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Original Research Article

Assessment of Selfcare Practices among Patients with Benign Prostatic Hyperplasia in Akwa Ibom State: Multi-Centres Cross-Sectional Study

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Abstract: ***Background*:** Benign Prostatic Hyperplasia (BPH) is a prevalent urological condition among men, characterized by urinary difficulties, discomfort and diminished quality of life. Despite advances in medical intervention, inadequate self-care practices remain a significant challenge. Hence, the study assessed the self-care practices of patients with Benign Prostatic Hyperplasia (BPH) in three selected hospitals, Akwa Ibom State, Nigeria. ***Materials and Methods*:** A prospective cross-sectional study among 251 patients was conducted in selected hospitals using the Self-care questionnaire. Data on self-care practices were obtained and analyzed using statistical tools. ***Results*:** Patients with BPH self-care practices involves lifestyle/dietary modifications (Mean=2.90, SD=0.80), physical activity and exercise (Mean=2.70, SD=0.87) and bladder training and fluid management (Mean=2.67, SD=0.86) and medication adherence/follow-up (Mean=3.08, SD=0.76), which were rated moderate. In the domain of Physical activity and exercise, Item 12 indicated mean score of 2.38 and standard deviation of 0.95 indicating a low-level level of self-care practice of exercises patients with BPH in the selected hospital. ***Conclusion*:** Most patients actively engage in self-management behavior such as adhering to medication schedules, modifying diet, maintaining personal hygiene, and attending follow-up appointments. Such a positive trend may be attributed to increased health awareness and education from healthcare professionals.

Keywords: Benign Prostatic Hyperplasia, Healthcare, Self-Care.

INTRODUCTION

Benign prostatic hyperplasia (BPH) also referred to as Prostatic Hypertrophy is one of the common urological health conditions that significantly affect the quality of life of men worldwide, particularly in advancing age. Recent studies estimate that approximately 11.26 million patients are diagnosed with BPB annually particularly in tertiary healthcare facilities [1, 2]. Globally, BPH prevalence increases with age, with approximately 50% of men aged 60 years and above and up to 90% of men aged 85 years and above affected by the condition [3]. In sub – Saharan African countries which Nigeria is inclusive, BPH constitute a serious health problem with majority of cases occurring from age 50 to 80 years and above.

Self-care practices are vital in management of BPH, it involves activities that individuals undertake to maintain health, manage illness and also prevent complications. Self-care, defined as the set of activities individuals undertake to maintain health and manage illness, has been widely recognized as essential in managing chronic non-communicable diseases, including BPH [4]. It also empowers patients to actively participate in their treatment and symptom management,

according to WHO, self-care delineates the ability to individuals, families and communities to promote health, prevent diseases, maintain health and cope with illness with or without the support to health care providers [4]. This definition underscores the proactive role patients with BPH should undertake to manage symptoms of BPH and promote their physical, psychosocial and social aspect of health to improve their overall QoL. For BPH patients, self-care entails lifestyle modifications which include dietary adjustments and regulation, weight management, fluid management, regular physical activity such as pelvic exercises, management of emotional and psychological stress, adherence to prescribed medications and regular medical checkups [5, 6]. Studies indicate that adopting healthy lifestyle habits, such as reducing caffeine and alcohol intake, avoiding fluid intake before bedtime, maintaining a balanced diet, and engaging in regular exercise, can alleviate LUTS and improve QoL [7]. Additionally, pelvic floor muscle exercises have been shown to enhance bladder control and reduce urinary incontinence, further improving patients' QoL. Research has shown that effective self-care practices can mitigate symptoms of BPH, reduce hospital visits and improve the overall QOL of patients with chronic health conditions like BPH [8]. Self-care practices are crucial non-pharmacological approaches for managing BPH symptoms [6]. However, studies identified factors influencing self-care practices among patients with BPH to include, self-care education and awareness, Socio-demographic factor (social and family support), healthcare health related factors. In addition, hindrances and barriers such as financial constraints, physical and psychological discomfort, access to healthcare service also affect BPH patient's self-care practices and quality of life [9].

