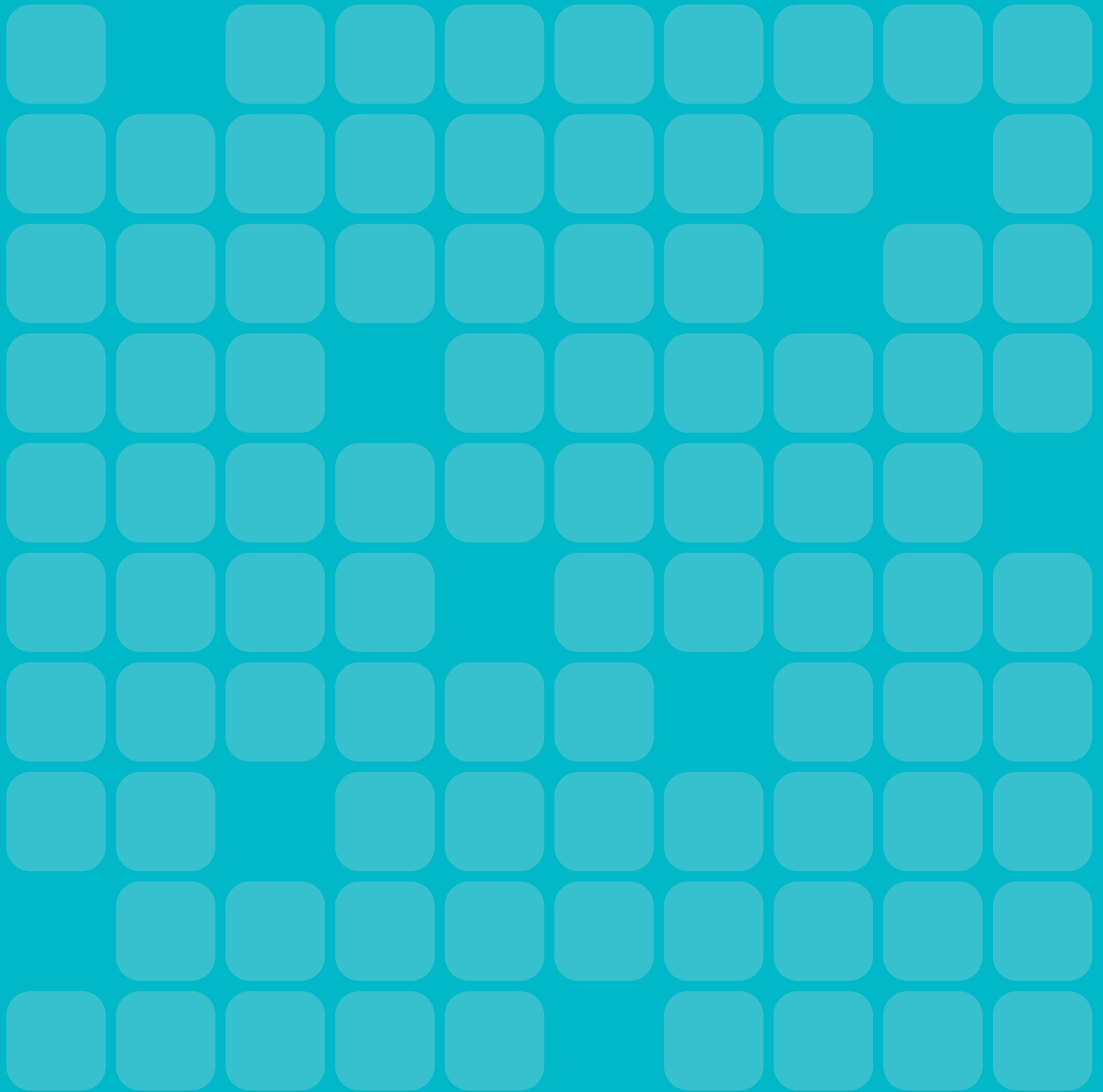


MEN'S HEALTH FORUM REPORT ON
MEN AND CHLAMYDIA

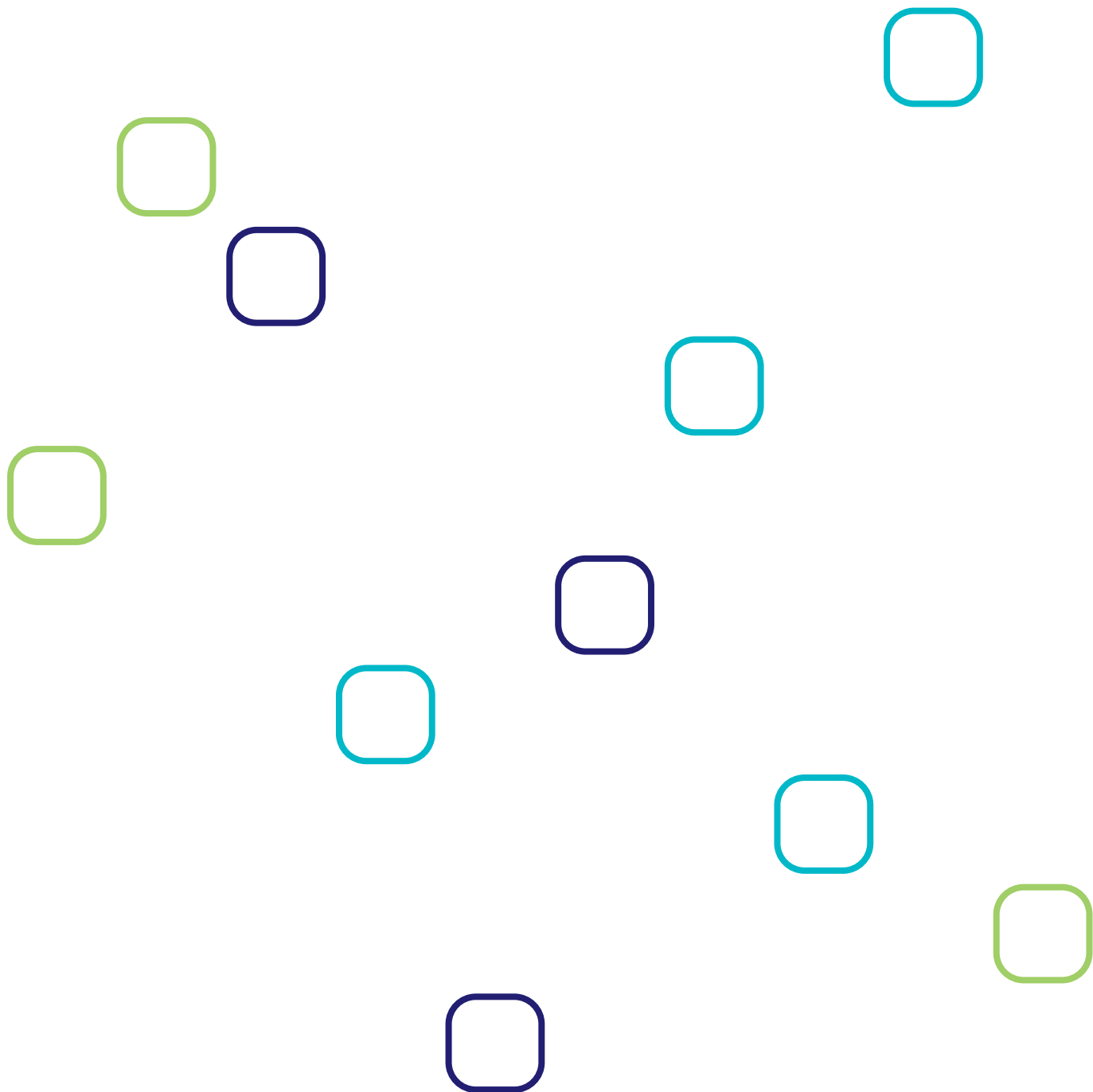
PUTTING MEN TO THE TEST

...up to one in ten sexually active young people now infected.





The number of young people diagnosed with chlamydia has more than doubled over the last ten years...



MEN'S HEALTH FORUM REPORT ON
MEN AND CHLAMYDIA

PUTTING MEN TO THE TEST

...up to one in ten sexually active young people now infected.

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“There are probably 5,000 or 10,000 cases of people needing IVF treatment because they have had chlamydia problems in the past.”

Professor Bill Ledger, University of Sheffield



PUTTING MEN TO THE TEST

Chlamydia is a serious and growing health threat. Unless people with the infection are identified and treated promptly, significant health and social costs will be incurred.

The most effective way to tackle chlamydia is to prevent infections and the Men's Health Forum (MHF) welcomes efforts to improve the prevention of sexually transmitted infections through improved public awareness and availability of barrier contraception.

We also strongly support efforts to improve the identification and treatment of people who have been infected but are concerned that the numbers of men currently being screened are far too low. Unless a higher proportion of men are screened, identified and treated, there is a danger that they will simply re-infect women.

It is critical that more men are tested and treated in order to tackle the chlamydia epidemic. We want to

help identify practical ways to increase the number of men screened for chlamydia as part of the National Chlamydia Screening Programme (NCSP).

For this reason, we have conducted an analysis of the NCSP and have developed several practical suggestions to make the screening of men far more effective.

