

Private Parts, Public Policy

Improving Men's Sexual Health

A report by the Men's Health Forum

Men's sexual health is poor, and in many ways getting poorer. Prostate disease – both benign and malignant – is becoming more common, the incidence of testicular cancer continues to rise, sexually transmitted infection rates are up, sexual dysfunctions (such as erectile problems and premature ejaculation) continue to affect large numbers of men. Even male fertility is widely believed to be in decline.

Despite greatly increased levels of public frankness about sex in recent decades, men are often unable to obtain the information they require in order to improve their sexual health. Risk-taking behaviour – for example, failing to practise safer sex or to use contraception – remains common. Men frequently delay seeking help when symptoms appear. Many men struggle to achieve sexual fulfilment and the sense of well-being that can derive from rewarding sexual relationships.

Sexual health policies and services have largely failed to take men's specific experiences and needs into account. There is still too little understanding of the impact of gender on men and their sexuality and of the implications this has for tackling men's health problems. The Department of Health's *National strategy for sexual health and HIV* pays limited attention to men, effective sex education for boys remains sparse and there are few sexual health promotion campaigns aimed at men. Moreover, GUM (genito-urinary medicine) clinics are currently struggling to cope with demand. Many men are denied NHS treatments for erectile dysfunction because of prescribing restrictions imposed on GPs by the Department of Health.

It is for all these reasons that the Men's Health Forum (MHF) has made sexual health the focus of National Men's Health Week 2003. The MHF's aim is to increase men's awareness and knowledge of sexual health and to encourage them to seek advice or treatment when appropriate. The Week will also promote the development of more effective and 'male-friendly' sexual health policies and services.

Men's Sexual Health

The MHF believes sexual health is about much more than sexually transmitted infections and erectile dysfunction – important though these issues are. Sexual health encompasses a wide range of other health concerns related to the male sexual and reproductive system, including prostate disease, infertility and testicular cancer. Crucially, it is also about sexual fulfilment, enjoyment and well-being.

A definition of sexual health encapsulating this vision is that used in the *National strategy for sexual health and HIV* published by the Department of Health in June 2002:

Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and

living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.¹

Some important sexual health issues affecting men are:

Sexually Transmitted Infections (STIs)

The number of men with STIs is increasing dramatically. There was an 84 per cent increase in gonorrhoea cases in England between 1997 and 2001² and an increase of over 600 per cent in the incidence of syphilis (although this remains a rare condition).³ Over 29,000 males were diagnosed with chlamydia in 2001, making this the commonest curable bacterial STI. By the end of 2002, over 54,000 people in the UK had been diagnosed with HIV, 77 per cent of them male.⁴ The total number of HIV cases is expected to

continue to rise significantly. Changes in sexual behaviour over the past 10 years – including a fall in the age of first intercourse, a rise in the number of sexual partners and a decline in safer sex practises among gay men – underpin the increase in STIs.

Testicular Cancer

The commonest cancer in young men, the incidence of testicular cancer in those aged 20-59 has almost doubled in the past 30 years.⁵ Fortunately, it remains a relatively rare disease (one man in 500 aged 15-50 will develop it) and it has a very high cure-rate. However, men take 14 weeks on average after their symptoms first appear before they seek medical help, suggesting a strong reluctance to make use of health services.

Prostate Cancer

Prostate cancer is now the most commonly diagnosed cancer among UK men. Almost 21,000 new cases were detected in England alone in 1999⁶ and over 8,000 men died from the disease.⁷ Men's awareness of prostate cancer, however, remains low. Experts continue to disagree about the value of screening asymptomatic men and about the best treatments for men with localised cancer (there is even doubt whether any treatment is better than none).

