ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26nov275

Prostate Cancer Risk Assessment and Screening Intentions Among Middle-Aged Men in Selected Barangays in San Pablo City, Laguna

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Publication Date: 2026/11/18

Abstract: Prostate cancer remains a significant public health concern, particularly in semi-urban communities where awareness and access to screening services are limited. Guided by Dorothea Orem's Self-Care Theory, Nola Pender's Health Promotion Model, and the COM-B Model of Behavior Change, this study examined prostate cancer knowledge, perceived risk factors, and screening intentions among middle-aged men in selected barangays of San Pablo City, Laguna. A quantitative cross-sectional design was employed involving 371 men aged 40–65 years selected through stratified sampling. Data were collected using a validated questionnaire and analyzed using descriptive and non-parametric statistics. Findings revealed that respondents generally had high knowledge of prostate cancer and its risk factors but lower awareness of advanced signs and symptoms. Screening intentions were moderate, with affordability, physician recommendation, and family support identified as important facilitating factors. A statistically significant but weak positive relationship was found between knowledge and screening intention, indicating that greater awareness is associated with a higher likelihood of considering prostate cancer screening. However, financial constraints and limited access to healthcare services remained barriers to screening participation. This study is limited to middle-aged men from selected barangays in San Pablo City, Laguna, which may limit the generalizability of the findings. Nevertheless, the results contribute to understanding prostate cancer awareness and screening behaviors among Filipino men and highlight the need for community-based health education and nursing interventions to improve knowledge, reduce barriers, and promote early prostate cancer screening.

Keywords: *Prostate Cancer; Knowledge; Screening Intention; Prostate Cancer Screening; Middle-Aged Men.*

How to Cite: Venessa D. Escartin; Nemmar Nathaniel F. Biglete; Jallieyhan Lilac G. Mendoza; Meagan Gail L. Mia; Girlie Mannphy A. Lacambra; Dr. Marc Lester F. Quintana (2026) Prostate Cancer Risk Assessment and Screening Intentions Among Middle-Aged Men in Selected Barangays in San Pablo City, Laguna. *International Journal of Innovative Science and Research Technology*, 11(11), 525-533. https://doi.org/10.38124/ijisrt/26nov275

I. INTRODUCTION

Prostate cancer is one of the most commonly diagnosed cancers among men worldwide and remains a significant public health concern due to its potential for progression and metastasis. Despite advances in screening and treatment, the global burden of prostate cancer continues to increase, particularly in low- and middle-income countries where access to healthcare services is often limited (Rawla, 2019; Sung et al., 2021).

In the Philippines, prostate cancer is among the leading cancers affecting men. However, screening uptake remains low due to limited awareness, misconceptions, fear of diagnosis, financial constraints, and inadequate access to healthcare services, contributing to delayed detection and poorer health outcomes (Chiong et al., 2024).

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26nov275

Previous studies have shown that knowledge and perceived risk influence participation in prostate cancer screening (Odongo et al., 2020; Mbugua et al., 2021). However, most research has focused on general or urban populations, leaving limited evidence among middle-aged men in semi-urban communities. This gap highlights the need to better understand their knowledge, perceived susceptibility, perceived severity, perceived barriers, cues to action, and screening intentions regarding prostate cancer.

Guided by the Health Belief Model, this study aims to assess the level of knowledge, perceived risk, and screening intentions regarding prostate cancer among middle-aged men in selected barangays in San Pablo City, Laguna. The findings may provide evidence for developing targeted health education and early detection programs to improve prostate cancer awareness and screening participation.

II. METHODOLOGY

➢ *Research Design*

This study utilized a quantitative, analytical cross-sectional design to examine the association between respondents' knowledge of prostate cancer and their intention to undergo screening. Data were collected at a single point in time, allowing for the efficient analysis of relationships between variables without establishing causality.

