Young Men's Sexual AND Reproductive *Health*

Toward a National Strategy

GETTING STARTED

Freya L. Sonenstein, editor

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AND

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SUMMARY

WHY FOCUS ON YOUNG MEN?

Human reproduction involves a man and a woman. In spite of this fact, efforts to improve reproductive health in the United States and elsewhere have typically targeted women.[1] But since men participate in sexual decisions and behavior associated with reproduction, the focus here is on the sexual and reproductive health of men in the United States and specifically on young men ages 12 to 24. While reproductive health is a concern for all men of all ages, the earliest part of the life course—adolescence and early adulthood—is of utmost importance. Promoting the sexual and reproductive health of young men is a keystone to enhancing their health overall, to reducing some of the major health risks they face, and to establishing habits that will protect them throughout their lives. Promoting sexual and reproductive health for young men, a population that has been largely ignored, can lead to new inroads in promoting healthier lifestyles, preventing disease transmission, and reducing the unplanned pregnancies and births that are implicated in poor outcomes for children.

Federal Context of Health Promotion Effort

Making sexual and reproductive health an integral part of a broader health promotion effort for young men is consistent with the Surgeon General's *Evolving Health Priorities*. It also will contribute to achieving the health goals established for the nation in the Healthy People 2010 initiative.[2] The initiative designates responsible sexual behavior as one of 10 leading health indicators for the nation, reflecting its status as a major public health concern as well as its amenability to change. The initiative targets the behavior of both men and women. But there is no traditional medical or public health infrastructure oriented to the sexual and reproductive health needs of men. Addressing these needs will require the development of new approaches and new partners for effective community health strategies. Such an effort can serve as a catalyst and model for other broad-based community health partnerships. Community partnerships are an important component of the Surgeon General's strategy to build a health system that balances treatment with disease prevention and health promotion.[3]

Reaching out to young men is not a new idea. The Office of Family Planning of DHHS funded a set of demonstration projects to encourage the involvement of men in the 1970s. The Office of Family Planning was established to administer Title X of the Public Health Services Act, to assist individuals and couples with the number and spacing of their children. Title X's federal family planning program, now a network of 4,600 family planning clinics, has grown and thrived for 30 years. In sharp contrast to this success, its early demonstration program designed to test the involvement of men in family planning

clinics showed limited success and was discontinued.

The Title X program has now renewed its efforts to involve men, testing a variety of approaches to including men in promoting reproductive health. These approaches range from expanding family planning clinics' services for men to using community-based organizations already serving young men as venues for delivering reproductive health services. But lack of consensus about what reproductive health services for young men should look like—and how this undefined complement of services should be delivered—presents an enormous challenge.

"LACK OF *consensus about what reproductive health services for young men should look like presents an enormous challenge."*

Source of Proposed Initiative

To help overcome this barrier, the Urban Institute convened a group of experts representing the major professional groups that could provide leadership for the development of reproductive health services for young men in the United States today. This group, whose names and affiliations are listed on pages 4–5, met for a two-day working session at Airlie House in Virginia on September 28–29, 1999, to review a set of working papers prepared for the meeting. The broad strategy and recommended actions presented here reflect the consensus developed by the participants at this meeting. The suggestions are grounded in part on the discussions held and on the information and analyses contained in the papers prepared for the meeting.

The following pages describe why the time is right for an initiative promoting young men's sexual and reproductive health, why it is so important, how it might be done, and how DHHS can help make it happen. The working group's blueprint for action is presented as a

starting point for building a broader consensus about the value of enhancing reproductive health among young men and for shaping promising intervention strategies.

Rationale for Acting Now

Recognition of men's crucial contribution to the healthy formation of families has increased remarkably over the past five years. This new awareness is apparent in the public policy realm, among service providers across the country, and among young men. The interest and energy of policymakers and service providers combined with the evident readiness of the men themselves make this moment particularly favorable for a new initiative promoting young men's sexual and reproductive health.

Recent Policy Shifts

More men than ever before are fathering children outside marriage and living apart from their children.[4] Recognition of these demographic shifts, and their consequences for children who grow up without the economic or emotional support of their fathers, has led American lawmakers to require more men to take greater responsibility for their children, even when those children are unintended or are born outside marriage. Key elements of the nation's welfare reform policy—set forth in the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996—discourage childbearing outside marriage, encourage abstinence until marriage, and step up efforts to link unmarried fathers with their biological children through establishment of paternity and enforcement of child support. A clear intent of

this legislation, signaled by the name of the bill itself, is to encourage responsible behavior.

These legislative efforts parallel national campaigns and state and local programs that encourage men to get more involved with their families. Private initiatives range from faith-based campaigns to non-custodial fathers' rights groups to programs aimed at shoring up fragile families.[5] On the public side, the federal government has implemented the president's 1995 memorandum to the heads of executive departments, which directs federal agencies to support the role of fathers in families.[6] And every state now has an initiative under way to encourage responsible fatherhood.[7] At the individual level, attitudes about the father's role in the family have shifted, with increasing emphasis on his role as caregiver and nurturer, as well as breadwinner.[8]

Other more recent efforts are beginning to help men avoid unintended parenthood and become more active in choosing when to become fathers.[9] This is, indeed, the first step in becoming a responsible father.[10] The past few years have brought many calls to include men in family planning strategies—ranging from conclusions of the Institute of Medicine, [11] to the U.S. DHHS National Strategy to Prevent Teen Pregnancy,[12] to the deliberations of the 1994 International Conference on Population and Development in Cairo and the 1995 Fourth World Conference on Women in Beijing. Thus, there is now general support for the goal of increasing men's participation in preventing unintended pregnancy. However, the type of male involvement, how the objective is to be attained, and how to pay for it are not yet clear.

There also is new interest and investment in identifying successful prevention programs, so that they can be more broadly implemented throughout the United States. These efforts range from rigorous reviews

"THERE IS *now general support for the goal of increasing men's participation in preventing unintended pregnancy."*

of the evidence about effective teenage pregnancy prevention programs conducted by the Centers for Disease Control and Prevention and the National Campaign to Prevent Teen Pregnancy[13] to efforts to identify what makes HIV prevention programs succeed, especially community-based initiatives.[14] Responding to criticism that no abstinence-only programs had undergone rigorous evaluation, Congress included funding in its 1996 welfare reform legislation for a scientifically conducted evaluation of the new abstinence-only programs. This evaluation is under way. While there is still more to learn, the reproductive health field is better equipped than before to take advantage of the accumulating knowledge about what programs and program elements work.

Recent Shifts in Existing Services

Many family planning clinics around the country are finding new reasons to serve the male partners of their customary female clientele. A key concern has been the emergence of HIV and other sexually transmitted diseases (STDs) as major public health problems. Some clinics are discovering, for example, that breaking the cycle of reinfection requires them to treat the partners of the many women who test positive for STDs. The appearance of HIV and rising rates of STDs among their patients also have given clinics a more urgent interest in encouraging use of condoms, a contraceptive method that had languished during the 1970s as medical methods like the pill were increasingly the method of choice.[15] Since 1979, condom use among adolescent men has more than doubled, and male condoms are now used more than half the time when teenagers have sex for the first time.[16]

The health care market is also putting new pressures on family

planning clinics. Some clinics have sought to expand their clienteles. Some now offer a broader array of care for the whole family, including job and sports physicals as well as reproductive care—STD testing and treatment, sterilization, fertility counseling—for men. Other clinics forged partnerships with youth development and criminal justice agencies to provide reproductive services to underserved populations in these nontraditional venues.

Efforts of family planning clinics to serve men have grown substantially. In a 1995 survey of publicly funded family planning agencies across the country, 39 percent reported that some of their patients were men, and more than half (52 percent) of Planned Parenthood affiliates include male partners in education and counseling efforts.[17] These efforts serve relatively few male clients overall, however. At the federal level, the Office of Family Planning is funding 30 projects to test new approaches to involving males in family planning. Some states also are funding family planning services for men. California has one of the most comprehensive efforts, which includes funding by the state Office of Family Planning for 22 community-based agencies to develop and implement male involvement programs. A 1999 report issued by the Family Planning Councils of America calls "meeting the reproductive health needs of men in our communities" one of the best-kept secrets of Title X.[18]

The past five years also have brought rapid growth in programs promoting men's involvement in families. The National Fatherhood Initiative reports more than 2,000 fatherhood programs across the country. Programs that include reproductive health promotion are more scarce. In 1995, about 100 such programs aimed at teenage and young adult men were identified across the country, and many were

"REDUCING *sexual risk-taking among young adult men...is an important strategy for reducing high rates of STDs and childbearing amoung female teenagers."*

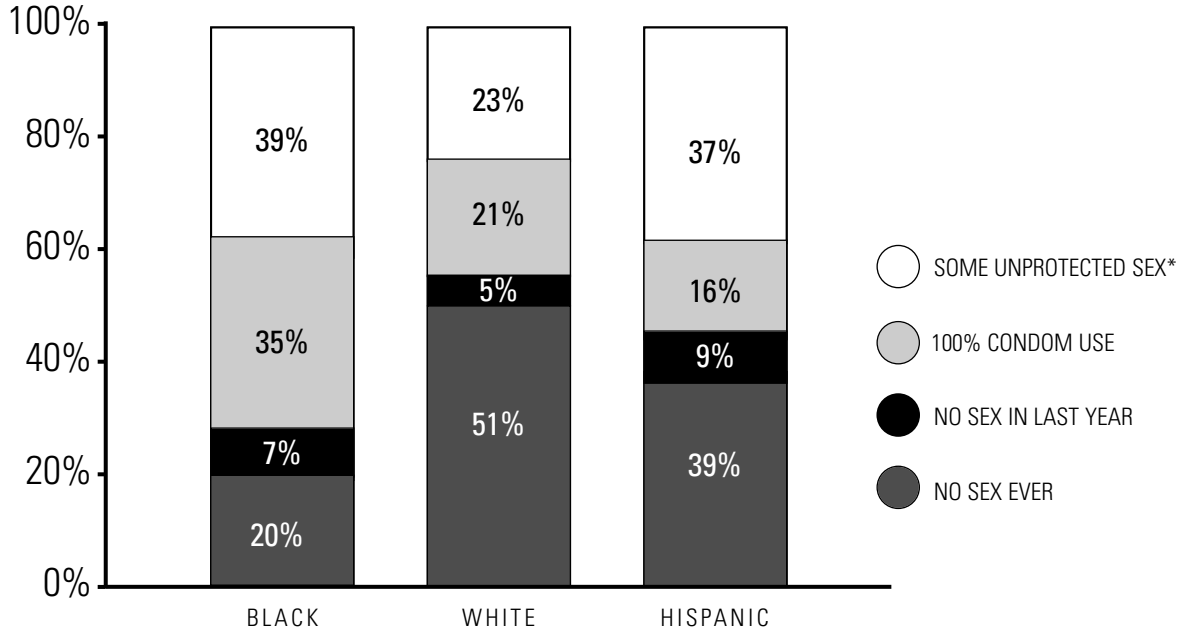
less than three years old.[19]

The field of male sexual and reproductive health is emergent. Much pioneering activity and enthusiasm are evident, not only among more traditional providers but also among the community-based agencies that often hold the trust of young men, particularly those disconnected from the mainstream. The next steps are to define the content of services, identify successful program models through inventorying program approaches, identify best practices, promote further innovation and partnerships, and invest in program evaluation for "best bets."

Recent Positive Changes among Men

National surveys asking about men's attitudes and behaviors regarding sex, contraception, pregnancies, and births reveal that young men and women are still at high risk of unintended pregnancy and disease.[20] The same surveys also show, however, that in recent years teenage men have begun to behave more cautiously in their sexual lives. Many of these men are highly motivated to use condoms and have dramatically increased their use of condoms since 1979. In addition, they have modestly cut back their levels of sexual activity since 1988. These two, in turn, have reduced the proportions of teen males who have had unprotected sexual intercourse in the past year. Still, the share of young men engaging in unprotected sexual intercourse remains high, and it is especially high among men of color. In 1995, just over one-fourth (27 percent) of all male teenagers reported having unprotected sex in the past year, but the proportions were substantially higher among African-American (40 percent) and Hispanic men (37 percent).[21]

Figure 1 Levels of Protection in the Last 12 Months against HIV/STDs among Never-Married Males Ages 15 to 19, by Race/Ethnicity, 1995



* Does not include 100% effective female contraception.
Source: Urban Institute 2000.
Note: Totals may not sum to 100 due to rounding.

Parallel Shifts in Health Outcomes

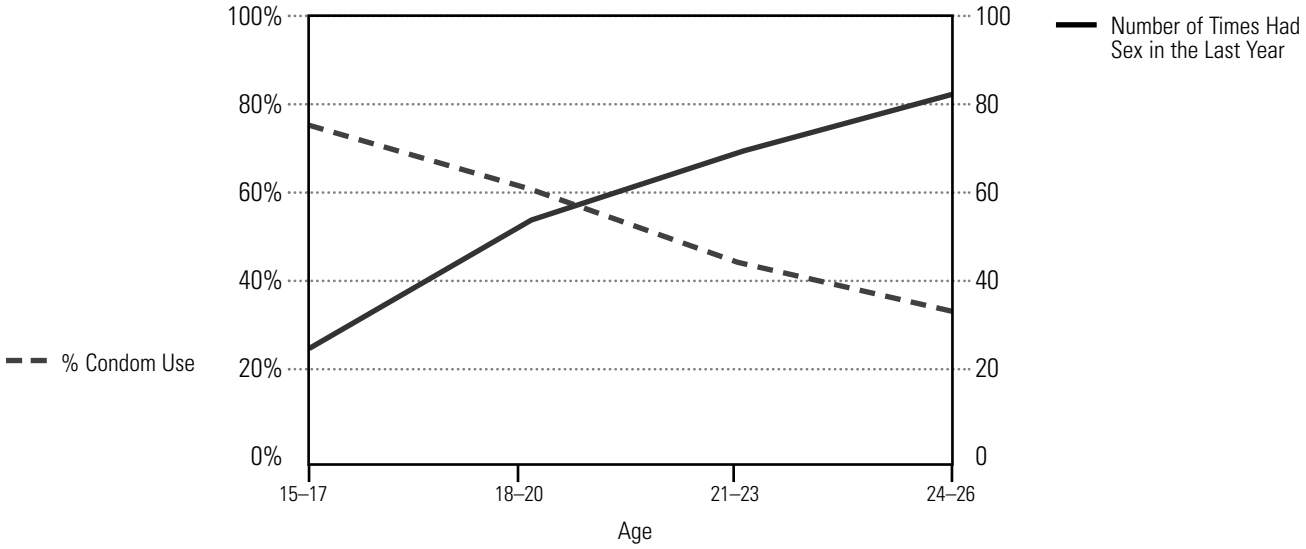
As sexual risk-taking by adolescents declines, their health improves. National population data show declines in adolescent pregnancy and childbearing.[22] Disease surveillance data indicate that some STD rates among adolescents also have declined.[23] These declines, combined with the shift in health behaviors at the same time, strongly suggest that public health efforts to educate teenagers and the public at large about the dangers of HIV, other STDs, and unintended pregnancy are beginning to pay off. Even so, AIDS is the seventh leading cause of death among men ages 15 to 24,[24] and the physical, social, and eco-

nomic costs of other STDs and unintended pregnancy remain great.

But adolescent men—the targets of much of the public effort and rhetoric—are not the age group with the greatest reproductive health risk. Young men in their early 20s actually face greater risks. They have sexual intercourse more often and use condoms less often (see chart, this page). One-third of unmarried sexually experienced men ages 22 to 26 have had three or more female sexual partners in the past year, compared with one-fifth of unmarried, sexually experienced men ages 18 and 19.[25] Not surprisingly, rates of STDs are also higher among men in their 20s. In 1998, the gonorrhea rate was 575 per 100,000 among men ages 20 to 24, compared with a rate of 355 among men ages 15 to 19.[26]

These behavior patterns among men in their early 20s affect the health of female adolescents, because such men father most births to

Figure 2 Sexual Risk Behaviors among Young Men, by Age



Source: Urban Institute 2000. Authors' tabulations based on data from the National Survey of Adolescent Males.

teenage girls. In 1988, 51 percent of births to girls ages 15 to 19 were fathered by men ages 20 to 24, for example; another 11 percent were fathered by men ages 25 to 29.[27] More generally, sexual relationships between teenage girls and older partners tend to be riskier than those between teen girls and their male peers, because use of contraception is lower with older male partners (Miller, Clark, and Moore 1997).[28] Among females, some STD rates peak among 15- to 19-year-olds, while among males they peak among 20- to 24-year-olds. Thus, reducing sexual risk-taking among young adult men, as well as their sexual involvement with teen women generally, is an important strategy for reducing high rates of STDs and childbearing among female teenagers.

Extent of Unmet Reproductive Health Needs of Men

Young men need more reproductive health information and services than they are getting. First, though in recent years young men have reduced their sexual risk-taking, more change is needed to protect them and their partners from AIDS, other STDs, and unintended or too early pregnancies and births. Second, young men report that they want more information about reproductive health issues than they receive. Parents often do not provide teens with the help they need. Only half of teen men, for example, say they have spoken to their parents about a reproductive health topic.[29] In addition, many opportunities for educating young men through school, family, the media, and health care professionals are missed. Third, many young men do not have access to preventive care or treatment. Together, these problems leave young men in need of much greater access to information

and services that could enhance their reproductive health.

Most male teenagers (71 percent) had a physical exam in the past year. Yet relatively few report getting information about reproductive issues from their health care providers. Less than one-third (31.5 percent) of the group who had a physical reported discussing even a single reproductive health topic with their doctor or nurse (Porter and Ku 2000). A smaller proportion of men in their 20s (56 percent) had a physical exam in the past year, although a similar proportion (31 percent) of those who had been examined discussed reproductive health issues with a doctor or nurse. Their lower overall contact with health providers reduces the overall proportion of men in their 20s who receive reproductive health information from this source.[30] Many of those providers miss prime opportunities for addressing reproductive health risks, like STDs, among this generally healthy population. And many men lack access to care altogether.

"THE LACK OF *access of adolescents and young men to preventive health care causes problems that can deepen over their lifetime."*

Reasons for Inadequate Access to Health Care and Information

The absence of health insurance is a major stumbling block to access to care. The same survey that found that almost three-quarters of males ages 15 to 19 received a physical exam in the past year found that fewer than half of the 11 percent of males without health insurance received a physical exam.[31] Among men ages 22 to 26, regardless of insurance status, only 56 percent received a physical exam in the past year.[32] Access to health care providers must be expanded, and the sexual and reproductive health content of these services must be improved.

