Bridging the Gap:
Male Service Recommendations

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Disclosures

• Nothing to disclose
  – No financial interests or relationships with
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  – I will not discuss unlabeled use of products or
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  – No commercial support provided for this activity
Objectives

1. Describe males’ sexual & reproductive health (SRH) needs
2. Discuss recommended SRH services to deliver to reproductive-aged males
3. Understand the process that was used in the development of these recommendations

Background

Males have substantial SRH needs related to…
- Puberty & development
- Sexual identity formation
- Achieving healthy relationships
- Sexual behavior & related outcomes
  - Preventing pregnancy (e.g., male & female methods)
  - Planning for pregnancy (e.g., preconception care & infertility concerns)
  - STDs & HIV
  - Reproductive-related cancers
  - Problems with sexual function
  - Comorbid behaviors (e.g., alcohol, drug use)
  - Comorbid conditions (e.g., depression, medications)

Why is it important to engage males in SRH?

1. Meet SRH needs in their own right
2. Improve health outcomes of partners
3. Involve them as critical partners in family planning to ensure pregnancies are planned & wanted
4. Improve capacity for parenting, fathering & child health outcomes
5. Use SRH as clinical hook to address other health needs
6. “Providers” (e.g., parents, teachers, healthcare) lack sufficient knowledge & skills on addressing males’ SRH
7. Males are not socialized around health care & SRH care

Few males receive SRH care
Disparities by gender

According to provider & patient reports

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess for sexual health</td>
<td>45%</td>
<td>15%</td>
</tr>
<tr>
<td>Counsel on STIs, HIV, pregnancy</td>
<td>61%</td>
<td>34%</td>
</tr>
<tr>
<td>Assess/counsel on contraception</td>
<td>33%</td>
<td>5%</td>
</tr>
<tr>
<td>Counsel on condoms</td>
<td>18%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Lafferty WE, et al. AJPH. 2002; 92, 1779-83
Chandra et al. NSFG. 2006-10.
Do young men want to talk about SRH care?

<table>
<thead>
<tr>
<th>SRH Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decreasing STI risk</td>
</tr>
<tr>
<td>2. HPV/genital warts vaccine</td>
</tr>
<tr>
<td>3. Using condoms correctly</td>
</tr>
<tr>
<td>4. Female birth control methods</td>
</tr>
<tr>
<td>5. Emergency contraception</td>
</tr>
<tr>
<td>6. Sexual function</td>
</tr>
<tr>
<td>7. Making someone pregnant</td>
</tr>
<tr>
<td>8. Fatherhood</td>
</tr>
<tr>
<td>9. Intimate/romantic partner relationships</td>
</tr>
<tr>
<td>10. Testicular cancer</td>
</tr>
<tr>
<td>11. Acne</td>
</tr>
</tbody>
</table>

• Sample of young African American & Latino male clinic patients in 2 urban cities

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Yes: Majority of males, regardless of age, want to talk with their healthcare provider about SRH

• 84-98% report being willing to talk about all SRH topics
• 45-86% report wanting doctor to bring it up 10 of 11 topics
What accounts for discrepancy in young men’s SRH care delivery?

Challenges in SRH care delivery to males

1. Until now, no one national organization has outlined clinical standards of SRH care to deliver to reproductive-aged males
2. Lack of research with males in clinical settings to inform clinical guidance
3. Existing guidelines are single-topic focused & lack a comprehensive SRH framework
What constitutes SRH care for males?

**QFP & MTC guidance on men’s SRH care**

1. CDC & DHHS Office of Population Affairs *Providing Quality Family Planning Services (QFP)*, 2014
2. Male Training Center (MTC) *Preventive Male SRH Care: Recommendations for Clinical Practice*, 2014

Guidance development

- **Used an evidence-informed approach**
  - Examined professional organizations for recommendations & relied on evidence-based recommendations whenever possible
  - Conducted systematic reviews for gap areas (e.g., topics without evidence)
- MTC convened **Men’s Health Technical Panel** to provide feedback (1 of 6 technical panels convened)
- Recommendations were then drafted & presented to an Expert Work Group (EWG) presiding over entire process
- CDC & OPA considered EWG feedback to develop final set of core recommendations for QFP

QFP decisions

**For men’s health guidance components**

1. Used WHO SRH definitions as starting point to consider SRH care to deliver to men
2. Identified core services: Contraception, Basic infertility, Preconception health, & STD services
3. Identified assessing client’s reproductive life plan & comprehensive sexual history as cornerstones to determine relevant services to deliver
4. Used hierarchical approach for providing each service given inconsistencies between organizations
   - #1 CDC (STD treatment, HIV testing, preconception care)
   - #2 USPSTF (United States Preventive Services Task Force)
   - #3 Other organizations (AAP’s Bright Futures for adolescents)
5. Identified other related preventive health services for men linked closely with family planning services
6. Made recommendations against providing services shown to be ineffective or when potential harm outweighs benefit
7. Integrated recommendations for men’s health throughout QFP rather than just separate section focused on men, or treated as “special population”
SRH definition & framework*

“A state of physical, mental & social well-being & not merely absence of disease, dysfunction or infirmity in all matters relating to reproductive system, its functions & its processes”

CDC. A public health approach for advancing sexual health in U.S. Atlanta, GA. 2011.