As part of this process the MHF has brought together an expert group of sexual health stakeholders (see appendix 1) to consider the issue and help to develop the MHF's recommendations for cost-effective actions to raise male screening levels.

KEY RECOMMENDATIONS

- 1. ENTRENCH BEST PRACTICE** - The DH should commission the Health Protection Agency (HPA) to conduct a detailed audit of screening offices to find out what strategies they use to target men and then develop and disseminate this best practice. The HPA should develop a 'men and chlamydia' strategy and the DH should ensure that local screening offices follow it.
- 2. INVEST IN TRAINING** - The HPA should use the opportunity of the roll out of phase 3 of the National Chlamydia Screening Programme to educate screening offices about the importance of targeting men.
- 3. MAKING THE MOST OF PHARMACIES AND THE BOOTS PHARMACY PILOT** - Pharmacists should seek out opportunities to work in partnership with chlamydia screening offices and the independent sector to explore ways to screen more men. Further consideration should be given to how the chlamydia testing kits made available in the Boots pilot project in London are promoted and made available in pharmacies in order to increase the number of men tested. An explicit aim of future pilots should be to explore ways to encourage young men to opt for Chlamydia testing.
- 4. PRIORITISING SEXUAL HEALTH SERVICES IN LOCAL HEALTH DELIVERY** - The DH should carry out an audit of Primary Care Trust Local Delivery Plans (LDPs) to help ensure that a commitment on chlamydia screening among 15 - 24 year olds is included in all LDPs for 2006/07 and 2007/08.
- 5. TARGET FOR SCREENING MEN** - The DH should aim for 50% of NCSP screens to be of men. This is equitable and allocates responsibility for the STI equally between the sexes. The DH should aim for the NCSP to achieve this target in two years - by Summer 2008.