Aggravating the situation for most young men is the absence of

any special setting where they can go to seek gender- and age-appropriate reproductive and sexual health services. The nature of routine care generally differs for men and women. Reproductive health and family planning care are much more common for young women. No comparable system ensures that young men receive reproductive and HIV/STD-related preventive health services. Some family planning clinics are not able to meet the reproductive and sexual health needs of young men and are generally perceived as not very welcoming to men. Further, education and training materials on men's reproductive and sexual health are limited.[33] In 1998, out of the 4.4 million family planning users served by Title X clinics, approximately 3 percent were men (116,584). This number does not include STD and HIV tests (144,608) funded by Title X for male clients. If these tests were added, the number of men served might double but it would still represent a small share of the clientele.[34] While Medicaid and Title X pay for the overwhelming majority of sexual and reproductive health care for low-income women, no such recognized funding source is routinely available to low-income men.

The medical specialties most pertinent to men's sexual and reproductive health needs are urology and infectious diseases. However, few young men see, or need to see, these specialists. Primary care physicians such as pediatricians (including adolescent medicine), family practitioners, and internists provide the bulk of care to young men. As previously noted, many of these providers fail to respond to young men's sexual and reproductive health needs—even though the American Medical Association,[35] the Society for Adolescent Medicine,[36] and a special commission sponsored by the Health Resources and Services Administration and the Health Care Financing

Administration[37] recommend that specific reproductive health services, counseling, and education be incorporated into routine care for adolescents. No medical or public health specialty responds comprehensively to sexual and reproductive health needs of young men, especially those beyond adolescence.

The lack of access of adolescents and young men to preventive health care in general, and to sexual and reproductive health care in particular, causes problems that can deepen over their lifetime. A recent survey commissioned by the Commonwealth Fund found that among adult men, one in four had not seen a physician in the past year, fewer than one in five said they would seek immediate medical care if they were sick or in pain, and one in five said they were not comfortable discussing their feelings with a doctor. Among men ages 50 and older, 41 percent had not been tested for prostate cancer.[38] Thus, few adult men develop health-seeking behavior in their youth that will protect their health, including their sexual and reproductive health, in their later adult years.

What Needs to Be Done

Most young men move from adolescence into adulthood with inadequate information about sex, little guidance about their sexual responsibilities and relationships, and little access to appropriate health care. Filling these gaps is a challenge that cannot be met with a single model.

Place Reproductive Needs in Life-Cycle Context

To understand how young men's reproductive health needs vary, those needs must be placed within the broader context of adolescent male

development. Adolescence is generally divided into three phases—early, middle, and late. Although the phases have distinct and recognizable characteristics, young men pass from childhood into adulthood at different speeds, and their place along this path influences their needs and their abilities to address their reproductive health at different ages.

Early adolescence—which is typically ages 12 to 14 but can be earlier or later—is marked by the onset of puberty. Middle adolescence—around ages 15 to 16—manifests a strong orientation to peers. Late adolescence—beginning typically at age 17—ends with the transition to adulthood, marked by some combination of taking on adult work roles, marriage, or fatherhood.

The age at which the transition from late adolescence to adulthood actually occurs is difficult to pinpoint. In many communities, the transition may not be complete until the mid-20s, as young men only slowly gain the maturity and self-sufficiency to assume their role as an adult. Lack of economic opportunity may further slow this transition, because financial self-sufficiency is often considered one of the marks of a man. At the other extreme, absent fathers, family stress, and some peer relationships may cause younger teens to take on adult roles before they are ready. Adolescent fatherhood may force even younger adolescents into adult roles.

Because adolescence is a period of substantial developmental change, it is both unrealistic and inappropriate to have a single set of health goals for all young men.[39] This has grown even more true as the time most young men spend between puberty and marriage has increased, creating wider variation in their sexual experience. For younger adolescents, reproductive health goals might focus on delaying the onset of sexual activity. For older adolescents, it may be

necessary to focus more on protection from the potentially negative consequences of sexual activity.

Differences in the types of relationships with partners also must be taken into account. Some young men have long-term monogamous relationships, some engage in serial monogamous relationships, some have many partners, and some have sex only once in a while. Each pattern requires different approaches to promoting healthy behavior and protecting young men and their partners. This range of experience points to the importance of a client-centered approach to the delivery of services.

Understand Multiple Risk-Taking of Young Men

One final point about context: Efforts to reduce sexual risk-taking must recognize that adolescent men who experiment with sexual risk-taking are likely to be taking other risks as well. Many studies have noted a disturbing clustering of risk behaviors, such as sexual behavior, substance use, and violence, among adolescents.[40]

According to one recent study, more than four out of five male 7th- to 12th-grade students engaging in unprotected intercourse also participate regularly in one or more additional health risk behaviors. These include regular tobacco use, regular alcohol use, regular binge drinking, marijuana use, other drug use, weapon carrying, physical fighting, and suicidal thoughts or attempts.[41] Particularly troubling in the context of sexual risk is the tendency to combine sexual activity and substance use. One in five young men report having been drunk or on a drug high the last time they had

intercourse.[42] More generally, a growing body of research is finding an association between substance use and a variety of sexual risk behaviors—nonuse of condoms,[43] multiple partners,[44] earlier initiation of sexual activity,[45] casual sex,[46] trading sex for money or drugs,[47] as well as increased sexually transmitted diseases rates.[48] Clearly, adolescent males' sexual risk-taking cannot be addressed in isolation from experimentation or regular participation in other health-risk behaviors.

Establish a New Vision of Men's Sexual Health

Any effort to enhance young men's sexual and reproductive health needs a clear definition of sexual and reproductive health for young men. Because such a definition has remained elusive ever since the unsuccessful effort in the 1970s to include men in Title X's programmatic initiatives, the working group developed a set of consensus goals for a comprehensive sexual and reproductive health promotion strategy for young men.

The fundamental belief guiding this effort to define sexual and reproductive health services for men is the group's vision of what constitutes sexual health for men.

According to this vision,

> *All males will grow and develop with a secure sense of their sexual identity, an understanding about the physical and emotional aspects of sexual intimacy, and attitudes that lead to responsible behavior. Achieving these developmental goals will result in men postponing sexual intercourse*

"CLEARLY, *adolescent males' sexual risk-taking cannot be addressed in isolation from experimentation or regular participation in other health-risk behaviors.*"

until they are emotionally mature enough to manage the physical and psychological aspects of sexual intimacy. When they have sexual intercourse it will occur with as little risk as possible to either themselves or their partner.

To achieve these results, all young men living in communities throughout the country need access to a range of educational, counseling, clinical, and social support services that, in combination, fulfill five goals:

- Promote sexual health and development.
- Promote healthy intimate relationships.
- Prevent and control STDs, including HIV.
- Prevent unintended pregnancy.
- Promote responsible fatherhood.

To attain each of these goals, the working group suggests that a comprehensive reproductive health strategy for young men must do the following:

- Convey necessary information.
- Foster skills development.
- Promote positive self-concept.
- Identify and develop positive values and motivation to act on those values.
- Provide access to clinical care, as appropriate.

Accomplish Five Key Goals

Below is a short summary of the types of information, skills, self-images, values and motivation, and clinical services that could plausibly accomplish each of the five goals the working group has set for sexual and reproductive health services for young men. The list is not meant to be all-inclusive, but rather to serve as a starting point for discussion. The group hopes that such discussion and other efforts will lead to modifications and extensions as consensus grows about what the core content of such services should be. To facilitate comparative review, the summary is also reproduced in table form (see page 30).

1 PROMOTE SEXUAL HEALTH AND DEVELOPMENT. Necessary information under this goal includes normal male and female pubertal development, social and emotional development, hygiene, and components of a healthy lifestyle. Skills development includes working on communication and decisionmaking skills. Promoting a positive self-concept includes coverage of masculinity and male role identity, sexual identity, self-respect, and personal potential. (The content of this element remains fairly constant across the five goals.) Positive values can include respect for others, cultural appreciation, and the importance of physical health. Access to clinical care includes regular visits to a health provider, screening and treatment for anomalies, and referrals for other services.

2 PROMOTE HEALTHY INTIMATE RELATIONSHIPS. Information under this goal includes stages in romantic relationships, forms of sexual expression, and sexual coercion and violence. Skills develop-

ment includes how to make decisions about initiating sex, how to refuse unwanted sexual overtures, how to avoid unhealthy relationships, and how to develop clear lines of communication with partners. Positive values can include the desirability of give and take in relationships, and mutual fidelity. Clinical care includes counseling, screening and treatment of sexual dysfunction, and identifying potential physical, emotional, or sexual abuse.

3 PREVENT AND CONTROL THE TRANSMISSION OF STDS, INCLUDING HIV. Information to be conveyed includes knowledge of the various types of STDs, how they are transmitted and prevented, and how they can be detected and treated. Skills development includes how to obtain and use condoms correctly and how to negotiate with partners about safe sex, including saying no to sex and obtaining information about the partner's HIV/STD risk status. In addition to the common elements promoting a positive self-concept, it is also important to convey recognition of personal vulnerability to disease. Positive values can include concern for one's own health and the health of one's partner. Access to clinical care includes screening, counseling, and treatment provided for all STDs. It also includes facilitating access to condoms through distribution programs or other approaches.

4 PREVENT UNINTENDED PREGNANCY. Information to be conveyed includes the biological mechanisms underlying reproduction and the merits and side effects of various types of contraceptive methods. Men need information about female contraceptive methods. Skills development, again, includes how to negotiate safe sex. Because the most effective methods for pregnancy prevention are abstinence or

methods used by female partners like hormonal contraceptives, intrauterine devices (IUDs), or sterilization, good communication with and expressions of support to these partners are also essential. An additional element of positive self-concept is conveying a sense of control over one's destiny. Positive values include life goals and how childbearing fits in. Clinical services include contraceptive counseling and services, counseling about pregnancies, and referrals for other health care.

5 PROMOTE RESPONSIBLE FATHERHOOD. Information to be conveyed includes the specifics about the responsibilities of parents, prenatal health and childbirth, child development, and well-child care. Skills development includes parenting and communication skills, which contribute to stronger parent-child and father-mother relationships. It also includes other life skills needed for the fulfillment of parental roles such as doing well in school, getting and keeping jobs, and managing finances. Promoting a positive self-concept includes recognizing the role of nurturance. Positive values include responsible fathering and manhood. Access to clinical services includes fertility services—to have children when they are desired—and the screening and treatment of infertility.

"FOUR MAJOR channels provide the most effective ways to reach young men: education, counseling, clinical services, and various support services."

Deliver Services Effectively

To be effective, the mechanisms through which this content is delivered need to be varied and extremely flexible. Four major channels provide the most effective ways to reach young men: education, counseling, clinical services, and various support services. The rationales for the first three are relatively obvious. The rationale for the fourth, support services, may need

Exhibit 1 Sexual and Reproductive Health Content

	Goal 1 PROMOTE SEXUAL HEALTH AND DEVELOPMENT	Goal 2 PROMOTE HEALTHY INTIMATE RELATIONSHIPS	Goal 3 PREVENT AND CONTROL STDs AND HIV	Goal 4 PREVENT UNINTENDED PREGNANCY	Goal 5 PROMOTE RESPONSIBLE FATHERHOOD
Information	normal anatomy and pubertal development social and emotional development hygiene STDs/HIV where and how to access services nutrition physical activity	stages in romantic relationships readiness for sexual involvement forms of sexual expression sexual coercion and violence	STD symptoms and transmission diagnosing and treating STDs prevention strategies (including effectiveness of condom use) prevalence of diseases short- and long-term consequences of STDs (for men and women) where to get condoms	contraception and its effectiveness (incl. 100% effectiveness of abstinence) reproductive biology and how pregnancy occurs where to obtain contraceptives consequences/costs (of pregnancy/contraception) forms of sexual expression	responsibilities of parents prenatal health and childbirth child development child health and well-child care paternity establishment, child support, and visitation
Skills	resisting peer pressure communication decisionmaking self-advocacy risk assessment and avoidance setting and achieving goals	communication and listening partner selection and avoiding unhealthy relationships negotiating safe sex recognizing difference between consent and coercion violence prevention	negotiating sexual activity and setting limits negotiating condom use how to use condoms properly communication (with partner about sex) how to recognize STD symptoms how to access services how to ask for more information	negotiating sexual activity and setting limits communication (with partners, providers) decisionmaking how to access services/resources resisting peer pressure how to be intimate with partners how to use contraceptives how to use condoms properly	parenting skills life skills (e.g., job, housing, medical care, etc.) training and opportunities for financial self-sufficiency communication (child and child's mother)
Positive Self-Concept	self-esteem self-respect sexual identity/orientation gender roles personal potential	self-esteem self-respect sexual identity/orientation gender roles	self-esteem self-respect awareness of vulnerability self-efficacy sexual identity/orientation	self-esteem self-respect confidence in the future sense of control over one's life and decisions	self-esteem self-respect nurturance sense of control over one's life and decisions
Values and Motivation	respect for others spirituality family expectations healthy lifestyles value of education social responsibility and contribution cultural appreciation value of healthy sexuality	healthy relationships role expectations mutual fidelity	health as a priority concern for partner's health	women's/men's role in contraception women's/men's role in pregnancy setting and achieving life goals parenting as a life goal	values regarding parenthood/fatherhood values regarding "being a man"
Clinical Services	physical exam screening for development abnormality primary health care services preventive health services mental health assessment access to services including counselors (adult and peer), mentors, health educators	physical exam screening and treatment for sexual dysfunction screening and treatment for sexual abuse counseling (individual, relationship)	physical exam STD testing, treatment, partner referral HIV testing and counseling HIV follow-up care counseling (safe sex) access to condoms	physical exam counseling (contraception, pregnancy options) contraceptive services (with partner) referral for health services	physical exam fertility assessment child health and well-child care support groups for young fathers referral for health, mental health, and other services

to be spelled out. The environment in which a young man is raised, the people with whom he has contact, and the opportunities and challenges of life presented to him will influence the health risks he faces and his sexual and reproductive decisionmaking. For this reason, enhancing the reproductive health of young men potentially necessitates not only clinical services, health education, and counseling but also a range of support activities such as recreation, employment and training, and spiritual guidance, which promote healthy social development, a positive self-image, meaningful interpersonal relationships, educational attainment, and meaningful employment. In addition, a comprehensive strategy must include efforts to change the environments of young men by also targeting policies and community norms and values for transformation.

Recommended Community and Federal Actions

Typically, agencies in communities specialize in some but not all of the types of services described in the preceding section. It is not realistic to expect organizations to provide every service young men potentially need. Community agencies have different capacities and will prioritize issues differently based on their community resources, their history, their mission, and how prepared they are to engage in reproductive health services for young men. For example, a health clinic may concentrate on integrating various areas of reproductive health, such as STD prevention and control, HIV prevention, and family planning services, but look to other organizations to gain access to (and the trust of) the young men they need to reach. Community-based youth-serving organizations that regularly see at-risk males may facilitate access to another organization' s clinical reproductive health services for their clients. These examples demonstrate that the

initiating agency can be a clinic, a neighborhood-based youth development organization, or some other type of community agency. The important point is that few agencies will be able to deliver comprehensive sexual and reproductive health services to young men alone. Partnerships across agencies are essential.

"THE DESIRE *to reach underserved populations further propels the need to collaborate across agencies."*

Importance of Collaboration among Community Organizations

Thus, to provide access to a full range of reproductive health resources for young men, most organizations will need to reach out into their communities and create partnerships with other agencies that specialize in complementary areas of reproductive health or service delivery modalities. Ideally, organizations can work together to create a network of services that benefits young men's sexual and reproductive health, maximizes reliance on community strengths and resources, and is easily accessible by youth.

The broader the range of desired activities, the greater the need for interaction with other organizations. Collaborative efforts will require the commitment of a wide variety of stakeholders, including young men themselves, their partners, their families, and their communities; many different types of nongovernmental health and social service organizations; and various sectors of local, state, and federal government. These groups bring different types of skills, expertise, and sensitivities to the promotion of men's reproductive health.

The desire to reach underserved populations further propels the need to collaborate across agencies. Because health providers have traditionally found it hard to reach young men, forming partnerships

with other community organizations that have longstanding experience working with young men is a promising strategy for them. Alliances with organizations offering activities that are especially attractive to young men, such as sports or job preparation, can be a good approach to recruiting young men into health promotion and care services. Collaborating with agencies that have captive populations of particularly high-risk young men with special needs, such as shelters for runaway and homeless youth, the foster care system, or the juvenile justice system, is yet another promising way to broaden the base of populations served. Beyond the young men themselves, agencies may want to reach the broader environments that shape these youth—their families; schools; communities; health, welfare, and social service agencies; government; and the business sector.

Value of Starting Small

Where existing resources are scarce, small-scale efforts (such as educational initiatives or pilot programs) may be the only realistic starting place. These efforts are worthwhile if they are planned thoughtfully and conducted well. However, making a commitment to address the reproductive health needs of young men—even if the effort is quite focused, like a health fair or a media spot—almost inevitably leads to additional opportunities to do more. For example, a simple media spot encouraging young men to be screened for STDs requires capacity in the community to conduct the tests, provide treatment, convey information, teach partner communication skills, follow up with partners, and provide other services that might keep young men from needing the screening and treatment again. Once young men are

engaged and motivated to improve their reproductive health, organizations need to be able to either provide the needed services or create partnerships with the clinical and other resources that meet young men's reproductive and other health needs. Many communities do not currently have anything approaching a full range of clinical and sexual reproductive health services for young men.

Federal Challenges and Opportunities

Promoting the sexual and reproductive health of young men is an extremely important and neglected policy concern—one of many aspects of young men's health that needs more attention and resources from the federal agency with the key responsibility for meeting these health needs, the U.S. Department of Health and Human Services (DHHS). The health of many young men in the country is compromised by participation in health-risk behaviors and lack of access to adequate health care and support services that affect their ability to make successful transitions into adulthood and lead to unacceptably high rates of mortality and morbidity. Consequently, the working group's overarching recommendation is that the U.S. Surgeon General spearhead a broad Young Men's Health Initiative to address these problems.

Young Men's Health Initiative

Key Actions Needed by Surgeon General

To implement a broad Young Men's Health Initiative, the working group recommends that the Surgeon General immediately take the following actions and rigorously evaluate these efforts three years

after implementation:

Determine Extent of Existing Federal Efforts. Solicit statements from the relevant operating agencies within DHHS—Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, Office of Population Affairs, National Institutes of Health, Health Resources and Services Administration, Bureau of Primary Care, Bureau of HIV/AIDS Prevention, Administration on Children and Families, and others—to describe their goals, plans, and financial resources they have that will address the pressing health needs of young men in the United States.

Assess Adequacy of Insurance Coverage. Review Medicaid and the State Children's Health Insurance Program (SCHIP) for the extent to which they provide coverage for the male health clinical package of services including sexual and reproductive health services, as well as for their outreach and enrollment strategies targeting young men. Particular attention should be paid to issues of confidentiality.

Expand Current Federal Efforts. Request additional funding from the Secretary of DHHS to support new program initiatives and to conduct research and evaluation to identify best practices.

Document Gaps between Needs and Federal Services. Develop a report on young men's health in the United States, to document the health condition of young men and to examine the evidence about DHHS's ability to address their health needs.