Benign Prostatic Hyperplasia (BPH)

This common but distressing condition affects large numbers of older men, causing problems with urination. Up to 2.5 million men in the UK could be affected by BPH⁸ and its incidence is set to double over the next 20 years.⁹ Many men are unaware of the symptoms (often believing they are the consequence of old age rather than an underlying disease) and as a result suffer unnecessarily by not seeking medical advice. Men's delay in seeking help for BPH could well explain why a significant proportion of associated surgical interventions in the UK are carried out as emergency procedures.¹⁰ There is also evidence of problems concerning the diagnosis of BPH, with cases in men under 65 frequently being diagnosed as a separate prostate condition, prostatitis.¹¹

Erectile Dysfunction

Erectile dysfunction (the partial or complete inability to obtain or maintain an erection sufficient to complete sexual activity) is a very common condition. Over half of men aged 40-70 will experience ED at some time¹² and some 2.3 million men in the UK are believed to be affected.¹³ ED is a distressing condition in its own right – damaging self-esteem, causing anxiety and depression, and affecting relationships.¹⁴ It can also be an indicator of underlying (and often undiagnosed) health problems such as diabetes or heart disease. Men are often very reluctant to seek help and it is estimated that just one man in 10 with ED receives treatment.¹⁵ Of those who do receive treatment, nearly half wait over two years before seeking help.¹⁶

Selected STIs: England, Wales and Northern Ireland ³¹ (total number of diagnoses of males in GUM clinics)			
	1996	2001	Increase
Syphilis	87	613	605%
Gonorrhoea	8088	15903	97%
Chlamydia	14757	30763	108%
First attack herpes simplex	6038	6787	12%
Genital warts	29419	35487	21%
All diagnoses	213183	292060	37%

All sexually transmitted infections are becoming increasingly common in men.

Premature Ejaculation

One man in three suffers from premature ejaculation at some stage in his life¹⁷ which may in turn cause embarrassment, anxiety and relationship difficulties. Although simple self-help techniques can bring about improvements, men remain particularly reluctant to discuss this problem and other worries about sexual performance.

Inadequate Sexual Health Services

Although prompt treatment is considered essential for the effective treatment of STIs, the length of waiting times for GUM clinics increased from five days for males in 2001 to 12 days in 2002.¹⁸ Given that men are already reluctant users of health services, and tend to prefer easy-access provision, this is a serious problem. The present policy of shifting some services to primary care may disadvantage men for the same reasons. Other sexual health services, such as community family planning clinics, are also under-used by men – more than 12 times as many women as men attended in 1999-2000¹⁹ – and little effort is made to attract more male users; indeed, family planning clinics are widely perceived to be a women-only service.

Men treated for ED are unlikely to receive the kind of treatment that complies with best practice (i.e. including the option of partner involvement and counselling).²⁰ There are only about 500 urologists in the UK – in fact, the UK has fewer urologists per 100,000 men aged over 40 than Denmark, Hungary, the Netherlands, Slovenia or Spain²¹ – putting enormous pressures on specialist services for a wide range of sexual health problems. Sex therapy services are also over-stretched and difficult to access in both the statutory and voluntary sectors.

Poor Sex Education

There have undoubtedly been improvements in sex education in recent years as a consequence of the National Healthy Schools Standard and other initiatives. School sex and relationships education (SRE) is still undervalued, however, and in some parts of the country teachers still receive inadequate training or support.²² Although young men have been identified in official policy as needing a new approach, the SRE that is delivered is still generally too biological, biased towards female reproduction and rarely targets young men's needs. It too often fails to provide young men with the information they require or to explore what it means to be a man.²³ There is also insufficient support in schools for adolescent boys struggling to come to terms with a sexual identity other than heterosexuality; the bullying of gay adolescents remains common.

As a consequence, many men grow up without basic knowledge, awareness or skills related to sex and sexual relationships or any acceptance of diversity. Much of the information available to young men is from less than reliable sources, including friends, the media and pornography. Consequently, many still adhere to what could be called 'the traditional male model of sex', believing for example, that 'men should always be ready for it', that sex is about performance rather than fun and pleasure, that contraception is a women's issue and that only straight sex is normal sex.

Proportions of men aged under 30 recognising the names of selected STIs ²	
STI	Percentage who recognise
Gonorrhoea	65%
Chlamydia	57%

Men's basic knowledge relating to sexually transmitted infections is poor.

