

THE NATIONAL STRATEGY FOR SEXUAL HEALTH AND HIV

The response of the Men's Health Forum

1. Introduction

1.1. This document is the Men's Health Forum's response to the Department of Health's consultation paper on The National Strategy for Sexual Health and HIV. Our responses to various issues raised in the national strategy are outlined below, with specific recommendations highlighted in bold.

1.2. The Men's Health Forum is a charity founded to promote a greater understanding and awareness of the health of men in the UK and to promote ways of improving male health. In responding to this consultation, we have therefore commented only on what would improve the health of men.

1.3. However, the Men's Health Forum advocates a greater understanding of how gender (in respect of both men and women) has an impact on health and believes there should be greater sensitivity to gender when designing health services, health information and health promotion initiatives. The Forum believes that the health of both men and women could be significantly improved by a greater understanding of gender and its impact on health and the use of health services. This is certainly the case in the area of sexual health.

1.4. While this response focuses on men, the Forum does not endorse the idea that the sexual health of women should be sidelined or suffer at the expense of improving the sexual health of men. Improving the sexual health of both men and women together can be the only way forward, even if those improvements are achieved by working differently with men than with women.

1.5. The sexual health strategy aims to apply the values and principles of the NHS Plan to sexual health, to redesign services around the people who use them, and to:

- Improve services, information and support for all who need them
- Reduce inequalities in sexual health
- Improve health, sexual health and well-being

1.6. While this is welcome, it should be noted that to achieve this for the wide range of groups within the population will require a number of different approaches. In particular, the needs of men are not the same as those of women and in order to provide improvements in male sexual health a gender perspective will be required.

1.7. Those involved in developing and delivering this strategy should take a gender perspective to all the various aspects of their work.

1.8. The strategy document sets out a definition of sexual health (in paragraph 1.2) that is a welcome statement about the range of determinants of sexual health. However, the rest of the consultation paper largely disregards this definition and focuses solely on the prevention and treatment of STIs and HIV. This is a missed opportunity. For example, the strategy could have included more initiatives that promote positive sexual health rather than paying attention only to what happens when things go wrong for individuals. It could also have paid far more attention to key issues like sexual dysfunctions and sex education.

2. Prevention

2.1. The strategy recognises that preventing poor sexual health depends upon everyone having the information, skills and services they need. The strategy also points out that

discrimination should never be tolerated. Discrimination should not be allowed to stop the effective delivery of health promotion messages, deter people from using services, or prevent people accessing good quality information on sexual health relevant to their personal need.

2.2. For this to become common practice, it will no longer be viable for sexual health services to use a generic approach. The information, skills and services that men need are not identical to those of women and services will need to be promoted in different ways.

2.3. If men are not specifically targeted with information that meets their needs, or with health promotion interventions that are more likely to impact on their awareness and behaviour, they are likely to miss out on the benefits of good sexual health services.

2.4. While some services lack the knowledge and experience required to effectively target men, services should not use their inexperience in targeting particular groups, such as men, as a way of avoiding doing this in the future.

2.5. Services must engage with men in a way that acknowledges their own particular experiences and uses the language they use when discussing sexual health. Too often individuals attempt to access services and are confronted by clinical language that means little or nothing to them, for example conversations about urinating mean little to men who talk about 'pissing' or 'peeing'. Service providers need to establish what language an individual uses to discuss sex and use that language in any intervention.

2.6. All sexual health services should develop a strategy to target specific groups of the population and be explicit within that strategy of the different steps they will take to reach and work with those different groups. These groups should include: men, women, young men, young women, lesbians and gay men, older men and older women and different ethnic groups within the local population.

3. HIV Prevention

3.1. The development of the HIV prevention strategy includes a number of actions that are to be welcomed. There are, however, some aspects that require further development in order to make them truly effective.

3.2. The localised adoption of the Making It Count framework is a welcome move. However, it should be recognised by those adopting the Making It Count framework that gay and bisexual men and their communities are not homogenous and what works in London or Bristol will not necessarily work in Cumbria or Cornwall.

3.3. Recognition of the diversity within the gay community must be a factor that is considered where this framework is adopted and these factors must be included in any implementation plan.

