Preventive Male Sexual and Reproductive Health Care:

Recommendations for Clinical Practice

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Introduction

The purpose of the Male Training Center (MTC) for Family Planning and Reproductive Health is to assist with improving the delivery of family planning and sexual and reproductive health [subsequently also called sexual and reproductive health] services for reproductive-aged males in Title X supported health and social service settings or other clinical settings that serve this population. The Male Training Center recognizes that reproductive-aged males in the U.S. have substantial sexual and reproductive health needs [1], but adequate integration of sexual and reproductive health care for this population is lacking. The Male Training Center also recognizes that the nation is lacking in recognized standards of care for delivering sexual and reproductive clinical and preventive services to males [2]. Although a number of professional organizations promote the delivery of clinical preventive services inclusive of sexual health [3-5], there is minimal guidance by national professional organizations as to what preventive sexual and reproductive health services to deliver to reproductive-aged males, unlike recommendations outlined for women [6].

The goal of this *Recommendations for Clinical Practice* document is to describe best practice recommendations for the organization and delivery of preventive clinical sexual and reproductive health services for reproductive-aged males. This document is intended for all levels of staff in clinical settings that offer services for male clients from adolescence through adulthood. Specifically, this document can serve as a guide in determining what clinical preventive sexual and reproductive health services for males should be provided or improved and examples of how to do so. Further, these recommendations for standards of care may be useful to a variety of other stakeholders, including insurers, by setting coverage standards for male clinical services as well as policy makers and advocates.

The content of this document is being addressed at an important time in the history of health care services. Historically, many women in the U.S. have gained access to reproductive health care through Medicaid waivers, State Plan Amendments, and publicly-supported health plans for low-income women and/or women with children. In addition to these programs which expand health care coverage, many adolescents and female adults have increased access to preventive sexual and reproductive health services now that the U.S. Department of Health and Human Services has adopted recommendations by the Institute of Medicine's report, *Clinical Preventive Services for Women: Closing the Gaps,* that outlines gaps in women's preventive health care services under the Patient Protection and Affordable Care Act (ACA) [7]. The U.S. Supreme Court's ruling on the ACA also affords coverage for preventive sexual and reproductive health care services for the first time in our nation's history. As health care providers and programs implement ACA, they will need guidance to help them provide the most effective and efficient services for individuals experiencing increased access to care, including males.

It is thus the long-term goal of this document to improve the practice of medicine with a particular emphasis on how clinical practice can incorporate preventive sexual and reproductive health care for reproductive-aged males by meeting males' current and emerging sexual and reproductive health needs.

Methods

This document outlines recommendations for delivering core clinical preventive sexual and reproductive health care services to reproductive-aged males. This document is based on two efforts: 1) MTC's support of a Federal effort to develop recommendations for providing family planning services to men and women, which culminated in the publication of the *Providing Quality Family Planning Services (QFP): Recommendations of CDC and the U.S. Office of Population Affairs* [8, 9]; and 2) deliberations by the MTC about other sexual and reproductive health services males might need outside of the family planning setting during the Men's Health Technical Panel that was convened by the MTC in July 2011.

The process of developing the *QFP:*

- Identified Federal and national professional medical organizations to include in the synthesis [refer to Appendix 1]. The Institute of Medicine criteria for 'trustworthy' clinical practice guidelines was used to decide which professional medical organizations to include in the review [10].
- Compiled and summarized current recommendations for preventive sexual and reproductive health care services for reproductive-aged males. For the purpose of this review, "services" refers to the clinical preventive care components of a client's health history; physical exam; and laboratory test; and counseling for behavior change.
- Conducted systematic reviews on areas where guidance was lacking.

The Men's Health Technical Panel [Appendix 2] Members:

- In advance of the meeting, reviewed and provided feedback on
  - the framework for sexual and reproductive health care goals for reproductive-aged males and services that included preventing sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), unintended pregnancy, and reproductive health-related cancers; promoting sexual health and development; promoting healthy relationships; planning for the timing and spacing of children; and addressing issues related to sexual function and fertility [11]. This relied on definitions of sexual and reproductive health by the 1994 Cairo United Nations International Conference on Population and Development and the World Health Organization for developing a framework for sexual and reproductive health care for reproductive-aged males [11, 12], secondary to the lack of any organizing care framework.
  - the Federal and national professional medical organizations to include.
- During and after the meeting, reviewed and provided feedback on
  - screening components of clinical care to be or not be provided based on the compiled synthesized evidence as well as systematic reviews on areas where guidance was lacking. This included considering inconsistent recommendations across Federal and professional organizations as well as services not recommended for care delivery because they have been shown to be ineffective or even harmful.

Since the field of males' preventive sexual and reproductive health care lacks clinical studies with males that examine service effectiveness on the full array of sexual and reproductive health care, expert review was also taken into consideration to inform best practice for health professionals working with this population until a sufficient evidence-base is developed and appropriately reviewed. Further, since the purpose of the MTC's effort was on the broader content of men's sexual and reproductive health, and not just on family planning, deliberations by the MTC resulted in the inclusion of five additional services to this document (assessment for intimate partner and sexual violence and issues with sexual function and counseling on sexuality/relationships, issues with sexual function, and condoms with opportunities for demonstration and practice).

Recommended core preventive sexual and reproductive health care services for reproductive-aged males are summarized in this document as follows:

- A summary of recommended services is provided on pg. 4.
- Table 1 (pg. 5) provides a checklist of these services.
- Table 2A (pg. 8) provides a detailed summary of service content and examples of how to provide these services.
- Table 2B (pg. 22) provides the frequency for delivering these services.
- Table 3 (pg. 23) provides a checklist and rationale for services that are not recommended.

Summary of Recommended Services

Preventive sexual and reproductive health care services recommended for reproductive-aged males are designed to assist providers in organizing and promoting the delivery of these services to reproductive-aged male patients. These core recommended services include components of screening questions about a client's history; performing a physical exam; performing screening laboratory tests; and counseling on key sexual and reproductive health topics. When an above service result indicates the potential presence of a health condition, further steps should be taken to provide or refer for treatment consistent with current professional standards of care. For example, this includes following the established CDC's STD Treatment Guidelines for persons presenting with STD symptoms or who screen positive for an STD [13]. Refer to Table 1 for a checklist of recommended services.

