



# Adherence to Osteoporosis Screening and Its Related Factors: A Population-Based Study, Kerman, Iran

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## Abstract

**Background:** Adherence to screening services is a prerequisite for the success of screening programs.

**Objectives:** This study aimed at determining factors associated with participants' compliance with Dual-energy X-ray Absorptiometry (DXA) screening for osteoporosis.

**Methods:** In this population-based participatory study, 1000 males and females older than 55 years old were invited to participate in the study. The study took place in the city of Kerman, Iran, where subjects were informed face to face about the risk factors and complications of osteoporosis and asked to complete a questionnaire. The subjects were then invited to visit a densitometry center for a free DXA study. Four rural areas and 4 locations in Kerman were selected based on municipal divisions.

**Results:** A total of 923 individuals completed the questionnaire: 562 (60.9%) were female, nearly two-thirds were from urban areas, and 284 (30.8%) were willing to undergo densitometry. Eight percent had a history of corticosteroid use for more than 3 months. About two-thirds of the participants were walking less than 150 minutes per week. In the logistic regression analysis, urban residents (OR = 1.88), females (OR = 1.52), and those who perceived high risk of osteoporosis (OR = 1.67) were more likely to adhere to DXA screening.

**Conclusions:** On the whole, despite informing people about osteoporosis and offering free services, compliance to densitometry was not remarkable.

**Keywords:** Hip Fracture, Prevention, Population-Based Screening

## 1. Background

Osteoporosis, known as a silent killer, is a major public health problem worldwide (1). Osteoporosis refers to bone density that is 2.5 standard deviations or less than (T-score  $\leq$  -2.5 SD) the mean peak bone mass in reference young individuals (2). Osteoporotic fractures reduce people's quality of life and increase their risk of mortality (3). Hip fracture, in particular, is the most devastating of all fractures, such that 1 in 5 people with this type of fracture die in the first year, post-injury (3). Estimates indicate that the number of hip fractures will increase by approximately 4 times, between 1990 and 2050 (4). Currently, hip fractures account for the highest share of mortality and disability (disability-adjusted life years) among osteoporotic fractures (5).

A recent meta-analysis showed that 17% of Iranians older than 30 years experienced osteoporosis, and the inci-

dence grew over time; the main reason being an increase in life expectancy in Iran (6). In terms of osteoporosis-induced hip fractures, Iran is among high incidence countries, or so-called "red countries" (7). A population-based study showed that peak bone mass is lower in Iran than in either American or European populations (8).

Osteoporosis does not appear clinically until bone fracture, therefore, early detection is crucial in high-risk patients, especially the elderly (9). Because 50% of hip fractures occur due to osteoporosis, any actions to prevent or facilitate early detection of osteoporosis can have a significant impact on controlling hip fracture (10). Different methods are used to screen for osteoporosis; among them, Dual-energy X-ray Absorptiometry (DXA) is the gold standard and most widely used method (11,12). The majority of professional societies agree with the screening age of 65 years and older for females (9); however, there is no con-

sensus regarding the screening age for males. The National Osteoporosis Foundation and the American College of Preventive Medicine recommend screening for males aged 70 years and older without risk factors (12).

Although no clinical trials on the impact of DXA screening have yet been reported, longitudinal studies have shown that the use of this type of screening was associated with a 36% reduction in the incidence of hip fracture (13). To increase the effectiveness of screening, it is very important to assess the participation of people in screening programs (14) and to explore factors associated with their nonadherence (15). Despite the importance of DXA screening in the early detection of osteoporosis (16), studies in the United States showed that only 30% of females and 4% of males older than 65 years had a DXA exam (9). In this regard, it seems necessary to study the adherence of individuals to DXA screening to increase their compliance because success will not be achieved in reducing the burden of disease "without a system that addresses the determinants of adherence" (17). According to the World Health Organization (WHO), adherence is defined as "the extent to which a person's behavior follows medical advice" (17). In general, studies have shown that osteoporosis screening adherence is lower than cancer screening adherence, and the few studies performed in Western countries (9,14) have placed more emphasis on treatment than on compliance to screening (18). To the best of the author's knowledge, this is the first study to assess the level of patients' adherence to DXA screening and the relevant factors under controlled conditions in a non-Western country.