In Nigeria, particularly in University of Uyo Teaching Hospital (UUTH) and major secondary health facilities, the burden of BPH continues to rise due to aging demographics and access to specialized urological care [10]. However, the extent to which BPH patients at UUTH and ISH engage in these self-care practices is unclear [11]. Therefore, this study seeks to assess the self-care practices of patients among Benign Prostatic Hyperplasia in selected Hospitals in Akwa Ibom State, Nigeria,

MATERIALS AND METHODS

A prospective cross-sectional study design was conducted among of two hundred and fifty one purposively sampled patients with BPH at selected hospitals in Akwa-ibom State, Nigeria from August 2025 to February 2026. The inclusion criteria include patients diagnosed with BPH and agreed to participate in this study. Ethical approval letter with reference no: RSU/FBMS/REC/25/330 was obtained from the Human Research and Ethic committee of the Faculty of Basic Medical Sciences, College of Medical Sciences, River State University, Port Harcourt, Nigeria. Permission for this study was also obtained from the study centers. The information obtained were held in strict confident and use for this study only.

i. The self-care practices among patients with BPH were assessed using self-care practice questionnaire (SCPQ). Items in this section were adapted from the Self-Care of Chronic Illness Inventory (SCCII) and modified to reflect the unique self-care behaviours associated with managing BPH [12]. The questions assessed practices such as lifestyle modification and dietary habits, medication adherence, fluid intake regulation, avoidance of bladder irritants, dietary habits, physical activity, urination schedules, and monitoring symptoms. Each item was rated on a 4-point Likert scale type responses as: strongly agreed (1), Agreed (2), disagreed (3), strongly disagreed (4) adapted by previous studies [7].

Each item on the questionnaire was evaluated based on relevance, representativeness and clarity using a 4-point relevance scale. Their ratings were used to compute a Content Validity Index (CVI): A content validity index (CVI) was calculated for each item based on expert ratings. Items with CVI values below 0.78 was revised or removed, Item-Level CVI (I-CVI) ensured each item scored ≥0.8. Scale-Level CVI (S-CVI) averaged above the acceptable threshold of 0.85. This procedure ensured the instrument comprehensively captured self-care practices.

Patients who indicated interest in participating in this study were ushered to a private seating area and were informed orally and in writing about the patterns of the study, and that their participation will involve filling out questionnaire and providing answers to some questions. Each patient filled in the self-care practice questionnaire based on their ability to care for themselves as at the time of administering the questionnaire and interview. The Nurses and patient's relatives who involved in this study were adequately informed about the study and their consents and supports were duly sought. The researchers administered the questionnaire using one-to-one method and the completed questionnaire was retrieved immediately. Data such as gender, age group, self-care practices responses were collected using data capture sheet and analyzed using descriptive statistics (mean standard deviation, tables, frequency, percentages and bar chart) and data processing and analysis were done using Statistical Package for Social Sciences (SPSS) version 20(SPSS, Inc, Chicago, IL USA). The mean score of 2.50 was set for decision-making.

