

Not all men

Knowledge guide to earlier detection of cancer in men

CANCERFONDEN

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Breaking down the unseen barrier to healthcare

Men consistently have slightly lower survival rates for cancers that affect both women and men. Although the differences for each type of cancer are small, they recur across several cancers and contribute to unequal outcomes in cancer care. Men are also less likely to participate in screening and tend to seek healthcare later when symptoms occur. As a result, cancer is more often detected at a later stage, when treatment is less effective.

Fewer men are also vaccinated against HPV, leaving them less well protected against related cancers. Differences in access to vaccination, including the absence of catch-up vaccination in some regions, and in uptake of existing programmes contribute to preventable cancers.

This report addresses what may be described as a silent barrier to healthcare. It arises when obstacles relating to knowledge, access and motivation delay or prevent healthcare-seeking and participation in screening, organised prostate cancer testing (OPT) and vaccination, without any deliberate rejection of healthcare.

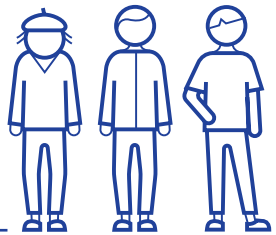
The report provides an accessible, evidence-based overview of the factors influencing men's healthcare-seeking, alongside tools and approaches that regional services can use to reach more men. By working more systematically and effectively, regions can encourage men to seek healthcare promptly, enabling earlier cancer detection and saving lives.

Although cancer screening uptake rates in Sweden are relatively high compared with other European countries, participation varies between regions and population groups. We therefore hope this guide can also inspire other countries seeking to increase participation in cancer screening and uptake of HPV vaccination.

The knowledge exists. The tools exist. But as long as they are not fully used, inequalities will persist. This report shows how they can be put into practice – and why action is needed now.

Together, we can defeat cancer.

This report is intended primarily for those who organise, plan and make decisions about regional services involving prevention, screening and early cancer detection.



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Summary

An unseen barrier to healthcare affects men's chances of detecting cancer

Men seek healthcare later and are less likely to participate in screening, HPV vaccination and organised prostate cancer testing (OPT), meaning that cancer is detected too late. This is not a matter of unwillingness, but of barriers that make timely action too difficult. This report has been produced for those who organise, plan and make decisions about regional services covering preventive measures, screening and early cancer detection.

Clear differences – but considerable potential too

In 2024, 38,865 men were diagnosed with cancer in Sweden. More than 40 per cent of all men will develop cancer at some point in their lives, and each year approximately 1,500 more men than women receive a cancer diagnosis at an advanced stage.

Early cancer detection makes a difference. Cancer mortality has declined over time and survival is now considerably higher than in the past. This means that there is considerable scope to improve outcomes further by reaching more men earlier.

The report shows that some groups face greater barriers than others, particularly socioeconomically disadvantaged men, men born outside Sweden, men living alone and young men eligible for HPV vaccination. These groups often have lower levels of knowledge about symptoms, testing, screening or vaccination.

To improve equity in early cancer detection, general measures are therefore not enough; regions need to combine a broad focus on men with targeted approaches for groups whose participation is particularly low.

Several factors influence men's behaviour

Men's participation and help-seeking behaviour are influenced by several interacting factors. According to the COM-B model, behaviour is shaped by three components:

- Capability (knowledge and individual ability)
- Opportunity (accessibility and routes into care)
- Motivation (risk perception, trust and norms)

To increase participation, interventions need to address all three factors simultaneously.

The report therefore focuses on the early stages of the pathway, from symptoms going unnoticed or not being taken seriously to delays in contacting healthcare services. These are stages at which regions can influence participation and early detection.

From knowledge to action – tools and approaches

The report aims to translate knowledge into practical action at regional level. It presents both tools for reaching men as a group and targeted tools for selected populations. It also includes a prioritisation matrix for assessing tools according to their expected impact and resource requirements.

This guide should not be read as a set of ready-made recommendations, but as a structured decision-making aid. Its purpose is to help regions identify groups with low participation, select appropriate interventions and prioritise according to local needs, resources and objectives.

The knowledge is available. The tools are available. The next step is to use them more systematically to reach more men in time and thereby improve the conditions for both preventive measures and early detection.



Reaching more men in time offers considerable potential to detect cancer earlier – and save more lives.

Men's behaviour is key to early detection and prevention

Sweden's cancer care is of world-class quality, and outcomes have improved over time. More and more people diagnosed with cancer now survive, and progress is moving in the right direction.

At the same time, healthcare services face several challenges. Under Sweden's Health and Medical Services Act, care must be provided on equal terms to the whole population. Opportunities to access healthcare and have cancer detected early should not depend on factors such as sex, socioeconomic circumstances or background.

Nevertheless, inequalities persist. Cancer outcomes vary between groups, as do opportunities for early detection and participation in preventive measures. These differences affect both when cancer is diagnosed and the treatment options available. This report focuses on inequalities in early detection and prevention, with particular emphasis on men's participation in screening, organised prostate cancer testing, vaccination and healthcare-seeking.



Men develop cancer more often – but survival is improving

Men develop cancer at a higher rate than women, and the number of new cancer cases has increased over time. At the same time, cancer mortality has declined, meaning that a greater proportion of those diagnosed today survive their disease. This progress demonstrates the value of investment in early detection and treatment.

Differences in cancer survival between the sexes have changed over time. In the 1970s, around 25 per cent of men and 35 per cent of women survived a cancer diagnosis. Today, survival is substantially higher – 73 per cent for men and 72 per cent for women.

Cancer mortality has therefore fallen more rapidly among men than among women over the past decade. Several factors may explain this trend. One important factor is changes in incidence and mortality across different types of cancer. For example, both the incidence of and mortality from lung cancer have fallen sharply among men over the past ten years, while no comparable decline has been seen among women. Because lung cancer

When more men take part in screening, testing and vaccination, and seek healthcare promptly, cancer can be detected earlier – and more lives can be saved.

is one of the deadliest cancers, such changes have a major impact on overall mortality.

The importance of early detection

Particularly significant is progress in prostate cancer, which accounts for more than a quarter of all cancer cases among men. Improvements in diagnosis and treatment have led to a marked reduction in mortality. In the late 1990s, around 40 per cent of men diagnosed with prostate cancer died, compared with just under 10 per cent today.

This trend coincides with regions beginning to offer voluntary prostate-specific antigen (PSA) testing in the mid-1990s. As a result, more cases of prostate cancer are detected, often at an earlier stage. Today, most cases are diagnosed at an early stage (stages 1–2), and a large proportion are detected through PSA testing in men without symptoms. Since the early 2000s, several prostate cancer screening studies have also been conducted across Sweden, further influencing the number of cases diagnosed.

Cancer is still detected later in men

Despite this positive progress, clear differences remain in when cancer is detected. Each year, approximately 1,500 more men than women are diagnosed at an advanced stage. This means that a greater proportion of men receive their diagnosis after the disease has progressed further, affecting both treatment options and prognosis.

One important explanation is that men are less likely to participate in screening and vaccination and more likely to wait longer before seeking healthcare for symptoms. This leads to later detection, more advanced disease at diagnosis and more extensive treatment.

Early detection and prevention depend on participation. To detect more cancers at an early stage, more people need to take part in screening, testing and vaccination and seek healthcare promptly.

The most common cancers among men in Sweden in 2024

1. Prostate cancer
   10,782 men
2. Skin cancer (excluding malignant melanoma)
   6,760 men
3. Malignant melanoma
   2,931 men
4. Lymphoma and leukaemia
   2,792 men
5. Colon cancer
   2,745 men
6. Bladder cancer
   2,447 men
7. Lung cancer
   1,829 men
8. Rectal cancer
   1,508 men
9. Kidney cancer
   878 men
10. Pancreatic cancer
    850 men

Source: National Board of Health and Welfare, Statistics on newly diagnosed cancer cases 2024

Men and cancer in Sweden

38 865 st
were diagnosed with cancer in 2024.

95 %
are over 50 when they receive their cancer diagnosis.

5 %
are diagnosed between the ages of 25 and 49.

Approx 1 500 st
more men than women receive a late-stage diagnosis each year.

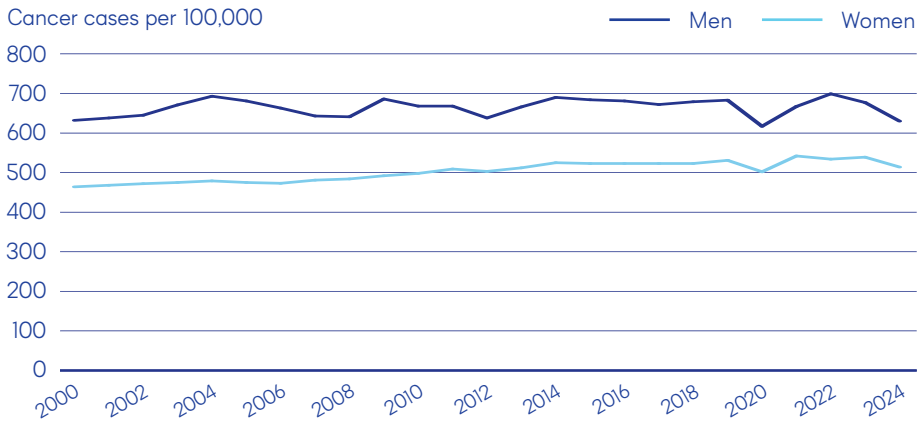
> 40 %
of all men will develop cancer during their lifetime.

Almost 20 %
of all men will develop prostate cancer.

3 av 100
of men will develop malignant melanoma.

Men develop cancer more often than women, and the number of new cases per capita has increased over time...

