

The Men and Chlamydia Project 2002 - 2004

Final Report

Acknowledgements

The Men's Health Forum acknowledges with gratitude the support of the three funding partners for the Men and Chlamydia Project:

The Department of Health

Roche Diagnostics

The National Pharmaceutical Association

Phase 2 of the project could not have happened without the enthusiasm and commitment of **Telford & Wrekin Primary Care Trust**. We are also extremely grateful to the following workplaces in Telford and Bridgnorth who were public-spirited and forward-thinking enough to take part:

ABRO Donnington

Alcan Ltd (now Novelis UK Ltd)

CeDo Ltd

DENSO Manufacturing UK Ltd

GKN Alvis

Lyreco

Finally, a project of this kind could not happen without the support of others. The following people have been especially generous with their time and their good advice. I extend my personal thanks to them.

Katie Carrick-Anderson at the Healthy Respect Project in Lothian

Caroline Davey at fpa

Dr Sarah Feather, Dr Sue Robin, Dr Sue Skidmore, Moira Kaye, Lesley Talbot, Marie Barber and Mark Crisp in Telford

John Fieldhouse at John Fieldhouse Design & Print

Prof. Kate Galvin at Bournemouth University

Colette McCreedy at the National Pharmaceutical Association

Pat Mahoney, Wendy Bowes and Martin Brown at British Forces Germany

Michelle Toal, Jon Walton and Stjohn Rowlands at Bellman

.... and my colleagues at the MHF; Peter Baker, Ian Banks and Robbie Porter

David Wilkins







The Men and Chlamydia Project

Final Report

Contents

Exe	cutive Summary	page	7
1.	Introduction	page	9
2.	The Development of the Men and Chlamydia Project	.page	11
З.	Phase 1: Qualitative Research	.page	12
4.	Phase 2: Pilot Project • Organisation and Administration	.page	20
5.	Phase 2: Pilot Project • Statistical Information	.page	23
6.	Conclusions and Recommendations	.page	27
7.	Collected Recommendations	.page	30
Арр	endices	page	31
Refe	erences	page	43

Introduction

The idea of the Men and Chlamydia Project was first proposed by the Men's Health Forum (MHF) in 2001. The MHF was concerned that national policy on treatment and prevention of chlamydia was almost entirely directed at women. This seemed short-sighted – by failing to address infection in men, it increased the likelihood of easy reinfection for women. It ignored the (albeit small) long-term health risks to men and, by placing the focus on women, seemed unfairly to place the entire responsibility on women too.

A funding partnership was established in which "Section 64" monies from the Department of Health were married to additional funding from the National Pharmaceutical Association and Roche Diagnostics. By the autumn of 2002 a firm plan was in place for a project that had three primary objectives – that it would:

- Increase men's awareness of chlamydia
- Promote the adoption of safer sexual practices
- Encourage men to seek screening and treatment where appropriate

The structure of the project involved two distinct phases - a research phase (Phase 1) and an implementation phase (Phase 2).

Phase 1

Conducted between June 2003 and January 2004, the first phase of the project involved a series of group discussions with young men aged between 18 and 25. The intention of the discussion groups was to develop a greater understanding of young men's attitudes to sex and sexual health in general, and chlamydia in particular. The knowledge gained was to be used to develop accurately targeted health promotion materials for use in the second phase of the project. The discussions were held with young British soldiers based in Germany and university students in the UK. As it happens, the findings from this phase were extremely interesting in their own right, although they did present a series of attitudinal obstacles to be overcome rather than a "magic key" to the engagement of young men.

Phase 2

Phase 2 took place between June and October 2004 in Telford in Shropshire. This phase was a partnership between the MHF and Telford & Wrekin Primary Care Trust (T&WPCT). Six local industrial workplaces, employing, between them, over 4,000 men, agreed to endorse and circulate the health promotion materials (posters and leaflets). These workplaces also agreed to make available for a three month period, specially designed, free kits which allowed young men to "self-test" for chlamydia infection. The kits comprised an instruction leaflet, a personal information form, a 20ml urine specimen tube, and special packaging to enable a urine specimen to be safely posted to the local microbiology laboratory. A FreePost envelope was provided for this purpose.

There was substantial local interest in the project in Telford – so much so that it was agreed to extend the project for a further month to

enable two other local workplaces and three educational establishments the opportunity also to participate.

Negative test results were notified directly to the individual by post. Those who tested positive were contacted by telephone by a Sexual Health Adviser who outlined the treatment options. Previous research had indicated that the more "streamlined" a healthcare process, the more likely men are to use it. As part of the project therefore, T&WPCT had agreed to institute a Patient Group Direction (PGD) to enable a named group of local pharmacists to issue the one-off antibiotic treatment for chlamydia "over the counter" i.e. without the young man having had to see his GP or visit a GUM clinic first, as would normally have been the case.

Outcomes

Every man (all ages) in all the factories received health promotion material specially written for a male audience. Almost 3,000 urinetesting kits were taken from the display boxes placed in the workplaces. 401 urine specimens were submitted to the lab — representing 14% of those that were taken. The great majority (77%) of the urine specimens submitted were submitted by men (it was always anticipated that some of the kits would be used by women) and almost 10% of men aged under 30 in the six workplaces chose to submit a specimen. In all, ten people tested positive for chlamydia. A minimum of five sexual contacts (exact figures are not known) of those ten people were also tested and treated.

Recommendations

A series of conclusions has been drawn from the findings of this project and nine attendant recommendations have been made. These recommendations can be found in full at the end of the project report. In general terms, they are that a number of the component parts of the present project worked well and should be used more widely; that the ability to understand and work with young men on the issue of sexual health is currently under-developed; and that some particular aspects of sexual health promotion could and should be addressed more honestly and effectively.

Further work

It was not within the remit of this project to evaluate the impact of the health promotion materials beyond a relatively simple analysis of the numbers of kits taken and used. A separate, independent, evaluation is underway which will involve questionnaires and interviews with workers at the participating factories, as well as questionnaires and interviews with local PCT and occupational health staff involved in the implementation phase. This evaluation is being conducted by the Institute of Health and Community Studies at Bournemouth University and will report in the late summer of 2005. Ultimately, that evaluation report should be read in conjunction with the present report. It will add to the learning about how to deliver chlamydia screening and treatment programmes as inclusively as possible, and how to engage more effectively with young men on the subject of their sexual health.

What is chlamydia?

Genital chlamydial infection is a sexually transmitted infection (STI) caused by the bacterium, Chlamydia trachomatis. The infection is generally referred to using the simplified form "chlamydia". Chlamydia is transmitted from the infected partner to the uninfected partner during unprotected sex (genital, anal or oral sex without a condom). In at least 50% of cases in men and 70% of cases in women, chlamydia has no symptoms. Where symptoms do occur, they are similar in both sexes and include discharge from the penis or vagina, and dysuria (pain on passing urine). Women may also experience abdominal pain. Symptoms are often transient, lasting only a few days, and may be so minor that the sufferer feels it unnecessary to investigate the cause or seek treatment. The infection itself lasts very much longer and may be present (and the sufferer remain infectious) for some years. Chlamydia is easily and effectively treated by antibiotics.

Why is chlamydia important?

Although the initial symptoms may be minor and self-limiting, untreated chlamydial infection can have significant and longlasting effects for both sexes. In men such complications are rare but include the possibility that chlamydia may lead to epididymoorchitis (infection of the male reproductive tubes and testes), which can cause painful swelling of the testicles. An episode of epididymo-orchitis may occasionally cause infertility. Additionally, recent research in Sweden has suggested that chlamydia may cause infertility in some men more directly, although the precise mechanism is unclear¹. Chlamydia is also believed by some experts to be implicated in the development of prostatitis, a chronic condition causing pain and discomfort associated with urination and ejaculation. There has even been speculation about a possible link with increased risk of prostate cancer several decades later².

It is in women however, that the more common and damaging long-term effects of chlamydia are seen. Untreated infection is a well-established cause of endometritis, cervicitis and – most frequently - pelvic inflammatory disease (PID). PID is a painful and hard to treat condition which occurs when the chlamydial infection damages the reproductive tubes. PID has other causes but it is thought that around 40% of cases are caused by chlamydial infection and that around a third of women whose chlamydia is not treated will go on to develop PID³.

PID is not only thoroughly unpleasant in itself, it is also the most common infectious cause of infertility and ectopic pregnancy. One woman in five who has experienced an episode of PID will become infertile. Ectopic pregnancy occurs in 1% of conceptions and can be extremely dangerous – it always results in the loss of the pregnancy and causes 21% of those deaths of the mother occurring as a complication of pregnancy or childbirth³. Ectopic pregnancy may itself cause subsequent infertility.

Both men and women can also, in rare cases, develop Reiter's Syndrome (also known as reactive arthritis), a painful and long-lasting condition causing inflammation of the joints.

The scale of the problem

Genital chlamydia infection is currently the most common sexually transmitted infection diagnosed at genito-urinary medicine (GUM) clinics in the UK. Diagnoses have been rising steadily since the 1990s, and between 2002 and 2003 rose by 9%. In 2003, approximately 40,000 cases were diagnosed in men and approximately 50,000 cases in women. The infection peaks between ages 16 and 19 in women and ages 20 and 24 in men³.

The figures for diagnoses in GUM clinics suggest an incidence rate of very roughly 1%. More concentrated studies of smaller populations however suggest that the real prevalence rate - particularly among young people - may be a great deal higher. In 1999, during the Department of Health's two trial screening programmes in Portsmouth and Wirral, the prevalence rate amongst those tested opportunistically (women aged between 16 and 24) was around 10%⁴. In a small study at Glencorse Military Barracks in Scotland in 2001, 798 new male recruits from around the UK were tested for chlamydia as part of their routine medical examination. The great majority of those tested were aged under 25. 9.8% tested positive for chlamydia⁵. The most recent data from the National Screening Programme found a rate of 13.3% in men aged 16 - 24 who were attending healthcare settings and who agreed to be tested opportunistically. The rate among those at the upper end of that age group (men aged 20 - 24) was 19.8%. 60% of these men reported two or more sexual partners within the preceding twelve months⁶.

Chlamydia and men

There is an obvious temptation to concentrate preventive initiatives on women, and the great majority of planning and provision so far has tended to do just that. The arguments for this approach are convincing; women — on the face of it at least - have the most to lose as a result of contracting chlamydia, they are also more commonly in contact with health services, easier to reach through messages in the media, and more likely to be cost-effectively receptive. Men on the other hand - especially young men - are widely believed to be an intractably difficult group to reach and engage.

For those committed to the improvement of men's health then, chlamydia presents an especially interesting challenge. It is an issue not without concern for men but is of much more pressing importance for women. Almost all cases of chlamydia in women are caused by sexual contact with an infected man (likewise, of course, most cases of chlamydia in men are caused by sexual contact with an infected woman). Chlamydia is therefore, uniquely, at the interface between men's and women's health. In order effectively to improve the health of all — but of women most particularly - we must find ways of encouraging men to take their sexual health more seriously and to change their behaviour.

That said, of course, we should not forget that one of the most serious potential long term consequences of chlamydia for individual women - infertility — is one that will ultimately, in all probability, affect a *relationship*. Viewed from this perspective, the issue is one of direct relevance to men, albeit one that the group most affected (young men) may find it hard to conceptualise in the short term. It is also worth noting that a concentration on interventions aimed largely at women not only runs the risk of putting all the responsibility (and hence the

"blame") on women but contributes to the perception that mainstream health services attach less value to the health of men than to the health of women. This latter point is of particular importance in the bigger picture where there is a widelyacknowledged need to find ways of encouraging and enabling men to take their health more seriously.

The National Policy Context

The Chief Medical Officer's (CMO) Expert Advisory Group on Chlamydia was established in 1996 to advise on "issues associated with screening programmes for chlamydia for different population groups (both male and female) and in different settings". The first report of the Advisory Group was published in 1998. In addition to the existing good practice of screening all male and female patients presenting with the symptoms of chlamydial infection, it recommended the implementation of a national screening programme with the following components:-

- Screening of both male and female attenders at GUM clinics
- Screening of women seeking termination of pregnancy
- Opportunistic screening of sexually active women aged under 25 and women aged over 25 with a new sexual partner or who had had two or more partners in the preceding 12 months.

The report gave three reasons for concentrating on the opportunistic screening of women:-

- The consequences of infection are more serious for women and complications can only be reduced if asymptomatic women are detected
- Women are "more likely than men to attend a health care setting where screening is feasible"
- · Computer modelling had shown this approach to be cost effective

In 1999 the two pilot programmes mentioned in the preceding section were initiated (in Portsmouth and Wirral) to test out the practicality and effectiveness of the CMO's recommendations. Opportunistic screening was offered to women meeting the stated criteria who attended GP practices and community clinics for any reason. In total 20,000 people were tested during the one year pilot, of whom around 1,400 were men. As already stated, the incidence of infection across the sample group as a whole (men and women) was found to be around 10%. Around 95% of those who tested positive accepted antibiotic treatment (although around 4,000 people declined the offer of screening in the first place). In total, 66% of the eligible female population was tested in Portsmouth and 39% in the Wirral. One of the factors which contributed greatly to the practicality and acceptability of the pilot programmes was the use of the relatively new procedure of urine testing (instead of the previously used endocervical or urethral swabs).

