MEN'S HEALTH TACKLING THE INEQUALITIES

Report of a one-day multidisciplinary conference held on Tuesday 11 December 2001 at the Royal College of Physicians, Regent's Park, London by kind permission of the treasurer

Tackling men's health inequalities: what can the government do?
Richard Parish, Health Development Agency

The state we're in: an overview of men's health
Peter Baker, Men's Health Forum

Why being apple shaped is such a big problem
Tony Barnett, University of Birmingham and Birmingham Heartlands Hospital

Testosterone and the cardiovascular system – friend or foe?
Peter Collins, National Heart & Lung Institute, Imperial College of Science, Technology and Medicine, London

Prevention: what works?
David Wilkins, Healthworks, Dorset

Prostate cancer: separating out the high-risk cancers
Tim Oliver, St Bartholomew's Hospital & Royal London Hospital

New treatments for erectile dysfunction
Roger Kirby, St George's Hospital, London

Getting men to see the doctor
Shaun O'Leary, The Prostate Cancer Charity

Hidden illness: hidden patients: hidden cost
Rodney Elgie, GAMIAN-Europe

Helping young men ask for help
Pippa Sargent, Campaign Against Living Miserably (CALM)

The role of health authorities
Meryl Johnson, Worcestershire Health Authority

Health promotion: getting the message across to men
Maggie Robinson, Community Learning Consultant

Community health development: opportunities and challenges
Terry Drummond, Community Health UK

Primary care: what can we do?
Jane Deville-Almond, Independent Nurse Consultant in Primary Care

Getting them young: promoting men's health in schools and colleges
Simon Forrest, University College London

MHF MEN'S HEALTH FORUM

MEN'S HEALTH JOURNAL

The Men's Health Forum in association with the Men's Health Journal

Lilly icos A Partnership for New Solutions™

Sponsored by an unrestricted educational grant from Lilly Icos

MEN'S HEALTH
TACKLING THE
INEQUALITIES

Welcome and Introduction

Dr Ian Banks, President, Men's Health Forum

Men's Health Conference
Royal College of Physicians
11 December 2001

"This conference could not be better timed," said Dr Banks:

- The UK Men's Health Forum now has six staff and an office in London
- There is an All-Party Parliamentary Group on Men's Health (chaired by Dr Howard Stoate MP)
- The *Men's Health Journal* was launched in 2001
- National Men's Health Week will take place on 10-16 June 2002
- The first, highly successful World Congress on Men's Health was held in Vienna in November 2001 and saw the launch of the European Men's Health Forum
- There is now an International Society for Men's Health with its own journal

The aim of the conference, continued Dr Banks, is not simply to complain about the condition of men's health, but to highlight the problems and to suggest practical action to improve the situation. He stressed that it is no longer appropriate to adopt the 'divide-and-rule' approach, which compares the health of men and women, since the health of men and the health of women are inextricably linked.

Instead, the conference should focus on more relevant inequalities such as the 10-year difference in male life expectancy between the north and south of the UK. "It is these inequalities that we wish to address," concluded Dr Banks.

THIS CONFERENCE WAS ORGANISED BY:
THE MEDICAL EDUCATION PARTNERSHIP IN ASSOCIATION WITH THE MEN'S HEALTH FORUM

For further information contact
Tel: 44 (0) 1279 714510
Fax: 44 (0) 1279 714519
Email: mep@stanstednews.com
Web: menshealthforum.org.uk

Tackling men's health inequalities: what can the government do?

Richard Parish, Chief Executive, Health Development Agency, London

According to Professor Parish, inequality – whether defined by social class, geography, ethnicity, or gender – is a major theme for all the work of the Health Development Agency (HDA). This is because the government regards inequalities in health as a major priority – an attitude that is influencing government policy for the National Health Service (NHS) and local government.

"We probably now have the best-ever policy canvas across the whole of government to tackle inequalities in health," continued Professor Parish. Some people may question the precise targets for reducing inequalities, but the very fact that targets now exist gives a sense of direction and raises the profile of the issue. The National Service Frameworks (NSFs) are another important move forward, though they do not necessarily focus on gender issues.

Professor Parish drew attention to the Chief Medical Officer's Annual Report for 1992, in which Sir Kenneth Calman commented on the considerable scope for men to improve their health and to prolong active healthy life[1]. For example:

- In general men experience five years less life expectancy than women. More importantly, the variation in life expectancy between social classes I/II and social classes IV/V is greater in men than in women – over 5 years compared to 3.5 years.
- Death rates for heart disease and all cancers are higher in men. The male suicide rate is almost four times that of women. More men are overweight, although slightly more women are classified as obese.
- Men visit their general practitioner (GP) much less frequently than do women.

As outlined in a recent HDA literature review[2], traditional male characteristics are rarely considered when planning services. Sexual health is still viewed very much as a female, and not a male, issue. Most significantly, there is still no proper understanding or definition of what constitutes men's health. "This is a barrier to the provision of services and the training of health and other professionals," commented Professor Parish.

There is the potential for many initiatives, but Professor Parish identified several priorities to be taken into account when developing services (Table). Services should also be sensitive to men's concerns and attitudes. There should be more men's health clinics (drop-in clinics seem to be especially popular). Telephone and online services should be developed, since men prefer the anonymity of such services. Opening hours should take account of the commitments of people who work full time, and the role of occupational health services should be strengthened. Professor Parish also drew attention to priorities in the Department of Health's R&D programme that are relevant to men's health such as: the prevention of deliberate self-harm and suicide, reducing risk-taking behaviour, diagnosis and treatment of male-specific diseases, and – perhaps most important – involving men in health-related decision-making.

Table: Priorities for men's health services

Improvements to existing services
New ways of providing services to men, such as outreach services
Health information that is sensitive to the needs of men and enables them to access the services that they need
Consideration of men's health through all the planning agencies
Professional training that takes account of men's health needs

Professor Parish stressed the importance of building men's health issues into Health Improvement (HImP) plans. Local authority community plans should also take account of men's health needs, and Local Strategic Partnerships will provide the opportunity to take an overarching view of inequalities of all kinds. "Increasingly, with the emergence of primary care trusts (PCTs) and the appointment of Directors of Public Health, I would certainly hope and expect that there will be an annual public health report from each PCT that will involve issues such as men's health."

To Professor Parish, the role of the voluntary sector is absolutely critical, since these organisations can act as strong advocates for men's health, representing the needs of a very diffuse group of people in planning and consultation mechanisms. The voluntary sector may play an important role in delivering services and contributing to the research agenda, in public education, and in monitoring the work of the NHS and agencies such as the HDA.

Finally, Professor Parish concluded: "It is essential to involve men in decision-making, since planning that truly takes into account the needs of people on the ground has to be at the heart of improvements in services."

References

1. Annual Report of the Chief Medical Officer. On the state of the public health. December 2001. www.doh.gov.uk/cmo/annualreport2001.
2. Health Development Agency. Boys' and Young Men's Health. London: HDA, 2001. ISBN 1-84279-061-7.

The state we're in: an overview of men's health

Peter Baker, Director, Men's Health Forum

"If I had to summarise the state of men's health, I would say that it could be better," commented Mr Baker.

Many analyses of men's health still make a simplistic comparison of men's and women's health statistics to demonstrate that men are disadvantaged, he continued. While this may have been a useful approach a few years ago when the case for men's health still needed to be made, it is now unhelpful because:

- Women's health is not the gold standard. Women have serious, specific health problems, which are neither highlighted nor solved by a comparison with men.
- An unsophisticated analysis that compares men with women masks inequalities within men's health.
- It also encourages unhelpful competition between men and women for resources.

"Now, however, we are moving towards to a position where men and women are working together to put gender on the agenda" said Mr Baker.