Identified SRH care goals for males

Prevent
• STIs & HIV
• Unintended pregnancy (e.g., family planning)
• Reproductive health cancers

Promote
• Sexual health & development
• Reproductive life plan (e.g., timing & spacing of children)
• Preconception health
• Healthy relationships & behavior

Reduce
• Sexual problems & infertility

Increase
• Lifespan/survival & quality of life
• Access to clinical services & client satisfaction
QFP decisions cont.
For men’s health components of guidance

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MTC Men’s Health Technical Panel

• MTC’s effort focused on men’s SRH more broadly, & not just on family planning
• MTC document
  – Summarizes QFP clinical preventive service recommendations,
  – Highlights further deliberations by Men’s Health Technical Panel for services to include, &
  – Provides tools & resources for providers
Recommended clinical preventive SRH services for males

Recommended services

<table>
<thead>
<tr>
<th>History</th>
<th>Key SRH Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive life plan 1</td>
<td>Condoms with demonstration/availability</td>
</tr>
<tr>
<td>Sexual health assessment 4</td>
<td>STD/HIV</td>
</tr>
<tr>
<td>Problems with sexual function</td>
<td>Pregnancy prevention including male &amp; female methods &amp; EC</td>
</tr>
<tr>
<td>Intimate partner &amp; sexual violence</td>
<td>Preconception health</td>
</tr>
<tr>
<td>Alcohol &amp; other drug use</td>
<td>Sexuality/relationships</td>
</tr>
<tr>
<td>Tobacco use</td>
<td>Sexual dysfunction</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Infertility</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Exam</th>
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</thead>
<tbody>
<tr>
<td>Height, weight &amp; BMI</td>
</tr>
<tr>
<td>Blood pressure</td>
</tr>
<tr>
<td>External genital/perianal exam</td>
</tr>
</tbody>
</table>

| Laboratory Tests | |
|------------------| |
| Chlamydia | |
| Gonorrhea | |
| Syphilis | |
| HIV/AIDS | |
| Hepatitis C | |
| Diabetes | |
## Screening services no longer recommended

<table>
<thead>
<tr>
<th>History</th>
<th>Teaching testicular self-exam (for cancer screen)</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Testicular exam (for cancer screen)</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Hernia</td>
<td>X</td>
</tr>
<tr>
<td>Labs</td>
<td>Gonorrhea (low risk)</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B (low risk) *</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Hepatitis C (not born ’45-’65)</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Herpes simplex</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Syphilis (not at increased risk)</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>PSA for prostate cancer</td>
<td>X</td>
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<tr>
<td></td>
<td>Urinalysis</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Hemoglobin / hematocrit</td>
<td>X</td>
</tr>
</tbody>
</table>

## No recommendation:

**Evidence still being accumulated**

<table>
<thead>
<tr>
<th>Labs</th>
<th>Trichomonas</th>
<th>?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Human papillomavirus</td>
<td>?</td>
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<tr>
<td></td>
<td>Anal cytology</td>
<td>?</td>
</tr>
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</table>
Details about each service

History components
Cornerstone Component 1

<table>
<thead>
<tr>
<th>Content</th>
<th>Reproductive life plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions</td>
<td>• Assess among individuals capable of having a child whether they have a reproductive life plan</td>
</tr>
<tr>
<td></td>
<td>• Have you ever made someone pregnant / are you currently a father?</td>
</tr>
<tr>
<td></td>
<td>• Do you want to have (more) children?</td>
</tr>
<tr>
<td></td>
<td>• How many (more) children would you like to have &amp; when?</td>
</tr>
<tr>
<td>Who/When</td>
<td>• All ages / Each encounter</td>
</tr>
<tr>
<td>Source</td>
<td>• CDC Preconception care</td>
</tr>
</tbody>
</table>
History: Reproductive life plan

• Prioritize appropriate services to deliver

Planning to have child in next 12 months?

- NO
- YES
- UNSURE

Pregnancy prevention services
Preconception health services
Consider both

History:
What is goal of preconception health?