History Components

Preventive sexual and reproductive health history assessment for males includes taking…

- A reproductive life plan to determine family planning or preconception health needs or difficulty achieving pregnancy
- A standard medical history including pregnancy and fatherhood status
- Additional visit-specific history components related to preconception health and basic infertility
- Comprehensive sexual health assessment (e.g., asking about sexual practices, partners, pregnancy prevention, protection from STDs, past STD history)
- Problems with sexual function **[additional service recommended by MTC]**
- Intimate partner and sexual violence **[additional service recommended by MTC]**

Taking a history also includes services that, while traditionally may be considered more distally related to males' sexual and reproductive health, have overlap and involve screening for…

- Alcohol and other drug use (e.g., alcohol and other drug use before and during sex may lead to lack of condom use, risk for acquiring STDs/HIV and/or unintended pregnancy or problems with sexual function)
- Tobacco use (e.g., nicotine can impair male reproductive function)
- Depression (e.g., certain male populations may be at increased risk for depression including those struggling with issues of sexual identity, experiencing stress during the coming-out process, experiencing a relationship break-up, or struggling with self-esteem, and certain classes of anti-depressants may lead to problems with sexual function)

History assessment also includes…

- Vaccination history as pertaining to the past receipt of sexual and reproductive health-related immunizations (e.g., human papillomavirus (HPV) vaccine)

Physical Exam Components

Preventive sexual and reproductive health physical exam services for males include…

- Height/weight for calculation of body mass index (BMI)
- Blood pressure
- Examination of external genital/perianal region for male adolescents

Laboratory Test Components

Preventive sexual and reproductive health laboratory services for males based on specific at-risk categories (including age for some) include screening for…

- Chlamydia
- Gonorrhea
- Syphilis
- HIV/AIDS
- Hepatitis C
- Diabetes

Counseling Components

Sexual and reproductive health services for males include counseling on…

- Condoms with demonstration/practice **[additional service recommended by MTC]**
- STDs/HIV
- Pregnancy prevention including male and female methods and emergency contraception
- Preconception health
- Sexuality/relationships **[additional service recommended by MTC]**
- Sexual dysfunction **[additional service recommended by MTC]**
- Infertility

Table 1 Checklist of Recommended Services

Services / Components	Core SRH*
History	
Reproductive life plan [1]	√
Standard medical history [2]	√
Additional visit specific history [3]	√
Sexual health assessment [4]	√
Problems with sexual function	√
Intimate partner & sexual violence	√
Alcohol & other drug use	√
Tobacco use	√
Immunizations	√
Depression	√
Physical Exam	
Height, weight & BMI	√
Blood pressure	√
External genital/perianal exam	√ [5]
Laboratory Tests	
Chlamydia	√ [6]
Gonorrhea	√ [7]
Syphilis	√ [8]
HIV/AIDS	√ [9]
Hepatitis C	√ [10]
Diabetes	√ [11]
Key SRH Counseling	
Condoms with demonstration/practice	√
STD/HIV	√
Pregnancy prevention including male & female methods & EC	√
Preconception health	√
Sexuality/relationships	√ [12] / √ [13]
Sexual dysfunction	√
Infertility	√

KEY FOR TABLE

1. Assess for number of children fathered/want (more) children &, if so, when?
2. Assess for medical & surgical history, medications & allergies.
3. Assess for visit specific additional history items (e.g., as part of STD visit, infertility visit, preconception care visit, etc.).
4. Assess for sexual health practices, partners (sexuality & relationships), pregnancy prevention methods, protection from STDs and STD history.
5. Among male adolescents also document sexual maturity rating.
6. Screen at risk males: MSM; males in teen, correctional facilities, high school & STD clinics; attending National Job Training Program; in military <30 years; entering jails <30 years; entering juvenile facilities; & high prevalence communities.
7. Screen at risk males: MSM; persons reporting multiple or anonymous sex partners; engaging in sex & illicit drug use (e.g., methamphetamine).
8. Screen at risk males: MSM; persons engaging in high-risk sexual behavior; commercial sex workers; persons who exchange sex for drugs; adult correctional facilities; & high prevalence communities.
9. Screen all clients aged 13-64 years & subsequently test high risk individuals at least annually. High risk includes: MSM; injection drug users & their sex partners; persons who exchange sex for money or drugs; sex partners of HIV-infected persons; & persons who themselves or whose sex partners have had >1 sex partner since most recent HIV test.
10. Conduct one-time testing without prior ascertainment of HCV risk for persons born during 1945–1965, a population with a disproportionately high prevalence of HCV infection and related disease.
11. Screen asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
12. Among males dealing with issues of sexuality inclusive of individual support, support for families, &/or referral to local resources as appropriate.
13. Among male adolescents, support having healthy relationships.

** Refer to Table 2A for guidance regarding "how to" elements*

BMI: body mass index; EC: emergency contraception; HIV/AIDS: human immunodeficiency virus/acquired immune deficiency syndrome; HCV: hepatitis C virus; MSM: men who have sex with men; SRH: sexual and reproductive health; STD: sexually transmitted disease

Discussion

This document describes best practice recommendations for the organization and delivery of preventive clinical sexual and reproductive health services for reproductive-aged males in the U.S. by using an evidence-informed approach that takes into account both evidence and expert review. Although expert review may be on the lower end of the evidence ladder [14], it has merit and can be useful in the context when high-quality evidence in the published literature is lacking [15-17] and when its limitations are mitigated through the use of explicit and transparent procedures. This guidance can serve as the basis for the standard of core clinical preventive sexual and reproductive health care delivery to reproductive-aged males in settings that serve this population (e.g., primary care, school-based health, justice, family planning and STD settings), although implementation may need to vary depending on the clinical setting and/or reason for visit.

These services, specifically for the context of clinical care, address a broad array of males' sexual and reproductive health. The scope of sexual and reproductive health care goals recommended in this document is consistent with broader definitions of sexual and reproductive health promoted by the World Health Organization [12] and includes preventing sexually transmitted diseases (STDs), human immunodeficiency virus (HIV), unintended pregnancy, and reproductive health-related cancers; promoting sexual health and development; promoting healthy relationships; planning for the timing and spacing of children; and addressing issues related to sexual function and fertility.

The content of preventive sexual and reproductive health care services described in this document is specific for reproductive-aged males. While some recommendations are similar to those for women, others are uniquely for males based on current evidence. Further, sexual and reproductive health behaviors and outcomes may be best approached by directly or indirectly engaging couples. Although recommendations described in this document focus on services for individuals, the MTC encourages practitioners to consider their relevance to patients' partners and the importance of partner outreach, regardless of a partners' gender.

The guidance described in this document highlights best practices for delivering sexual and reproductive health care to reproductive-aged males. Whereas the QFP had a more focused approach to providing guidance on family planning and preconception health, the MTC's approach emphasized addressing broader content on men's sexual and reproductive health. Further, content in this document highlights services important for men who have sex with men (MSMs) since this population has substantial sexual and reproductive health needs [18] beyond HIV concerns which may also include planning families.

This document can serve as the foundation for establishing national standards of preventive clinical sexual and reproductive health care for reproductive-aged males within a larger agenda for male health as recommended by the Institute of Medicine's report, Clinical Preventive Services for Women: Closing the Gaps: "a parallel approach could be equally useful for determining covered preventive services for men, …, and male adolescents" (Recommendation 6.3) [7]. Future work can also extend standards of care described here for males across the lifespan including older-aged males as well as younger boys and their families. These standards should ensure, as recommended for women, that all men with reproductive capacity have the full range of contraceptive methods available to them including sterilization procedures (e.g., vasectomy), and related patient education and counseling.