“The problem...is that women go for treatment, receive it and then go out and have sex with the guys who infected them in the first place. That does not make sense.”

Public Health Minister, Caroline Flint MP

CHLAMYDIA IN CONTEXT

Levels of chlamydia in young people have now reached epidemic levels. The number of young people diagnosed with chlamydia has more than doubled over the last ten years and evidence suggests that up to one in ten sexually active young people are now infected. Chlamydia is the most common STI diagnosed at GUM clinics.

As a result, the Public Health White Paper *Choosing Health: Making healthier choices easier* has identified sexual health as a new priority area. The White Paper announced additional funding and a stronger commitment to accelerate the roll out of the NCSP nation wide.

The NCSP has made good progress in raising the level of screening overall. However, the NCSP needs to make a step change in the number of screens undertaken due to the sheer scale of the problem. The danger is that without screening large amounts of men, not enough people overall will be tested and treated - and so infection rates will grow.

According to the *National Chlamydia Screening Programme Report 2004/05*¹, only 12.5% of those tested by the NCSP were men. It is vital however to ensure that men are pro-actively targeted by the NCSP in order for the programme to achieve its aims.

The reasons to invest in innovative screening methods and to target men are twofold:

- Screening offices need to raise the volume of screens significantly if they are to meet the best practice aim of screening 50% of their target audience² (sexually active men and women under 25). Screening 50% of the target audience is a necessary objective given the sheer scale of the problem, but it is unlikely that this will be achieved without screening significant numbers of men.
- One of the NHS' priorities for 2006/07 is "to deliver the 2006/7 LDP trajectories so that by 2008 everyone referred to a GUM clinic should

have an appointment within 48 hours". Improved screening in non-traditional settings is a key way to raise screening and treatment levels overall and so contain, and then reduce, the incidence of chlamydia in the medium term. As chlamydia is the number one STI that GUM clinics deal with, this will go some way to reducing their workload. Increased NCSP screening may lead to more treatment in GUM clinics in the short term, but not significantly as 75% of treatments take place outside of GUM clinics.

The gender equality duty for public bodies will come into force in April 2007. The duty will require public authorities to pay due regard to promoting gender equality and means that the NHS will have to design services that meet the particular needs of men and women. The current NCSP is a classic example of a service that does not consider gender differences properly, as the bulk of its service is offered through general practices or family planning clinics - locations which men are generally reluctant to use. The Equal Opportunities Commission states that in order to comply with the duty, public authorities should identify gender equality goals, draw up an action plan and train staff in connection with the duties imposed by the Act. The NCSP should therefore take into account men's specific needs when designing services.

¹ NCSSG. *Looking back, moving forward. Annual Report of the NCSP in England, 2004/05*. London: DH, November 2005

² *National chlamydia Screening Programme: Phase 3 Guide, August 2005*

CHLAMYDIA - The No. 1 STI in the UK

Chlamydia, if untreated, can lead to pelvic inflammatory disease, ectopic pregnancy and infertility in women years after they are infected. Complications among men with untreated infection include urethritis, epididymitis and Reiter's syndrome (chlamydia associated arthritis).

In the UK the number of chlamydia diagnoses in GUM clinics rose by 223% (32,288 to 104,155) between 1995 and 2004. Between 2003 and 2004 alone, the number of diagnoses increased by 8.6% (95,879 to 104,155).

Importantly, the number of men diagnosed with chlamydia is increasing rapidly. Indeed, the number of heterosexual men diagnosed with chlamydia

increased by 13% (40,956 to 46,099) between 2003 and 2004 alone.

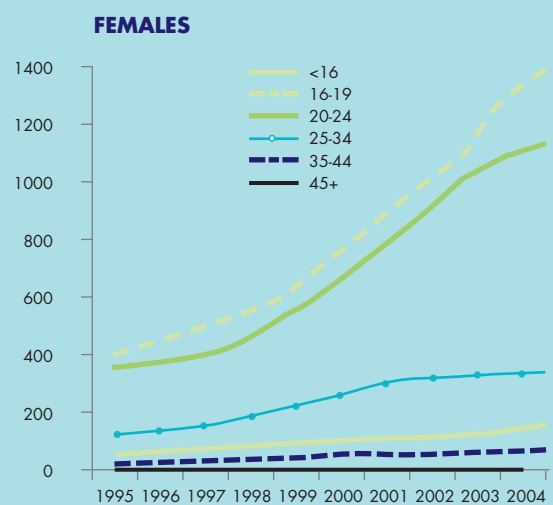
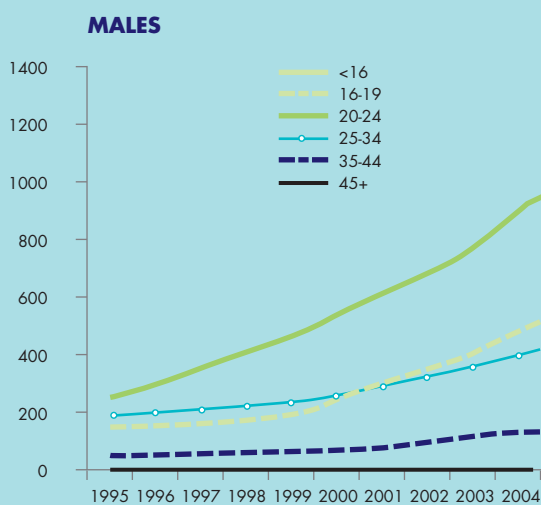
The chart below³ shows that the positivity of screens in men and women is very similar. As young men are at the same risk as women, and can easily pass the infection on to them, it makes sense for there to be an equitable investment of resources and effort in screening both men and women.