## 2. Methods

### 2.1. Setting

This study was conducted during year 2016, using a community-based participatory approach in Kerman, the largest city in the South-East of Iran, where two-thirds of the people live in urban areas. Kerman as the 10th most populous city of Iran has a population of nearly 800000 with moderate climate and a strong cultural heritage. More than 8% of inhabitants are aged 60 years or over. The target population consisted of people older than 55 years. The reason for choosing people in this age group is the high prevalence of osteoporosis in Iranians, who are younger than 65 years (8); in addition, most females are expected to experience menopause at this point in their lives. Recently, some Western studies have also suggested this age cut-off for DXA study (19).

### 2.2. Sampling

Trained Community Health Workers (CHWs) visited various households selected through cluster sampling.

The target population consisted of Kerman county residents. Sampling framework included 4 rural areas and 4 municipal divisions of Kerman city, which were randomly chosen from a list of areas under coverage of urban and rural health centers. A total of 30 clusters, each with 35 households, were enrolled in the study. From these households, 1000 people were invited to complete a questionnaire. It was estimated that a sample size of 1000 subjects was needed to estimate the prevalence in densitometry compliance of 30% with a statistical precision of  $\pm 4\%$  (95% confidence interval) and a design effect of 2.0 due to cluster sampling.

Inclusion criteria were oral informed consent and age older than 55 years. People, who were taking bisphosphonates or calcitonin and those undergoing hormone replacement therapy for treatment of osteoporosis were excluded.

### 2.3. Protocol

Primary care services in Iran are routinely provided in both rural and urban areas by CHWs. Community Health Workers are required to communicate with the covered population either directly or through health volunteers by phone or in person at least once every 3 months. After introducing themselves and explaining the objectives of the study, an eligible member of the household was randomly selected and interviewed on the doorstep of their home. An informed consent was obtained from the subject before completing the questionnaire, and he or she was then invited to visit a densitometry center for a free hip densitometry exam. The subject was also informed face to face about the risk factors and complications of osteoporosis, and an illustrated pamphlet with scientific descriptions and the address of the densitometry center was provided. In cases where there was a definite diagnosis of osteoporosis, the patients were referred to a rheumatologist.

### 2.4. Ethical Considerations

The study protocol was approved by the Ethics Committee of Kerman University of Medical Sciences (IR.KMU.REC.1394.364). After explaining the goal and the protocol of the study for the potential participants, verbal consent was obtained.

### 2.5. Assessment Tool

A questionnaire was prepared by the authors and its content validity was confirmed according to experts and an extensive literature review (1,3,13,20-22), and previous experience which showed acceptable validity and reliability (20). The questions addressed demographic variables and possible factors associated with osteoporosis,

and measured the perceived risk of osteoporosis using a visual analogue scale. Arbitrarily, if the perceived risk score was higher than the median (i.e. 3), it was considered high and otherwise low.

### 2.6. Statistical Analysis

A multivariate logistic regression model was used to determine the relationship between variables and their adherence to DXA screening, and the Hosmer-Lemeshow test was used for model fitness. P values of  $< 0.5$  were considered significant. Statistical analyses were done using the SPSS 21 software.

## 3. Results

A total of 1000 individuals were invited for interviews, and 923 of them accepted the interview (93.2% response rate), 562 (60.9%) of whom were females. Table 1 shows the baseline characteristics of the study population. Mean ( $\pm$  SD) body weight and height of male participants were 69.0 (12.1) and 165.6 (11.8), and for females, they were 66.5 (12.3) and 158.7 (8.2), respectively. Mean ( $\pm$  SD) body mass index in the sample was 26.6 (5.6).

**Table 1.** Demographic Characteristics of Participants (n = 923)

Variable	Number	Percentage
<b>Age, y</b>		
55.0 - 59.9	293	31.7
60.0 - 64.9	224	24.3
65.0 - 69.9	147	15.9
> 70	259	28.1
<b>Gender</b>		
Male	562	
Female	361	60.9
<b>Education</b>		
Illiterate	39.1	37.2
Elementary	290	31.4
Secondary	81	8.8
High school diploma	121	13.1
College	88	9.5
<b>Residency</b>		
Urban	563	61.0
Rural	360	39.0

Several risk factors associated with osteoporosis had different frequencies (Table 2); thus, some risk factors were observed in a significant percentage of respondents, including menopause occurring before the age of 45 in

nearly one-fourth of the females, consumption of corticosteroids for more than 3 months in 8% of patients, and opium use in 16.4%. Only one person reported consuming alcohol.