During its review of Federal and professional clinical guidelines, the MTC identified substantial gaps in recommendations on preventive clinical sexual and reproductive health care services for reproductive-aged males. One major contributing factor to this gap is a lack of research conducted among males in clinical settings in the area of males' sexual and reproductive health. Another contributing factor is a lack of coordinated and integrated discourse across the fields of reproductive health care, family planning and sexual health. The MTC hopes that this document can help stimulate both discourse and research in these areas which can in turn inform the evidence base and, ultimately, clinical care for this population. This document also highlights services that should no longer be delivered to reproductive-aged males based on current evidence. Finally, regular updates to these recommendations will be necessary for content areas in which further data is still being accumulated and thus current guidance is lacking.

Investment in training and capacity-building will be necessary to successfully implement this guidance. Programs and staff, including clinicians, health counselors and educators, managers and administrative staff, and other clinic staff,

Discussion

will need to ensure they have the requisite knowledge, skills, and resources to effectively implement these recommendations. Programs may want to consider alternate staffing approaches to ensure efficient implementation. The MTC has tools available on its website (www.maletrainingcenter.org), including tools for billing and coding for male services, patient educational materials, and training materials for conducting a male patient examination. The MTC has released a report on a national summary of clinicians' scope of practice pertaining to clinical services provided to males within the context of family planning settings [19]. The MTC is available to help provide training and technical assistance with implementation of these recommendations, including support for issues associated with clinicians' scope of practice.

Table 2A Detailed Summary of Recommended Service Content

History	
Reproductive life plan	Assess among all individuals capable of having a child whether they have a reproductive life plan [20] by asking: • Have you ever made someone pregnant/are you currently a father? • Do you want to have (more) children? • How many (more) children would you like to have and when?
Standard medical history	Assess for medical and surgical history, current medications and supplements, allergies, family medical history and pregnancy and father history [20, 21].
Additional visit – specific history	**Preconception health** [20] • Past medical and surgical history that may impair his reproductive health (e.g., genetic defects, history of reproductive failures, &/or conditions that can reduce sperm quality, such as obesity, diabetes mellitus, varicocele and STDs). • Occupational or environmental exposures. **Basic infertility** [21] • Additional medical history including: – Childhood illnesses and developmental history; – Systemic medical illnesses (e.g., diabetes mellitus) and prior surgeries; – Medications (prescription and non-prescription) and allergies; – Lifestyle exposures and a review of systems; – Family reproductive history; and – Review of past infections such as sexually transmitted diseases. • Reproductive history including: – Coital frequency and timing; – Duration of infertility and prior fertility; – Sexual history including STDs; and – Gonadal toxin exposure including heat.

Table 2A Detailed Summary of Recommended Service Content, cont.

History	
Sexual health assessment	Use the 5 P's approach to conduct a sexual health assessment [13, 22, 23]: 1. ***Practices:*** Assess for the types of sexual behavior that your patient engages in, such as vaginal, anal, and/or oral sex. 2. ***Partners:*** Ask questions to determine the number, sex, and concurrency of your patient's sex partners. You may need to define the term "partner" to the patient or use other, relevant terminology. 3. ***Pregnancy prevention:*** Discuss current and future contraceptive options with partner. 4. ***Protection* from STDs:** Ask about condom use, with whom they do or do not use condoms, and situations that make it harder or easier to use condoms. 5. ***Past* STD history**: Ask about history of STDs, including whether their partners have ever had an STD (The likelihood of an STD is higher with a past history of an STD).
Problems with sexual function	Ask do you have any difficulty with intercourse/problems when having sex? • Asking males about problems with sexual function is particularly important to identify underlying cardiovascular disease among men who present with symptoms of sexual dysfunction routinely starting at age 25. Specific questions include if the male is experiencing sexual dysfunction such as inability to obtain and maintain an adequate erection for satisfactory sexual activity (impotence, erectile dysfunction [ED]), premature or delayed ejaculation, loss of libido, painful intercourse, and also priapism, a prolonged painful erection not associated with sexual desire [24-26].
Intimate partner & sexual violence	Assess for history of abuse including intimate partner and sexual violence [4, 27]. Given that abuse may be bidirectional within the context of relationships [28], assessing for both experience and perpetration may be warranted along with a history of childhood/family violence exposure. Note: providers must comply with state mandatory reporting guidelines regarding abuse, rape and incest [29]. • **An example evidence-based approach for assessment includes:** HITS... (Hurt, Insult, Threaten, Scream) [30] How often does your partner: **H** Physically HURT you? **I** INSULT or talk down to you? **T** THREATEN you with harm? **S** SCREAM or curse at you? Score each item using 1 to 5 on a Likert scale as follows: never (1); rarely (2); sometimes (3); fairly often (4); frequently (5). Scores for this inventory range from 4 to 20. A score of greater than 10 is considered positive for partner violence. Provide counseling and referral as appropriate.

Table 2A Detailed Summary of Recommended Service Content, cont.

History	
Alcohol & other drug use	Assess for alcohol misuse in adults and adolescents and for other drug use [4, 31-36]. • **Example evidence-based approaches for assessment include:** A. Among Adolescents through age 21 – CRAFFT [37]: During the past 12 months, did you: 1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.) 2. Smoke any marijuana or hashish? 3. Use anything else to get high? ("Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff.") If patient answered "no" to all of the above 3 questions, ask only CAR question below. If patient answered "yes" to any of the above 3 questions, ask all questions below. **C** Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? **R** Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in? **A** Do you ever use alcohol/drugs while you are by yourself, ALONE? **F** Do you ever FORGET things you did while using alcohol or drugs? **F** Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use? **T** Have you gotten into TROUBLE while you were using alcohol or drugs? Probability of abuse/dependence increases with increasing yes answers to above questions. B. Alcohol screening and brief intervention for youth. A practitioner's guide [38]: STEP 1: ASK THE TWO SCREENING QUESTIONS For Middle School (ages 11–14): **Friends: Any drinking?** "Do you have any friends who drank beer, wine, or any drink containing alcohol in the *past year?*" ANY drinking by friends heightens concern. **Patient: How many days?** "How about you—in the past year, on how many days have you had more than a few sips of beer, wine, or any drink containing alcohol?" Classify ANY drinking: Moderate or Highest Risk. For High School (ages 14–18) **Patient: How many days?** "In the past year, on how many days have you had more than a few sips of beer, wine, or any drink containing alcohol?" Classify Lower, Moderate, or Highest Risk. **Friends:** How much? "If your friends drink, how many drinks do they usually drink on an occasion?" Binge drinking by friends heightens concern. *(3 to 5+ drinks)* Counseling guidance is provided based on assessment per above (refer to original source for specifics).