³ Diagnoses of selected STIs by region, sex and age group; United Kingdom: 1995 – 2004. Health Protection Agency

“Chlamydia diagnoses have more than doubled in the last ten years, It is a public health crisis”

Professor George Kinghorn, Member of the Government's Independent Advisory Group on Sexual Health and HIV

RATES OF DIAGNOSES OF UNCOMPLICATED GENITAL CHLAMYDIAL INFECTION BY SEX AND AGE GROUP, GUM CLINICS, UNITED KINGDOM: 1995 - 2004



Data source: KC60 statutory returns and ISD(D)5 data

PUTTING MEN TO THE TEST

THE SILENT CAUSE OF INFERTILITY

The Department of Health has recognised that tackling chlamydia is a high priority in its sexual health strategy. Reducing levels of infection is a public health priority, not only because chlamydia cases are threatening to overwhelm GUM clinics, but also because of the very serious long term problems that chlamydia can cause if left untreated.

The key problem with chlamydia is that infection may not result in any visible symptoms. It is asymptomatic in 70% of women and 50% of men, so it often goes undiagnosed. Perhaps the biggest threat from chlamydia is that 10-40% of untreated infected women develop pelvic inflammatory disease (PID). PID affects the uterus, ovaries and fallopian tubes. Over time, this causes irreparable scarring of the fallopian tubes, which can lead to infertility. Up to one in five women who develop PID will consequently become infertile and the risk of ectopic pregnancy greatly increases. It is because the damage caused by chlamydia only manifests itself years later that the STI represents a ticking time bomb for the women infected.

Quite apart from the profound distress caused to the affected individuals, increasing chlamydia infection

will result in added costs for and burden on the NHS. The Department of Health has estimated that by helping reduce the incidence of infertility, which can occur by leaving chlamydia untreated, chlamydia screening can ultimately save the NHS over £100 million per year in treatment.⁴

Clare Brown, the Chief Executive of Infertility Network UK has welcomed the Department of Health's focus on chlamydia screening, commenting:

"We welcome any move towards more preventative measures for causes of infertility, including fertility problems caused by sexually transmitted diseases. We believe this additional funding will be cost effective in the long term and might prevent many hundreds of couples each year having to seek fertility treatment in order to conceive."

⁴ Official Report, Col 100 WS, 15 March 2006

" The Chlamydia Screening Programme will...help reduce the incidence of infertility...and will ultimately save the NHS over £100 million per year in treatment"

Public Health Minister, Caroline Flint MP



Infertility Network UK has stated that chlamydia is a major contributing factor to infertility. Some infertility experts believe that the rising level of chlamydia infections will contribute to a serious increase in infertility.

For instance, in an episode of Panorama entitled 'Love Hurts', broadcast in November 2005, Professor Bill Ledger, a leading infertility expert at the University of Sheffield, said:

"There are 30,000 IVF treatments a year in Britain now, and chlamydia is responsible for a quarter or a third...There are probably 5,000 or 10,000 cases of people needing IVF treatment because they have had chlamydia problems in the past."

The Public Health Minister Caroline Flint MP acknowledged in an interview with Panorama that Ledger "could be right". The Minister said:

"I'm not denying the extent of the problem with chlamydia and its consequences, but we have a strategy in place [the Government's new screening programme, aimed at getting all sexually active 16- to 24-year-olds tested for chlamydia] to tackle the issue head-on."

Fertility treatment is expensive, costing an average of £5,000 a cycle, and only has a 23% success rate. It is difficult to produce accurate statistics in this area, as it could take approximately a decade for the damage caused by chlamydia to young people to manifest itself in infertility. Based on Professor Ledger's estimates however, £25 million to £50 million may be being spent on IVF treatment courses annually as a result of chlamydia. This does not include additional costs to the NHS such as infertility testing and counselling.

Investing a modest amount in chlamydia screening and testing now could save the NHS tens of millions of pounds in infertility costs in the future, as well as preventing much human heartbreak. As Dr Howard Stoa MP, the Chair of the All Party Parliamentary Group on Men's Health, said in a Commons debate on sexual health, *"The Government could save significant money simply on infertility treatment services, by directing money at a much earlier stage to chlamydia screening services."*⁴

Increased chlamydia screening is vital to help prevent today's young people from becoming tomorrow's infertility clinic patients.

⁴ Official Report, Col 339WH, 9 February 2006

"Chlamydia is a major contributing factor to infertility"

Infertility Network UK

CHLAMYDIA AND HIV

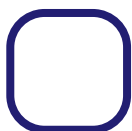
The consequences of chlamydia are not limited to pregnancy. Untreated chlamydia may make a person with HIV more infectious as chlamydia can cause breaks in the mucous membranes of affected areas, and increases the number of HIV-infected cells in those areas.

Having chlamydia can also make it more likely that an HIV-negative person will be infected with HIV if they are exposed to the virus. Research has shown that women infected with chlamydia are three to five times more likely to acquire HIV if exposed to the virus.

Some groups, most notably young women or men who have sex with men, are more likely to be infected with chlamydia and it is important that the NCSP targets these hard to reach groups. Some good work is already being done in this regard.

For instance, the Coventry chlamydia screening office is working with the Terrence Higgins Trust (THT) to target commercial sex workers and men who have sex with men. THT hold drop-in sessions throughout the week, for sex workers to come in and address issues around their sexual health, as well as going out into the community two nights a week. Like infertility, a relatively small investment in chlamydia screening could pay for itself in the long term by reducing the incidence of, and the cost of treating HIV.