Integrate Young Men's Health Needs across Federal Efforts and Agencies. Actions here would include integrating young men's health

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into the U.S. Department of Health and Human Services Interagency Fatherhood Initiative; including a broader array of young men's health objectives and indicators among the Healthy People 2010 priorities; and reaching out to other federal agencies such as the Departments of Education, Justice, Labor, and Defense to develop coordinated efforts addressing young men's health needs.

Expand Training of Health Professionals. Provide leadership in the expansion of training for health professionals and others regarding young men's health.

Reorient Focus of Managed Care Providers. Spur medical directors of major managed health care programs to address young men's health.

Collaborate with Media to Convey Positive Images. Partner with the media to highlight how current images of men may convey messages that are harmful to their health and to spotlight the health needs of young men.

"THE WORKING group also urges the Surgeon General to make sexual and reproductive health concerns a major priority within this effort."

How to Make Sexual and Reproductive Health a Priority

The working group also urges the Surgeon General to make sexual and reproductive health concerns a major priority within this effort. To this end, the group offers more specific recommendations about how to improve the capacity of the communities and federal agencies to address these concerns.

Monitor the Five Goals. First, the overall goals set by the working group are consistent with the Healthy People 2010 goals for the nation, such as the prevention of STDs and unintended pregnancy. However, a system for monitoring and measuring the receipt of services by men and the outcomes is still underdeveloped for the Healthy People Campaign. The group recommends explicitly monitoring the attainment of its goals for young men's sexual and reproductive health.

The goals are repeated here for emphasis:

- Promote sexual health and development.
- Promote healthy intimate relationships.
- Prevent and control STDs, including HIV.
- Prevent unintended pregnancy.
- Promote responsible fatherhood.

Target Most Vulnerable Groups. Second, while all men face a current health care system that is mostly unresponsive to their sexual and reproductive health, the working group identified seven high-priority target populations because of their higher levels of participation in risky sexual behaviors, their greater levels of negative reproductive heath outcomes, and their greater barriers to service. These populations are (1) young men of color, (2) men living in poverty or impoverished neighborhoods, (3) out-of-school men, (4) men involved in the criminal justice system, (5) men in foster care, (6) gay/bisexual men, and (7) men in their early 20s. Substantial numbers of young men fall into at least one of these at-risk groups. Many belong to more than one of these groups and face multiple and related sources of disadvantage.

Emphasize Collaboration across Agencies and Organizations. Third, any action to promote sexual and reproductive health is encouraged. But the working group particularly recommends that community agencies and organizations collaborate to leverage existing resources and to develop new resources that will provide accessible and effective educational, counseling, clinical, and other supportive services for young men.

"DHHS SHOULD *take steps to ease access to funds and build the capacity of community agencies to use them for sexual and reproductive health services for young men."*

These collaborative efforts should:

- Promote a comprehensive, client-centered approach to sexual and reproductive health.
- Provide a minimum standard of clinical sexual and reproductive health services for young men.
- Ensure meaningful community involvement through the participation of organizations that are rooted in the community, that hold community trust, and that have a longstanding relationship with young men in the community. These types of organizations can be lead agencies or partners.

Building partnerships across agencies and organizations is challenging but can be highly rewarding when the result is a comprehensive range of services that meets young men's sexual and reproductive health care needs.

Strengthen Federal Facilitator Role. DHHS should take steps to facilitate the development of collaborative partnerships. One obstacle to establishing and maintaining sexual and reproductive health programs for men is the scarcity of designated sources of funding for such programs. No federal program has a mandate or mission to

serve the sexual and reproductive health needs of men. At the same time, several relevant federal programs that do exist are underutilized for delivery of these services to male populations.

Federal health insurance programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) could be more important in reimbursing the clinical component of men's reproductive health services. It must be noted, though, that reproductive health services represent a minuscule fraction of these programs' multibillion-dollar budgets. And men's health projects will need to maneuver within the rules, requirements, and managed care aspects of these vast insurance programs if they are to be successful in tapping their funds. In particular, DHHS should examine whether certain dimensions of Medicaid and SCHIP implementation, including the issue of confidentiality, unintentionally act as barriers to reimbursing reproductive health services delivered to young men.

Existing federal grant programs also can be tapped to broaden access to sexual and reproductive health care for young men. The relevant programs are the Title X Family Planning Program, the Title XX Adolescent Family Life Program, the Centers for Disease Control Reproductive Health and HIV and STD Prevention Programs, the Title V Maternal and Child Health Block Grant Program, the Community Health Center Program, the Ryan White Care Act, the Title XX/Social Services Block Grant Program, and Temporary Assistance for Needy Families. In addition to these are other categorical grant programs—from agencies such as the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration—that could support some of the services recommended.

Ease Access to Federal Funding. To deliver the full range of services, community agencies will almost certainly need multiple sources of funding. While doing this is cumbersome for program administrators because of the need for multiple grant applications and the fragility of some sources of funding, such as demonstration programs, it does reflect the current fiscal reality faced by health and human service agencies throughout the country, including family planning agencies. DHHS should take the following steps to ease access to funds and build the capacity of agencies to use them for sexual and reproductive health services for young men:

- Request additional funding from the Secretary for a program that supports community agencies in gaining access to existing resources to deliver sexual and reproductive health services to men. Without some programmatic funds devoted to building infrastructure and supporting key administrative functions, the working group strongly believes that community agencies will be unable to access existing resources and maintain continuity of services.
- Solicit plans from the relevant operating agencies within DHHS that show how those agencies will contribute resources to meet the sexual and reproductive health needs of men.
- Support technical assistance and training for agencies to build their capacity to access existing sources of financial support, including nonfederal funding sources.

Enhance Information and Technical Assistance. DHHS can encourage community agencies to develop services for young men in addition to providing program financing. A key function is supporting activities that will promote the dissemination of knowledge about

effective service approaches, community mobilization strategies, innovative ideas, and administrative practices. DHHS should also encourage and fund communication among programs, so that existing knowledge and experience can be readily shared and integrated quickly into practice. Making this knowledge and experience accessible to planners of new programs is essential to the effective mobilization and use of people resources in communities. The working group recommends that DHHS provide support for the following:

- A clearinghouse to inventory and collate information about existing program approaches and to make them readily accessible to programs and program planners.
- Training and technical assistance to community agencies and program planners.
- Forums in which innovative ideas and practices can be shared.
- Dissemination of information and program promotion.

Build a Stronger Research and Evaluation Base. DHHS should support basic and program evaluation research to build an information base capable of monitoring shifts in the sexual and reproductive health of young men in the United States, gaining an understanding of the factors contributing to outcomes for various population groups, and identifying effective program practices. A continual investment in research and development will build the base of knowledge and contribute to innovation. Strategies include the following:

- Supporting and encouraging routine national surveys that include measures of men's sexual and reproductive health. For example, the National Survey of Family Growth in 2002 is planning to include men in the sample for the first time.

- Supporting analysis of data from surveys and other sources to build an understanding of the factors contributing to better sexual and reproductive health outcomes.
- Supporting innovative demonstration programs in which new programmatic approaches can be tested and studied.
- Supporting rigorous outcome evaluation of programs to identify programs that are very promising models of service delivery.

Support More Effective Professional Training. DHHS should support the development of training curricula for health professionals and other community agency personnel to provide them with the information and skills needed to deliver sexual and reproductive health services to young men. In addition, curricula are needed for medical schools and other institutions providing training to health professionals and for continuing education for personnel in the field. The development of such curricula will also build consensus about the core content and practice of promoting young men's sexual and reproductive health.

Benefits of a National Effort

Young Men Themselves

Expanding efforts to promote the sexual and reproductive health of young men in the United States will improve health outcomes among the young men themselves, their partners, their children, and society as a whole. A broad strategy to facilitate the development of young men into physically and emotionally healthy adults must focus on the whole array of their health needs, with sexual and reproductive health

an important part. Meeting the sexual and reproductive health needs of young men, as the working group has stated, will increase men's knowledge and understanding of their own health—including their sexual health—and give them better skills to reduce disease and to adopt healthy lifetime practices. Men will also benefit from increased understanding and better skills to negotiate and sustain successful relationships with partners. And they may avoid premature fatherhood and unintended pregnancies and births. Offering both men and women the means and opportunity to plan their families may lead to greater nurturing and parental support for the children they have.

Female Partners

Providing men with the knowledge and skills that many of them lack will complement and leverage existing investments in women's reproductive health services. These men's sexual partners will reap similar benefits in the form of reductions in disease and unintended pregnancies and births. Partners will also experience more support from these men for their own preventive health efforts. And improved communication and negotiation between partners will improve the chances of healthy relationships that sustain themselves over time, to the benefit of both partners and their children.[49]

Society

Society as a whole also will benefit from investing in promoting sexual and reproductive health for men. The public sector now pays a substantial amount to cover health costs associated with STDs. It also

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covers the birth and delivery costs of people not covered by private health insurance. Additional public funds are expended to establish paternity for nonmarital children and to collect child support for children who do not live with their biological fathers. To the extent that efforts to promote male sexual and reproductive health lead to reductions in STDs or unintended pregnancies and births, these investments will pay for themselves.

Promoting the sexual and reproductive health of young men in the United States could produce direct health benefits for the men themselves and additional benefits for their partners, their children, taxpayers, and the social fabric of our society. As this report shows, developing strategies to deliver the array of services needed to accomplish this objective will require commitment, ingenuity, a break with tradition, and collaboration across diverse community agencies. Each of these requirements will create both psychic and financial demands beyond the actual dollars that are required for programs and services. While the working group acknowledges the scope and difficulty of the task, it believes that the benefits resulting from integrating men's sexual and reproductive health needs into public health promotion efforts will be well worth the investment. The group urges the U.S. Surgeon General and DHHS to provide leadership in promoting the dialogue and program experimentation now required to ensure that the sexual and reproductive health needs of both young men and young women in the United States are addressed.

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CHAPTER 1

WHY MALES, WHY NOW: THE RATIONALE FOR ADDRESSING THE REPRODUCTIVE HEALTH OF YOUNG MEN

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Young men in their teens and 20s need reproductive health information and services for many reasons. This chapter documents the extent of their needs by examining a range of research evidence. Although in recent years young men in the United States have reduced their involvement in sexual risk-taking, many remain unprotected from the serious negative consequences of their risky behaviors, such as AIDS, other sexually transmitted diseases (STDs), and unintended or too early pregnancies and births. Indeed, young men report that they want more information about reproductive health issues than they now receive, and many opportunities for educating young men through school, family, the media, and health care professionals are missed. In addition, many young men do not have access to preventive care or treatment, because they lack health care insurance or a regular health provider. Together, these factors leave many young men, regardless of race, class, or social status, in need of greater access to information and services that could enhance their sexual reproductive health. In addition, some young men—by virtue of their sexu-

al risk-taking behaviors, or because of their greater lack of access to relevant care and health services—have particularly high need for preventive efforts. They include (1) young men of color, (2) young men living in poor neighborhoods, (3) out-of-school men, (4) young men involved in the criminal justice system, (5) young men in foster care, (6) gay and bisexual young men, and (7) men in their 20s.

The Context of Reproductive Health in Young Men's Lives

Reproductive health is a concern for men at all stages of life. This project focuses on the earlier part of the life course, addressing young men's reproductive health through adolescence and into early adulthood. Generally, this refers to men ages 12 to 24. To study this age range requires understanding the broader context of adolescent development and the changes that occur during this period.

Teens make the passage from childhood into adulthood at different speeds, and their place along this path influences their sexual and reproductive health needs. Generally, distinctions are made between early, middle, and late adolescence, typically defined as ages 12 to 14, 15 to 16, and 17 and older. These phases may occur at somewhat different chronological ages for different individuals, but they have distinct characteristics. Early adolescence is marked by the onset of puberty. In middle adolescence, there is a strong orientation to peers. Late adolescence ends with the transition to adulthood, generally marked by some combination of taking on adult work roles, marriage, or fatherhood. Yet in many communities, the transition from late adolescence into adulthood may not be complete until the mid-20s, as young men only slowly gain the maturity and economic self-

sufficiency to assume their role as adults. Lack of economic opportunity may slow this transition, because financial self-sufficiency is often considered one of the marks of a man. At the other extreme, absent fathers, family stress, and some peer relationships may cause younger teens to believe they must take on an adult role before they are ready. Furthermore, adolescent fatherhood may thrust some younger adolescents into typically adult roles.

The great diversity in sexual experiences within this broad age range requires that programs vary their goals and approaches.[1] For younger adolescents, reproductive health goals might focus on delaying the onset of sexual activity. For older adolescents, the goals would include the use of condoms, other contraception, and partner selection practices. In addition, as young men make the transition into adulthood, their relationships with female partners may change. Some will marry, some will cohabit, some will have steady long-term partners, some will have a series of monogamous partnerships, some will have many partners, and some will have none. As the amount of time young men spend between puberty and marriage has increased, the likelihood of their experiencing several of these situations increases. The messages that programs convey need to be tailored to the varied risks of each situation.

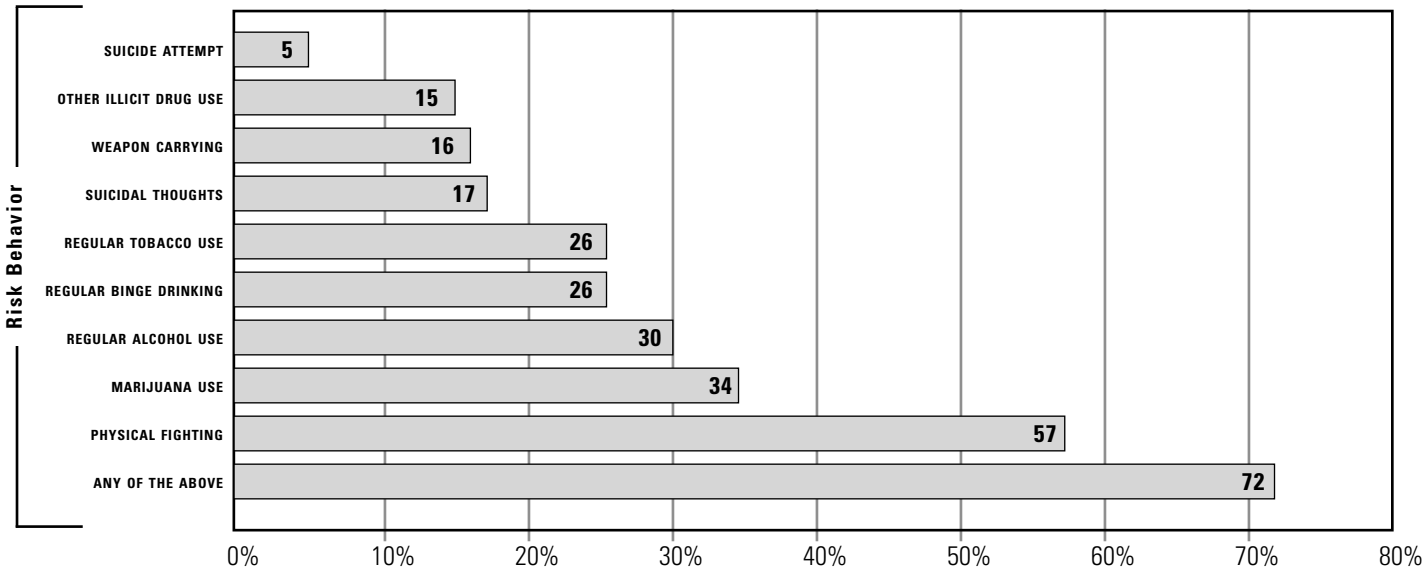
Adolescence is a time of great physical, psychological, and social change in which the foundations for healthy behaviors and outcomes over the life course are established. It is also a time for trying out new behaviors. This experimentation is essential for development, but it may lead to risks that have negative physical and emotional consequences. Adolescent males may experiment not only with sexual risk-taking, but with involvement in other risk behaviors as well. Many

"SEXUAL RISK-taking of adolescent males cannot be addressed in isolation from their other risk behaviors."

studies have noted a disturbing confluence or clustering of risk behaviors, such as risky sexual behavior, substance use, and violence, among adolescents.[2] For example, a recent analysis of a survey of 7th to 12th graders found that more than four out of five male students engaging in unprotected intercourse also participated regularly in at least one other of the following health risk behaviors: regular tobacco use, regular alcohol use, regular binge drinking, marijuana use, other drug use, weapon carrying, physical fighting, or suicidal thoughts or attempts, as shown in figure 1.1.[3]

Also troubling is the co-occurrence of substance use and sexual activity during a single point in time; 20 percent of young males report being drunk or high at their most recent intercourse.[4] A growing body of research has examined the association between substance use and a

Figure 1.1 Prevelence of Risk-Taking among 7th- to 12th-Grade Males Engaging in Unprotected Intercourse



Source: Authors' tabulations from 1995 National Longitudinal Survey of Adolescent Health.

variety of sexual risk behaviors, such as non-use of condoms,[5] multiple partners,[6] earlier initiation of sexual activity,[7] casual sex,[8] and having sex for money or drugs,[9] as well as increased sexually transmitted disease rates.[10] It is clear that the sexual risk-taking of adolescent males cannot be addressed in isolation from their other health risk behaviors.

Adolescents must also be viewed in relation to their key social contexts, such as family, peers, school, and the broader community.[11] A supportive environment in each of these contexts is needed to foster individual responsibility and decisionmaking with respect to reproductive health. For example, opportunities to engage in positive activities and supportive relationships with adults can help to make the transition from adolescence to adulthood safer, "protecting adolescents from harm."[12] Limited access to these opportunities and social connections, especially in impoverished communities where resources for teens are severely limited, can lead teens to take risks that may compromise their health and well-being.[13] Furthermore, exposure to violence may limit teens' motivation to protect themselves sexually. Thus, health promotion efforts need to target not only individual teens but the social contexts in which they live.[14]

Reproductive Risk-Taking and Its Consequences

Young Men Are Decreasing Their Sexual Risk-Taking, But More Change Is Needed

National data about men's attitudes and behaviors regarding sex, contraception, pregnancies, and births have only recently become available. National surveys of fertility-related behavior before the late 1980s exclusively studied women. Since 1988, though, periodic surveys of

teenage and adult men[15] provide a current portrait of reproductive behaviors among this population and a description of changes over time. Overall, these surveys reveal a population that in recent years has adopted safer behaviors. But the share of young men engaging in behaviors that put themselves and their partners at substantial risk of unintended pregnancy and disease is still uneccesarily high.