Mr Baker explained that, while life expectancy for all men at birth is 74 years in England and Wales, this masks wide differences between professional and unskilled men (77.7 years versus 68.2 years)[1]. There are also inequalities between areas of the country: for example, there is a 10-year difference in life expectancy between men living in central Glasgow and men living in parts of Buckinghamshire[2]. Indeed, the CMO's latest Annual Report commented that the current death rates of unskilled men in parts of Stockton-on-Tees, Liverpool and St Helens were similar to the national average for the 1940s[3].

Disease of the circulatory system, especially heart disease and stroke, is the largest single cause of death in men, continued Mr Baker. This illustrates why men's health must be considered in its widest sense and not be confined to male-specific diseases. Mr Baker added that the CMO's report also highlighted the growing problem of alcohol misuse. Twenty-seven per cent of men drink over the recommended 21 units a week, a percentage that rises to 36% in younger men (aged 16-24 years), who are also more likely to engage in binge drinking[3].

An increasing proportion of men have a body mass index (BMI) >25 (usually considered the upper limit of desirable). Being overweight increases a man's risk of diabetes, heart attack, hypertension and coronary heart disease (CHD): a man with a BMI of 22-23 is about half as likely to suffer from CHD than a man with a BMI >30 and he is eight times less likely to develop diabetes[4]. This problem will worsen as men become increasingly sedentary and eat a high fat diet, he added.

Mr Baker drew attention to another important indicator of male health: the recent increase in rates of sexually transmitted infections (STIs). In 1999, 271,552 new episodes were reported to genitourinary medicine (GUM) clinics compared with 217,639 in 1995. It is, however, surprising that so many men are attending these clinics, continued Mr Baker, because a Men's Health Forum/Doctor-Patient Partnership survey found that about 20% of men believe that a GUM clinic deals with gum problems. "It is difficult to think of a more ludicrous name for a service that is supposed to be about easy access," he commented.

Table: Main causes of death in men (1999)[1]

Circulatory system	40%
Cancer	26%
Respiratory disease	16%
Digestive system	4%

The increase in reported cases of chlamydia – from 14,303 in 1995 to 24,523 in 1999 – is a particular problem, continued Mr Baker, because although it is largely asymptomatic in men, the infection can have serious consequences for the future fertility of women. As a result, the Men's Health Forum is now pressing the case for improved male screening for chlamydia.

According to Mr Baker, hours of work are one indicator of growing male levels of stress, which is a known cause of mental and physical problems. On average, men work 40 hours per week, but 25% of men without, and 33% of men with, dependent children work more than 50 hours.

Mr Baker reported that the average man goes to the GP four times a year – a figure that means little in isolation but that is relatively low – and men are particularly poor at attending preventive primary care health clinics. He advised that any strategy to improve men's health must increase men's use of primary healthcare services, which could mean operating clinics in non-traditional settings, such as the workplace, pubs, clubs and barber shops.

"I think that, until we develop a health service and policies that effectively meet men's needs, men's health will remain a contradiction in terms and one of the greatest areas of health inequality will remain entrenched," concluded Mr Baker.

References

1. Office for National Statistics. Social Focus on Men. London: The Stationery Office 2001.
2. Griffiths C, Fitzpatrick J. Geographical inequalities in life expectancy in the United Kingdom, 1995-97. *Health Statistics Quarterly* 2001; (October): 12-28.
3. The Annual Report of the Chief Medical Office at the Department of Health. London: Department of Health, 2001.
4. Baker P. *Real Health for Men.* London: Vega, 2002.

Why being apple shaped is such a big problem

Tony Barnett, Professor of Medicine, University of Birmingham and Birmingham Heartlands Hospital

Professor Barnett reported that in the last 15 years UK rates of obesity (body mass index [BMI] >30) have trebled from about 6% to around 20%, and approximately 60% of the population is now overweight (BMI >25)[1]. This has particular implications for men because, although there are more obese women, a higher proportion of men are overweight. In addition, there will be major public-health problems in future because about 15% of teenagers and over 12% of young children in the UK are now clinically obese[2]. Professor Barnett explained that the reasons for this explosion in obesity are increased fat in the diet and, more important, sedentary lifestyle. "As a nation, we are very, very sedentary. We do not take sufficient exercise" he observed.

Obesity is a disease in its own right. This is especially true of central obesity involving the abdominal organs in a so-called 'apple distribution' of fat. This is not only very strongly linked to insulin resistance, but also to increased cardiovascular risk, dyslipidaemia, hypertension and type 2 diabetes.

Professor Barnett outlined the long-term consequences of obesity. It trebles the risk of sudden death by about three fold, doubles the risk of stroke or heart failure, and increases the risk of coronary heart disease (CHD) by 1.5 fold. "It is important to point out that this is predictive and independent of age, cholesterol, blood pressure, smoking, glucose intolerance, and other risk factors," he added[3].

Similarly, there is a 100-fold increased relative risk of type 2 diabetes in middle-aged people with the highest BMI compared with those with the lowest BMI[4]. In short, obesity is the single most important modifiable risk factor, not only for cardiovascular disease but also for type 2 diabetes. The likelihood of respiratory disease, hormonal abnormalities, and gout are also increased, and there is a higher (and less well known) risk of certain cancers, for example colon and prostate cancer.

In the UK the insulin resistance syndrome is a particular problem in some ethnic groups, especially the Asian population, added Professor Barnett. Recent data suggest that 25% of adult members of the Asian community now have type 2 diabetes[5]. "This is a real problem in many parts of the country. For example, people of Asian ethnicity comprise well over one third of my patients in Birmingham and represent 12% of the UK diabetic population."

According to Professor Barnett, this increased risk of type 2 diabetes is not a consequence of migration, but of westernisation, since the prevalence of type 2 diabetes rises dramatically among people living in, for example, India who become westernised. The explanation is not entirely clear, but one of the major factors appears to be the presence of abdominal fat. "If you are a woman with a ≥ 36 inch waist or if you are a man with a ≥ 40 inch waist, you have a greatly increased risk of type 2 diabetes, insulin resistance and cardiovascular disease" [6].

Professor Barnett explained that adipocytes (fat cells) secrete several factors involved in insulin resistance, including a recently identified fat-cell-derived hormone called resistin. Levels are increased in female rats with either genetic or diet-induced obesity[7]. In these animals, resistin causes impaired glucose tolerance, and insulin action is improved if resistin protein expression is reduced. These animal data may not apply to humans, but according to a recent report[8], there is four times the level of resistin expression in central fat stores compared with peripheral fat, possibly linking the hormone with insulin resistance, and suggesting the possibility of future treatments.

Professor Barnett ended on a positive note by drawing attention to the potential benefits of even moderate weight loss (Table). "What is more, these benefits do not include the substantial benefits to psychological and physical wellbeing."

Table: Benefits of 10 kg weight loss over five years in a person with obesity

Mortality	>20% ↓ total mortality >30% ↓ diabetes-related deaths >40% ↓ obesity-related cancer deaths
BP	↓ 10 mmHg systolic ↓ 20 mmHg diastolic
Diabetes	↓ 50% fasting glucose
Lipids	↓ 10% total cholesterol ↓ 15% LDL ↓ 30% triglycerides ↑ 8% HDL

Adapted with permission from Obesity in Scotland, SIGN 1996[9]

References

1. Report of the British Nutrition Foundation Task Force. Oxford: Blackwell Scientific Ltd, 1999.
2. Reilly JJ, Dorosty AR. Epidemic of obesity in UK children. *Lancet* 1999; 345: 1874.
3. Hubert HB, Feinleib M, McNamara N, et al. Obesity as an independent risk factor for cardiovascular disease: a 26-year follow-up of participants in the Framingham Heart Study. *Circulation* 1983; 67(5): 968–77.
4. Colditz GA, Willett WC, Rotnitzky A, et al. Weight gain as a risk factor for clinical diabetes mellitus in women. *Ann Intern Med* 1995; 122: 481–86.
5. Mather HM, Keen H. The Southall diabetes survey: prevalence of known diabetes in Asians and Europeans. *BMJ* 1985; 291: 1081–84.
6. Lean MEJ, Hans TS, Seidell JC. Waist circumference indicates a larger burden of ill health than body mass index. *Lancet* 1998; 351: 853–56.
7. Steppan CM, Bailey ST, Bhat S, et al. The hormone resistin links obesity to diabetes. *Nature* 2001; 409: 307–12.
8. McTernan CL, McTernan PG, Harte AL, et al. Resistin, central obesity and type 2 diabetes. *Lancet* 2002; 359: 46–47.
9. Scottish Intercollegiate Guidelines Network. *Obesity in Scotland.* Edinburgh: SIGN 1996.