Current Sexual Health Policy

It is clear that if men's sexual health is to be improved, efficient and reliable services are needed. In 2001, the Government published *The National strategy for sexual health and HIV*, an ambitious statement of intent to 'modernise sexual health and HIV services' and to address '... the rising prevalence of sexually transmitted infections and of HIV.'²⁴

The MHF broadly welcomed the Strategy, in particular its commitment to a recognition that good sexual health is represented by more than simply the treatment and prevention of disease. The 'Aims and Principles' of the Strategy highlight the need to shape services around patients, to reduce health inequalities and to respond to the different needs of different populations. Starting points like these potentially pave the way for advice and treatment services that take structural account of men's (and women's) specific needs. This broad vision also seems, rightly, to encompass the idea that improving sexual health is not the province of healthcare specialists alone but involves other practitioners in a wider, cross-cutting approach.

Unfortunately, these commendable objectives are somewhat lost in the main body of the document, which concentrates largely on service provision in relation to the prevention and treatment of STIs. Although the needs of some particular population groups are addressed directly, the issue of gender-sensitive approaches is not discussed at all, and the specific sexual health needs of men are virtually absent.

There has, furthermore, been some criticism since the publication of the Strategy that, rather than developing the intended structural improvements and enhanced sensitivity, sexual health services are, in fact, struggling to cope at the most basic level. Professor Michael Adler, who was seconded to the Department of Health to take a lead in the development of the National Strategy, has recently reviewed the nation's sexual health over the last 10 years:

*The past decade has seen a continuing and considerable deterioration in the nation's sexual health. All infections have increased alarmingly, teenage pregnancies are yet to decrease, and changes in sexual behaviour regardless of sexual orientation can only continue to drive this situation. It is no exaggeration that we now face a public health crisis in relation to sexual health... Sexual health is not an NHS or political priority. Until it becomes so we will witness further failure upon further failure.*²⁵

Clearly, these shortcomings within sexual health services need to be addressed with urgency. The priority must be greater investment. Professor Adler makes the further point that the

Changes in selected male sexual behaviours associated with increased risk of sexual ill health. Ages 16 – 44.³³

Behaviour	1990	2000
Number of sexual partners in a lifetime	8.6	12.7
Number of new sexual partners in past 5 years	3.0	3.8
Had concurrent sexual relationships in past year	11.4%	14.6%
Inconsistent condom use (where 2 or more partners in past year)	13.6%	15.4%
Paid for sex in past 5 years	2.1%	4.3%
Ever had homosexual partner	3.6%	5.4%

Sexual behaviours that carry a higher risk of infection are on the increase.

Men agreeing with the statement: 'When I change partners I have a test for STIs'. By age.³⁴

16-19	20-24	25-29	30-34
4%	5%	5%	3%

Men are unlikely to consider it necessary to screen themselves for infection.

present allocation of £47.5 million is inadequate to meet some individual objectives of the Strategy, let alone the entire range. In considering the best use of resources it is now time to ensure that healthcare services and broader strategic priorities are developed in a way that takes account of the specific needs of men.

The Government's cross-cutting review on health inequalities recognised that, to be successful, health interventions must be designed for specific target groups and delivered through settings that are accessible and appropriate.²⁶ The Review also observes, quite correctly, that insensitivity to gender differences affects access to health and other public services. Unless men's specific experiences and needs are assessed and addressed, men's sexual health will continue to be unnecessarily poor. This will not only be a problem for men – it is also a matter of great importance to women.

National Men's Health Week 2003

The aim of this year's National Men's Health Week is to achieve improvements in men's sexual health. Throughout England and Wales, many hundreds of local events are being held at which men of all ages are being offered information, given the opportunity to ask questions and, in many cases, having comprehensive health checks. At a national level, the MHF is working with a range of commercial and public sector organisations to improve the health – and especially the sexual health – of 'the man in the street'.

As part of this national initiative, the MHF is advocating ten key policy objectives, which, if implemented, would have the potential to enhance the sexual health and well-being of tens of thousands of men. These objectives build on those contained in the Forum's men's health policy document *Getting It Sorted*, which was published in National Men's Health Week 2002.²⁷ They have been chosen for their straightforwardness, their practicality, their potential to deliver significant health gain and, not least, for their achievability.