**Table 2.** Variables Associated with Osteoporosis (n = 923)

Variable	Number	Percentage
Corticosteroids consumption	74	8.0
Antiepileptic	16	1.7
History of osteoporosis or fracture of hip, wrist, or lumbar vertebrae in father	49	5.3
History of osteoporosis or fracture of hip, wrist, or lumbar vertebrae in mother	70	7.6
Consumption of calcium pills/syrup	247	26.8
Smoking/hookah use	120	13.0
Opium abuse	151	16.4
Alcohol consumption	1	0.1
<b>Walking time per week, min</b>		
< 150	578	62.6
> 150	345	37.4
<b>Daily use of milk/yogurt, cup</b>		
not at all	199	21.6
1 - 3	609	66.0
> 3	115	12.5
Hearing about osteoporosis	153	16.6
Amenorrhea before 45 years	132	23.5
Breastfeeding	138	24.6
Mean $\pm$ SD of age of menarche	13.6 $\pm$ 1.6	
Mean $\pm$ SD of delivery number	1.6 $\pm$ 3.1	

Of the 932 people, who were invited for densitometry, 284 people underwent the exam (30.8%, CI 95%: 27.9 to 33.8). In logistic regression analysis, place of residence, gender, and perceived risk of osteoporosis were significantly associated with adherence to DXA (Table 3).

As shown in Table 4, the prevalence of osteoporosis increases in patients, who have undergone densitometry as they age ( $P < 0.001$ ), so that more than one-third of people older than 70 years experienced osteoporosis.

## 4. Discussion

The study showed that despite initially informing the subjects about the risks of osteoporosis and providing free densitometry, less than one-third of people older than 55 years adhered to the DXA study. In a relatively similar study by the same team in the same settings regarding adherence to mammography in breast cancer screening, 22.4%

**Table 3.** Factors Associated with Densitometry Compliance Based on Logistic Regression Analysis

Variable	Adherence Frequency (%)	OR (Adjusted)	CI 95%	P Value
<b>Age, y</b>				
55.9 - 59	87 (29.7)	Reference	Reference	
60.9 - 64	76 (33.9)	1.46	(0.2 - 98.17)	0.060
65.9 - 69	51 (34.7)	1.34	(0.2 - 86.09)	0.201
> 70	70 (27.0)	1.01	(0.1 - 67.52)	0.950
<b>Gender</b>				
Male	88 (24.4)	Reference	Reference	
Female	196 (34.9)	1.52	(0.0 - 44.83)	0.012
<b>Education</b>				
Illiterate	94 (27.4)	Reference	Reference	
Primary	84 (29.0)	1.07	(0.1 - 74.56)	0.716
Secondary	31 (38.3)	1.45	(0.2 - 83.54)	0.190
High school diploma	45 (37.2)	1.38	(0.2 - 84.26)	0.199
University	30 (34.1)			
<b>Residency</b>				
Urban	77 (21.4)	Reference	Reference	
Rural	207 (36.8)	1.88	(1.2 - 34.62)	< 0.001
<b>Dealing with educational materials</b>				
Yes	49 (32.0)	Reference	Reference	
No	235 (30.5)	0.93	(0.1-62.40)	0.731
<b>Perceived risk</b>				
Low	124 (24.7)	Reference	Reference	
High	160 (38.1)	1.67	(1.2 - 23.25)	< 0.001
<b>History of osteoporotic fracture in parents</b>				
No	248 (30.0)	Reference	Reference	
Yes	36 (37.5)	1.20	(0.1 - 76.90)	0.430

**Table 4.** Prevalence of Femoral Neck Osteoporosis in Different Age Groups that Accepted Densitometry (284 People)

Age Group	Number	Normal	Osteopenia	Osteoporosis
55.0 - 59.9	87	32 (36.8)	41 (47.1)	14 (16.1)
60.0 - 64.9	76	18 (23.7)	42 (55.3)	16 (21.1)
65.0 - 69.9	51	10 (19.6)	29 (56.9)	12 (23.5)
> 70	70	4 (5.7)	41 (58.6)	25 (35.7)
<b>Total</b>	284	64 (22.5)	153 (53.9)	67 (23.6)

of females, who had completed the risk assessment questionnaire performed the free mammogram (23), which was lower than the participation rate obtained from this study (i.e. 30.8%). In African American and Caucasian postmenopausal females, 21% and 27% were adherent to DXA (24), respectively, whereas the mammography screening rate was far higher in the same subgroup of population in

the United States (70%) compared with densitometry (25). The reason for the variation in adherence between the 2 countries can be attributed to the difference in perceived risk, self-efficacy for screening, illness behavior of individuals, and affordability and accessibility of services (26,27). However, it has been proven that free services can increase compliance (26); in other words, if the people had to pay

for densitometry, then the adherence rate would certainly be lower.