• To optimize health before conception & reduce adverse maternal & infant outcomes (e.g., preterm birth, low birth weight, infant mortality)
• More recently inclusion of males
  – Attuned to “anticipatory fatherhood” & minimize gender disparities
• Specific benefits for men
  – Improve genetic & biologic contributions to a pregnancy
  – Be involved in planning & spacing of pregnancies
  – Improve overall health
• Additional history: Past medical/surgical history impairing reproductive health (e.g., genetic defects, reproductive failure), conditions reducing sperm quality (e.g., obesity, DM, varicocele & STDs), occupational/environmental exposures

History components
Cornerstone Component 2

Content: Sexual health assessment

Questions:
• Use 5 P’s approach to conduct sexual health assessment

Who/When:
• All ages / Each encounter

Source:
• CDC

History: Sexual health assessment

5 P’s approach
Practices
Assess for types of sexual behavior patient engages in (e.g., vaginal, anal, &/or oral sex)

Partners
Ask questions to determine number, sex, & concurrency of patient’s sex partners. May need to define term “partner” to patient or use other, relevant term

Pregnancy prevention
Discuss current & future partner contraceptive options

Protection from STDs
Ask about condom use, with whom they do or do not use condoms, & situations that make it harder or easier to use condoms

Past STD history
Ask about STD history, including whether partners ever had STD
### History components

#### Problems with sexual function

**Content**

Problems with sexual function

**Questions**

- Ask do you have any difficulty with intercourse/problems when having sex?
- **Rationale**: Identify underlying cardiovascular disease among men presenting with sexual dysfunction symptoms

**Who/When**

- All ages but especially above 25 / Each encounter

**Source**

- Princeton Consensus Conference
- Male Training Center

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#### Intimate partner & sexual violence

**Content**

Intimate partner & sexual violence

**Questions**

- Assess for history of abuse including intimate partner & sexual violence experience & perpetration along with a history of childhood/family violence exposure
- **Rationale**: Abuse may be bidirectional within relationship context
- Providers **must** comply with state mandatory reporting guidelines regarding abuse

**Who/When**

- All ages / Each encounter

**Source**

- Bright Futures
- Male Training Center
### Mandatory reporting

**Maryland law**

- When is it considered a crime if minor has consensual vaginal intercourse with older (or younger) partner?

<table>
<thead>
<tr>
<th>AGE OF PATIENT (VICTIM'S AGE)</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
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<td>21+</td>
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</tr>
</tbody>
</table>


- Providers are mandated to report all physical abuse & sexual abuse only when perpetrator is family member or other caretaker**

  ** Has had permanent or temporary care, custody or responsibility for supervision of child, or by any household or family member

http://www.jhsph.edu/research/centers-and-institutes/center-for-adolescent-health/publications_resources/

### History components

**Alcohol & other drug use**

- Assess for alcohol misuse in adults & adolescents & for other drug use
- **Rationale:** alcohol & other drug use before & during sex may lead to lack of condom use, STD/HIV acquisition, &/or unintended pregnancy; problems with sexual function

**Questions**

- All ages / Each encounter

**Source**

- CDC Preconception Care
- USPSTF & Bright Futures
### History components

#### Tobacco use

**Content**: Tobacco use

**Questions**
- Assess about smoking & use of other tobacco products

**Who/When**
- All ages / Each encounter

**Source**
- CDC Preconception Care
- USPSTF & Bright Futures

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#### Immunizations

**Content**: Immunizations

**Questions**
- Assess SRH-related vaccine receipt & offer (as needed)
  - Human papillomavirus (HPV)
  - Hepatitis B (HBV)
  - Hepatitis A (HAV)

**Who/When**
- Refer to next slides / At least annually

**Source**
- CDC ACIP
History: HPV

• **Recommended for all males aged 11-26 (minimum age 9)**
  - Start: age 11-12 years
  - Catch-up: ages 13-21 who have not been vaccinated previously or completed 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 & immune-compromised males, through age 26 years

History: HBV

• **Recommended among males aged <19 years & all adults who are at-risk**
• **At-risk defined**
  - 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
  - HIV-positive
  - Persons who request vaccination
**History: HAV**

- **Recommended for persons at-risk**
- **At-risk defined**
  - Sexual exposure including MSM
  - MSM
  - Users of injection & non-injection drugs
  - Persons who have occupational risk for infection
  - Persons with clotting-factor disorders
  - Persons with chronic liver disease
  - During outbreaks
  - Persons traveling to or working in countries that have high or intermediate endemicity of infection

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**History components**

**Depression**

- **Questions**
  - Assess for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment & follow up
  - **Rationale**: Increased depression risk seen among those struggling with sexual identity issues, stress during coming-out process, relationship break-up, or self-esteem

- **Who/When**
  - All ages / Each encounter

- **Source**
  - CDC Preconception Care
  - USPSTF & Bright Futures
History: Suicide

- Assess for suicide risk among persons reporting symptoms of depression & other risk factors

Risk factors defined
- 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 gun
- History of mood/conduct or psychotic disorders
- Impulsive behaviors or attention deficit/hyperactivity disorder
- Concerns about sexual identity
- History of physical/sexual abuse

Physical exam components

**Content**
- Height, weight & BMI

**Exam**
- Assess for obesity including measure weight, height, & calculation of body mass index (BMI)
- Obese persons should be offered or referred to intensive counseling & multicomponent behavioral interventions