RESULTS

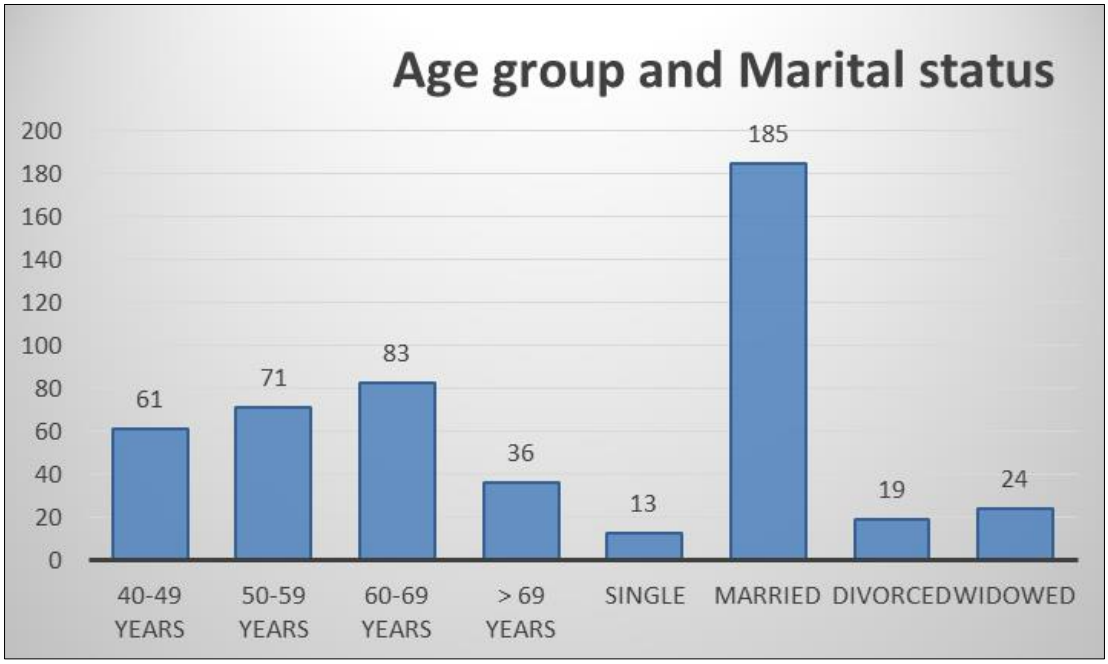

Figure 1: Distribution showing age group and marital status

Form figure 1 above based on age, out of 251 respondents the majority 83 (33.1%) were within the age group of 60 to 69 years followed by age group 50 to 59 years 71 (38.3%) and the least 36 (14.3%) were in the age bracket of 70 years and above. Large proportion 185 (73.7%) of the respondents we're married and the least 13 (5.2%) were single (Figure 1).

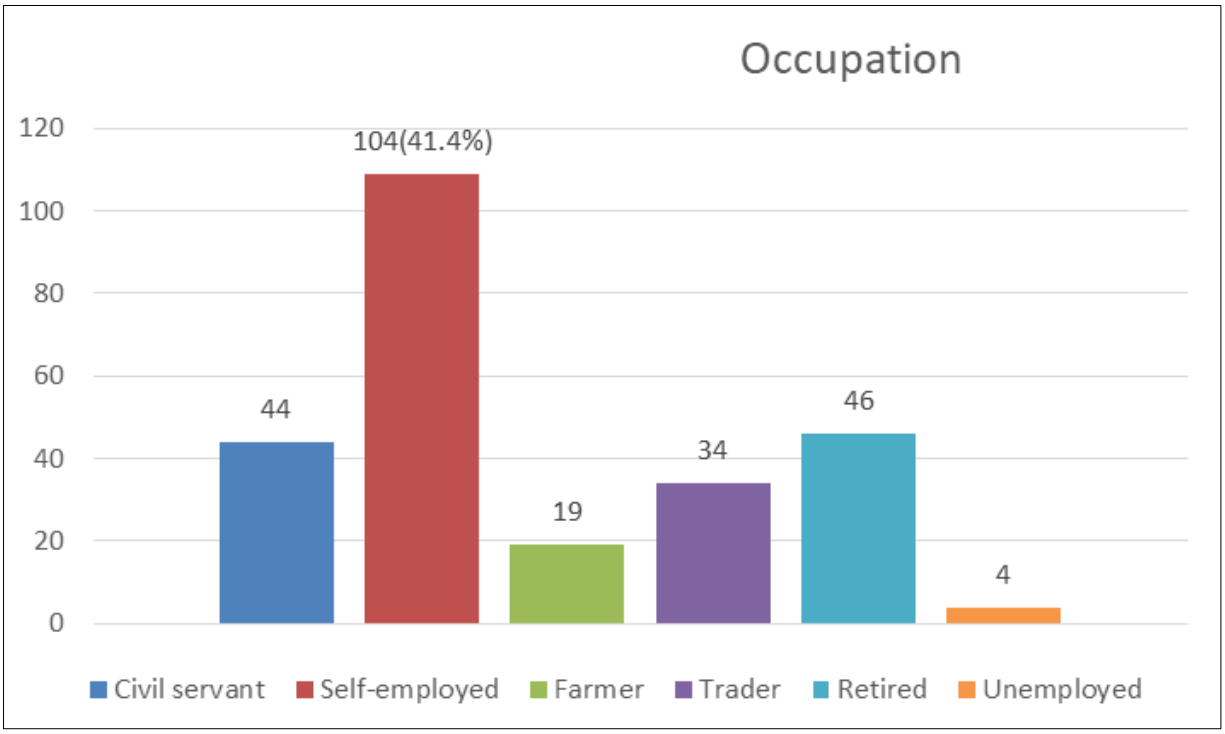

Figure 2: Distribution showing occupation

By occupation, 104 (41.1%) were self-employed followed by 46 (18.3%) were retired while 4 (1.6%) were unemployed (Figure 2).