Testosterone and the cardiovascular system – friend or foe?

Peter Collins, Professor of Clinical Cardiology and Honorary Consultant Cardiologist, National Heart & Lung Institute, Imperial College of Science, Technology and Medicine, London

Although myocardial infarction (MI) or heart attack – caused by atheroma (fatty plaques) in the coronary blood vessels – is the commonest cause of death in both men and women, women usually develop coronary artery disease (CAD) 10-15 years later than men. According to a long-standing theory, this is because women are protected by oestrogen, which is said to benefit the cardiovascular system, unlike testosterone – the so-called 'male' hormone – which is thought to increase the risk of CAD.

However, research indicates that the relationship between levels of free testosterone (i.e. in the blood) and CAD in men is not so straightforward in practice. For example, the extent of CAD was scored in 55 men, based on the amount of atheroma in their coronary arteries. The investigators expected that there would be a positive relationship between CAD and levels of free testosterone, but they found quite the opposite. There was in fact an inverse relationship – that is, CAD was more likely in men with low levels of free testosterone[1]. "Of course, this did not tell us that testosterone is good for the heart, but it made us think about whether testosterone is actually as bad as we thought," commented Professor Collins.

Subsequent animal studies demonstrated that testosterone is in fact a coronary vasodilator. It relaxes, rather than constricts, coronary arteries[2], and in relatively high concentrations increases coronary blood flow in animals[3]. It seems that this effect is specific to testosterone and is reduced in analogues of the hormone. "Using different testosterone analogues the relaxing potency can decrease by almost 90%[2]. This suggests that the relaxing response to testosterone relies on the shape of the molecule", explained Professor Collins.

The beneficial, vasodilatory effects of testosterone were demonstrated in humans in a study involving 13 men with a mean age of 61 (± 11) years with either one or two vessel CAD. Testosterone was infused directly into the coronary artery, and at low concentrations significantly increased coronary blood flow from baseline. This was not dose-dependent, but a direct effect of testosterone on the coronary arteries[4]. Interestingly, the baseline levels of testosterone were at the lower limit of normal (about 11 nmol/L) in these men – who were not selected because of their testosterone levels but because they had CAD – while oestradiol was 139 p/L. "This level of oestrogen is probably higher than in most postmenopausal women; indeed many people do not realise that oestrogen levels in men are on the whole greater than in postmenopausal women," added Professor Collins.

Testosterone has also been investigated for its potential anti-anginal properties; that is, whether it can improve myocardial ischaemia (inadequate blood flow to the heart because of coronary atheroma). In this study, 14 men with CAD and low testosterone underwent a treadmill test to assess their exercise capacity. The men were then given an i.v. dose of testosterone, followed 40 minutes later by another treadmill test. When the men received testosterone they were able to exercise further to angina pain than when they were given a placebo, demonstrating that testosterone has a beneficial effect on myocardial ischaemia[5]. This property has been confirmed in a recently published four-week transdermal testosterone treatment study, demonstrating a chronic beneficial effect on myocardial ischaemia in men with coronary heart disease[6]. The mechanism of benefit may involve its ability to increase the release of nitric oxide from the endothelium (lining of the blood vessels)[8].

Testosterone may not be that detrimental to women with CAD. All women release androgens ('male hormones') including testosterone from the ovaries and adrenal glands, and the relationship between endogenous or natural levels of free testosterone and atheroma in the carotid artery has been assessed in pre- and postmenopausal women. The investigators found that, within the physiological range, higher endogenous levels of testosterone in women are associated with a lower risk of carotid atheroma, suggesting that testosterone may not adversely effect the cardiovascular system in women[7].

"In conclusion," said Professor Collins, "testosterone may not be as bad or as harmful to the cardiovascular system as we once thought. I cannot make any claims about long-term benefit, as those studies have not been done, but I think we have enough information now to develop scientific rationales for further long-term randomised studies on the effect of testosterone on the vasculature in men with low plasma levels."

References

1. Phillips GB, Pinkernell BH, Jing TY. The association of hypotestosteronaemia with coronary artery disease in men. *Arterioscler Thromb* 1994; 14 (5): 701–16.
2. Yue P, Chatterjee K, Beale C, et al. Testosterone relaxes rabbit coronary arteries and aorta. *Circulation* 1995; 91 (4): 1154–60.
3. Chou TM, Sudhir K, Hutchison SJ, et al. Testosterone induces dilatation of canine coronary conductance and resistance arteries in vivo. *Circulatio*n 1996; 94 (10): 2614–19.
4. Webb CM, McNeill JG, Hayward CS, et al. Effects of testosterone on coronary vasomotor regulation in men with coronary artery disease. *Circulation* 1999; 100 (16): 1690–96.
5. Webb CN, Adamson DL, de Zeigler D, Collins P. Effect of acute testosterone on myocardial ischaemia in men with coronary artery disease. *Am J Cardiol* 1999; 83 (3): 437–39.
6. English KM, Steeds RP, Jones TH, et al. Low-dose transdermal testosterone therapy improves angina threshold in men with chronic stable angina. A randomised, double-blind placebo-controlled study. *Circulation* 2000; 102(16): 1906–11.
7. Ong PJ, Patrizi G, Chong WC, et al. Testosterone enhances flow-mediated brachial artery reactivity in men with coronary artery disease. *Am J Cardiol* 2000; 85 (2): 269–72.
8. Bernini GP, Sgro' M, Moretti A, et al. Endogenous androgens and carotid intimal-medial thickness in women. *J Clin Endocrinol Metab* 1999; 84 (6): 2008–12.

Prevention: what works?

David Wilkins, Lecturer/Practitioner in Health Promotion, Healthworks, Dorset

Mr Wilkins described a Dorset-based programme that has successfully educated and improved the health of men aged over 40. The programme was inspired by three facts:

- Two thirds of men in the UK are overweight
- Weight gain increases with advancing age and peaks between the ages of 35 and 55
- Being overweight increases a man's risk of a number of diseases, including heart disease and diabetes.

Against this background, the aims of the programme were to encourage men aged over 40 to lose weight, increase their physical activity and improve their knowledge of coronary risk.

Mr Wilkins explained that the first step was to hold structured discussion groups drawn from men in the target age group – 'a process of reflective analysis' – that revealed not only the men's negative attitudes towards fitness and exercise, but also their positive, practical advice (Table). The men's feedback was used to design a programme that has been relatively successful in working with a target group which is acknowledged to be difficult to reach.