Recent trends toward safer behaviors among male teenagers indicate positive change. In 1995 just over half (55 percent) of U.S. males ages 15 to 19 were sexually experienced, a proportion that was slightly but significantly lower than the share in 1988.[16] The Youth Risk Behavior survey, which surveys high school students, also reports a significant decline in the proportion of males in grades 9 to 12 who were sexually experienced from 1991 to 1997. Trends in sexual experience rates among teenage girls leveled off during the same period.[17] Condom use at last sexual encounter increased from 53 percent to 64 percent among males who had had sex in the last three months. Consistent condom use rates also increased, but remained substantially lower than at the most recent encounter. In 1995, 45 percent reported using condoms every time they had sex in the last year, a significant increase from 33 percent in 1988.[18] Together, these trends—reduced sexual experience level and greater condom use among young men—have led to reductions in the proportion of teenage males who have had unprotected sexual intercourse in the last year. In 1995, just over one-quarter (27 percent) of male teenagers overall had unprotected sex in the last year. This proportion was substantially higher among African American and Hispanic men, of whom 40 percent and 37 percent, respectively, had sex unprotected by a condom in the last year.[19]

Increases in condom use among male teenagers demonstrate that they are assuming increased levels of responsibility for contraception. These trends point to the need to target males so that they use condoms correctly and consistently. With increased condom use in the 1980s and 1990s, the levels of protection at first intercourse have doubled for young women. More women now report having used contraception, especially condoms, before their first family planning visit (75 percent in 1995, compared with 51 percent in 1988).[20] Evidence about method use at most recent intercourse indicates reduced reliance among teenage girls on contraceptive pills accompanied by increased reliance on condoms, as well as hormonal injections among African Americans.[21]

These shifts toward less sexual risk-taking play an important role in the parallel shifts toward improved reproductive health outcomes among adolescents. National data show declines in adolescent pregnancy and childbearing between 1991 and 1998.[22] Disease surveillance data indicate STD rates among adolescents also declined.[23] These declines, combined with the contemporaneous shift in health behaviors, may indicate that public health efforts to educate teenagers and the public at large about the dangers of HIV, other STDs, and unintended pregnancy are beginning to pay off.

"INCREASES IN condom use point to the need to target males so that they use condoms correctly and consistently."

Reproductive Risk Behaviors Have Important Health Consequences

Many young males and their partners may face negative health consequences—particularly HIV/AIDS, other STDs, and unintended pregnancy and childbearing—from their risky sexual behaviors. While the burden of some of these outcomes tends to be felt disproportion-

ately by adolescent girls, the consequences to young men and their role in transmission have been underemphasized.

AIDS and STDs

AIDS is the seventh leading cause of death among males ages 15 to 24.[24] Because of its long incubation period, it is believed that for many of the AIDS cases diagnosed among adults, the actual transmission of the virus occurred during adolescence. Up to 25 percent of the new cases of HIV infection that occur in the United States each year may be among young adults ages 21 and younger, and as many as 50 percent may be among young adults under age 25.[25] Most of these infections are transmitted sexually.[26] In addition, because nearly all AIDS cases among adolescent girls result from heterosexual activity, young men play a critical role in the spread of AIDS among young women.

"MANY YOUNG fathers do not live with their children, and the consequences for their children are severe."

Every year, approximately 3 million adolescents are diagnosed with an STD (including HIV), and two-thirds of all cases of STDs are diagnosed in people younger than 25.[27] Males are often asymptomatic, which both reduces the likelihood of treatment and facilitates their role in the transmission of these STDs to their female partners. Age groups at greatest risk for gonorrhea and chlamydia, two common bacterial STDs, are 15- to 19-year-old females and 20- to 24-year-old males.[28] The age difference in the risk groups mirrors the age difference in young couples, with males tending to partner with younger females. The risk of morbidity resulting from STDs can be seen in both men and women, who can experience genital cancers and other long-term complications, including death from untreated syphilis, resulting from STDs. Active STD infection can also facilitate HIV transmission, whether or not ulcerated tissue is present.[29] Additional severe

outcomes in women are estimated to produce direct medical costs alone in the order of billions of dollars annually.[30] The same risk behaviors that can expose adolescents to STDs also expose them to HIV risk, and one of the strongest predictors of HIV transmission is a history of sexually transmitted disease.[31]

Pregnancy, Childbearing, and Responsible Fatherhood

A small group of teen males experience fatherhood. According to the 1995 National Survey of Adolescent Males, 6 percent of sexually experienced males between the ages of 15 and 19 fathered a child and 14 percent made a partner pregnant.[32] By the time young men turn 20, it is estimated that 8.3 percent will have become teen fathers.[33] Teen fatherhood occurs disproportionately among males from disadvantaged backgrounds, such as those with lower parental education and those whose mothers were teen mothers.[34]

Teen fatherhood imposes some long-term consequences on the young men involved. Although teen fathers are more likely to enter the labor market at an earlier age and earn higher wages than non-fathers, their long-term employment and wage outcomes are less promising.[35] The psychological outcomes of early fatherhood and early labor force participation have not been well-studied for teen fathers, but the psychosocial effects on teen mothers seem to indicate the likelihood of adjustment difficulties for teen fathers as well.[36]

Facing the burdens of their parents' youth, and often poverty, many children of teen fathers, and even of fathers in their early 20s, are born into "fragile families" that lack stable living arrangements, marital arrangements, and income.[37] Many young fathers do not live with their children, and the consequences for their children are

severe. Growing up without a father in the home is associated with many negative personal and social outcomes for children, especially because poverty rates are almost six times higher for single-parent families than for two-parent families.[38] Yet even controlling for socioeconomic status, studies show that children from single-parent families are more likely than those from two-parent families to face poor outcomes in childhood, adolescence, and into adulthood.[39]

Teen fatherhood appears to be a salient concept for young men. In a 1997 survey, fully 16 percent of white males and 25 percent of black males ages 15 to 17 expect to become fathers by the time they are 20.[40] Although these expectations appear to far exceed the actual rates of teen fatherhood they will experience, they support the contention that young males are aware of the risks of teen childbearing and believe it is something to which they themselves are vulnerable.

Little is known directly about young men's attitudes toward the pregnancies and births they experience.[41] But there is substantial indirect evidence that most of these pregnancies are unintended. For example, in 1994, 41 percent of pregnancies fathered by males ages 15 to 19 ended in abortion. Pregnancies involving teenage males are more likely to end in abortion than pregnancies involving older males, suggesting that more of these pregnancies are unintended.[42]

Young men report a range of beliefs and attitudes that support the contention that they tend to consider unintended pregnancies a problem. According to analyses of the 1995 National Survey of Adolescent Males, although most young men want to father children at some point in their lives, two-thirds of 15- to 19-year-old males say that an unintended pregnancy would make them "very upset." About one-third of these males think they would have to quit school. Almost all

males think they would have to give money to help support the baby. Hardly any males think that the availability of the options of abortion and of marriage means that unintended pregnancy is "not worth worrying about" or "not a big problem." At the other extreme, only a small proportion of males view pregnancy as validating their masculinity. When asked, "If you got a girl pregnant now, how much would it make you feel like you were a real man?" only 5 percent of young men say that fathering a child would make them feel "a lot" like "a real man."[43]

To What Extent Do Young Men Have Unmet Reproductive Health Needs and Why?

Many Young Men Need, But Do Not Receive, Critical Health Information

When asked, young men say that they want more reproductive health information. In a recent national survey of young men and women ages 12 to 18, 45 percent of sexually experienced respondents said they themselves need more information on how to prevent AIDS and other STDs, 38 percent need more information on how to use birth control, 30 percent want more information on where to get birth control, and 24 percent need more information on how girls get pregnant.[44]

Many young men appear to have false or inadequate information about reproductive health issues, as illustrated in table 1.1. In addition, in a recent national survey of 15- to 17-year-olds, 77 percent of male respondents underestimated the incidence of STDs, and almost one-fourth (24 percent) could not name any STD except for HIV. Among the sexually experienced respondents in this survey, 67 percent considered themselves "not much" or "not at all" at risk of getting an STD—although an estimated 25 percent of sexually experienced teens will become

Table 1.1 Lack of Contraceptive Knowledge among Males Ages 15 to 19

Thought that "if a male pulls out before he 'comes,' he cannot make a female pregnant" **20%**

Did not know that "oil-based lubricants like Vaseline or baby oil can cause latex condoms to break" **15%**

Did not know that "some people who are infected with sexually transmitted diseases like herpes, gonorrhea, or chlamydia will show no symptoms at all" **38%**

Did not know whether they were circumcised **20%**

Source: 1995 National Survey of Adolescent Males.

infected with an STD each year.[45] In addition, teens tend to overestimate their peers' sexual activity—an important influence on their own sexual activity.[46] Such inaccurate perceptions and information can have important consequences for young men's reproductive behaviors.

Many Opportunities for Providing Information to Young Men Are Being Missed

Young men are exposed to many settings and resources that *could* provide reproductive health information, such as schools, family, the media, and health care professionals. Unfortunately, many opportunities for educating young men are lost. Parents, teachers, doctors, and the media don't talk about reproductive issues with young men, don't talk enough, or convey messages contrary to responsible sexual behavior. This section describes the extent to which young men receive reproductive health information from a variety of key sources, and highlights important missed opportunities to educate and inform young men about reproductive health issues.

Parents

Parents have a unique opportunity to educate their teens about reproductive health issues and to share their personal values and beliefs. Teens report that they believe their parents are the most complete and reliable source of information on sex and birth control.[47] Yet many parents miss the opportunity to talk with their teens about these sensitive topics. In 1995 only about half of young males reported ever having spoken with their parents about AIDS, condoms, STDs, or the consequences of getting a girl pregnant. More surprisingly, the level of communication between parents and their teen sons in 1995 was the same reported in 1988. Parents have not responded to the AIDS epidemic and its risks to their children's health by increasing their communication about AIDS, STDs, or contraception with their sons.[48] Parents may be uncomfortable discussing sexual issues with their teens, and they may not have accurate reproductive health information themselves. While parents can potentially play a critical role in educating their sons about reproductive health topics, current patterns indicate they cannot be relied on to be young men's sole source of information.

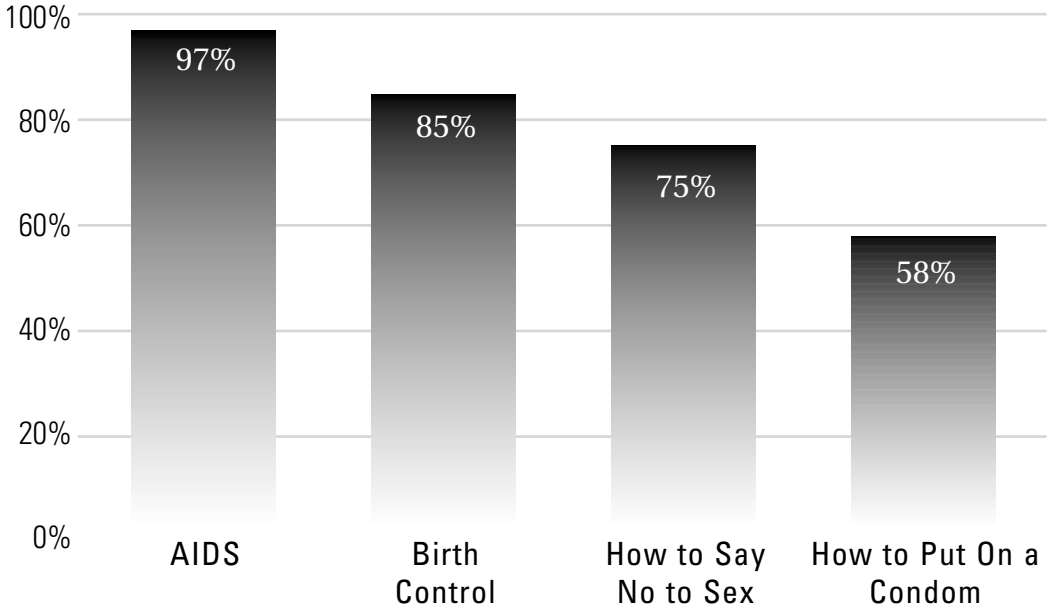
"PARENTS HAVE *not responded to the AIDS epidemic by increasing their communication with their sons."*

Recent research suggests that it may not be what parents talk to their teens about, but other aspects of the parent-child relationship, that can influence sexual risk-taking. A strong sense of connection to parents has been shown to be important in "protecting adolescents from harm," in part by delaying the onset of sexual activity, as well as participation in many other health-risk behaviors.[49] In a recent review of the effect of parent-child communication on teen sexual behavior, Miller concludes that, "While parents cannot determine whether their children have sex, use contraception, or became pregnant, the quality of their relationships with their children can make a real difference."[50]

School

School-based instruction is a primary mode of formal reproductive health education. Several recent studies suggest that this formal instruction can reduce sexual risk behaviors by delaying age at first intercourse, reducing levels of sexual activity, and increasing contraceptive or condom use.[51] Overall, school-based reproductive health education expanded significantly in the past decade, but issues of content, timing, and quality still create many missed opportunities to educate young men. For example, although 97 percent of males ages 15 to 19 in the 1995 National Survey of Adolescent Males reported having received formal instruction about AIDS, fewer young men reported instruction in how to say no to sex (75 percent) or in birth control methods (85 percent), and still fewer in how to put on a condom (58 percent), raising questions about the comprehensiveness of instruction (see figure 1.2). Furthermore, only about half of sexually experienced young males

Figure 1.2 Receipt of Sex Education among Males Ages 15 to 19



Source: Lindberg, L.D., L. Ku, and F. L. Sonenstein, 2000.
Authors' tabulations from 1995 National Survey of Adolescent Males.

received instruction in each topic before first intercourse.[52] Recent policy shifts toward abstinence-only education raise further concerns about the comprehensiveness of the classroom instruction received by adolescents.[53] School-based instruction also does not reach out-of-school teen males and/or many young men in their early 20s.

The Media

Media exposure among teens is nearly universal, through sources such as TV, music, and films. The spread of new technologies such as the Internet increases this exposure. Together, these avenues of communication have the potential to educate and inform in a positive manner. Examples abound of recent focused efforts to harness the pervasive influence of the media to promote responsible reproductive behaviors.[54]

"MANY OF THE *images of sex in the media are not responsible or healthy."*

While the media may be an opportunity to provide positive information to teens, the risk of promoting negative attitudes and behaviors also exists.[55] Limited research is available for a careful evaluation of the general influence of the media on teen sexual behavior, but most available research does suggest that many of the images of sex in the media are not responsible or healthy. While the various media offer teens much information about sexuality, they rarely provide a positive message about sexual responsibility, healthy communication, or contraceptive use.[56] Adolescents watch an estimated 11 sexual behaviors per hour during prime time, and in only 4 percent of these interactions is the use of contraceptives or the risk of contracting AIDS mentioned.[57] The media also play a role in shaping norms and beliefs about masculinity and appropriate male behavior. In a 1996 survey of adolescents ages 12 to 18, more than one-third of males (36 percent) reported that one reason teens have sex is because "movies/TV make it seem like it is normal for teens to have sex."[58]

Health Professionals

Despite widely accepted recommendations, preventive health services that address sexual and reproductive health do not appear to be incorporated into routine care, especially for young men.[59] Although most adolescent males receive routine physical exams (71 percent), fewer than one-third of those receiving a physical exam discussed even a single reproductive health topic with their doctor or nurse (29 percent overall). Males in their 20s were even less likely to receive a physical exam (56 percent), reducing their opportunities to discuss reproductive health issues with a doctor or nurse (22 percent overall).[60]

Research about the extent to which adolescents seek health care and the practices of health care providers provides some clues about why some teenagers do not get services. Honesty, confidentiality, and friendliness are important considerations for youth in seeking health care and in disclosing risk behavior to health care providers. Physicians who are more confident and comfortable discussing sexuality and STDs/HIV are more likely to conduct sexual risk screening than are doctors who graduated from medical school more recently, who are female, who specialize in obstetrics and gynecology, or who practice in a health maintenance organization (HMO). Medical personnel in teen clinics and community family practice settings are far more likely to conduct appropriate reproductive health screening than are private family and pediatric practitioners. Lack of reimbursement for preventive services, time constraints, lack of educational material, limited personnel, or a small referral network may also hinder the provision of appropriate preventive services.[61]

Many Males Lack Access to Care

In addition to focusing on these missed opportunities to capitalize on current access to health care, efforts to improve young men's reproductive health need to expand access to appropriate preventive health services. Access issues are usually thought to revolve around affordability and insurance. Young men without health insurance are at particular risk of not receiving services. A recent study using data from the 1995 National Survey of Adolescent Males found that while more than two-thirds of males ages 15 to 19 with health insurance received a physical exam in the past year, fewer than half of the 11 percent of males without health insurance had received a physical exam.[62] Furthermore, boys from lower-income households are estimated to be less likely than those from higher-income families to have a usual source of health care.[63]

"NO SYSTEM *ensures that young men receive reproductive and HIV/STD-related preventive health services."*

While affordability is an important factor in determining access to reproductive health care, other issues are important as well. To achieve accessibility, the Society of Adolescent Medicine recommends that health care services for adolescents be

- Affordable
- Available
- Visible
- Confidential
- Coordinated
- Of reasonable quality
- Sensitive to teens' cultural, ethnic, and social diversity[64]

An additional concern is that care should be *responsive to teens' specific and distinct needs by gender.* For example, a major reason for the

"HEALTH CARE *providers cannot wait until young men ask about contraception to talk about reproductive health issues."*

lack of access just noted is that the nature of routine care generally differs for men and women. Gynecological and family planning care are routine for young women, often ensuring a mechanism for addressing women's preventive health needs. Yet no comparable system ensures that young men receive reproductive and HIV/STD-related preventive health services. Also, the types of contraception available to young men and women are likely to influence their receipt of health care. Condoms, the only effective reversible male method, are available without a prescription and without a visit to a health care provider. This contrasts sharply with the use of hormonal methods of contraception, such as the pill or Depo-Provera, that require repeated visits to a health care provider. Health care providers cannot wait until young men ask about contraception to talk about reproductive health issues. They must take advantage of other opportunities, such as sports physicals, work exams, routine care, and even emergency room visits, to educate and counsel young men about reproductive health issues.

Aggravating the situation for most young men is the absence of any special setting where they can go to seek gender- and age-appropriate reproductive and sexual health services. Many family planning clinics are not able to meet the reproductive and sexual health needs of young men and are generally perceived as not very welcoming to men. While family planning clinics increasingly recognize the need to provide services to young men, serving young men in these settings can be difficult because of limited funding and staff time, lack of male staff, and, at times, criticism about diverting limited resources to males.[65] Further, education and training materials on men's reproductive and sexual health are limited.[66] There are now a few examples of clinics especially designed to serve young men, either separately or as part of preexisting

family planning clinics. Experience gained in these efforts is a good starting point for program development.[67]

Identifying Pockets of Highest Need

Lack of sexual and reproductive health services is an issue for all young men, regardless of race, class, or social status. But some young men have greater reproductive health needs than others, because they participate in more risky sexual behaviors, because they lack access to appropriate care, or because their levels of negative reproductive outcomes are higher. Identifying the characteristics of young men with particularly high need helps to focus effort when resources are limited. Seven groups of young men have heightened levels of reproductive health risks: (1) young men of color, (2) young men living in poverty/poor neighborhoods, (3) out-of-school men, (4) young men involved in the criminal justice system, (5) young men in foster care, (6) gay, bisexual, and transgender young men, and (7) men in their early 20s. Substantial numbers of young men fall into at least one of the at-risk groups. Many at-risk youth belong to more than one of these groups and face multiple and related sources of disadvantage.