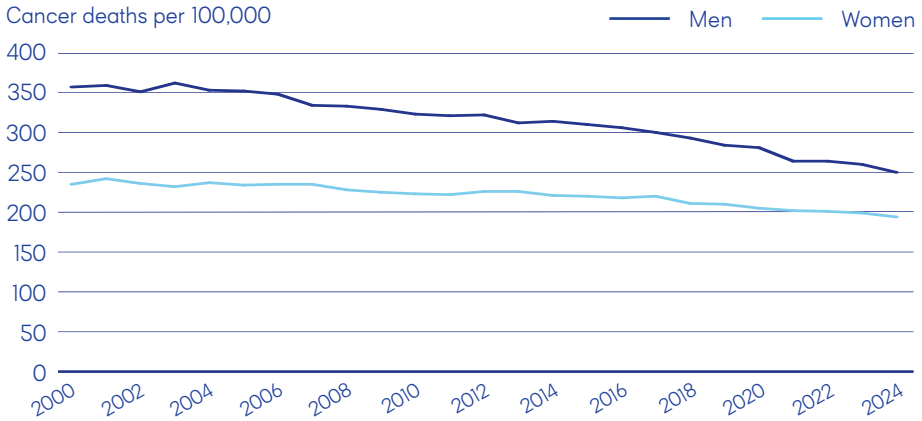
Number of new cancer cases per 100,000 people, age-standardised to the 2024 population.



Source: National Board of Health and Welfare, Cancer in Sweden – statistics and analysis, April 2026

...but cancer mortality has declined over the same period

Number of cancer deaths per 100,000 inhabitants, age-standardised to the 2024 population.



Source: National Board of Health and Welfare, Cancer in Sweden – statistics and analysis, April 2026



More men are developing cancer, but mortality is falling – demonstrating what early detection can achieve. Seeking medical advice promptly makes a difference.

Greater participation and timely healthcare-seeking save lives

Today, men are diagnosed later in the course of their disease than women. Lower awareness and greater barriers to seeking healthcare contribute to symptoms being recognised later and delays in contacting healthcare services. This can affect both treatment options and survival, despite opportunities for early detection.

Differences in participation between men and women are clearly evident in national screening programmes. In 2024, participation in colorectal cancer screening was 63 per cent among men, compared with 68 per cent among women. The gap is greater in younger age groups: among those aged 60–64, participation was 59 per cent for men and 67 per cent for women.

Participation also varies between groups of men and between regions. In some regions, the difference between the sexes is around 5 percentage points, while in others it can be approximately 10 percentage points. Socioeconomic differences are also clear, as seen in other screening programmes. In abdominal aortic aneurysm screening, participation is 9 percentage points lower among men with only compulsory schooling than among those with post-secondary education.

Similar differences are seen in organised prostate cancer testing (OPT). In Västra Götaland, approximately 21 per cent of men on low incomes participate, compared with approximately 44 per cent of men with higher education. Opportunistic PSA testing, undertaken without an invitation, is also less common among men on lower incomes.

Overall, available data show that participation in screening and early detection varies between groups of men. Since men are more often diagnosed at a later stage than women for several types of cancer, there is considerable potential to improve outcomes by reaching more men earlier in the course of the disease.

Stage at diagnosis is one of the most important factors in survival

Stage at diagnosis is crucial to both treatment options and survival. Later detection increases the risk of advanced disease and more extensive treatment. Lower participation in preventive measures and delays in seeking healthcare therefore contribute to unequal outcomes in cancer care. Reaching more men earlier in the course of their disease is essential to improving both survival and quality of life.

Five-year relative survival among men by cancer stage at diagnosis, 2020–2024.

Cancer type	Stage I	Stage II	Stage III	Stage IV
Prostate cancer	102%*	102%*	80%	58%
Colon cancer	92%	86%	84%	17%
Bladder cancer	82%	51%	41%	17%
Lung cancer	72%	53%	25%	7%
Rectal cancer	91%	85%	80%	22%
Kidney cancer	94%	90%	82%	25%
Pancreatic cancer	40%	25%	4%	1%

* For prostate cancer detected at an early stage, relative survival may sometimes be overestimated. One reason is that some tumours might never have caused symptoms or affected life expectancy if they had not been detected. Relative survival compares mortality among people with prostate cancer with that of the general population. If the group with cancer is healthier than average, survival may be overestimated – sometimes exceeding 100 per cent.

Source: National Board of Health and Welfare, Cancer in Sweden – statistics and analysis, April 2026

What influences men's healthcare-seeking behaviour

Seeking healthcare promptly is not straightforward for everyone. For many men, the decision is shaped by a combination of capability, opportunity and motivation – factors that together determine whether contact is made or postponed.

The COM-B model is an established model of behaviour used to understand and influence how people act. In this report, it is used as an analytical framework to organise evidence on the factors affecting men's participation and to identify where barriers arise. It also makes clear that effective interventions need to address several factors at once.

The model assumes that behaviour is shaped by three interacting factors: Capability, Opportunity and Motivation, which together lead to Behaviour. For someone to participate in screening, receive a vaccination or seek healthcare promptly, all three must be present.

The way healthcare services are organised affects all three factors. How information is provided, how services can be contacted and how easy it is to participate directly influence capability, opportunity and motivation. Participation can therefore be substantially improved through the design of interventions.

Together, these factors shape the behaviour that determines whether a person takes part in preventive measures or seeks healthcare promptly. This means that more men can be reached in time – if we change the factors that currently cause them to wait.





Screening, testing and vaccination programmes for men

Screening is estimated to reduce mortality by approximately 15 per cent. Early detection often means that the disease can be treated while it is still curable. It can also allow less extensive treatment, reducing the risk of long-term or permanent problems, such as the need for a stoma, chronic bowel and abdominal symptoms, impaired urinary or sexual function, and infertility.

	Start date and geographical coverage	Population	Effects
Vaccination against human papillomavirus (HPV)	Part of the national childhood vaccination programme for boys since 2020. Catch-up vaccination for men has been under way since 2024. Most regions now offer subsidised or free vaccination up to and including the age of 26.	Vaccination is offered free of charge to girls and boys in Year 5, with eligibility up to the age of 18. Catch-up vaccination is recommended up to and including the age of 26. Arrangements and charges vary between regions.	HPV can cause cancer and genital warts in both men and women. Vaccination provides protection of up to approximately 90 per cent in those without a previous infection, and 50–70 per cent in those with an existing infection.
Colorectal cancer screening	Introduced gradually from 2008. The programme is being expanded nationally and is expected to be fully implemented in all regions in 2026.	Women and men aged 60–74 are invited for screening every two years.	Screening is estimated to reduce mortality by approximately 15 per cent. Early detection often means that the disease can be treated while it is still curable.
Organised prostate cancer testing (OPT)	There is no national screening programme. Regional organised testing programmes have been introduced or are planned in most regions.	Men aged 50–74 are offered testing, with the aim of detecting cancer at an early stage. Arrangements vary between regions.	Prostate cancer is the most common cancer among men. Organised testing can reduce mortality and enable earlier detection before symptoms develop.

Identified barriers to participation and seeking healthcare

Taking part in screening or testing, or seeking healthcare promptly, requires an active decision. But when barriers relating to knowledge, access or trust are high, it becomes easier to opt out or postpone contact with healthcare services.

The table summarises research evidence on the factors influencing men's participation in screening, testing and vaccination, as well as their healthcare-seeking behaviour. Research shows that there is no single explanation: several factors interact. These include knowledge and perceptions of risk, access to healthcare, trust and previous experiences. Norms and social factors also play a role. Expectations of independence and 'managing on one's own' can make seeking healthcare seem less natural, while weaker social support may reduce the likelihood of contacting healthcare services. The table also indicates the strength of the research evidence. The evidence level reflects the strength of the supporting research, from strong (1) to limited (5). Some associations are well established and recur across several studies, while others are based on more limited research.

The table therefore shows not only *what* influences participation, but also *how confident we can be in the evidence*. This provides a basis for prioritising interventions where the evidence is strong, while also highlighting the need to test and develop approaches in areas where knowledge is more limited.

Several factors influence men's participation	Level of evidence
Delayed recognition of symptoms, delayed help-seeking and social stigma Men often recognise symptoms later, are less likely to seek healthcare and have less trust in healthcare services than women. Weaker social support and stigma surrounding engagement with health can also discourage help-seeking.	1
Knowledge and concerns Lower levels of knowledge, less concern and a lower perceived risk of prostate cancer are associated with lower participation in prostate cancer screening.	1
Motivation, fear and practical barriers Studies of prostate screening show that fear of cancer can act both as a barrier and as a motivator. Other obstacles include lack of time, low motivation, limited trust in healthcare services and poor access. Decisions are often based on intuition rather than guidance.	1
Knowledge, trust and accessibility Systematic reviews show that participation in colorectal cancer screening is influenced by several factors: limited knowledge of cancer and screening, lack of time, fear of or discomfort about the examination, low trust in healthcare services and difficulties understanding screening information.	1
Norms and attitudes towards healthcare In US studies, the belief that one should 'be strong' is associated with lower participation in colorectal cancer screening. Negative attitudes towards healthcare professionals and medical examinations are also associated with lower participation.	4
Masculinity norms and behaviour Masculinity norms have been linked to a lower likelihood of seeking healthcare. Health-damaging behaviours are more often associated with masculinity, while health-promoting behaviours are more often associated with femininity. These norms are influenced by factors including socioeconomic circumstances, education, ethnicity and age.	5
Socialisation and healthcare habits Men are generally socialised to seek healthcare less than women. Women often establish early contact with healthcare services through reproductive healthcare, whereas men are more likely to lack comparable experience and confidence in dealing with healthcare services.	3