3.4. The development of a strategic framework for prevention for African Communities is welcome.

3.5. The framework that is developed must include recognition of how gender and culture inter-react within particular ethnic groups. The framework must have specific recommendations within it for working with men from various ethnic groups and not treat all non-white men as a homogenous group.

3.6. Development of a national information campaign targeted at young drug users and those who are already HIV positive and Hepatitis B or C infected is a welcome initiative.

3.7. It should be recognised by those engaged to develop this campaign that young men and young women access and respond to health services and to health

information campaigns differently. It may be necessary for different strands, created on gender lines, to be developed within one overall campaign.

3.8. The proposed development of a new information campaign for the general population in 2002 on preventing STIs and unintended pregnancies is also an important initiative.

3.9. This campaign has to take into account and act upon the different ways that men and women access and respond to health information. A generic approach is no longer a viable option.

4. Provision of Information for HIV/STI prevention

4.1. The strategy recognises that particular groups require targeted and specific sexual health information and that strategies need to be developed to meet the specific information and prevention needs of local populations. However, the strategy does not recognise that within the named groups there will be some differences that will require modifications to the overall approach used.

4.2. The strategy should recognise that a gender specific approach will be required within some of the groups named as requiring targeted information. For example the needs of male sex workers will not be the same as the needs of female sex workers.

4.3. The action to develop wide ranging information provision giving people choices in the way they can access information, including telephone help lines, digital television and the internet as well as leaflets and posters where appropriate is a welcome recognition of the changing ways in which information is now available. Experience gained in providing men with information shows that they particularly welcome telephone and internet information provision due to the anonymity of the process.

4.4. It is also important that the information being provided meets their needs and is not generic. The lessons learned from providing gay men with 'sex positive' information through HIV prevention efforts should in future be applied to all sexual health information provided to all groups. Information, however it is distributed, should be in a language that men understand and in a tone that promotes sex as a positive aspect of a healthy life and not simply an exercise in procreation.

4.5. In developing these new methods of information it is important that a gender perspective is considered for both the method of delivery used to provide the information as well as the appropriateness of the information itself.

5. Better Services

5.1. While the Forum welcomes the recognition that existing service provision is variable in availability, quality and choice across the country, it should also be noted that these are often compounded by a lack of gender sensitivity, making existing services even less accessible to men.

5.2. The proposed new model of working, as set out in the strategy, suggests how local services could be improved. However, the strategy does not address the important issue of competing needs. The strategy implies that particular groups will each have a particular set of needs and that, in organising services, these different sets of needs may compete with each other. The strategy does not go on to suggest how such competition can be resolved.

5.3. In order to reduce health inequalities and improve the health status of men it is essential that the sexual health needs of men are met, but not at the expense of the sexual health needs of women.

6. Managed Service Networks

6.1. The development of services at three distinct levels is an important step in coordinating services. However the suggested developments are focused on the needs of the NHS and not the people who use its services. It also needs to be noted that the shift in focus to primary care may result in problems reaching many men. Men are poor users of primary care and will miss out on important services if they are not available elsewhere.

6.2. *These developments need to be properly patient focused. It may well be that patients do not want services at a primary care level – often sexual health and contraception services are successful because they are at a distance from general practice.*

6.3. Many men do not know what the term 'GUM' means and there is often the assumption that men are not welcome at family planning services. To make these different services and levels work effectively together they need to be linked in the minds of those who use them and not just linked in an NHS service model.

6.4. *Sexual health services, including GUM clinics and family planning services should be re-named and re-branded using non-medical language and form a unified service in the minds of those who use health services.*

7. Chlamydia Screening

7.1. The strategy makes no mention of working with men on chlamydia. As most men with chlamydia are asymptomatic or have minor symptoms that can be easily ignored, it is essential that men are encouraged to get tested for the infection and to seek treatment. Pilot projects that seek to inform men about chlamydia and encourage testing where appropriate should be established. These pilot projects should aim to develop a body of knowledge on health promotion interventions aimed at men on this issue otherwise it will continue to be perceived as a 'female condition' and only half the infected population will have been targeted.

7.2. *Men are part of the solution to reducing the levels of chlamydia and need to be targeted and worked with in ways that engage them, otherwise they will go untreated and women will continue to be re-infected.*

8. Contraception Services

8.1. Local contraception provision needs to be re-thought in order to attract more men. The number of men currently attending contraception services is very low. Partly this is due to the perception that has grown that contraception services are services for women and that men are not involved (except when they attend to support their partner.) If initiatives to reduce unintended pregnancies are to be more effective, contraception services must become services that are for men as well as women.