With emphasis by US health policy makers on the risks of osteoporosis (28) and growing public awareness of the benefits of densitometry screening, the rate of people undergoing DXA exams is increasing (9). The study also showed that the rate of adherence to the DXA study in people, who perceived high risk of osteoporosis was 1.7 times higher. The rate of adherence in females was 1.5 times that of males. This finding was also indicated by other studies, so that in comparison with 4% of males, 30% of females in the elderly population of the United States had a history of DXA screening (9). Although the risk of osteoporosis in females is twice that of males, it should be noted that the risk of death due to hip fracture in hospitals is 2 times greater in males than in females (29).

One other important factor that affects adherence to screening is physical access to services and disparity (24). In this study, the odds ratio was considered in relation to the location of people's homes, so that urban residents were 1.9 times more likely than rural residents to adhere to DXA screening. Thus, one reason for attendance to screening after listening to the recommendations of CHWs was perhaps due to people's proximity to the densitometry center. A small percentage of respondents (about 17%) were trained or had read an article about osteoporosis, which was lower compared with similar studies from Western countries (20). It should be noted that the high level of information about osteoporosis that comes from the media and friends does not necessarily lead to increased concern (18).

According to the World Health Organization (WHO), a screening program is effective when at least 70% of eligible people are covered (30). The adherence rate of 31% is very low despite CHWs providing face-to-face education to individuals, providing them with a pamphlet, and offering them free DXA screening.

Due to low acceptance rate of densitometry (about 31%), one cannot argue about the prevalence of osteoporosis with confidence, and it was found that only 6% of people older than 70 years had normal bone density, which confirms the need for screening even in males older than 70 years old (31). Non-adherence remains a major challenge in screening of osteoporosis, which has recently been emphasized by authorities (32).

Prevalence of 2 risk factors was worrisome in this study. It has been shown that opium addiction is a potent risk factor for osteoporosis and increases the risk threefold (22). More than 16% of the study population were opium users, which was similar to a study in the same geographical area for people older than 50 years (33). The prevalence of this risk factor should be considered in national guidelines of

osteoporosis screening in Iran. A second risk factor involved corticosteroid use. That is, 8% of the participants had a history of corticosteroid consumption for longer than 3 months, and studies have shown that the frequency of corticosteroid consumption in Iranian females is about 4 times higher than in Hindi females (21).

The main limitation of the current study was that it was done in Kerman city and due to cultural and infrastructural differences, the generalizability of results to the whole country should be done with caution.

As a result of the low adherence of participants in this study, despite initial sensitization through face-to-face education and free densitometry, an abundance of some unique risk factors, and the prevalence of osteoporosis, especially in subjects older than 70 years, it is necessary to perform additional studies to increase adherence to densitometry screening.