➢ *Participants and Sampling Technique*

The study involved 371 middle-aged men aged 40–65 years residing in selected barangays of San Pablo City, Laguna (San Francisco, Del Remedio, and Concepcion). Respondents were selected through stratified sampling to ensure proportional representation from each barangay. Eligible participants were males within the specified age range, residing in the selected barangays, and willing to participate. Individuals diagnosed with prostate cancer, those with severe medical or cognitive conditions, and those who declined informed consent were excluded.

➢ *Research Instruments*

The study employed a structured questionnaire adapted from Salah M. et al. (2024) and patterned after De Leon et al. (2024), modified to align with the study objectives and local context. The 42-item instrument assessed respondents' socio-demographic profile, prostate cancer knowledge, risk factors, signs and symptoms, screening intentions, and facilitating and limiting factors using a 4-point Likert scale. Translated into Tagalog for better comprehension, the tool underwent expert validation and pilot testing among 30 middle-aged men, yielding an acceptable overall Cronbach's alpha of 0.742.

➢ *Data Gathering Procedure*

The data for this study were collected throughout January 2026 in selected barangays of San Pablo City, Laguna after securing approval from appropriate authorities and barangay officials. Ethical principles, including informed consent, confidentiality, anonymity, and voluntary participation, were observed. Using a hybrid approach, questionnaires were distributed through both paper-and-pen and Google Forms. Completed responses were collected, encoded, and subjected to statistical analysis.

➢ *Data Analysis Procedure*

Data were analyzed using frequency count, percentage, mean, and standard deviation to describe the respondents' profile, knowledge of prostate cancer, and screening intentions. The Kruskal–Wallis test, Mann–Whitney U test, and Spearman's rho correlation were used to determine significant differences and relationships among variables. Instrument validity was established through expert review, while reliability was ensured through pilot testing and standardized data collection procedures.

➢ *Ethical Considerations*

This study adhered to the ethical principles of beneficence, justice, and respect for persons. Approval was obtained from the research adviser and panel prior to data collection, and permission to adapt the research instrument was secured from the original authors. Informed consent was obtained from all participants after explaining the study's purpose, procedures, risks, and benefits. Participation was voluntary, and respondents could withdraw at any time without penalty. Confidentiality and anonymity were maintained by collecting no identifying information and storing data in password-protected files

III. RESULTS AND DISCUSSION

➢ *Sociodemographic Profile*

Table 1 presents the sociodemographic profile of the 371 respondents. The respondents were almost equally distributed across the age groups of 40–49 years (33.15%), 50–59 years (33.42%), and 60–65 years (33.42%), ensuring adequate representation of middle-aged men, particularly those at increased risk for prostate cancer due to advancing age. Most respondents were married (46.63%), had attained at least a high school education, belonged to the lower-income brackets, and were PhilHealth members (62.80%), while a considerable proportion (37.20%) were non-members. These findings suggest that although most respondents may have adequate social support and educational backgrounds that could facilitate health awareness, financial limitations may still hinder access to preventive healthcare services and prostate cancer screening. Previous studies have shown that married individuals are more likely to engage in preventive health behaviors due to spousal support and shared decision-making (Kim & Kim, 2024). Similarly, higher educational attainment has been associated with better health literacy and improved understanding of prostate cancer and its early detection (Salah et al., 2024). However, lower income remains a significant barrier to healthcare utilization and screening participation, as financial constraints often limit access to preventive services despite the availability of health insurance (Vergara et al., 2024). These demographic characteristics provide important context for understanding the respondents' knowledge and screening intentions regarding prostate cancer.