**Who/When**
- All ages / At least annually

**Source**
- CDC Preconception Care
- USPSTF & Bright Futures
### Physical exam components

#### Blood pressure

**Content**

- Measure among adults every 2 years if normal (blood pressure <120/80) & every year if client has pre-hypertension (blood pressure 120-139/80-89)

**Exam**

- Measure in adolescents annually

**Who/When**

- All ages / At least annually (as per above)

**Source**

- CDC Preconception Care
- USPSTF & Bright Futures

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#### External genital / perianal

**Content**

- Document normal growth & development (e.g., testosterone effect [Sexual Maturity Rating (SMR) for hair & genitals]) & other common genital findings (e.g., hydrocele, varicocele, STD signs)
- Inspect skin & hair, palpate inguinal nodes, scrotal contents & penis, & inspect perianal region (as indicated, e.g., history of receptive anal sex)

**Exam**

**Who/When**

- Adolescents / At least annually

**Source**

- Bright Futures & Society for Adolescent Health & Medicine
### Laboratory test components

#### Chlamydia

**Content**
- Urine-based nucleic-acid amplification tests (NAATs) is preferred approach
- Rescreen males with Chlamydia for reinfection at 3 months (via urine or rectal swab; not pharyngeal)

**Lab**

**Who/When**
- At-risk <25 / At least annually

**Source**
- QFP: CDC

**At-risk defined**
- MSM (men who have sex with men)
- Specific settings
  - Adolescent clinics
  - Correctional facilities
  - STD clinics
  - National Job Training Program
  - In military <30 y/o with any sexual experience
  - Entering jails <30 y/o or juvenile facilities
  - High prevalence communities

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#### Gonorrhea

**Content**
- Urine-based nucleic-acid amplification tests (NAATs) is preferred approach

**Lab**

**Who/When**
- At-risk including MSM / At least annually

**Source**
- CDC STD Treatment Guidelines
Laboratory: Gonorrhea

- Rescreen males with gonorrhea for reinfection at 3 months
- More frequent STD screening (i.e., at 3–6-month intervals) indicated for MSM who have multiple or anonymous partners
- For MSM who've had sex in last year, screen at least annually:
  - Using urine NAAT, for men reporting insertive sex
  - Using rectal swab NAAT, for men reporting receptive anal sex
  - Using pharyngeal swab NAAT, for men reporting receptive oral sex

Laboratory test components

<table>
<thead>
<tr>
<th>Content</th>
<th>Syphilis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab</td>
<td>RPR / VDRL</td>
</tr>
<tr>
<td>Who/When</td>
<td>At-risk / At least annually</td>
</tr>
<tr>
<td>Source</td>
<td>QFP: CDC</td>
</tr>
</tbody>
</table>

**At-risk defined**
- MSM
- Men engaging in high-risk sexual behavior
- Commercial sex workers
- Persons who exchange sex for drugs
- Persons in adult correctional facilities
- High prevalence communities
- Young MSM with risky behaviors may require more frequent screening (3-6-month intervals) (e.g., multiple or anonymous sex partners)
### Laboratory test components

**Content**
- **HIV / AIDS**

**Lab**
- Rapid test (3\textsuperscript{rd} gen)
- Serology (3\textsuperscript{rd} or 4\textsuperscript{th} gen)
- Provide opt-out screening (notify test is performed as part of general medical consent unless patient declines)

**Who/When**
- All 13-64 initial; Follow-up at-risk

**Source**
- QFP: CDC

#### At-risk defined
- MSM
- Injection drug users & sex partners
- Persons exchanging sex for money/drugs
- Sex partners of HIV-infected persons
- MSM or heterosexual persons who themselves or whose sex partners have >1 sex partner since most recent HIV test

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### Laboratory test components

**Content**
- **Hepatitis C**

**Lab**
- Serology

**Who/When**
- Born 1945-65 / At least annually

**Source**
- CDC STD Treatment Guidelines
Laboratory: Hepatitis C

- Anti-HCV test 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)
- Persons identified with HCV infection should receive brief alcohol use screen & intervention as clinically indicated, followed by referral for HCV care

Laboratory: Positive tests or testing for diagnostic purposes

Refer to
- CDC STD Treatment Guidelines 2010
  (2015 guidelines forthcoming)
  PDF: cdc.gov/std/treatment/2010/default.htm
  iPad, iPhone & iPod Touch: cdc.gov/std/2010-ebook.htm
- CDC HIV Prevention & Treatment Guidelines 2013
  PDF: cdc.gov/hiv/living/treatment/guidelines.htm
### Laboratory test components

