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Knowledge, Attitudes and Practices Towards Prostate Cancer Screening Amongst Men Aged 40-60 Years in The Buea Health District: A Cross-Sectional Study

Ngende Rosine[1], Divine Enoru Eyongeta[2], Cyril Kamadjou[3], Ghislain Dema[4], Ngwa Fred Ngunjoh[5], Asu Carine Ndum[6] Tendongfor Nicholas[7]

[1]Department of Public Health, Faculty of Health Sciences, University of Buea, Buea, Cameroon

[2]Department of Surgery and Specialities, Faculty of Health Sciences, University of Buea, Buea, Cameroon

[3]Saint Cyr Endoscopy Urology Centre, Bonapriso, Douala, Douala, Cameroon

[4]Department of Public Health, Faculty of Health Sciences, University of Buea, Buea, Cameroon

[5]Department of Public Health, Faculty of Health Sciences, University of Buea, Buea, Cameroon

[6]Department of Public Health and Administration, Faculty of Health Sciences, Buea, Biaka University Institute of Buea, Cameroon.

[7]Department of Public Health, Faculty of Health Sciences, University of Buea, Buea, Cameroon

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ABSTRACT

Background: Prostate cancer is a significant global health burden, particularly in low- and middle-income countries where late diagnosis is common. It is the second most diagnosed cancer among men and contributes substantially to cancer-related deaths. In Cameroon, prostate cancer is the second most deadly cancer among men, highlighting the need for improved awareness and screening practices.

Objective: The objective of the study was to assess knowledge, attitudes and practices towards prostate cancer screening among men aged 40-60 years in the Buea Health District.

Method: A cross-sectional study was conducted in the Buea Health District, Cameroon, from February 2024 to May 2024. A multi-stage sampling method was used to recruit 314 men aged 40-60 years. Data were collected using a structured questionnaire and analyzed using SPSS version 26.0.

Results: The study revealed that 62.74% of participants had poor knowledge on prostate cancer, while 50.32% exhibited positive attitudes towards screening. However, only 3.18% reported good practices regarding screening. Participants from Molyko were 4.637 times more likely to have poor knowledge (AOR = 4.637; CI: 0.79-6.28; $p < 0.001$). Participants from Molyko were significantly more likely to have a positive attitude (AOR = 18.556; CI: 6.897-20.944; $p < 0.001$). Secondary education level (AOR = 2.807; CI: 0.327-3.865; $p = 0.004$) and being aged 40–49 years (AOR = 0.467; CI: -1.335-0.972; $p = 0.009$) were also significant predictors. Self-employed participants were significantly less likely to have poor practices (AOR = 0.046; CI: -5.00-0.250; $p = 0.002$). Participants aged 40–49 years were more likely to have poor practices compared to those aged 50–60 years (AOR = 5.828; CI: 0.13-9.39; $p = 0.034$).

Conclusion: Most participants had poor knowledge and practices but a relatively positive attitude towards prostate cancer screening. Key predictors of KAP included health area, income, education level, employment

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status, and age group. Targeted educational and behavioral interventions are needed to bridge knowledge gaps and improve screening practices.

Key words: Attitudes, Knowledge, Practices, Prostate cancer screening

INTRODUCTION

Prostate cancer is a malignancy that affects most adult males globally and has a devastating impact if not discovered early. It is currently regarded as the second most diagnosed type of cancer and contributes to the increasing death rates in adult males [1]. Non communicable diseases are responsible for about 70% of all deaths worldwide with majority of these deaths occurring in the low and middle income countries. Prostate cancer remains the most commonly diagnosed non- cutaneous cancer. Incidence rates increase drastically over the age of 65 years with mortality rates increasing rapidly over the age of 70 [2].

According to the Global Cancer Observatory (GLOBOCAN) report of 2020, about 1,414,259 new prostate cancer cases were reported in 2020, representing 7.3% of all cancers worldwide. It explained that the mortality due to prostate cancer is estimated to be 375,304, representing 3.8% of all cancer deaths globally. Prostate cancer is an important health burden among men worldwide with the highest incidence rates being in sub-Saharan Africa [2].

