess sufficiently accurate knowledge to recognize future risk, understand the purpose of professional screening, and make informed decisions as they age or if they develop risk factors. In this sense, the study is primarily a prostate cancer literacy and preventive-health study rather than an assessment of adherence to age-based screening recommendations.

Reported practice was low across all measured indicators. Twenty-five percent reported ever performing what the original questionnaire termed self-prostate examination, 22% reported ever having or performing DRE, 22.5% reported current practice, 20% routine practice, and 21% reported previous examination or screening by a nurse or physician. Low uptake of prostate cancer screening services has similarly been described among men in Kenya, Tanzania, Zambia, and Nigeria [1, 7, 8, 10]. Nevertheless, those studies largely involved older adult men for whom screening or diagnostic evaluation was more immediately relevant. The lower practice levels observed among university students may therefore reflect both genuine knowledge deficits and their younger age.

The questionnaire's use of the expression "self-prostate examination" requires particular caution. DRE is conventionally performed by a trained healthcare professional, and untrained self-examination cannot be considered a substitute for professional assessment. The source literature cited in the manuscript notes that self-examination may be inaccurate and may create discomfort, injury, infection risk, or false reassurance [2, 5]. Consequently, the public-health implication of the present findings should not be to encourage students to perform self-DRE. Instead, education should correct misconceptions, explain what PSA testing and DRE are, clarify who should discuss screening with a clinician, and emphasize appropriate help-seeking when symptoms or risk factors are present.

Feeling healthy or having no symptoms was the most frequently reported barrier, identified by 37% of respondents. This finding is particularly important because it reflects a possible symptom-driven model of healthcare utilization. When preventive assessment is understood only as something needed after symptoms appear, opportunities for timely risk assessment and early detection may be missed. Comparable studies have identified low perceived vulnerability, fear, embarrassment, cost, discomfort, and competing priorities as barriers to prostate cancer screening [1, 4, 13]. The present finding therefore reinforces the need to distinguish preventive health behaviour from symptom-triggered care.

Discomfort with the examination was reported by 24% of respondents, while 15% were uncomfortable with body exposure and 14% reported embarrassment. These concerns highlight the intimate nature of prostate assessment and the role of psychosocial barriers in men's health. Embarrassment may be intensified by misconceptions about DRE, limited familiarity with clinical procedures, fear of pain or diagnosis, and cultural norms surrounding masculinity and bodily privacy. Health education that simply provides biomedical facts may therefore be insufficient. Effective interventions should also normalize respectful clinician-patient discussion, explain what examinations involve, protect privacy and dignity, and allow men to ask questions without stigma.

The Health Belief Model helps integrate these findings. The predominance of "feeling healthy"

as a barrier suggests low perceived susceptibility, while discomfort and embarrassment represent perceived barriers to action. Knowledge gaps may reduce perceived benefits because students who do not understand the purpose of screening are less likely to value future assessment. University health campaigns, professional counselling, peer education, and credible media messages can function as cues to action. Such interventions should be age-appropriate: for younger adults, the priority is not indiscriminate screening but accurate risk communication, healthy future screening intentions, and knowledge of when professional assessment becomes appropriate.

The distribution of respondents across seven faculties also has practical implications. Men's health education should not be confined to health-science students. Participants came from engineering, science, law, arts and management disciplines, as well as health-related faculties. University-wide wellness programmes could therefore provide a more equitable platform for disseminating accurate prostate cancer information. Incorporating men's health into orientation programmes, periodic health weeks, student clinic counselling, and digital health communication may help reach students who would otherwise have limited exposure to cancer-prevention information.

The study also points to a broader issue in prostate cancer communication: terminology matters. Conflating self-examination, DRE, screening, and diagnosis can produce misunderstanding. Future educational materials and questionnaires should use clinically precise language, distinguish PSA testing from DRE, explain that neither alone confirms cancer, and avoid presenting self-examination as an established screening method. Clear terminology will improve both health literacy and the validity of future research measurements.

Taken together, the results indicate that the main intervention need in this young population is not routine screening but foundational prostate cancer literacy. Universities have an opportunity to build preventive-health competence before students reach higher-risk ages. Such early education may improve later willingness to seek advice, reduce embarrassment, and support informed decision-making within families and communities.

5. Strengths and Limitations

The study included students from multiple faculties and years of study and provides useful baseline information on prostate cancer-related awareness within a Nigerian university setting. Nevertheless, several limitations should be considered. First, the study was cross-sectional and relied on self-reported responses, making recall and social-desirability bias possible. Second, the questionnaire used the term "self-prostate examination," which is not equivalent to guideline-based prostate cancer screening and could have affected respondents' interpretation. Third, the source manuscript did not report psychometric indices for the questionnaire or item-level frequencies for all knowledge statements. Fourth, inferential analyses were not reported, so associations between socio-demographic characteristics, knowledge, barriers, and practice cannot be established from the available data. Finally, the single-university setting limits generalizability.

6. Conclusion

Male undergraduate students in this study demonstrated inadequate knowledge of prostate examination and prostate cancer screening based on the study's predefined scoring criterion.

Reported engagement with examination and screening-related practices was also low, while feeling healthy or symptom-free emerged as the leading perceived barrier. Discomfort, concerns about body exposure, embarrassment, and competing demands further shaped preventive behaviour. Because the study population was predominantly young, these findings should not be interpreted as evidence that students ought to undergo routine prostate cancer screening. Instead, they demonstrate a need for accurate prostate cancer literacy, clearer understanding of future risk, and better awareness of evidence-based pathways for professional assessment. University health education can play an important role in correcting misconceptions early and in preparing young men to make informed screening decisions later in life or earlier when individual risk or symptoms warrant medical evaluation.