Table: Attitudes to exercise and fitness of men aged over 40

It is 'natural' to put on weight with increasing age and it is not an indication of lack of fitness
It is a pity to lose physical attractiveness but it is 'unmanly' or a 'women's thing' to worry about it
They knew little about nutrition and depended on their wives
Exercise is boring and time consuming
'Keeping fit' is a 'middle class' concern
Team sports are more fun than exercising alone
Competition makes exercise enjoyable
If you are unfit, it is embarrassing to exercise with people who are in good shape
A work-based programme is more likely to attract support

The programme takes the form of an inter-workplace competition in which teams of eight men compete over six months to lose body fat, continued Mr Wilkins. Each team is supported by a local health professional – usually a health visitor – who advises on healthy eating, physical activity and stress management. In order to avoid embarrassment and to build up team camaraderie, teams can only be selected from men aged 40-55 with a BMI >27. A monthly 'league table' is published, and at the end of each 'season' a trophy is awarded to the winning team and the individual who has lost most weight.

Mr Wilkins reported that the competitive element in the programme had provoked some adverse comments from fellow health-promotion professionals. "Typically I am asked whether the programme panders to the 'worst aspects' of being a man. However, if we are going to encourage men to improve their health, we need to take specific account of male sensibilities," he commented.

Since 1995, the programme has been operated four times with a new season about to start. Mr Wilkins added that the programme has been refined over the years, most notably with a final quiz to maintain interest in the competition. The programme, which has been well supported by both participants and local employers, was evaluated in 1995 and is about to be reassessed. Men involved have shown clear improvements in fitness, knowledge of health, and reduced stress levels, while longer-term follow-up suggests that the men maintain their weight loss and increased levels of physical activity.

Although work itself is a major cause of illness and stress, the programme has demonstrated that the workplace can be a key setting for health improvement. It also should also be recognised that some individuals (such as working-class men) are more at risk. Furthermore, it is essential to consider not only prevention of illness, but also how we improve men's health. "People don't just want to prevent illness, they want to feel well and happy. We should ask ourselves what we can do to work with men to improve men's health and quality of life," he added.

Mr Wilkins' final recommendation was that men's health should be seen within a sociological and cultural context. "We cannot hope to improve men's health simply by individual health promotion programmes – important as they are – and we cannot just leave it to the NHS to provide treatment. We must think, for example, about work/life balance, the way we work with young men in schools and social centres and so on. We need to do this in a coordinated and structured way. It is the only way that we will make the changes that are needed," he concluded.

Prostate cancer: separating out the high-risk cancers

Tim Oliver, Sir Maxwell Joseph Professor in Medical Oncology, St Bartholomew's & Royal London Hospital

Despite at least 25 studies, no one has ever shown that patients at time of diagnosis of prostate cancer have higher testosterone levels than unaffected men. The majority of studies have shown no difference; in fact, there are more showing a possible connection with lower, rather than higher, levels of testosterone.

However, the association between testosterone levels at puberty and future risk of prostate cancer is clearer, and may be critical for the initiation of cancer, particularly when the ethnic distribution of prostate cancer is examined. At puberty, Africans have higher levels and greater risk than Caucasians, but interestingly Japanese men, who have an intermediate level of testosterone, are at lowest risk. Professor Oliver explained that this is due to them having a much lower level of androgens in the prostate as a result of a relative deficiency of 5-alpha reductase – the enzyme that converts testosterone into 5-alpha-dihydrotestosterone (DHT), which plays a key role in controlling prostatic growth.

At puberty high testosterone levels might interact with sexual behaviour to initiate damage to the prostate. One study suggested that starting sexual intercourse below the age of 16, and the acquisition of subclinical (early, asymptomatic) infection with chlamydia increases levels of prostate-specific antigen (PSA) more than 50 years before prostate cancer develops[1]. "This observation has important implications for health promotion given the conventional focus on the consequences of chlamydial infection in women," commented Professor Oliver.

The concept that low-grade sexually acquired infection may lead to prostate and testes damage, causing accelerated loss of testosterone drive, may explain why there is a less clear association with testosterone levels at the time of diagnosis of prostate cancer than at puberty. It may also explain why, because of the promotion of safer-sex practices following the AIDS' epidemic, mortality from prostate cancer has declined both in the UK and the USA in the last 15 years despite the lack of a prevention programme in the UK. Professor Oliver described testosterone as the 'tiger in the tank' of prostate cancer. It is involved in the initiation and development of the disease, but it is not the main cause – indeed, the most malignant cancers are seen in men with low testosterone levels at diagnosis, perhaps because of prostate damage acquired after puberty.

Other factors that increase the risk of prostate cancer include exposure to pesticides, radiation or heavy metals such as cadmium, and nutritional deficiencies, especially of vitamins A and D. In short, prostate cancer may be the result of early, subclinical prostate damage that is maintained over a lifetime by environmental factors. These risk factors are equally relevant even in a low risk population. In one Japanese study, there was a significant association between prostate cancer and prostatitis, phimosis, high animal fat and low consumption of vegetables[2].

The role of testosterone in controlling progression of prostate cancer is equally relevant in determining treatment strategy. There has been a long-standing debate about the timing of chemical castration (endocrine therapy), especially whether it should be deferred for as long as possible. However, it is now thought that the gain from endocrine therapy is far clearer in patients who receive treatment early, despite the inevitable increasing problems from side effects.

Animal studies suggest that intermittent androgen therapy may double survival time[3], but at present most men – over 95% – are given continuous treatment. This issue has been investigated in phase II studies involving over 400 men[4], but there needs to be randomised phase III studies to be sure it is safe to use intermittent therapy. "However," commented Professor Oliver, "over one quarter of men can go for more than three years off treatment. So there are definitely men in whom intermittent treatment is safe."

After a cycle of intermittent anti-androgen therapy, men are still candidates for radical surgical or radiotherapy treatment if their PSA rises (an indication of disease progression). "In my opinion, the use of intermittent androgen blockade, even just bicalutamide (Casodex), could be a method of improving case selection to determine which men with early prostate cancer need radical treatment," added Professor Oliver.

Professor Oliver concluded that testosterone definitely plays a part in the development of prostate cancer, but its role is modulated by low-grade sexually acquired infection. Young men need to be educated about these risks around the start of puberty. As a substantial number of men with prostate cancer survive without disease progression after a cycle of intermittent anti-androgen treatment, despite maintaining their testosterone levels, it may be possible to use early relapse after such therapy to distinguish those men who need radical treatment.

References

1. Oliver JC, Oliver RTD, Ballard RC. PSA in patients attending an STD clinic. *Prostate Cancer and Prostate Diseases* 2001; 4: 228–31.
2. Nakata S, Imai K, Yamanaka H. Study of risk factors for prostatic cancer. *Hinyokika Kiyo* 1993; 39 (11): 1017–24.
3. Sato N, Gleave M E, Bruchovsky N, et al. Intermittent androgen suppression delays progression to androgen-independent regulation of prostate-specific antigen in the LNCaP prostate tumour model. *J Steroid Biochem Mol Biol* 1996; 58 (2): 139–46.
4. Oliver RTD, Farrugia D, Answell W et al. Intermittent hormone therapy for M+ +MO prostate cancer. *Prostate Cancer and Prostate Diseases* 2000; 3: 1–4.

New treatments for erectile dysfunction

Roger Kirby, Professor of Urology, St George's Hospital, London

"There is probably no field of medicine that has seen a greater transformation in the way treatment is directed than erectile dysfunction (ED). Over a decade, treatment has gone from surgery to injection therapy and then to effective oral drugs," said Professor Kirby.

Since its launch in 1998, sildenafil (Viagra™) has been a phenomenal success, continued Professor Kirby. It has been given to over 15.5 million men in over 45 million prescriptions and has revolutionised the treatment of ED. In randomised, controlled studies, sildenafil produces dramatic improvements in erectile function and intercourse satisfaction with a mean 5.9 successful attempts at intercourse in men taking sildenafil compared to 1.5 for those taking placebo[1]. Interestingly in depressed men with ED, sildenafil not only improves erections, but also seems to relieve depression.