<table>
<thead>
<tr>
<th>Content</th>
<th>Diabetes</th>
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<tbody>
<tr>
<td><strong>Lab</strong></td>
<td>• Screen among asymptomatic adults with sustained blood pressure (either treated or untreated) &gt;135/80 mm Hg</td>
</tr>
<tr>
<td><strong>Who/When</strong></td>
<td>• At-risk adults (see above) / At least annually</td>
</tr>
<tr>
<td><strong>Source</strong></td>
<td>• USPSTF &amp; CDC Preconception care</td>
</tr>
</tbody>
</table>

### Key SRH counseling components

<table>
<thead>
<tr>
<th>Content</th>
<th>Condoms with demonstration / practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Counsel</strong></td>
<td>• Offer male patients to view &amp; practice condom demonstration</td>
</tr>
<tr>
<td><strong>Who/When</strong></td>
<td>• All ages especially adolescents / Based on need</td>
</tr>
<tr>
<td><strong>Source</strong></td>
<td>• Male Training Center</td>
</tr>
</tbody>
</table>
Counseling: Condoms

Teach steps for putting on & removing a condom
1. Pinch tip of condom
2. Roll condom down to base while leaving tip pinched
3. After ejaculation occurs, hold condom at its base before withdrawing
4. Hold condom at its tip & base & remove it from penis
5. Throw it away

Other teachable points
1. Check expiration date
2. Check package for air bubbles
3. Do not open package with teeth or sharp object
4. Use only water-based lubricants with latex condoms,
5. Do not use spermicides (e.g., nonoxynol-9) since can break down latex & increase susceptibility to STDs including HIV

Teachable points for partners to discuss for optimal use
1. Contraception methods in advance including who will purchase condoms
2. Latex allergies
3. Type of condom to use (ie, latex, polyurethane, lambskin)
4. Condom characteristics (e.g., size, ribbed, lubricated, contain spermicides, etc.)
5. Try different condoms to find one that fits & feels best

Counseling: Condoms

Bottom line: Condoms come in different sizes & varying thickness

➡️ Make wide variety of condoms, lubrication & other barrier methods (dental dams) available at your clinic
Key SRH counseling components

<table>
<thead>
<tr>
<th>Content</th>
<th>STD / HIV</th>
</tr>
</thead>
</table>
| Counsel | • Provide high intensity behavioral counseling about STD prevention  
  • Provide access to HIV pre-exposure prophylaxis (PREP) & post-exposure prophylaxis (PEP) as appropriate |
| Who/When | • All sexually active adolescents & at-risk adults / At least annually |
| Source | • USPSTF / CDC |

Counseling: STD/HIV

Example
• 2 separate 20-minute clinical sessions 1 week apart
  1st session Patients assessed for personal risk, barriers to risk reduction, & identification of a small risk-reduction step within 1 week
  2nd session Review prior week’s behavioral change successes & barriers, provide support for changes made, identify barriers & facilitators to change, & develop a long-term plan for risk-reduction
**Key SRH counseling components**

**Content**

**Pregnancy prevention**

- Counsel about **male methods** (e.g., vasectomy, condoms, withdrawal) & **female methods** (e.g., long-acting reversible methods, combination methods & emergency contraception (EC))
- Provide EC in advance as allowed by state law

**Counsel**

- All ages / Based on need

**Source**

- Bright Futures

---

**Counseling: Pregnancy prevention**

- Work with client to establish patient-centered plan for using contraceptive method(s) of choice
  1. Address “4 Cs”
     - Choice
     - Correct use
     - Consistent use
     - Continued use & switching
  2. Discuss effectiveness
  3. Ensure understanding of side effects (use “teach back” approach)
  4. Involve partner in plan
  5. Plan for follow-up
- Promote dual protection for clients at-risk for STDs (i.e., effective method to prevent pregnancy plus condom to prevent infection)
Key SRH counseling components

**Sexuality & relationships**

- **Sexuality**: Provide support to males who may be dealing with issues of sexuality that can affect their psychosocial & physical health via individual support, support for families, &/or referral to local resources as appropriate.
- **Relationships**: Provide support to adolescents in how to have healthy relationships.

**Who/When**
- All ages especially adolescents / Based on need

**Source**
- Male Training Center

---

**Problems with sexual function**

- Provide support based on sexual problem etiology
- These are common medical conditions that may need to be managed from multidisciplinary perspective

**Who/When**
- Based on need

**Source**
- American Urological Association
- Male Training Center

---
Counseling: Sexual function

• For specific evaluation, treatment guidelines, & algorithms refer to:

• Note: Erectile dysfunction (ED) may be an early sign of systemic cardiovascular disease (esp ≥25 years old)
  - Prevention opportunity, especially in high-risk & underserved minority populations

---

Key SRH counseling components

**Content**

**Preconception health**

**Counsel**

• Counsel about preconception care services for patient & their partner

**Who/When**

• All ages / Based on need

**Source**

• CDC Preconception care
### Key SRH counseling components

<table>
<thead>
<tr>
<th>Content</th>
<th>Infertility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Counsel</strong></td>
<td>• Provide basic infertility services, which includes initial infertility history &amp; physical exam (as previously described), &amp; appropriate education &amp; referrals as needed</td>
</tr>
<tr>
<td><strong>Who/When</strong></td>
<td>• Based on need</td>
</tr>
<tr>
<td><strong>Source</strong></td>
<td>• American Urological Association</td>
</tr>
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</table>

### Bringing it together
**Scenario 1**

15-year-old male is at your clinic for a routine physical examination.