Young Men of Color

Young men of color are becoming an increasing proportion of all adolescent men, making the needs and behaviors of these young men of even greater concern. The proportion of nonwhite males in the United States among all males ages 10 to 19 increased from 20 percent in 1980 to 34 percent in 1997.[68] It is projected that by 2020, 45 percent of U.S. children under age 18 will be children of color.[69]

Black and Hispanic teen males are exposed to higher levels of sexual risks than are their white peers. In 1995, 80 percent of the black males ages 15 to 19 and 61 percent of Hispanic males reported being sexually experienced, compared with 50 percent of white males. Black males also initiate sex earlier, with half having sex by age 16, compared with a median age of 17 for sexual initiation among Hispanic males and age 18 among white males. On the other hand, black males have the highest levels of condom use at last intercourse of the three groups of teenagers, and 47 percent of the sexually experienced used condoms 100 percent of the time, a rate comparable to that of the white male teenagers. In contrast, condom use practices among Hispanic males put them at special risk. Fewer than one-third of Hispanic males always used condoms in the past year. Hispanic males were the only racial/ethnic group that did not significantly increase their use of condoms at last intercourse between 1988 and 1995.[70]

This greater behavioral exposure to sexual risks is paralleled by minority males' disproportionate involvement in AIDS, STDs, pregnancy, and childbearing. Among adolescents ages 13 to 19, cases of AIDS among African Americans and Hispanics accounted for approximately 84 percent of all reported cases in 1999.[71] Rates of gonorrhea and chlamydia are highest among African American teens and higher among Hispanic youth than non-Hispanic youth. Non-Hispanic black males are three times as likely as non-Hispanic white males to father a child by age 20 (17.9 percent vs. 5.9 percent), and Hispanic males are almost twice as likely as non-Hispanic white males to become teen fathers (9.9 percent vs. 5.9 percent).[72]

Young Men Living in Poverty/ Poor Neighborhoods

Both family poverty and neighborhood poverty expose young men to increased reproductive health concerns. Family poverty, neighborhood poverty, and race are highly correlated, making it difficult to distinguish the unique influences of each of these factors on young men's health. In 1995, about one out of five American children under age 18 lived in families with incomes below the federal poverty level, but for Hispanic and African American children the figure was two out of every five.[73] Together, these factors multiply the needs of young men of color.

Teens living in poverty tend to be in poorer health than teens from more affluent families. Family poverty and neighborhood poverty make young men more vulnerable to reproductive health concerns because of their poor access to health care or education, their quality of housing, their exposure to violence, and many other determinants of adolescent health.[74] Communities with high unemployment are less stable, and their key institutions such as schools are less able to function well. For young men living in poverty, other concerns, such as violence, may appear more immediate or threatening than STDs and unintended pregnancies. Teens who feel that they have little chance of living to the age of 30 frequently report little motivation to delay parenthood.[75]

"FOR YOUNG men living in poverty, other concerns may appear more immediate or threatening than STDs and unintended pregnancies."

Out-of-School Males/ Loosely Connected Men

Out-of-school men face unique reproductive health challenges. They have higher levels of sexual activity and unprotected inter-

course than in-school males, as well as greater participation in other health risk behaviors such as substance use, which may increase their exposure to health risks.[76] Yet they are disconnected from schools, the primary source of formal reproductive health education and a key venue for services and interventions aimed at improving adolescents' health behaviors.

Another challenge is reaching "loosely connected males"—those with limited participation in the workplace and weak connections to parents or partners. Loosely connected males also may have less access to the health system, making it more difficult to screen and treat reproductive health problems. Because of their lack of connections to traditional sources of information and support, they face increased behavioral risks. Health promotion efforts need to turn to less traditional venues such as job training, the workplace, or the criminal justice system to reach these disconnected young males.[77]

Estimates of the number of homeless youth ages 11 to 18 have increased from just over 500,000 in 1975 to 1.5 million in 1988.[78] With little or no social and economic support, these runaway, throwaway, and street youth are often susceptible to high reproductive health risks. The need to trade sex for shelter, food, or money (survival sex) places these teens at high risk of negative health outcomes, especially becoming infected by HIV or other STDs. For males, "survival sex," primarily male-to-male, increases the risks of exposure to HIV. A recent nationally representative study of teen males in shelters found that 11 percent of them had participated in survival sex; 28 percent of homeless teen males living on the street reported this behavior.[79]

Young Men Involved in the Criminal Justice System

Adolescent males involved in the criminal justice system are more likely to participate in sexual risk behaviors than other males. A 1991 study found that incarcerated teen males were more likely to be sexually active, initiated sex at an earlier age, reported more sexual partners, and were less likely to use condoms consistently than in-school adolescents. These factors, combined with a higher prevalence of injection drug use among the incarcerated youth, put them at greater risk for HIV infection than the school sample.[80] Indeed, confined youth tend to have higher rates of STDs than adolescents in the community.[81] Many incarcerated young males are fathers; these men find it hard to be active and responsible parents.

"HEALTH promotion efforts need to turn to less traditional venues such as job training, the workplace, or the criminal justice system."

Young Men in Foster Care

Little information exists on sexual and reproductive behaviors among adolescents in foster care, and most of what is available focuses on the experiences of girls. Yet it is well-known that adolescents in foster care are a particularly risky group. They have already suffered physical, sexual, and/or emotional abuse or neglect, making them vulnerable to reproductive risk-taking.[82] A few studies document that girls in foster care are more likely to be sexually active and initiate sex at earlier ages, and yet they use contraceptives less frequently than those not in care. This increased risk-taking likely extends to males as well.[83] Yet only six states in the nation have a written policy to provide both sexuality education and family planning services for youth in out-of-home care.[84]

Gay, Bisexual, and Transgender Young Men

Engaging in male-to-male sexual contact exposes teen males to greater reproductive health risks, including an increased risk of HIV and other STD transmission, than does engaging in heterosexual behavior.[85] Yet this group of young males is difficult to reach, in part because of the stigma of self-identification, which may be exacerbated by the fact that homosexuality often is not adequately discussed in school health settings.[86] A 1993 study in Massachusetts found that 28 percent of gay youth who dropped out of school did so because they were uncomfortable with the school environment.[87] Teens in this sexual minority face harassment, isolation, and violence because of their sexuality, and they are more likely than their peers to have been victimized or threatened or to have had sexual contact against their will.[88] Bisexual male teens may be less likely to identify with gay populations and therefore may not see themselves as at risk for HIV and other STDs.

Men in Their Early 20s

While much of the public effort and rhetoric has focused on adolescents, young men in their early 20s actually face greater reproductive health risks. They engage in more acts of sexual intercourse and use condoms less often than those ages 15 to 17. Not surprisingly, rates of STDs are also higher among males in their 20s. In 1998, the gonorrhea rate was 575 per 100,000 among men ages 20 to 24, compared with a rate of 355 among males ages 15 to 19.[89] Reducing sexual risk-taking in this age group may assist in reducing childbearing and STDs among

teenage girls as well. In 1988, 51 percent of births to girls ages 15 to 19 were fathered by men ages 20 to 24, and another 11 percent were fathered by men ages 25 to 29 (table 1.1).[90] More generally, sexual relationships between teenage girls and older partners tend to be riskier than those with peers, because use of contraception, especially condoms, is lower with older male partners.[91]

Men in their early 20s face constraints in their ability to obtain reproductive health information. Many are not attending school, a primary source of education and information. Instead, men ages 22 to 26 report receiving AIDS/STD information in the past year from a health provider (22 percent), attending a lecture or reading a brochure (48 percent), or talking to a friend, a partner, or family members (51 percent). Overall, 30 percent of men in this age range did not receive AIDS/STD prevention information from any of these sources.[92] In contrast AIDS education is nearly universal among teen males.

"MEN IN THEIR *20s face constraints in their ability to obtain reproductive health information."*

Developing and maintaining healthy relationships with partners and children may be of more paramount concern for men in their early 20s. Compared with teen males, they are substantially more likely to be married or cohabiting, and more likely to be both biological and social fathers. Reproductive health concerns for these older males may focus more on the demands of being a responsible partner and a responsible parent.

The evidence covered in this chapter highlights young men's needs for reproductive health information and services. Enhancing the reproductive health of young men in their teens and 20s will require reducing their sexual risk-taking behaviors. Even with the recent hopeful trends toward reduced sexual risk-taking, many young men and their partners still face the negative consequences of their risky

behaviors. This chapter documents a range of missed opportunities to address young men's reproductive health through school, family, the media, and the health care system. In addition, many young men do not currently have access to relevant preventive care or treatment, especially care that is age- and gender-appropriate. Meeting young men's sexual and reproductive health needs can lead to improved health outcomes for the young men themselves, positive health outcomes for their partners and children, and reduced societal costs associated with disease and unintended pregnancy. The next chapters of this report present key components of a strategy for enhancing young men's reproductive health.

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CHAPTER 2

ENHANCING YOUNG MEN'S SEXUAL AND REPRODUCTIVE HEALTH: A FRAMEWORK

Laura Porter, Freya L. Sonenstein, and Laura Duberstein Lindberg

No medical or public health specialties exist that are devoted to men's sexual and reproductive health. For women, gynecology and obstetrics function as medical reproductive health specialties, with associated training and practice requirements. Family planning and maternal and child health services function for women as public health areas of specialization with common core services and activities. Nothing like these exists for young men's reproductive health, and thus there is no common understanding of the purpose or the content of sexual and reproductive health services for young men. The primary charge of the working group, therefore, was to draft a statement about what sexual and reproductive health promotion and care for young men in the United States should look like. This statement presents a starting point for a discourse that might eventually lead to a shared vision about the form and content of services addressing young men's sexual and reproductive health care needs.

The working group challenged itself to think beyond a simple disease model of health and instead to look more holistically at young

men's experiences as they develop into healthy adults. The group agreed that sexual and reproductive health involves not just the absence of disease, but the presence of positive personal and social assets. Efforts to promote reproductive health for young men must address more than the condition and functioning of reproductive organs; these efforts should promote reproductive and sexual health within the context of the whole person. To this end, the group formulated a set of goals for promotion of sexual and reproductive health that cover the breadth of young men's needs as they make the successful transition into physically and emotionally healthy adults.

Sexual and Reproductive Health: What Should Be Achieved?

The fundamental belief guiding these efforts to define sexual and reproductive health services for men is the group's vision of sexual health for men. According to this vision,

> *All males will grow and develop with a secure sense of their sexual identity, an understanding about the physical and emotional aspects of sexual intimacy, and attitudes that lead to responsible behavior. Achieving these developmental goals will result in men postponing sexual intercourse until they are emotionally mature enough to manage the physical and psychological aspects of sexual intimacy. When they have sexual intercourse it will occur with as little risk as possible to either themselves or their partner.*

To achieve these results, the group believes that all young men living in communities throughout the country need access to educational, counseling, clinical, and social support services that, in combination, fulfill five goals:

- Promote sexual health and development.
- Promote healthy intimate relationships.
- Prevent and control STDs, including HIV.
- Prevent unintended pregnancy.
- Promote responsible fatherhood.

Two of these goals—**the prevention of STDs including HIV** and **the prevention of unintended pregnancy**—are familiar and traditional components of reproductive health. They focus on the prevention of the negative consequences of sexual behavior. Indeed, the existing reproductive health infrastructure, such as family planning clinics and STD clinics, tends to be organized around these goals. Three additional goals are proposed that promote positive outcomes as well. These additional goals—**promoting sexual health and development, promoting healthy intimate relationships,** and **promoting responsible fatherhood**—focus on not just the well-being of individuals, but also positive interactions with partners and potential children. A comprehensive effort to promote reproductive and sexual health needs to address the new social roles and relationships young men take on as they make the transition into adulthood. Reproductive health is not just about the health of one's body, but the health of one's sexual and reproductive relationships.

The promotion of responsible fatherhood in the context of sexual and reproductive health promotion is a relatively new concept and therefore requires additional discussion. Many initiatives promoting "father involvement" focus on men *after* they become fathers, in effect conceptually removing fathering from sexual behavior. Instead, we draw from recent discussions[1] that clearly identify the link between responsible sexual behavior and responsible fathering.

Box 2.1 Components of Responsible Fatherhood

Waits until prepared to care for a child

Establishes legal paternity

Shares emotional and physical care

Shares financial support

Levine and Pitt have defined the components of responsible fatherhood (box 2.1).[2] One crucial theme in responsible fatherhood is not having children until one is financially and emotionally able to care for them. Sexual and reproductive health thus attends to responsible fathering in two ways—first, by forestalling unintended fatherhood, whether through abstinence or contraception, and second, by encouraging the care of one's children.

These five goals should guide the development of programs to promote young men's reproductive and sexual health. Of course, any individual program probably cannot give equal emphasis to each of the five goals. A program's particular emphasis will depend on the clients it seeks to reach (e.g., younger adolescents, fathers, high-risk youth), its existing services and capacity, and its mission. For example, a family planning clinic that wants to reach out to male clients may find itself best suited to focus on preventing unintended pregnancy, with less attention and resources devoted to the other goals. Alternatively, a job training program for young men might find itself best situated to focus on promoting responsible fathering.

Because of the conceptual and programmatic overlap across the five goals, most programs will address multiple goals. Progress toward achieving any single goal has implications for the others. Healthy personal development is needed to establish and maintain healthy interpersonal relationships, for example. Knowing how to develop and maintain healthy relationships plays a key role in facilitating the partner selection, communication, and decisionmaking required to prevent STDs and unintended pregnancies. Healthy personal development and strong relationships with a partner form the foundation for responsible fathering.

The Content of a Comprehensive Reproductive Health Strategy

Having identified the goals of sexual and reproductive health programs for young men, the working group developed recommendations about the content of service strategies. To fulfill each goal, programs should

- Convey necessary information.
- Foster skills development.
- Promote positive self-concept.
- Identify and develop positive values and motivation to act on those values.
- Provide access to clinical care.

Exhibit 2.1 illustrates the types of information, skills, self-images, values and motivation, and clinical services that could plausibly address each of the five goals. The list is not meant to be all-inclusive. The working group anticipates that the list will be extended and modified as consensus grows about what the core content of such services should be. It is important to note that clinical care, while a necessary element for achieving the reproductive health goals, is only one of the identified components. (See chapter 3 for a description of the full range of components of clinical care.) This fact reflects the group's understanding that young men's reproductive health must include not only disease prevention but also the development of skills and promotion of positive self-concept noted above. The recommended content of each of the reproductive health goals is described below.

Goal 1: Promote sexual health and development. Necessary information under this goal includes normal male and female pubertal development, social and emotional development, hygiene, and components of a healthy lifestyle. Skills development includes working on

communication and decisionmaking skills. Promoting a positive self-concept includes coverage of masculinity and male role identity, sexual identity, self-respect, and personal potential. (The content of this element remains fairly constant across the five goals.) Positive values can include respect for others, cultural appreciation, and the importance of physical health. Access to clinical care includes regular visits to a health provider, screening and treatment for anomalies, and referrals for other services.

Goal 2: Promote healthy intimate relationships. Information under this goal includes stages in romantic relationships, forms of sexual expression, and sexual coercion and violence. Skills development includes how to make decisions about initiating sex, how to refuse unwanted sexual overtures, how to avoid unhealthy relationships, and how to develop clear lines of communication with partners. Positive values can include the desirability of give and take in relationships and mutual fidelity. Clinical care includes counseling, screening and treatment of sexual dysfunction, and identifying potential physical, emotional, or sexual abuse.

Goal 3: Prevent and control the transmission of STDs, including HIV. Information to be conveyed includes knowledge of the various types of STDs, how they are transmitted and prevented, and how they can be detected and treated. Skills development includes how to obtain condoms and use them correctly and how to negotiate with partners about safe sex, including saying no to sex and obtaining information about their HIV/STD risk status. In addition to the common elements promoting a positive self-concept, it is also important to convey recognition of personal vulnerability to disease. Positive values can include concern for one's own and one's partner's health.

Access to clinical care includes screening, counseling, and treatment for all STDs. It also includes facilitating access to condoms through distribution programs or other approaches.

Goal 4: Prevent unintended pregnancy. Information to be conveyed includes the biological mechanisms underlying reproduction and the merits and side effects of various types of contraceptive methods. Males need information about female contraceptive methods. Skills development, again, includes how to negotiate safe sex. Because the most effective methods of preventing pregnancy are abstinence or methods used by female partners such as hormonal contraceptives, intrauterine devices (IUDs), or sterilization, good communication with and expressions of support to these partners are also essential. An additional element of positive self-concept is conveying a sense of control over one's destiny. Positive values include life goals and how childbearing fits in. Clinical services include contraceptive counseling and services, counseling about pregnancies, and referrals for other health care.

Goal 5: Promote responsible fatherhood. Information to be conveyed includes the specifics about the responsibilities of parents, prenatal health and childbirth, child development, and well-child care. Skills development includes parenting and communication skills, which contribute to stronger parent-child and father-mother relationships. It also includes other life skills needed for the fulfillment of parental roles such as doing well in school, getting and keeping jobs, and managing finances. Promoting a positive self-concept includes recognizing the role of nurturance. Positive values include responsible fathering and manhood. Access to clinical services includes fertility services—how to have children when they are desired—and the screening and treatment of infertility.

"YOUNG MEN'S reproductive health must include not only disease prevention but also the development of skills and promotion of positive self-concept."

