spectra 87

Male health

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«Checkpoints» to become gay health centres

Queer health. Not only is HIV and other sexually transmitted infections (STIs) prevalence higher in average among gay men than in the general population, but their general health is much poorer too. To counterbalance this trend, five health centres designed to respond specifically to gay men's needs are to be set up in Switzerland.

The «Santé Gaie» («Gay Health») study carried out by Dialogai Geneva and the University of Zurich, and the GAYSURVEY conducted by the University of Lausanne every four years, highlight the relatively poor health status of gay men. Signs of a negative trend have been observed in the last few years, particularly with regard to mental health. Suicides and attempted suicides are significantly more frequent among young homosexuals than among heterosexuals of the same age. This is due to coming-out problems and discrimination by other young people or other social groups.

More psychosocial support

The Federal Office of Public Health (FOPH) has been supporting «Checkpoints» in Zurich and Geneva for the last five years. These are facilities where gays can be counselled and tested for HIV and other STIs. Since the publication of the «Santé Gaie» study, the Checkpoints have extended their exclusively disease-related services to include health-promoting elements, such as psychosocial care.

This development is now to go even further, with a network of five gay health centres in Basel, Berne, Geneva, Vaud and Zurich being envisaged. They will offer comprehensive gay-friendly healthcare and health promotion services to the approximately 5% of the Swiss male population who are gay. Just as women prefer to go to female gynaecologists, gay men feel that that their problems are more specifically addressed and dealt with at gay-friendly facilities where they usually encounter greater knowledge and understanding of their situation.

Effective approaches at the Zurich Checkpoint

But what kind of services would such gay health centres provide? The Zurich Checkpoint has already made considerable progress towards becoming a gay health centre, developing many interesting services that could be a model for further centres.

- Voluntary counselling and testing (VCT): Zurich Checkpoint is one of twelve centres in Switzerland that offer voluntary rapid testing, and also risk assessments, counselling and support using a uniform, Internet-based tool.
- Queer+: This is a three-day course at which people recently diagnosed with HIV, along with their partners, receive support and information on the topics of medicine/treatment, legal issues, insurance aspects and psychosocial problems. The aim of the course is to enable people with HIV and their partners to cope more effectively with the infection and the new challenges facing them in everyday life. In addition, they will learn how to avoid infecting others with HIV and STIs and what they can do to keep themselves healthy. The evaluation of the first course (see article in spectra no. 77) has shown that it meets a great need. But, though the course was enthusiastically rated, it was found to have little lasting impact in everyday life.

The evaluation of «Queer+» has resulted in the creation of a series of open-door services for coping with the challenges of everyday life:

- «Queer Talk» is a service targeting mental health; it focuses on the investigation of mental problems and on possible referral for psychotherapy.
- «KISS» is a group-structured service aimed at controlling drug use. It is needed because HIV and other STIs are often transmitted when people are under the influence of drugs.
- «Queer Help» group: In this group, HIV-positive experts help people recently diagnosed with HIV to become experts themselves in dealing with their positive status. With other chronic diseases, treatment is easier to self-manage. Diabetics, for instance, immediately sense when something is not right with their treatment. They can perform a brief test and, if necessary, take an additional dose of their medicine. This is not possible with HIV. If people with HIV forget to take their medicines, they do not feel anything. They cannot perform a test on themselves, nor can they change the treatment on their own. But the treatment quickly loses its efficacy if not taken regularly. So in future, iPhone apps, for instance, will help people with HIV remember to take their medicines and go regularly for check-ups.

A number of the health-related services provided by the Zurich Checkpoint is aimed at HIV-negative gays, e.g.:

- «Du-bist-Du» (You are who you are): This project uses a peer-to-peer approach in which young gays help others to come out. This approach is one of the most important in preventing suicide among young people.
- «Queer Quit»: This stop-smoking project has already helped some 60 gay men give up smoking.

Most of these services have a distinctly emancipatory character, i.e. they help people living with HIV to become experts on their own situation and that of others. The idea is that members of the «Queer Help» group will eventually assume responsibility for conducting the entire «Queer+» course. Similarly, «Queer Quit» participants who have given up smoking as a result of the course will themselves become leaders of courses on quitting smoking. Experience shows that participants learn more effectively from people who have had the same problems because they regard them as possessing greater skills in dealing with difficult situations than professionals without such experience.