Prostate cancer incidence increases with age. Although only 1 in 350 men under the age of 50 years are diagnosed with prostate cancer, the incidence rate increases up to 1 in every 52 men for ages 50 to 60 years. The incidence rate is nearly 60% in men over the age of 65 years. The worldwide variations in prostate cancer incidence might be attributed to PSA testing [3].

According to the WHO, cancers are the fifth largest killer and non-communicable disease with a mortality rate of about 3%. The annual incidence would be 15 thousand new cases and its prevalence estimated at 25 thousand cases. The most deadly cancers in Cameroon are cancer of the cervix, breast, lung and prostate. Of these cancers, prostate cancer is the second most deadly cancer in men in Cameroon. It is responsible for 23.5% of deaths recorded for all human cancer deaths in the country [4].

Prostate cancer is the fourth leading cancer-related cause of death worldwide and the second most common cancer among men. An estimated 1.1 million men worldwide were diagnosed with prostate cancer in 2012, accounting for 15% of the cancers diagnosed in men. The burden of prostate cancer is expected to grow to 1.7 million new cases and 499,000 new deaths by year 2030. Various epidemiological data have supported the high incidence and mortality of this malignancy amongst the blacks. In contrast to high-income countries, where mortality rate is low as a result of routine screening leading to early detection, majority of the cases in low and middle-income countries like Cameroon are diagnosed among symptomatic men at advanced stages with higher mortality rates [5].

MATERIALS AND METHODS

Study Design and population

A cross-sectional study was conducted in the Buea Health District (BHD), located in the South West Region of Cameroon from February, 2024 to May 2024. The study population was men aged 40-60 years in the Buea Health District.

Study Area

The study was conducted in the Buea Health District (BHD), located in the Southwest Region of Cameroon. BHD is a semi-urban area with diverse socio-economic and cultural characteristics. It serves as a key administrative and healthcare hub in the region, providing access to several health facilities and services. The district comprises multiple health areas and communities, which were included in the study through a cluster sampling approach.

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The focus of the study was on men aged 40–60 years residing in selected communities within BHD. This age group was chosen due to its higher risk of developing prostate cancer. The study aimed to assess their knowledge, attitudes, and practices (KAP) regarding prostate cancer screening, as well as the challenges they face in accessing screening services.

Sampling

In this study, a multi-stage sampling method was used to recruit 314 study participants wherein 4 Health areas were randomly selected from the 7 health areas of the BHD. Eight communities were further randomly selected, 2 communities from each of the 4 health areas. A simple random sampling technique was used to select the households. Finally, study participants were selected using purposive sampling. Calculation of the sample size used a 5% margin of error with a 95% confidence level. A minimum sample size of 314 was determined using the Conchran's formula.

Data Collection: A structured questionnaire was used to collect data for this study. The development of the questionnaire was guided by past studies on a similar topic carried out by Nawafia et al. in Namibia and Ernest et al. in Cameroon.

The questionnaires were self-administered and with the help of research assistants among selected households in the community.

Statistical Analysis

Analysis was done using SPSS version 26.0 where data was exported from excel and later analysed summarizing results on tables and charts.

Ethical Considerations: Ethical clearance for this study were obtained from the Institutional Review Board, Faculty of Health Sciences, University of Buea (reference number 2024/2340-01/UB/SG/IRB/FHS). Authorization was also obtained from the Delegation of Public Health (reference number P42/MPH/SWR/RDPH/CB.PT/730/636). Authorization was obtained from the District Health Service Buea. Authorization was also gotten from different chief of centers at selected health areas and verbal authorization obtained from the chiefs of the selected communities in those health areas. An informed consent was gotten from the study participants.