Exhibit 2.1 Sexual and Reproductive Health Content

	Goal 1 PROMOTE SEXUAL HEALTH AND DEVELOPMENT	Goal 2 PROMOTE HEALTHY INTIMATE RELATIONSHIPS	Goal 3 PREVENT AND CONTROL STDs AND HIV	Goal 4 PREVENT UNINTENDED PREGNANCY	Goal 5 PROMOTE RESPONSIBLE FATHERHOOD
Information	normal anatomy and pubertal development social and emotional development hygiene STDs/HIV where and how to access services nutrition physical activity	stages in romantic relationships readiness for sexual involvement forms of sexual expression sexual coercion and violence	STD symptoms and transmission diagnosing and treating STDs prevention strategies (including effectiveness of condom use) prevalence of diseases short- and long-term consequences of STDs (for men and women) where to get condoms	contraception and its effectiveness (incl. 100% effectiveness of abstinence) reproductive biology and how pregnancy occurs where to obtain contraceptives consequences/costs (of pregnancy/contraception) forms of sexual expression	responsibilities of parents prenatal health and childbirth child development child health and well-child care paternity establishment, child support, and visitation
Skills	resisting peer pressure communication decisionmaking self-advocacy risk assessment and avoidance setting and achieving goals	communication and listening partner selection and avoiding unhealthy relationships negotiating safe sex recognizing difference between consent and coercion violence prevention	negotiating sexual activity and setting limits negotiating condom use how to use condoms properly communication (with partner about sex) how to recognize STD symptoms how to access services how to ask for more information	negotiating sexual activity and setting limits communication (with partners, providers) decisionmaking how to access services/resources resisting peer pressure how to be intimate with partners how to use contraceptives how to use condoms properly	parenting skills life skills (e.g., job, housing, medical care, etc.) training and opportunities for financial self-sufficiency communication (child and child's mother)
Positive Self-Concept	self-esteem self-respect sexual identity/orientation gender roles personal potential	self-esteem self-respect sexual identity/orientation gender roles	self-esteem self-respect awareness of vulnerability self-efficacy sexual identity/orientation	self-esteem self-respect confidence in the future sense of control over one's life and decisions	self-esteem self-respect nurturance sense of control over one's life and decisions
Values and Motivation	respect for others spirituality family expectations healthy lifestyles value of education social responsibility and contribution cultural appreciation value of healthy sexuality	healthy relationships role expectations mutual fidelity	health as a priority concern for partner's health	women's/men's role in contraception women's/men's role in pregnancy setting and achieving life goals parenting as a life goal	values regarding parenthood/fatherhood values regarding "being a man"
Clinical Services	physical exam screening for development abnormality primary health care services preventive health services mental health assessment access to services including counselors (adult and peer), mentors, health educators	physical exam screening and treatment for sexual dysfunction screening and treatment for sexual abuse counseling (individual, relationship)	physical exam STD testing, treatment, partner referral HIV testing and counseling HIV follow-up care counseling (safe sex) access to condoms	physical exam counseling (contraception, pregnancy options) contraceptive services (with partner) referral for health services	physical exam fertility assessment child health and well-child care support groups for young fathers referral for health, mental health, and other services

How to Deliver Sexual and Reproductive Health Services to Young Men

A very broad range of content has been identified for a comprehensive effort that addresses the five reproductive health goals for young men. Given this breadth, the approaches used to deliver services must be varied and flexible. They also need to take account of the fact that young men live in families, communities, and broader policy environments that define and constrain their opportunities. Therefore such an effort primarily targets young men but may also seek to influence their environments. Exhibit 2.2 illustrates the variety of delivery vehicles that can be used to convey needed services to young men. Young men themselves can be reached through four major channels: education, counseling, clinical services, and support services. The first three are relatively obvious. Education is a key mechanism for providing the information and skills related to reproductive health. Counseling is an important mechanism for addressing young men's self-concept and their development of values and motivation related to reproductive health. Clearly, clinical services are needed to provide the health care content outlined in exhibit 2.2 and more fully detailed in chapter 3.

The rationale for the fourth channel, support services, may need more explanation. The environment in which a young man is raised, the people with whom he has contact, and the opportunities and challenges of life presented to him will influence the health risks he faces and his sexual and reproductive decisionmaking. For this reason, enhancing the reproductive health of young men potentially necessitates a range of support activities—such as recreation, employment and training, and spiritual guidance—that promote healthy social development, a positive self-image, meaningful interpersonal relationships, educational attainment, and integration into the formal economy.

Exhibit 2.2
Channels to Promote Sexual and Reproductive Health

Clinical services

History
Physical
Laboratory
Immunizations

Counseling

Individual counseling
Couple counseling
Family counseling
Group counseling

Education

On-site individual health education
Group health education
Health fairs
Outreach education

Support services

Mental health services
Drug and alcohol treatment
Youth development and mentoring
Recreation and sports
Violence prevention
Education assistance and literacy
Employment assistance, including job readiness
Foster care, independent living, and child welfare
Justice and legal services

In addition to providing services to individual young men, a comprehensive reproductive health promotion strategy should include efforts aimed at the families, schools, neighborhoods, and the larger political, legal, and normative environment. These might include policy and legislative advocacy around such topics as health insurance,

educational opportunity, or availability of contraceptives. Also, social marketing and media campaigns can provide specific information and influence attitudes and public opinion.

Neither the reproductive health content nor the channels for service delivery identified here are limited to specific settings or specific types of service providers. Instead, most of these approaches can be implemented in a range of settings by a wide array of service providers. While the provision of clinical services is specific to trained medical staff, it need not take place in a medical setting. Clinical staff can provide off-site services, essentially bringing clinical services to locations where young males can be found. Education and counseling can be provided by either medical or nonmedical personnel. Counseling, as discussed here, refers not just to "professional" psychological services but to mentoring as well. Support services for young men, such as those identified here, are generally offered by a wide range of community-based organizations.

To provide access to a full range of reproductive health resources for young men, most organizations will need to reach out into their communities and create linkages with organizations that specialize in different areas of reproductive health or in delivery of services to young men. Organizations can work together to create a seamless network of services that benefits young men and maximizes community strengths and resources. The next section describes how several different types of organizations can come together to enhance male sexual and reproductive health in their communities.

"A COMPREHENSIVE reproductive health promotion strategy should include efforts aimed at the families, schools, neighborhoods, and the larger environment."

Collaborating to Provide Comprehensive Reproductive Health Services in Communities

In general, the wider the range of goals and activities, the greater the need for interaction and partnership across organizations and agencies in the community. A comprehensive effort will require the commitment of a variety of stakeholders including young men themselves, their partners, their families, and their communities; nongovernmental health and social organizations; and local, state, and federal government. These groups bring diverse levels of capacity, skill, expertise, and sensitivity to the promotion of sexual and reproductive health.

Organizational collaborations can take many forms. Examples abound of organizations exchanging information, swapping referrals to obtain needed services for clientele, regularly loaning staff to enhance activities at another site, and forming partnerships that join the resources of two or more facilities. Brindis and Davis, for example, describe the many ways that organizations might share services and staff, including co-location, out-stationing, staff loans, and joint intake and assessment.[3] (For a more formal conceptualization of the forms of exchanges that can occur between agencies, see the work of Himmelman,[4] whose framework is described in box 2.2.)

Beyond their service specialties, organizations have different abilities to attract young men. At one extreme, some organizations will start from a successful history of gaining access to young men and gaining their trust, but will have little or no experience in providing reproductive health services. At the other extreme, some organizations will have reproductive health promotion as their central mission, but have limited experience or expertise in attracting, retaining, or serving young men by collaboration.

The desire of an organization to reach underserved populations may further propel the need to collaborate across organizations. The follow-

Box 2.2

Organizations come together in a variety of ways, which can be placed on a continuum of increasing complexity and commitment. Himmelman (1996, pp. 19–23) has classified organizational interaction into four types:

Networking, the least formal organizational interaction, occurs when stakeholders exchange information for mutual benefit.

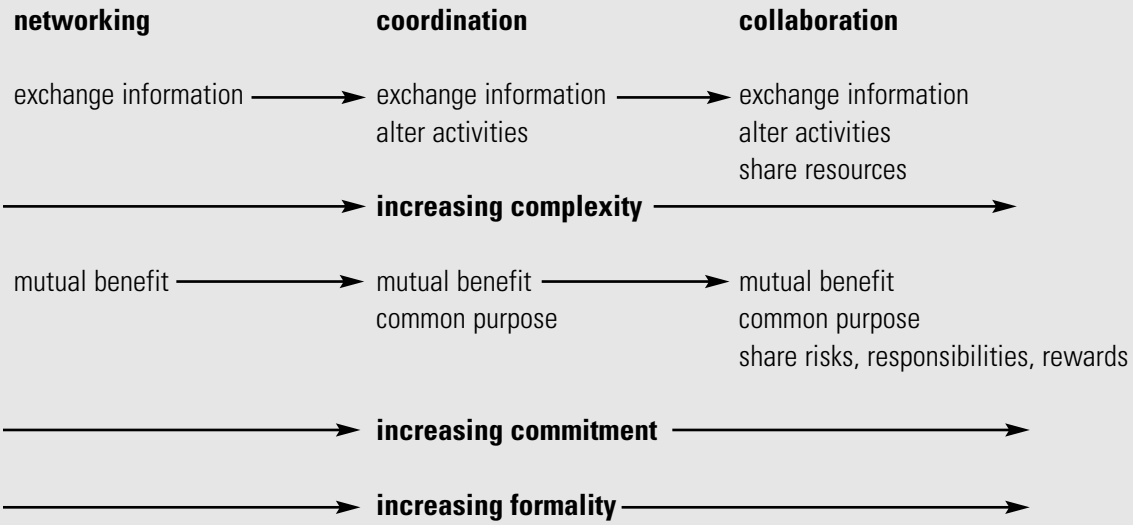
Coordination happens when organizations both exchange information and alter activities for mutual benefit and to achieve a common purpose.

Cooperation occurs when organizations exchange information, alter activities, and share resources for mutual benefit and to achieve a common purpose. A variety of resources can be shared—such as information, staff, funding, skills, or office space—and many different arrangements can be made to share these resources.

Collaboration goes even further on the continuum, when organizations exchange information, alter activities, share resources, and enhance each other's capacity for mutual benefit and a common purpose by sharing risks, responsibilities, and rewards.

Below is an adaptation of Himmelman's classification; the last two categories are collapsed into one, called collaboration, because although the two categories may be theoretically distinct, the working group finds them difficult to distinguish in real practice. The most intensive form of organizational interaction indicates a level of shared resources, risks, responsibilities, and rewards that is distinct from coordination.

Steps Needed to Move from Networking to Collaboration



Source: Adapted from Himmelman.[5]

ing are some examples of the mutual benefits that might be attained:

- Health providers who have traditionally found it hard to reach young men can form partnerships with other community organizations that have longstanding experience working with young men.
- Alliances with organizations offering activities that are especially attractive to young men, such as sports or job preparation, can be another good approach to recruiting young men into health promotion and care services.
- Collaborating with agencies that have captive populations of particularly high-risk young men with special needs, such as runaway and homeless youth shelters, the foster care system, or the juvenile justice system, is yet another promising way to broaden the base of populations served.
- Beyond the young men themselves, agencies may want to reach the broader environments that shape these youth—their families/parents, schools, communities, health systems, government agencies and their representatives, nongovernmental service organizations, and professional organizations.

"THE DESIRE *to reach underserved populations may propel the need to collaborate across organizations."*

The need to focus on diverse populations drives the need for greater interagency collaboration. This is the only realistic way limited community resources can be fully applied to building more comprehensive strategies.

It is also important to point out that the agency initiating a sexual and reproductive health promotion initiative for young men can be a clinic, a neighborhood-based youth development organization, or some other type of community agency. No matter which type of agency commences the effort, few will be able to deliver comprehensive services by themselves. Partnerships with other agencies need to

be forged to address the broad range of needs young men have.

Where existing resources are scarce, organizations may start small, with educational efforts or pilot projects. Even small-scale efforts are worthwhile if conducted thoughtfully and well. It is important to realize, though, that making a commitment to address the reproductive health needs of men—even if the effort is quite focused, like a health fair or a media spot—is likely to lead to additional opportunities to do more. For example, a simple media spot encouraging young men to be screened for STDs requires capacity in the community to conduct the tests, provide treatment, convey information, teach partner communication skills, follow up with partners, and provide other services that might keep young men from needing the screening and treatment again. Once young men are engaged and motivated to improve their reproductive health, organizations need to be able to either provide the services or maintain linkages to the resources that meet young men's reproductive needs and other health needs. Organizations also need to consider creative ways of using existing community resources, and in many communities new reproductive health services will likely need to be developed.

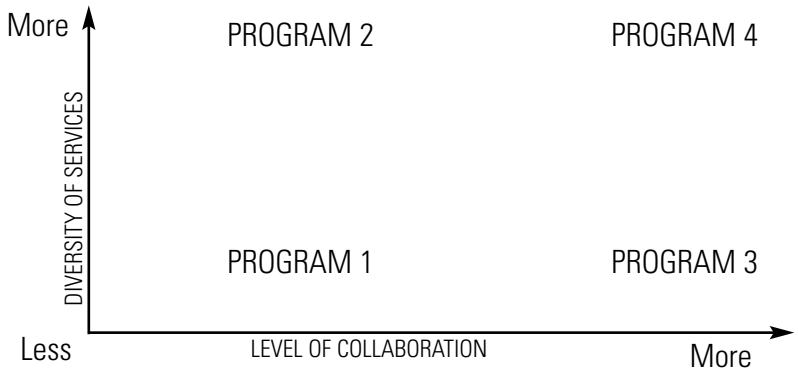
A key guiding principle for collaborative efforts should be that they are client-centered—that their primary objective is making a range of services available to meet young men's disparate sexual and reproductive health needs. By holding to this principle, the collaborating parties may be able to avoid some of the pitfalls of collaborative efforts that can bog down in turf battles or administrative maneuvers. When community agencies and organizations work together, they can leverage existing resources and develop new resources. Building partnerships across agencies and organizations

is challenging, but it can be highly rewarding when the result is a comprehensive range of services responsive to young men's sexual and reproductive health care needs.

Levels of Organizational Collaboration

When agencies collaborate, the process can vary on two important dimensions: (1) how complex and diverse the service package and (2) how committed, formal, and intertwined the agencies' mutual relationship. This section illustrates how agencies may choose to vary their program development activities along these two dimensions and how different program models emerge. Chapter 5 provides examples of agency partnerships and how they combine the four channels of service delivery to meet the reproductive health needs of young men. As organizations set out to develop a set of activities for young men that enhance reproductive health, they will need to evaluate how complex and comprehensive their program activities will be and how they want to interact with other community agencies. These decisions will affect not only the types of services available to young men but also how attractive the program is to young men and whether existing community resources are used efficiently. Exhibit 2.3 illustrates how reproductive health programs developed for young men could vary on these two dimensions. The four programs used as examples of prototypes have been selected from a guidebook titled *Involving Males in Teen Pregnancy Prevention*.[6] They demonstrate a range of program activities and types of organizational interaction. More information about the programs can be obtained in the guidebook.

Exhibit 2.3
Variation of Programs by Comprehensiveness and Collaboration



Program 1 has a narrow set of activities and limited commitment across community agencies. This kind of project is a good starting point for agencies that want to address the sexual and reproductive health needs of young men but are not ready for a full-scale comprehensive partnership effort. An example is ***Project Alpha,*** which is cosponsored by the Alpha Phi Alpha Fraternity, Inc., and the March of Dimes Birth Defects Foundation and implemented by 700 local fraternity chapters around the country. The program usually is delivered to young men in half-day workshops or one-shot weekend camping retreats. For a typical retreat, young men and facilitators go to a campground outside of their community and spend the day in educational workshops, group discussions, and recreational activities. These are designed to build knowledge, convey attitudes, and teach skills relat-

ed to teen pregnancy prevention. Even though linkages with other organizations are fairly limited, they are by no means absent in this program. As noted, the March of Dimes funds the program, and in each community the fraternity chapters rely on schools, church groups, Big Brothers/Big Sisters, the Boy Scouts, and other youth service programs to refer young men.

Program 2 is comprehensive in the range of activities it offers, but it provides most of the services itself. ***The Men's Services Program of the Center for Fathers, Families, and Work Force Development (CFWD)*** is an example of a program that strives, in an early intervention program, to provide a broad array of comprehensive services to men who are the fathers of babies. The services are housed in the Baltimore Healthy Start program. The men's services program takes a holistic approach by working with fathers on their parenting skills, job skills, and employment and educational opportunities. The program assumes that active parenting begins at conception, and it encourages fathers to participate in prenatal and pediatric appointments. The program also includes weekly life skills education, group therapy sessions, and an educational curriculum. To address the employment needs of men in the program, CFWD operates a job training program, and it has developed agreements with other area employers to hire men from the program. The program has also developed a strategic partnership with the Maryland Department of Child Support Enforcement to pilot test an arrearage forgiveness program.

Program 3 provides a focused set of activities within a highly developed partnership arrangement. ***The Young Men's Clinic*** in the Washington Heights section of New York City is illustrative because it has intense organizational collaboration around a relatively limited

set of services. This program is the result of a collaboration between New York Presbyterian Hospital's Ambulatory Care Network Corporation and the Columbia University Mailman School of Public Health's Center for Population and Family Health. Its mission is to provide reproductive health care, education, and counseling to young men. The young men's health clinic is run several times a week in a facility that also houses a young women's clinic at other times of the week. When the clinic is open, a typical session starts with a slide presentation focused on male reproductive concerns and facilitated by a public health student intern. This session can be followed by an individual or group counseling session. Health assessments are conducted using the "biheads formula," a version of which is described in more detail in chapter 3. Biheads stands for *body image, employment, education activities, drugs, and sexuality.* Routine health care and treatment are provided. Staff are also taught to take advantage of "teachable moments" for providing reproductive health education and counseling as opportunities present themselves. Collaboration between the clinic and the College of Physicians and Surgeons has led to the placement of medical students in the clinic to improve the quality of medical care and educate medical students about reproductive health.

Program 4 represents a multiagency partnership that provides a broad array of activities that might comprehensively address the five goals of reproductive health promotion for young men. An example is the ***Fifth Ward Enrichment Program*** in Houston. This program is located in a community center and serves young men from several neighborhood schools—elementary, middle, and high school levels. It provides a wide array of workshops and activities after school and on

weekends during the school year. The workshops address such issues as dating and communication, contraception, human growth and sexuality, self-awareness, conflict resolution, career planning, and drug and alcohol use. The program also offers academic tutoring, individual counseling, and small-group support sessions. A variety of activities provide young men with opportunities for personal growth, including field trips, community service, drama, chess, arts, camping, competitive sports, leadership training, and academic clubs. In the summer the program offers enrichment activities, paid employment, and experience running small businesses. The program provides a comprehensive array of activities for young men through a complex array of relationships with the Houston Independent School District, the Baylor Teen Clinic, local law enforcement, health providers, and local churches. It refers program participants to neighborhood resources such as outpatient drug and alcohol support groups. It also participates in a Young Fathers in Families Coalition and an HIV emergency coalition.

These four examples illustrate the array of programs that could be developed to meet young men's reproductive and health care needs. An agency can start small in terms of the goals emphasized, the activities provided, the agencies collaborated with, and the level of partnership commitment made. These examples demonstrate that no agency provides services in isolation from other resources in the community. Later chapters in this volume describe how community partnerships can be built, how to get started, and where to find funding.

Notes

[1] Levine, J. A., and E. W. Pitt. 1995. *New Expectations: Community Strategies for Responsible Fatherhood.* New York: Families and Work Institute; and Federal Interagency Forum on Child and Family Statistics. 1998. *Nurturing Fatherhood: Improving Data and Research on Male Fertility, Family Formation and Fatherhood.* Washington, D.C.: author.

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CHAPTER 3

CLINICAL CARE FOR THE SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENT AND YOUNG ADULT MEN

Jonathan M. Ellen

Clinical services are an important component of a comprehensive sexual and reproductive health strategy for young men. Indeed, the working group agreed that any comprehensive effort should provide minimum standards of clinical sexual and reproductive health services for young men. In contrast to the well-developed guidance available for the family planning and maternal and child health practitioners who deal with the sexual and reproductive health needs of young women, no generally accepted guidelines exist that define the scope of these services as they should be delivered to young men.[1] The American Medical Association[2] and the Society for Adolescent Medicine[3] have recommended that specific reproductive health services, counseling, and education be incorporated into routine care for adolescents. Yet the specific needs of males are not addressed and, by definition, young adult males who are beyond adolescence are not covered.