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26nov275

Table 1 Demographic Profile of the Respondents

AGE	FREQUENCY	PERCENTAGE
40 - 49	123	33.15
50 - 59	124	33.42
60 - 65	124	33.42
CIVIL STATUS		
Single	90	24.26
Married	173	46.63
Widowed	35	9.43
Live-in / Common Law Partner	40	10.78
Annulled	2	0.54
Separated	31	8.36
HIGHEST EDUCATIONAL ATTAINMENT		
Elementary undergraduate	20	5.39
Elementary graduate	32	8.63
High school undergraduate	55	14.82
High school graduate	101	27.22
College undergraduate	67	18.06
College graduate	85	22.91
Master's/Doctorate	11	2.96
INCOME		
Below ₱10,957	111	29.92
₱10,957–21,194	113	30.46
₱21,194–43, 828	71	19.14
₱43,828–76,669	45	12.13
₱76,669–131,484	17	4.58
₱131,484–219,140	8	2.16
Above 219,140	6	1.62
PHILHEALTH STATUS		
Member	233	62.80
Non-Member	138	37.20
Total	**371**	**100.00**

➢ *Knowledge of Respondents in Prostate Cancer*

Table 2 shows that respondents generally had a high level of knowledge regarding prostate cancer, with a composite mean of 2.90 (SD = 1.03). The highest-rated indicators were awareness that prostate cancer can become life-threatening if left untreated (M = 3.30, SD = 0.89) and that early detection improves treatment outcomes (M = 3.21, SD = 0.94). However, lower mean scores were observed in knowledge of prostate cancer stages (M = 2.68, SD = 1.05) and its ability to develop without symptoms (M = 2.69, SD = 1.10), indicating gaps in more specific disease-related information. These findings suggest that while respondents recognize the seriousness of prostate cancer and the importance of early detection, additional health education is needed to improve understanding of disease progression and asymptomatic presentation. This finding is consistent with Khalil et al. (2024), who reported that although men generally demonstrate good knowledge of prostate cancer, important gaps remain in specific aspects of the disease, highlighting the need for targeted educational interventions.

Table 2 Knowledge of the Respondents on Prostate Cancer

Knowledge on Prostate Cancer	Mean	SD	Interpretation
1. The prostate is a gland found only in men.	2.82	1.09	High
2. The prostate's main role is to help produce semen.	2.69	1.10	High
3. Prostate cancer is one of the most common cancers among men.	2.98	1.06	High
4. Prostate cancer is a malignant disease.	2.50	1.10	High
5. Prostate cancer has four stages (Stage I–IV).	2.68	1.05	High
6. Prostate cancer can be treated if detected early.	3.23	0.91	High
7. Prostate cancer can become life-threatening if left untreated.	3.30	0.89	Very High
8. Prostate cancer is most treatable when detected early.	3.21	0.94	High
9. Prostate cancer can develop in early stages without symptoms.	2.69	1.10	High
Composite Mean	2.90		High
SD	1.03		

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26nov275

➢ *Knowledge on Risk Factors*

Respondents demonstrated generally high awareness of prostate cancer risk factors, particularly regarding age, while awareness of lifestyle-related factors such as obesity was comparatively lower. This finding is consistent with Deng et al. (2024), who reported limited knowledge of modifiable risk factors among middle-aged men, as well as the American Cancer Society (2023) and the National Cancer Institute (2024), which identify advancing age as the primary risk factor for prostate cancer. The higher level of awareness regarding age-related risk may be attributed to greater exposure to basic cancer information through healthcare services and media sources, whereas modifiable risk factors receive less emphasis in health education. These findings underscore the need to strengthen educational interventions on lifestyle-related risks, as improved awareness may promote preventive behaviors and contribute to reducing the burden of prostate cancer (Chen et al., 2023).

Table 3 Knowledge of the Respondents on Prostate Cancer's Risk Factors

Risk Factors	Mean	SD	Interpretation
1. The risk of prostate cancer increases with age.	3.07	0.97	High
2. A family history of prostate cancer increases one's risk.	2.52	1.08	High
3. Being overweight or obese increases the risk of prostate cancer.	2.26	1.06	Low
4. A sedentary lifestyle may increase prostate cancer risk.	2.76	1.03	High
5. Frequent eating of red meat raises the risk of prostate cancer.	2.65	1.06	High
6. A diet high in fatty foods increases prostate cancer risk.	2.70	1.07	High
7. Cigarette smoking increases the risk of prostate cancer.	2.89	1.10	High
8. Exposure to pollution or workplace chemicals increases prostate cancer risk.	2.53	1.13	High
Hormonal imbalance, especially involving testosterone, contributes to prostate cancer.	2.60	1.05	High
Composite Mean	2.66		High
SD	1.06		