RESULTS

Socio-Demographic Characteristics of Participants

Table 1 presents the socio-demographic characteristics of study participants. Out of the 314 participants, 104 (33.1%) of them were from Molyko health area while 68 (21.7%) were from Bokwango health area. Also, 71 (22.6%) were from Ndongo community while 20 (6.4%) were from Likoko membea. Most of the participants were Christians 273 (86.9%) and 158 (50.3%) belonged to the age group 50-60 years. As per the employment status, 156 (49.7%) were self-employed while 50 (16%) were unemployed. More so, 101 (32.2%) earned more than 100000frs monthly while 32 (10.25) earned less than 25000frs monthly. One hundred and seventeen (37.3%) of the participants had attained the secondary level of education while 9 (2.9%) had no formal education. Most, 230 (73.2%) of the participants were married while 10 (3.2%) were separated (See Table 1).

Table 1: Socio-demographic Characteristics of Participants

Variables	Categories	Frequency (n)	Percent (%)
Health area	Bokwango	72	22.9
	Buea Town	68	21.7

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	Molyko	104	33.1
	Tole	70	22.3
	Total	**314**	**100**
Community	Bokwai layout	33	10.5
	Bwiyuku	43	13.7
	Likoko Membea	20	6.4
	Mevio	27	8.6
	Naanga	53	16.9
	Ndongo	71	22.6
	Stranger East	38	12.1
	Wonyalyonga	29	9.2
	Total	**314**	**100**
Religion	Christian	273	86.9
	Muslim	22	7.0
	Others	19	6.1
	Total	**314**	**100**
Age group	40-49 years	156	49.7
	50-60 years	158	50.3
	Total	**314**	**100**
Employment status	Employed	110	35.0
	Self-employed	154	49.0
	Unemployed	50	16.0
	Total	**314**	**100**
Income per month (x1000 CFA)	<25	32	10.2
	25-50	93	29.6
	50-100	88	28.0
	>100	101	32.2
	Total	**314**	**100**

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Educational level	No formal education	9	2.9
	Primary	82	26.1
	Secondary	117	37.3
	University	106	33.8
	Total	**314**	**100**
Marital status	Married	230	73.2
	Separated	10	3.2
	Single	63	20.1
	Widower	11	3.5
	Total	**314**	**100**

Overall Knowledge on Prostate Cancer

For overall knowledge, 62.74% (197) of the participants had poor knowledge on prostate cancer while 37.26% (117) of the participants had good knowledge on prostate cancer (See Figure 1).

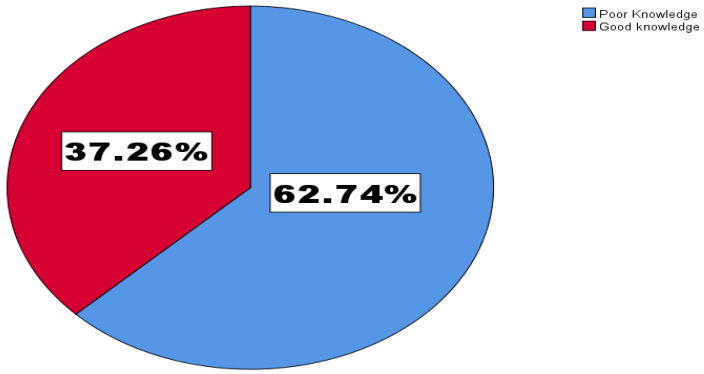

Figure 1: Overall Knowledge on Prostate Cancer

Tables 2 shows the association between overall knowledge and demographic characteristics. There was a significant association between knowledge on prostate cancer and health area (χ^2=33.1, p<0.001), community (χ^2=36.75, p<0.001), income per month (χ^2=9.83, p=0.020), age group (χ^2=4.41, p<0.036) (See Table 2)

Table 2: Association between overall knowledge and demographic characteristics.