In July 2001, the National Strategy for Sexual Health and HIV⁸ was published, followed in June 2002 by its associated Implementation Action Plan⁹. On chlamydia, the Strategy drew attention to the developments arising from the CMO's Report and announced a plan to

institute a national chlamydia screening programme by 2008. It also stressed the "importance of giving women good information and dealing promptly with positive cases". It made no reference to chlamydia and men. The first ten opportunistic screening programmes came on-stream during 2002 and a further 16 programmes were announced in December 2004. The screening programme now includes over 25% of PCTs in England, covering 30% of the eligible population¹⁰. The "Choosing Health" White Paper published in December 2005 announced that the full implementation of the National Screening Programme would be brought forward by one year to March 2007.

The need to improve chlamydia screening services by delivering them more flexibly, and the need to involve men in the drive to reduce incidence levels has been acknowledged by the two most important independent bodies concerned with scrutinising policy. In its *Annual Report 2003/04*, the Independent Advisory Group for Sexual Health and HIV noted that:

Chlamydia screening needs an innovative approach and must be locally driven — linked to local chlamydia prevention and control efforts — and evaluated. Models of good practice and innovation should be disseminated widely. PCTs do not need to wait for the roll-out of the national programme and should be encouraged to commence screening as soon as possible.

In its report on Sexual Health published in 2003 (*Third Report of the Session 2002-03*), the Health Select Committee, having heard evidence about the difficulties of delivering screening services to men, said:

We recommend that the Department explores the possibility of offering screening and advice on STIs, including chlamydia, to men outside traditional health service settings. Imaginative solutions will be needed if the male population is to be engaged.

Early history

The Men's Health Forum (MHF) became interested in the issue of chlamydia in 2001 amid concern within the organisation and among the wider sexual health community that the focus of almost all national planning and investment was on advising, educating and screening women. That approach seemed both inequitable and short-sighted; even if it made sense for the primary target solely to be reduced incidence in women, how could that be achieved unless there was a concerted effort to reduce infection levels in men too?

In the middle of that year, the MHF organised a meeting of interested parties to look at the possibility of developing a pilot project aimed at delivering a chlamydia screening programme targeted at men. Although there was some interest in this idea, the consensus was that the proposal was too ambitious and the project was put on hold until February of 2002 when a second meeting was called. This time debate centred around the idea of a project whose main objective would be to discover the most effective means of communicating with men about this issue (rather than a project to deliver screening). Such an approach would, of course, still allow the inclusion of a screening element within the project – although the provision of a screening service would not be its central objective.

In the Autumn of 2002, a Steering Group for the Men and Chlamydia Project (as it was now named) was established and an initial funding package was put together. Membership of the Steering Group is given at Appendix 1. Aims and objectives for the Project were agreed in principle by the Steering Group at that stage, and a final working Project Plan was approved by the Steering Group in December 2002. It was decided at this stage to delegate all on-going responsibility for the implementation and day-to-day management of the Project to the MHF with David Wilkins, the MHF's Policy Officer acting as Project Leader and Robbie Porter, the MHF's Training and Information Services Officer, also working on the Phase 1 research. The Steering Group was to be kept informed of progress by regular e-mail updates and would continue to meet on an "as and when necessary" basis to offer advice and guidance. Individual members of the Steering Group would also be available to offer expertise in their particular fields where that would be helpful.

The Project Plan

The Project Plan was approved by the Steering Group in December 2002. Copies of the plan are available on request from the MHF. In practice, the original plan was adapted over time in response to the developments and changing circumstances that are described in this report - but the essential components identified at the outset remained in place throughout the duration of the project.

The project had three primary objectives - that it would:

- Increase men's awareness of chlamydia
- Promote the adoption of safer sexual practices
- Encourage men to seek screening and treatment where appropriate

The structure of the project involved two distinct phases – a research phase (Phase 1) and an implementation phase (Phase 2). Detailed descriptions of these two phases follow in the next two sections but in short, the methodology of the two phases was as follows:-

Phase 1 (Research)

The Steering Group understood from the outset that the obstacles to encouraging young men to take the issue of chlamydia seriously were formidable; after all, if chlamydia has only minor symptoms and only has serious long term risks for women, why should a young man engaging in casual sexual relationships care about it at all? It was decided that the Men and Chlamydia Project should concentrate initially on learning about young men's attitudes to sex, sexual relationships and sexual health. The knowledge gained in this process would be used to ensure that the implementation phase was as accurately targeted as possible within the framework of current knowledge.

Phase 2 (Implementation)

The idea of Phase 2 was to use materials developed from the knowledge gained in Phase 1 to encourage young men to volunteer for chlamydia testing, as well as to deliver more general information about sexual health. The chlamydia testing itself and the treatment options for those men testing positive were to be made as "streamlined" as possible within the limits of current technologies and procedures. In particular, it was decided that Phase 2 would take place in a large industrial workplace. The MHF had achieved some notable success with previous workplace based initiatives and is committed to the principle of taking health improvement programmes to places where men "already are" as a means of making services more accessible to men.

It had been intended from the outset to offer chlamydia testing within the implementation phase of the project and it had been made easier to do so by developments in the preceding few years. Of particular importance had been the development of nucleic acid amplification technology (NAAT). NAAT requires only a specimen of urine in order for a laboratory test for chlamydia to be performed. Because the urine does not need to be immediately refrigerated, there was now the option of the man submitting his specimen to the laboratory by post. The "Healthy Respect" Project in Lothian had successfully demonstrated over the 12 months or so prior to the inception of the Men and Chlamydia Project, that young people (though predominantly young women) would respond to a "postal testing" programme. It was decided to replicate the Lothian approach of making available free of charge, chlamydia testing kits containing information about chlamydia, a small specimen bottle and a FreePost envelope to send a urine sample to the local microbiology laboratory.

In addition, the Steering Group decided also to test out the option of offering treatment under a "Patient Group Direction" (PGD) to those testing positive. PGDs were introduced in 2000 and allow Primary Care Trusts to empower named groups of health professionals (e.g. community nurses, pharmacists) to issue specified medications to particular groups of patients. In the case of the Men and Chlamydia Project, the idea was to allow young men who tested positive to pick up the single dose antibiotic, azithromycin, "over the counter" at a limited number of community pharmacies local to the workplace where the screening programme was being offered.

The advantage of this integrated approach for a young man, is that it maximises convenience and privacy, and allows the participant to go through the whole process without ever having to make an appointment, queue for an examination – or indeed have any contact at all with a medical professional unless he chooses to do so.

Introduction

The primary purpose of the qualitative research phase was to inform the development and content of Phase 2, the implementation phase. In particular, it was the objective of Phase 1 to gain an understanding of young men's attitudes to sex, sexual relationships and sexual health. It was recognised from the outset that both time and financial constraints meant that we needed to have realistic aspirations about what could be achieved. It was decided to accept an existing, longstanding offer from the Health Promotion Service of British Forces Germany (BFG) to arrange access to young soldiers to talk about these issues. On the broad assumption that soldiers might represent the views of men from lower socio-economic groups, it was decided to approach a university to organise the opportunity of talking to students, who might (equally broadly) be seen to represent the views of young men from better-off backgrounds. After a false start with one university, which unfortunately lost us a great deal of time, we were eventually able to organise access to students at an English university by the good offices of the local Students Union.

We recognise of course, that the generalisations that underpin the choice of soldiers and students are by no means perfect but we were driven at the time by pragmatic considerations. Both these groups were, for obvious reasons, very easy to approach and offered settings (barracks and campus) in which it was extremely straightforward to bring groups of young men together to talk. A detailed account of the research follows below. There is no doubt that a wide and representative range of very valuable information was obtained but there remains a pressing need for a larger and more structured examination of the sexual attitudes and behaviour of young men. Such a piece of work would be of enormous value to the construction of effective sexual health promotion programmes in the future (see Recommendation 1 at end).

Process and Methodology

It was decided to undertake structured group discussions with the soldiers and students following a broad "focus group" model. A series of five key "subject areas" was developed, each of which had a number of subsidiary, related issues which the group facilitator was to aim to cover if possible. Full details of the structure of the discussion groups are contained in a grid in the document, "Guidelines for Discussion Group Facilitators", at Appendix 2. The five key subject areas were as follows:-

- Attitudes to sex
- Attitudes to sexual health
- Attitudes towards sexual partner
- Chlamydia
- Attitudes to advice and testing

Four discussion groups were held with soldiers and four with students. The discussion groups with soldiers took place on two separate dates in June 2003 at two garrisons in northern Germany. Two of the groups were led by David Wilkins and two by Robbie Porter.

In all cases, a local member of staff from the BFG Health Promotion Service was present to help with the practicalities. All participants were volunteers. The smallest group size was four and the largest nine; in total twenty one soldiers took part in the discussions. The soldiers came from several different units. All were aged under 25, with the exception of one participant who was aged 32 (we had requested that all participants should be aged under 25 but there was a misunderstanding in this one case).

The discussion groups with students were held over two consecutive days in January 2004 in the Union Building at the university concerned. All the participants were volunteers and had been recruited via advertisements in the students union newsletter and on noticeboards on union premises. The smallest group was eight and the largest eleven; in total thirty nine students took part in the discussions. All participants were paid £10.00 for taking part. All groups were attended by both facilitators (David Wilkins and Robbie Porter) with two being led by each, while the other functioned as helper. All participants were aged under 25 and a small number (around four or five in total) were international students.

Exactly the same process was followed in all eight discussion groups. Participants were first invited to give their names by way of introduction. Ground rules (about confidentiality, disclosure of personal information etc.) were then established, followed by a very brief outline of the Men and Chlamydia Project and an explanation of the specific purpose of the discussion groups. Participants were asked at this stage whether they had heard of chlamydia, but no further information about chlamydia was given. As an "icebreaker", they were then asked to take part in a short, light-hearted quiz about well known men who had been publicly associated with sexual health in some way, either negatively or positively. The facilitator then led the discussion through each of the key subject areas in turn, allowing full exploration of each, whilst gently guiding the participants to consider as many of the subsidiary issues as possible. The facilitator intervened specifically to redirect the discussion only when the group strayed unconstructively from the point. Attempts were made to encourage all group members to participate, without unduly embarrassing those who clearly preferred to say less.

When the discussion reached the fourth of the key subject areas, that of chlamydia itself, the facilitator gave an outline of the symptoms, incidence and health risks of chlamydia, stressing particularly the potential consequences for women. This was specifically to challenge the participants to think about their own behaviour and attitudes in relation to the long term implications for women and to enable the discussion to take place in that context. Each discussion group lasted somewhere between an hour and two hours. At the end, assurances of confidentiality were re-iterated and participants were thanked for their involvement.

All eight discussion groups were audio-taped. Technical difficulties meant that there were inaudible sections in the recordings of two of the soldier groups but otherwise, the quality of the sound on the tapes was mostly very good and it was possible to make full transcripts of the great majority of the discussions that had taken place. These transcripts were analysed by the two facilitators over two lengthy meetings and shared with Professor Kate Galvin, academic advisor to Phase 1 of the Project. At the end of this process we felt confident to draw conclusions that would be helpful in planning the second phase of the project.

The Experience of the Discussion Groups

Soldiers

The groups of soldiers were the more challenging from the facilitators' point of view. All the discussions began with some wariness on the part of the participants; in all cases, the soldiers seemed to anticipate that they were about to be lectured to in some way about their own sexual health. Not all the participants seemed to be "volunteers" in the usual sense, so there was also some initial resentment to be overcome in some cases. Even once the purpose of the groups had been established, there was still a feeling that some participants were - at least initially - reluctant to say "too much". This reluctance, combined perhaps, with an unfamiliarity with expressing opinions in group settings, meant that the facilitator had to work hard at times to create a constructive atmosphere. The discussion groups also happened to take place during the war in Iraq, so some participants who apparently were awaiting deployment, had other, far more pressing, matters on their minds. Despite all of this however, all of the soldier groups had periods when they worked well and a couple were positive throughout, once the misconceptions had been dispelled. As a consequence, there was some extremely frank discussion in all the groups, and opinions were expressed - as might perhaps have been expected - in a lively and colourful way.

Students

The students had much more confidence about participating in group discussions. The process of being asked to think critically was familiar to them (even if the context was unusual) and, as several participants pointed out, it is part of student life to explore these kinds of attitudes openly with friends, often in mixed sex groups. The ability of the participants to speak about sex without any apparent reluctance or embarrassment was indeed, quite striking (although it should be noted that they were, of course, a self-selected group, who had come along knowing the intended topic of discussion). In general terms, the students also had a much greater sense of what was "expected" of them; they understood the research process and tried hard to be helpful by sticking to the point, taking the matter seriously and thinking reflectively about the matters that were put before them. There were, from time to time, disagreements of principle - for example participants challenging each other about their attitudes to relationships - and when this happened, the facilitators allowed the debate to continue to the extent that it seemed to be contributing to the objectives of the discussion. It was noticeable that at the end of each of the student discussions, some participants stayed behind to say that they had found the discussion groups enjoyable or enlightening. Several wanted to know more about the project or more about the MHF, or to express thoughts that had not come up in the discussion but which they thought might be relevant.