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The long road to a Law on Narcotics fit for today's needs

Swiss drug policy. The revised Law on Narcotics (BetmG) and the respective ordinances are due to come into effect on 1 July 2011, finally providing a legal framework for the Swiss drug policy's «fourfold» or» four-pillar» model that has been successfully implemented over the last twenty years.

The current law on narcotics has been revised only once, in 1975, since coming into force in 1951. The purpose of that revision was to broaden the purely repressive drug policy to include prevention and treatment. But the misery and squalor of the open drug scenes and the emergence of HIV and AIDS soon necessitated a further realignment of the drug policy. In practice this resulted in the development of the successful and internationally acknowledged fourfold model, in which harm reduction was added to the existing pillars of law enforcement, prevention and treatment. This model has been largely responsible for stopping the rise in drug-related crime, reducing healthcare costs and improving the health of dependent drug users. It was first described by the Federal Council in 1991 in its First Package of Measures to Reduce drug-related Problems and then again in 1996 in the report of an expert commission. The Swiss electorate approved the fourfold model by clearly rejecting two popular initiatives, for a more restrictive drug policy (1993, «Youth without drugs») and a more liberal approach (1994, «For a reasonable drug policy – Droleg») respectively.

Success the second time round

The planned partial revision of the law on narcotics in 2001 aimed- among others - to create a legal framework for the fourfold model and the heroin-assisted treatment. With regard to cannabis, consumption was to be decriminalised and practicable regulations introduced to govern cultivation, processing and trade. In 2004, this partial revision failed to obtain the approval of Parliament, which rejected the introduction of the more liberal regime it entailed. The current partial revision of the law on narcotics includes the main features of the 2001 draft. Parliament approved the bill on 20 March 2008. The decision was contested in a nationwide referendum. But the partial revision was approved by a majority of over 68% of votes, and now the revised law on narcotics and its respective ordinances are due to come into effect on 1 July 2011.

Drawing up and anchoring the fourfold policy

One of the goals of the revision of the law on narcotics was to legally anchoring the fourfold policy. Some other important new features of the revised law on narcotics:

- the legal base for public offices and other professionals working in the field of addiction to report existing or impending addiction-related problems, particularly concerning children and adolescents, in order to ensuring the earliest possible identification of problems followed by intervention (Art. 3c)

Men play sport and women cook

Gender differences and health. Men do more sport and feel mentally healthier than women. But they display shortcomings in their eating habits and suffer more often from diet-related illnesses. These conclusions are based on current data obtained from the diet and physical activity monitoring system MOSEB.

The data reveal a number of gender differences in nutritional and physical activity behaviour, for instance in relation to certain diseases of dietary origin. According to a study conducted in the city of Geneva covering the period from 1993 to 2007, men suffer more frequently from high blood pressure, diabetes and elevated cholesterol levels than women. In the peak year 2005, the prevalence of high cholesterol was 38% in men and 33% in women. The equivalent value in 2007 was 27% in men and 21% in women. The prevalence of high blood pressure also felt in both men and women over the 15-year study period. Here, too, the values for men are higher than those for women, although the difference declined somewhat in 2006 and 2007 (men: 30%, women: 26%). A similar picture is found for diabetes treatment: with a prevalence of 3.5%, men are more likely to suffer from insulin deficiency than women (1.5%; 2007).

Don't cook much, but enjoy sports

The data do not allow elucidation of the factors responsible for men's poorer health nor the extent to which these factors are responsible. It is just clear that men devote less attention and time to their diet than women do. Shopping for food and preparing meals is an important aspect of a healthy food culture and is not only associated with diet but is also a starting point for bringing about changes in eating habits. The pilot study of the National Dietary Survey (2009) showed that over 90% of women interviewed did their own cooking «frequently» or «almost always», while only 50% of men did so. 16% of men stated that they have never ever cooked. Gender differences regarding health awareness also exist in relation to grocery shopping, with only 20% of men reading the label information on nutritional value, compared with 35% of women.