8.2. *Contraception services should be required to target men through specific interventions and to promote the concept of decisions about contraception as being decisions that a couple have to make together. Such an approach may also involve the development of assertiveness and negotiation skills that are essential to optimal sexual health and are some of the skills that the strategy's original definition of sexual health refers to.*

9. Psychological and sexual problems

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9.1. The strategy makes important and welcome suggestions about the treatment of sexual dysfunctions. However, the recommendations do not go far enough. It is estimated that 1 in 10 men is affected by erectile dysfunction at any one time and that many more are affected by loss of desire or ejaculatory problems. It is difficult for men to access services for these conditions, partly because of their own embarrassment and partly because men are generally reluctant users of primary care. There is compelling evidence that more men would present for treatment if there were more points of access for information and treatment about sexual problems, including telephone services, websites and walk-in clinics as well as traditional primary care.

9.2. There is also evidence from patient surveys that a significant number of GPs continue to deal with sexual dysfunctions inadequately, for example telling older men that erectile dysfunction is something they must live with 'at their age' rather than a symptom of an underlying condition that in many cases can be effectively treated. Schedule 11, which continues to restrict many men's access to NHS treatments for erectile dysfunction, is also a major problem. It reinforces inequalities – low income men with erectile dysfunction caused by heart disease or depression, for example, are unlikely to be able to afford a private prescription – and potentially delays the detection of serious underlying diseases.

9.3. Finally, even if a man is treated for erectile dysfunction or another sexual dysfunction, this is very unlikely to be done on the basis of best practice. Few physicians, for example, have the training or the time to undertake psychosexual counselling, preferably with the man as well as his partner, in conjunction with any medical treatment.

9.4. *Services must develop and implement strategies to engage with men affected by erectile dysfunction and other sexual dysfunctions, particularly through non-traditional methods of service delivery such as drop-in clinics, websites and telephone information services. Schedule 11 must be reviewed to eliminate the restrictions on access to NHS treatments for erectile dysfunction. Best practice in the areas of erectile dysfunction and psychological and sexual problems must be more widely implemented by services.*

10. Access and information

10.1. It is well documented that men can be a difficult group to reach. If the opening hours and locations of services are reviewed in order to place them within easy reach of men, and then advertised to men in a suitable manner, it is likely that more will attend services. It is also essential that services recognise that men have a wide range of concerns that relate to sexual health and sexual function that are not routinely considered by services. Many of the issues relate to poor sex education but nonetheless remain important to men, particularly young men. Issues of concern include penis size, semen volume and consistency, intensity of orgasm, masturbation (e.g. how often is normal?), the workings of the female body, etc. In order to achieve optimal sexual health it is important to address the everyday concerns as well as tackling sexually transmitted infections. Information that answers these types of questions should be provided alongside the information provided about sexually transmitted infections.

10.2. When providing information by telephone it should be noted that men are reluctant to access telephone lines that are labelled 'helplines', 'advice' lines or 'counselling' services. Men prefer to access 'information services' and to retain a sense of control of the experience of accessing this type of information. It is also important that the Contraception Education Service helpline is renamed to make it clear that it offers information on a broad range of sexual health issues, not just contraception.

10.3. *There are examples of outreach clinics in community settings that have attracted large numbers of men because they offer a service that meets the needs of men, including information, at a time and place that is convenient to those men targeted. This approach should be evaluated and where appropriate expanded upon.*

11. Self care

11.1. There are emerging possibilities for men to self test for various STIs using simple home testing kits. The development of this type of service should be explored as many men will not attend a traditional service until they know for certain, or strongly suspect, that something is wrong. Research should be undertaken into what STIs men will self test for and how best to follow up those who test positive. Best practice in promoting self testing must be developed for the benefits of self care to be fully realised.

11.2. *Promoting self testing for certain STIs could be one key to attracting more men into sexual health services and reducing part of the burden on the sexual health services.*

12. Circumcision

12.1. The strategy fails to mention the issue of male circumcision for non-medical reasons and the lack of evidence to show that circumcision in these circumstances in any way benefits the health of men and boys. Information should be provided to all new parents informing them that, in the absence of medical advice, the removal of the foreskin is unnecessary and inadvisable. This information should be provided in a way that recognises religious and cultural sensibilities concerning this issue.