Delays along the care pathway – from symptoms to treatment

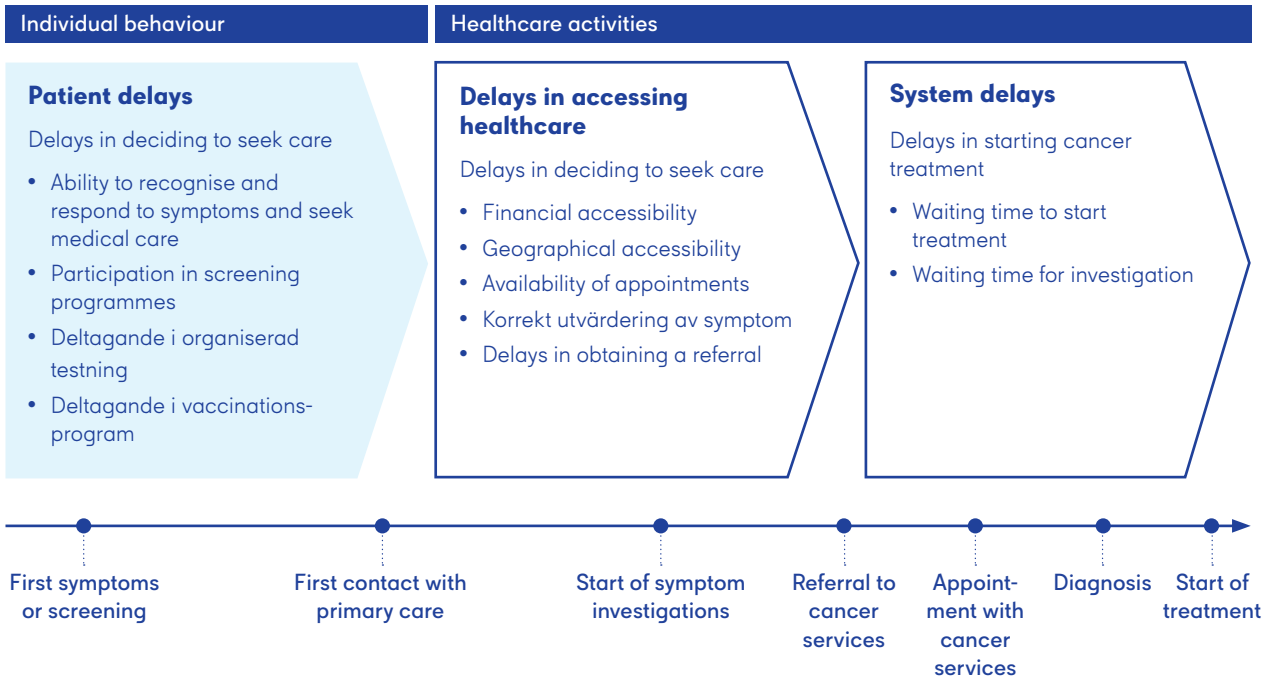
Delays that lead to cancer being detected later, from the recognition of symptoms to the start of treatment. These may involve delays in seeking healthcare, making contact with healthcare services, or undergoing investigation and treatment.

Crucially, delays rarely arise from a single factor. They often result from several smaller barriers along the care pathway, from the individual's initial decision to internal healthcare processes.

This report focuses particularly on the early stages of the pathway, where participation in screening and testing, and prompt contact with healthcare services, determine whether cancer is detected in time. This is where disparities in participation are greatest and where there is considerable potential to reach more men earlier.

For regions, this means that work on early detection must address both how people are reached and encouraged to seek healthcare and how initial contact with healthcare services works in practice. The aim is to make it easier to recognise symptoms, take part in preventive measures and contact healthcare services promptly.

Although delays can occur throughout the care pathway, the report focuses on the stages at which regions have the greatest opportunity to influence participation and early detection.



How to read the model

The model illustrates how the period from the first symptom or screening invitation to the start of treatment can be divided into stages. It shows how the process extends from an individual's initial decision to recognise symptoms or take part in prevention, through contact with healthcare services and investigations, to diagnosis and treatment within the healthcare system.

The stages of the model are interdependent. Delays at an early stage affect what follows and can, together, result in a later diagnosis. The model is therefore used to show where barriers may arise and how, in combination, they affect the time to diagnosis.

By showing the entire pathway, the model helps identify where interventions can reduce delays and enable more cancers to be detected at an earlier stage.

Differences in men's participation can rarely be explained by a single factor. Instead, they arise when several barriers interact – for example, when limited knowledge is combined with unclear routes to accessing care or low trust in healthcare services.

This means that interventions targeting only one factor, such as information, may have limited impact unless other factors, including accessibility and motivation, are addressed at the same time. The same intervention may also have different effects in different groups. Measures to improve accessibility may be crucial for some groups, whereas others may be influenced more strongly by trust, social norms or knowledge. To make interventions more effective, efforts should therefore be based on an analysis of the barriers that matter most to the target group in question, rather than on assumptions that the same measures will work for everyone.

At the same time, several of the factors influencing men's decisions to seek healthcare fall within the remit of regional healthcare authorities. These include, in particular, how services are offered, how information is communicated and how easy it is to contact healthcare providers. Addressing these aspects more systematically can reduce barriers and help reach more men at an earlier stage.

To make their work more effective, regions therefore need to analyse the factors limiting participation locally and design interventions that address several barriers simultaneously. The conditions for behavioural change are in place only when capability, opportunity and motivation work together.



An accessible, reassuring first encounter with healthcare services can reduce barriers and make it easier for more men to seek care in good time.

Tools for reaching men

Increasing participation in cancer screening, HPV vaccination and organised prostate cancer testing, while encouraging timely contact with healthcare services, requires interventions that both reach a wide audience and target those most in need. Reaching different groups of men calls for different strategies.

Men participate less in screening and vaccination and are more likely to delay seeking medical attention when symptoms arise. However, men are not a homogeneous group. Participation varies considerably among men, and some groups face much greater barriers than others. Effective regional action therefore needs to take two perspectives simultaneously. The first is a general approach to men: designing information, offers and routes into healthcare services to reach men more effectively as a group. The second is a targeted approach: identifying groups of men with particularly low participation rates and the greatest need for tailored interventions.

Research and analyses repeatedly identify certain groups as particularly important to consider, including men experiencing socioeconomic disadvantage, men born outside Sweden, men living alone and young men eligible for HPV vaccination. These groups have different circumstances, but what they often have in common is less knowledge about symptoms, screening or vaccination, lower trust in healthcare services, less social support or greater practical barriers to participation.

This is also why general interventions alone are insufficient. A region may improve invitations, communication and accessibility for all men, but inequalities in participation will persist unless efforts are also adapted for groups facing greater barriers. To make interventions more effective, regions need to identify the groups with lower participation, determine which barriers matter most and select the interventions most likely to make a difference.

Different men, different barriers

The most relevant groups may vary between regions. Nevertheless, the report identifies target groups that recur so frequently in research and practical development work that they warrant particular attention. This is why the report presents both general tools for reaching men as a group and targeted tools for selected groups.

Reaching men more effectively is therefore not about choosing between broad and targeted interventions. It is about combining the two. Only then can efforts be sufficiently focused to enable more men to participate in preventive measures, seek medical attention promptly and have cancer diagnosed earlier.

Work should begin with an analysis of local participation rates. Interventions can then be prioritised according to their impact, resource requirements and feasibility within the organisation.

From insight to action – developing interventions aimed at men

Once groups with low participation have been identified, the next step is to prioritise which interventions to implement. Not all tools are equally relevant in every region, and their effectiveness depends on both the target group and local circumstances.

Regions therefore need to balance expected impact against resource requirements. This means focusing on interventions that have the potential to reach groups with low participation while also being feasible for the organisation to implement.

The report includes a prioritisation matrix to support these decisions. It provides an overview of which interventions may have the greatest impact relative to the resources required, but does not replace regional assessment.

The interventions chosen should reflect the region's needs, circumstances and priorities.

Tools for all men Read more on p. 17

Men eligible for HPV vaccination



Read more on p. 21

Men living alone



Read more on p. 25

Men experiencing socioeconomic disadvantage



Read more on p. 29

Men born abroad



Read more on p. 34

Structure of the tools

Increasing men's participation in screening, testing and vaccination, and encouraging timely contact with healthcare services, requires interventions that are both targeted and feasible. The tools in the report are designed to help regions choose the right interventions for the right target groups.

The structure is based on selected target groups, including men in general and groups of men with lower participation rates, and the barriers affecting their willingness to participate. For each target group, the guide presents tools considered capable of reaching more men.

The tools are presented in a consistent format to make them easy to compare and use in practice. They show how interventions can be designed, what is particularly important to consider when reaching men and the contexts in which they may have an impact. Each tool is supplemented with examples, relevant programmes and an assessment of expected impact and resource requirements.

Taken together, this approach provides practical decision-making support for identifying the interventions with the greatest potential and prioritising them according to local needs, resources and objectives.

Identified tools

För att öka deltagandet i respektive målgrupp har verktyg identifierats som är relevanta för just den gruppen.

Description

Each tool is introduced and described in terms of how it works in practice and how it may help increase participation in screening, organised prostate cancer testing or HPV vaccination. The description gives a practical picture of how the intervention can be designed, what it may involve and the contexts in which it can be used. It focuses on what makes the tool relevant to the target group and which barriers it may help reduce.

Expected impact and resource requirements

For each tool in the guide, a broad estimate is provided of its expected impact and resource requirements. These estimates reflect a general assessment of circumstances across Sweden and are based on the interviews and literature reviews underpinning the report.

Expected impact refers to the extent to which the tool may increase participation in cancer screening or HPV vaccination programmes. Expected impact may be:

- High
- Medium
- Low

By *resource requirements* we mean an estimate of the staffing and financial resources a region would need to implement and use the tool. Resource requirements may be:

- High
- Medium
- Low

Level of evidence

Identified tools are classified into four levels based on the strength of the evidence.