Table 2A Detailed Summary of Recommended Service Content, cont.

History	
Alcohol & other drug use ***– continued***	STEP 2: GUIDE PATIENT *For patients who DO NOT drink…* STEP 2: ASSESS RISK *For patients who DO drink…* STEP 3: ADVISE AND ASSIST *For patients who DO drink…* STEP 4: AT FOLLOWUP, CONTINUE SUPPORT *For patients who DID drink…* C. Among Adults - **CAGE**: **C** Have you ever felt you needed to CUT down on your drinking? **A** Have people ANNOYED you by criticizing your drinking? **G** Have you ever felt GUILTY about drinking? **E** Have you ever felt you needed a drink first thing in the morning (EYE-OPENER) to steady your nerves or to get rid of a hangover? Two "yes" responses indicate that the possibility of alcoholism should be investigated further. Offer behavioral counseling interventions to reduce alcohol misuse in adults and adolescents and for other drug use.

Table 2A Detailed Summary of Recommended Service Content, cont.

History	
Tobacco use	Assess all adults and adolescents about smoking and use of other tobacco products [4, 35, 39-44]. • **Example assessment approaches include:** A. The Hooked on Nicotine Checklist (HONC) [45] 1. Have you ever tried to quit, but couldn't? 2. Do you smoke now because it is really hard to quit? 3. Have you ever felt like you were addicted to tobacco? 4. Do you ever have strong cravings to smoke? 5. Have you ever felt like you really needed a cigarette? 6. Is it hard to keep from smoking in places where you are not supposed to, like school? *When you tried to stop smoking…(or, when you haven't used tobacco for a while…)* 7. Did you find it hard to concentrate because you couldn't smoke? 8. Did you feel more irritable because you couldn't smoke? 9. Did you feel a strong need or urge to smoke? 10. Did you feel nervous, restless, or anxious because you couldn't smoke? A positive response to any question signals a loss of autonomy and the onset of dependence. B. The "5 A's" approach Developed by the National Cancer Institute (NCI), this approach can be used by health care providers when caring for persons with nicotine dependence [46]. This counseling technique requires less than 3 minutes and includes a mnemonic of the following "5 A's": 1. **ASK:** "Do you smoke cigarettes or use tobacco?" 2. **ADVISE:** "Quitting smoking/tobacco use is the most important thing you can do to protect your health now & in the future. The clinic staff & I will help you." 3. **ASSESS:** "Are you willing to make a quit attempt in the next 30 days?" 4. **ASSIST:** 1 - Help develop a quit plan including setting a quit date in the next 2 weeks, telling friends and family of intent to quit & request support, anticipate challenges to quit, & remove nicotine products from environment; 2 - Give key advice including total abstinence, reviewing past quit experiences in any & factors that hindered past quit attempts, & limit or abstain from alcohol; & 3 - Consider use of nicotine replacement therapy or refer to someone who can. 5. **ARRANGE:** Refer to intensive services (help lines, websites, treatment programs and follow-up to review progress. Data from randomized control studies conducted in 1989 among adult patients utilizing this technique demonstrated 5 to 15 percent abstinence from smoking at one year. An even shorter version of this, a "2A and an R" model — Ask, Advise and Refer — has been promoted as the minimal acceptable intervention. Provide or refer those who use tobacco products to evidence-based tobacco cessation interventions including referral to quitlines: • You Can Quit Smoking Now — www.smokefree.gov • www.teenquit.com/QuitLines/index.asp • HHS National Quitline Number (1-800-QUITNOW)

Table 2A Detailed Summary of Recommended Service Content, cont.

History	
Immunizations	Assess and offer all clients (as needed) [4, 13, 47, 48]: • **Human papillomavirus (HPV) vaccination** for males aged 11-26 (minimum age 9) [recommendations include starting at age 11-12 year olds and catch up vaccine among males ages 13-21 who have not been vaccinated previously or have not completed the 3-dose series through age 21; males aged 22-26 years may be vaccinated (permissive recommendation for this age group). Routine vaccination is recommended among at risk males, including MSM and immune-compromised males, through age 26 years [49, 50]. • **Hepatitis B vaccination (HBV)** among persons aged <19 years and for all adults who are at risk (as defined by at risk for infection by sexual exposure including MSM; injection-drug users; household contacts of persons with chronic HBV infection; developmentally disabled persons in long-term care facilities; persons at risk for occupational exposure to HBV; hemodialysis patients; persons with chronic liver disease; travelers to HBV-endemic regions; and HIV-positive persons) or who request vaccination. o Anti-HBV testing may be considered among adult men at high risk (e.g., intravenous drug user & MSM) in context of vaccination, but not among adolescents who are asymptomatic for HBV [51]. However, young MSM might require more thorough evaluation. • **Hepatitis A (HAV)** among persons at risk as defined by MSM; users of injection and non-injection drugs; persons who have occupational risk for infection; persons with clotting-factor disorders; vaccination of persons with chronic liver disease; Hepatitis A vaccination during outbreaks; and persons traveling to or working in countries that have high or intermediate endemicity of infection.

Table 2A Detailed Summary of Recommended Service Content, cont.

History	
Depression	Assess adolescents and adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment and follow up [4, 52-55]. • Staff assisted care supports are defined as clinical staff that assist the primary care clinician by providing some direct depression care, such as care support or coordination, case management or mental health treatment. For example, the minimal effective staff supports consisted of a screening nurse who advised primary care clinicians of a positive screen and provided a protocol facilitating referral to behavioral therapy. Assess for risk of suicide among persons reporting symptoms of depression and other risk factors (mania or hypomania, or mixed states especially when complicated by comorbid substance abuse, irritability, agitation, or psychosis; previous suicide attempts; family history of suicide; friends who have committed suicide; access to a gun; history of mood/conduct or psychotic disorders; impulsive behaviors or attention deficit/hyperactivity disorder; concerns about sexual identity; history of physical/sexual abuse) [4, 55-58]. • **Example screening approaches include:** A. Screening for depression in primary care with two verbally asked questions [59] 1. During the past month have you often been bothered by feeling down, depressed, or hopeless? and, 2. During the past month have you often been bothered by little interest or pleasure in doing things? B. Things to watch for when assessing potential risk (P.L.A.I.D. P.A.L.S.) [60]: **P**lan – Do they have one? **L**ethality – Is it lethal? Can they die? **A**vailability – Do they have the means to carry it out? **I**llness – Do they have a mental or physical illness? **D**epression – Chronic or specific incident(s)? **P**revious attempts – How many? How recent? **A**lone – Are they alone? Do they have a support system? Partner? Are they alone right now? **L**oss – Have they suffered a loss? Death, job, relationship, self esteem? **S**ubstance abuse (or use) – Drugs, alcohol, medicine? Current, chronic?