The only published sub-group data on ED treatments for patients with cardiovascular disease relate to sildenafil, showing improvement in erections in 70% of patients with ischaemic heart disease (IHD), compared with 20% in the placebo group. Similar efficacy is seen in men with hypertension. A recent analysis of pooled data confirms treatment to be effective and well-tolerated in ED patients across a wide range of conditions including IHD, diabetes and depression[2]. Published Prescription Event Monitoring data confirms no increase in cardiovascular events or risk in users of sildenafil than in the average population. Also, in a study including men with exercise-limiting angina, sildenafil actually increased the time men were able to exercise before they experienced angina pain[3].

Professor Kirby continued with data relating to apomorphine SL (Uprima), licensed in the UK in October 2001. Apomorphine promotes an erection by acting on the brain rather than on the blood vessels in the copora cavernosa in the penis. It may be less effective than sildenafil[4], but there have been no head-to-head studies published to date. In clinical trials, 30% of patients taking 3 mg apomorphine SL reported an improvement in erectile function and 28% improvement in intercourse satisfaction versus 4% and 12% in the respective placebo groups. Apomorphine SL is taken sublingually, and has a rapid onset of action (20 minutes). It is associated with nausea and yawning when the dose is increased from 3 mg to 4 mg[4], but Professor Kirby reported a positive response from several of his patients.

Not yet licensed, tadalafil and vardenafil, like sildenafil, belong to the drug class, phosphodiesterase type-5 (PDE5) inhibitors. Vardenafil appears to be as effective in treating ED in men with diabetes as in other physical causes of ED. Professor Kirby added that vardenafil has a reassuring dose-response curve with clear improvement in rigidity and duration of erections as the dose increases[5].

Tadalafil has similar efficacy rates. At 16-24 hours it has a longer half-life than sildenafil and vardenafil[6]. According to Professor Kirby, the longer duration of action of tadalafil would avoid the need to take the tablet just before intercourse. This may mean that for some patients less planning is involved in their sex life. The optimum dose of tadalafil appears to be 20 mg.

Although there are no comparative data yet for the PDE5 inhibitors, side effects for vardenafil and tadalafil, like sildenafil, appear to be mild and transient and include headache and dyspepsia. Vardenafil is not associated with any blue vision reporting, but there have been reports of some vision disturbance[7]. Tadalafil is not associated with any visual disturbances and incidence of facial flushing is low, but has reports of back pain.

Professor Kirby said that three years after its launch, there is no question that sildenafil is an effective and well-tolerated treatment for ED. Apomorphine SL is likely to be the first of many drugs that act on the brain to improve sexual function. Early data suggest that other new drugs may also offer benefits to millions of patients suffering from this prevalent condition that demoralises both men and women. However, despite the revolution in the treatment of ED, just 10% of men with the condition currently receive NHS prescriptions. The government remains concerned about the potential costs to the NHS and Professor Kirby believes that it remains extremely difficult to convince the Department of Health that ED is a serious condition – patients deserve effective treatment on the NHS.

References

1. Goldstein I, Lue TF, Padma-Nathan H, et al. Oral sildenafil in the treatment of erectile dysfunction. Sildenafil Study Group. *N Engl J Med* 1998; 338; 1397–404.
2. Osterloh I, Gillies H, Siegel R, et al. Efficacy and safety of Viagra™ (sildenafil citrate). Presented at the 4th Congress of the European Society for Sexual and Impotence Research 2001, Rome, Italy.
3. Fox K, et al. Time to onset of limiting angina during treadmill exercise in men with erectile dysfunction and stable chronic angina: effect of sildenafil citrate. Presented at the American Heart Association's Scientific Sessions 2001, Anaheim, California. A100019. (Fox K, et al, *Circulation* 2001; 104 (17 Suppl): II-601-II-602)
4. Dula E, Bukofzer S, Perdock R, et al. Apomorphine SL Study Group. Double-blind crossover comparison of 3 mg apomorphine SL with placebo and with 4 mg with placebo in male erectile dysfunction. *Eur Urol* 2001; 39 (5): 558–63.
5. Klotz T, Sachse R, Heldrich A, et al. Vardenafil increases penile rigidity and tumescence in erectile dysfunction patients; A RigiScan and pharmacokinetics study. *World J Urol* 2001; 19(1): 32–39.
6. Patterson B, Bedding A, Jewell H, et al. Dose-normalised pharmacokinetics of tadalafil (IC351) administered as a single dose to healthy volunteers. Presented at the 4th Congress of the European Society for Sexual and Impotence Research 2001, Rome, Italy.
7. Porst H, Rose R, Padma-Nathan H, et al. The efficacy and tolerability of vardenafil, a new oral selective phosphodiesterase type 5 inhibitor, in patients with erectile dysfunction; the first at-home clinic trial. *Int J Impotence Res* 2001; 13 (4): 192–99.

Getting men to see the doctor

Shaun O'Leary, Director of Operations, The Prostate Cancer Charity

Mr O'Leary reported that men (especially young men) are far more reluctant than women to consult their GP. There are significant differences between men's and women's use of health services because women are brought into the healthcare system at an early age. For example, young women visit health professionals to obtain contraception, and then antenatal and postnatal care. Later in adult life, women tend to be responsible for bringing the children to the GP for immunisation, and also attend the surgery for their own regular preventive care, such as cervical smears or menopause clinics.

Men's lack of contact with primary care is important because, in the long run, it prevents them from addressing their healthcare needs, continued Mr O'Leary. Visits to GPs are not only concerned with the treatment of illness. If men do not visit their local surgery, GPs and other primary healthcare professionals miss vital opportunities to intervene to discuss health promotion and offer preventive treatment, he explained.

According to Mr O'Leary, there are several reasons why men do not visit their doctor. Married men tend to rely on their wives to manage their health[1], and as a result are in general much less likely to follow up and question symptoms, or to seek information on health promotion. Men also differ fundamentally from women in their experience, expression and response to pain. A man will go through a process of rationalisation and denial of, for example, chest pain that unfortunately prevents him from obtaining healthcare services that he needs. In short, said Mr O'Leary, men do not see themselves at risk or are unable to make the connection between their symptoms and a serious health condition that may be the cause[2].

Mr O'Leary also reported the results of an analysis of telephone calls to The Prostate Cancer Charity helpline that suggests other reasons why men delay in consulting a health professional:

- Some men (and some women) are afraid to confront the reality that their symptoms might involve.
- Men may not have enough knowledge about symptoms to relate them to their experience.
- Equally, many men do not have the vocabulary in which to express their concerns. "We spend a lot of time talking about providing information, but less time on checking how that information is assimilated," commented Mr O'Leary.
- Embarrassment may also cause men to ignore potentially serious conditions. This is a particular problem when discussing 'trouser problems' such as prostate cancer, and is probably one reason why many men prefer to use the telephone or the internet to seek health information, especially about intimate problems. Men's embarrassment may be heightened by their lack of the correct vocabulary to describe their symptoms: for example, they may not be familiar with terms such as 'frequency' or 'hesitancy'.
- Socialisation – that is, how we see ourselves and how we believe that we should behave – also makes it difficult for men to regard a concern with health as part of the masculine way of life[2].

Mr O'Leary advised that health interventions are more likely to be effective if they are targeted to the needs of different groups of men. Health services should be made more attractive to men – at present health centres seem dominated by health promotion material for women and children – and evening surgeries and drop-in clinics should be provided. Services should also seek men out at work and at sports centres, and in pubs and clubs. Male-specific health-promotion materials should be produced to challenge typical risk-taking behaviour, such as heavy drinking, an unhealthy diet, and dangerous driving.