## Footnote

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## References

1. Parsons LC. Osteoporosis: incidence, prevention, and treatment of the silent killer. *Nurs Clin North Am.* 2005;**40**(1):119-33. doi: [10.1016/j.cnur.2004.09.001](https://doi.org/10.1016/j.cnur.2004.09.001). [PubMed: [15733951](https://pubmed.ncbi.nlm.nih.gov/15733951/)].
2. Kanis JA, McCloskey EV, Johansson H, Oden A, Melton LJ, Khaltaev N. A reference standard for the description of osteoporosis. *Bone.* 2008;**42**(3):467-75. doi: [10.1016/j.bone.2007.11.001](https://doi.org/10.1016/j.bone.2007.11.001). [PubMed: [18180210](https://pubmed.ncbi.nlm.nih.gov/18180210/)].
3. Lane NE. Epidemiology, etiology, and diagnosis of osteoporosis. *Am J Obstet Gynecol.* 2006;**194**(2 Suppl):S3-11. doi: [10.1016/j.ajog.2005.08.047](https://doi.org/10.1016/j.ajog.2005.08.047). [PubMed: [16448873](https://pubmed.ncbi.nlm.nih.gov/16448873/)].
4. Cummings SR, Melton LJ. Cummings SR, Melton LJ 3rd. Epidemiology and outcomes of osteoporotic fractures. *Lancet.* 2002;**359**:1761-7. *Lancet.* 2002;**359**:1761-7.
5. Briggs AM, Cross MJ, Hoy DG, Sanchez-Riera L, Blyth FM, Woolf AD, et al. Musculoskeletal Health Conditions Represent a Global Threat to Healthy Aging: A Report for the 2015 World Health Organization World Report on Ageing and Health. *Gerontologist.* 2016;**56** Suppl 2:S243-55. doi: [10.1093/geront/gnw002](https://doi.org/10.1093/geront/gnw002). [PubMed: [26994264](https://pubmed.ncbi.nlm.nih.gov/26994264/)].
6. Irani AD, Poorolajal J, Khalilian A, Esmailnasab N, Cheraghi Z. Prevalence of osteoporosis in Iran: A meta-analysis. *J Res Med Sci.* 2013;**18**(9):759-66. [PubMed: [24381618](https://pubmed.ncbi.nlm.nih.gov/24381618/)].
7. Kanis JA, Oden A, McCloskey EV, Johansson H, Wahl DA, Cooper C, et al. A systematic review of hip fracture incidence and probability of fracture worldwide. *Osteoporos Int.* 2012;**23**(9):2239-56. doi: [10.1007/s00198-012-1964-3](https://doi.org/10.1007/s00198-012-1964-3). [PubMed: [22419370](https://pubmed.ncbi.nlm.nih.gov/22419370/)].
8. Larijani B, Hossein-Nezhad A, Mojtahedi A, Pajouhi M, Bastanagh MH, Soltani A, et al. Normative data of bone Mineral Density in healthy population of Tehran, Iran: a cross sectional study. *BMC Musculoskelet Disord.* 2005;**6**:38. doi: [10.1186/1471-2474-6-38](https://doi.org/10.1186/1471-2474-6-38). [PubMed: [15992408](https://pubmed.ncbi.nlm.nih.gov/15992408/)].
9. Curtis JR, Carbone L, Cheng H, Hayes B, Laster A, Matthews R, et al. Longitudinal trends in use of bone mass measurement among older americans, 1999-2005. *J Bone Miner Res.* 2008;**23**(7):1061-7. doi: [10.1359/jbmr.080232](https://doi.org/10.1359/jbmr.080232). [PubMed: [18302495](https://pubmed.ncbi.nlm.nih.gov/18302495/)].