		Overall Knowledge			
Variables	**Categories**	**Poor**	**Good**	**Chi-square**	**P-value**
		n (%)	**n (%)**		
Health area	Bokwaongo	49(68.1)	23(31.9)	33.1	**<0.001**
	Buea Town	44(64.7)	24(35.3)		

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	Molyko	31(29.8)	73(70.2)		
	Tole	40(57.1)	30(42.9)		
	Total	**164(52.2)**	**150(47.8)**		
Community	Bokwai layout	11(33.3)	22(66.7)	36.755	**<0.001**
	Bwiyuku	21(48.8)	22(51.2)		
	Likoko Membea	13(65.0)	7(35.0)		
	Mevio	19(70.4)	8(29.6)		
	Naanga	37(69.8)	16(30.2)		
	Ndongo	20(28.2)	51(71.8)		
	Stranger East	25(65.8)	13(34.2)		
	Wonyalyonga	18(62.1)	11(37.9)		
	Total	**164(52.2)**	**150(47.8)**		
Religion	Christian	142(52.0)	131(48.0)	5.73	0.057
	Muslim	8(36.4)	14(63.6)		
	Others	14(73.7)	5(26.3)		
	Total	**164(52.2)**	**150(47.8)**		
Employment status	Employed	62(56.4)	48(43.6)	4.983	0.083
	Self-employed	83(53.9)	71(46.1)		
	Unemployed	19(38.0)	31(62.0)		
	Total	**164(52.2)**	**150(47.8)**		
Income per month(X 1000CFA)	<25	9(28.1)	23(71.9)	9.826	**0.020**
	>100	56(55.4)	45(44.6)		
	25-50	55(59.1)	38(40.9)		
	50-100	44(50.0)	44(50.0)		
	Total	**164(52.2)**	**150(47.8)**		
Educational level	No formal education	6(66.7)	3(33.3)	3.702	0.295

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	Primary	40(48.8)	42(51.2)		
	Secondary	56(47.9)	61(52.1)		
	University	62(58.5)	44(41.5)		
	Total	**164(52.2)**	**150(47.8)**		
Age-group	40-49 years	90(58.1)	66(41.9)	4.411	**0.036**
	50-60 years	73(46.2)	85(53.8)		
	Total	**164(52.2)**	**150(47.8)**		
Marital status	Married	119(51.7)	111(48.3)	2.636	0.451
	Separated	3(30.0)	7(70.0)		
	Single	36(57.1)	27(42.9)		
	Widower	6(54.5)	5(45.5)		
	Total	**164(52.2)**	**150(47.8)**		

Table 3 shows the demographic factors independently associated to knowledge. Men who were from Molyko health area were 0.422 time less likely to have poor knowledge on prostate cancer compared men from Tole (AOR=0.422, CI=0.79-6.28, P<0.001) (See Table 3)

Table 3: Association between Overall Knowledge and Socio-demographic characteristics of Participants using Multivariate Analysis

	Categories	**AOR**	**CI (95%)**	**P-value**
Health Area	Bokwaongo	1.385	(-0.39,1.64)	0.370
	Buea Town	0.777	(-0.97,0.95)	0.488
	Molyko	4.637	(0.79,6.28)	**<0.001**
	Tole	1		
Income per month (X1000CFA)	<25	2.950	(0.08,3.09)	**0.035**
	25-50	0.553	(-1.25,0.2.33)	0.079
	50-100	1.194	(-0.46,3.33)	0.586
	>100	1		

Attitudes towards Prostate Cancer Screening

Regarding the overall attitude of men towards prostate cancer screening, 50.32% (158) of them had positive attitude while 49.68% (156) had negative attitudes towards prostate cancer screening (See Figure 2).

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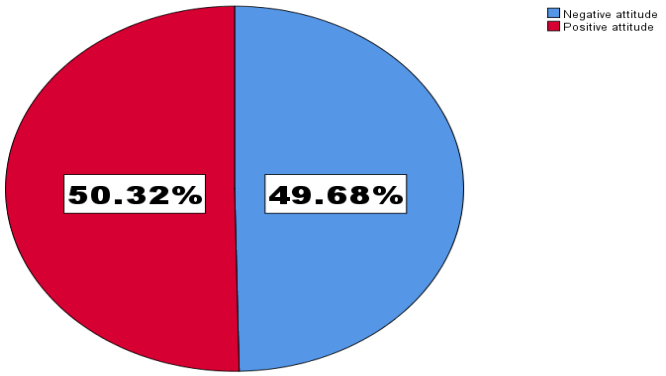

Figure 2: Overall Attitude towards Prostate Cancer Screening

Socio-demographic characteristics were associated with overall attitudes and associations which were significant were: health area, community, age-group, Income per month, educational status and marital status (see Table 4).