Table 2A Detailed Summary of Recommended Service Content, cont.

Physical Exam	
Height, weight and BMI	Assess all adolescent and adult clients for obesity including measurement of weight, height, and calculation of body mass index (BMI) [4, 61-66]. Obese persons should be offered or referred to intensive counseling and multicomponent behavioral interventions [4, 61, 62, 66].
Blood pressure	Measure blood pressure among adults every 2 years if normal (blood pressure <120/80) and every year if the client has pre-hypertension (blood pressure 120-139/80-89) and in adolescents measure blood pressure annually [4, 20, 67-69].
External genital/ perianal exam	Perform external genital/perianal exam to document normal growth and development and other common genital findings, including hydrocele, varicocele, and signs of STDs [4, 70, 71]. Components of this exam include inspecting skin and hair, palpating inguinal nodes, scrotal contents and penis, and inspecting perinanal region (as indicated, e.g., history of receptive anal sex). Perform a genital exam as part of the evaluation for male infertility [21] including • Examination of the penis; including the location of the urethral meatus; • Palpation of the testes and measurement of their size; • Presence and consistency of both the vas deferens and epididymis; • Presence of a varicocele; • Secondary sex characteristics including body habitus, hair distribution and breast development; and • Digital rectal exam in all men 18 and older if there are signs and symptoms of prostatitis (dysuria, pelvic pain, hematospermia) or ejaculate volume is lower than 1.5 mL. The diagnosis of congenital bilateral absence of the vasa deferentia (CBAVD) is established by physical examination (scrotal exploration is not needed to make this diagnosis).
Laboratory Tests	
Chlamydia	Screen at risk male adolescents and adults under age 25 years for Chlamydia (urine-based nucleic-acid amplification tests (NAATs) is the preferred approach). At risk includes MSM, and specific settings in which to screen males, e.g., adolescent clinics, correctional facilities, STD clinics and high prevalence communities [4, 13, 72-74]. • Additional guidance recommends screening men who are attending National Job Training Program, in military <30 years of age with any lifetime sexual experience, entering jails <30 years of age, entering juvenile facilities, in communities with high Chlamydia prevalence (programs here should consider screening men <25 years of age in emergency departments, attending high school clinics, and attending adolescent clinics) [73]. • Males with Chlamydia infection should be re-screened for reinfection at 3 months. • Screening includes for urethral infection with *C. trachomatis* in men who have had insertive anal intercourse during the preceding year and rectal infection with *C. trachomatis* in men who have had receptive anal intercourse during the preceding year (NAAT of a rectal swab is the preferred approach). • Screening for *C. trachomatis* pharyngeal infection is not recommended.

Table 2A Detailed Summary of Recommended Service Content, cont.

Laboratory Tests	
Gonorrhea	Screen at risk male adolescents and adults for gonorrhea (urine-based nucleic-acid amplification tests (NAATs) is the preferred approach) [4, 13, 74, 75]. At risk populations include MSM. • Males with gonorrhea infection should be re-screened for reinfection at 3 months. • More frequent STD screening (i.e., at 3–6-month intervals) is indicated for MSM who have multiple or anonymous partners. • MSM who have sex in conjunction with illicit drug use (particularly methamphetamine use) or whose sex partners participate in these activities should be screened more frequently. • The following screening tests need to be performed at least annually for sexually active MSM: screen for urethral infection with *N. gonorrhoeae* in men who have had insertive intercourse and screen for rectal infection with *N. gonorrhoeae* in men who have had receptive anal intercourse (NAAT of a rectal swab is the preferred approach); and screen for pharyngeal infection with *N. gonorrhoeae* in men who have had receptive oral intercourse (NAAT is the preferred approach) during the preceding year, respectively.
Syphilis	Screen persons at increased risk for syphilis infection. Populations at increased risk include MSM and men who engage in high-risk sexual behavior such as commercial sex workers, persons who exchange sex for drugs, those in adult correctional facilities, and those in high prevalence communities [4, 13, 76]. • Young MSM might require more frequent STD screening based on risky behaviors (i.e., at 3–6-month intervals) as is indicated for MSM who have multiple or anonymous partners. • MSM who have sex in conjunction with illicit drug use (particularly methamphetamine use) or whose sex partners participate in these activities may need to be screened more frequently.
HIV/AIDS	Screen for HIV infection all clients aged 13-64 years and all persons at high risk for HIV should be re-screened at least annually [4, 13, 77-81]. Persons likely to be at high risk include MSM; injection drug users and their sex partners; persons who exchange sex for money or drugs; sex partners of HIV-infected persons; and MSM or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test. • CDC recommends that screening be provided after the patient is notified that testing will be performed as part of general medical consent unless the patient declines (opt-out screening).

Table 2A Detailed Summary of Recommended Service Content, cont.

Laboratory Tests	
Hepatitis C	Screen for hepatitis C virus (HCV) infection and HCV-related chronic disease by conducting one-time testing without prior ascertainment of HCV risk for persons born during 1945–1965, a population with a disproportionately high prevalence of HCV infection and related disease [82, 83]. Anti-HCV testing is recommended for routine screening of persons at risk for infection or based on a recognized exposure (e.g., MSM, injecting drug user, high risk sexual behavior). Among MSM and intravenous drug users, screening among past or current drug users should include HCV testing [13]. Persons identified as having HCV infection should receive a brief screening for alcohol use and intervention as clinically indicated, followed by referral to appropriate care for HCV infection and related conditions.
Diabetes	Screen for diabetes among asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg [20, 84].
Key Sexual and Reproductive Health Counseling	
Condoms with demonstration/practice	Offer male patients to view and practice condom demonstration [4, 13, 85]. • For example, condom demonstration and practice should include steps for putting on (and removing) a condom including 1) pinching the tip of the condom, 2) rolling the condom down to base while leaving the tip pinched, 3) after ejaculation occurs, holding the condom at its base before withdrawing, 4) holding the condom at its tip and base and removing it from the penis, and 5) throwing it away. [86] • Other teachable points include 1) checking the expiration date, 2) checking the package for air bubbles, 3) not opening the package with teeth or a sharp object, 4) using only water-based lubricants with latex condoms, and 5) not using spermicides (e.g., nonoxynol-9) since they can break down latex and increase susceptibility to STDs including HIV. • Other points for discussion for optimal use include partners 1) discussing contraception methods in advance including who will purchase condoms; 2) latex allergies; 3) the type of condom used (ie, latex, polyurethane, lambskin) and condom characteristics (e.g., size, ribbed, lubricated, contain spermicides, etc.) and 4) try different condoms to find the one that fits and feels the best; condoms are available in different sizes and varying thickness.
STD/HIV	Provide high intensity behavioral counseling about STD prevention for all sexually active male adolescents and adult men at increased risk on an annual basis [23]. • For example, this consists of two separate 20-minute clinical sessions 1 week apart. During the first session, a patient is assessed for personal risk, barriers to risk reduction, and a small risk-reduction step within 1 week is identified. During the second session, the prior week's behavioral change successes and barriers are reviewed, support for changes made is provided, barriers and facilitators to change is identified, and a long-term plan for risk-reduction is developed. Provide access to HIV pre-exposure prophylaxis (PREP) and post-exposure prophylaxis (PEP) as appropriate [87, 88].