➢ *Knowledge on Signs and Symptoms*

As shown in Table 4, respondents demonstrated a high level of knowledge regarding the signs and symptoms of prostate cancer (M = 2.60, SD = 1.08). Higher mean scores were observed for commonly recognized urinary symptoms such as difficulty in urination (M = 2.74, SD = 1.08) and the presence of blood in urine or semen (M = 2.73, SD = 1.10), while lower scores were noted for advanced symptoms, including persistent lower back pain (M = 2.43, SD = 1.10), unexplained weight loss (M = 2.48, SD = 1.04), and weakness or numbness (M = 2.47, SD = 1.11). These findings suggest that respondents are more familiar with early urinary manifestations of prostate cancer than with symptoms associated with disease progression. This finding is consistent with the Mayo Clinic (2025), which identifies urinary difficulties and blood in urine or semen as the most commonly recognized symptoms of prostate cancer, whereas advanced manifestations are less frequently recognized by the general population.

Table 4 Knowledge of the Respondents on Prostate Cancer's Signs and Symptoms

Knowledge on Sign and Symptoms	Mean	SD	Interpretation
1. Frequent urination at night is linked to prostate problems, including cancer.	2.65	1.06	High
2. Difficulty starting or maintaining urine flow can be a sign of prostate cancer.	2.74	1.08	High
3. Pain or burning during urination may indicate prostate problems.	2.62	1.10	High
4. Blood in urine or semen can be a sign of prostate cancer.	2.73	1.10	High
Persistent pain in the lower back, hips, or pelvis is linked to advanced prostate cancer.	2.43	1.10	Low
6. Difficulty in maintaining an erection may indicate prostate enlargement.	2.71	1.07	High
7. Feeling very tired or weak may be an effect of prostate cancer.	2.58	1.07	High
8. Losing weight without trying can be a possible sign of prostate cancer.	2.48	1.04	Low
9. Weakness or numbness in the legs or arms may happen in advanced stage of prostate cancer.	2.47	1.11	Low
Composite Mean	2.60		High
SD	1.08		

➢ *Level of Respondents Screening Intentions*

As shown in Table 5, respondents demonstrated a high level of intention to undergo prostate cancer screening, with a composite mean of 2.77 (SD = 1.09). The highest-rated item was the belief that screening is important even without symptoms (M = 3.26, SD = 0.97), indicating strong awareness of the value of early detection. High ratings were also observed for willingness to take the PSA blood test (M = 2.99, SD = 1.04), intention to undergo screening (M = 2.64, SD = 1.12), and planning to schedule a medical check-up (M = 2.66, SD = 1.15). However, willingness to undergo Digital Rectal Examination (DRE) was low (M = 2.30, SD = 1.16), suggesting hesitancy toward more invasive screening procedures.

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26nov275

These findings indicate that although respondents generally have positive screening intentions, psychological and cultural factors may discourage participation in DRE. This finding is supported by Ngowi et al. (2023), who reported that embarrassment and fear are major barriers to prostate cancer screening uptake among men.