Health professionals should not only talk to men in their language, but should also be prepared to learn from them. Men should be informed about symptoms, but this education should be ongoing. "We should never stop giving out straightforward information," commented Mr O'Leary. "Health services should be demystified; for example, The Prostate Cancer Charity's 'Secret Sex Gland' campaign, to be launched in 2002, aims to educate men about the existence and function of the prostate gland."

It is important to work with peer support groups – for example, The Prostate Cancer Charity offers men the opportunity to talk to another man to reduce embarrassment when discussing symptoms. Finally, said Mr O'Leary, health professionals should explain their activities, and share good practice about successful programmes in men's healthcare services. "We must also keep the dialogue going, learn from our mistakes and never be afraid to take risks," he concluded.

References

1. Umberson D. Gender, marital status and the social control of health behaviour. *Soc Sci Med* 1992; 34(8): 907–17.
2. White A K, Johnson M. Men making sense of their chest pain – niggles, doubts, denials. *J Clin Nurs* 2000; 9(4): 534–41.

Hidden illness: hidden patients: hidden cost

Rodney Elgie, President, GAMIAN-Europe

In Europe, the issue of mental health was raised by Finland during the country's Presidency of the European Union (EU) on the grounds that 'there can be no health without mental health'. Even so, Mr Elgie reported that one of the many problems faced by mental health organisations is to persuade politicians to accept that mental illness is a serious issue.

Mr Elgie believes that most European politicians do not take mental illness seriously because it is not seen as life threatening – unlike cardiovascular disease, HIV and AIDS, and cancer. However, continued Mr Elgie, each year among the 272 million people in the 15 member states of the EU, there are 50,000 suicides and about 300,000 attempt suicide, while in the 870 million people of Europe as a whole, there are about 120,000 suicides and 2 million attempted suicides each year. "Globally there is one suicide every 30 seconds, one attempted suicide every 1.7 seconds," he added[1].

In addition, within the EU in any one week, 59 million people are affected by mental illness to the extent that it adversely impacts on their life, either at work, when looking after family or when engaging in social activities[2]. "Mental illness is therefore a major problem, yet there is incredible ignorance, misunderstanding, prejudice and stigmatisation," commented Mr Elgie. For example, depression is seen as a woman's illness, or an illness of old age, and therefore it seems impossible for the young to be depressed. In fact, continued Mr Elgie, depression and subsequent suicide are one of the major causes of death in young men.

People with depression suffer from the stigma and fear that still surrounds mental illness in general, or depression is dismissed as 'just a mental illness'. In fact, reported Mr Elgie, five out of ten of the leading causes of disability in the world are mental illnesses, including depression, bipolar disorder (manic depression), schizophrenia, and obsessive compulsive disorder. Indeed, the World Health Organisation (WHO) has forecast that depression will become the leading cause of disease, disability and the burden of disease by the year 2020 in the developing world, and will be second only to ischaemic heart disease in economically advanced countries[3].

Depression should therefore be a major cause for concern, especially for men. In the UK three times as many men take their own lives compared to women, a ratio that rises to ten to one in countries such as Russia and Latvia[4]. Depression may be one reason why over the last 50 years, life expectancy of males in Russia has declined by ten years and is continuing to fall[4]. Men with depression or other mental illness may drink heavily, and become involved in accidents when driving. "They may also engage in high-risk sexual activity. As a result, it is not South Africa, but Russia that has one of the highest rates of deaths from AIDS," he commented.

The burden on depression is increasingly recognised in Europe, particularly the rising incidence of stress and depression in the workplace, Mr Elgie continued. In the 1911 UK census, 90% of people lived within a 10-mile radius of where they were born; in 1991 the proportion had fallen to 10%, so most people do not have a family network to support them. Work and work colleagues form an increasingly central part of an individual's social circle, and that too can be stressful if people lose their jobs.

Such factors are likely to become increasingly important over the next five to 10 years with enlargement of the EU from 15 to possibly 31 member states. Mr Elgie explained that many countries in central and eastern Europe will go through the agricultural, industrial and technological revolutions in 20 years – an experience that took over 200 years in western Europe. So there is likely to be huge amount of unemployment in agricultural and rural communities. "In western Europe, the highest incidence of mental illness is in inner-city areas; in central and eastern Europe the highest incidence is in rural communities," he said.

As increasingly recognised by the European Commission (EC), these problems take place against the background of an ageing population. This has cost and personal implications for everyone, including men, since women are no longer willing to act as a pool of unpaid carers. Mr Elgie ended his presentation by reminding the audience of the link between depression and many physical illnesses, including heart disease and many cancers, concluding that, "there can indeed be no health without mental health".

References

1. Angst J. Suicide in Europe: Amsterdam 1998. EUROSAVE Report to the European Commission. University of Glasgow, 2002.
2. Thompson C. Presentation to European Parliament, 21 March 2001.
3. Mental Health: new understanding, new hope. Geneva: WHO 2001.
4. Rutz W. Gamian-Europe Convention. Malta, November 2001.

Helping young men ask for help

Pippa Sargent, National Coordinator, CALM

The government has set national targets to reduce suicide, and Ms Sargent explained that these are especially relevant to young men since suicide is the main cause of death, after road accidents, in men aged 15-24. One way of tackling the problem would be to offer advice and information at the onset of depression, but young men are resistant to health promotion messages, and are reluctant to engage with conventional helplines and primary care.

Ms Sargent presented an overview of the Campaign Against Living Miserably (CALM), and discussed some of the lessons from this experience that might be useful to other professionals involved in enabling young men to ask for help about mental health problems. "We need to find new approaches that specifically target young men," she commented.

Young men may question the relevance of helplines and so only contact them as a last resort. Ms Sargent explained that CALM is a communications strategy, based on a freephone helpline that aims, not only to encourage young men to talk about their problems and seek help at the onset of depression, but also to raise awareness about depression among the general public.

From the outset CALM's strategy was to copy the advertising industry and appeal to young men through the design and promotion of its message. Seeking help became the 'product' and was deliberately marketed by a brand designed to appeal to young men. This philosophy was reflected in the product design – produced by a large advertising agency – that was influenced by men's style magazines, CD covers, music flyers, websites, and current themes in youth culture.

In promoting the service, CALM used traditional media, but also used posters in urinals, information on beer mats, gym water bottles, and bus tickets. CALM also recruited partners and supporters from among people whom young men admired and aspired to emulate, including local celebrities drawn from bars, clubs, bands, sports teams, record labels, radio stations, and music and clothes shops.

"It is much more powerful for a young man to hear a DJ say that he too has been depressed, than to receive information from a health professional," commented Ms Sargent. CALM's supporters advise on keeping up with current trends and suggest the future direction of the campaign. They also endorse CALM's materials to convey a positive message about seeking help.

CALM's helpline is staffed by a specialist charity operator. Trained professional advisers offer callers counselling, information and self-referral based on a database of local and national agencies and can help to plug young men into these other services. A variety of problems are reported to the helpline, but relationship issues inspire the largest number of calls, followed by drugs and alcohol, loneliness and worries about sexuality. "Most men begin by asking for

CALM urinal poster

information rather than counselling, but many find that they need both services," said Ms Sargent. CALM's service is free, confidential and anonymous. It is also available out of hours: from 5.00 pm to 3.00 am every day of the year.

Between December 1997 and December 2001 CALM's helpline received over 25,000 interactive calls (many are non-interactive since callers appear to sound out the service before they decide to talk to an adviser). Most calls are quite long and can last 45 minutes or more. Ninety-four per cent of callers are ringing on behalf of themselves, and 68% of callers are male. "This is unusual," commented Ms Sargent, "as women are traditionally more likely than men to use helplines."