Thus, the purpose of this chapter is to define and describe the scope of clinical care for the sexual and reproductive health of adolescents and young adult men. It builds on the efforts cited above, as well as

those of the international family planning field,[4] to describe an array of services that address the five goals of sexual and reproductive health: to promote sexual health and development, to promote healthy intimate relationships, to prevent and control STDs including HIV, to prevent unintended pregnancy, and to promote responsible fatherhood.

It is important to acknowledge that it is not always clear to the practitioner when sexual and reproductive health care should be delivered. Obviously, patients or clients seeking specific sexual and reproductive health care should be given all the appropriate services possible. In addition, men seeking routine preventive health care should be offered these services because they could be considered part of routine male health care. But when men seek clinical care for reasons unrelated to sexual, reproductive, or preventive health concerns, it is a matter of clinical judgment whether the encounter should include sexual and reproductive health care. It may not be feasible to address the sexual and reproductive health needs of a man when there is a more pressing issue such as an acute medical or mental health problem. It is also possible that bringing up sexual and reproductive health issues may deter a patient from returning, especially if he thinks that his initial concerns were neglected. Practitioners therefore need to use judgment in deciding what to do in individual encounters. They should be aware, however, that clinics providing services to young men have found that many adolescents and young men appreciate the opportunity to talk about sexual and reproductive health issues with trained professionals.[5]

"CLINICS providing services to young men have found that many adolescents and young men appreciate the opportunity to talk about sexual and reproductive health."

Services, Settings, and Opportunities

Clinical sexual and reproductive health services for young men can be delivered in different settings. These can include private physicians' offices, hospital or community-based medical clinics staffed by physicians and nurses, or community-based organizations staffed by paraprofessionals. Given variations in location, physical layout, and level of training of the staff, some sites may be better suited to provide specific sexual and reproductive health care services than others. Clinical services are best delivered to young men in conjunction with counseling and education, but settings also vary in terms of their ability to combine these different types of services. Thus, if the goal is to provide a minimum standard of clinical care within a comprehensive array of services, it may be necessary to form alliances or partnerships across agencies. Through this collaboration, adolescents and young men can then access a broad range of services that will address their sexual and reproductive health needs.

Potential collaborations could take a variety of forms. Some traditional medical clinics might, for example, lack the staffing and expertise to deliver educational and counseling services. In this case, the clinic could work with community-based organizations in the patients' neighborhoods with capacity to provide these services. Community-based organizations might be the first point of contact for men who seek sexual and reproductive health care. In this case the community-based organization could establish a relationship with a traditional medical clinic to provide clinical services. Finally, some sites, with no clinically trained staff, could perform triage and make referrals.

The Scope of Sexual and Reproductive Clinical Care for Men

The working group formulated five goals for sexual and reproductive services for men. These goals have guided the choice here of practices that comprise the standards of quality preventive reproductive health care. The practices encompass the interrelated components of history and physical assessment, laboratory screening and vaccines, STD and HIV services, and counseling. Depending on the purpose and the setting of the clinical encounter, different aspects of clinical practice could and should be emphasized.

The working group drew these quality standards from various professional practice guidelines, position papers, and policy recommendations,[6] but this approach has limitations. Many of the specific guidelines and recommendations are not based on empirical data; rather, they draw from expert opinion and current standards of care. Furthermore, few of the guidelines and recommendations are context-specific, and thus they fail to inform the practitioners when it is appropriate to engage in certain practices. Clearly, adopting these untested guidelines and recommendations involves risks. Nonetheless, drafting guidelines is far more useful than saying nothing. This approach provides an initial benchmark from which scientific and policy knowledge can grow. The group hopes that new scientific evidence or clinical, economic, or ethical considerations will emerge from this discussion and will help refine and improve the proposed standards. Nonetheless, it is important to remain alert to setting standards for care that might be burdensome to the practitioner, might be costly to the health care system, and might yield little benefit to male clients or patients, their sex partners, or their children.

Finally, the group suggests that the practices recommended here

should occur at least annually as part of a general preventive health care visit, but it has not determined the optimal frequency of these services unless otherwise noted. These practices have been selected from source guidelines and recommendations as being consistent with the stated goals for male reproductive health promotion and health care services. Given the uncertainty about optimal frequency, clinical discretion about more frequent delivery of these services is advised.

History and Assessment

General

The promotion of healthy sexual development of adolescent and young adult men is linked to maintenance of overall health. For example, chronic disease, medicines, or heart disease may affect sexual functioning. Furthermore, as with women, males seeking reproductive health services may not seek preventive care elsewhere. Thus, with every male client it is appropriate to conduct a brief review of systems (general health status, hospitalizations, surgeries, allergies to medicines, and current medications); assess coronary artery disease risk factors such as smoking, cholesterol, and hypertension; review medications; and ask about inherited disorders such as sickle cell anemia and cystic fibrosis.

Family, Social, and Psychological Health

A comprehensive approach to male sexual and reproductive health also demands that clinicians recognize that men's sexual and reproductive behaviors occur in a larger context that includes families, peers, and society. This aspect of the history is particularly important when the

encounter is not for medical purposes. In these instances, counseling and education may comprise the bulk of the interaction and could be guided by assets or risks identified in this part of the history.

Emerging evidence suggests that parents' involvement in their adolescents' lives, including discussions about sexual relationships and sexual behavior, may result in more desirable reproductive health outcomes. Thus, it is important to assess the level of communication and monitoring as well as the quality of the relationship between clients and their parents or other significant adults. Indeed, some adolescents and young adults may wish their parents to be present or involved in the visit. In other cases, families may be a source of stress and trauma—for example, in families where sexual abuse or physical and emotional abuse has occurred.

"THE PROMOTION *of healthy sexual development of adolescent and young adult men is linked to maintenance of overall health."*

In addition, to the extent that identifying psychosocial risk factors and behaviors may ultimately lead to better general and reproductive health outcomes, providers should briefly screen for psychosocial risk factors and behaviors. Table 3.1 shows the elemental questions for a HEADSS (Home, Education, Activities, Drugs, Sexuality, and Suicide/Depression) Psychosocial Assessment. Peer behaviors and norms should also be included in this part of the history-taking, as well as an assessment of body image, drug and alcohol addiction, and depression or other major psychiatric disorders.

Providers should also explore their clients' sexual identity (gay, straight, lesbian, transgender, questioning) distinct from their sexual behavior. This discussion should be used to determine whether clients have experienced any conflict, internal or external, over their emerging identity. Younger adolescents may have difficulty with this discussion; older adolescents and young adults may welcome it.

Finally, providers should recognize the impact that society and the dominant culture may have on male sexual and reproductive health. Experiences with racism, sexism, and oppression, as well as culture-specific values and spiritual beliefs, may affect their own psychological health as well as the nature and dynamics of their intimate relationships.

Sexual. Clearly, taking a good sexual history is necessary to determine appropriate laboratory tests and counseling as well as to serve as a springboard to broader assessment of sexual relationships and sexual behavior. It may also be important to assess the quality of sexual relationships in order to determine if any emotional (e.g., inability to be intimate or maintain a relationship) or physical (e.g., erectile dysfunction, anorgasmia, or loss of interest in sex) concerns are interfering with the client's romantic relationships and sexual fulfillment. The interview should also be used to uncover instances of intimate partner violence and sexual coercion. Table 3.2 describes the specific elements of this history.

Table 3.1 Elements of HEADSS Psychosocial Assessment

TOPIC AREA	SAMPLE QUESTIONS
Home	"Who lives in your home?"
Education	"Are you in school?" "What do you plan on doing after school?"
Activities	"Do you play any sports?" "What do you do for fun?" "Do you work?" "Are you a member of a gang?"
Drugs	"Do you smoke cigarettes?" "Do you drink alcohol?" "Do you use drugs?"
Sexuality	see table 3.2
Suicide/ Depression	"Do you ever feel sad?" "Do you ever feel like hurting yourself or wish you were dead?"

Physical Assessment

In settings that provide the appropriate space, appropriately trained clinicians (e.g., nurses, nurse practitioners, physicians, physician assistants) should perform a physical assessment.

Table 3.2 Elements of a Comprehensive Sexual History

TOPIC AREA	SAMPLE QUESTIONS
Sexual Behavior	"Have you ever had sexual intercourse?"
	"Have you ever fooled around?"
	"Have you ever dated?"
	"How many people have you had sexual intercourse with?"
	"When was the last time you had sex?"
	"Do you have sex with boys, girls, or both?"
	"Are you in a main relationship now?"
	"Have you ever masturbated?"
	"Have you ever had a wet dream?"
	"Have you ever traded money or drugs for sex?"
	"Have you ever traded sex for money, drugs, food, or a place to sleep?"
	"Have you ever had sex with someone you know uses injection drugs or has HIV?"
Condom Use	"Do you consistently and correctly use condoms with main sex partners?"
	"Do you consistently and correctly use condoms with nonmain sex partners?"
Current Main Partner	"How long have you been with your most recent main sex partner?"
	"Do you feel close to your partner?"
	"Do you feel that you may have problems trusting your partner or other partners you may have had in the past?"
	"How do you decide when you are going to have sex?"
	"What do you two do to keep from getting pregnant?"
	"How do the two of you resolve your differences?"
	"Do you or your partner want to have a baby any time soon?"
Pregnancy	"Have you ever gotten a girl pregnant?"
	"What happened after she got pregnant?"
Sexual Enjoyment	"Do you enjoy your sex life?"
	"Do you have any problems having an erection?"
STD History	"Have you ever had or been treated for an STD?"
	"Do you have HIV?"

General. In keeping with most preventive guidelines, providers should check blood pressure, at least annually, in order to identify adolescents and young adults with hypertension.

Growth and Development. Physical growth and development should be evaluated at least annually during preventive visits for adolescents who have not gone through puberty or who are in the midst of puberty. Assessments should be conducted more frequently if there are concerns and discontinued when puberty is complete. In order to assess whether pubertal development is normal, providers should determine height, weight, and Tanner puberty stage (pubic hair distribution, penis morphology, and testicular size). These data should be plotted on a growth chart, preferably a Tanner growth chart. Providers should also screen for gynecomastia.

Genital. There is insufficient evidence to recommend for or against routine screening of asymptomatic men for testicular cancer by physician examination or patient self-examination. Nonetheless, most guidelines suggest doing a testicular exam to screen for tumors. In addition, providers should examine the scrotum for varicoceoles, spermatoceoles, or hydroceoles; check the inguinal canal for hernia; and inspect the penis for meatal abnormalities, and phimosis or paraphimosis.

Laboratory

Chlamydia. There is insufficient evidence to recommend for or against routine screening for chlamydia in high-risk men. In clinical settings where asymptomatic infection is highly prevalent in men (e.g., urban adolescent clinics), screening sexually active young men

may be recommended on other grounds, including the potential to prevent transmission to uninfected sex partners.

Gonorrhea. There is insufficient evidence to recommend for or against screening high-risk men for gonorrhea. In selected clinical settings where asymptomatic infection is highly prevalent in men (e.g., adolescent clinics serving high-risk populations), screening sexually active young men may be recommended on other grounds, including the potential benefits of early treatment for preventing transmission to uninfected sex partners. Screening men with urine leukocyte esterase (LE) dipstick is convenient and inexpensive, but it requires confirmation of positive results. Screening men with the new nucleotide amplification tests using urine specimens is acceptable to patients and providers, even those in nonclinical settings, but it is more expensive.

HSV. Routine screening for genital herpes simplex in asymptomatic persons, using culture, serology, or other tests, is not recommended.

Syphilis. Routine serologic testing for syphilis is recommended for all men at increased risk for infection, including commercial sex workers, persons who exchange sex for money or drugs, persons with other sexually transmitted diseases (including HIV), and persons who have had sexual contact with persons with active syphilis. The local incidence of syphilis in the community and the number of sex partners reported by an individual should also be considered in identifying persons at high risk of infection.

HIV. Clinicians should assess risk factors for HIV infection in all patients by obtaining a careful sexual history and inquiring about drug use. The purpose of HIV testing is not only to ensure early initiation of effective medical care but also to gain an opportunity for prevention counseling. Counseling and testing for HIV should be offered to all per-

sons at increased risk for infection: those seeking treatment for sexually transmitted diseases; men who have had sex with men after 1975; past or present injection drug users; persons who exchange sex for money or drugs, and their sex partners; women and men whose past or present sex partners were HIV-infected, bisexual, or injection drug users; and persons with a history of transfusion between 1978 and 1985. The frequency of repeat testing of seronegative individuals is a matter of clinical discretion. Periodic testing is most important in patients who continue high-risk activities. In patients with recent high-risk exposure (e.g., sex with an HIV-infected partner), repeat testing at three months may be useful to rule out initial false-negative tests. People who test positive should be offered additional counseling and referral for early treatment

Hepatitis B and C. There is insufficient evidence to recommend for or against routinely screening asymptomatic high-risk individuals for hepatitis B virus (HBV) infection in order to determine eligibility for vaccination, but recommendations for screening may be made based on cost-effectiveness analyses. Such analyses suggest that screening is usually cost-effective in groups with an HBV marker prevalence greater than 20 percent. It is not clear whether routine testing for hepatitis C virus (HCV) infection is or is not necessary for persons with a history of multiple sex partners or sexually transmitted diseases and long-term steady sex partners of HCV-infected persons.

IMMUNIZATIONS

Hepatitis B. Hepatitis B vaccine is recommended for all infants, and for all adolescents not previously immunized, particularly those in high-risk populations. The vaccine schedule is at the current visit and

one and six months later. Clinicians may wish to inform patients that booster doses may be required to maintain immunity through adolescence and adulthood.

Hepatitis A. Hepatitis A vaccine is recommended for sexually active men who have sex with men (both adolescents and adults). Prevaccination testing is not indicated for the vaccination of adolescents in this group, but it may be warranted for adults, especially those older than age 40.

Counseling and Education

Research has shown that client-centered counseling that uses *personalized* risk reduction plans is more effective than didactic messages. To develop a personalized risk reduction plan, providers should work with their patients to identify their personal risk. This dialogue requires trust and comfort, which can be facilitated by a discussion of confidentiality as well as efforts to normalize the sensitivity of the topic and to appear nonjudgmental.

Puberty. Educate about pubertal changes and, if present, gynecomastia.

Genitals. Discuss the need for precautions with contact sports. Adolescent and young adult males should be advised to seek prompt medical attention if they notice a scrotal abnormality. Patients with an increased risk of testicular cancer (those with a history of cryptorchidism or atrophic testes) should be informed of their increased risk of testicular cancer.

Sexuality. Clarify the difference between sexual identity and behavior. Normalize nocturnal emission, masturbation, fantasies, and fetishes.

Romantic Relationship. Empathy, confidentiality, and a nonjudgmental, supportive attitude are especially important when discussing issues of sexuality with adolescents. Clinicians should involve young pubertal patients (and their parents, where appropriate) in early, open discussion of sexual development, limiting sexual partners, and effective methods to prevent unintended pregnancy and STDs. Clinicians should explore attitudes and expectations of adolescents and other patients who are not currently involved in a sexual relationship to anticipate future need for contraception, and inform them how to obtain information and contraception if they plan to engage in sexual intercourse. It may also be appropriate to discuss intimacy, sexual functioning, sexual fulfillment, intimate partner violence or coercion, and gender equality.

STD and HIV Prevention and Control. All adolescent and young adult males should be advised about risk factors for STDs and HIV and counseled appropriately about effective measures to reduce risk of infection. This recommendation is based on the proven efficacy of risk reduction, although the effectiveness of clinician counseling in the primary care setting has not been evaluated adequately. Counseling should be tailored to the individual risk factors, needs, and abilities of each patient.

Assessment of risk should be based on a careful sexual and drug use history and consideration of the local epidemiology of STDs and HIV. A sexual history should include questions about the number and nature of current and past sex partners (including same-sex partners or partners who have injected drugs), any history of past STD infections, the use of condoms or other barrier protection, and particular high-risk sexual practices such as anal intercourse.

"ASSESSMENT of risk should be based on a careful sexual and drug use history and consideration of the local epidemiology of STDs and HIV."

Patients at risk of STDs and HIV should receive information on their risk and be advised about measures to reduce their risk. Effective measures include abstaining from sex, maintaining a mutually faithful monogamous sexual relationship with a partner known not to be infected, regular and proper use of latex condoms, and avoidance of sexual contact with casual partners and high-risk individuals (e.g., injection drug users, commercial sex workers, and persons with numerous sex partners). Patients who have sex with multiple partners, casual partners, or other persons who may be infected should be advised to use a latex condom at each encounter and to avoid anal intercourse. Patients using condoms should be informed about the importance of using them in accordance with recommended guidelines.

"PATIENTS AT *risk of STDs and HIV should receive information on their risk and be advised about measures to reduce their risk."*

Advice should be provided, as appropriate, that using alcohol or drugs can lead to high-risk sexual behavior. Persons who inject drugs should be referred to available drug treatment facilities, warned against sharing drug equipment, and, where possible, referred to sources for uncontaminated injection equipment and condoms. Drug users should be advised of the importance of being tested for HIV, of using condoms regularly with both casual and steady partners, and of following specific steps to reduce the risk of transmitting infection during preparation and injection of drugs. All patients at risk for STDs should be offered testing in accordance with recommendations on screening for syphilis, gonorrhea, HIV infection, and chlamydial infection and should receive hepatitis B vaccine.

Patients diagnosed with an STD, including HIV, should receive information about the meaning of the results, measures to reduce risk to themselves and others, symptoms requiring medical attention, and, in the case of HIV infection, available community resources for

HIV-infected persons. Clinicians should explore potential barriers to changing high-risk behavior. All infected individuals should be encouraged to notify sex partners, persons with whom injection needles have been shared, and others at risk of exposure. Cases should be reported confidentially or anonymously to public health officials in accordance with local regulations.

Contraceptives. Periodic counseling about effective contraceptive methods is recommended for all women and men at risk for unintended pregnancy. Because men can influence contraceptive use, including female-controlled methods, clinicians should engage men in discussions about their partner's choice of methods. Counseling should be based on information from a careful history that includes direct questions about sexual activity, number of sexual partners, current and past use of contraception, level of concern about pregnancy, and past history of unintended pregnancies. Counseling should take into account the individual preferences, concerns, abilities, and risks of each patient and his partner, including risk of STDs.

Counseling should include a discussion of the risk associated with the patient's current contraceptive practice and, when indicated, available alternatives for more effective contraception. Clinicians should inform adolescent patients that abstinence is the most effective way to prevent unintended pregnancy and STDs, although the effectiveness of abstinence counseling has not been established. They should also emphasize the importance of a back-up method and emergency contraception.