Background to the Analysis of the Discussion Groups

Despite the great difference in character between the discussions with students and the discussions with soldiers and the differences of dayto-day experiences between the two groups, there was a surprisingly high degree of correlation in the attitudes expressed. It should be made extremely clear at this point that in analysing the transcripts of the discussions groups, we were looking particularly for attitudes and beliefs which met *both* of two criteria:-

- Attitudes and beliefs which are widely held by young men in this age group. This emphatically does not mean attitudes and beliefs that are held by <u>all</u> students or <u>all</u> soldiers or <u>all</u> young men; it means attitudes and beliefs that are familiar enough that they are common currency in young men's daily social and sexual experience. These attitudes and beliefs might have been expressed, for example, as belonging to young men of the speaker's acquaintance and not to the speaker himself. They are, in other words cultural norms which are widely understood and which resonate with this social group even though any one individual young man may not share all or indeed, any of them.
- Attitudes and beliefs which present an obstacle to the prevention of chlamydia. It may seem unduly pessimistic to concentrate on negative attitudes that need to be challenged (rather than to select positive attitudes on which to build) but it was apparent from the very beginning of the process of analysis, that the climate was almost overwhelmingly discouraging. Even where young men felt they fully understood the risk of infection, for example, or accepted in principle their responsibility towards their sexual partner, they were still likely to say that in the heat of sexual desire and under the influence of alcohol, their behaviour might easily deviate from their ideal. Similarly, there was a wide consensus that at their age, it was very difficult to take into account the potential long term consequences of their present behaviour.

Because there was such a lot of common ground between the two groups, we have chosen to present the findings as being familiar to the experience of all the young men to whom we spoke. The attitudes and beliefs are therefore – potentially at least – familiar to all young men in the target age group. Where there were significant differences between the soldiers and the students we have highlighted that that is the case (in other words, unless the text specifies the contrary, the analysis should be read as referring broadly equally to both groups).

The themes are ordered in relation to the five key subject areas which formed the basis of the discussion in the groups. For each theme we have also picked out verbatim quotes from the discussions that exemplify the attitude or belief concerned. These quotes have been chosen specifically because we believe their immediacy will help the reader to see the point more clearly. It is very important to note however, that for each of these opinions an opposing view will probably have been advanced at some point in one or other of the discussions. It should therefore be re-emphasised that for the purposes of the Project our task was to capture familiar perceptions and cultural norms that need to be overcome in order to encourage young men to take their sexual health more seriously. These quotes should not, in other words, be taken pejoratively and out of context, to represent the fixed view of all soldiers, all students, or all young men.

Finally, it should be added that the majority of the discussions revolved around the participants' experiences of heterosexual relationships. This was for two reasons. First, the starting point of the Project was of course, to do with the relationship between men's attitudes and beliefs, and women's sexual health. This was made clear at the outset of all the groups - so the discussions began with

an assumption that that was the area of greatest interest. Secondly, the content of the discussion was influenced by the participants. In the case of the soldiers, and despite recent rulings liberalising attitudes to homosexuality in the armed forces, it was perhaps inevitable that all participants should assume that all other participants were heterosexual. A small number of the students identified themselves as gay during the course of the discussion. These students contributed fully to the discussion from their own experience but appeared happy to accept that the primary reason for tackling chlamydia is to protect and improve the health of heterosexual women.

The Discussion Groups

- S =Soldier
- S =Student

1. Attitudes to sex

There was a widely held belief that sexual desire is a powerful natural instinct that can often drive male behaviour and decision-making. The sense was not exactly that it cannot be controlled but certainly that it was powerful enough to overcome finer considerations:

- # Animal urge, isn't it?
- She [regular girlfriend] is back home so you almost feel like you've got a need and you need to fulfil your need.
- # I've got a girlfriend in the UK. I see her once every couple of months when I can away on leave and so there are some nights when you just want to go out and have a few beers and just get a shag. Get it over and done with, have a laugh, have some fun and get out.

This idea was rationalised by one student as follows:

 ... it might be a genetic thing as well – I mean a bloke is designed to go out and have lots of partners and women are meant to settle down with one ...

Achieving a sexual "conquest" was said to be a pleasurable and important experience independent of the sex itself. This was tied up with the "thrill of the chase", the idea of demonstrating manhood, gaining kudos or simply boosting self confidence:

- ~ But to be fair, there is the chase . . .
- # If we were all single here, if us four went out Friday, Saturday and Sunday and didn't pull a bird, Friday, Saturday or Sunday and we did that for three months. We'd all start thinking are we turning ginger ("ginger beer" = queer) or are we gay?
- Also, being a student, you're in this competitive environment where all your friends are like, "I've got this mark" so that also extends to other aspects like, "I've pulled this one" and so, it does give you kind of like a thrill and it means something to you.

 I think that it's everything that surrounds it basically, the excitement when you actually pull a girl . . .

It was even suggested by one soldier that there is more fun to be had in the "chase" or "conquest" element than in the sexual experience that results:

Getting it is more important than having it.

The idea of the pursuit of sex being a central objective of a night out was more common among the soldiers. This may be because their time off is so much more sharply delineated than that of the students, and their opportunities for socialising more limited – or possibly, in the case of these particular soldiers, a consequence of their being stationed abroad. Students tended more to consider sex and relationships within the context of their other priorities. They were also more likely to consider an initial sexual encounter as potentially being the beginning of a longer term relationship:

- # Some nights you go out to get laid some you go out to be with your mates.
- # Any single soldier going home for three weeks on leave, you've got the English bank account not being touched, rolling in cash and if you've got some gorgeous blonde slapper coming on to you, you're going to go for her rather than look at the girl you're going to settle down with in two years time because you're getting your leg over there and then.
- # If it was at home and that you would probably get to know them but out here it's just a case of "oh, let's fuck them and that's that".
- For me, I want to get a good degree that's why I'm here. So like if I was asked to go around like by my girlfriend and stay over and I had a big day ahead so I'd say, I'm going to bed.
- 1. Between the girlfriend and a dissertation, it would be the dissertation.
- 2. I'd like to agree with that but I just don't think that I can. I think that I'm far too weak willed.

Some students highlighted the popular notion that universities and colleges are a hotbed of sexual activity. This influences their own expectations and those of their peer group as well as the view of the general public. It also creates a prevailing atmosphere within some aspects of students' social lives – although the reality may well be different:

- ... there's a big student thing that assuming that you're I remember walking around the sports hall on [Freshers' Day] seeing different clubs and every single thing was like to do with sex. Like it was that side of [name of city] and you know that rock climbing was having a dirty weekend and stuff like that.
- As a student community we are a group of I don't know how many thousand, young men and young women bursting with
- 5 Yeah, get shagged and it gives you that little morale boost

3. Phase 1: Qualitative Research

hormones and lying their arses off about how much sex they're getting and living in very close quarters and drinking lots.

- Very few people actually go out and take people home to sleep with them on a regular basis during the course of something like Freshers which is meant to be, is seen by students as being like a rampant week of almost an orgy and lots of sex and lots and lots of alcohol.
- Hmmm, it's actually different between like talking about sex and actually doing it.

Sex was considered to be central to a "relationship". No-one in any of the groups demurred from the following proposition:

- ~ No, it wouldn't be 'boyfriend and girlfriend' if you didn't have sex.
- With no sexual contact I think that the majority of young people would just walk away from it.

There was some debate among some of the students about what actually constitutes "sex" in the light of the potential risks associated with penetrative sex - but one soldier offered a very succinct response when asked whether he would consider an exclusive emotional relationship with a woman with whom he didn't have sex:

I've already got that with my mum!

2. Attitudes to sexual health

There was widespread acceptance among both groups that using a condom with a new or casual sexual partner is strongly advisable. The students particularly felt that condom use in such circumstances is the routine expectation of both parties. In practice however, there were a number of common circumstances that were likely to undermine these good intentions. The starting point is that condoms are seen to have nothing to commend them in terms of the male sexual experience:

- *#* It's not the same feeling. It's definitely not the same feeling as when you don't wear protection.
- # ... it's horrendous I've had [oral sex] done with one on and you just don't get the same sensation as without ...
- # ... it's like shagging in a bin liner.

The act of putting on a condom was regarded as being a "passion killer":

- 4 It's like putting a commercial break right in the middle of an action sequence isn't it?
- Fumbling around a bit, trying to put a condom on, can kill the mood to the extent that it's not going to happen any more.

For both soldiers and students, the most pressing reason to consider using a condom was to prevent unwanted pregnancy:

- I would say that the main reason for me using protection would be actually getting someone pregnant rather than thinking about STDs.
- # If they've said they are on the pill and you're not going to get them pregnant, then you don't take STDs into account.
- # That's the main issue on a bloke's mind getting pregnant.
- ... you just think about you know you put on a condom so she doesn't get a baby but you wouldn't think about the sexual health.
- *# I'm more worried about the CSA than an STI. They're the letters that matter.*

The only sexual health concern which was seen to present a strong argument for the use of condoms was HIV:

 HIV and AIDS - if you mention that to people they tend to be a bit more shocked about that.

A point made by some of the soldiers was that the association between condoms and STIs was in some ways actually an obstacle the use of a condom directly draws to the attention of the couple that one or other might be infected:

- # if you pull one out, she goes "cheeky" and thinks that you're assuming she's got something wrong with her.
- # It makes you seem not trusting it's a sensitive area.
- # It's not a very good chat line "Have you got an STD?"

Students tended not to share this viewpoint:

- I'd say that the women I've slept with since coming to university have always been well . . . more pro condom that I have.
- I'd've thought that a girl would think better of a bloke for thinking of using a condom than not.

Despite this, there was clear shared ground with the soldiers about the awkwardness of negotiating condom use with a new partner:

- ~ [lt's] a bit tricky.
- It's a right hassle. You're just too lazy it sounds really bad but there you are. It's just an extra thing that can get in the way.
- ... the thing I find is that you don't want to bring it up in case she all of a sudden, you know ... [changes her mind?]

The discussion — if it takes place at all — may not happen until the very last moment:

 I suppose you leave it until you know, you're actually just about to have sex. # If the woman doesn't stop you and say "have you got a rubber" then you're going to go for it, not sounding awful, because then you take it as read that the woman is on the pill.

There was overwhelming agreement across all eight groups that alcohol is the biggest single factor in precipitating risk-taking sexual behaviour (drugs were mentioned only on a couple of occasions). Alcohol increases the likelihood of engaging in casual sex by interfering with rational decision-making and magically making everyone more attractive:

- … at that stage like, your mind becomes simplified and it's just … drugs and booze and any girl that shows an interest … it's as if the hormones are running, you can't control yourself there's that much alcohol in your system whereas like, when you're sober it's completely different.
- # Your "beer goggles" come on and you see this size 88 woman turn to a size 8 all of a sudden . . .
- The more you drink, the more available girls are as you get more drunk.

Alcohol also makes it significantly more likely that a young man will decide to go ahead with penetrative sex without a condom:

- ... if I'm really drunk the thing is that if I was in a position where I could and I didn't have a condom, then I probably would.
- ... if you're drunk and you don't have a condom, then you'll just go, "oh well, never mind" and go [ahead] anyway

Even if a condom is available, alcohol makes it more likely that a young man won't bother to use it:

- ~ When you're drunk, you don't think about it.
- *#* If you're drunk sometimes you don't think about it, do you?

It was neatly acknowledged by one student, that these alcohol-related effects function independently of one's good intentions when sober:

 Yeah, there's always a gap between what you believe and how you actually act and that gap sort of grows as you get drunk

Even where alcohol is not a factor, there's a likelihood for some, in the immediacy of the moment, of deciding not to use a condom.

- # . . . sometimes you realise you've forgotten one and you just think ah well, fuck it – I'll just carry on.
- ~ Yeah. I've had a couple of slips.
- # Sometimes you do, sometimes you don't. Everyone's different. You don't know what you're going to do that night do you – whether you are or you aren't going to bag up (i.e. wear a condom)?

... you could give johnnies out and say "there you go lads" they will still not wear them. They've had a few beers they want to get emotionally involved and that is the best way to - not wear protection.

Soldiers were more likely to perceive risk-taking as normal behaviour (although the actual quote was lost in one of the poorer audio-taped sections, the facilitators recall at least one soldier remarking that there seemed no point in him worrying about sexual health today when he might be shot dead tomorrow):

At the end of the day it's just a risk. That's what a young person's going to do isn't it, take risks?

Finally, some participants also claimed that the cost of condoms was too high:

- # You use them once and bin them and the amount you use them whether it be 15 seconds or two hours, it's a lot of money for that and that's all people look at is that pack of three is going to cost me four quid.
- If you go into the toilet [to get condoms from a vending machine] one shag is a whole pint.