10. Oden A, McCloskey EV, Johansson H, Kanis JA. Assessing the impact of osteoporosis on the burden of hip fractures. *Calcif Tissue Int*. 2013;**92**(1):42-9. doi: [10.1007/s00223-012-9666-6](#). [PubMed: [23135744](#)].
11. Lochmuller EM, Muller R, Kuhn V, Lill CA, Eckstein F. Can novel clinical densitometric techniques replace or improve DXA in predicting bone strength in osteoporosis at the hip and other skeletal sites? *J Bone Miner Res*. 2003;**18**(5):906-12. doi: [10.1359/jbmr.2003.18.5.906](#). [PubMed: [12733731](#)].
12. Kling JM, Clarke BL, Sandhu NP. Osteoporosis prevention, screening, and treatment: a review. *J Womens Health (Larchmt)*. 2014;**23**(7):563-72. doi: [10.1089/jwh.2013.4611](#). [PubMed: [24766381](#)].
13. Kern LM, Powe NR, Levine MA. Association between screening for osteoporosis and the incidence of hip fracture. *Ann Intern Med*. 2005;**142**:173-81.
14. World Health Organization. *Cancer Control: Knowledge Into Action: WHO Guide for Effective Programmes: Module 4: Diagnosis and Treatment. WHO Guidelines Approved by the Guidelines Review Committee*. Geneva; 2008.
15. Street RJ, Gordon HS, Ward MM, Krupat E, Kravitz RL. Patient participation in medical consultations: why some patients are more involved than others. *Med Care*. 2005;**43**(10):960-9. [PubMed: [16166865](#)].
16. Levy BT, Hartz A, Woodworth G, Xu Y, Sinift S. Interventions to improving osteoporosis screening: an Iowa Research Network (IRENE) study. *J Am Board Fam Med*. 2009;**22**(4):360-7. doi: [10.3122/jabfm.2009.04.080071](#). [PubMed: [19587249](#)].
17. Sabate E. *Adherence to long-term therapies: evidence for action*. World Health Organization; 2003.
18. Alami S, Hervouet L, Poiraudau S, Briot K, Roux C. Barriers to Effective Postmenopausal Osteoporosis Treatment: A Qualitative Study of Patients' and Practitioners' Views. *PLoS One*. 2016;**11**(6). e0158365. doi: [10.1371/journal.pone.0158365](#). [PubMed: [27355576](#)].
19. Nayak S, Roberts MS, Greenspan SL. Cost-effectiveness of different screening strategies for osteoporosis in postmenopausal women. *Ann Intern Med*. 2011;**155**(11):751-61. doi: [10.7326/0003-4819-155-11-201112060-00007](#). [PubMed: [22147714](#)].
20. Jalili Z, Nakhaee N, Askari R, Sharifi V. Knowledge, attitude and preventive practice of women concerning osteoporosis. *Iran J Pub Health*. 2007;**36**(2):19-25. Persian.
21. Keramat A, Patwardhan B, Larijani B, Chopra A, Mithal A, Chakravarty D, et al. The assessment of osteoporosis risk factors in Iranian women compared with Indian women. *BMC Musculoskelet Disord*. 2008;**9**:28. doi: [10.1186/1471-2474-9-28](#). [PubMed: [18304358](#)].
22. Gozashti MH, Shahesmaeili A. Is opium addiction a risk factor for bone loss? *Iran Red Crescent Med J*. 2011:464-8. Persian.
23. Jafari M, Nakhaee N, Goudarzi R, Zehtab N, Barouni M. Participation of the Women Covered by Family Physicians in Breast Cancer Screening Program in Kerman, Iran. *Asian Pacific J Cancer Prevent*. 2015;**16**(11):4555-61. Persian.
24. Hamrick I, Cao Q, Agbafé-Mosley D, Cummings DM. Osteoporosis healthcare disparities in postmenopausal women. *J Womens Health (Larchmt)*. 2012;**21**(12):1232-6. doi: [10.1089/jwh.2012.3812](#). [PubMed: [23140203](#)].
25. Gathirua-Mwangi WG, Monahan PO, Stump T, Rawl SM, Skinner CS, Champion VL. Mammography Adherence in African-American Women: Results of a Randomized Controlled Trial. *Ann Behav Med*. 2016;**50**(1):70-8. doi: [10.1007/s12160-015-9733-0](#). [PubMed: [26416127](#)].
26. Adonis L, Basu D, Luiz J. Predictors of adherence to screening guidelines for chronic diseases of lifestyle, cancers, and HIV in a health-insured population in South Africa. *Glob Health Action*. 2014;**7**:23807. doi: [10.3402/gha.v7.23807](#). [PubMed: [24647130](#)].
27. Barcenilla-Wong AL, Chen JS, March LM. Concern and risk perception: effects on osteoprotective behaviour. *J Osteoporos*. 2014;**2014**.
28. U.S. Dept of Health and Human Services RMU. *Bone health and osteoporosis: a report of the Surgeon General*. 2004.
29. Cheng N, Green ME. Osteoporosis screening for men: are family physicians following the guidelines? *Can Fam Physician*. 2008;**54**(8):1140-1. 1141 e1-5. [PubMed: [18697977](#)].
30. World Health Organization WHO. *Cancer control: knowledge into action: WHO guide for effective programmes*. World Health Organization; 2007.
31. Mottaghi P. Osteoporosis in Men: A Neglected Problem. *Iran Red Crescent Med J*. 2010;**12**(1):79. Persian.
32. LaVallee LA, Scott MA, Hulkower SD. Challenges in the Screening and Management of Osteoporosis. *N C Med J*. 2016;**77**(6):416-9. doi: [10.18043/ncm.77.6.416](#). [PubMed: [27864493](#)].
33. Nakhaee N, Divsalar K, Meimandi MS, Dabiri S. Estimating the prevalence of opiates use by unlinked anonymous urine drug testing: a pilot study in Iran. *Subst Use Misuse*. 2008;**43**(3-4):513-20. doi: [10.1080/10826080701772348](#). [PubMed: [18365947](#)].