He has a history of asthma & ADHD. He has no concerns.

He states he does not intend to have children in the next 12 months, but that he has a sexual partner.

**What clinical preventive SRH services do you provide him?**

---

### Scenario 1

**15-year-old male is at your clinic for a routine physical examination.**

He has a history of asthma & ADHD. He has no concerns.

He states he does not intend to have children in the next 12 months, but that he has a sexual partner.

**What clinical preventive SRH services do you provide him?**

---

### QFP/MTC checklist for male services

Organizing/bundling by content area

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<thead>
<tr>
<th>Component</th>
<th>Service</th>
<th>Content area</th>
<th>Contraceptive</th>
<th>Preconception health</th>
<th>STD</th>
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<th>Related preventive health</th>
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<tr>
<td>History</td>
<td>Reproductive life plan</td>
<td>Screen</td>
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<td>Sexual health assessment</td>
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<td>Screen</td>
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<td>Intimate partner &amp; sexual violence</td>
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<td>Immunizations</td>
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<tr>
<td>Genital exam</td>
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<td>Screen</td>
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<td>Exam</td>
<td>Height, weight, BMI</td>
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<td>STD/HIV</td>
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</tbody>
</table>

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**Chlamydia**

**Gonorrhea**

**Syphilis**

**HIV/AIDS**

**Hepatitis C**

**Diabetes**

---

**Counseling**

**Contraceptive**

**Preconception health**

**Pregnancy prevention**

**Sexuality & relationships**

**Sexual dysfunction**

**Infertility**

---

**Screen**

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**Screen**

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**Screen**

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**Screen**

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**Screen**

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**Screen**

---
Scenario 1 cont.

What if this same 15-year-old came for an acute visit?

“He states he does not intend to have children in the next 12 months, but that he has a sexual partner.”

What clinical preventive SRH services do you provide him?

• Conduct same-day STD screening
• Make follow-up appointment to address his sexual health

Scenario 2

25-year-old male presents to your clinic for a work physical.

He shares he & his partner are planning to start a family in the next year.

What clinical preventive SRH services do you provide him?
QFP/MTC checklist for male services
Organizing/bundling by content area

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<thead>
<tr>
<th>Component</th>
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<td>Infertility</td>
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</tbody>
</table>

Summary

- Males have substantial SRH & family planning needs & deserve to receive quality care
- QFP & MTC use an evidence-informed approach to make recommendations for delivery of clinical preventive SRH services to males
- Strength of guidance is its integrated approach for addressing men’s SRH
Limitations

• During process of synthesizing recommendations we identified a number of gaps in clinical guidance on males’ SRH & a dearth of research in this area
• Although some recommendations by expert opinion may be on lower end of evidence ladder*, they can have merit & be useful in context when
  − High-quality evidence is lacking &
  − Procedures used to develop them are explicit & transparent


Conclusion

• Guidance by QFP & MTC defines for 1st time quality of SRH care to deliver to males
• These guidelines can
  − Serve as foundation for national standards to deliver SRH care to males in the US, &
  − Assist healthcare providers & programs to provide most effective & efficient services while also improving males’ access to SRH care
Resources

Male Training Center
http://www.maletrainingcenter.org/

CDC/OPA Providing Quality Family Planning Services

CDC STD Treatment Guidelines 2010
cdc.gov/std/treatment/2010/default.htm
For iPad, iPhone & iPod Touch
cdc.gov/std/2010-ebook.htm

CDC HIV Prevention & Treatment Guidelines 2013
cdc.gov/hiv/living/treatment/guidelines.htm

Acknowledgements

Male Training Center
• Anne Rompalo, MD, ScM
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• Christine Woolslayer

Office of Population Affairs
• Susan Moskosky, MS, RNC
• David Johnson, MPH

Centers for Disease Control
• Lorrie Gavin, PhD, MPH
### Men’s health technical panel members