3. Attitudes toward sexual partner

Participants were almost universally of the view that the purpose of wearing a condom was to avoid *catching* an STI - not to prevent transmitting one. In none of the eight groups did any participant reflect on the possibility that they might unknowingly have chlamydia. This was true even among the students, where participants were more likely to say, in principle, that the decision to use a condom was one made out of mutual respect.

- ~ I'd say myself my sexual health
- # You need to protect yourself.
- # You don't know what they've got off other people
- ~ You're not really thinking as much about her.

A few took this even further and made the implication contained in the preceding statements more explicit:

- ~ It's her job to look after herself; you look after yourself.
- # It's not my responsibility is it? It's hers she's the one who's going to be affected.

A complex range of value judgements was associated with attitudes to sexual partners. These value judgements helped decide the level of "risk" and influenced decisions about condom use for self-protection.

[If] it's the first night you've met her and she's willing to sleep with you and she's on the pill, then I would wear a condom because . . . she's obviously done it before # Depends how much they've been around and if they've not bagged up on other blokes.

Casual sexual partners were less deserving of consideration:

- # If you respect her, you will both be considerate and use condoms. If you don't respect her because the chances are you're not going to see her again, that's a different issue.
- # ... if it's a one night stand you couldn't give a toss.

Although there was a recognition by many that it was illogical of them to think it, there was a very common perception that you can "tell by looking" whether a girl is likely to be carrying an STI. Higher "risk" was not only associated with women who looked "slutty" but also – especially by the soldiers - with women who were thought to be less attractive:

- ~ ... eight times out of ten you can tell
- # Yes with certain people aye, aye. If she's that ugly, she'll go with anyone. That's the only way she can get a shag.
- I know you can't tell, but I wouldn't sleep with a girl if I did think she had something to catch.
- # I always think if she's a fat horror you know what I mean I think, "I'm definitely wearing a glove (condom)".
- Like a girl who has small breasts will go out and try and get laid, or a fat girl is easier you'd think, Yeah?
- I think that even when you're drunk, the fact that you've recognised that she's a hussy, that kind of pushes the question of sexual health back up to the top of your brain . . .

The reverse of this of course, is that "nice" girls are less likely to have an STI:

- If you saw a like really young girl, you probably think that she was nice and sweet and you wouldn't have to use a condom much.
- # [a girl | like] she's generally fine you know what I mean she's a good looking girl, she's clean and healthy and fit . . .
- I probably wouldn't but I should [wear a condom] but I think if I thought she was a really nice girl, I probably wouldn't.
- MHF What is it you get back from this girl that tells you whether . . .?
- What course she's on, what school she went to, who her parents are.
- # ... if she's single and you're single at the time when you get that chance, you think I've known her for 4 years and know she is generally a clean person, she's not a grotty old slapper and you think there's no need for one.

One consequence of these perceptions is that when a relationship that begins casually, blossoms into something potentially more permanent, the couple are likely to stop using condoms very quickly. Once it has

been established that both parties like and trust each other, then the risk of an STI ceases to become a consideration. This idea of mutual "trust" is not dependent on actually establishing that neither partner has an STI:

- The first time [a student couple] may use a condom but if they're actually going out for a bit of time, then eventually they just don't.
- # You can stop using [a condom] with long term partners.
- It's quite a big point of trust there. I think in a relationship when you've known them long enough for them not to be lying [you can stop using a condom]

4. Chlamydia

The participants were asked to consider their attitudes and behaviour in the light of the long term risks of chlamydia for women. Nearly all the soldiers and many of the students believed that eventually they would settle down with a long term partner and were likely to want to have children. They were asked to imagine the possible consequences for themselves of finding that their future long-term partner was infertile as a consequence of an infection earlier in her life. This provoked reflective and thoughtful discussion in most of the groups - but the consensus tended to be that, realistically, it was difficult to take account of these long term implications when they seemed so far away:

- I think that as an 18 year old, five or ten years is a lifetime. Well, it is isn't it?
- # I'm not going to say that what [the facilitator] just said there is going to change my mind because anybody would be lying through their teeth but it makes you think a little bit more but as [the other participant] said all your sexually transmitted diseases go straight to the back of your head.
- ... kids are just such a long way off and it's not even a concept to me. I can't consider having them, it's like something that would ever really come up naturally in my head.
- # There'd be nothing you could do about it no point in getting wound up about it.

5. Advice and testing

A number of the soldiers had had direct experience of sexual health services in the army. For those who had not, and for most of the students, the detail of testing and treatment was shrouded in mystery (and misconception). Nevertheless, testing and treatment were closely associated with fear, pain and embarrassment:

 I've been in a relationship and gone to the clinic with my girl, she's gone in and I didn't because I was scared . . .

- [I wouldn't want to take a test] because I might find out that I had AIDS. I know that you get a choice of tests, but I wouldn't want to find out.
- I think the main problem is the fear. Fear not only of getting tested which apparently hurts like buggery, but also of actually getting the results and finding that you do have an STI.
- # the cocktail umbrella!
- [You can] get tested hopefully without them ripping half your linings out.
- But if someone you know saw you walk into a sexual health clinic, they would start pushing rumours and like, even if you were just going in there to pick up a leaflet or something
- # You don't want [medical staff] laughing at you.
- # Can't you produce tests where men don't have to get their tackle out for other men?
- [If it was a woman doctor] another problem would be that I might get an erection.

There was a strong feeling from the students that to contract an STI was both "dirty" and "stupid" — whether that was oneself or someone else:

- You look [at some girls] and think of the word "dirty".
- ~ [At the clinic] Everyone looking at you, going "you dirty . . . "
- ... if you have a STI or whatever, people almost look down on you these days for being that stupid It depends on the group of people you are with but I think that once people are aware that someone has got STI, it's like, "what are you doing!?"
- STIs are preventable and if you're too stupid to use the proper protection then that's your own fault.
- I could imagine proposing to future wife and then looking at her and thinking hang on, am I going to be able to actually have kids with you and do I really want to propose to you? Have you had some stupid guy, doesn't use a condom and gave you chlamydia?
- ... an awful lot of blokes are going to be worried about going because ... if they're going to go, or they're thinking about going, there's a very real possibility that they do have an STI and they're worried about what people will think of them.

There was consensus that one was likely to visit any kind of sexual health service only in the event of experiencing symptoms:

MHF So the only thing that would prompt you to actually go to the medical block or go to the GU clinic, would be if you had symptoms?

- I have learnt that as soon as I start to get symptoms, I think that it's going to get worse and I make my appointment then.
- # I don't think anybody, once you've had sex right, you reminisce with the lads but you don't think "God, I wonder if she actually had this?" Because she didn't show any symptoms of it, you've got no reason to think that. You'd think that you're just - what's the word I'm looking for? Hypochondriac.

One notable difference between the soldiers and the students was that the soldiers were much more comfortable with the process of testing and treatment — this was particularly so for those who had actually needed to use services. The army's familiarity with STIs and its need to keep soldiers fit and available for duty means that the service is fast, accessible, and matter-of-fact. On the face of it, this seems to be unhelpful in terms of prevention (i.e. if treatment is easily and quickly available then why consider prevention at all?) but of course, the routine nature of the army's approach serves to demystify the process and to encourage young men to make use of services, which is essentially very positive:

- # Basically it was a case of go in, get it done and on your way.
- # I don't know about here (Germany) but in Britain it was efficient. Quick. They sorted me out. It was good.
- # ... you get things done faster in the army than what you do on civvy street.
- # I much prefer the army because I believe army doctors for all that we say they're butchers and whatever else - they have a little bit more welfare about your confidentiality and how embarrassing it is being in amongst a battalion of 800 men.

That for me is for 99% of men.

Summary of findings

The most notable aspect of these findings is that despite the huge changes in the role and status of women in recent decades, "traditional" attitudes and preoccupations remain very familiar to some young single men. This appears to hold true across the quite different social settings in which soldiers and students spend their time. The language differs, but many of the young men taking part in the discussion groups participate in similar activities: getting drunk, going out in the hope of meeting "available" women and so on. They are better informed about sex and more able to talk frankly and openly than would have been the case twenty or thirty years ago - but they are still quite likely to leave discussion of contraception with a new partner to the last desperate, fumbling moment. They know it is ridiculous even to think it - but they believe that they can make an educated guess about whether a woman is likely or not to have a sexually transmitted infection. They regard it as unlikely that they might have an STI themselves without their knowing it - but even if they had symptoms they would hesitate to seek help because they claim to believe that the treatment is primitive. Even when they try, they may find it almost impossible to conceptualise the potentially negative consequences of their immediate behaviour.

All this sounds pessimistic but it was clear that many of these young men anticipated that their attitudes would change and develop as they got older. In many cases, they simply assumed that they would eventually settle down into a stable relationship and have a family. In other words, they recognised that they are young now and their understanding of being young is likely to involve experimentation, misjudgements, mistakes and some degree of irresponsibility. The challenge for those seeking to improve the sexual health of young people is not simply to confront these attitudes – necessary though that may be on occasion - rather it is to find ways of engaging constructively with the young men who hold them.



Introduction

The original idea for the pilot phase was that it should have a framework comprising the following key components:

- It should take place in a large workplace employing several thousand men (e.g. a car factory) where the management was willing to invest time and effort in supporting the project.
- The workplace should be so situated that most employees lived within a few miles' radius.
- The area in which most employees lived should be served by only one or two PCTs.
- The local PCT(s) should be willing to enter into a planning partnership with the MHF and to commit staff time to the ongoing local work that would required for the duration of the project, as should the local NHS Trust responsible for microbiology services and genitourinary medicine.
- The local PCT(s) should be willing to implement a Patient Group Direction (PGD) to allow local pharmacists to issue antibiotics "over the counter" to those people testing positive for chlamydia during the project.

In mid 2003 we ran articles in the health press outlining the project and inviting PCTs who might be interested in taking part to contact the MHF. Five PCTs did so. Only one had a major workplace within its area however, and unfortunately that was a PCT in inner London where most staff at the workplace concerned were commuters travelling from a wide geographical area. This workplace was therefore unsuitable. The decision was eventually made to work with Telford & Wrekin PCT (T&WPCT) in Shropshire, where it was clear that there was considerable enthusiasm for the project. Telford is a "new town" with a population of just under 160,000. It has a concentration of small-to-medium-sized light industrial premises. Although close to Wolverhampton, it is otherwise surrounded by countryside and most people who work in Telford live in or around the town. T&WPCT covers the whole of the town and its immediate surrounding area.

In the absence of a single large workplace, it was decided to put together a group of workplaces whose total staff numbers approached the several thousand that we needed to make the project viable. This was achieved by a combination of working through a local occupational health agency and "cold-calling". Seven workplaces eventually agreed to take part, between them employing over 4000 men. One workplace (fortunately the smallest of the seven) decided to drop out during the week of the project launch but the other six went ahead as planned. Details of the participating workplaces are given in Section 5.

During the seven or eight months prior to the launch of the project in June 2004, three different "strands" of the project were developed in parallel with each other:

1. Translation of the findings of the Phase 1 research into promotional materials appropriate to the target group.

- 2. Establishment of the infrastructure within the PCT and NHS Trust to enable the project to be managed and administered efficiently at a local level.
- 3. Development of the partnership with the participating workplaces.

The development process and the most important practical elements involved with each of these "strands" are described briefly in the following sections.

Development of the health promotion materials

It should be admitted at this point that our hope at the outset of Phase 1 was that the group interviews would lead neatly to a key that would open the door to young men's constructive engagement. As the introduction to Section 3 made clear however, this proved to be over-optimistic, and at the conclusion of the research, we were faced with the absence of any obvious inspiration for a positive message. On the plus side however, we had a good understanding of the kind of circumstances in which decisions relevant to sexual health are made and a clear list of myths and preconceptions that needed to be dispelled. We also had good indications for a "tone of voice" for the campaign.

We were fortunate at this stage to be offered by Roche Diagnostics, one of the funding partners for the project, the opportunity to work with its design agency, Bellman, to develop the raw material from the research into a concise and coherent message. Over a series of meetings and consultations it was agreed that the central single message of the health promotion materials (the "strap line") should be a simple one which was not intended to change attitudes or to appeal to a latent sense of responsibility - instead it should concentrate entirely on urging the young men in the workplaces to take up the offer of the urine test. At the same time, it was decided to develop supporting materials that, using language familiar to the target group, aimed both to demolish myths and present a case for behaving responsibly - while acknowledging that it is not always easy to do so. It was also agreed that the images used should reflect the kind of drunken circumstances in which a casual sexual relationship might be struck up, and that the campaign should be underpinned by the unspoken idea (reflecting the importance placed by young men on sexual conquest), that it is only men who are successful with women in the first place who are at risk of contracting and transmitting an STI.