Strong evidence

1. Scientific evidence that the method increases participation in cancer screening, organised prostate cancer testing or HPV vaccination
2. Established practical experience of using the method in cancer screening, organised prostate cancer testing or HPV vaccination, or scientific evidence that it increases participation in similar healthcare activities
3. Practical experience without structured follow-up
4. Tools that have not yet been tested, or have only been tested on a very limited scale without follow-up

Limited evidence

Prioritisation matrix – assessing the tools

The tools in the guide have been placed in a prioritisation matrix using two dimensions: their estimated impact on participation or timely contact with healthcare services, and the resources needed to introduce the intervention in the region.

Each letter (A–G) represents a specific tool described in the guide. The letters illustrate how different interventions relate to one another, rather than providing an overall ranking. The same intervention may occupy a different position depending on regional circumstances.

The matrix is divided into four quadrants:

High expected impact – low resource requirements
Tools in this quadrant may be priorities for implementation, provided they are relevant to the region's target groups.

High expected impact – high resource requirements
These interventions may be justified but require planning, funding and potentially small-scale introduction before wider implementation.

Low expected impact – low resource requirements
Interventions in this quadrant may be considered as supplementary measures but are not expected to bring about substantial change on their own.

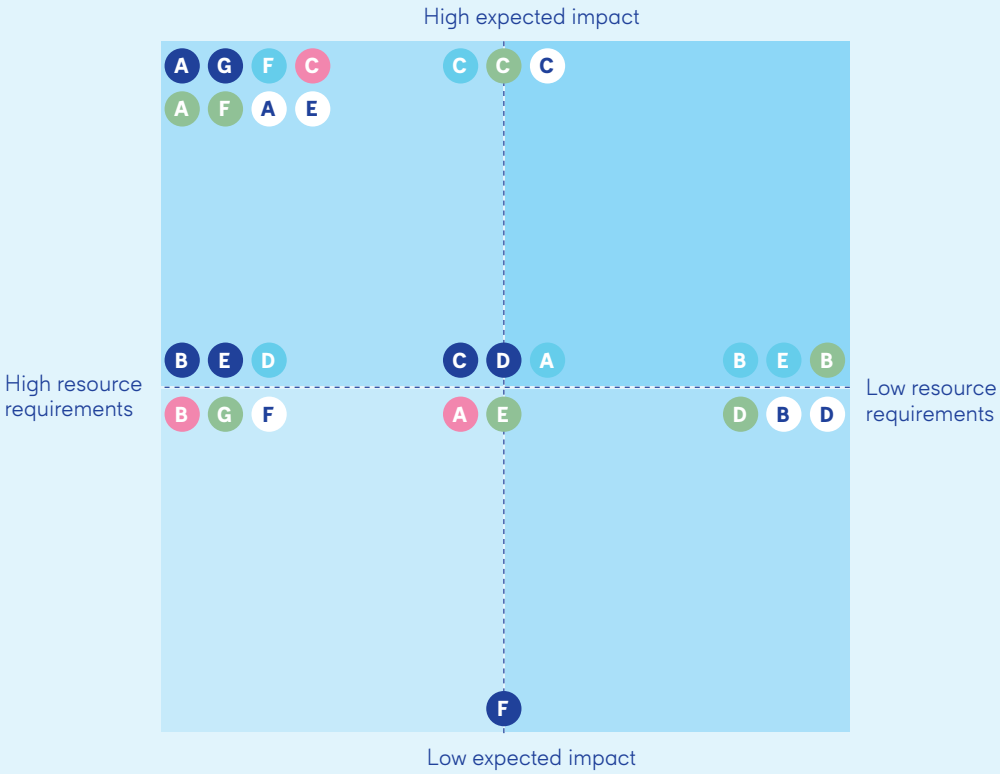
Uncertain expected impact or high resource requirements
It may be appropriate to await further evidence or conduct pilot interventions before deciding on wider implementation.

The matrix supports structured prioritisation. It does not replace regional analysis and should be used alongside knowledge of local needs, capacity and strategic objectives.

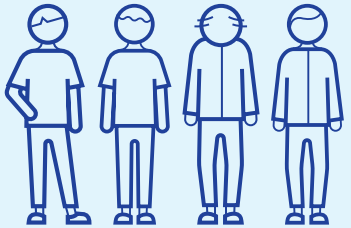
How to read the matrix

Each letter (A–G) represents a specific tool described in the guide.

Tools for all men ..... p. 17 — A B C D E F G
Men eligible for HPV vaccination ..... page 21 — A B C D E F
Men living alone ..... page 25 — A B C
Men experiencing socioeconomic disadvantage ..... page 29 — A B C D E F G
Men born outside Sweden ..... page 34 — A B C D E F



Tools for all men



Men generally participate less in screening and vaccination and are more likely to delay seeking medical attention when symptoms arise. As a result, cancer is more often diagnosed at a later stage, affecting both treatment options and prognosis.

Men's willingness to participate in preventive measures and seek medical attention is influenced by several interacting factors. Many men do not recognise symptoms promptly, perceive their risk to be low or delay contacting healthcare services. At the same time, expectations of independence and 'managing on one's own' may make seeking help seem less natural.

The way healthcare services are offered is also important. Invitations and information do not always reach their intended recipients or seem relevant to them, and routes for contacting services may be perceived as unclear or difficult to use. Practical barriers, such as inconvenient appointment times or complicated booking processes, may also cause people to postpone or forgo participation.

Research shows that these factors often interact. Limited knowledge combined with low trust or poor access can create barriers that prevent men from attending screening, lead them to decline vaccination or delay seeking medical attention despite symptoms.

Because these patterns are widespread among men, there is considerable potential in general interventions that make it easier to understand information, take up available services and contact healthcare providers promptly.

Facts about the target group

- Approximately 1,500 more men than women are diagnosed at a late stage each year.
- Men have lower screening participation rates, for example, 62.5% compared with 68.2% among women in colorectal cancer screening (2024).
- The differences are greater among younger age groups, where participation among men is 58.8% compared with 65.5% among women (aged 60–64).
- Men seek medical care later than women when experiencing symptoms, contributing to later detection.
- Lower levels of awareness of symptoms, screening and vaccination are common.
- Trust in healthcare services and previous experiences influence the likelihood of seeking medical care.
- Norms surrounding independence and masculinity may contribute to greater barriers to seeking medical care.

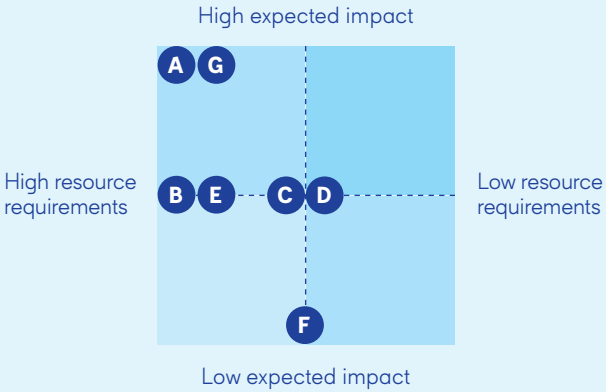
Source: National Board of Health and Welfare, Statistics on newly diagnosed cancer cases 2024

Potential points of contact

- Digital channels (1177, text messages, online services)
- Workplaces and employers
- Sports and leisure settings
- Pharmacies and other healthcare-related providers
- Mass communication and targeted campaigns
- Local settings men visit in everyday life

Positioning of identified tools based on estimated impact and resource requirements

Tools A, B, C, D, E, F and G are described on the next page.



Tools to increase participation in screening, testing and vaccination programmes

Tools	Description	Particularly important for men	Examples	Expected impact	Resources required	Level of evidence	Source
A Information campaigns	Information campaigns about vaccination, cancer screening and testing can be used for all target groups. Information should be accessible, easy to understand, written in plain language and explain biomedical terminology. Campaigns may be delivered online and through other digital channels, in print or as public lectures.Campaigns should be tailored to different socioeconomic and cultural backgrounds and translated into different languages.	Men prefer plain, straightforward language without medical or patronising terminology, ideally with some humour and a clear focus on men.	*Give prostate cancer the finger* – a campaign by Movember in partnership with Praise U in Ireland.	High	High	1	64, 31, 63, 53, 54 -56, 79
B Flexible healthcare provision: extended opening hours, home visits and mobile units	Men want more flexible healthcare provision. Extended opening hours, a wide choice of appointment times and easy rescheduling proved effective during COVID-19 vaccination. Healthcare professionals can also offer screening or vaccination during a routine appointment. In addition, mobile screening or vaccination units can reach men at home or at work, while pop-up tents can reach men in public spaces.	Working-age men have poorer prostate cancer outcomes. Men in lower-skilled occupations often find it difficult to access healthcare.	*Man Van* offers free health checks and prostate cancer testing for men aged 45 and over in the United Kingdom.	Medium	High	1	64, 63, 40, 20, 61, 39
C Public figures as spokespeople	Men's ideas about masculinity and their perceptions of other men's health behaviours can predict their own health behaviours. Working with prominent public figures and celebrities whom men can relate to may therefore be effective. These individuals can build trust and encourage men to seek healthcare.	It is important to engage male spokespeople whom men respect and who represent relevant areas of interest, such as sport, television and music.	When television journalist Bill Turnbull and actor Stephen Fry spoke publicly about their experiences of prostate cancer, more men sought healthcare.	Medium	Medium	1	31, 63, 43