The findings for sport present a different picture. Clear gender differences favouring boys are already evident in childhood. Of the approximately 700,000 children and young people who attended a «Youth + Sport» (J+S) course in 2008, about 415,000 were boys and about 285,000 girls. (J+S is the Confederation's principal sports promotion programme for 10-20 year olds.) This distinction continues into adulthood. According to 2007 figures provided by the Swiss Observatory for Sport, membership of sports clubs is considerably higher among men than among women. Thus, 30% of 35–44 year old men are members of a sport club, compared with only 17% of women in the same age group. Fitness centres, on the other hand, are more or less equally popular among both genders at 15% for men and 16% for women. When considering these figures, however, it should not be forgotten that the large majority of people who do sport in Switzerland – for instance, jogging, swimming or cycling – do so outside of formal organisational structures.

Men tend to suffer less from mental pressures

Given men's higher level of sporting activity, it is not surprising that they enjoy better mental health than women. According to the 2007 Swiss Health Survey (SGB), there is a connection between physical activity and mental stress. The Survey shows that in all age groups the proportion of those suffering from severe to moderate mental stress is lower in men than in women. The differences are greatest in the youngest and oldest age groups, even though mental pressures decline in the course of a lifetime (except in women aged over 75, who have a relatively high value). The Swiss Health Survey also shows that women tend to be slightly less optimistic than men. In particular, the proportion of only slightly to moderately optimistic interviewees is higher among women than men (about 30% as compared with about 24%).

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MOSEB

The MOSEB diet and physical activity monitoring system is a systematic and constantly growing collection of comparable, representative data on certain diet and physical activity indicators in Switzerland. Wherever possible it draws on established data sources. MOSEB collects data on the following six topics: health literacy, eating habits, physical activity, bodyweight, state of health, general conditions and service provision.

At first hand

In 2001, Parliament established a Gender Health Office within the Federal Office of Public Health (FOPH). In 2008, the «Gender and Health» focus report was published, containing precise core statements and recommendations, with the aim of promoting equal opportunities for both genders in terms of health and the quality of services. Men and women were to benefit from healthcare provision and health promotion services adequately suited to their biological and social gender. After twenty years of gender discussion, the fact that different needs and demands exist in this regard is nowadays almost entirely uncontested.

Nevertheless, enthusiasm for gender health recently seems to be declining. For instance, women increasingly expect to be able to combine their work (or career) with family obligations, while this challenge is being made more and more difficult for men. Men are confronted with personal and societal expectations to take on a more pivotal role within the family than their fathers did. However, as work pressures also mount, the area that suffers is personal relaxation. This may seem almost stoic at first glance, but hard facts in the form of suicide rates and psychiatric inpatient statistics for men reveal the consequences.

The authorities – public wealth in general and especially public health – need to take action to turn the tide in worrying social developments of this nature. The State Secretariat for Economic Affairs (seco) and the Federal Social Insurance Office (FSIO) are setting a good example in the field of public wealth. Together, they have established an information platform on combining work and family obligations addressed to the business and political spheres and individuals. And what is happening with public health? In line with its current self-perception, the Federal Office of Public Health (FOPH) is committed to its tasks in the area of gender health: «… the FOPH puts forward suggestions … (for) … a coherent Swiss health policy … The FOPH does not allow itself to be manipulated by the various interest groups, but … (advocates) … a big-picture perspective»; the tasks of this health policy explicitly mention gender health (FOPH in Brief, 2011).

May these words be followed by actions – for the good of women and men alike.