Table 4: Socio-demographic characteristics associated with overall attitude towards prostate cancer screening

Variable	Categories	**Overall attitude**		**Chi-square**	**P-value**
		Negative n (%)	**Positive n (%)**		
Health area	Bokwaongo	33(23.9)	39(22.2)	85.97	**<0.001**
	Buea Town	17(12.3)	51(29.0)		
	Molyko	80(580)	24(13.6)		
	Tole	8(5.8)	62(35.2)		
	Total	**138(100.0)**	**176(100.0)**		
Community	Bokwai layout	24(17.4)	9(5.1)	94.96	**<0.001**
	Bwiyuku	4(2.9)	39(22.2)		
	Likoko Membea	7(5.1)	13(7.4)		
	Mevio	4(2.9)	23(13.1)		
	Naanga	26(18.8)	27(15.3)		
	Ndongo	56(40.6)	15(8.5)		
	Stranger East	4(2.9)	34(19.3)		
	Wonyalyonga	13(9.4)	16(9.1)		
	Total	**138(100.0)**	**176(100.0)**		
Age-group	40-49 years	54(39.1)	101(57.7)	10.66	**0.001**
	50-60 years	84(60.9)	74(42.3)		

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	Total	**138(100.0)**	**176(100.0)**		
Employment status	Employed	54(34.1)	56(31.8)	2.032	0.362
	Self-employed	62(44.9)	92(52.3)		
	Unemployed	22(15.9)	28(15.9)		
	Total	**138(100.0)**	**176(100.0)**		
Religion	Christian	121(87.7)	152(86.4)	0.124	0.940
	Muslim	9(6.5)	13(7.4)		
	Others(Pagan)	8(5.8)	11(6.3)		
	Total	**138(100.0)**	**176(100.0)**		
Income per month	<25,000CFA	15(10.9)	17(9.7)	36.276	**<0.001**
	>100,000CFA	62(44.9)	39(22.2)		
	25,000-50,000CFA	18(13.0)	75(42.6)		
	50,000-100,000CFA	43(31.2)	45(25.6)		
	Total	**138(100.0)**	**176(100.0)**		
Educational level	No formal education	3(2.2)	6(3.4)	33.79	**<0.001**
	Primary	15(10.9)	67(38.1)		
	Secondary	69(50.0)	48(27.3)		
	University	51(37.0)	55(31.3)		
	Total	**138(100.0)**	**176(100.0)**		
Marital status	Married	108(78.3)	122(69.3)	17.67	**0.001**
	Separated	7(5.1)	3(1.7)		
	Single	15(10.9)	48(27.3)		
	Widower	8(5.8)	3(1.7)		
	Total	**138(100.0)**	**176(100.0)**		

Table 5 presents the demographic factors independently associated with attitude towards prostate cancer screening. Men who lived in Bokwaongo were 4.392 times more likely to have a negative attitude towards prostate cancer screening compared to those who lived in Tole (AOR=4.392, CI=0.48-8.478, P=0.004) (See Table 5).

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Table 5: Socio-Demographic factors independently associated with attitude towards prostate cancer screening.

		AOR	CI (95%)	P-value
Health area	Bokwaongo	4.392	(0.48,8.478)	**0.004**
	Buea town	2.148	(-.0224,1.753)	0.129
	Molyko	18.556	(6.897,20.944)	**<0.001**
	Tole	1		
Income per month(x1000CFA)	<25	0.943	(-1.095,0.977)	0.912
	>100	1.629	(-0.210,1.186)	0.171
	25-50	0.458	(-1.572,0.671)	**0.053**
	50-100	1		
Educational level	No formal education	1.734	(-1.284,2.385)	0.556
	Primary	1.281	(-0.689,1.457)	0.604
	Secondary	2.807	(0.327,3.865)	**0.004**
	University	1		
Age-group	40-49 years	0.467	(-1.335,0.972)	**0.009**
	50-60 years	1		

Overall Practices towards Prostate Cancer Screening

As per the overall practice of prostate cancer screening, 96.82% (304) of them had poor practice while 3.18% (10) had good practice (See Figure 3).