Cumulative numbers of males diagnosed with HIV and AIDS in the UK and alive at end of December 2002. By probable means of infection³⁵

Probable means of infection	Number
Sex between men	18936
Sex between man and woman	5766
Intravenous drug use	2086
Mother to baby	372
Blood products/other/undetermined	1640
Total	28688

The numbers diagnosed continue to rise (figures for 2001 are the highest on record). More than half (52%) of new cases diagnosed in 2002 are thought to have resulted from heterosexual sex (of these, over two thirds are associated with exposure to the infection in Africa).

Improving Men's Sexual Health

A 10-Point Plan

Like all other areas of health, men's sexual health is subject to variation by economic status, age, ethnicity, geographical area and so on. All of the recommendations below should be viewed within an overall policy context which gives priority to tackling health inequalities. The MHF also believes they should form part of a much-needed national men's health policy that covers all aspects of male health.

1. More Effective Sex Education in Schools

It is essential to ensure that improvements in sex education in schools are sustained and that the approach is appropriate for boys and young men. The recent report prepared for the Department of Health by Working With Men, *Building Bridges*, highlights how best to engage young men in SRE, for example by exploring the meaning of masculinity to young men, by teachers being positive about young men and by teachers consulting male students about the content of SRE and teaching methods.²⁸ It is also important to recognise that many boys' concerns about sex are to do with everyday practicalities (penis size, ejaculation, performance, masturbation, etc.) and everyday skills (communication with partners, how to use health and other services, etc.). It is important that the approach in schools takes frank account of these factors as a way of engaging with male students. The real and perceived restrictions on teachers discussing homosexuality in schools also need to be tackled and action taken to develop partnerships between schools and providers of sexual health services.

2. Targeted Services for Young Men

This specific population group is highlighted because young men are simultaneously the most sexually active and the least likely to make use of existing services. The Health Development Agency's report *Boys and Young Men's Health: What works?* identified a number of tried and tested approaches within the limited range of existing good practice.²⁹ Though not specifically about sexual health, this evidence challenges service planners to find new ways of working that will reflect the needs and sensibilities of a group universally recognised to be among the hardest to reach. There are exemplars of innovation within the voluntary sector (e.g. CALM helplines in the north west have made great strides in encouraging young men to seek help for depression and anxiety; Brook has pioneered dedicated sexual health services for young people). It is important that the statutory sector both acquires greater skills in working with young men and becomes flexible enough to allow the design and marketing of services that appeal to young men.

3. Improved GUM and other Sexual Health Services

GUM clinics must be made easier to access. Besides ensuring prompt treatment, a speedy service helps minimise onward transmission, reduces complications, and allows quicker tracing and treatment of sexual partners. GUM services must be more effectively and pro-actively marketed to men so that there is wider knowledge of what is available and a dispelling of myths (particularly about some of the STI diagnostic tests). It is also important to recognise that the present problem of over-stretched services is rooted in the shortages of specialist staff, poor resources and lack of investment. These structural problems should be addressed without delay.

The MHF also recommends a change of name: 'Genito-Urinary Medicine' is a medical term not readily understood by many. Indeed, a MHF/Doctor Patient Partnership survey in 2000 found that only half of adult men knew that a GUM clinic provides sexual health advice and treatment. Other sexual health services, such as family planning clinics, should be made more male-friendly and new ways of delivering information to men should be investigated – particularly utilising media that men are more likely to use, such as telephone services and websites. There is also a role for outreach services to places where men often feel more comfortable, such as workplaces, pubs, barbers' shops and working men's clubs.

4. Chlamydia Screening for Men

The emphasis of the pilot chlamydia screening programmes in Portsmouth and the Wirral in 2001 was specifically on increasing the opportunistic screening of young women and this approach continues to inform the national roll-out of services. By and large, chlamydia is more serious for women than men but it will be more difficult to improve the health of women unless men are also informed about chlamydia and encouraged to seek screening if they think they are at risk. It is important to understand men's attitudes to chlamydia (and STIs in general) in order to create effective means of engaging them in screening programmes. One positive development is that the Department of Health is funding a MHF-led research project on men and chlamydia; if the findings demonstrate the potential for involving men in screening, it is hoped the Department will extend the national programme accordingly.