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– the task of the Federal Council to draw up recommendations on the principles governing the funding of addiction treatments and reintegration measures (Art. 3d para. 5)
– the promotion of continuing education and professional training (Art. 3k)
– the formulation of quality assurance recommendations for the four pillars of Switzerland's drug policy (3l)
– the creation of a legal framework for heroin-assisted (diacetylmorphine-assisted) treatment (Art. 3e para. 3)
– the creation of a legal framework to enable the compassionate use treatment with cannabis (Art. 8 para. 5)
– the introduction of an obligation on the part of physicians to report the off-label use of drugs (Art. 11 para. 1bis and 2)

The respective ordinances were reorganised. The previous six ordinances and two Federal Council decisions were combined to form three new ordinances, one for the control and regulation of narcotic substances, one for the regulation of the three pillars prevention, therapy and harm reduction and the third one that lists the narcotic and psychotropic substances. The first ordinance mainly regulates the activities of Swissmedic, particularly the issue of authorisations for the «legal» use of controlled substances. It is aimed primarily at the corporate sector. Implementation of the second ordinance is largely the responsibility of the Federal Office of Public Health and is aimed primarily at institutions operating in the health sector. It lays down the principles of the fourfold model anchored in the law on narcotics and the regulations governing the substitution treatment involving the use of narcotics, particularly the separate regulations for heroin-assisted (diacetylmorphine-assisted) treatment. The third ordinance is the list of all controlled substances and their classification into directories a to e. Cannabis, for instance, has been assigned to directory d, which covers banned controlled substances.

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New platform for promoting a diversity approach in addiction

Infodrog, the Swiss Office for the Coordination of Addiction Facilities, offers a new national platform for addiction professionals to exchange experience and knowledge of «diversity in addiction work». This is an approach that takes account not only of migration and gender, but of all aspects of the complex of problems related to addiction.

Diversity management is concerned with handling human diversity. The concept originated in the equality and civil rights movement in the USA and is now widely used in corporate management. In the educational field, the term «diversity education» has become current in the last few years for an approach that takes factors such as age, socio-economic status or personal resources as well as gender and origin into account. By analogy, diversity in the field of addiction involves a holistic approach to handling the multifaceted nature of the clientele and the heterogeneity of the problems involved.

Professionalisation and differentiation

The professionalisation of addiction aid has generated a broad range of services for dealing with addiction problems in Switzerland. There are services targeting women, men, young people and both male and female migrants; preventive, harm-reduction, outpatient and residential measures; abstinence-based and substitution-based treatments, and medical, social-work and social-therapy based approaches. For a long time, a clear distinction was drawn between these categories and approaches – when they were not in fact being pitted against each other. The rigid boundaries have been blurred in the last few years, making way for a broader understanding of the nature of addiction. This development is a reaction to the realities of addiction work practice, which is now confronted with a massive increase in the problems it has to deal with (e.g. new, non-substance-related addictions, poly-addiction) and in its client groups (e.g. minors, well integrated individuals, ageing addicts). Many cases can no longer be addressed using a single-issue approach. Not infrequently, financial constraints are forcing institutions to abandon target group-specific services in favour of a broader approach that encompasses a wide array of problems.

Diversity – more than just gender and migration

The target group-driven approach of the last few years has made a significant contribution towards further developing the services available in the addiction field. Infodrog and the Federal Office of Public Health have successfully implemented a range of projects for the sector, particularly in the areas of gender and migration. At the same time, however, the drawbacks of the single-issue approach have become evident. Focusing on a target group means that insufficient account is taken of other features such as age or resources. Addiction facilities with a comprehensive treatment mandate often find it impossible to give priority to a service geared to the needs of a specific target group. What's more, the case numbers are usually too small for them to be able to maintain such specific services. However, the fact remains that the more specifically an intervention targets the problems and resources of an individual, the greater its effect is. Hence, personalised interventions continue to be indispensable, even in facilities with a broad mandate.

Diversity model requires cooperation

The diversity model lends itself readily to use in facilities with a comprehensive treatment mandate. In smaller, specialised facilities, however, it is scarcely practicable. Here there is a need for regional, cooperation-based models that take the different aspects of diversity into account. To this end, Infodrog has launched the nationwide platform «Diversity in addiction work», at which addiction professionals from all fields and language regions meet twice a year to exchange experience and transfer knowledge about «managing diversity». The experience gained at the introductory events held so far suggest that in future the focus will be on presentation and discussion of examples from good practice. There are also plans to draw up a set of guidelines on the topic. Infodrog's aim is to publicise and institutionalise the diversity approach in addiction work without neglecting the further development of more specific approaches. This will enhance equality of opportunity and improve the quality of care given to people with addiction problems.

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