7. Recommendations

Universities should incorporate age-appropriate men's health education into student wellness programmes, orientation activities, periodic health campaigns, and student-clinic counselling. Educational content should explain prostate cancer risk factors, the fact that early disease may be asymptomatic, the purpose and limitations of PSA testing and DRE, and the importance of consulting qualified clinicians rather than relying on unsupervised self-examination. Communication strategies should explicitly address embarrassment, discomfort, privacy concerns, and the misconception that preventive care is unnecessary in the absence of symptoms.

Future studies should employ validated instruments and clinically precise terminology that clearly separates prostate cancer awareness, screening intention, clinician-performed DRE, PSA testing, and diagnostic procedures. Access to individual-level data would also permit inferential analysis of factors associated with knowledge and future screening intention, including age, faculty, year of study, prior exposure to health information, family history, and perceived susceptibility. Multi-centre studies involving several Nigerian universities would improve generalizability and provide stronger evidence for the design of men's health interventions.

Acknowledgements

The authors acknowledge the male undergraduate students who participated in the study and the Department of Nursing Science, Edo State University, Iyamho, for supporting the original data-collection process.

Conflict of Interest

The authors declare no conflict of interest based on the information available in the source manuscript.

Funding

No external funding information was reported in the source manuscript.

Author Contributions

The manuscript was developed from the original study and revised for journal publication. The specific contributor roles of the authors should be confirmed and stated in accordance with the target journal's authorship policy before submission.

Copyright and License

Copyright © 2026 The Author(s).

This article is published by *Annals of Nursing and Clinical Medicine* under Ktrend Journals and is distributed under the terms of the Creative Commons Attribution License (CC BY 4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Journal website: <https://ktrendjournals.org/>

References

References

- [1] Abonor, L., Isangha, S., Eya, O., Umoh, V., & Afia, M. (2023). Utilization of prostate cancer screening services in the Niger Delta region of Nigeria: Situation analysis and implications for oncology social workers. *European Journal of Scientific Research*, 154(3), 280–293.
- [2] American Cancer Society. (2021). *Prostate cancer*. <https://www.cancer.org/cancer/types/prostate-cancer.html>
- [3] Asare, B. Y., & Ackumey, M. M. (2021). Awareness and knowledge about prostate cancer among male teachers in the Sunyani Municipality, Ghana. *African Health Sciences*, 21(2), 655–662.
- [4] Baratedi, W. M., Tshiamo, W. B., Mogobe, K. D., & McFarland, D. M. (2020). Barriers to prostate cancer screening by men in sub-Saharan Africa: An integrated review. *Journal of Nursing Scholarship*, 52(1), 85–94.
- [5] Benedict, M. O. A., Steinberg, W. J., Claassen, F. M., Mofolo, N., & Van Rooyen, C. (2023). Knowledge, attitude and practice on screening and early diagnosis of prostate cancer of primary health care providers in the Free State. *African Journal of Primary Health Care & Family Medicine*, 15(1), e1–e12.
- [6] Bray, F., Ferlay, J., Soerjomataram, I., Siegel, R. L., Torre, L. A., & Jemal, A. (2021). Global cancer statistics 2020: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries. *CA: A Cancer Journal for Clinicians*, 71(3), 209–249.
- [7] Bugoye, F. C., Leyna, G. H., Moen, K., & Mmbaga, E. J. (2023). Knowledge, perceived risk and utilization of prostate cancer screening services among men in Dar es Salaam, Tanzania. *Prostate Cancer*, 2463048.

-
- [8] Gift, S., Nancy, K., & Victor, M. (2020). Assessment of knowledge, practice and attitude towards prostate cancer screening among male patients aged 40 years and above at Kitwe Teaching Hospital, Zambia. *African Journal of Urology*, 26(1).
- [9] Nartey Laweh, V., & Manortey, S. (2021). Assessment of knowledge and practices of prostate cancer screening among men in the Lower Manya Krobo Municipality in the Eastern Region of Ghana. *Cancer Research Journal*, 9(1).
- [10] Mbugua, R. G., Oluchina, S., & Karanja, S. (2021). Prostate cancer awareness and screening among men in a rural community in Kenya: A cross-sectional study. *African Journal of Urology*, 27(1).
- [11] Mbugua, R., Oluchina, S., Karanja, S., & Cheboi, S. (2020). Practice of prostate cancer screening and associated intra-personal factors among men aged 40–69 years: A cross-sectional study in a rural community in Kenya. *African Journal of Health Sciences*, 33(3).
- [12] Ndikom, C. M., Oluwole, T. G., & Ilesanmi, R. E. (2021). Risk perception and practice of prostate cancer screening among a population of civil servants in Ibadan, Nigeria. *African Journal of Biomedical Research*, 24, 231–237.
- [13] Oladiran, A. A. O. (2022). Practice of cancer screening among staff of Military Hospital Lagos. *Texila International Journal of Public Health*, 10(1), 134–145.
- [14] Opondo, C. O., Onyango, P. O., & Asweto, C. O. (2022). Effect of perceived self-vulnerability on prostate cancer screening practice and associated factors: A cross-sectional study of public health facilities in Western Kenya. *Annals of Global Health*, 88(1), 12.
- [15] Taofiq, S., Agwu, N. P., Yunusa, E. U., & Awosan, K. J. (2021). Knowledge of prostate cancer and screening practices among men in Sokoto, Nigeria. *Asian Journal of Medical Sciences*, 9(6), 51–56.
- [16] Tikkinen, K. A. O., Dahm, P., Lytvyn, L., Heen, A. F., Vernooij, R. W. M., Siemieniuk, R. A. C., & Agoritsas, T. (2021). Prostate cancer screening with prostate-specific antigen (PSA) test: A clinical practice guideline. *BMJ*, 362, k3581.