5. Action on Prostate Cancer

Signed by 17 charities and professional associations (including the the MHF), the Prostate Cancer Charter for Action was launched earlier this year and calls for government action on Transparency, Public Awareness, Patient Care, Resources and Partnership. The specific recommendations include the establishment of a national database on all aspects of incidence, treatment and outcomes; an audited programme of education on prostate cancer for primary care providers; investment in trained prostate pathologists, specialist prostate cancer nurses and research into diagnosis and treatment; and better partnership between the voluntary sector and the government. The MHF welcomes the Department of Health's decision to establish a Prostate Cancer Advisory Group as an important first step towards achieving all the above objectives.

6. Action on Benign Prostate Disease

There is a need for a high-profile, national, publicly-funded health promotion campaign on benign prostate disease to increase men's awareness and to encourage men with symptoms to seek help. The MHF's recent initiative with postal workers shows the potential of relatively cheap and simple methods of awareness-raising.³⁰ The healthcare infrastructure must also be improved to meet both current and future demand from men with benign prostate disease. This should include the improved education of GPs in diagnosis, treatment and appropriate referral of patients to secondary care; an expansion in urology services in secondary care to reduce waiting times and to cope with the near-inevitable steady increase in workload linked to an ageing male population; and more research into the causes of benign prostate disease and how best to treat it.

7. Improved Treatment of Sexual Dysfunctions

The Department of Health's 'Schedule 11' restrictions on GPs' ability to prescribe ED treatments on the NHS are arbitrary, illogical and unfair; not least because they discriminate particularly against low-income men whose ED is caused by cardiovascular disease. It makes no sense to deny treatment to men if their ED is caused by cardiovascular disease while those whose ED is caused by diabetes are entitled to treatment. The MHF believes that GPs, in consultation with their patients, should be free to decide on the best form of treatment. Improving access to ED treatments is also an important public health issue since it could increase the early detection of serious underlying conditions. The current anomalies should be reviewed urgently and a more equitable system introduced. There is also a need to expand the services available for the treatment of other sexual dysfunctions, such as premature ejaculation.

8. New Training for Healthcare Professionals

Mounting evidence suggests that many men are discouraged from making best use of health services by a generalised feeling that their needs are not understood. This difficulty may be especially marked in the area of sexual health where the subject is a sensitive one which touches at the very heart of many men's sense of their masculine identity. It is therefore essential that training programmes for doctors, nurses and other health professionals include components which encourage the development of skills specific to working with men and encompass the respectful treatment of all sexual orientations and cultural values.

9. More Research into Sexual Health Promotion

Research continues to suggest that men's knowledge of sexual health is poor. At the same time, it is widely understood that simply imparting knowledge does not, of itself, bring about changes in behaviour and attitude. There is an urgent need to improve understanding of those factors associated with the motivation of men to enable the development of approaches to health promotion that are in tune with men's sensibilities and that consequently have the maximum likelihood of success. The recent initiative of the Health Development Agency to improve the evidence base for health improvement work with men could provide a starting point for this.

10. Encouraging Openness

It remains difficult to have a serious discussion about men's sexual health, whether at a simple personal level between male friends or at the level of public debate. Media coverage tends either to concentrate on male 'incompetence' (e.g. not visiting the doctor) or to perpetuate traditional stereotypes (e.g. that a 'real man' has lots of sex with lots of women). In sexual health, greater self-awareness, an acceptance of vulnerability and a willingness to seek early treatment are the keys to an increased likelihood of the best outcome. A key objective – perhaps the most important objective – must be to create a climate in which men's sexual health can be discussed openly and without embarrassment, shame or judgement.

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About the Men's Health Forum

The Men's Health Forum aims to provide an independent and authoritative voice for male health and to tackle the issues affecting the health and well-being of boys and men in England and Wales.

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