Table 5 Level of Respondents' Screening Intentions

Screening Intentions	Mean	SD	Interpretation
1. I am planning to schedule a medical check-up soon.	2.66	1.15	High
2. I intend to undergo a prostate screening test.	2.64	1.12	High
3. I am willing to undergo a Digital Rectal Exam (DRE) if necessary.	2.30	1.16	Low
4. I am willing to take the PSA blood test if recommended.	2.99	1.04	High
5. I believe screening is important even without symptoms.	3.26	0.97	Very High
Composite Mean	2.77		High
SD	1.09		

➢ *Facilitating Factor*

As shown in Table 6, facilitating factors had a high influence on prostate cancer screening intentions, with a composite mean of M = 2.83 (SD = 1.05). Affordability (M = 3.25, SD = 0.98) and doctor recommendation (M = 3.24, SD = 0.90) were the highest-rated factors, indicating that financial accessibility and professional advice strongly encourage screening, while awareness campaigns received the lowest rating (M = 2.13, SD = 1.12). These findings suggest that respondents are more likely to consider screening when it is affordable and recommended by healthcare providers. This is consistent with the American Cancer Society (2024), which identified physician recommendation as a key factor influencing participation in preventive health screening.

Table 6 Facilitating Factor

Facilitating Factors	Mean	SD	Interpretation
1. I will undergo screening if my doctor recommends it.	3.24	0.90	High
2. I will undergo screening if my family encourages me.	3.01	1.04	High
3. I will undergo screening if it is affordable.	3.25	0.98	Very High
4. Awareness campaigns encourage me to consider screening.	2.13	1.12	Low
5. Having PhilHealth or insurance helps me decide to undergo screening.	2.51	1.22	High
Composite Mean	2.83		High
SD	1.05		

➢ *Hindering Factor*

As shown in Table 7, the respondents experienced a high level of hindering factors in participating in prostate cancer screening (M = 2.77, SD = 1.14). The highest-rated barrier was "I avoid screening because I feel healthy" (M = 3.10, SD = 1.02), followed by "Screening is expensive or financially difficult" (M = 2.83, SD = 1.08) and "Lack of time prevents me from undergoing screening" (M = 2.79, SD = 1.12), indicating that perceived good health, financial difficulty, and time limitations were the primary barriers to screening participation. In contrast, "I avoid screening due to embarrassment" obtained the lowest mean score (M = 2.23, SD = 1.14), indicating that embarrassment was a less influential barrier among the respondents. This finding is consistent with Komane and Mosalo (2025) and Hao et al. (2025), who noted that low perceived risk reduces preventive health practices. Similarly, Waihenya et al. (2025) and Kim (2020) identified cost and time constraints as common barriers to screening participation.

Table 7 Hindering Factors

Hindering Factors	Mean	SD	Interpretation
1. I avoid screening because of fear or anxiety about the possible result.	2.34	1.17	Low
2. I avoid screening due to embarrassment.	2.23	1.14	Low
3. I avoid screening because I feel healthy.	3.10	1.02	High
4. Lack of time prevents me from undergoing screening.	2.79	1.12	High
5. Screening is expensive or financially difficult.	2.83	1.08	High
6. The screening facility is far from my location.	2.47	1.14	Low
Composite Mean	2.77		High
SD	1.14		

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26nov275

➢ *Significant Difference of the Respondents Level of Knowledge*

- *In Terms of when Grouped According to Age*

Table 8 Significant Difference of the Respondents' Knowledge on Prostate Cancer when Group According to Age

	Knowledge	**Sig.[a,b]**	**Decision**
1	Knowledge on Prostate Cancer	0.404	Retain the null hypothesis.
2	Signs and Symptoms	0.644	Retain the null hypothesis.
3	Risk Factors	0.803	Retain the null hypothesis.
a. The significance level is .050.			
b. Asymptotic significance is displayed.			

As shown in Table 8, the Kruskal–Wallis test revealed no significant difference in respondents' knowledge of prostate cancer when grouped according to age, including knowledge of the disease (p = 0.404), signs and symptoms (p = 0.644), and risk factors (p = 0.803), all of which are above the 0.05 level of significance. This indicates that age does not significantly influence respondents' knowledge across all domains, suggesting that individuals from different age groups have relatively similar levels of understanding. This may imply that exposure to information about prostate cancer is not age-dependent but may be influenced more by other factors such as education and access to health information. This finding is supported by Vergara et al. (2024), who reported that prostate cancer knowledge is more strongly associated with educational background and access to healthcare services than with age, emphasizing that chronological age alone is not a strong determinant of health knowledge.