A decision was also taken at this stage that the urine testing kits themselves should be contained within glossy and appealing packaging. Although this added to the expense, it was believed that this approach would encourage young men to pick the urine testing kits up and would serve to assure them that the test was valuable and important. The selected "strap line" for the campaign used the double entendre *Put Ya Tackle to the Test*. The campaign materials comprised three different A3-sized posters, a general information leaflet and the boxes containing the urine testing kits. The kits themselves comprised: an instruction leaflet; a 20 ml specimen bottle; a cardboard tube lined with absorbent material in which to enclose the filled specimen bottle; a FreePost envelope and some additional packaging in which to return the cardboard tube to the laboratory; and a short personal information form. This latter was designed to be as simple to complete as possible and required the user to supply only the very minimum of information necessary for the specimen to be processed. All the materials used are shown at Appendix 5.

The Role of the PCT

A small working group was established comprising Dr Sarah Feather and Dr Sue Robin, who job-share lead responsibility for sexual health at Telford & Wrekin PCT, and Dr Sue Skidmore, Clinical Microbiologist at the Princess Royal Hospital NHS Trust, Telford. Over a period of several months leading up to the launch of the project, this group secured the approval of the PCT for the project, ascertained that ethical approval was not necessary, and made all the necessary practical and administrative arrangements necessary for the project to be run efficiently.

In particular, this working group drafted and expedited the Patient Group Direction which would allow local pharmacies to issue azithromycin to those people who tested positive and who chose to seek their treatment at a pharmacy rather than at a GUM Clinic. As part of this process, the working group (with the support of the National Pharmaceutical Association) also organised a training session for those pharmacists who were to issue the azithromycin.

Urine specimens submitted were analysed at the microbiology laboratory at the Princess Royal Hospital in Telford on equipment loaned for the duration of the project by Roche Diagnostics. The Princess Royal Hospital NHS Trust also set up the system for recording and collecting the data from the returned and processed urine samples. In most cases, a simple system of standard letters was used to notify those who had tested negative.

Two existing members of staff, Marie Barber, a Health Adviser, and Lesley Talbot, Lead Nurse, were given some sessional time to work on the project for its duration, in particular to telephone those people who tested positive and to answer general telephone enquiries (the number of a dedicated phone line was included on all the campaign materials). T&WPCT also organised the local media launch of the project, which was held on June 29th 2004 and resulted in good, positive coverage in local print media and local radio.

Partnership with participating workplaces

In some ways, this was the most difficult aspect of the project to manage. The local workplaces were enthusiastic and committed but most communication between the Project Leader and the individual workplaces in Telford was necessarily conducted by telephone and e-mail because of the geographical distance. The local working group at the PCT was on occasion able to "troubleshoot" specific problems but its responsibilities were primarily to deal with the administration of the project at PCT level and the process of dealing with specimens, patients and data once the kits had been picked up.

Given these circumstances, it is perhaps not surprising that things did not go as smoothly as they might have, had the project been managed by - say - a local sexual health promotion specialist. Nevertheless, three well attended meetings were held between the Project Leader, T&WPCT and the workplaces in the six months prior to the project. All workplaces were represented at these meetings either by their Occupational Health staff or by their Human Resources Department. This group of people was extremely supportive of the project and a number of helpful and creative suggestions were made during the meetings that influenced the implementation of the project.

Difficulties arose subsequently in three of the original seven workplaces because local senior and middle management raised objections which occupational health and HR staff had not foreseen. These were either to do with nervousness and/or scepticism about the subject matter and/or concerns about whether it was a "good time" for that workplace to be taking part in a health initiative. These kinds of concerns led to one workplace withdrawing in the week of the project launch and to another workplace imposing significant restrictions on distribution of the materials (the urine testing kits had to be requested in person from the Occupational Health Office). One workplace which considered withdrawal for internal reasons invited contact between the MHF and senior management to resolve the problem and subsequently became extremely helpful and supportive.

Communication with those staff who were actually responsible for putting out the kits and distributing the information materials was perhaps the most troublesome aspect of all. All the staff in the workplaces were, of course, taking on a task additional to their usual responsibilities and it was not always possible to ensure – for example – that materials were distributed by the agreed date in the intended manner, not least because we also experienced manufacturing delays in the production of the materials. Given the time span between the first planning meeting and the end of the implementation phase, it was also perhaps inevitable that the contact person in some workplaces changed during the lifetime of the project either because they changed jobs or, as in one case, went on maternity leave.

Sequence of events

The following process took place in each of the participating workplaces:-

During May 2004:

All staff (male and female) received a letter signed by a senior manager, which notified them of their employer's forthcoming participation in the project. This letter also contained an information sheet outlining the aims and objectives of the project. The information sheet further explained why the project was aimed solely at male employees. For female staff, a leaflet prepared by T&WPCT and explaining how to access local sexual health services was also enclosed with the letter. Men were told that they would receive further detailed information about the project in due course. Copies of the letter and the information sheet are at Appendices 3 and 4 respectively.

During June 2004:

All male staff (all ages) received a copy of the main project leaflet. In most cases this leaflet was distributed with wage slips. The leaflet was A4 size, folded into three and printed on both sides on good quality glossy paper. It was circulated in a sealed envelope bearing the legend "inside . . . top tips for all you lads that like the ladies".

June 29th 2004

The press launch of the project at ABRO, one of the participating workplaces. With one exception, all the participating workplaces sent a representative to attend the launch and to appear in the group photographs.

June 29th - July 9th 2004

At some point during this two week period, each workplace launched the project internally by placing display boxes of kits (25 per box) in "male" areas of the workplace (gents' toilets, locker rooms, rest rooms etc). The only exception to this was that of Alcan, whose approach to distribution of the kits has already been described. Each workplace also put up A3-sized project posters on noticeboards and placed batches of additional leaflets (i.e. extra copies of the main project leaflet that men had received individually) where men could pick them up easily. The kits and posters were to remain in place in all the workplaces until the end of September. If a display box became empty, the occupational health nurse would replace it. Photographs of the display boxes and the contents of the kits are at Appendix 5, as are reproductions of the posters and leaflet.

End of August 2004

All men (all ages) in the participating workplaces received a leaflet sealed in a glossy silver envelope. At first sight the leaflet looked like an advertisement for a holiday company with a photograph of a beach and the phrase "sun, sea & . . ." on its front page. Once unfolded the whole phrase was seen to read "sun, sea & chlamydia?". The purpose of the leaflet was to remind men of the opportunity to take the chlamydia test, particularly in the light of their possibly having had casual sexual relationships while abroad on holiday over the summer.

October 1st 2004

The project ended in all the workplaces. Posters were taken down from noticeboards and the boxes of kits removed.

October 1st - October 31st 2004

During the course of the project, two other local employers approached T&WPCT with a request to offer the kits to their staff one of these employers was a local factory, the other, a military base. At the same time, it was decided that it would be sensible to use up some of the kits, posters and leaflets that were left over at the end of the project. It was therefore decided to extend the project for a further month in six new settings: the factory and military base which had approached the PCT, plus a local young people's sexual health advice service, a post-16 college, an agricultural college and a small local college which forms part of the University of Wolverhampton. Because these settings were "added on" in this way, and because we have had access to less statistical information about them and the arrangements made with them were rather ad hoc, their results are tabulated separately in the section that follows. For the sake of clarity, this group of settings will be referred to from here onwards as the "add-ons".

December 2004 - Summer 2005

The Department of Health has funded an independent evaluation of the administrative and organisational aspects of Phase 2 of the Men and Chlamydia Project. This evaluation — which will be conducted by the Institute of Health and Community Studies at Bournemouth University - will focus particularly on the reaction of people in the participating workplaces to the health promotion materials. It will use qualitative methodology to look at whether the campaign had the effect of enhancing knowledge or changing attitudes and will - for example - explore why some men who took urine testing kits home decided to use them and some did not. The report of this evaluation will be published in due course and should be read as a companion to the present document. This on-going evaluation is referred to throughout the rest of this report as the "post-project evaluation".



Settings

Table 1: Workplaces; nos. of male staff, male staff aged under 30, description

Work place	Total staff	Total no. of men	Men, 30 or under	Employer's business
ABRO	1100	920	213	Maintenance of military vehicles to government contract (civilian workforce).
Alcan	472	423	60	Manufacturer of aluminium packaging products.
Lyreco UK	531	331	155	Office stationery supplies. UK HQ and base for national distribution centre.
DENSO	1500	1008	390	Manufacture of in-car electrical systems (e.g. heating and air conditioning).
CeDo	349	229	24	Manufacture of cling film and aluminium foil. Regional sales HQ also on- site.
GKN Alvis	1451	1362	183	Engineering and manufacture in metal for motor industry, military applications etc.
Total	5403	4273	1025	

Table 2: Description of add-on settings

Setting	Description
Harper Adams	Agricultural college
Priorslee	Satellite college of Wolverhampton University
RISQ	Young people's drop - in clinic (sexual health and contraception)
Ricoh	Small factory manufacturing audio equipment
TCAT	LEA post-16 college
Venning	Military Police training centre

Take-up

Table 3: Workplaces; Numbers of kits taken, numbers of specimens submitted

Workplace	Kits picked up from display	Specimens submitted to lab	Percentage of kits used
ABRO	458	41	8.9%
Alcan	42	9	21.4%
Lyreco UK	150	21	14.0%
DENSO	811	93	11.4%
CeDo	170	9	5.2%
GKN Alvis	728	55	7.6%
Workplace unspecified	n/a	57	n/a
Total	2359	285	12.1%

Table 4: Add-ons; Numbers of kits taken, numbers of specimens submitted

Setting	Kits picked up from display	Specimens submitted to lab	Percentage of kits used
Harper Adams	100	41	41.0%
Priorslee	28	4	14.3%
RISQ	87	15	17.2%
Ricoh	25	9	36.0%
TCAT	205	17	8.3%
Venning	88	12	13.6%
Total	533	98	18.4%

Table 5: Origin unspecified (i.e. not known whether workplace or add-on)

Setting	Kits picked up from display	Specimens submitted to lab	Percentage of kits used
Origin unspecified	n/a	18	n/a
Total	n/a	18	n/a

Table 6: Total kits picked up and specimens returned

	Kits picked up from display	Specimens submitted to lab	Percentage of kits used
Workplaces	2359	285	12.1%
Add-on settings	533	98	18.4%
Origin unspecified	n/a	18	n/a
Total	2892	401	13.9%

At first sight, the figures in the tables above might appear somewhat disappointing. In fact, very little is previously known about what to expect from this kind of campaign, so it is difficult to make any kind of judgement about what constitutes a successful take-up rate. In Lothian, where postal urine testing kits have been available in a variety of community settings (colleges, sports centres, pharmacies) for several years, the number of kits returned as a percentage of those taken from display has varied from 17% to 27% according to setting. The great majority of submitted specimens in Lothian however are returned by women. There is no previous male-specific campaign at all, with which to make a comparison.

Within our figures, there is also great variation – from a return rate of only a little over 5% at CeDo to a return rate of 41% at Harper Adams, the agricultural college. It is extremely important that we learn why this should have been the case, and this will form one of the central questions of the post-project evaluation. There are two helpful observations that it is possible to make at this stage. The first is that the return rates in the add-ons are much better than in the workplaces – despite the campaign having lasted three times as long in the latter. The most likely explanation for this is that the add-ons either actually asked to take part or were recruited by direct personal contact with

T&WPCT staff. This may well have resulted in higher levels of motivation among on-site staff. Certainly in some cases, the add-ons ran specific promotional campaigns in which health staff spoke directly to potential participants and encouraged them to submit a specimen (i.e. compared with the largely paper-based promotional systems in the workplaces). Particular evidence for the difference this may have made, is the very high uptake at of 36% at Ricoh, which is an industrial workplace no different from the original six. Interestingly, among the original six, the workplace with the highest percentage of specimens submitted was Alcan, which made an internal decision only to make the kits available on personal request. At the time, this was seen as being likely to inhibit participation rather than encourage it (of course, higher proportional take-up is not in itself a measure of success if men who would have liked to take a kit were too embarrassed to ask for one).

There are, additionally, two provisos to interpreting these figures too negatively. The first is that specimens continued to arrive at the lab after the cut-off date for the writing of this report. This is unlikely to have made a substantial difference, as the numbers had tailed off significantly, but does mean the totals reported here are a little lower than the actual final totals. The second point however is an absolutely critical one. As well as providing the opportunity to take a chlamydia test, the kits also function as a means of raising awareness, delivering education and stimulating discussion among young people. Viewed in these terms, each kit taken from the display represents a potential success whether or not it resulted in the submission of a urine specimen to the lab. This is another important issue that will be considered in the post-project evaluation, which will endeavour by interview and questionnaire, to establish whether there has been a change in attitude and knowledge among people who came into contact with the project materials.