Tool	Description	Particularly important for men	Example	Expected impact	Resources required	Level of evidence	Source
D Invitations and reminders for vaccination, cancer screening and testing	Invitations and reminders for check-ups, vaccination, screening and testing have been shown to be effective. Men want invitations written in clear, straightforward language, with a clear explanation of the benefits and risks. Invitations offering pre-booked appointments with the option to cancel may also be beneficial.	Use clear, concise and specific language, avoiding shame and stigma.	The SMARTERscreen trials use text-message reminders and digital invitations through dedicated apps to encourage colorectal cancer screening among men in Australia.	Medium	Medium	1	9, 47, 53, 54, 63-64, 89-90, 94-95
E Personal contact and relationship-building with healthcare professionals	A good relationship with healthcare professionals, such as GPs, particularly those of the same gender, can increase trust and participation in cancer screening. Motivational interviewing (MI) and person-centred conversations based on empathetic dialogue have also proved effective.	Many men respond better to practical, solution-focused conversations, with clear explanations such as "this is how it works". It can make a considerable difference when a medical doctor or nurse proactively raises and recommends an intervention, preferably as part of ongoing care. Normalising participation, for example by explaining that "many people do this", can also help reduce barriers.	Various programmes to increase screening uptake among men use motivational interviewing as a central component. Examples include the VHA Colorectal Cancer Screening Outreach Program and initiatives incorporating motivational interviewing into contact with men.	Medium	High	1	11, 14, 63-64, 89-92, 97-98

Tool	Description	Particularly important for men	Example	Expected impact	Resources required	Level of evidence	Source
F Telephone helplines offering support, information and reassurance	Telephone helplines that men can call with questions about screening, vaccination or symptoms may be effective in increasing knowledge and trust. Examples include Cancerlinjen, for anyone affected by cancer, and a multilingual national coronavirus helpline.	Men often emphasise the importance of anonymity and confidentiality, which can make it easier to get in touch. Being able to ask a quick question without first booking an appointment, and receive clear, direct advice about the next step, can therefore facilitate help-seeking and participation in screening or vaccination.	Examples of dedicated helplines for questions about screening and testing include ZERO360 for prostate cancer in the United States, Cancer Research UK in the United Kingdom and Cancerlinjen in Sweden.	Low	Medium	1	3, 64, 89, 93
G Increasing incentives through prizes or payments	Offering incentives for participation in vaccination or cancer screening, such as payments, gift vouchers or the chance to win prizes, has been shown to be effective.	Men may be particularly motivated by tangible, immediate benefits and a process requiring little effort. A small guaranteed reward, such as a gift voucher, tends to work better than a prize draw, whose effects are more variable. Incentives generally need to be combined with easy access to screening, such as drop-in appointments, straightforward booking and clear instructions.	Team-based screening challenges in which workplaces compete for the highest screening participation in return for a shared reward; or small cash incentives or gift vouchers for US veterans after completing a colonoscopy.	High	High	1	35, 53, 89, 99-102



TOOLS FOR

Men eligible for HPV vaccination

The Public Health Agency of Sweden recommends HPV vaccination for boys and young men from school year 5 up to the age of 26. Vaccination is currently provided free of charge through the childhood vaccination programme for pupils in year 5 and for young men born in 2009 or later. For men under 27, eligibility and costs vary. Some regions offer free vaccination to everyone under 27, while others charge a fee or restrict eligibility to particular age groups.

Several factors influence whether young men take part in the HPV vaccination programme. Knowledge of HPV, understanding of how vaccination protects against cancer, and trust in healthcare services are all important. For younger boys, parents usually make the decision, whereas older adolescents and young men make the decision themselves. As HPV vaccination was previously promoted mainly to girls and women, many people are unaware that boys are also included in the programme and that vaccination protects against other HPV-related cancers, including penile, anal and tonsillar cancer.

Research shows that limited knowledge of HPV and its link to cancer reduces willingness to be vaccinated, while providing more information to parents and young men increases uptake [51][55–56]. Trust in healthcare is another factor, and is generally lower among younger men than among older men [72]. For young men, cost, the perception that the vaccine is not intended for them, and the belief that they are not at risk are also significant barriers. In addition, some people do not complete the vaccination course, as two doses are required for those over the age of 15 [62].

Facts about the target group

- The Public Health Agency of Sweden recommends catch-up HPV vaccination for men up to the age of 26 [62]
- For boys and teenage boys, parents usually decide whether their children should be vaccinated.
- Young men do not believe they are at risk of developing the disease and do not think the vaccine is intended for them [56]
- An estimated 300,000–400,000 men are eligible for HPV vaccination [19]

Potential points of contact

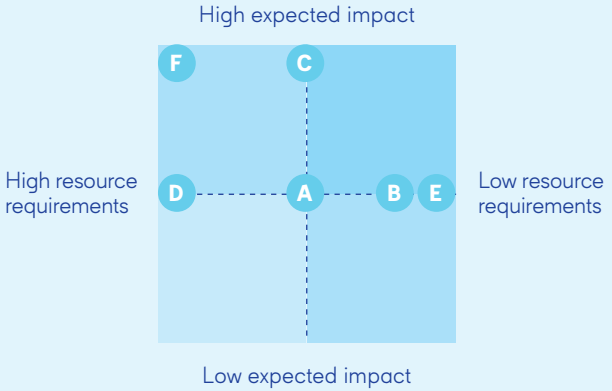
- Digital channels, social media, mobile phones, 1177 and Kivra
- Universities and workplaces
- Gyms, clubs and bars
- Sports clubs
- Public transport
- Youth centres
- School health services

Relevant programmes

- ☒ HPV vaccination
- ☐ Colorectal cancer
- ☐ Prostate cancer

Positioning of identified interventions according to their estimated impact and resource requirements

Interventions A, B, C, D, E and F are described on the following page.



Factors affecting the target group's likelihood of seeking healthcare or participating in screening, testing and vaccination programmes

- Individual capability (Capability): > Knowledge-related
- Individual opportunity (Opportunity): > Time-related > Geographical > Cost-related
- Individual motivation (Motivation): > Trust-related

Factors influencing HPV vaccination among boys and young men

The table sets out factors influencing HPV vaccination uptake among boys and young men. It summarises key barriers and motivators, together with the strength of the evidence, and can inform the design of more targeted interventions.	Cancer type or area of healthcare	Level of evidence	Source
Knowledge of HPV, vaccination and its benefits Parents generally decide whether their children or teenagers should be vaccinated. Many parents have limited knowledge of the diseases prevented by HPV vaccination and its benefits for boys. Some are concerned about side effects and regard the vaccine as relatively new. Many young men also have limited awareness of why they need vaccination, as earlier campaigns focused on women.	HPV vaccination	1	62
Cost and accessibility The Public Health Agency of Sweden recommends catch-up HPV vaccination for men up to the age of 26. However, at the time this guide was finalised, not all regions offered the vaccine free of charge to men under 27, which is one of the greatest barriers. Men in this age group may still be studying or working in low-paid jobs.	HPV vaccination	1	62
Knowledge and previous vaccination behaviour In the United Kingdom, only 23 per cent of parents are aware of the HPV vaccination programme for boys. Although additional information improved attitudes towards vaccination, parents of girls were more likely to have their children vaccinated than parents of boys.	HPV vaccination	4	51
Knowledge and previous vaccination behaviour A systematic review of studies from several countries examined HPV vaccination uptake among males. Parents with greater knowledge of HPV and vaccination were more likely to have their sons vaccinated. High uptake of other vaccination programmes was also associated with greater willingness to participate in HPV vaccination. Vaccination rates were higher in urban than in rural areas.	HPV vaccination	4	55
Educational attainment, socioeconomic circumstances and perceived risk A systematic review of studies from Asia on HPV vaccination among boys under 18 found that parents with higher levels of education were more likely to have their sons vaccinated. Vaccine costs, however, were a substantial barrier for parents and teenagers from socioeconomically disadvantaged groups. Many boys and teenagers also felt that they were not personally at risk and therefore considered the vaccine irrelevant to them.	HPV vaccination	4	56
Practical requirements of the vaccination process Men aged 15 or over require two doses of the vaccine, which may increase the risk of not completing the vaccination course.	HPV vaccination	1	62

Interventions to increase participation in screening, testing and vaccination programmes

Tool	Description	Expected impact	Resources required	Level of evidence	Source
A Offer a wide range of appointment times and easy rescheduling	The majority of people who miss scheduled healthcare appointments are young men. Barriers for this target group can be reduced by offering a wide range of appointment times and the option to reschedule easily. In Stockholm, vaccination centres were used during the COVID-19 vaccination campaign to increase capacity. Similarly, existing vaccination infrastructure in the region could be utilised. Pre-booked appointments for COVID-19 vaccination have been shown to increase vaccine uptake.	Medium	Medium	1	73, 74, 75
B Awareness-raising campaign on HPV and vaccination	Many parents of boys and adolescents, as well as young men themselves, have limited knowledge of HPV vaccination, and some scepticism about the vaccine exists. To increase uptake and enable informed choices, there is a need for awareness-raising initiatives and targeted information about HPV and the importance of vaccination. Communication channels and messages should be tailored to the target audience, including both parents and young men.	Medium	Low	2	50, 51, 52
C Offer vaccination at multiple locations	By offering vaccination at a wide range of locations, particularly places where the target group naturally spends time, barriers to participation can be reduced. Vaccination could, for example, be offered at pharmacies, shopping centres, universities and workplaces. In the Västra Götaland Region, for instance, vaccination has been offered at the Volvo factory, enabling more people to get vaccinated in connection with their work. There are also examples of vaccination being offered at universities during orientation weeks for new students.	Medium	Medium	1	38, 63, 64, 103
D Mobile teams combined with outreach	To increase uptake in areas where vaccination clinics are a long distance away, mobile units can be used. This approach has been trialled successfully in northern Sweden. To maximise the number of people vaccinated, those concerned were contacted in advance and informed when the mobile unit would be visiting their area.	Medium	High	3	64

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Tool	Description	Expected impact	Resources required	Level of evidence	Source
E Awareness-raising among healthcare professionals	The target group may have many questions about HPV vaccination. To ensure that these questions can be addressed in a reassuring and informative manner, and to enable informed choices, it is important that healthcare professionals have the appropriate knowledge and tools. A national training resource developed by the Regional Cancer Centres in Collaboration is available to healthcare professionals throughout Sweden.	Medium	Low	1	76
F Offer free vaccination to young men aged 16–26	Several other countries offer free HPV vaccination to broader groups of men. For example, the programmes cover all men aged 12–22 in Ireland, all men under the age of 19 in Finland, all men born in 2005 or later through a catch-up programme in Denmark, and all men who have sex with men under the age of 46 in Scotland.	High	High	3	57, 58, 59, 60

TOOLS FOR

Men living alone

Men living alone include unmarried, divorced and widowed men who live on their own. Research shows that this group is more likely to be diagnosed at a later tumour stage for several types of cancer and is more often among those experiencing the longest waits for care [27].