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Bell</td>
<td>Columbia University</td>
</tr>
<tr>
<td>Ward Cates</td>
<td>Family Health International</td>
</tr>
<tr>
<td>Linda Creegan</td>
<td>California STD/HIV Prevention</td>
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<tr>
<td>Dennis Fortenberry</td>
<td>Indiana University School of Medicine</td>
</tr>
<tr>
<td>Robert Garofalo</td>
<td>Children’s Memorial Hospital</td>
</tr>
<tr>
<td>Emily Godfrey</td>
<td>University of Illinois at Chicago</td>
</tr>
<tr>
<td>Wendy Grube</td>
<td>University of Pennsylvania</td>
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<tr>
<td>School of Nursing</td>
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<tr>
<td>Arik V. Marcell</td>
<td>The Johns Hopkins University</td>
</tr>
<tr>
<td>Elissa Meites</td>
<td>Division of STD Prevention, CDC</td>
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<td>Erica Monasterio</td>
<td>UCSF</td>
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<tr>
<td>Demetrius Porche</td>
<td>Louisiana State University</td>
</tr>
<tr>
<td>John Rich</td>
<td>Drexel University</td>
</tr>
<tr>
<td>Jacki Witt</td>
<td>Clinical Training Center for Family Planning, University of Missouri, Kansas City</td>
</tr>
<tr>
<td>Thad Wilson</td>
<td>University of Missouri, Kansas City</td>
</tr>
<tr>
<td>Thomas Walsh</td>
<td>University of Washington Medical Center</td>
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<tr>
<td>Sandra Wolf</td>
<td>Drexel University School of Medicine</td>
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</tbody>
</table>

**AND input from members of Title X Expert Work Group & the MTC’s Advisory Committee**
2011 USPSTF statement

**Screening for testicular cancer**

*D Recommendation* = against routine screening for testicular cancer in asymptomatic males

**Additional note**

“Clinicians should be aware that patients who present with symptoms of testicular cancer are frequently diagnosed as having epididymitis, testicular trauma, hydrocele or other benign disorders”

---

USPSTF statement rationale

1. No new evidence found that
   - Screening with clinical examination OR
   - Testicular self-examination is effective in reducing mortality from testicular cancer
2. In screening absence, current treatments provide favorable health outcomes
3. Harm of screening exceed potential benefits, given
   - Low prevalence of testicular cancer
   - Limited accuracy of screening tests
   - No evidence for incremental benefits of screening
4. However…
   - No study has ever assessed harms associated with testicular cancer screening
   - Individuals at increased risk may not know they are (e.g., correction for cryptorchidism)
Exam: External genital
2012 SAHM Position Statement: The Male Genital Exam

Recommend perform genital exam among adolescents to
1. Document Sexual Maturity Rating (SMR) & progress in development
   – Document SMR separately for Hair & Genitals
2. Screen for visual STI symptoms (warts, HSV lesions)
3. Screen for genetic diseases (Klinefelter’s; 21-CAH)
4. Identify structural anomalies (varicocele, spermatocoele, hydrocele, meatal abnormalities (hypospadias), signs of testicular trauma)
5. Issues related to an uncircumcised penis (phimosis/ paraphimosis; Hygiene issues)
6. Hair/skin issues (folliculitis/ jock itch)
7. Absent testes (cryptorchidism)
8. Testicular atrophy (central cause; steroid/MJ use)
9. Reassure normal variations (penile pearly papules, sebaceous cyst)
10. Help patient gain a better understanding of his body

Socio-Ecological Framework for Male SRH & Care Seeking
Barriers to SRH care delivery
Influences at multiple levels

**Individual patient level**
- Lack of public health messages that sexually active males should seek care in general or for SRH
- Access to & use of healthcare

**Provider level**
- Gender, specialty, year of graduation
- Training, self-efficacy in care delivery (comfort taking sexual history)

**Clinic setting level**
- Services not designed to meet males’ SRH needs
- Time, competing demands, financial incentives, compensation
- Decision-support tools (reminder systems) & access to internal (e.g. health educators) or external (e.g. urology) referral resources

**System level (HEDIS measures)**
- No one professional organization makes recommendations for male SRH care across lifespan
- But, guidelines alone do not ensure provider compliance*

---


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**Minor Consent in Maryland**

Minors can seek following types of care without needing parental permission:

1. Sexual & reproductive health
   - STD/HIV-related care
   - Contraception (except sterilization)
   - Pregnancy-related care
   - Abortion (requires parental signature)

2. Substance abuse
3. Alleged rape/sexual offence
4. Urgent problem
5. Mental health (≥16 only)
6. If minor is married; a parent; or living separate/apart from parent(s)/guardians & self-supporting, they can consent for all care
**History components**

**Content**
- Standard medical history

**Questions**
- Assess for pregnancy & father history as part of standard medical history

**Who/When**
- All ages / Each encounter

**Source**
- CDC Preconception care

---

**Clinical pathway for providing SRH services to males**

*Step 1*
Clinical pathway for providing SRH services to males

QFP clinical pathway for providing SRH services
History: Intimate partner violence

Example evidence-based screen

- HITS... 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 range from 4 to 20. Score >10 considered positive for partner violence. Provide counseling & referral as appropriate.