Table 7: Specimens submitted by age and sex (total nos: workplaces and add-ons)

Sex	Number	Percentage of all specimens submitted
Male 30 or under	175	43.6%
Male over 30	132	32.9%
Male age unknown	5	1.2%
Female 30 or under	58	14.5%
Female over 30	29	7.2%
Female age unknown	2	0.5%
Male all ages	312	77.8%
Female all ages	89	22.2%
All	401	100.0%

On the face of it, it may seem odd that any specimens were submitted by women at all since the project was directed entirely at men. It was recognised from the outset however, that women were likely to have easy access to the kits and, although all the promotional material was written with men in mind, the leaflet contained in the kit boxes said explicitly that specimens submitted by women would be processed in just the same way as specimens submitted by men. The outcome here is a positive one; 77% of those kits used, were used by men, suggesting that men have recognised that the campaign was aimed at them and have chosen to take part as a consequence. The percentage of kits returned by men in the present project, is an exact reversal of the position in the "unisex" campaign in Lothian where 75 - 80% of urine specimens come from women. Additionally, 57% of the men who returned kits in Telford were aged thirty or under – the prime target audience – and 70% were aged 35 or under, suggesting that the campaign was successful in identifying itself with a younger audience.

Table 8: Male responders by age – workplaces only

Age	Number of respondents	Number in age group	Percentage of age group
30 or under	93	1025	9.1%
Over 30	105	3248	3.2%
Age unknown	3		
Total	201	4273	4.7%

It is not easy to make a judgement about this matter, since there is virtually no other data to go by. The National Chlamydia Screening Pilot Study achieved a take-up figure of 50% of all women aged under 25 in Portsmouth and the Wirral by offering chlamydia screening to every woman in this age group attending a wide variety of health and community settings (i.e. "official" settings) over a twelve month period. Almost 10% of men taking a test at their own volition, prompted only by written materials in their workplace, over a 13 week period therefore seems a reasonable achievement.

It should also be noted that a further 19 men aged 30 or under submitted urine specimens, having obtained kits from friends or relatives who worked at the participating workplaces, and that we received seven other specimens from men in this age group where the man's setting was unknown. It is particularly encouraging to note the significant difference in percentage take-up between the younger and older age groups. These figures confirm the analysis suggested earlier in this section by the raw numbers, that the project materials had some success in targeting the relevant age group.

Screening outcomes

Table 9: Test results by age and sex (total nos: workplaces and add-ons)

Age and sex	Negative	Positive	Percentage of specimens submitted
Male 30 or under	169	6	3.4%
Male over 30	131	1	0.7%
Male age unknown	5	0	0.0%
Female 30 or under	55	3	5.2%
Female over 30	29	0	0.0%
Female age unknown	2	0	0.0%
Total	391	10	2.5%

Location Sex Age Workplace 19 male Workplace 34 male Workplace 18 female 18 Workplace female Workplace female 20 Add-on male 18 18 Add-on male Add-on 20 male 20 Add-on male Add-on 20 male

Table 10: People testing positive by sex, age and location

Some information about the probable prevalence rates for chlamydia was given in the introduction to this document but there has never been a detailed study aimed at establishing chlamydia prevalence rates among the general UK population. Most of the work that has been done has looked at particular sub-sections of the population and the results have varied according to factors like age group, setting, diagnostic test used and so on. Most studies have been based on people attending healthcare settings for one reason or another and it is believed that prevalence among this group is likely to be higher than in the population at large.

A systematic review of chlamydia prevalence studies dating back several decades suggested a 5% prevalence rate among women aged under 20 in the general population¹¹. This study was unable to calculate equivalent figures for men because of the "paucity of data on prevalence in males" but the on-going "Healthy Respect" programme in Lothian has found a 6.3% prevalence rate among men under 33 submitting urine specimens by post¹². It is generally accepted that rates are increasing and that the peak occurs at an earlier age in the female population.

In the present project, the incidence rates for women in the workplace and men in the add-on settings were the highest; 13% of women aged 30 or under (17.6% of those aged 25 or under) in the former case; and 8.9% of men aged under 30 in the latter (all but one of whom were aged under 25). By contrast, only two positive specimens were returned by men in the workplace, making an incidence rate of 1% among that group in total.

Overall, the number of people testing positive in the present project seems roughly consistent with what might be expected among the general population. In the case of the workplace specifically however, the incidence rate for men is markedly lower than might have been expected (by contrast, the rate for women in the same setting is – as noted above - markedly high). This may well be accounted for by the small sample size, or it may indicate that, despite our best efforts, the project was somewhat more effective at reaching the "worried well" – in other words, that it did not strike a chord as successfully with the group at greatest risk (those engaging in more casual sex, for example). This latter question will be among those tackled in the forthcoming evaluation. It should be remembered however that the primary purpose of this project was *not* to find men who were infected

with chlamydia but to test out whether men could be effectively engaged in the testing and treatment process.

Treatment choices

Table 11: Choice of treatment setting by those testing positive

Setting	Number
Pharmacy	5
GUM clinic	4
GP	1

One of those treated at GUM would have preferred treatment at pharmacy but for some reason, the detail of which is unclear, she was not able to gain access to the service and attended GUM instead. One of the positive testers was from another part of the country (he was working as a contractor at one of the factories) and had left Telford before he received his result. He therefore did not have access to option of treatment at a local pharmacy. Two further people were advised by the Health Adviser to attend GUM because they had symptoms which could have indicated concurrent infection. At least one of these latter said that they would have much preferred to seek treatment via the pharmacy. Only two of the ten positive testers therefore actively chose not to seek treatment at a pharmacy (one was the single individual who chose to go to his GP). Although this is a very small sample, it is therefore clear that the option of obtaining treatment at the local pharmacy was the most popular by a considerable margin. The ongoing evaluation of the project may be able to establish whether this option was a factor in people deciding whether to seek testing and/or treatment at all.

Contact tracing

When someone tests positive for an STI at a GUM clinic, a number of options are available to maximise the likelihood of tracing all that person's sexual contacts and encouraging those contacts to seek treatment for potential infections of their own. Most of these options rely on the persuasive power of health staff in face-to-face conversations with the infected person. If the infected person is willing to give the names of recent sexual partners, then those people can be "cross referenced" when they attend for treatment. These recent partners can also be contacted by other means if the infected person is not willing to contact them personally. GUM staff can consequently maintain an overview of their success in reaching as many inter-connected patients as possible.

Obviously, in the case of the present project, there was less personal interaction between the person testing positive and health professionals. At its minimum level, this interaction would be the phone call from the Health Adviser notifying of the positive test result, a conversation with the pharmacist issuing the antibiotic and a follow-up phone call from the Health Advisor to check that the person had sought treatment. Greater reliance is necessarily therefore placed on the person testing positive to notify his or her sexual partners personally. This departure from the accepted norm caused some concern in the planning of the project – although the original project plan drew attention to the fact that most people testing positive during the project were likely to be those who were asymptomatic and who would never have presented at the GUM clinic anyway.

In the event, the results were mixed. Four of the positive testers (one female and three male) refused to disclose the names of their recent sexual partners to the Sexual Health Adviser in the phone conversation but did give assurances that they would contact them personally. Four people out of ten refusing to name their partners is broadly consistent with the percentage refusing to do so in the on-going postal-testing campaign in Lothian but is thought to be higher than the numbers who refuse during face-to-face discussions with a Health Adviser in a GUM Clinic. (From the point of view of the present project incidentally, it also means that we are not able to include these partners in the final figures because we have no way of knowing if they presented themselves for treatment or not). Between them, the remainder of the positive testers produced five sexual partners who are known themselves to have tested positive and to have been treated either at GUM or by their GPs. One further recent sexual partner of one of the female positive testers was named but could not be contacted. The total number of people who tested positive and received treatment as a direct result of the Men and Chlamydia Project is therefore fifteen people (seven women and eight men) with the possibility of at least four others who remain unconfirmed.

Costs

The detailed overall costs of the project are probably not relevant here but readers will want to know the cost of the materials. The costs of the display boxes used to hold the kits and the reminder leaflet issued halfway through the project have been <u>excluded</u> from the figures below, since these were essentially "optional extras" that would not be necessary in replicating the project elsewhere. The costs of artwork, copy-writing and design are also <u>excluded</u>, since these are one-off costs that are only incurred at the outset. The figures below are therefore *production costs only*. Any organisation interested in replicating the project is welcome to use the existing artwork and copy by arrangement with the MHF:-

Posters (A3, glossy, full colour):

 $\pounds 1.00$ each on a print run of 350 for each of three designs $= \pounds 1050$

Main project leaflet (A4 folded in three, glossy, full colour): 12p each on a print run of $10,000 = \pounds 1200$

Urine testing kits (unit costs)	
Outer box	£0.92
Explanatory leaflet (A5 folded, glossy, full colour)	£0.18
Laboratory form	£0.14
20 ml specimen tube	£0.20
Protective sleeve lined with absorbent material	£0.64
Polythene bag in which to seal sleeve	negligible
Polythene FreePost envelope (pre-printed)	£0.12
Packing of kits by specialist firm	£0.28
TOTAL	£2.48

Additionally, a FreePost account is required and each kit returned to the lab incurs an individual postage cost. In the present project, that was around 60p per specimen. Each specimen processed in the laboratory requires the use of chemical reagents costing very roughly £5.00 and requires the cost of postage to notify the result. Excluding all staff costs and other overheads therefore, the cost of a completed test "door to door" is as follows:

TOTAL	£8.36
Return postage	£0.28
Laboratory materials	£5.00
FreePost fee	£0.60
Urine testing kit	£2.48

The cost of kits used in the project was therefore as follows:

2852 kits taken but not used @ $\pounds2.48$	£7,072.96
401 specimens submitted @ £8.36	£3,352.36
Total	£10,425.32

In terms of <u>testing kits only</u> and including the five contacts of the ten positive testers, the cost of each case of chlamydia identified and treated during the course of the Men and Chlamydia Project was £695.00. If a theoretical minimum of four other contacts is included (see "Contact Tracing" above), the cost of each individual case falls to £549.00.

The ongoing evaluation will establish whether the kits taken but not used were simply "wasted" or whether they have made an effective contribution to increased knowledge and behaviour change. The evaluation may also suggest reasons why a good number of specimens were submitted by older men (and some older women) despite the materials being aimed at younger men, who are at much greater risk. One possible explanation is that some of these men did consider themselves at risk, either because they are single and sexually active with new and/or casual partners for example, or that they are in more than one relationship, or are visiting sex workers. Another explanation is that they took part solely because it was free to do so and they thought it worthwhile just to "check". If the latter, it seems likely that some of the potential waste could be eliminated very easily by simply adding a note to the kits making it clear that anyone who has had only one sexual partner for a certain number of years, has no need to take a test.

The project had two distinct phases and it seems sensible to deal separately with the conclusions and recommendations arising from each (recommendations in bold italics).

Phase 1

Relatively little qualitative research has been undertaken with young men about their attitudes to sex and sexual health — especially with young men in the critical age group (late teens — early twenties). Our research was practical in intent and directed very specifically to the needs of the project that was to follow. It was small in scale and was probably imperfectly representative in terms of a number of demographic indicators. It nevertheless yielded a rich mix of findings. In particular it revealed a surprisingly homogenous range of views held by two very different groups of young men. This latter observation does not, by any means, mean that all young men hold the views that were expressed by the young men to whom we spoke – but it does suggest a broad framework of attitudes and preconceptions that is familiar to young men and that informs their sexual behaviour. This small project however, is nowhere near enough to form a sound basis for decision-making on a larger scale.

 A comprehensive study is needed in order to develop a better understanding of the knowledge, attitudes and behaviour of men aged 18 – 25 in relation to sex and sexual health. Without such a body of research it will not be possible to target sexual health promotion strategies at this critical group with optimal effectiveness.

The range of attitudes and experiences that were described to us during the discussion groups suggest that there are two particular pre-disposing factors that are absolutely central to risk-taking sexual behaviour. These factors are as difficult to tackle as they are easy to understand. The first is that casual and/or risky sexual behaviour is invariably accompanied by significant alcohol intake:

 Strategies which seek to help young people manage their drinking are as likely to be as effective for sexual health as strategies which concentrate on sexual behaviour.

The second is that poor communication between sexual partners is commonplace. Despite being able to speak openly and frankly about sex in a group discussion, it was clear that for many young men (and by implication, women), decision-making in an intimate situation with a sexual partner is a different matter. Critical decisions are frequently made chaotically in the heat of the moment. Furthermore, anything that draws attention to the risk of infection is potentially a "turn-off", as is anything else that interrupts the passion and intensity, especially condom use. It is not possible to make condoms "sexy":

• Condom use should be promoted more honestly - that is, that condoms are an unfortunate necessity. It is critical that both partners expect that there will be a conversation about condoms, and that they have the language and the self confidence to deal with it with the minimum of awkwardness, preferably in advance and even with someone who may effectively be a stranger. We need to work with people earlier in their lives to enable better communication skills. "Rehearsing" discussions between the sexes about sexual choices should form part of sex education in schools. Despite an acceptance of the shifts in status between men and women in recent decades, and despite a good basic knowledge of sexual health, some young male attitudes remain resolutely "traditional". In particular, young men enjoy the "thrill of the chase" and the kudos of sexual "conquest". Likewise, young men, with the best will in the world, find it hard to look ahead and to conceptualise the long term negative consequences of some of their behaviour. It is essential that sexual health promotion strategies recognise this.

Strategies predicated on instilling, or appealing to, a sense of responsibility are less likely to succeed than strategies based on acceptance of young men "as they are".