Table 2A Detailed Summary of Recommended Service Content, cont.

Key Sexual and Reproductive Health Counseling	
Pregnancy prevention including male & female methods & EC	Counsel male patients about male methods (e.g., vasectomy, condoms, withdrawal) & female hormonal contraception methods (e.g., long-acting reversible methods, combination methods and emergency contraception (EC)) and provide EC in advance as allowed by state law [4, 13, 89, 90]. • Work with the client to establish a patient-centered plan for using the contraceptive method(s) of choice including addressing the "4 Cs" (choice, correct use, consistent use, continued use and switching) and effectiveness; understanding side effects; involvement of partner in plan and plan for follow-up. • Promote dual protection for a client who is at risk for contracting an STD (i.e., effective method to prevent pregnancy plus a condom to prevent infection).
Preconception health	Provide support to address males' sexual and reproductive health in their own right that may also otherwise impact future reproductive capacity, to improve health outcomes for males' partners including direct benefits (e.g., decreased infection transmission between partners) and indirect benefits (e.g., shared health practices promoted by the male partner), as critical partners in family planning and to ensure all pregnancies are planned and wanted, and to improve males' capacity for parenting and fathering as well as improved outcomes for their children [20].
Sexuality & relationships	**Sexuality:** Provide support to males who may be dealing with issues of sexuality that can affect their psychosocial and physical health via individual support, support for families, and/or referral to local resources as appropriate [4, 13]. • **An example sexuality assessment tool:** A. Adapted from Helping families with lesbian, gay, bisexual and transgender children [91]: • Have you ever been hit, slapped or physically hurt because of your LGBT identity? • Have you ever experienced verbal harassment or name-calling because of your LGBT identity? • Have you ever been excluded from family events and family activities because of your LGBT identity? • Have you ever been blocked access to LGBT friends, events, and resources? • Have you ever been blamed when you have been discriminated against because of your LGBT identity? • Have you ever been pressured to be more (or less) masculine or feminine? • Have you ever been told that God will punish you because you are gay? • Have you ever been told your family is ashamed of you or that how you look or act will shame the family? • Have you ever been told to keep you LGBT identity a secret in the family and not letting you talk about your identity with others? **Relationships:** Provide support to adolescents in how to have healthy relationships [4]. • **Example assessment approaches include:** A. From Building Healthy Teen Relationships [92]: Friend, girlfriend, or boyfriend – all deserve healthy relationships.

Table 2A Detailed Summary of Recommended Service Content, cont.

Key Sexual and Reproductive Health Counseling	
Sexuality & relationships – *continued*	**Respect.**Are you accepted for who you are? No one should pressure you into doing things you are not comfortable with such as drinking, drugs, or unwanted physical contact. **Safety.** Do you feel emotionally and physically safe? You should feel comfortable being you without fear of being put down. Being hurt or feeling pressured is definitely not safe! **Support.** Do your friends care for you and want what is best for you? Your friends should understand if you can't hang out because you have to study or if you have plans with other friends. **Individuality.** Do you pretend to like something you don't or be someone you aren't? Be yourself; after all, being an individual is what makes you, you! **Equality.** Do you have an equal say in relationships and but equal effort into the relationship? From the activities you do together to the friends you hang out with, you should have equal say in the choices made in relationships. **Acceptance.** Do your friends or girlfriend or boyfriend accept you for who you really are? You shouldn't have to change who you are, or compromise your beliefs to make someone like you. **Honesty and Trust.** Are you always honest? Honesty builds trust. You can't have a healthy relationship without trust! If you have ever caught your friend or boyfriend or girlfriend in a huge lie, you know that it takes time to rebuild trust. **Communication.** Do you talk face to face (nt jst txt!) about your feelings? Listen to one another and hear each other out. Text or Facebook messages should be respectful, not mean or inappropriate. **Signs of Unhealthy Relationships** • Texts you all the time to find out where you are, who you're with, or what you're doing. • Has to be with you all the time. • Doesn't listen to your opinion. • Makes all the decisions in the relationship. • Makes fun of you or puts you down when you are alone or with friends. • Does things to upset you or make you cry. • Wants you to change who you are. • Asks you to give up activities you enjoy. • Won't let you hang with your friends. • Pressures you to do things you are not comfortable with. • Makes you feel guilty, "gets back at you" or punishes you for things you do for yourself. • Threatens to hurt you or him/herself as a way to control you. B. From Stanford University Family Abuse Prevention Council [93]: A healthy relationship is based on caring and respect. Both partners: • Communicate openly. • Trust each other. • Share decisions. • Compromise when there is disagreement. • Take responsibility for their own actions.

Table 2A Detailed Summary of Recommended Service Content, cont.

Key Sexual and Reproductive Health Counseling	
Sexuality & relationships – *continued*	Warning signs of an unhealthy relationship include: • Jealousy, accusing you of things you didn't do. • Making all of the decisions about what to do and where to go. • Not letting you hang out with your friends. • Putting you down in front of other people. • Telling you what to wear or how to act. • Texting and checking up on you all of the time. • Blaming you for problems, guilt trip. • Hitting or hurting. • Threatening you if you try to leave. • Forcing sex, refusing to practice safe sex.
Sexual dysfunction	Provide support based on etiology of sexual problem. Note that sexual dysfunction in men represents a group of common medical conditions that need to be managed from a multidisciplinary perspective. For specific evaluation, treatment guidelines, and algorithms developed for every sexual dysfunction in men, including erectile dysfunction; disorders of libido, orgasm, and ejaculation; Peyronie's disease; and priapism, refer to the following resources [94, 95]: • Montorsi F, Adaikan G, Becher E, et al. Summary of the recommendations on sexual dysfunctions in men. J Sex Med 2010 Nov;7(11):3572-3588. • Montorsi F, Basson R, Adaikan G, et al., eds. Sexual medicine: Sexual dysfunctions in men and women. Paris, France: Editions 21; Co-Sponsored by International Consultation on Urological Diseases (ICUD) and International Society for Sexual Medicine (ISSM); http://www.icud.info, 2010. Note also that erectile dysfunction (ED) can be seen as an early sign of systemic cardiovascular disease and that this can offer an opportunity for prevention, particularly in high-risk and underserved minority populations [24, 25]. • According to the Minority Health Institute (MHI) algorithm, all men 25 years old and older regardless of sexual dysfunction complaints should be asked about ED & the presence of ED should prompt an aggressive assessment for cardiovascular risk and occult systemic vascular disease [24]. • According to the consensus study from the Second Princeton Consensus Conference, its algorithm for evaluation emphasizes the importance of risk factor evaluation and management for all patients with ED based on risk stratification for cardiovascular disease (low, intermediate (including those requiring further evaluation), and high risk) and that increasing evidence supports the role of lifestyle intervention in ED, specifically weight loss & increased physical activity, particularly in patients with ED & concomitant cardiovascular disease [25].