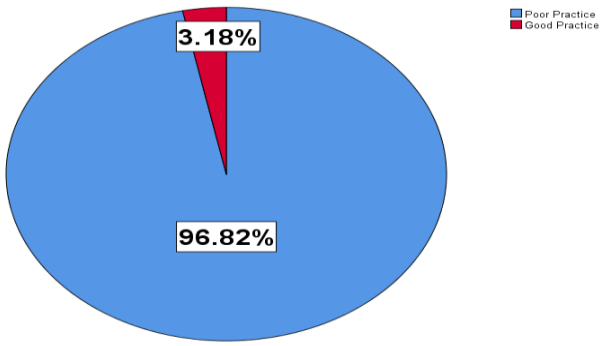

Figure 3: Overall Practice Level

Overall practice level was associated with socio-demographic characteristics and associations that were significant was: employment status (See Table 6).

Table 6: Association between Socio-demographic characteristics and overall practice of prostate cancer screening among men aged 40-60 years.

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		Overall Practice			
	Category	**Poor n (%)**	**Good n(%)**	**Chi-square**	**P-value**
Health area	Bokwaongo	70(23.0)	2(20.0)	3.491	0.322
	Buea Town	65(21.4)	3(30.0)		
	Molyko	103(33.9)	1(10.0)		
	Tole	66(21.7)	4(40.0)		
	Total	**304(100.0)**	**10(100.0)**		
Community	Bokwai layout	32(10.5)	1(10.0)	5.242	0.630
	Bwiyuku	41(13.5)	2(20.0)		
	Likoko Membea	19(6.3)	1(10.0)		
	Mevio	25(8.2)	2(20.0)		
	Naanga	52(17.1)	1(10.0)		
	Ndongo	71(23.4)	0(0.0)		
	Stranger East	36(11.8)	2(20.0)		
	Wonyalyonga	28(9.2)	1(10.0)		
	Total	**304(100.0)**	**10(100.0)**		
Age-group	40-49 years	149(48.8)	7(70.0)	1.733	0.188
	50-60 years	155(51.2)	3(30.0)		
	Total	**304(100.0)**	**10(100.0)**		
Employment status	Employed	107(35.2)	3(30.0)	9.384	**0.009**
	Self-employed	152(50.0)	2(20.0)		
	Unemployed	45(14.8)	5(50.0)		
	Total	**304(100.0)**	**10(100.0)**		
Income per month (x1000CFA)	<25	30((9.9)	2(20.0)	2.564	0.464
	>100	98(32.2)	3(30.0)		
	25-50	89(29.3)	4(40.0)		
	50-100	87(28.6)	1(10.0)		

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	Total	**304(100.0)**	**10(100.0)**		
Educational level	No formal education	9(3.0)	0(0.0)	7.158	0.067
	Primary	82(27.0)	0(0.0)		
	Secondary	114(37.5)	3(30.0)		
	University	99(32.6)	7(70.0)		
	Total	**304(100.0)**	**10(100.0)**		
Marital status	Married	222(73.0)	8(80.0)	0.755	0.860
	Divorced	10(3.3)	0(0.0)		
	Single	61(20.1)	2(20.0)		
	Widower	11(3.6)	0(0.0)		
	Total	**304(100.0)**	**10(100.0)**		

Association using multiple logistic regression was done between overall practice level and socio-demographic characteristics. Associations that were significant were: employment status (Self-employed) and age-group (40-49 years) (See Table 7).