Increased chlamydia screening is vital to help prevent today's young people from becoming tomorrow's infertility clinic patients.



“Women are the likelier of the two sexes to be treated and tested and they will only be subjected to a further threat of re-infection by the large proportion of sexually active men who do not get tested”

David Amess MP, Member of the Health Select Committee



KEY BENEFITS OF SCREENING MORE MEN

£80 million is being invested in the roll out of Phase 3 of the NCSP. The risk is that not enough value will be derived from this spending if the proportion of young men screened does not approach that of women. Indeed, only an eighth of those tested as part of the NCSP in 2004/05 were men.

Some progress has been made on testing men and provisional data suggests that by December 2005 men accounted for 17% of those screened by the NCSP.⁶ Clearly, contact tracing and partner testing is important and this action is in fact included in the NCSP's clinical performance indicators. However, the NCSP needs to organise more opportunistic screening of men to make a real impact on the spread of chlamydia.

The reasons to invest in innovative and pro-active initiatives that are attractive to men but are also open to women are threefold.

1. PREVENTING MEN FROM RE-INFECTING WOMEN

The NCSP will be seriously undermined if men who are infected with chlamydia continue to infect women because of the asymptomatic nature of the disease in men. Indeed, women could be screened and treated by the NCSP, only to be re-infected by men. Public Health Minister Caroline Flint MP has herself acknowledged that:

"...we should consider the gender take-up, in case we are not catching men. The problem, which I have heard many times, is that women go for

*treatment, receive it and then go out and have sex with the guys who infected them in the first place. That does not make sense."*⁷

Current guidance and best practice suggests that screening offices should reach 50% of their target population (sexually active people under 25).⁸ In 2003/04 across both phase 1 and phase 2 programme areas, only 4.3% of sexually active people under 25 years of age accepted screening within the NCSP. Even those programme areas achieving the highest proportions screened only 11.8% in the same period. It is clear that it will be very difficult for screening offices to achieve the 50% best practice objective unless they achieve a step change in the number of men screened.

Although a 50% target may seem ambitious, this needs to be considered within the context of the ballooning levels of chlamydial diagnosis. Unless something approaching 50% of screening offices' target audience are screened, and those found positive are treated, it is difficult to see how the rising tide of chlamydia can be reversed.

⁶ Official Report, 15 March 2006: Column 2320W

⁷ Official Report, 9 Feb 2006: Column 360WH

⁸ Performance Measures for the National Chlamydia Screening Programme, October 2005, HPA and Department of Health

"We are reaching only a small proportion of men who are potentially at risk (through the NCSP)"

Dr Howard Stoute MP, Chair of the APPG on Men's Health

A slightly higher proportion of men than women tested by the NCSP are diagnosed with chlamydia. According to the NCSP Annual Report 2004/05, 11% of women who were screened for chlamydia tested positive whereas 12% of men tested positive. The group with the single highest rate of positivity were 20 - 24 year old men with a positivity rate of 14%.

The Operating Framework for 2006/7 for the NHS in England, published in January 2006, set out specific service priorities for the NHS in 2006/07. One of the six is "to deliver the 2006/7 LDP trajectories so that by 2008 everyone referred to a GUM clinic should have an appointment within 48 hours". This is a challenging target as the workload of GUM clinics has soared in recent years.

CHLAMYDIA POSITIVITY BY GENDER AND AGE IN NCSP SCREENS, 2004/05

Total men	12%
Total women	11%
Men aged 20 - 24	14%
Women aged 20 - 24	9%

Screening areas will only be able to achieve this step change by thinking carefully about the specific ways in which men need to be targeted. Men are a group that is hard to reach by traditional services and they require a different approach if they are to be tested in sufficient numbers. Men do not readily visit the majority of NCSP venues – family planning clinics and general practices – but are often willing to take part in other events such as health 'MOTs' or an occupational health programme.

Screening offices are exploring a number of different methods to reach men. The key point is that the NCSP in general, and screening offices in particular, need to systematically amend their practices to be more gender-sensitive if they are to stand a realistic chance of hitting the 50% target.

2. INCREASE CHLAMYDIA SCREENING TO RELIEVE BURDEN ON GUM CLINICS

Sexual health has been identified as one of the top six priorities for the NHS in 2006/7.

The workload of GUM clinics has almost doubled from 1.14 million items of service (diagnoses and meetings with clients) in 2000 to 2.25 million items of service in 2004 - and continues to rise.⁹

The ambition of the target can be seen in the fact that the most recent survey of GUM clinics (November 2005) showed that only 49% of attendees were seen within 48 hours. It also showed that 21% of attendees were not seen within two weeks.¹⁰

Given that chlamydia is the most commonly diagnosed STI it is clear that tackling the chlamydia epidemic is a crucial way to reduce the burden on GUM clinics. The MHF believes that an accelerated development of opportunistic testing in 'male friendly' locations such as colleges, military bases or workplaces will allow the NCSP to boost the volume of screens overall and, within that, increase the number of males screened. The potential of pharmacies to improve uptake by men is being explored and, if successful, should be added to this list of male friendly locations to be included in the NCSP.

⁹ Official Report, Col 758W, 1 March 2006

¹⁰ Official Report, Col 264W, 21 March 2006

Increased screening volumes may lead to increased treatment in GUM clinics in the short term. According to the NCSP Annual Report 2004/05 however, less than a quarter (1,300 people) of those who were diagnosed with chlamydia through the NCSP were treated at GUM clinics. In fact, two thirds of those who tested positive for chlamydia were treated either in their local chlamydia screening office (2,547) or a contraception clinic (1,225). It is likely therefore that raising NCSP screening levels by targeting men, and then working hard to treat them outside of GUM clinics, will go a long way to alleviating the pressure on GUM clinics and help them meet their target.