Finally, there is a wide range of preconceptions that underpin young male attitudes to sexual health. Some of these preconceptions approach the status of urban myth – for example the persistence of the idea that the diagnosis for STIs involving the insertion of a "cocktail umbrella" device in the urethra. Other preconceptions include the idea that only certain "types" of women are a sexual health risk; that contracting an STI is "dirty" and/or "stupid"; that treatment may involve embarrassment, ridicule or a telling off; that – in the case of chlamydia – the absence of symptoms and low risk of long term consequences for men make it an acceptable risk.

 Sexual health promotion strategies should seek continually to address common preconceptions, and should not assume that just because these issues have been covered in the past, that they have been successfully put to rest. In some cases, young men know – or at least, suspect - that these preconceptions are incorrect but that does not mean that they can just shake them off. They may cling on to them as a means of absolving themselves of responsibility. Humour may be the key to engaging with these ideas.



Phase 2

It is worth repeating here the that the objectives of phase 2 of the project were to:

- Increase men's awareness of chlamydia
- Promote the adoption of safer sexual practices
- Encourage men to seek screening and treatment where appropriate

It was *not* the specific purpose of the second phase of the project to identify young men with chlamydia – although the extent to which it succeeded in doing so is one factor to be taken into account in considering recommendations. It is also worth reiterating that a separate, independent evaluation of the project materials is underway. That evaluation has the capacity to consider much more sophisticated data than the bald statistical information that has been presented in this report; for example it will be able to address the question of whether the materials used in this project influenced attitudes and behaviour among those who did not go so far as to submit a urine specimen – a consideration that is completely beyond the scope of the present report. That evaluation will make recommendations of its own and in the fullness of time should be read as a companion to this project report.

Although there is little previous work in this field to go by, it is possible to make a fairly confident judgement that by developing materials that spoke directly to young men, the project has demonstrated that this group can be encouraged to self-screen and, where necessary, to seek treatment for chlamydia. Over three quarters of those taking up the offer of a test were men — an exact reversal of the take-up figures in "unisex" campaigns that have been run previously. Almost 10% of the total audience targeted by the project (i.e. men aged under 30 in the six workplaces) chose to go to the trouble of submitting a urine specimen, prompted only by written material and the easy availability of the testing kits. All the men who tested positive agreed to be treated. This offers further confirmation of the MHF's previous experience that male-specific approaches can be effective and that men are prepared to engage with health services where those services are designed with male sensibilities in mind.

There should be further exploration of the effectiveness of targeted ("gender-sensitive") work with men in the field of sexual health.

The present project does not however, comprehensively make the case for chlamydia screening in the *workplace*. Although the take-up within the workplace was reasonably good and the targeting appears to have been effective, it is noticeable that the kits distributed in colleges resulted, by and large, in fewer kits taken-but-not-used, and relatively more positive cases of chlamydia identified. The reasons for this are unclear (the uptake in workplaces varied from very low, at 5%, to very high, at 36%) and it is difficult to make reliable judgements on the basis of the small sample sizes. It is probably safe to conclude however, that the use of a variety of different settings in which men feel comfortable and "at home" is likely to be effective.

Without prejudging the outcomes of the forthcoming evaluation of the materials, it is possible tentatively also to speculate that the content

and style of the materials was a contributory factor to the success of the campaign in engaging with the target audience, as was the relative simplicity and anonymity of the system (self-testing, private results, treatment over-the-counter etc.).

Freely available postal testing kits combined with encouragement to use them and used in conjunction with a Patient Group Direction allowing pharmacists to issue medication, create an effective, streamlined system. Such a system may particularly appeal to young men. It is worth reminding ourselves that, although we cannot know it for certain, it is probable that none of the 15 (minimum) cases of chlamydia identified in Telford would have come to light at all without the Men and Chlamydia Project.

Although the present project experienced some problems of organisation and administration, these could largely be overcome if future projects were organised under local management.

- The following four key elements are useful and effective when used in combination. Approaches based on this model have the potential to generate male inclusion in local chlamydia screening initiatives and the model should be replicated and further developed:
 - * Partnership between the PCT and a variety of local non-NHS partners
 - * Well designed, well written, "male-friendly" materials
 - * Self-testing
 - * Availability of treatment at pharmacies

The cost-effectiveness of the Men and Chlamydia Project is difficult to judge without constructing a complex equation that compares the cost of each positive test with the hypothetical cost of treating those potential cases of PID and infertility that might have resulted. This is a particularly apposite matter to consider in the light of the publication in February 2004 of NICE guidelines recommending that all infertile couples should have access to up to three cycles of in vitro fertilisation treatment within the NHS. The construction of such an equation however, is beyond the scope of this report and may, indeed, not be possible at all.

It is probable however that the costs of future campaigns using the recommended model could be reduced in three ways. First, by making it very clear that there are some groups of men who have no need to take the test at all and who should refrain from doing so, even though the test is straightforward and free; secondly by working to develop means of promotion that discourage people from taking the kits and not using them. The tentative conclusion of the present project is that these two objectives might be accomplished by more verbal explanation. This conclusion is tempered however, by our not knowing at the moment whether kits taken-but-not-used have an effect on the knowledge, attitudes and behaviour of those who took them.

The final means of improving cost-effectiveness is rather more complex and to some extent cannot be properly considered until the results of the evaluation are known. It hinges on the critical question of whether or not the project and its promotional materials were successful in reaching the group of men *at greatest risk* of having

6. Conclusions and Recommendations

chlamydial infection. This group is, broadly, the group which has the most sexual partners and/or is least likely to use a condom. The intention of both the materials and the streamlined healthcare "pathway" was to engage this group of men. It is too early to say that this objective was not achieved but at the same time, it would not be safe to conclude that it was. It should be noted that while the materials can be adjusted or changed completely, it is hard to imagine any way in which the testing and treatment process could be made any easier within current provision.

• Materials promoting a self-test approach to chlamydia infection in men should explicitly discourage the submission of urine specimens from men whose risk of chlamydia is negligible. The promotional materials should also "market" the self-test kits in such a way as to discourage men from taking kits unless they are at least considering using them. Further work needs to be undertaken to establish the approach most conducive to encouraging the involvement of those young men at highest risk of infection.

Finally, the question of whether a project of this kind can incorporate effective mechanisms for contact tracing remains unresolved. It is doubtful whether community-based programmes in which treatment as well as testing is made available in a community setting (i.e. in this case the pharmacy) can ever offer the "gold standard" contact tracing that has become established in GUM clinics. At the same time, it is probably safe to assume that some – probably, most - positive testers in this sort of programme would not otherwise have been found at all.

It would certainly be worth trying to establish what proportion of positive testers can be relied upon to notify their recent sexual contacts personally. The long term solution however, would seem to be to look for new means of encouraging and monitoring contact tracing that are appropriate to informal testing and treatment programmes.

It should not be seen as an obstacle to community-based testing and treatment programmes for chlamydia that they are not perfectly compatible with established procedures for contact tracing. At the same time, alternative models for contact tracing should be explored – for example, people testing positive should perhaps be offered a private meeting with a Sexual Health Adviser in a non-health setting of their own choice, or there may be a role for the pharmacist in talking the matter through with people collecting their medication.



7. Collected Recommendations

- A comprehensive study is needed in order to develop a better understanding of the knowledge, attitudes and behaviour of men aged 18 – 25 in relation to sex and sexual health. Without such a body of research it will not be possible to target sexual health promotion strategies at this critical group with optimal effectiveness.
- 2. Strategies which seek to help young people manage their drinking are as likely to be as effective for sexual health as strategies which concentrate on sexual behaviour.
- 3. Condom use should be promoted more honestly that is, that condoms are an unfortunate necessity. It is critical that both partners expect that there will be a conversation about condoms, and that they have the language and the self confidence to deal with it with the minimum of awkwardness, preferably in advance and even with someone who may effectively be a stranger. We need to work with people earlier in their lives to enable better communication skills. "Rehearsing" discussions between the sexes about sexual choices should form part of sex education in schools.
- Strategies predicated on instilling, or appealing to, a sense of responsibility are less likely to succeed than strategies based on acceptance of young men "as they are".
- 5. Sexual health promotion strategies should seek continually to address common preconceptions (e.g. that treatment is painful, that "nice girls" cannot have STIs), and should not assume that just because these issues have been covered in the past, that they have been successfully put to rest. In some cases, young men know or at least, suspect that these preconceptions are incorrect but that does not mean that they can just shake them off. They may cling on to them as a means of absolving themselves of responsibility. Humour may be the key to engaging with these ideas.
- There should be further exploration of the effectiveness of targeted ("gender-sensitive") work with men in the field of sexual health.

- 7. The following four key elements are useful and effective when used in combination. Approaches based on this model have the potential to generate male inclusion in local chlamydia screening initiatives and the model should be replicated and further developed:
- Partnership between the PCT and a variety of local non-NHS partners
- Well designed, well written, "male-friendly" materials
- Self-testing
- Availability of treatment at pharmacies
- 8. Materials promoting a self-test approach to chlamydia infection in men should explicitly discourage the submission of urine specimens from men whose risk of chlamydia is negligible. The promotional materials should also "market" the self-test kits in such a way as to discourage men from taking kits unless they are at least considering using them. Further work needs to be undertaken to establish the approach most conducive to encouraging the involvement of those young men at highest risk of infection.
- 9. It should not be seen as an obstacle to community-based testing and treatment programmes for chlamydia that they are not perfectly compatible with established procedures for contact tracing. At the same time, alternative models for contact tracing should be explored – for example, people testing positive should perhaps be offered a private meeting with a Sexual Health Adviser in a non-health setting of their own choice, or there may be a role for the pharmacist in talking the matter through with people collecting their medication.



Appendices

Men and Chlamydia Project

Project Steering Group

Dr Ian Banks (Chair)	Men's Health Forum
David Brayshaw	Roche Diagnostics
Peter Carter	National Chlamydia Screening Programme, Dept of Health
Caroline Davey	fpa
Prof. Kate Galvin	Bournemouth University
Colette McCreedy	National Pharmaceutical Association
Pat Mahoney	British Forces Germany Health Promotion Unit
Robbie Porter	Men's Health Forum
Pam Prentice	Developing Patient Partnerships

David Wilkins Men's Health Forum

Guidelines for Discussion Group Facilitator

Introduction

Welcome and thank participants. Give a very brief overview of the structure of the project and its purpose. Explain that the project is about STIs in general but specifically about chlamydia - however, knowledge of chlamydia is not required in order to participate. At this stage, ask only if have heard of chlamydia. Explain that a more detailed introduction to chlamydia will be given during the discussion. Explain that the whole idea is that discussion should be informal and frank. It should be enjoyable and interesting.

Ground rules

- Participants agree to keep discussions confidential
- Discussion will be recorded but comments will not to be attributed to any one participant. Names will not be used in final report.
- There will be no direct personal questions, although participants are free to describe direct personal experience if they wish.

 In particular there will be no discussion about personal sexual interests or orientation unless participants wish to volunteer it.

Icebreaker

Make sure everyone has a pen. All the men pictured on the sheet are well known public figures. Each of them has either a famous connection with some aspect of sexual health, or has been embroiled in a sex scandal of some kind. Participants are asked to name the person and the sex/sexual health connection. Do this fairly quickly. It should be fun. Read out the answers when everyone has finished, allowing each participant to mark his own. One mark for naming the person, one mark for the connection. Distribute answer sheets for participants to keep. Give a prize to winner.

Discussion

To proceed through the following stages ("Subject Areas") in order. As many "Related Questions" to be addressed as is consistent with the natural flow of discussion.

Subject area	Related questions	Notes
Attitides to sex	How important is sex? How important in relationship — would they consider relationship without sex or sex without relationship? What is the important bit of sex e.g. penetration? orgasm? the achievement? emotional connection? How much of a motivator is sex — is sex (or the pursuit of it) the most important aspect of their personal lives. if not, what is more important)?	
Attitudes to sexual health	Is the consideration of risk/disease in their minds — if so when (before, during, after)? Is the consideration of risk/disease a turn-off? - if so, how could it be made less so? How easy/difficult is it to negotiate safer sex practices? Does the "type" of sexual partner make a difference to their assessment of degree of risk?	If time allows, explore where value judgements come from.

Subject area	Related questions	Notes
Attitudes toward sexual partner	Who are they considering when they think about sexual health (themselves, their partner, other people whom they don't know)?	
	Is the consideration of other s something they should think about? - if so why; if not why not?	
Chlamydia	Is the potential risk for women something that should worry them — if so why; if not why not? Challenge them — do they think they will want children one day? If so, what if their partner turned out to be infertile or even to die as a result of a previously unknown chlamydia infection? What is their response to that?	To be preceded by the introduction of some basic facts about chlamydia (most common STI, asymptomatic, up to 10% of their age group, effects on men, effects on women etc.)
Attitudes to advice and testing	What would prompt them to seek help/advice and where would they go? What is their attitude to doctors, nurses, clinics, self-testing; process of treatment? What would put them off/What would make them feel positive? What style of message would appeal to them	

Close of Discussion

Thanks.