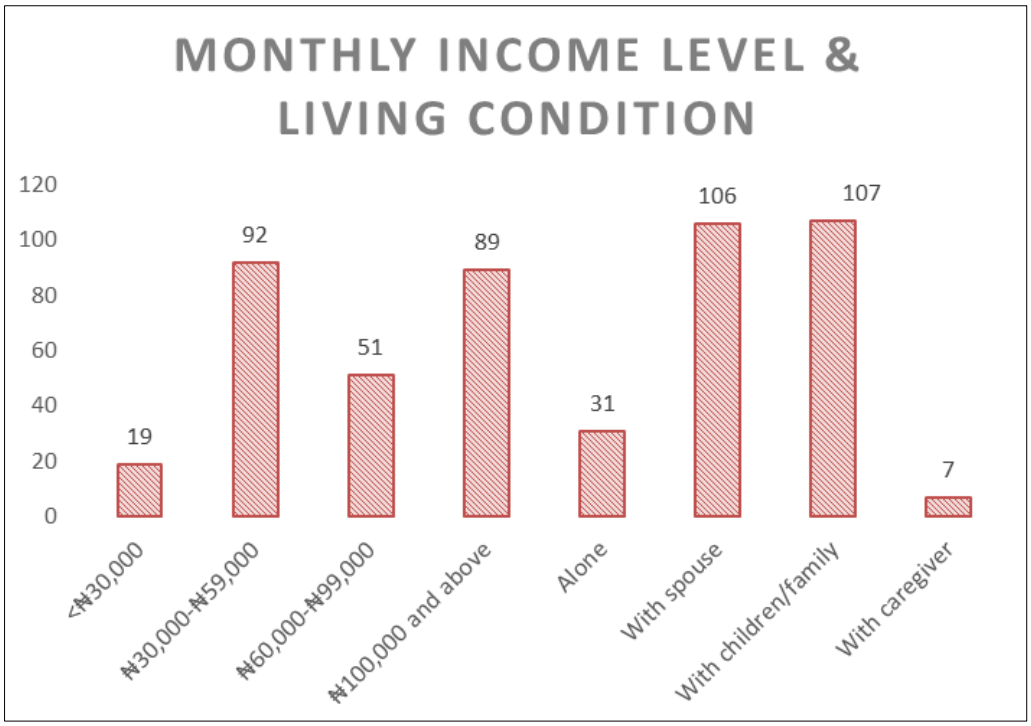

Figure 3: Distribution showing Monthly income and Living condition

Based on monthly income level, majority 92 (36.7%) earned ₦30,000–₦59,999 monthly, followed closely by 89 (35.5%) who earned ₦100,000 and above monthly, lastly 19 (7.6%) earned less than ₦30,000 monthly. The majority 107 (42.6%) lived with family and children followed by106 (42.2%) who lived with their spouses and the least 7 (2.8%) lived with caregivers (Figure 3).

Table 1: Frequency and percentage distribution of the respondents' socio-demographic variables

Variables	Categories	Frequency	Percentage (%)
Highest Educational Qualification	No formal education	5	2.0
	Primary education	34	13.5
	Secondary education	109	43.4
	Tertiary education	103	41.0
Duration of BPH Diagnosis	Less than 1 year	60	23.9
	1–3 years	90	35.9
	4–6 years	85	33.9
	More than 6 years	16	6.4
	Total	**251**	**100.0**

Based on highest educational qualification majority 109 (43.4%) and the least 5 (2%) have no formal education. On the duration of BPH diagnosis most respondents 90 (35.9%) have been diagnosed for 1-3 years subsequently 85 (33.9%) 4-6 years and least 16 (16.4%) for more than 6 years (Table 1).

Table 2: Summary of descriptive statistics (Mean & SD) on the level of self-care practices adopted by patients with BPH from selected hospitals in Akwa Ibom State

S/N	Statement	SA	A	D	SD	Mean	SD	Ranking	Decision Rule
A	**Lifestyle / Dietary Modification**								
	Caffeinated drinks, alcohol, and spicy foods were avoided to prevent worsening urinary symptoms.	85	110	49	7	3.09	0.80	3rd	moderate
	Diets rich in fruits, vegetables, and whole grains were consumed regularly.	61	134	52	4	3.00	0.72	6th	Moderate
	Reducing the intake of red meat and fatty foods helped to manage weight gain.	36	130	72	13	2.75	0.76	12th	Moderate