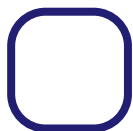
3. MEN HAVE AN EQUAL DUTY TO PREVENT CHLAMYDIA - AND AN EQUAL RIGHT TO TESTING CONVENIENT TO THEM

Although there are strong clinical reasons for chlamydia screening to target men, there are important gender equality reasons as well. Encouraging men to opt for testing helps make sure that sexual health policy avoids placing all the responsibility for stopping the spread of chlamydia onto women. If chlamydia screening in particular,

and sexual health services in general, are primarily focused on and used by women there is a risk that men, and perhaps society, will feel that it is primarily women's responsibility to get tested and treated.

It is very important that both sexes feel that they have a equal sense of responsibility to the wider community to prevent chlamydia from spreading. Not targeting men loads this responsibility unfairly onto women, and contributes to an overall perception that health services do not take men's health seriously. The converse of this is that making it easy for men to test themselves can be seen as a first step to educating them about sexual health more generally and helping them to make better use of the NHS overall.

It may be easier to screen women, but health services have a duty to men as well, as they are also at risk of health problems as a consequence of chlamydia. For these reasons, and given that equal amounts of men as women have chlamydia, it is fair for the NCSP to aim for an equal proportion of tests and treatment to be from each sex.



“What I am describing is one of those situations in which a relatively small amount of money up front can have a beneficial long term effect. The cost will be contained, not continuing”

Dr Howard Stoa MP

“We will have at the cornerstone of the drive for better sexual health a systematic campaign to reduce the incidence of chlamydia”

Choosing Health White Paper, November 2004



SCREENING TO DATE – A good start, but a lot more to do

Chlamydia screening in England is currently made up of 26 programmes that cover 25% of all PCTs and offers opportunistic screening to asymptomatic sexually active men and women under 25 years of age.

In Phase 3 the NCSP is being rolled out to the remaining 75% of PCTs in England and 80 chlamydia screening offices will be set up.

Part of the reason for the low take-up of screening by men to date, is the locations where screening is offered. In 2004/05 screening was offered in 539 family planning clinics and general practices, but only 195 young person's clinics, military bases, prisons and universities. The chart below¹¹ shows how current NCSP screening locations are heavily weighted towards more 'female friendly' locations.

Of course, men are able to go to general practices and family planning clinics, but they are much less likely than women to do so. Under the age of 45, men visit their GP only half as often as women. It is only in the elderly that the gap narrows significantly – and even then women see their GP measurably

more frequently than men.¹² Many individual screening offices are reaching out to men using a variety of innovative settings. However, more work needs to be done to encourage this to take place across the country.

It had been hoped that making chlamydia testing kits available in pharmacies (currently being piloted for two years by Boots in London) would increase the number of tests taken by men. The Boots pilot is an innovative and exciting development and has the potential to make it much easier for both men and women, but especially men, to pick up testing kits in a convenient and non-embarrassing way. However, the early results are not encouraging. Boots has stated that in the first month of the pilot 79% of the kits were given to women and only 21% to men.

¹¹ NCSSG. *Looking back, moving forward. Annual Report of the NCSP in England, 2004/05.* London: DH, November 2005

¹² Office for National Statistics. *General Household Survey 2003.*

NUMBER AND TYPE OF DIFFERENT SCREENING VENUES, PHASE 1 AND 2, NCSP, 2004/05

General Practice	309
Family planning clinic	230
Young person's clinic	99
University / college	67
Antenatal / infertility	63
Other	45
Chlamydia screening office	17
Prison	15
Military base	14

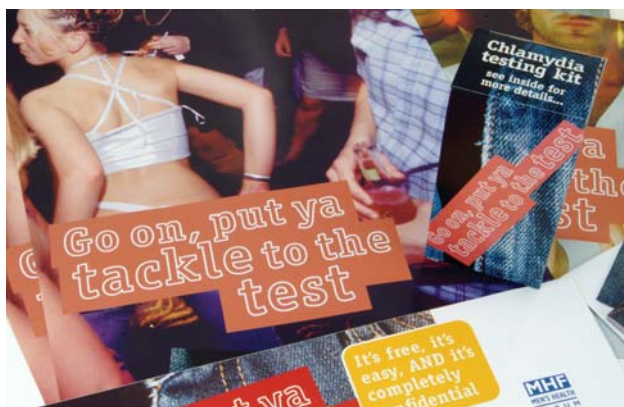
SCREENING MEN – The way forward

1. THE MEN AND CHLAMYDIA PROJECT 2002-04

It is defeatist to assume that there are no ways to influence young men. The Men's Health Forum has taken the lead in exploring ways to increase male screening rates and managed a ground-breaking men and chlamydia campaign with Telford and Wrekin PCT.¹³ The campaign, part funded by the DH, aimed to find ways to encourage young men to have themselves tested for chlamydia. In the project, urine testing kits and health promotion literature were provided in six work places in Telford and men were invited to return their urine samples to a local laboratory.

The key conclusions of the project were that:

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



Publicity material used in the Telford and Wrekin PCT pilot

- Strategies predicated on appealing to a sense of responsibility are less likely to succeed than strategies based on acceptance of young men 'as they are'.
- 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.
- 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.