Men living alone are also less likely to participate in organised prostate cancer testing (OPT) than men living with a partner [4]. Lower participation in screening, testing and vaccination programmes may be partly explained by limited awareness of these programmes, as well as factors such as optimism, self-esteem, perceived autonomy and a limited social network [15][17].

Studies show that men living alone often want personal contact and guidance from healthcare professionals throughout the process, from receiving an invitation to attending screening, testing or vaccination. As many lack a supportive social network, they express a need to meet healthcare professionals who listen, answer questions and understand their circumstances [17][71]. Sweden has introduced an initiative involving social activities on prescription, inspired by the English concept of 'social prescribing'. Its aim is to reconnect isolated older people with their communities and the healthcare system, thereby improving their overall health [44,77].

This target group also values proactive information and personal reminders, and prefers invitations with pre-booked appointments, which may increase participation [17].

Facts about the target group

- Men living alone are generally more likely to be diagnosed with cancer at a more advanced tumour stage than men in a relationship [27][29].
- Participation in cancer screening programmes is lower among men without a partner [4][16–17].
- Living alone or being socially isolated is often associated with poorer mental health and a reduced likelihood of seeking healthcare [15].
- Around one million men in Sweden are single [18–19].

Potential points of contact

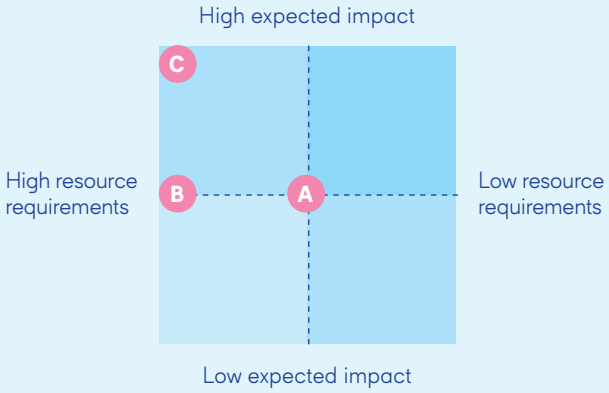
- At home
- Local services, such as supermarkets and pharmcies

Relevant programmes

- ☒ HPV vaccination
- ☒ Colorectal cancer
- ☒ Prostate cancer

Positioning of identified interventions according to their estimated impact and resource requirements

Interventions A, B and C are described on the following page.



Factors influencing the target group's willingness to seek healthcare or participate in screening, testing and vaccination programmes

- Individual capability (Capability) –
- Individual opportunity (Opportunity) > Time-related > Social network
- Individual motivation (Motivation) –

Factors influencing participation in cancer screening and early detection among men living alone

This table summarises research evidence on factors influencing participation in cancer screening and early detection. It shows how social, psychological and structural factors can affect the likelihood of taking part, as well as the strength of evidence for each association. The findings can help identify barriers and inform more targeted interventions.	**Cancer type or area of healthcare**	**Level of evidence**	**Source**
Social support and living arrangements There is no national prostate cancer screening programme, but several regions have introduced organised prostate cancer testing (OPT) initiatives. In Region Västra Götaland, living in a single-person household is negatively associated with participation. Men living alone are less likely to take part than men living with a partner.	Prostate cancer	1	4
Living arrangements and social connections A Danish study reported that living alone was associated with lower participation in colorectal cancer screening among both men and women.	Colorectal cancer	1	16
Awareness of screening and participation A Danish study investigated barriers to cancer screening among people experiencing loneliness and social isolation. This group showed a lack of awareness of, and regular participation in, cancer screening programmes.	All cancer screening programmes	1	17
Psychosocial wellbeing and social networks An analysis of general psychosocial factors and their influence on participation in cancer screening in Germany found that people who felt less lonely were more likely to take part. Cognitive wellbeing, optimism, high self-esteem, perceived autonomy, low stress levels and a supportive social network were also associated with greater participation in cancer screening.	All cancer screening programmes	2	15
Marital status and healthcare waiting times Married people are less likely to be among those experiencing the longest waiting times. The largest differences are among unmarried people, whose likelihood is higher than that of married people by 1 percentage point for breast cancer, 3 for prostate cancer and 3 for colorectal cancer. For divorced people, the corresponding differences are 2 percentage points for breast cancer and 3 for prostate cancer; for widowed people, they are 2 percentage points for breast cancer and 2 for lung cancer. The figures are adjusted for relevant control variables, including comorbidities, year of diagnosis, educational attainment, sex, country of birth and age.	Breast cancer Lung cancer Prostate cancer Colorectal cancer	1	27

	Cancer type or area of healthcare	Level of evidence	Source
Marital status and social support Marital status and social support. Married people are more likely to be diagnosed with stage I cancer. The largest differences are among unmarried people, whose likelihood of a stage I diagnosis is lower than that of married people by 2 percentage points for lung cancer, 3 for prostate cancer, 2 for colon cancer and 5 for rectal cancer. For divorced people, the corresponding difference is 3 percentage points for prostate cancer; for widowed people, it is 3 percentage points for prostate cancer and 1 for colon cancer. The figures are adjusted for relevant control variables, including comorbidities, year of diagnosis, educational attainment, sex, country of birth and age. The differences are statistically significant at the 5% level.	Lung cancer Prostate cancer Colorectal cancer	1	27
Living arrangements and social support People living alone are diagnosed at later stages of cancer than people living with a partner. The differences are greatest among men but are also observed among women. Compared with men living with a partner, men without a partner are more likely to be diagnosed at stage II rather than stage I, and at stages III–IV rather than stage I. Women living without a partner are also more likely to be diagnosed at stage II rather than stage I than women living with a partner. All figures are adjusted for potential confounding factors.	Malignant melanoma	1	29
Living arrangements Men living alone are less likely than men living with a partner to undergo opportunistic PSA testing (prostate cancer testing without invitations through an organised programme).	Prostate cancer	1	4
Social isolation and willingness to be vaccinated Studies from Sweden, Norway and Japan examining uptake of COVID-19 or influenza vaccines among older people (over 60) show that people who are lonely or socially isolated are less likely to be vaccinated.	COVID-19 and influenza vaccination	1	65, 66, 67

Tools to increase participation in screening, testing and vaccination programmes

Tool	Description	Expected impact	Resources required	Level of evidence	Source
A Personalised screening or vaccination invitations	People in this target group often have limited social networks and value personalised communication, as well as proactive information and reminders from healthcare services or their GP. The target group also prefers to receive personal invitations to pre-booked appointments.	Medium	Medium	1	17
B Increase personal contact with healthcare services	Close relationships and personal contact are major motivating factors for participation in screening. The group prefers face-to-face interaction with healthcare professionals and guidance rather than self-sampling.	Medium	High	1	17
C Social prescribing	See description below.	High	High	1	44, 49, 77

Social prescribing is an approach to reaching socially isolated people, particularly older people, and improving their health. It is based on the concept of *social prescribing*, in which individuals receive support from link workers connected to primary care or civil society organisations. Through tailored support, people can rebuild social connections and gain better access to healthcare and community resources.

Examples from practice and research

Social prescribing originated in the United Kingdom and has long been used in primary care to address social isolation, long-term health conditions and mental ill health. A link worker provides tailored support and helps people access social activities and community resources. Participants often report better health and more joined-up support, and the approach is considered to have potential to increase participation in cancer screening among socially isolated groups.

In Sweden, the concept has been developed as social activity on prescription, including in Umeå, through collaboration between primary care, local authorities and civil society. The intervention aims to reduce loneliness and improve health through social activities. The approach is relatively new and is being evaluated in ongoing studies, but early findings are promising for improving wellbeing and reducing loneliness. It could also be used to reach men living alone with information about screening, thereby helping to increase participation.[44][49][77-78]

What the region needs to do

- *Resources and organisation* Ensure that link workers involved in social activity on prescription understand the approach and are informed about cancer screening.
- *Relevant external stakeholders* Establish partnerships with organisations delivering social activity on prescription to help disseminate information about screening programmes.
- *Important considerations* Social activity on prescription is a relatively new approach in Sweden. Implementation takes time and should be monitored to ensure that it works and reaches men living alone.

TOOLS FOR

Socioeconomically disadvantaged men

Men in this target group often have little or no education beyond upper secondary level and below-average incomes. Socioeconomically disadvantaged men generally find it harder to recognise symptoms and have a limited understanding of the importance and benefits of cancer screening, testing and HPV vaccination [3]. They are therefore less likely to take part in these interventions and face a higher risk of cancer-related mortality [4][11–14][64].

This group often has lower levels of trust in healthcare services and public authorities, and is less inclined to seek medical care [3]. Healthcare information often fails to reach them, and many do not know where to turn if they experience symptoms or have questions.

Several studies show that some men in this target group are more likely to engage in behaviours that may adversely affect their health, partly in connection with norms surrounding masculinity and self-image. Acknowledging a need for healthcare or taking part in screening and vaccination programmes may be perceived as stigmatising [22].