Table 2A Detailed Summary of Recommended Service Content, cont.

Key Sexual and Reproductive Health Counseling	
Infertility	Provide basic infertility services, which include the initial infertility history and physical exam (as described above), and appropriate education and referrals as needed, in accordance with professional recommendations, in male partners of an infertile couple if pregnancy has not occurred within one year of regular unprotected intercourse [21]. • An early evaluation may be warranted if a known male or female infertility risk factor exists or if a man questions his fertility potential as outlined here: – A couple attempting to conceive should have an evaluation for infertility if pregnancy fails to occur within one year of regular unprotected intercourse. – An evaluation should be done before one year if 1. Male infertility risk factors such as a history of bilateral cryptorchidism are known to be present; 2. Female infertility risk factors, including advanced female age (over 35 years), are suspected; or 3. The couple questions the male partner's fertility potential. – Men who question their fertility status despite the absence of a current partner should have an evaluation of their fertility potential. • Counseling and referral provided during the clinical visit should be driven by information elicited from the client during the initial infertility history and physical exam (as described above). • Referral may be needed for further evaluation, including semen analysis (2 specimens), endocrine evaluation for testosterone and Follicle Stimulation Hormone (FSH) levels, or post-ejaculate urinalysis (when the ejaculate volume is less than 1mL). • For patients who fall under the definition above, but are concerned about infertility, if there is no apparent cause, providers should provide education about how to maximize fertility.

Table 2B Frequency for Delivering Recommended Services

Service	To Be Done	Accomplishes This Recommended Practice
History	Every encounter*	• Reproductive life plan • Reason for visit • Standard medical history • Sexual health assessment • Sexual dysfunction • Partner violence • Tobacco, alcohol, drug use
History	At least annually	• Immunizations • Depression
Physical exam	At least annually	• Height, weight, BMI calculation • Blood pressure • Genital exam (among male adolescents)
Laboratory tests	At least annually	• If at risk, STD testing should be considered: – Chlamydia – Gonorrhea – Syphilis – HIV/AIDS – Hepatitis C • If at risk, diabetes testing should be considered
Counseling	Periodicity based on need	• Demonstrate condom/practice • STD/HIV counseling • Pregnancy prevention including male & female methods & EC • Preconception health • Sexuality/relationships • Sexual dysfunction • Infertility

**May be an opportunity to offer these services using clinical judgment*
BMI: body mass index; EC: Emergency Contraception; HIV/AIDS: human immunodeficiency virus/acquired immune deficiency syndrome; SRH: sexual and reproductive health; STD: sexually transmitted disease

Table 3 Checklist and Rationale for Services Not Recommended

Summary of services where evidence supports recommendations AGAINST delivery for males	
History	
Teaching testicular self-exam (TSE)	Not recommended to routinely counsel about testicular self exam for cancer for male adolescents and adults and may cause harm. There is also no evidence that teaching young men how to examine themselves for testicular cancer would improve health outcomes, even among men at high risk, including men with a history of undescended testes or testicular atrophy [96, 97].
Physical exam	
Testicular cancer screen	Not recommended to routinely examine testicles for testicular cancer for asymptomatic male adolescents and adults and may cause harm. However, clinicians should be aware that patients who present with symptoms of testicular cancer are frequently misdiagnosed as having other genital complaints, such as epididymitis, testicular trauma, hydrocele or other benign disorders [96, 97]. Refer to physical examination for recommendations about male genital exam.
Laboratory tests	
Gonorrhea	Not recommended to routinely screen for gonorrhea infection in men and who are at low risk for infection [75].
Hepatitis B	Not recommended to routinely screen the general asymptomatic population for chronic hepatitis B virus infection [51].
Hepatitis C	Not recommended to routinely screen for hepatitis C virus (HCV) in asymptomatic adults who are not born during 1945–1965 and not at increased risk [83].
Herpes Simplex	Not recommended for routine serological screening for herpes simplex virus in asymptomatic adolescents and adults [98]. Young MSM might require more thorough evaluation. Type-specific herpes simplex virus serologic assays might be useful in the following scenarios: 1) recurrent genital symptoms or atypical symptoms with negative herpes simplex virus cultures; 2) a clinical diagnosis of genital herpes without laboratory confirmation; or 3) a partner with genital herpes. herpes simplex virus serologic testing should be considered for persons presenting for an STD evaluation (especially for those persons with multiple sex partners), persons with HIV [13].
Syphilis	Not recommended to routinely screen asymptomatic persons who are not at increased risk for syphilis infection [76].
PSA for Prostate Cancer	Not recommended to use prostate-specific antigen (PSA)-based screening for prostate cancer by the U.S. Preventive Services Task Force [99]. Other organizations make different recommendations [100-104]: • American Urological Association: Recommends using both a prostate-specific antigen (PSA) test and a digital rectal exam routine detection to men aged 40 and older who have a life expectancy of at least 10 years. • American Cancer Society: Recommends starting at age 50 for men at average risk, at age 45 among men at high risk (e.g., African Americans and men who have a first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65)) and age 40 among men at higher risk (e.g., those with several first-degree relatives who had prostate cancer at an early age). ➤

Table 3 Checklist and Rationale for Services Not Recommended, cont.

Laboratory tests	
PSA for Prostate Cancer – *continued*	• American College of Preventive Medicine: Recommends against routine population screening with digital rectal exams and prostate-specific antigen. Men age 50 or older with a life expectancy of greater than 10 years should be given information about the potential benefits and harms of screening and allowed to make their own choice about screening, in consultation with their physician.
Services that are no longer recommended by organizations for males	
Physical exam	
Hernia	No evidence to support routine screening for hernia unless clinically indicated. Evidence does not exist that reviews the harms and benefits to routinely screen for hernia.
Laboratory tests	
Urinalysis	Not recommended for routine screening urinalysis of male clients. Despite an appearance of "lack of guidance" in recommendations for screening for urinalysis in men, all organizations agree that males do not require routine screening for urinalysis which represents an update from older recommendations that did recommend routine screening for a variety of reasons: leukocyte esterase test, kidney function [e.g., protein, red blood cells]) [105].
Hemoglobin/hematocrit	Not recommended for routine screening blood count (hemoglobin/hematocrit) of male clients. Despite an appearance of "lack of guidance" in recommendations for hemoglobin/hematocrit screening for men, all organizations agree that males do not require routine screening for hemoglobin/hematocrit which represents an update from older recommendations that did recommend routine screening.
Services for which evidence is still being accumulated for males	
Laboratory tests	
Trichomonas	Evidence is still being accumulated to determine routine screening for trichomonas for males. Organizations do not review and thus make any recommendations for routine trichomonas screening among males.
Human papillomavirus	Evidence is still being accumulated to determine routine screening for human papillomavirus for males. Organizations do not review and thus make any recommendations for routine human papillomavirus screening among males.
Anal cytology	Evidence is still being accumulated to determine routinely perform anal cytology (Pap smear) for males. Although there may be a role of anal cytology among men who have had receptive anal intercourse; the evidence described as limited. HIV-infected MSM also have increased incidence of anal cancer. Screening for anal cytologic abnormalities among this population can be considered; however, evidence is limited concerning the natural history of anal intraepithelial neoplasias, the reliability of screening methods, the safety and response to treatments, and the programmatic support needed for such a screening activity [13] [106].