S/N	Statement	SA	A	D	SD	Mean	SD	Ranking	Decision Rule
	late night meals and sugary foods were avoided, helped to manage my BPH condition.	39	124	51	37	2.66	0.91	17th	Moderate
	Balanced diet was followed as recommended by my health care provider maintain a healthy weight.	80	101	65	5	3.02	0.81	5th	Moderate
	Grand Total					**2.90**	**0.80**		**Moderate**
B	**Bladder Training and Fluid Management**								
	Double voiding is practiced (wait and attempt to urinate again after 20 seconds) to assist completely empty my bladder.	32	133	75	11	2.74	0.73	13th	Moderate
	Urinating at set intervals even though I do not feel like urinating (timed voiding) is encouraged	58	83	84	26	2.69	0.94	15th	Moderate
	Drinks that stimulate the bladder (alcohol, coffee, artificial sweeteners and acidic drinks) were avoided	39	139	38	35	2.73	0.89	14th	Moderate
	Drinking water at least 2 hours before bedtime to reduce nighttime urination is practice.	67	106	64	14	2.90	0.86	9th	Moderate
	keeping bladder diary daily to track urination habits and symptoms is practiced	25	70	109	47	2.29	0.88	20th	Low
	Grand Total					**2.67**	**0.86**		**Low**
C	**Physical Activity and Exercise**								
	Engaging in regular physical activities or exercises weekly is practiced.	48	85	111	7	2.69	0.81	16th	Moderate
	Pelvic floor exercises (e.g., Kegel exercises) is practiced regularly to tighten my bladder.	42	54	113	42	2.38	0.95	19th	Low
	Engaging in exercise regularly to stay physically active is practiced.	55	121	63	12	2.87	0.80	11th	Moderate
	Walking or stretching at least 30 minutes daily is always practiced.	69	113	51	18	2.93	0.87	7th	Moderate
	Following exercise plan as recommended by health care providers is practiced	38	105	78	30	2.60	0.89	18th	Moderate
	Grand Total					**2.70**	**0.87**		**Moderate**
D	**Medication Adherence / Follow-up**								
	BPH medication is taken as prescribed by my healthcare provider.	94	130	21	6	3.24	0.70	2nd	High
	BPH prescribed medication is not skipped	50	131	64	6	2.90	0.74	3rd	Moderate
	Schedule follow-up appointments are kept regularly.	62	115	63	11	2.91	0.82	10th	Moderate
	Side effects of BPH medication are reported to my healthcare provider.	11	92	35	6	3.28	0.79	1st	High
	Importance of always taking BPH medication is under stood.	69	142	26	14	3.06	0.77	4th	moderate
	Grand Total					**3.08**	**0.76**		**Moderate**
	Grand Mean score					**2.84**	**0.82**		**Moderate**

Key: SA - Strongly Agreed, A-Agreed, D- Disagreed, SD - Strongly Disagreed

From table 2 above the mean and standard deviation values for statement used to evaluate lifestyle and dietary modification such as, avoid caffeinated drinks alcohol and spicy food to prevent urinary symptoms and I consume diets rich in fruits, vegetables, and whole grains regularly are 3.09 0±.80 and 3.00 ±0.72 respectively while I reduce the intake of red meat and fatty foods to manage weight gain was 2.75 ±O.76. The grand mean value or score for lifestyle modification is 2.90 0.±80. The grand mean of 2.90 was greater than the cut-off mean score of 2.50, indicating a moderate level of self-care practices.

The table further revealed that the mean and standard deviation use to determine the domain of bladder training and fluid management patients with BPH self-care practices such as i avoid drinking water at least 2 hours before bedtime to reduce nighttime urination and I urinate at set intervals even though I do not feel like urinating (timed voiding) were 2.90 ±0.86 and 2.69±0,94 respectively while I keep bladder diary daily to track urinary habits was 2.29 +- 0,88. The grand mean value for Bladder training and fluid management is 2.67±0.86 indicating moderate bladder training practice (Table 2).

Moreover, table on physical activity and exercise statements such as and I walk or stretch at least 30 minutes daily and i avoid sedentary lifestyle by engaging in exercise to stay physically active showed mean value and standard deviation of 2.93±0.87and 2.87± 0.80 while the least follow exercise plan as recommended by health care providers was 2.60 ± 0.89. The grand total Mean value for physical activity and exercise is 2.7±0.87 (Table 2).

The last component of the table above, the mean and standard deviation statement value for statement used to examine medication adherence/follow-up such as I report any side effects of my medications to my healthcare provider and I take my BPH medication as prescribed by my healthcare provider a were 3.2±40.70 ±and 3.06 ± 0.77 while I do not skip doses of my prescribed medication was 2.9 ± 0.74. The total mean score and in this domain 2.70, 0.87. The grand mean Score of all the areas of self-care practices is 2.84 and 0.82 indicating moderate level of self-care practices (Table 2).