“We need extra support and advice in setting up a urine postal service as we are struggling to set this up”

Screening area manager

PUTTING MEN TO THE TEST

So, the MHF and its partners have already developed some useful ideas and recommendations on how to attract men to take part in chlamydia screening initiatives that the DH ought to develop further. The Institute of Health and Community Studies at Bournemouth University has recently completed an independent evaluation of the project.¹⁴ The key findings of the evaluation were:

- **KNOWLEDGE OF CHLAMYDIA** - Young men in the workplaces included in the MHF project indicated during interviews that they were already aware of the STI through sexual health programmes in schools.
- **WORKPLACE ACCESS** - 97% of young men felt that it was a good idea to have access to the chlamydia testing kits in the workplace.
- **TAKING THE TEST** - There was a very high level of satisfaction with the actual practicalities of taking and administering the test.
- **IMPORTANT TO BE FREE** - A strong point of the campaign was that testing kits were free at the point of use. While they might pay if they felt they had an infection, the fact that the test was free was a strong motivating factor in taking part.
- **EMBARRASSMENT FACTOR** - The most embarrassing part was the actual 'picking up' of the testing kits in the changing rooms or staff toilets.

The key overall finding is that if chlamydia testing is made easy, efficient and relevant to men, then many more will test themselves. Of the 400 people who took the chlamydia test in the Telford and Wrekin PCT pilot, almost 80% were male.

2. CHLAMYDIA SCREENING OFFICES

One of the most positive aspects of the NCSP is that individual screening offices have scope to experiment and explore ways to improve screening rates. Some screening offices have made great strides in targeting men. For example, in the Durham screening area over 40% of those screened are men. However, too many screening offices are not making similar levels of progress, affecting their ability to reach their overall screening targets.

The chart on the next page shows the wide variation between the proportion of men screened by each screening office in 2004/05. Disappointingly, in half of the screening areas fewer than one in ten of those screened were men.¹⁵

The MHF has surveyed a number of screening offices that screen a high proportion of men and these have reported that large numbers of male screens will only be achieved through events or testing locations that are developed specifically with men in mind. The screening offices surveyed managed to screen large number of men by offering testing at a wide range of 'male-friendly' locations such as pharmacies, young person's clinics, military bases, prisons, colleges, gyms, sports venues and occupational health schemes.

¹³ *The Men and Chlamydia Project 2002–2004, Men's Health Forum*
http://www.menshealthforum.org.uk/userpage1.cfm?item_id=1533

¹⁴ *Men and chlamydia campaign findings, Institute of Health and Community Studies, Bournemouth University, February 2006*

¹⁵ *Official Report, Col 2320W, 15 March 2006*

In the majority of screening areas fewer than one in ten of those screened were men.

TABLE RANKING NATIONAL CHLAMYDIA SCREENING PROGRAMME AREAS BY PROPORTION OF MEN SCREENED
APRIL 2004 TO MARCH 2005

PROGRAMME AREA	MALES	FEMALES	TOTAL	PROPORTION OF SCREENS THAT ARE MALE
Durham	488	712	1,200	40.6%
Winchester	400	1,112	1,512	26.4%
Hull	982	3,060	4,042	24.2%
Cornwall	745	2,485	3,230	23.0%
Leeds	721	2,474	3,195	22.5%
Brighton	434	1,707	2,141	20.2%
Slough	134	558	692	19.3%
Luton	136	651	787	17.2%
East Kent	208	1,073	1,281	16.2%
Lambeth / Southwark / Lewisham	1,187	7,760	8,947	13.2%
Brent and Harrow	83	590	673	12.3%
York	141	1,065	1,206	11.6%
Birmingham	412	3,149	3,561	11.5%
East Cheshire	139	1,373	1,512	9.1%
Coventry	22	248	270	8.1%
Liverpool	570	7,580	8,150	6.9%
Norfolk	23	313	336	6.8%
Sheffield	111	1,543	1,654	6.7%
Portsmouth	260	3,712	3,972	6.5%
Nottingham	318	4,876	5,194	6.1%
Wirral	166	2,745	2,911	5.7%
Stoke	27	458	485	5.5%
Southend	75	1,544	1,619	4.6%
Camden and Islington	145	3,623	3,768	3.8%
West Cheshire	8	494	502	1.5%
Enfield	0	431	431	0
TOTAL	7,935	55,336	63,271	12.5%

PUTTING MEN TO THE TEST

The screening offices stressed the need to proactively seek out events where men are likely to be well represented. Chlamydia screening programme managers have said:

- “The key appears to be taking the test to men and not waiting for them to come to us.”
- “Taking the testing to men [works] as they do seem apathetic about their own health but if they fall over it they are always willing to take part.”

This small survey gave a number of examples of how screening offices have successfully screened more men. These included screening men at military bases, organising holistic health events where men take health MOTs, using men’s sexual health promotion experts, using men’s health clinics and making good use of events. One programme manager said: “we find our events really important in generating a high volume of screens.”

Another used local radio to advertise postal kits.

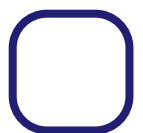
Other typical responses on screening men were:

- “We find screening events at universities and colleges are very popular with males and we actually screen more males than females in these locations.”
- “Screening in colleges and university is always popular with men. The postal service is available via e-mail or telephone request and again is popular, accessible and non-threatening for young men.”

The key point however is that *none* of these screening offices were offered any specific support or guidance on how to target men and would have really valued it. One manager said they would have appreciated “knowing what other programmes have done and whether it has been successful.”

Another programme manager commented: “we need extra support and advice in setting up a urine postal service as we are struggling to set this up.” Training is also key: “Most importantly you need highly trained, committed, personable staff.”