Participants welcome to receive final report if they are interested – can leave name and address with us. Leave some information about chlamydia and details of where to get advice locally.

Model letter to all staff (male and female)

Dear

Men and Chlamydia Project

As part of our on-going commitment to the good health of our employees and because we believe it will benefit the wider community, [NAME OF COMPANY] has agreed to take part in the Men and Chlamydia Project. More information about this project is contained in the enclosed information sheet. As you will see, the project is aimed at men only, for reasons that are explained in the information sheet. Male employees will also receive a leaflet about how to take part in the project. Female employees will receive a general leaflet giving more information about chlamydia. Six other workplaces in Telford and District are also taking part in the project.

The project will commence during June and last until the end of September, and is a partnership between the Men's Health Forum (based in London) and the Telford & Wrekin Primary Care Trust. It is funded by the Department of Health and is part of an official national programme trying to establish ways of reducing the level of chlamydia infection in the population. This particular approach (concentrating on men) is not being tried anywhere else in the country. Telford has been chosen, solely because of the commitment of local NHS professionals to reducing chlamydia infection locally. Telford's infection rates are no higher than anywhere else in the country.

I very much hope you will support [NAME OF COMPANY]'s decision to take part in this project and I would encourage any men – particularly our younger male staff – to think seriously about taking this opportunity to screen themselves for chlamydia infection. It will never be easier to do so.

If you have any further enquiries about the project, please do contact [NAME OF STAFF MEMBER/DEPARTMENT] who will be pleased to help you.

Yours etc.

Information sheet for all staff (male and female)

What is the idea behind the "Men and Chlamydia" Project?

The Men's Health Forum (MHF), the leading national organisation campaigning for improvements in the health of men, has been asked by the Department of Health to run this project. One of the aims of the project is to try out a "streamlined" method of testing and treatment for chlamydia infection in men.

What is chlamydia?

Chlamydia is a bacterial infection which is transmitted from one partner to another during unprotected sex (sex without a condom). It is estimated that as many as one in ten men and women aged under 25 may be infected. Chlamydia can cause some minor symptoms in the short term but many people may not even know they have it. It is easily treated by a simple course of antibiotics. Chlamydia infection is a common cause of very serious health problems in women, particularly pelvic inflammatory disease and infertility. In rare cases it can also cause long term health problems for men.

What does the project consist of?

The project began at the end of 2002 and has two "phases". Phase 1 - the research phase - is now completed. Phase 2 of the project will begin during June 2004 and last until the end of September. Phase 2 is happening in partnership with Telford & Wrekin Primary Care Trust and is taking place in seven workplaces in Telford and district. It is the first and only project of its kind in the UK.

What is happening in Telford and district?

Publicity will be distributed in the seven workplaces informing male staff about the project and encouraging them to take part. Chlamydia testing kits will be placed around the workplaces and can be picked up anonymously and free of charge by any man who works there. If you are a man you will receive full details nearer the time.

Which local workplaces are taking part?

If you have received this information at work, you can be sure that your own employer is one of those taking part. Your Occupational Health Department will be able to tell you which other workplaces are involved if you are interested. We are extremely grateful to the participating employers for their commitment to this project.

Why is the project concentrating on men?

There have been a number of attempts in recent years, in different parts of the country to increase the numbers of people taking tests for chlamydia. None has made a special effort to reach men. Those that have intended to reach both sexes have in, all cases, had a much better response from women. Because chlamydia is sexually transmitted, it is obvious that we can only reduce the level of infection in the population as a whole, if men also participate in testing and treatment. Although this project concentrates on men, the main health benefits are to women.

What can women do if they are concerned about chlamydia?

All female staff will receive a general leaflet about chlamydia. Anyone – male or female - can seek a chlamydia test at any time simply by attending the GUM (Genito-urinary Medicine) Clinic at the Princess Royal Hospital (referral from your GP is not necessary). Telephone 01952 222536 to make an appointment.

How do men find out more about the project?

There is plenty of information included in the chlamydia testing kits and in the project information leaflet mentioned earlier. The occupational health departments in all the seven workplaces are fully involved in the project and will be able to talk to staff members about it.

Finally . . .

If you want to know more about the Men's Health Forum, you can visit our website at <u>www.menshealthforum.org.uk</u> You might also like to know that the MHF also has a comprehensive "consumer" advice website at <u>www.malehealth.co.uk</u> offering fast, free independent information about all aspects of male health.

Appendix 5

Poster 1 • A3



36

Poster 2 • A3



37

Appendix 5

Poster 3 • A3











Go on, put ya tackle to the test

How do you get it?

Phome just doing what comes naturally. We can catch chiamydia during any kind of unprotected sex - veginal, anal, even oral, it's not fusey. But, of course, you can stay very much asket if you use a condom.

Wouldn't I know if I had it?

Probably not. Most people have no symptoms, or they might be so mild that you just won't notice. But if it's painful to pee, or you are something you don't like the look of discharging from your penis, this could be a sign.

If I've got no symptoms, why should I worry?

Are you sitting down? Then III begin. In rare cases chlamydia can spread to your teaticlea and cause them to swell up. It doesn't feel good, and it doesn't look good either In some cases it can also spread to your joints and lead to a form of arthritis. Plus -and it's probably the furthest thing from your mind right now -it's now thought that chlamydia may even make some men infertile. And maybe aomeday you'll want to make use of all that training your tackle has been getting.

I think I'll just take my chances

OK. But what about the lucky ladies you sleep with? If you are infected, they won't turn out to be so lucky. For women the complications are much more common and it can be really serious. They may develop pelvic inflammatory disease (PID), which can cause severe recurrent abdominal pains. They may become infertile, and if they do conceive, they could have a life-threatening ectopic pregnancy. So if you do get yourself tested your female friends will have a lot to thank you for.

Can't I just avoid the sort of women who have it?

People with STIs don't wear hadges. And when you're out at night with your beer goggles on you probably wouldn't spot them anyway. You can't tell who might have it. You may think it's never going to be you or the women you have sex

with, but chiamydia is now very common (remember the two packed nightchubs?). After a few pints, and with the temperature rising, you might just forget to use a condom. But if it does bappen to you, and you do get chiamydia, it's nothing to be ashamed of.

"Il bet the test is complicated and painful

No. There are no doctors, no blood tests and no cocktail umbrellast You just have to pee in a pot. It's the same for men and women. Thanks to the Put Na Tackle to the Test project in Telford you can have the test, get the results, and get yourself treated without any fuss or embarrassment.

How does that work then?

You can pick up a free urine testing kit here at work. Follow the instructions and post off your sample. No one will know unless you tell them. You'll find out the result within a couple of weeks. You don't even need a stamp!

What if I do have chlamydia?

Don't worry, it's not a disaster. You just need one dose of antibiotics. It's fast, easy, effective and absolutely painless. You don't even need to see a doctor. We will give you more details if you do tast positive. Obviously it's bettar not to get chlamydia and it would make sense to protect yourself with a condom the next time you have sex.

What If, like me, you have regular success with the indies?

We'd like to know your secret! Of course if you do have unprotected sox after you've done the test, then you can simply do another test. But you'll need to wait at least two weeks after first having sex with a new partner before doing this, and try to remember the condoms if you do pull again in the meantime!



This sounds a hit too easy

Well, you're locky that here in Telford we're trying out this new way for men to get tested and get treated, all in the time it takes to have a pee and walk to the postbox. But if you do test positive, you'll need to think about contacting your most secent sexual conquests. And now that you know how easy it is to treat chiamydia, you can do the right thing and advise them to get tested too.

What about the women that work here, or my mates who work somewhere size?

The easiest way to arrange a test locally is to call the GUM (Gemito-urinary Medicine) Clinic at the Princess Royal Hospital - and this can be done at any time. Telephone 01952 222536 for an appointment. You don't have to go through your own GP - you can make the arrangements directly with the clinic.

Will my employer know I've taken the test?

No. We are organising this scheme at work because it's easy and convenient. Your employer has no way of knowing who has sent in a test. In fact, your employer should be congratulated for letting you take part. No one will be told, not even your own GP

Airight, Til give it a go

Thanks. You know it makes sense.



Chlamydia testing kit leaflet





DESTING FUR CHLAMYDIA

The Port We Section to the Test Project in designed to make chilamydia testing an anny as possible. If you need more details about chilamydia and welky you might want to take a test, see the larger Pirr We Testie to the Test leadlet. If you can't find a copy in your workplace, ask your Occupational Headth Decortment.

IT'S EASY

Just follow these instructions. It only takes a few minutes, it's completely confidential, and you won't need to involve anyone else.



WHAT TO DO

Follow these 10 steps in order:

Parst check that your kit is complete. It should contain:

- A yellow cardboard tube with a plastic stopper at each end
- A small plastic bottle with a white cap A clear plastic bag
- A plastic envelope pre-printed with a Prespost address
- A short form for you to complete with some basic personal details.
- White your name clearly on the label on the plastic bottle. There's no need to add any further information.
- Fill in the form with your personal details. Please fill in all the sections as this will help us process your test and make sure that you get your results.
- 1 Place the form in the clear plastic hag.

Wait at least an hour from when you last passed urine. Now pass the very first hit of your urine into the clear plastic bottle. Fill the bottle at least three quarters full.

Beplace the cap on the bottle, making sure that it is tight. Wips the outside of the bottle with tissue to make sure it's dry

Put the bottle in the yellow cardboard tube and replace the plastic stoppers to both ends.

Place the yellow tabe in the clear plastic bag (with your completed form) and seal the bag. Place the bag in the pre-addressed plantic envelope and seal it by peeling off the strip and closing the adhesive flap.

Post the envelope in any post best. You don't need a stamp - the postage has already been paid. Please post the envelope as som as possible after giving the urms sample.

YOUR TEST RESULT

We should receive your result within a couple of weeks. Most people can expect not to have chiamydia.

If this near shows that you that Chass champing, we will part the world by you if the address we have great in this down not have in the your house white the down not have in the your house white the down not have in the your house white the source as a mail the world. Parameters within a great he white to be only you within a second he will be down you down would be supplying

If the loss already due was do have through a Masse car banch Advance will sampling was due with the abirs to tell year whose rout can per contrast, and advance period can per contrast.

Romanilor treatmont is easy first, effortive and painters. The writ's seen prod to see a destar!

Appendix 5

Chlamydia Testing Kit • 25 box display unit



Contents of the Chlamydia testing kit



- 1. Idahl A et al, "Demonstration of *Chlamydia trachomatis* IgG antibodies in the male partner of the infertile couple is correlated with a reduced likelihood of achieving pregnancy". *Human Reproduction* Vol. 19, No. 5, May 2004.
- 2. Oliver T, "Prostate cancer: identifying the 'tiger tumours'" Men's Health Journal Vol 1 no. 3, 2002.
- 3. Health Protection Agency. Chlamydia information pages at <u>www.hpa.org.uk/infections</u>.
- 4. The Chlamydia Research Office, A Pilot Study of Opportunistic Screening for Genital Chlamydia Trachomatis in England (1999 2000). (Department of Health, London 2000).
- 5. McKay et al, "Genital Chlamydia trachomatis infection in a subgroup of young men in the UK". The Lancet 361, 2003.
- 6. LaMontagne et al, "Establishing the National Chlamydia Screening Programme in England: results from the first full year of screening". Sexually Transmitted Infections 2004.
- 7. Chief Medical Officer's Expert Advisory Group, Chlamydia Trachomatis: Summary and Conclusions of the CMO's Expert Advisory Group. (Department of Health, London 1998).
- 8. Department of Health, The National Strategy for Sexual Health and HIV. (Department of Health, London 2001).
- 9. Department of Health, The National Strategy for Sexual Health and HIV Implementation Action Plan. (Department of Health, London 2002).
- 10. Visit http://www.dh.gov.uk/assetRoot/04/08/60/40/04086040.pdf to see the full list of PCTs covered.
- 11. Adams et al, "Chlamydia trachomatis in the United Kingdom: a systematic review and analysis of prevalence studies". Sexually Transmitted Infections 2004.
- 12. Scott G, "Testing for chlamydia" Men's Health Journal Vol 2 no. 2, 2003.



Men and Chlamydia Project Final Report

Published by:

The Men's Health Forum Tavistock House Tavistock Square London WC1H 9HR

Tel: 020 7388 4449 Fax: 020 7388 4477

Email:office@menshealthforum.org.ukWeb:www.menshealthforum.org.ukWeb:www.malehealth.co.uk

March 2005

The mission of the Men's Health Forum (MHF) is 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.

Our vision is a future in which all boys and men in England and Wales have an equal opportunity to attain the highest possible level of health and well-being.

We aim to achieve this through:

- Policy development
- Research
- Providing information services
- Stimulating professional and public debate
- Working with MPs and Government
- Developing innovative and imaginative projects
- Professional training
- Collaborating with the widest possible range of interested organisations and individuals
- Organising the annual National Men's Health Week

The Forum's mission, vision, values and beliefs statement can be read in full at www.menshealthforum.org.uk

Registered Office as above. A registered charity (No 1087375). A company limited by guarantee (No 4142349 - England).