Many in this group spend most of their time in their local area– at shopping centres, supermarkets, neighbourhood squares or on public transport [14][36][63]. The Swedish Public Employment Service may also be an important channel for reaching this group with information and support.

Facts about the target group

- Generally limited ability to understand and interpret health information, and lower levels of trust in healthcare services.
- More likely to engage in behaviours that may adversely affect health, partly linked to norms surrounding masculinity [22].
- Residents of socioeconomically disadvantaged areas have a higher risk of dying from cancer and are less likely to participate in cancer screening programmes than the population as a whole [4][11–14].
- An estimated 300,000 men are socioeconomically disadvantaged. Of these, 74% have a foreign background [18].

Potential points of contact

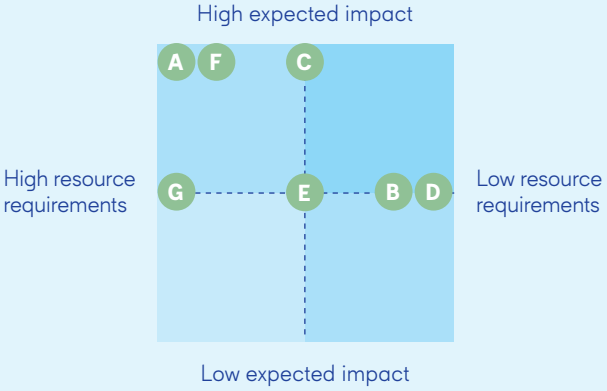
- In residential neighbourhoods, such as public squares, shopping centres, local food shops and public transport
- Health cafés, where participants receive accessible health information, or other activities in the local area
- Public employment service

Relevant programmes

- ☒ HPV vaccination
- ☒ Colorectal cancer
- ☒ Prostate cancer

Positioning of identified interventions according to their estimated impact and resource requirements

Interventions A, B, C, D, E, F and G are described on the following page.



Factors influencing the target group's willingness to seek healthcare or participate in screening, testing and vaccination programmes

- Individual capability (Capability) > Knowledge-related
- Individual opportunity (Opportunity) > Time-related > Geographical > Access to digital tools
- Individual motivation (Motivation) > Trust-related > Self-image-related

Factors influencing participation in cancer screening and early detection among socioeconomically disadvantaged men

This table summarises research evidence on factors affecting participation in screening and vaccination, and help-seeking behaviour. It shows how socioeconomic circumstances, such as education and income, affect both the opportunity and willingness to participate. The findings can help identify barriers and design interventions to reach groups with lower participation rates.	**Cancer type or area of healthcare**	**Level of evidence**	**Source**
Income and education affect participation in prostate cancer testing There is no national screening programme for prostate cancer, but several regions have introduced organised prostate cancer testing (OPT) projects. In the Västra Götaland region, participation is associated with socioeconomic factors. Men on low incomes participate less often than men who are not on low incomes, and men with lower educational attainment participate less often than men with intermediate levels of education.	Prostate cancer	1	4
Educational attainment affects participation Screening for abdominal aortic aneurysm is offered to all men over 65. Participation among men with less than upper secondary education is 76%, nine percentage points lower than among men with post-secondary education.	Abdominal aortic aneurysm	3	28
Lower socioeconomic status reduces screening uptake A systematic review of studies from several countries examined participation in colorectal cancer screening. Globally, including in Sweden, lower socioeconomic status is associated with lower screening uptake among both men and women.	Colorectal cancer	4	12, 13, 14
Socioeconomic inequalities affect screening uptake worldwide A systematic review examined studies from countries around the world on participation in colorectal, breast and cervical cancer screening. Globally, lower socioeconomic status is associated with lower screening uptake among both men and women.	Colorectal cancer, breast cancer and cervical cancer	4	11
Lower educational attainment is linked to poorer awareness and trust Men with lower educational attainment recognise symptoms later, seek healthcare less frequently and have less trust in healthcare services than men with higher educational attainment.	Cancer and healthcare	1	3
Low income reduces screening uptake Lower income and educational attainment are associated with less healthy lifestyle behaviours.	Cancer and healthcare	5	22

	Cancer type or area of healthcare	Level of evidence	Source
Low income reduces screening uptake A Danish study reported lower participation in colorectal cancer screening among men and women with low incomes and those receiving social assistance.	Colorectal cancer	1	16
Lower education and income reduce vaccination uptake A Swedish government inquiry report and a Swedish study of COVID-19 vaccination found that vaccine acceptance and uptake are influenced by socioeconomic circumstances. People with lower educational attainment and lower incomes have lower vaccination uptake.	COVID-19 vaccination	3	64, 67
Higher income increases the likelihood of early detection Men in the highest income quartile are more likely to have prostate cancer detected during a health check than men in the lowest income quartile.	Prostate cancer	1	5
Socioeconomic disadvantage increases the risk of late diagnosis Men living in socioeconomically disadvantaged areas are at greater risk of being diagnosed with bladder cancer at an advanced stage (stage III–IV). Among men living in areas facing substantialsocioeconomic challenges, 17% of bladder cancer cases are diagnosed at an advanced stage,compared with 11% among men living in areas with very favourable socioeconomic conditions. This represents a difference of six percentage points.	Bladder cancer	1	28
Low income reduces participation Men living alone are less likely than men living with a partner to undergo opportunistic PSA testing (prostate cancer testing without invitations through an organised programme).	Prostate cancer	1	4
Lower educational attainment is associated with later cancer diagnosis Men with lower educational attainment are five percentage points less likely to be diagnosed with stage I cancer than men with post-secondary education, and five percentage points more likely to be diagnosed with stage IV cancer. This association is also evident when comparing areas with different levels of socioeconomic disadvantage: the proportion of patients with prostate cancer diagnosed at a late stage increases with the level of disadvantage in the area.	Prostate cancer	1	27, 28
Lower educational attainment increases the risk of late detection of colorectal cancer Men with lower educational attainment aremore frequently diagnosed with rectal cancer at stages II, III and IV. The proportion of patients with colorectal cancer diagnosed at an advanced stage (III–IV) is higher among men living in areas facing substantial socioeconomic challenges than among men in other areas.	Colorectal cancer	1	6, 28

Tools to increase participation in screening, testing and vaccination programmes

Tool	Description	Expected impact	Resources required	Level of evidence	Source
A Provide information about cancer screening through civil society organisations	The target group often has a more limited ability to understand and process health information, some scepticism towards public authorities, and recurring concerns about their financial situation. It is therefore important to make clear which healthcare services are free of charge and easily accessible. Initiatives such as informal health information sessions over coffee, or other informal gatherings providing information in plain Swedish, can help increase health literacy and strengthen trust in health-care services.	High	High	1	3
B Communicate in places frequented by the target group	As the target group often moves within geographically limited areas and seeks information through channels other than those traditionally used by healthcare services, communication needs to take place where people spend their time, for example in local squares, shopping centres, on public transport and in workplaces.	Medium	Low	1	31, 36
C Establish contact with key individuals in the local community	The target group sometimes exhibits low levels of trust in public authorities and general scepticism towards tests and vaccinations. Information about screening, testing and vaccination is therefore often received with greater trust when communicated by someone who is trusted within the individual's local community. One example is the patient and family representative programme run by the Regional Cancer Centre Stockholm Gotland (RCC Stockholm Gotland), in which people with personal experience act as links between healthcare services and the public.	High	Medium	1	36, 37, 54
D Design invitations that are accessible in terms of language and visual presentation	An accessible invitation should be written in clear, everyday language, with explanations of any technical terms. Readability can be improved by using clearly defined text boxes, appropriate font sizes and line spacing, and visually highlighting important sentences. The Swedish Association of Local Authorities and Regions (SALAR) has developed a national invitation template to support consistent and accessible communication.	Medium	Low	1	14, 33, 34

Tool	Description	Expected impact	Resources required	Level of evidence	Source
E Regular reminders about invitations for screening, testing or vaccination	Regular reminders, particularly via mobile messaging (e.g. text messages or digital mailboxes) and email, have been shown to increase participation in cancer screening among this target group.	Medium	Medium	2	32
F Creating safe spaces for men	The target group often has limited health literacy and may be sceptical of public authorities, while many also experience stigma associated with their own health. Creating safe, welcoming and inclusive environments where men feel seen and understood can help improve knowledge of health, screening, testing and vaccination, strengthen trust in health services, and reduce stigma. International initiatives such as the DUDES Club, Men's Sheds and Football in the Community have demonstrated positive results in engaging men in health promotion activities and preventive care.	High	High	2	30, 31, 41, 42
G Patient navigation	Patient navigators may include healthcare professionals or social workers who provide individualised support to help people overcome barriers to accessing healthcare. This support may include education, assistance with appointment scheduling, language support, and help bridging cultural differences. Patient navigation has been shown to be particularly effective among socioeconomically disadvantaged groups and people born outside the country.	Medium	High	4	45, 46

TOOLS FOR

Men born outside Sweden

Men born outside Sweden are a diverse group, with substantial differences in background, educational attainment and language skills. Nevertheless, studies identify recurring factors that may influence their willingness to take up preventive measures. Limited ability to access and interpret health information can also make it difficult to understand and navigate the Swedish healthcare system.

Some people in this target group may have limited awareness of the importance and benefits of cancer screening, testing and HPV vaccination, contributing to lower participation in these programmes [4][64][71].

Cultural and religious beliefs may also influence attitudes towards screening and contribute to feelings of shame or reluctance to undergo examinations [7][14]. Some may also have an external locus of control, perceiving health and illness as being determined primarily by external factors rather than their own actions [14].

Scepticism towards public authorities and healthcare services is not uncommon, and information is considered more credible when communicated by people from similar cultural backgrounds. Low levels of trust may also be linked to previous negative experiences of healthcare [7][25].