The table further revealed that patients with BPH self-care practices adopted lifestyle/dietary modifications (Mean=2.90, SD=0.80), physical activity and exercise (Mean=2.70, SD=0.87) and bladder training and fluid management (Mean=2.67, SD=0.86) and medication adherence/follow-up (Mean=3.08, SD=0.76), which were rated moderate. In the domain of Physical activity and exercise, Item 12 indicated mean score of 2.38 and standard deviation of 0.95 indicating a low-level level of self-care practice of exercises patients with BPH in the selected hospital (Table 2).

Table 3: Summary of descriptive Statistics (Mean & SD) on the hindrances (barriers) to effective Self-Care Practices and Quality of life among patients with BPH in selected hospitals in Akwa Ibom State

S/N	Statement	SA	A	D	SD	Mean	SD	Remark
i.	BPH patients receive enough knowledge and adequate information about condition	37	148	62	4	2.87	0.67	Moderate
ii.	healthcare providers always teach and educate patients on self-care practices of BPH	36	165	49	1	2.94	0.59	Moderate
iii.	The hospital is far from my home to receive care for BPH and self-care practices	27	123	94	7	2.68	0.70	Moderate
iv.	family support affect self-care routines or practices	17	138	70	26	2.58	0.77	Moderate
v.	Adequate information and education on self-care is provided by health care provider	23	104	103	21	2.51	0.78	Moderate
vi.	Cultural believes and the use of traditional medicine and herbs hinder self-,care of patients with BPH	29	78	111	33	2.41	0.86	Moderate
vii.	Side effects of BPH medicine discourages taking of BPH medicine	43	93	108	7	2.69	0.79	Moderate
viii.	The belief that as a man discussing my BPH condition affect self-care practices	19	62	153	17	2.33	0.71	low
ix.	The shame (stigma) of sharing my BPH symptoms affect self-care practices	31	91	101	28	2.50	0.85	low
x.	Not receiving regular follow-up reminders for checkups for managing my BPH	24	157	50	20	2.74	0.74	moderate
xi.	Money to purchase medicine and eat healthy diet hinders self-care practice	35	130	66	20	2.72	0.80	Moderate
xii.	Religious beliefs about BPH do not support hospital medicine to treat BPH and attribute it to spiritual causes	28	52	77	94	2.06	1.01	moderate
	Grand Total					**2.58**	**0.77**	**Moderate**

Key: SA - Strongly Agreed, A-Agreed, D- Disagreed, SD - Strongly Disagreed

From table 3 above, on Hindrance (Barriers to effective self- care practices of patient with BPH, the mean and standard deviation for statement such as I have knowledge about my provider always teach and my health care provider always teach and educate me on self- care practices of BPH are 2.87 $\pm$0.67 and 2.94 while my religion do not support hospital medication and BPH attributed to spiritual causes and I am a man and do not belief I need to share my BPH condition ware 2.06 $\pm$ 1.01 and 2.23 $\pm$ 00.71. The grand mean value for barriers to self- care practices is 2.58 $\pm$ 0.77

Also, the grand mean score of 2.58 was greater than the cut-off mean score of 2.50, indicated moderate self- care practices (Table 3).

Table 4: Summary of descriptive statistics (Mean & SD) on how healthcare providers support system promotes self-care practices among patients with BPH in selected hospitals in Akwa Ibom State

S/N	Statement	SA	A	D	SD	Mean	SD	Ranking	Remark
1.	Healthcare providers explain in details, self-care practices of BPH to me	89	115	45	2	3.16	0.74	2nd	Moderate
2.	Adequate information and education is provided on how to manage BPH	65	135	48	3	3.04	0.71	5th	Moderate
3.	The provider encourages on adoption of healthy lifestyle practices.	76	145	28	2	3.18	0.65	1st	Moderate
4.	Adequate emotional support, counseling and monitoring of self-care by my healthcare provider is provided	40	156	47	7	2.99	1.38	6th	Moderate
5.	Educational materials (e.g. pamphlets, videos) were given to me to read on self-care practices	42	124	63	22	2.74	0.84	7th	Moderate
6.	Referred to support services is available (e.g., counseling, dietician).	33	139	59	20	2.74	0.79	8th	Moderate
7.	Health provider answers questions and listens to BPH concerns (feed-backs communication).		159	30	5	3.07	0.65	4th	moderate
8.	Prescribed medications are always adhered, side effects are reported and routine checkups.	70	152	22	7	3.14	0.68	3rd	Moderate
	Grand Total					**3.01**	**0.80**		**Moderate**