Table 7: Association between overall level of practice and socio-demographic data using Multivariate Analysis

	Category	**AOR**	**CI (95%)**	**P-value**
Employment status	Employed	0.098	(-4.05,-0.60)	0.008
	Self-employed	0.046	(-5.00,.0.25)	**0.002**
	Unemployed	1		
Age-group	40-49 years	5.828	(0.13,9.39)	**0.034**
	50-60 years	1		

Challenges Faced Towards Prostate Cancer Screening

For the challenges faced towards prostate cancer screening, most participants did not have any challenge towards screening 72.9% (229) and amongst the participants who faced challenges, they identified lack of finance as their main challenge representing 40.2% (85) of the participants (See Table 8)

Table 8: Challenges faced towards Prostate Cancer Screening

Variable	**Response**	**Frequency (n)**	**Percent (%)**

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Faced challenges towards Prostate Cancer screening	No	229	72.9
	Yes	85	27.1
	Total	**314**	**100**
Challenges faced towards Prostate cancer screening	Lack of finance	45	40.2
	Lack of time	13	11.6
	Laziness	12	10.7
	Ignorance	32	28.6
	Fear	10	8.9
	Total	**112**	**100**

DISCUSSION

Knowledge towards prostate cancer screening

In assessing level of knowledge, a greater proportion of the participants could not define prostate cancer. Above half of the participants could not identify the gender prostate cancer affects. The findings of this study were different from a study carried out in Namibia which reported that 42.4% of the participants could not define prostate cancer [7]. The findings of this study were also different from a study carried out in South Africa, where they reported that 54.4% of their participants could not identify the gender affected by prostate cancer [8,9].

With all the questions on risk factors, treatment, prevention and symptoms on prostate cancer being asked, the overall knowledge levels were graded and our findings showed that, Below half of the participants had good knowledge on prostate cancer. The findings on overall knowledge of the participants was similar to a study carried out by in Nigeria where they reported that 54.9% of their participants had poor knowledge on prostate while 45.1% had good knowledge on prostate cancer [9].

The findings were also similar to a study carried out in Tanzania where they reported 52% of their respondents to have poor knowledge on prostate cancer while 48% of their respondents had good knowledge on prostate cancer [10].The similarities in the studies may be due to the fact that all the studies carried out were in low income African countries with similar characteristics to the participants in our study.

Men in the Molyko community were more likely to have poor knowledge on Prostate cancer compared to those in the Tole community.

Also, men who earned less than 25,000CFA were more likely to have poor knowledge on prostate cancer compared to those who earned more than 100,00CFA

Attitudes towards prostate cancer screening

Understanding men's attitudes towards prostate cancer screening is necessary for informing effective public health information and promoting informed decision making. Our findings on attitudes towards prostate cancer screening showed that most participants do not consider screening for prostate cancer. Our findings are in contrast with a study carried out in Nigeria which showed that 96.1% of the participants were willing to screen for prostate cancer [8].

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Also, 35.7% of participants from this study disagreed to the fact that screening was not necessary if one was fit and healthy which was different from a study carried in South Africa which reported that, 67.8% of their participants disagreed to the fact that, screening was necessary if one was fit and healthy [1].

Furthermore, 20.4% of the study participants had never considered screening for prostate cancer which was different from a study carried out in South Africa which reported that 60.8% of their participants had considered screening for prostate cancer [1,10]. A greater proportion of the participants agreed to the fact that all adults should undergo a prostate cancer screening test which was different from a study carried out in Nigeria which showed that, 39.2% of their participants agreed that it was necessary to screen for prostate cancer as an adult [5,11].

Overall attitude levels were obtained after grading the individual questions and it showed that 56.05% of our participants had positive attitudes towards prostate cancer screening and 43.95% had negative attitudes towards prostate cancer screening.

Our findings were different from a study carried out in Nigeria where 65.7% of participants expressed positive attitudes towards prostate cancer screening while 34.3% of the participants expressed negative attitudes towards prostate cancer screening [1,12]. Also, the findings were different from a study carried out in South Africa where 84.9% of the participants expressed positive attitudes towards prostate cancer screening while 15.1% expressed negative attitudes towards the screening for prostate cancer [1].