People in this target group can be found in many settings, including shopping centres, supermarkets, public transport and other local meeting places [14][36][63]. These settings may provide useful opportunities for information campaigns.

Facts about the target group

- Around 1.3 million men in Sweden were born abroad [18].
- Limited proficiency in Swedish; often attends Swedish for Immigrants (SFI) classes.
- Generally limited ability to understand and interpret health information, and difficulties navigating the Swedish healthcare system.
- Cultural and religious beliefs may influence attitudes towards examinations and contribute to discomfort or shame, as may a perception that health and illness are largely determined by external factors.
- Residents of socioeconomically disadvantaged areas with a high proportion of people born abroad face a higher risk of dying from cancer and are less likely to participate in cancer screening programmes than the population as a whole.

Potential points of contact

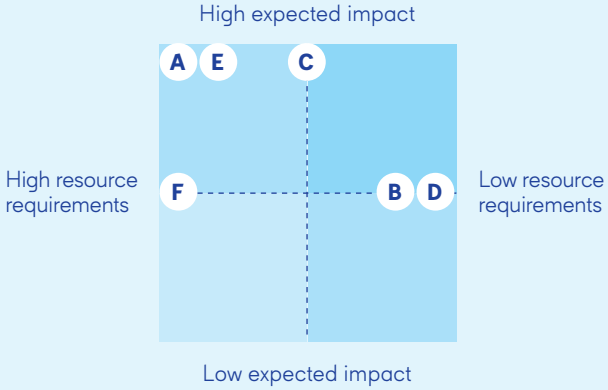
- In residential neighbourhoods, for example in local squares, shopping centres, local food shops and on public transport.
- Through Swedish for Immigrants (SFI) classes or informal health information sessions
- Faith communities
- Through healthcare professionals of the same gender and cultural background

Relevant programmes

- ☒ HPV vaccination
- ☒ Colorectal cancer
- ☒ Prostate cancer

Positioning of identified interventions according to their estimated impact and resource requirements

Interventions A, B, C, D, E and F are described on the following page.



Factors influencing the target group's willingness to seek healthcare or participate in screening, testing and vaccination programmes

- Individual capability (Capability): > Knowledge-related
- Individual opportunity (Opportunity) > Geographical
- Individual motivation (Motivation) > Trust-related > Self-image-related

Factors affecting participation in cancer screening and early detection among men born abroad

This table summarises research evidence on factors affecting participation in screening, vaccination and healthcare-seeking among men born abroad. It shows how language skills, cultural beliefs, trust in healthcare and knowledge about disease affect both opportunities and willingness to participate. The findings can help identify barriers and design interventions that better reach men born abroad and increase participation in early detection and prevention.	**Cancer type or area of healthcare**	**Level of evidence**	**Source**
There is no national prostate cancer screening programme, but several regions have introduced organised prostate cancer testing (OPT) projects. In Västra Götaland, participation is associated with socioeconomic factors. Men born outside the Nordic countries participate less often than men born in the Nordic countries.	Prostate cancer	1	4
People born abroad living in the UK are less likely to participate in colorectal cancer screening, partly because of lower awareness of the disease and feelings of embarrassment.	Colorectal cancer	2	7
A systematic review of studies from several countries on colorectal cancer screening found that participation was generally lower among men and women born abroad, with differences according to country and ethnic background.	Colorectal cancer	4	12, 13, 14
A systematic review of studies from several countries on colorectal, breast and cervical cancer screening found that participation was generally lower among men and women born abroad, although the extent varied between countries and ethnic groups.	Colorectal cancer; breast cancer; cervical cancer	4	11
Black men in the UK are less likely to participate in prostate cancer screening, partly because of low trust in the healthcare system, feelings of social alienation, and other cultural and religious beliefs.	Prostate cancer	2	25
A systematic review of studies from several countries on colorectal cancer screening found that participation was generally lower among men and women born abroad. Contributing factors included lower awareness of the disease, religious factors (with the lowest participation among Muslims), cultural beliefs involving disgust or embarrassment about screening, and an external locus of control.	Colorectal cancer	1	14
A Swedish Government Official Reports (SOU) report and a Swedish study of COVID-19 vaccination found that both acceptance of vaccination and actual vaccination coverage were lower among people born abroad than among those born in Sweden.	COVID-19 vaccination	3	64, 67

Tools to increase participation in screening, testing and vaccination programmes

Tool	Description	Expected impact	Resources required	Level of evidence	Source
A Provide information about cancer screening through civil society organisations, ideally in combination with language training	The target group rarely seeks out information independently and may be sceptical of public authorities. Health literacy is often limited. At the same time, there is an interest in learning Swedish, which can create opportunities for health promotion and communication. Language training combined with the involvement of people from the same cultural group can be an effective way of sharing information. Initiatives such as informal health information cafés (hälsofika) and other informal gatherings offering information in plain Swedish can also help improve health literacy and strengthen trust in health services.	High	High	1	3, 36
B Communicate in places where the target group spends time	Some men in the target group tend to remain within geographically limited areas and access information through channels other than those typically used by health services. Communication should therefore be tailored to the places where these men actually spend time. Examples include local squares, shopping centres, religious gathering places, barbershops, public transport and Swedish for Immigrants (SFI) classes.	Medium	Low	1	14, 31, 36, 71
C Establish contact with key individuals in the local community or cultural group	The target group may have limited trust in public authorities and general reservations about testing and vaccination. Information about screening, testing and vaccination is therefore often received with greater trust when conveyed by someone who is trusted within the individual's local community, such as a religious leader or another influential local figure. A cultural mediator can act as a link between health services and local residents on behalf of the regional healthcare authority and should be trained in matters relating to screening and vaccination. One positive example is the patient and family representative programme run by the Regional Cancer Centre Stockholm–Gotland, in which people with personal experience help foster greater understanding and trust between health services and the population.	High	Medium	1	36, 63

Tool	Description	Expected impact	Resources required	Level of evidence	Source
D Design invitations that are linguistically and visually accessible	An invitation should be accessible and written in plain, everyday language, with explanations of any technical terms. Readability can be improved by using clearly defined text boxes, an appropriate font size and line spacing, and visually highlighting key sentences. If the invitation is translated into another language, the wording should be adapted to the relevant cultural context to ensure that the message is understood correctly. The Swedish Association of Local Authorities and Regions (SALAR) has developed a national invitation template to support consistent and accessible communication.	Medium	Low	1	14, 63
E Improve the initial contact with healthcare professionals	The target group may have limited health literacy and may sometimes be sceptical of healthcare professionals. It is therefore important to strengthen the ability of health services to meet the needs of patients from diverse cultural and linguistic backgrounds. Treating patients with respect for their experiences and circumstances can improve understanding and build trust. It may also be beneficial to offer patients the opportunity to meet healthcare professionals of the same gender and linguistic background. For some individuals, this can facilitate communication and increase their willingness to participate in screening, testing and vaccination.	High	High	1	14, 63
F Patient navigation	Patient navigators may include healthcare professionals or social workers who provide individualised support to help people overcome barriers to accessing healthcare. This support may include education, assistance with appointment scheduling, language support and help bridging cultural differences. Patient navigation has been shown to be particularly effective among socioeconomically disadvantaged groups and people born outside the country.	Medium	High	4	45, 46

How the study was conducted

The tools were developed through a systematic review of both scientific and grey literature, supplemented by interviews with relevant stakeholders. The aim was to produce a reliable and practical evidence base to help regions increase men's participation in screening, vaccination and testing, as well as their willingness to seek healthcare.

The literature review covered scientific studies, systematic reviews, guidelines and other evidence resources, as well as government inquiries and reports. Searches were carried out using publicly available databases and search engines, including PubMed and Google, and supplemented with AI-based tools to broaden and streamline the identification of relevant material. Search terms included key concepts relating to men's health, participation in cancer screening, HPV vaccination and organised prostate cancer testing (OPT), alongside factors such as inequality, socioeconomic circumstances, ethnicity and social norms. Searches were conducted in both Swedish and English and covered studies from Sweden, the Nordic countries and other international settings.

To strengthen the practical relevance of the findings, the literature review was supplemented by interviews with representatives of regional and local authorities, researchers, patient organisations and non-profit organisations. The interviews provided insights into implementation, barriers encountered in practice and examples of approaches used across different parts of the healthcare system.

The work was carried out in several stages. First, groups of men with lower participation in screening or vaccination, or lower rates of healthcare-seeking, were identified. Selection was based on recurring patterns in the literature and confirmed through interviews. Next, tools and methods showing potential to increase participation were identified, both for men generally and for specific target groups. In the third stage, these tools were analysed and synthesised, with individual interventions grouped into broader categories to make the material easier to navigate and more useful for regional service development.

The identified tools and methods were classified according to the strength of the evidence. Classification was based on an overall assessment of research evidence, transferability to the Swedish context and the extent to which methods had been tested in practice. Evidence levels range from methods supported by scientific research in cancer care to methods based on established practice or not yet systematically evaluated.

The report aims to provide structured decision-making support to identify relevant target groups, select the most promising interventions and set priorities according to local needs, resources and objectives. This creates better conditions for more targeted work on early detection and prevention – and for reaching more men in time.

The Swedish Cancer Society's vision is to defeat cancer. By funding the best research, sharing knowledge about cancer and influencing decision-makers on important issues, we work to ensure that fewer people develop cancer and more survive it.The Swedish Cancer Society is an independent, non-profit organisation that receives no government funding. Our work depends entirely on legacies and donations from individuals and businesses. We are one of the largest funders of cancer research in Sweden. Since 1951, we have awarded approximately SEK 17 billion to leading research projects in Sweden. Cancer survival has more than doubled over the same period. Thanks to advances in research, seven in ten people diagnosed with cancer now survive.
We have come a long way, but there is still more to do.

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