CALM seems to be getting the message across to its target group of young men. Over one half of callers to the helpline are aged between 15 and 35, and of the young men who call 60% have not accessed health services before telephoning. Only 8% of callers telephone because of suicidal thoughts, and again this suggests that CALM is fulfiling its brief by reaching young men before they are sufficiently depressed to contemplate self harm.

Young men have a very negative image of conventional health services, but since its launch as a pilot in December 1997 in the Manchester area CALM's service has been extended to Merseyside, Cumbria and Bedfordshire. "There are many reasons for CALM's success, but the campaign's image, sponsors, and branding mean that young men respect CALM and feel a sense of ownership," concluded Ms Sargent.

For an information pack about CALM contact:

Patricia Dillon
CALM Administrator
Tel: 0161 237 2038

Pippa Sargent
Email: pippa@manchester.nwest.nhs.uk

See also www.thecalmzone.net

The role of health authorities

Meryl Johnson, Health Promotion Coordinator, Worcestershire Health Authority

On 31 March 2002, health authorities will be replaced by primary care trusts (PCTs), explained Ms Johnson. The aim is an integrated approach to planning, commissioning and delivery of local services, via a common agenda for health and social care, based partly on priorities set out in the government's NHS Plan[1]. "This process of modernisation and change is unprecedented in its attempt to incorporate multiple organisational shifts into a new configuration designed to optimise a health improvement strategy, particularly in terms of health inequality".

The following two comments summarise why change is necessary:

- 'Too often in the past, the members and officers take the paternalistic view that it is for them to decide what services are provided and the interests of the public come a poor second best'[2].
- 'Patients are the most important people in the health service. It does not always appear that way and too many patients feel talked at rather than listened to and this has to change'[1].

Since 1990 there have been efforts to make user involvement in the NHS a reality, but it remains a challenge to tackle the culture that restricts change and to develop an approach that takes into account performance-management arrangements between strategic health authorities and PCTs, local issues as well as national targets – a truly shared vision.

More important, NHS health professionals must recognise that they never have all the answers. "We have to recognise that others may have some of them, and that those who are disconnected from the issues faced by the NHS are not just the socially excluded," said Ms Johnson. Health professionals need to engage with entrepreneurs and leaders in science, industry, business, commerce, learning, and the community. Decision-makers should be informed about key health issues, so that targets are based on gender-specific principles. "We want to build healthy communities that recognise the inequalities that are suffered by some, but disadvantage everyone. This will be achieved by understanding the issues, by changing how we do things and accepting that the needs of people must be at the heart of everything we do".

Ms Johnson gave the example of a successful day clinic held at a hospital building site in Worcester and organised at just three weeks' notice. As part of European Health and Safety Week and in cooperation with Bovis Lend Lease (the project managers of the construction site), all site workers were offered a health check. The process began with a questionnaire, which investigated the men's health and informed workers about the health day at the site. Eighty-five of 200 questionnaires were returned, which was regarded as a good response. The health day was operated by 18 professionals, including health visitors, occupational therapists, a dermatologist, Ms Johnson and a health-promotion colleague. Weight, height and blood pressure were measured, and staff discussed health problems and lifestyle issues with each of the men. Bovis also offered healthy food and fresh fruit, free of charge, in the site canteen.

Ms Johnson reported that 89 of the 200 men received a health check. As expected, there were many problems related to smoking, drinking and unhealthy diet, while the men also reported stress because of the insecurity of short-term contract work. However, the men did not highlight only physical problems. "Men were using us to allow themselves to talk more openly, and some health workers found out more about men's psychological ill health in those two hours than they had in the previous two years," she said.

Typical comments included:

"Basically I'm pretty healthy, but I'm an emotional wreck"

"I don't want to bother my GP with my concerns"

"This is the first time I have spoken about my depression; I felt I should pull myself together, but I just can't"

"I didn't know other people felt like me; that information has made my year"

Many men appeared to be clinically depressed and their sense of isolation was profound because they did not talk to one another about their concerns. Two men cried and said that they had never spoken to anyone about their feelings, for example, about the death of a father.

"The challenge is to remind ourselves of the job that we are here to do. Like those health visitors at Bovis, we need to find a real purpose working with less motivated or less able people." commented Ms Johnson. Health care should be accessible, approachable and achievable for everyone. Professionals should work with local businesses, especially those found in poorer communities, to set up drop-in clinics. Roaming services should be developed in clubs, factories, offices, shopping centres, motorway service stations, and port terminals to attract people working long hours or away from home. "If we really want change, it must begin with us as professionals. It must begin now and it must begin with people who want to make change happen," she concluded.

References

1. Department of Health. NHS Plan. London: The Stationery Office, July 2000.
2. DETR. Modern Local Government. London: The Stationery Office, July 1998.

Health promotion: getting the message across to men

Maggie Robinson, Community Learning Consultant

Ms Robinson had been involved with a men's health project run in conjunction with the Department of Health called 'Alive and Kicking', in which she worked with weekend football clubs. It had been a positive experience, but there were several practical lessons.

At the beginning, it had been very difficult to get through to health authorities. "I had the funding," she explained, "but it was very hard to find the right person within a trust who could discuss men's health. Some trusts – even though I was bringing money to them – could not get round to seeing me or working out who should see me." She therefore believes each trust should appoint a named individual for men's health, even if it is not their sole responsibility.

When Ms Robinson joined the board of her local trust, she discovered that men's health was never on the agenda, even though it ought to have been central to health planning. In addition, because women access health services more regularly, it seems much easier to consult them. "I would say that when we consult people during clinical governance work, we are on the whole consulting women and not men," she added.

Health services are also inflexible. During the football project, the local health promotion service could not supply the services of a dietitian because the games took place during the evenings. "If we are going to work with men, we must go to where they are. We must be more flexible in delivering services."

As a woman, Ms Robinson had at first found it difficult to go to a working men's club and talk about health issues, but it had been rewarding to see the positive peer pressure from the club committee in improving the younger men's health. Interestingly, these young men told Ms Robinson that they looked in the Yellow Pages when they needed health information, although she wondered how many health organisations make sure that they are listed.

Sensitivity to language and literacy is essential. Men do not ring up 'helplines', but they will contact 'information lines'. Any organisation advertising 'health' or 'advice' will not attract men. Furthermore, poor health and literacy are connected. On the whole men have poorer literacy skills than women, and so find it more difficult to access information.

According to Ms Robinson, men's health could be improved in future by working with young boys in nurseries and first schools. Similarly, natural places for a health check should be found in men's lives, such as before a driving test. "Women's lives are perhaps over-medicalised with regular health checks, but at present men's lives are certainly under-medicalised," she concluded.

Community health development: opportunities and challenges

Terry Drummond, Chair, Community Health UK and Advisor in Social Responsibility

Mr Drummond said that he started from the premise that it was essential to work with and understand the views of members of the local community in shopping centres, pub and clubs, football and sports clubs, gyms and other sports facilities. In addition, places of worship were another, currently underestimated, venue for health promotion.

Faith buildings are to be found in every community and all faiths have health and wholeness at the centre of their understanding. "If you want to contact minority ethnic men, particularly Muslims, the mosque is a natural place to go to. If you want to meet Afro-Caribbean men, many of them will go to black majority churches. Churches, mosques, and temples are about people coming together in a community and there is an opportunity to learn from each other," advised Mr Drummond.

Health professionals should think laterally. They should work with local businesses, especially small companies where people are under pressure. They should base services in youth centres, unemployment centres, cafes and shops, and the many small groups in the community. The development of local strategic partnerships offers opportunities for health authorities and the local authority to discuss health issues. Similarly, public organisations should ensure that they work with the voluntary sector. "Partnership is about equality, not about people with authority saying to those without authority that, 'We know best'," he said.