12.2. *Information about the lack of evidence for circumcision for non-medical reasons should be provided to all new parents.*

12.3. There is also evidence that an unnecessarily high number of boys aged under 15 are being circumcised as a result of phimosis, a condition in which the foreskin cannot be retracted to expose the head of the penis. In many cases, there are effective alternative treatments and there is a need for improved medical training to ensure that doctors recommend circumcision only when strictly necessary.

13. HIV Testing

13.1 The strategy proposes an increase in HIV testing in primary care. A major concern is the issue of HIV testing and insurance. Men need to know that if they have an HIV test in primary care then it will be noted within their medical records and that this information could be disclosed to insurance companies. As insurance often forms the bedrock of financial stability for many households, for this to be threatened could jeopardise the overall health and wellbeing of the household and could seriously dent confidence in the NHS.

13.2. *This approach should be reversed and testing should be undertaken by specialist workers who have been fully trained in the medical and social implications of an HIV diagnosis.*

13.3. Another concern is the widespread introduction of antenatal testing of mothers without explicit information about the approach to partner notification.

13.4. *The needs of men being diagnosed 'by proxy' must be fully explored. Expectant mothers and their male partners need to be informed about the implications of receiving an HIV-positive diagnosis before the expectant mother consents to the test.*

14. Standards

14.1. Developing standards locally as suggested in the strategy will lead to further geographical inequalities, something the strategy condemns, unless a uniform approach is taken within each local health area.

14.2. ***The Department of Health must take a lead on setting minimum standards and suggestions on how to improve from that baseline.***

14.3. When setting these standards local organisations should involve patients and their representatives from the outset. Too often in the past strategies and plans are developed and the only input that patients get is to pass comment on a final draft – this is not an acceptable method of patient involvement.

14.4. ***Patients and their representatives must be involved from the outset in order to provide them with the opportunity to shape the development of local strategies and plans.***

14.5. ***When developing standards attention should be given to setting gender-specific standards for clinical care and health promotion.***

15. Commissioning

15.1. Multi-agency commissioning groups suggested in the strategy must be supported in order to gain an understanding of gender and health and how this impacts on sexual health.

15.2. ***To support this it is essential that gender should be a factor that is considered within the assessments of local need that the multi-agency commissioning groups undertake.***

15.3. Partnerships and the effective processes for involving stakeholders must include representatives from all the groups served by sexual health services.

15.4. ***It is important that the needs of men as a group and the needs of young men, black and minority ethnic men, older men, and gay and bisexual men as sub-groups are heard within these partnerships. It may be appropriate for local agencies to seek information and support from national organisations in order to seek the views of these particular groups.***

16. Supporting Change

16.1 Information and data collection – ***it is important to include a gender perspective to all data and information that is collected*** in order to ensure that the appropriate needs of men and women are being met and are not distorted by generic reporting. Having gender-specific information will also help commissioners evaluate the impact of initiatives on both men and women and assess whether any adjustments are required.

16.2. Evidence and research – ***the Department of Health should include a gender perspective in all relevant research that is undertaken.*** This would assist in gathering information about the differences and similarities between men's and women's approach to sexual health information, health promotion and prevention initiatives.

16.3. Professional education and training – ***all education and training should include a gender component which covers both the different needs of men and women and the different approaches that men and women take to health in general and to sexual health in particular.*** This will go some way towards recognising that practices for work with men may need to be different if men are to be fully engaged as users of services.

16.4. Human resources – ***the National Workforce Development Board and the local Workforce Development Confederations must include a gender perspective in all the training and development that they support.*** As gender is a key determinant of health, and of particular importance to sexual health, it needs to be explicitly referred to as a component of any learning undertaken.

16.5. Estate – the location and condition of clinics, as well as their internal environment, has an impact on whether men will use such services. ***Any review of the physical location of, and environment within, sexual health clinics must also include a gender perspective.*** Undertaking a gender acceptability audit, with criteria set by both men and women, would go some way toward making the clinics more welcoming and accessible to both.

16.6. Performance management – ***performance indicators should have a gender component to ensure that services are attracting and meeting the specific needs of men and women.***

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