Key: SA - Strongly Agreed, A-Agreed, D- Disagreed, SD - Strongly Disagreed

From table 4 above, the mean and standard deviation values for statement used to evaluate healthcare provides support system such as the healthcare providers encourage me to adopt healthy lifestyle practices and my healthcare provider explains in details self-care practices to me 3.18 =0.65 and 13.16 $\pm$0.71. I was educational materials (eg. Pamphlets, video) where given or shown to me to read and watch on BPH self-care and I was referred to support services (counseling, dietician) are 2.74$\pm$079 and 2.74$\pm$. Also, the grand mean score of 3.01 was greater than the cut-off mean score of 2.50, indicated that patients agreed that a healthcare providers support system promote self-care practices enhance the quality of life among patients with BPH in the tertiary hospitals in Akwa Ibom State (Table 4).

DISCUSSION

The results of the study indicate that level of self-care practices adopted by patients with BPH from selected hospitals in Akwa Ibom State is moderate, with the grand mean score of 2.84 which was greater than the cut-off mean score of 2.50. These results suggest that most patients with BPH engage in slightly consistent self-care practices aimed at managing their condition. This high level of self-care practice in some domain could be attributed to several factors. First, increased health awareness and patient education efforts by healthcare providers in Akwa Ibom State may have improved patients' knowledge and motivation toward personal health management. Second, counselling and urology clinic attendance in hospital settings might have reinforced patients' compliance with recommended lifestyle adjustments. Third, access to information through media and community health campaigns also enhanced patients' understanding of how self-care practices contribute to symptom control and improved quality of life. Patients with chronic conditions who receive consistent health education tend to adopt higher self-care behaviours.

There is consistency between the findings of this study and that of G [13], mixed method study in Nigeria who noted that most respondents adhered to medication regimens lifestyle modification, but few reported engaging in regular exercise.

Similarly, these findings are in agreement with the findings of the study conducted by [14], in India that although majority of respondents were aware of self-care recommendations, only 53% practiced them consistently. The study also found that self-care practices are significantly associated with symptom severity among patients with BPH. They recommended that outpatient clinics adopt brief, repeated education sessions for BPH patients and suggested inclusion of family members in educational interventions.

Findings of this study is inconsistent with Alzahrani *et al*., [15], study in Saudi Arabia which reported low awareness and knowledge of BPH and that many men did not adopt recommended self-care (fluid timing, bladder training,

reducing stimulants), and recommended that healthcare providers should implement public health educational campaigns and primary care counseling to improve awareness and practical self-care adoption. Contrary to this finding, Albarqouni *et al.,* [16], and Emberton [17], studies in Northern Uganda revealed that quantitative data showed low levels of self-care adherence, with only few participants performing fluid management properly. It recommended mobile clinics, partnerships with community leaders, and culturally sensitive BPH health talks on local radio stations to improve self-care practices.

The result regarding the hindrances (barriers) to effective self- care practices by patients with BPH in selected hospitals in Akwa Ibom State indicated that the grand mean score of 2.58 was greater than the cut-off score of 2.50. Similarly, based on the responses, lack of regular follow-up reminders for checkups highest followed by insufficient money to purchase medicine and eat healthy diet to promote self-care practice, side effects of BPH medicine, distance from home to hospital to receive care for BPH and self-care practices, lack of family support to maintain self-care routines or practices were rated high as key hindrances (barriers) to effective self- care practices among patients with BPH in selected hospitals in Akwa Ibom State. The finding corroborates with Tadesse *et al*., [18], study that identified distance and transport limitations as major structural barriers of which the researcher went further to recommend mobile clinics, transport stipends, and decentralized BPH care. This is because, of the distance between the treatment centre and place of residence of the patients, transport fare always constitute barrier to their mobility for accessing medical treatment. The multiple barriers participants identified are health system inefficiencies, high cost of medication, stigma, side-effects from administering drugs, are widely reported as drivers of delayed diagnosis and poor adherence. Interventions that address affordability, strengthen primary care education, and integrate culturally-sensitive counselling show promise for improving engagement [19].