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Appendix 1 Professional Organizations Included in the Final Review

American Academy of Child and Adolescent Psychiatry (AACAP)	www.aacap.org
American Academy of Family Physicians (AAFP)	www.aafp.org
American Academy of Nurse Practitioners (AANP)	www.aanp.org
American Academy of Pediatrics (AAP)	www.aap.org; brightfutures.aap.org
American Cancer Society (ACS)	www.cancer.org
American College of Physicians/ American Society of Internal Medicine (ACP)	www.acponline.org
American College of Preventive Medicine (ACPM)	www.acpm.org
American Diabetes Association (ADA)	www.diabetes.org; professional.diabetes.org
American Heart Association (AHA)	www.heart.org
American Medical Association (AMA)	www.ama-assn.org
American Society for Reproductive Medicine (ASRM)	www.asrm.org
American Urological Association (AUA)	www.auanet.org
Centers for Disease Control and Prevention (CDC)	
• HIV/AIDS	www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm
• Immunization	www.cdc.gov/vaccines/acip/index.html
• STD treatment	www.cdc.gov/std/dstdp; www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf
• Select Panel on Preconception Care	www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm
Family Violence Prevention Fund – Futures Without Violence (FVPF)	www.futureswithoutviolence.org/section/aboutus
National Association of Pediatric Nurse Practitioners (NAPNAP)	www.napnap.org
National Heart, Lung, and Blood Institute (NHLBI)	www.nhlbi.nih.gov
Society for Adolescent Health and Medicine (SAHM)	www.adolescenthealth.org
U.S. Public Health Service (USPHS)	www.usphs.gov
U.S. Preventive Services Task Force (USPSTF)	www.uspreventiveservicestaskforce.org

Appendix 2 Male Training Center's Staff, Technical Panel, Advisory Committee & Other Contributors for Feedback on Men's Clinical Services

Male Training Center

AccessMatters (formerly Family Planning Council)

Robert McKenna, MS, MCHES, PhD, Director/MTC Co-Principle Investigator

Daryn Eikner, MS, Director of Service Improvement

Shelley Miller, MA, Deputy Director of Training & Performance Improvement

The Johns Hopkins University

Anne Rompalo, MD, ScM, Medical Director/Co-Principle Investigator

Arik V. Marcell, MD, MPH, Associate Medical Director/Co-Principle Investigator

M. Terry Hogan, MPH, Program Administrator

Men's Health Technical Panel

David Bell, MD, MPH, Assistant Professor, Columbia University

Willard Cates, MD, MPH, President of Research, Family Health International and Professor University of North Carolina, Chapel Hill

Linda Creegan, MS, FNP, Clinical Training Coordinator, California STD/HIV Prevention Training Center

Dennis Fortenberry, MD, MS, Associate Professor, Indiana University School of Medicine

Robert Garofalo, MD, MPH, Associate Professor, Children's Memorial Hospital, Northwestern University

Wendy Grube, PhD, CRNP, Practice Assistant Professor, University of Pennsylvania School of Nursing

Robert L. Johnson, MD, FAAP, Professor and Dean, New Jersey Medical School

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Thomas Walsh, MD, Assistant Professor of Urology, University of Washington Medical Center

Sandra Wolf, MD, Associate Professor, Drexel University School of Medicine **Chair*

Male Training Center Advisory Committee

Alfonso Carlon, Project Director, Cardea Services

Clare Coleman, President & CEO, National Family Planning and Reproductive Health Association

Dana Cropper Williams, MPA, MHR, Training Director, National Coalition of STD Directors

Nancy Keohane, RNC MSN OGNP, Virginia Department of Health, Family Planning Program Manager, State Family Planning Administrators

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Sandy Worthington, MSN, WHNP-BC, CNM, Director of Medical Continuing Education and Special Projects, Planned Parenthood Federation of America

Appendix 2 Male Training Center's Staff, Technical Panel, Advisory Committee & Other Contributors for Feedback on Men's Clinical Services, cont.

Office of Population Affairs

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Centers for Disease Control

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Elissa Meites, MD, MPH, Division of STD Prevention, CDC
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Any disclosures from participants are available upon request

About the Male Training Center

The purpose of the Male Training Center is to help improve delivery of family planning and reproductive health services for males in Title X, and other sexual and reproductive health, and social service settings. The Male Training Center has five major aims designed to make information, resources, and learning opportunities accessible for staff working in Title X services: 1) national partnership building; 2) development, compilation, coordination, and dissemination of training information; 3) design and facilitation of training events; 4) translating research into practice; and 5) capacity building of Title X training, research, and service grantees.

Established in 2009, the Male Training Center is a project of AccessMatters, formerly Family Planning Council, and a collaboration with the Johns Hopkins University School of Medicine, Center for Sexually Transmitted Disease and Reproductive Health Research, Prevention, and Training.

The Male Training Center seeks guidance and input into project activities from its advisory committee members, consisting of individuals representing international, national, and regional organizations with shared interest in quality family planning and reproductive health services for males.

The Male Training Center was originally funded through a cooperative agreement (FPTPA006011) with the Office of Population Affairs, Department of Health and Human Services from September 2009 through December 2012. Although this funding has ended, the Male Training Center is committed to continuing its work to improve the delivery of services to males in all settings.

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About Arik V. Marcell, MD, MPH

Dr. Marcell is an Associate Professor with a primary appointment in the Johns Hopkins University School of Medicine's Department of Pediatrics and a joint appointment in the Bloomberg School of Public Health's Department of Population, Family and Reproductive Health. He is a board certified pediatrician and adolescent medicine specialist. Dr. Marcell is a nationally recognized expert in male adolescent and young adult health. He has extensive experience training health professionals on the delivery of male sexual and reproductive health care and conducting theory-driven research designed to better understand and improve adolescent and young adult males' involvement in sexual and reproductive health care.

Notes

MALE TRAINING CENTER

FOR FAMILY PLANNING & REPRODUCTIVE HEALTH