➢ *In Terms of when Grouped According to Civil Status*

Table 9 Significant Difference of the Respondents' Knowledge on Prostate Cancer when Group According to the Civil Status

	Knowledge	Sig.[a,b]	Decision
1	Knowledge on Prostate Cancer	0.895	Retain the null hypothesis.
2	Signs and Symptoms	0.448	Retain the null hypothesis.
3	Risk Factors	0.837	Retain the null hypothesis.
a. The significance level is .050.			
b. Asymptotic significance is displayed.			

As shown in Table 9, the Kruskal–Wallis test revealed no significant difference in respondents' knowledge of prostate cancer when grouped according to civil status, including knowledge of prostate cancer (p = .895), signs and symptoms (p = .448), and risk factors (p = .837), as all p-values exceeded the 0.05 level of significance. These findings indicate that civil status does not significantly influence respondents' knowledge across the three domains, suggesting that men have relatively similar levels of awareness regardless of their relationship status. This implies that knowledge of prostate cancer may be influenced more by factors such as educational attainment, access to health information, and exposure to health promotion programs than by civil status. Similar findings have been reported in previous studies, which found that prostate cancer awareness is more strongly associated with health education and information access than with marital status (Echeverri et al., 2025; Adewoye et al., 2023).

➢ *In Terms of when Grouped According to Highest Educational Attainment*

Table 10 Significant Difference of the Respondents' Knowledge on Prostate Cancer when Group According to the Educational Attainment

	Knowledge	**Sig.[a,b]**	**Decision**
1	Knowledge on Prostate Cancer	<0.001	Reject the null hypothesis
2	Signs and Symptoms	0.003	Reject the null hypothesis
3	Risk Factors	0.014	Reject the null hypothesis
a. The significance level is .050.			
b. Asymptotic significance is displayed.			

As shown in Table 10, the results revealed a statistically significant difference in respondents' knowledge on prostate cancer (p < .001), signs and symptoms (p = .003), and risk factors (p = .014) when grouped according to educational attainment. Since all computed p-values were lower than the 0.05 level of significance, the null hypothesis was rejected. These findings indicate that respondents' knowledge regarding prostate cancer, including its signs and symptoms and risk factors, varies significantly according to educational attainment. These findings are consistent with Salah et al. (2024), who reported higher prostate cancer knowledge among more educated individuals. Similarly, Tapera et al. (2025) found that lower educational attainment is associated with poorer understanding, while Kariri (2025) emphasized the role of education in improving health literacy and awareness of prostate cancer.

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26nov275

➢ *In Terms of when Grouped According to Income*

Table 11 Significant Difference of the Respondents' Knowledge on Prostate Cancer when Group According to Income

	Knowledge	**Sig.[a,b]**	**Decision**
1	Knowledge on Prostate Cancer	0.026	Reject the null hypothesis
2	Signs and Symptoms	0.744	Retain the null hypothesis.
3	Risk Factors	0.808	Retain the null hypothesis.
a. The significance level is .050.			
b. Asymptotic significance is displayed.			

The Kruskal–Wallis test showed a significant difference in respondents' prostate cancer knowledge based on income level (p = 0.026), indicating that income influences general knowledge of the disease. However, no significant differences were found in knowledge of signs and symptoms (p = 0.744) and risk factors (p = 0.808). These findings are consistent with Akunna (2024), which reported that higher-income men were more likely to undergo prostate cancer screening, and are further supported by Waihenya et al. (2025), who identified financial constraints as barriers to prostate cancer help-seeking and early presentation.