History: Alcohol & other drug use

CRAFFT is example evidence-based screen for adolescents through age 21

During past 12 months, did you:
1. Drink any alcohol (more than few sips)? (Don’t count sips taken during family or religious event)
2. Smoke any marijuana or hashish?
3. Use anything else to get high? (e.g. illegal drugs, OTC/prescription drugs, things you sniff/“huff”)

   If answer is “No” to all questions, ask only CAR question below.
   If answer is “Yes” to any of 3 questions, ask all questions below.

- C Have you ever ridden in **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.

- Other validated screening tool includes the ASSIST

**History: Tobacco use**

The “5 A’s” approach:

**ASK**
“Do you smoke cigarettes or use tobacco?”

**ADVISE**
“Quitting smoking/tobacco use is most important thing you can do to protect your health now & in future. Clinic staff & I will help you.”

**ASSESS**
“Are you willing to make quit attempt in next 30 days?”

**ASSIST**
1. Help develop quit plan (e.g., set quit date in next 2 weeks, tell friends & family quit intent & request support, anticipate challenges to quit, & remove nicotine products)
2. Give key advice (e.g., total abstinence, review past quit experiences if any & factors that hindered past attempts)
3. Consider nicotine replacement therapy or refer

**ARRANGE**
Refer to intensive services (help lines, websites, treatment programs & follow-up to review progress.


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**History: Depression**

Staff-assisted care support defined

• Assist primary care clinician by providing some direct depression care
  - Care support or coordination, case management or mental health treatment
  - For example, screening nurse who advises clinician of positive screen & provides protocol facilitating referral to therapy

Example screening approach

• Screening in primary care with 2 questions*
  1. During past month, have you often been bothered by feeling down, depressed, or hopeless?
  2. During past month, have you often been bothered by little interest or pleasure in doing things?

• Other validated screening tools:
  - PHQ9
  - CES-D

History: Suicide

Things to watch for when assessing potential risk

**P.L.A.I.D. P.A.L.S.**

- **Plan**  
  Do they have one?

- **Lethality**  
  Is it lethal? Can they die?

- **Availability**  
  Do they have the means to carry it out?

- **Illness**  
  Do they have a mental or physical illness?

- **Depression**  
  Chronic or specific incident(s)?

- **Previous attempt**  
  How many? How recent?

- **Alone**  
  Are they alone? Do they have a support system? Partner? Are they alone right now?

- **Loss**  
  Have they suffered a loss? Death, job, relationship, self esteem?

- **Substance abuse**  
  Drugs, alcohol, medicine? Current, chronic?

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Physical exam components

- **Content**  
  **External genital / perianal**

- **Exam**  
  - Perform as part of evaluation for male infertility (older male)

- **Who/When**  
  - Based on need

- **Source**  
  - American Urological Association

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Counseling: Infertility

• Early evaluation if known male or female infertility risk factor exists or if man questions his fertility potential:
  – Couple attempting to conceive should have evaluation for infertility if pregnancy fails to occur within 1 year of regular unprotected sex
  – An evaluation should be done before 1 year if
    1. Male infertility risk factors such as history of bilateral cryptorchidism are known to be present
    2. Female infertility risk factors (e.g., advanced female age (>35 years)), are suspected, or
    3. Couple questions male partner’s fertility potential
  – Men who question their fertility status despite absence of current partner

Counseling: Infertility cont.

• Counseling & referral provided during clinical visit should be driven by information elicited from client during initial infertility history & physical exam (as described above)
• Referral may be needed for further evaluation (for semen analysis (2 specimens), endocrine evaluation for testosterone & FSH levels, or post-ejaculate urinalysis (when ejaculate volume is <1mL)
• For patients who fall under prior definition, but are concerned about infertility & no apparent cause, provide education about how to maximize fertility
Counseling: Sexuality

Example tool: Have you ever...

- been hit, slapped or physically hurt because of your LGBT identity?
- experienced verbal harassment or name-calling because of your LGBT identity?
- been excluded from family events or activities because of your LGBT identity?
- been blocked access to LGBT friends, events, & resources?
- been blamed when you have been discriminated against because of your LGBT identity?
- been pressured to be more (or less) masculine or feminine?
- been told that God will punish you because you are gay?
- been told your family is ashamed of you or that how you look or act will shame the family?
- been told to keep you LGBT identity a secret in the family & not letting you talk about your identity with others?


Counseling: Relationships

Example tool: Friend, girlfriend, or boyfriend – all deserve healthy relationships.

- **Respect.** Are you accepted for who you are? No one should pressure you into continued doing things you are not comfortable with such as drinking, drugs, or unwanted physical contact.
- **Safety.** Do you feel emotionally & 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 & 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 & put equal effort into the relationship? From activities you do together to friends you hang out with, you should have equal say in 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 & 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 & hear each other out. Text or Facebook messages should be respectful, not mean or inappropriate.

Counseling: Relationships

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

Position Paper

The Male Genital Examination: A Position Paper of the Society for Adolescent Health and Medicine

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