The difference in attitude levels may be due to differences in cultural beliefs and religious factors which play a significant role in shaping attitudes towards prostate cancer screening.

Overall attitude levels were associated with socio-demographic characteristics, whether they had heard of prostate cancer before and whether they had heard of prostate cancer screening before. Significant associations were found with: health area (Bokwango and Molyko), Income level (25,000-50,000 CFA), whether they had heard of prostate cancer before and whether they had heard of prostate cancer screening before with p-values <0.05 and confidence intervals excluding zero. The findings were different from a study carried out in Italy which showed that attitudes towards prostate cancer screening were influenced by fear, discomfort and trust in healthcare providers [13].

Practices Towards Prostate Cancer Screening.

Our findings revealed 91.7% of the participants had not screened for prostate cancer before while 8.3% had screened for prostate cancer before which was similar to a study carried out in Cameroon which reported that 8.1% of their participants had screened for prostate cancer before [6].

Most (95.9%) of the participants had never undergone a Prostate Specific Antigen test before and most (97.8%) of them had never undergone a digital rectal examination. Our findings were similar to a study carried out in Tanzania which showed that 92.3% of participants had never undergone a PSA test and a DRE. The findings may be similar due to similarity in study participants like the age and race [10].

Also, our findings revealed only 4.1% of the participants had undergone a PSA test before which was different from a study carried out in Italy where they reported that 29.6% of men had undergone a PSA test before and similar to a study carried out by Bugoye et al. (2019) which reported that, 7.7% of the participants had undergone a PSA test. This difference may be due to the different strategies put in place to enhance screening practices in the different countries [12].

Overall practice level from our study showed that 3.18% of the participants had good practices towards prostate cancer screening while 96.82% of the participants had bad practices towards prostate cancer screening from their screening rates. These findings were similar to a study carried out in Namibia where it showed that 4.7% of the participants had good practices towards prostate screening [7].

Multiple logistic regression indicated that employment status, age-group and whether they had heard of prostate cancer screening before were significantly associated with overall screening levels with p-values

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<0.05 and confidence intervals excluding zero. These findings were different from a study carried out in France that showed that healthcare provider recommendations and accessibility to screening services influenced screening practices [14].

Challenges faced towards prostate cancer screening

Challenges most often are being faced which may limit certain practices. Our study brought out some of the challenges the participants faced towards screening for prostate cancer which may have limited their practice.

Most of our participants did not face challenges towards prostate cancer screening while 27.1% of the participants faced challenges towards prostate cancer screening. These results may be due to the fact that most participants did not see a need for screening and so, they could not determine whether they had a challenge or not.

Out of the challenges specified by most participants, lack of finance was the highest challenge faced with 40.2% followed by, ignorance with 28.6% then laziness with 11.6%. Lack of finance is mostly common among individuals in low income countries. Also, ignorance on prostate cancer screening was seen as a challenge because most of the individuals had never been informed about screening techniques and so, had limited information about the screening procedure. These challenges being specified are most often common amongst low income countries

CONCLUSIONS

Prostate cancer is a significant Public Health issue in Cameroon but we find most men neglecting it and paying attention to it only when it has started presenting with signs and symptoms which may be at a terminal stage. From this study, conclusions made were:

Majority of our study participants had poor knowledge on prostate cancer despite the fact that most of them had heard of prostate cancer before and majority had not heard of its screening before. The poor knowledge made them inquire more about it after answering the questionnaires.

A greater proportion of the participants had positive attitudes towards prostate cancer screening which made them have a positive approach towards screening for prostate cancer.

Most of the participants had poor practices towards prostate cancer screening which makes them more exposed to it if interventions are not put in place to enhance practice levels.

Almost all the participants did not face challenges towards prostate cancer screening which was not expected due to their low level of practice towards screening for prostate cancer. Notwithstanding, specific challenges being faced by some participants were brought out and strategies can be put in place based on those challenges.

Finally, with prostate cancer being one of the leading causes of death amongst men and of Public health concern, we still find most men avoiding screening for it.

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests.

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