"To build healthy communities, professionals need to work with local people by bringing them into partnership within the locality in which services are placed, working within a context of dialogue that leads to action," added Mr Drummond. "People often know better than you or I ever will what is best for them. Professionals may know more about health, but first of all we need to trust people and then they need to trust us so that we meet on an equal basis. The aim should always be to help people to feel secure in obtaining help and information about health," he concluded.

Primary care: what can we do?

Jane Deville-Almond, Independent Nurse Consultant in Primary Care

"There is a rumour that men are not interested in their health. The problem is not that men are uninterested in health, it's that health professionals are not interested in men," said Ms Deville-Almond.

According to Ms Deville-Almond, part of the problem relates to the names and locations of conventional health services. 'Surgery' has unpleasant connotations, 'Men's Clinic' does not sound inviting, while 'Well Man Clinic' is also unlikely to attract men who do not use health services. Men who attend such clinics are usually well and already know about health. Non-attenders are probably unhealthy men, who know that they are likely to be told off about their lifestyle when they see a health professional. "In this way, we alienate half the population who are overweight or obese," she said.

In contrast, Ms Deville-Almond described a clinic held in the local pubs, where three health professionals saw 100 men over three days.

Of the first 100 men seen in the local pubs:

68-72% had at least one long-term health problem
Of these 46% had BMI ≥28
25% drank more than 140 units of alcohol a week, and seven had drink-related problems
62% of the overweight men had high blood pressure
7% were diagnosed with type-2 diabetes

Young men are an especially difficult group to reach, because they are not interested in the long-term results of an unhealthy lifestyle. They can, however, be persuaded to consider the immediate impact of current ill health. "We need to change the way in which we market health," she said. Ms Deville-Almond therefore approached the Harley Davidson Group, which has motorbike showrooms throughout Britain. Every third month, the showrooms hold an 'MOT pit stop', an open weekend where men can get their bikes checked. "So I decided to dress up as a mechanic and offer 'MOTs' for the men at the Wolverhampton showroom," she said.

Of the first 55 men seen at Wolverhampton 'MOT pit stop':

65% had more than one long-term health problem
55% had BMI >28; 6% had BMI >40
55% with BMI >28 had high blood pressure (25% of total)
6% had blood sugar >9

Ms Deville-Almond explained that the idea for the MOT clinic had originated in Australia. "Don't be afraid to copy other people's ideas. A good idea is only brilliant if someone puts it into practice."

Ms Deville-Almond wanted to operate a surgery that took place regularly but was still accessible to men. "A clinic in a pub is a great way of getting men to think about health, but it is difficult to continue because men go to the pub to relax, not to be talked at about health and lifestyle," she explained. Next to the Harley Davidson shop, there is a barbers called GI's, a well-known establishment in Wolverhampton that sees over 1000 men each month, which seemed an ideal location.

The health session at GI's barbershop is held one day a week at varying times so that different men can attend. This clinic focuses on weight control since many men are worried about being overweight, but are reluctant to seek help at a conventional weight control clinic or female-dominated slimming group. Every man is offered a complete health check, including height and weight, blood pressure and cholesterol levels, peak flow, and blood sugar. Smoking, drinking and family histories are also discussed. Each man is seen for about 25 minutes. "Fellow health professionals have said that they do not have time for a 25 minute check, but if you take the time during the first visit, you can probably give a man all the information that he needs and he will not have to keep on coming back," said Ms Deville-Almond.

Forty-one per cent of the men seen to date have one or more long-term health problem, and the proportions with specific health problems are similar to the previous clinics. In addition, 22% complained of prostate problems or erectile dysfunction. Ms Deville-Almond explained: "This is because I actually asked about these symptoms. If we do not raise an issue, we will not always get the answer." It was also important to use language that men understand. "Urinate does not mean anything to a lot of people. We need to feel comfortable in using a language that people understand," she added.

Ms Deville-Almond said that she was often asked if she is intimidated when running a clinic at, say, a garage or barber shop. But men feel exactly the same intimidation when they visit a conventional health clinic. "We need to remember that the services we provide are for the men and not for our convenience. And, if we carry on doing what we have always done, we will end up with what we already have. We need to be more innovative in providing services that truly meet men's needs," she concluded.

Getting them young: promoting men's health in schools and colleges

Simon Forrest, Fellow, University College London

When working with boys and men, health professionals experience problems of access, observed Mr Forrest. "You have information for men, but you can't reach them".

In general, UK data about young men's sexual behaviour is patchy – indeed, until 1997 hardly anyone had asked a population-sample of young British people under 16 years if they had had sex. Consequently, information is derived from aggregated data from national, retrospective surveys (Table). "Based on the figures, sex seems pretty good for most young men. Professionals worry about young men's failure to use barrier contraceptives – and it is certainly an issue – but men seem to realise that there is the need".

Young men say that they learn about sex primarily from their mothers, their school and each other. In fact, there is an 'endemic use' of pornography among young men and this is a primary source of information about sex. The reality is that most young men feel poorly informed about 'having sex' and say that they feel excluded from school-based sex and relationship education (SRE) and sexual health services. "Young men say it's all too little, all too late, all too biological," he said.

Current SRE promotes the primary message that young men should not have sex, preferably not outside marriage, but as a second best not outside a loving relationship. Young men should also always use contraception and should be motivated primarily by concerns about love. Mr Forrest felt that such messages are unhelpful because they are unrealistic. "They do not reflect a lot of adult behaviour, let alone that of young people," he observed.

There are a number of issues that are of great concern to young men, yet these are not addressed by current SRE. Young men worry, for example:

- How big should my penis be? ('it depends' is not a satisfactory answer)
- How much should I ejaculate and how far?
- How long should sex last?
- How often should I do it?
- How noisy should sex be?
- How can I give a woman an orgasm?

Mr Forest reported that young men do not want to know very much about fertilisation or contraception. "We insist on talking to them about the Pill, when their primary concern might be losing an erection".

Professionals should be explicit when discussing sex, especially about sex and pleasure: "We cannot seem to talk about sex as fun, when this is most people's primary motivation." Professionals should also be realistic and honest about the risk of pregnancy. Nine per 1000 pregnancies are in women aged under 16. This is high compared to other European countries, but it is still small.

Table: Young men aged 16-19 and sex (aggregated data)[1,2]

About 30% had sex for the first time when they were aged under 16
Most started foreplay about three years before first intercourse (approximately age 12-13)
70% of all sex takes place within the context of a relationship, either long-standing or close
80% said their first sexual relationship occurred at about the right time
About 7% have been attracted to another man, and about 3% have had some physical sexual contact with another man
25-40% used a condom at first intercourse
A man's experience of sex is influenced by his class and ethnicity

It was equally important not to stereotype young men. They are not necessarily heterosexual; they do not always want to have sex immediately and with anybody; not all are macho and sexist. Many young men are anxious about their performance and masculinity. Professionals would gain more information by asking realistic questions, such as "How's your sex life?". It was essential to have a positive view of masculinity and to abandon monolithic preconceptions. "Traditional masculine qualities of independence, strength, action when necessary, and purpose, are good for young men and should not be discarded along with negative aspects of masculinity," said Mr Forrest.

Current SRE is inadequate, and is certainly failing to meet young men's needs, concluded Mr Forrest. He recommended that more men should be involved in SRE, more fathers should talk to their sons and there should be less moralistic and pathological approaches and more respect given to young men. Finally, Mr Forrest advised professionals to seek opportunities to take SRE to settings beyond secondary education, for example to further and higher education, or the armed forces.

References

1. Wight D, Henderson M, Raab G, et al. Extent of regretted sexual intercouse among young teenagers in Scotland: a cross sectional survey. *BMJ* 2000; 320: 1243–44.
2. Wellings K, Nanchahal K, Macdowall W, et al. Sexual behaviour in Britain: early heterosexual experience. *Lancet* 2001; 358: 1843.