So, even those screening offices that are leaders in screening men need extra support to target them. All offices should receive advice on this aspect of screening and be made aware of best practice that has already been developed. The NCSP cannot afford for the lessons already learned to be lost.



“The key appears to be taking the test to men and not waiting for them to come to us”

Screening Area Manager

KEY RECOMMENDATIONS

To help the DH tackle the chlamydia epidemic, the MHF makes the following recommendations:

1. ENTRENCH BEST PRACTICE

- The DH should commission the Health Protection Agency (HPA) to conduct an audit of screening offices to find out what strategies they use to target men. An MHF audit of screening offices conducted in February 2006 shows that some already work hard and use innovative methods to target men.
- The HPA should develop and disseminate this best practice. Best practice could be disseminated simply and efficiently in, for example, the NCSP newsletter or co-ordinator workshop.
- A 'men and chlamydia' toolkit, giving examples of male friendly venues and ways of targeting men, could be sent to all screening offices.
- The HPA should develop a 'men and chlamydia' strategy and the DH should ensure that is followed by all local screening offices.

2. INVEST IN TRAINING

- The HPA should use the opportunity of the roll out of phase 3 of the National Chlamydia Screening Programme to educate screening offices about the importance of targeting men.
- The NCSP training co-ordinator should integrate gender sensitivity into relevant training tools and supplies provided to screening offices.
- The HPA has made good progress in hiring a training manager and should ensure that the national training programme stresses the importance of targeting men and gives high quality advice on how screening offices can achieve this.

3. MAKING THE MOST OF PHARMACIES AND THE BOOTS PHARMACY PILOT

- Pharmacists should seek out opportunities to work in partnership with chlamydia screening offices to offer confidential consultations and testing.
- Pharmacists and screening offices should also seek out opportunities to work with private sector suppliers and the voluntary sector to explore ways to screen more men.
- The early results of the Boots chlamydia testing kit dispensing pilot are not encouraging in terms of uptake among men. The results from the first month of the pilot (November 2005) show that 79% of the kits were given to women and only 21% to men.



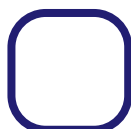
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- More thought needs to go into how the testing kits are advertised, displayed and made available in pharmacies in order to increase the number of men tested.
 - Boots should produce an action plan showing how it intends to target men.
 - The DH should evaluate the Boots pilot on how successful it has been in encouraging young men to take and return, chlamydia testing kits.
 - Boots should publish regular updates showing how many people, broken down by gender and age, have taken, and returned, the testing kits.
 - An explicit aim of future pilots should be to explore ways to encourage young men to test themselves for chlamydia.

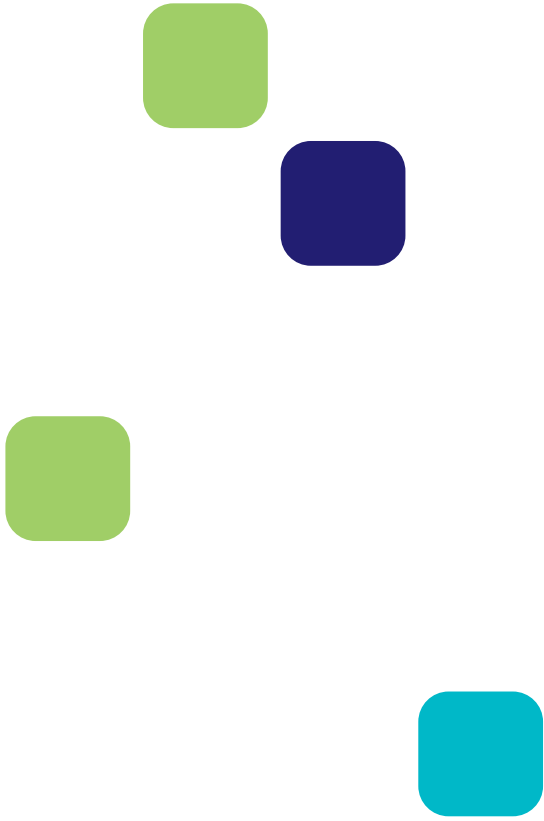
4. PRIORITISING SEXUAL HEALTH SERVICES IN LOCAL HEALTH DELIVERY

- The DH should carry out an audit of Primary Care Trust Local Delivery Plans (LDPs) to help ensure that a commitment on chlamydia screening among 15 - 24 year olds is included in all LDPs for 2006/07 and 2007/08.
- Although increasing the uptake of chlamydia screening is a key Public Service Agreement, research by Brook, fpa, MedFash, NAT and the Terrence Higgins Trust published in January 2006 showed that 23% of LDPs do not even mention chlamydia.

5. TARGET FOR SCREENING MEN

- As of January 2006 only a fifth of those screened by the NCSP are men. However, the Durham screening office has achieved a male screening rate of at least 40%.
- The DH should aim for 50% of NCSP screens to be of men. This is equitable and allocates responsibility for the STI equally between the sexes.
- The DH should aim for the NCSP to achieve this target in two years – by Summer 2008.





APPENDIX 1 – Sexual Health Stakeholders

The Men's Health Forum has consulted the following stakeholders with an expertise in health and equality issues in drawing up this report's recommendations. The views in the report are those of the MHF and do not necessarily represent those of the organisations shown below.



Diagnostics



Royal
Pharmaceutical
Society
of Great Britain



Telford and Wrekin  Medical Foundation for AIDS & Sexual Health (MedFASH)
Primary Care Trust





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PUTTING MEN TO THE TEST