➢ *In Terms of when Grouped According to Philhealth Membership Status*

Table 12 Significant Difference of the Respondents' Knowledge on Prostate Cancer when Group According to PhilHealth Membership Status

	Knowledge	Sig.[a,b]	Decision
1	Knowledge on Prostate Cancer	<0.001	Reject the null hypothesis
2	Signs and Symptoms	0.036	Reject the null hypothesis
3	Risk Factors	0.194	Retain the null hypothesis.
a. The significance level is .050.			
b. Asymptotic significance is displayed.			

As shown in Table 12, the Mann–Whitney U test revealed significant differences in respondents' knowledge of prostate cancer (p < .001) and signs and symptoms (p = .036) when grouped according to PhilHealth membership status, as both p-values were below the 0.05 level of significance. However, no significant difference was found in knowledge of risk factors (p = .194). These findings indicate that PhilHealth membership is associated with higher levels of knowledge regarding prostate cancer and its signs and symptoms, possibly due to greater access to healthcare services, health information, and screening opportunities. In contrast, knowledge of risk factors appears to be similar regardless of membership status, suggesting that access to healthcare alone may not be sufficient to improve awareness of disease risk factors. This implies the need for targeted health education programs that emphasize preventive knowledge and risk-factor awareness among both PhilHealth members and non-members. Similar findings have been reported by Montemayor (2025) and Gonzalez et al. (2021), who noted that health insurance coverage enhances access to healthcare information and services, thereby improving disease awareness and health knowledge.

➢ *Association Between the Respondents' Level of Knowledge about Prostate Cancer and their Level of Intention to Undergo Screening*

Table 13 Association Between the Respondents' Level of Knowledge about Prostate Cancer and their Level of Intention to Undergo Screening

Level of Risk	**R Value**	**Degree**	**P Value**	**Decision**	**Conclusion**
General Knowledge	.248	Weak Positive	<.001	Reject Ho	Significant
Risk Factors	.258	Weak Positive	<.001	Reject Ho	Significant
Signs and Symptoms	.278	Weak Positive	<.001	Reject Ho	Significant

As shown in Table 13, all domains of knowledge demonstrated a significant weak positive relationship with respondents' intention to undergo prostate cancer screening. Signs and symptoms showed the highest correlation (R = 0.278, p < .001), followed by risk factors (R = 0.258, p < .001) and general knowledge (R = 0.248, p < .001). These findings indicate that respondents with higher knowledge about prostate cancer were more likely to express an intention to undergo screening, although the weak correlation values indicate that knowledge has only a limited influence on screening intention. This finding is consistent with the Health Belief Model, which states that health behavior is influenced by both knowledge and perceived barriers (Alyafei & Easton-Carr, 2024). Similarly, Khalil et al. (2024) and Aynaci et al. (2024) reported that increased knowledge is associated with higher screening intention.

IV. CONCLUSION

This study establishes that socio-demographic factors, particularly educational attainment, income level, and PhilHealth membership, are key determinants of prostate cancer knowledge among middle-aged men in San Pablo City, while age and civil status show no significant influence.

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/26nov275

It contributes evidence that disparities in knowledge are mainly driven by access to education and healthcare resources rather than general demographic characteristics. The findings also demonstrate a significant but weak positive association between knowledge and intention to undergo screening, indicating that increased awareness is linked to higher screening intention but is not sufficient to independently drive behavior. This highlights that prostate cancer prevention is influenced by a combination of cognitive, economic, and accessibility-related factors.

In practice, the results emphasize the need to strengthen community-based and workplace health education programs that specifically target men with lower educational and income levels. At the policy level, improving accessibility and utilization of health insurance systems such as PhilHealth may enhance awareness and encourage preventive health behaviors. In the field of education, integrating prostate cancer awareness into health promotion campaigns and primary care education may help bridge knowledge gaps across populations. For research, future studies may explore additional behavioral and psychosocial determinants such as perceived susceptibility, cultural beliefs, and healthcare accessibility to better explain the gap between knowledge and screening behavior. Overall, the study underscores that improving prostate cancer screening uptake requires not only increasing knowledge but also addressing structural and behavioral barriers that influence health decision-making.

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