Furthermore, the finding shows that the respondents homogeneously agreed to all the items, that healthcare providers support system promote self-care practices and quality of life among patients with BPH in the tertiary hospitals in Akwa Ibom State, given to the grand mean of 3.01 was greater than the cut-off score of 2.50. in particular the respondents agreed that healthcare providers encourage patients to adopt healthy lifestyle practices, explaining self-care practices of BPH to patients in details, encourage patients to adhere to prescribed medications, report side effects and routine checkups, answer their questions and listens to their concerns (feedback communication), give adequate information and education on how to manage BPH, give emotional support, counseling and monitoring of self-care, referred them to support services (e.g., counseling, dietitian) and give educational materials (e.g. pamphlets, videos) on self-care practices.

That healthcare providers (HCPs) can correct misconceptions and promote self-care but are under-utilized aligns with patient-centred BPH literature: provider counselling, tailored education and follow-up improve knowledge, adherence and outcomes, yet many systems fail to deliver consistent counselling or culturally. The finding is in tandem with Essiet [20], study which found that effective communication is essential to ensure understanding and engagement in self-care. This buttress and support regular consultation/counseling between the caregivers and the patients. This regular consultancy helps the physician to monitor and evaluation the healing progress of the patient.

Participants' understanding of BPH being shaped by personal experience, culture and spiritual explanations rather than prior medical knowledge matches findings from several African and mixed-setting studies that report low public knowledge about prostate disorders and the dominance of cultural/spiritual interpretations of urinary/men's health problems. These knowledge gaps are associated with low screening and late presentation. It further revealed that urinary symptoms (difficulty, frequency, nocturia) prompt care-seeking, i.e., reactive rather than preventive behaviour is consistent with literature showing that lower urinary tract symptoms (LUTS) are the main drivers for presentation and that men often delay seeking care until symptoms interfere with daily life [20].

The mix of lifestyle change, inconsistent medication adherence, financial barriers, and use of herbal remedies in reflects that patients commonly adopt fluid/alcohol adjustments and other self-care strategies; herbal/ethno-botanical remedies remain widely used in many African settings for prostate problems; and adherence to long-term BPH medication is often poor, amplified by cost, side effects and beliefs. These dynamics explain why informal advice and cultural practice continue to influence management. BPH reduces quality of life causing sleep disruption, fatigue, embarrassment, social withdrawal, anxiety, financial strain and sexual dysfunction is strongly supported by QoL and psychosocial studies of men with BPH/LUTS that report marked effects on sleep, daily functioning, mental health and sexual function, and consequent reductions in well-being and productivity [21]. That healthcare providers (HCPs) can correct misconceptions and promote self-care but are under-utilized aligns with patient-centred BPH literature: provider counselling, tailored education and follow-up improve knowledge, adherence and outcomes, yet many systems fail to deliver consistent counselling or culturally.

CONCLUSION

The finding suggests that most patients actively engage in self-management behaviour such as adhering to medication schedules, modifying diet, maintaining personal hygiene, and attending follow-up appointments. Such a

positive trend may be attributed to increased health awareness and education from healthcare professionals. The study shows that for every increase in self-care activities; there is a corresponding improvement in quality of life. This result found that self-care behaviour such as medication adherence and diet regulation significantly improved life satisfaction among men with lower urinary tract symptoms, self-care behaviour mediated both symptom relief and psychological well-being among prostate patients.

Analysis of socio-demographic factors revealed that educational qualification and marital status had statistically significant relationships with self-care practices among patients with BPH. Educated patients exhibited better understanding of their condition, followed instructions more effectively, and complied with treatment plans as report of the findings reveals that education level and social support significantly improved health-seeking behaviour among men with prostate conditions. Likewise, married patients benefited from spousal encouragement and family support, which enhanced adherence to prescribed therapies through structured education programs and family involvement enhanced patient self-management.

The study also showed that barriers such as limited health literacy, cost of care, access to healthcare, masculinity, stigma, and inadequate family support did not significantly predict the adoption of self-care practices. Although these barriers existed, their impact was minimal, possibly because most patients received sufficient counselling and institutional support to overcome them. This implies that while logistical and financial challenges existed, continuous education and follow-up by healthcare providers mitigated their effects, health facilities provided supportive care and regular communication, and perceived barriers did not substantially hinder patients' self-management behaviour. Finally, the relationship between healthcare provider support systems and self-care practices was found to be strong and significant, indicating that healthcare provider supports accounted for patients' self-care practices. This reveals that healthcare provider support through education, counselling, communication, and follow-up increases, patients' self-care practices substantially. This highlights the importance of the patient-provider relationship in promoting better disease management outcomes.

Conflict of Interest: None declared among the authors.

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