Clear instructions should be provided for the proper use of recommended contraceptive techniques. Hormonal contraceptives, barrier

HOW TO USE CONDOMS CORRECTLY

- Handle condoms carefully to avoid damaging with fingernails or sharp objects.
- Use a new condom in good condition for each act of intercourse.
- Use a new condom if a condom is put on inside-out to prevent STD transmission.
- Place the condom on an erect penis before any intimate contact and unroll completely to the base.
- Leave a space at the tip of the condom and remove air pockets in the space.
- Ensure adequate lubrication during intercourse. Water-based lubricants (e.g., K-Y jelly, spermicidal foam or gel) should be used. Petroleum jelly, mineral oil, hand lotion, baby oil, cold cream, massage oil, and other oil-based lubricants should not be used because they may damage latex condoms.
- Hold condom firmly against base of penis during withdrawal, and withdraw while the penis is still erect so that the condom remains in place.

methods used with spermicides, and IUDs should be recommended as the most effective reversible means of preventing pregnancy in sexually active persons. Sexual abstinence, the maintenance of a mutually faithful monogamous sexual relationship, and consistent use of condoms should be emphasized as important measures to reduce the risk of STDs. Clinicians should monitor satisfaction and compliance of patients with any chosen form of contraception, recognizing that beliefs about the deleterious effects of contraception may affect compliance and proper use.

Couples Counseling. Although it is commonly believed that adolescent and young adult men do not have concerns about their romantic relationships, clinical experience as well as research suggest that adolescent and young adult men are often very invested in their relationships. Thus, some young men would probably appreciate the opportunity to work with their partners in a therapeutic setting to improve their relationship.

Summary

The clinical encounter offers an important opportunity to screen, identify, counsel, and educate young men about reproductive health issues. Many clinicians may feel uncomfortable about broaching many of the topics mentioned above with their patients. But these topics are all parts of the practices identified by the working group that comprise the standards of quality preventive reproductive health care. Male patients may benefit greatly from clinical interventions.

Notes

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CHAPTER 4

GETTING STARTED: PRACTICAL ADVICE

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Taking the initial steps to develop a young men's sexual and reproductive health initiative may be the most challenging part of the process. Because sexual and reproductive health for men is a relatively novel idea, program planners need to worry about whether their own organization will commit to such an effort (a philosophical question), whether resources within their own organization or within the community are sufficient to deliver the needed services (an economic question), and whether the community can be mobilized to provide these services (a community readiness question). This chapter will help agencies think about their own philosophical willingness and their community's readiness to develop sexual and reproductive health services for young men. A series of worksheets is provided to encourage agencies to assess their assets and their requirements. This self-assessment can help agencies understand the changes that need to occur in order for such an initiative to succeed and may forestall potential problems.

Is Your Organization Ready to Serve Men?

One dimension of readiness relates to providing services that meet the needs and preferences of men. For example, programs that now primarily serve women, such as family planning clinics, may need to address a host of issues ranging from the magazines in the waiting room to the scope of the medical care that is provided for men. Many programs that are successful with men have the following characteristics in common:

- Reject stereotyped views of men and adopt a view that males can be positively involved in their own reproductive health and supportive of their partners' decisions related to their health.
- Hire men on staff who feel comfortable working with women and relate well to the male clientele who outreach efforts will attract.
- Willing to address issues that will improve communication between men and women, at the staff and client levels.
- Provide men with opportunities to play leadership roles in traditionally female organizations.
- Conduct training for men and women staff together so that any concerns can be discussed openly and constructive solutions can be identified.

The evaluation worksheet below highlights the issues that organizations might consider in assessing their readiness to develop services for young men. These questions can be the focus of joint discussion with staff members before your efforts begin.

Evaluating Organizational Readiness: Are You Ready to Serve Young Men?

Have you ever served young men? If not, is there a reason why males have not been served by your clinic or organization?

How would you recruit young men? If men are successfully recruited, what will be the first thing they see when they arrive at your clinic or agency?

Do you offer a male-friendly environment (e.g., educational posters, staff attitudes when male partners join your current clients)?

Do you train staff to serve males?

Do you employ male staff?

Do you have male staff or volunteers who participate in outreach activities?

Do you display magazines of interest to males in the waiting room?

Do any staff object to serving young men? If so, how are these concerns dealt with?

Has staff received information and training on male reproductive health and related health issues, such as testicular cancer?

Do you provide or can you refer clients to ancillary services of interest to young men, such as job readiness or sports?

Do you provide referrals for support services?

Do you maintain linkages with other organizations that serve young men?

Have you ever developed media campaigns around male involvement in pregnancy prevention?

Are there staff who have strong opinions against serving males? Providing an opportunity to share concerns may be a good first step in the process of organizational change. Continued dialogue will likely be required.

Is Your Organization Ready to Offer Men Sexual and Reproductive Health Services?

Another dimension of readiness is an agency's preparedness to address sexual and reproductive health issues. Community-based organizations with many teenage and young adult men in their programs will probably have no difficulty providing male-friendly services. But many may have little existing capacity to provide sexual and reproductive health information and counseling or to link to clinical health services. On the other hand, while clinical programs provide medical services, they may fail to provide needed education, counseling, or additional support services that males are interested in receiving. The next worksheet is designed to guide specific types of organizations in determining whether they are ready to promote sexual and reproductive health for young men.

Evaluating Organizational Readiness: What Reproductive Health Activities for Men Do You Already Conduct?

If you are a community-based youth-serving organization...

Do you serve young men?

Do young men frequently come to your organization or agency?

Are you providing accurate health information?

Does your organization have the staff resources to offer services that are language-appropriate and delivered in a manner that is respectful of a person's cultural background and heritage?

Are you linking young men to clinical services? For example, do you help facilitate appointments for the following services?

General primary health care?
STDs/HIV screening?
Family planning?

Are you linking young men to social support services, such as employment counseling, and housing?

If you are an STD clinic...

Do you serve young men? Do you encourage young men to bring their partners for services?

When serving females, do you inquire whether their partners also need services?

Are you integrating STDs/HIV and family planning services by, for example, providing education and counseling regarding other methods of birth control in addition to condoms? Do you provide urine-based STD screening services?

Are you devoting resources to education, counseling, and/or outreach specifically to young men?

Are you linking young men to other health services, such as mental health and substance abuse treatment?

Are you linking young men to social support services, such as employment counseling and housing?

(continued)

If you are a family planning clinic...

Do staff and practitioners recognize the benefits of increased effective contraceptive use achieved when men and women have open and supportive dialogue about family planning decisions?

Do you serve young men? Do you encourage clients to bring their partners with them?

Are your facilities and staff inviting to young men?

Are you integrating STDs, HIV, and family planning services? Do you provide urine-based STD screening services?

Are you devoting resources to education, counseling, and/or outreach specifically to young men?

Are you linking young men to other health services, such as mental health and substance abuse treatment?

Are you linking young men to social support services, such as employment counseling and housing?

If you are an adolescent clinic...

Do you serve young men?

Are you integrating STDs, HIV, and family planning services? Do you provide urine-based STD screening services?

Are you devoting resources to education, counseling, and/or outreach specifically to young men?

Are you linking young men to other health services, such as mental health and substance abuse treatment?

Are you linking young men to social support services, such as employment counseling and housing?

Is Your Community Ready?

Community readiness is a very important component that is often overlooked. Some communities often see service initiatives enacted without their input or guidance. As community diversity increases, so does the need to begin the process by obtaining the input and suggestions of community residents and stakeholders.

Before an organization gets started, it needs to gauge the readiness of its community to mobilize and address the sexual and reproductive health needs of young men. This task may be difficult for an individual organization to accomplish on its own. Bringing together a group of representatives from the community to get involvement and buy-in may make this task easier. Through this process, organizations can gauge the level of concern and commitment in the community and find out about any experience other agencies have had serving young men. At this stage, it is also useful to find out about the perspectives of the young men themselves. One way to do this is to conduct focus group interviews with young men by recruiting them from the places where they gather in the community—for example, parks, schools, fast-food outlets, churches, juvenile justice, gyms, and other community sites. Information from these interviews may give the group a better idea of what is going on in the community and what is needed. The worksheet below provides a list of questions and issues that organizations might consider in assessing the readiness of their community for an initiative.

"COMMUNITY readiness is a very important component that is often overlooked."

Taking the Pulse Worksheet

- How do the community residents feel about issues related to reproductive health and family planning?
- Are young men viewed positively by the general community?
- Is the community aware of how young men's health status affects it?
- What is the magnitude of sexual and reproductive health problems among young men in the community, for example, the incidence of STDs, HIV/AIDS, or unintended pregnancy?
- Is there a nucleus of individuals concerned about the problems who are sufficiently motivated and committed to addressing young men's reproductive health efforts?
- What kinds of synergy can be created and fostered around the issue of young men's reproductive health?
- What resources and efforts are currently available to build on? Could additional new or existing resources be channeled into young men's reproductive health?
- How can the community mobilize its resources, including financial; existing health, education, and social service providers; and existing community settings where education, counseling, and services could be included?
- Is the community sufficiently aware of how reproductive health issues affect young men? Can the issue be raised to a priority?
- How much buy-in exists from key stakeholders to develop and implement a strategic plan of action aimed specifically to meet the needs of young men?
- What are the potential barriers to advancing a young men's reproductive health agenda?
- How can common ground be developed so that the plan of action reflects the best research in the field and also incorporates the diverse viewpoints of the community?
- How can community organizations work with researchers, policymakers, and the media to create a new social norm related to reducing adolescents' risk for reproductive health problems?
- What potential pathways to prevention is the community ready to explore?
- What is the community's vision for the situation of its teens next year? In five years? In 10 years?
- With what agencies in the community do young men interact (e.g., community recreation/sports or juvenile justice staff/law enforcement)?

Source: Brindis and Davis 1998.[1]

In assessing the readiness of the community, program developers may encounter attitudes that question the allocation of reproductive health resources to men. For example, there may be concern that funding or other resources for women's reproductive health may be diverted to men. When funds and resources are restricted, these attitudes and feelings may be unavoidable. Organizations might anticipate such challenges and be prepared to invest time and effort in finding a common ground. As noted earlier, both men and women can benefit from these efforts.

Starting the Planning Process

When the pulse of a community indicates support for a larger effort, it is wise to make a more thorough assessment of the needs and assets of the young men in the community and the resources that could be used to improve their sexual and reproductive health. Assessments might include gathering and examining available data about the young men in the community (e.g., on population characteristics and population projections, STD prevalence, pregnancies and births, causes of male mortality, school dropout rates, youth unemployment rates). In addition, this effort might include the collection of new data through representative surveys of young men—by telephone, mail, in-person interviews, or group-administered formats. Data gathered from other sources or collected especially for this initiative can serve as baseline indicators of how the young men were doing before the initiative began. The data collection likely will continue as the initiative gets under way so that progress can be monitored. The list below provides suggestions about how to collect information on the assets

and needs of young men in the community. It emphasizes the need to build support within the community as the assessment is planned, implemented, and evaluated.

Steps to Success: The Community-Based Needs and Assets Assessment

- Carefully define the parameters of the community.
- Determine the availability and specificity of baseline data.
- Actively engage community members, including formal and informal leaders, adolescents, and their parents, in the needs and assets assessment process.
- Use a variety of data collection strategies, including existing data sources as well as complementary qualitative approaches, such as focus groups, to ensure a comprehensive picture of the community.
- Have skilled, trained, and knowledgeable individuals conduct the assessment process and interpret the data.
- Obtain the cooperation of key stakeholders in collecting the information.
- Establish a favorable climate for the needs and assets assessment within the community by demonstrating ways the information will assist the community.
- Be sensitive to the concerns about the confidentiality of information gathered, as well as the negative ways the information might be used.
- Ensure that the needs assessment is broad in scope, reaching beyond family planning and sexuality education to youth development and the cultural and community context of young people's lives.
- Allocate adequate staff time and funding to conduct a thorough needs assessment.

Source: Brindis et al. 1991.[2]

Mapping Existing Resources

Another essential step is developing an inventory of existing programs, activities, and resources that might be integrated into a comprehensive sexual and reproductive health initiative. This community assessment will provide a snapshot of the state of community health and resources. It may uncover the gaps in the provision of services in the community, as well as untapped resources and potential collaborators. The list below provides guidance about the types of service resources that need to be identified or developed and made readily available. We include a broad array of services, from parent-child communication regarding sexuality, to education and clinical services related to sexuality, STDs and HIV, and pregnancy prevention, as well as other community resources—for example, employment and youth development opportunities—recognizing that young men, as well as young women, often need viable alternatives to early childbearing. It is based on table 1 in chapter 2 of this report, which provides examples of the types of services that meet the five goals of a male sexual and reproductive health initiative. The chart can be consulted for more detail about examples. You may also want to develop a grid as you gather this information to assess which of the following is available in your community. You may also want to gather information as to the number of young men being reached through these efforts to ascertain whether they should be expanded to reach additional young people.

Which Agencies in the Community Provide the Following to Teenage and Young Adult Men?

Sexual Health and Development

- Information about sexual health and development
- Development of skills related to sexual health and development
- Positive self-concepts regarding one's sexuality (and one's sexual orientation)
- Values and motivation regarding sexual health and development
- Clinical services related to sexual health and development

Healthy Relationships

- Information about healthy relationships
- Skills for developing healthy relationships
- Positive self-concepts regarding the ability to establish healthy relationships
- Values and motivation regarding healthy relationships
- Clinical services related to healthy relationships

STDs and HIV

- Information about STDs and HIV
- Development of skills for avoiding and treating STDs and HIV
- Positive self-concepts related to taking personal responsibility
- Values and motivation for protecting one's own and one's partner(s)'s health
- Clinical services related to STDs and HIV

Preventing Unintended Pregnancy

- Information about preventing unintended pregnancy
- Development of skills for avoiding unintended pregnancy: abstinence and contraception
- Positive self-concepts regarding effective decisionmaking in delaying sexual relations and use of protection, if sexually active
- Values and motivation for avoiding unintended pregnancy
- Clinical services related to avoiding unintended pregnancy

Parenting and Child Development

- Information about parenting and child development
- Development of skills in parenting
- Positive self-concepts regarding decisions to plan to have a child
- Values and motivation regarding parenting
- Clinical services related to fertility and parenting

Parent and Child Communication

- Information about parent and child communication regarding sexuality, STDs and HIV, and pregnancy prevention
- Development of skills for parents to assure improved communication regarding these topics
- Positive self-concepts regarding one's ability to communicate with their children regarding sexuality, STDs, HIV, and pregnancy prevention
- Values and motivation to communicate effectively with children regarding sexuality, beginning when children are young and continuing into young adulthood
- Community services related to parenting education

Youth Development

- Information about education and career development, job training, and other youth development opportunities, beginning in early childhood and continuing into young adulthood
- Family, school, and community opportunities to develop personal and cultural pride, as well as to support young men's sense of connection to parents, friends, family, and schools
- Development of skills that encourage the development of personal pride, a sense of responsibility, and abilities to successfully achieve economic independence and well-being
- Community services related to youth development, education and career development, and other social supports
- Opportunities for community leadership on issues that affect young people and the larger community in a positive manner

Positive Male Role Identification

- Information addressing the positive role males can offer their families, children, and communities
- Information on effective communication with males' partners, fathers' involvement in child rearing, and community leadership
- Opportunities for males to share experiences and feelings

Beyond services targeted to individuals, the assessment should also examine other community resources that can target aspects of young men's environment. Organizations with skills in policy development, legislative advocacy, social marketing, and public relations could all be very useful in developing a successful young men's sexual and reproductive health initiative.

Next Steps

At the end of the process described above, agencies that want to initiate a sexual and reproductive health initiative will have a thorough understanding of both their own capacities and the resources available in the community to develop such an effort. Because the suggested activities incorporate recommendations to bring other community stakeholders and organizations into the fact-finding process, all participants will also gain a good estimate of the level of interest and commitment to taking the next steps. Through this process, agencies may find that their communities may not be fully prepared to implement a comprehensive male initiative. Or they may find that some components are already in place; organizations may merely need to find additional ways to make the services more readily available to other men in the community. Other communities may find that while it is not feasible to implement a full reproductive health program aimed at young men, they can work with local agencies to assure that other types of educational efforts are implemented that emphasize male responsibility, parent-child communication, and partner communication regarding sexual and contraceptive decision-making. Along this continuum, a number of options may be selected, creating building blocks while additional resources are sought.

"THE PORTRAIT of the community can be used as a powerful tool to move an agenda forward."

A community assessment can be resource-intensive. It should only be conducted if an organization is prepared to use and act upon the results. Dissemination of results is important so that the findings are widely shared. Through this process, the assessment can increase community awareness of its needs, assets, and resources. The portrait of the community can be used as a powerful tool to move an agenda forward.[3]

Although the assessment takes time and resources, it provides essential information about the needs of young men in the community, the gaps in service, and the potential opportunities for collaborative remedies. Having obtained a thorough understanding of the situation in their communities, the initiators of a young men's sexual and reproductive health initiative will be poised to move to the next stage, which is identifying specific program objectives, putting these objectives in order of priority, and developing service approaches that address these objectives. Chapter 5 provides some descriptions of how agencies have actually engaged in these processes.

Notes

[1] Brindis, C. D., and L. Davis. 1998. *Communities Responding to the Challenge of Adolescent Pregnancy Prevention.* Vol. I, *Mobilizing for Action.* Washington, D.C.: Advocates for Youth. Pp. 32–33, 41–43, and 54–56.

[2] Brindis, C. D. 1991. *Adolescent Pregnancy Prevention: A Guidebook for Communities.* Palo Alto, Calif.: Health Promotion Resource Center, Stanford Center for Research in Disease Prevention.

[3] Brindis, C. D. 1991. *Adolescent Pregnancy Prevention: A Guidebook for Communities.* Palo Alto, Calif.: Health Promotion Resource Center, Stanford Center for Research in Disease Prevention.

CHAPTER 5

THE KEYS TO ENHANCING YOUNG MEN'S REPRODUCTIVE HEALTH: COLLABORATIVE PARTNERSHIPS

Kay A. Armstrong, Shawn E. Gibson, Roberta Herceg-Baron, and Dorothy Mann

Previous chapters highlight a wide range of activities and organizational strategies to enhance young men's reproductive health. Any organizational action to promote reproductive health is positive, but partnerships across agencies and organizations are the best approach to enhance young men's reproductive health. Three central principles should guide organizations interested in enhancing young men's reproductive health: Promote a comprehensive, client-centered approach; set a minimum standard for services; and ensure meaningful involvement of the organization with other service-based agencies in the community. This chapter explains these principles and the underlying rationale for each. It then expands on the idea of collaboration, describing its advantages for enhancing young men's reproductive health and providing examples of collaboration and some challenges these efforts faced. The last section outlines steps that a collaborative partnership will need to take, both initially and as it grows, to be successful.

Guiding Principles

1. Promote a comprehensive, client-centered approach to reproductive health care. Organizations involved in promoting reproductive health care among young men should focus on the needs of each individual. Their efforts must respect the social and environmental influences that affect reproductive health behavior, while at the same time not stereotyping individuals. This aim is best accomplished by an integrated, client-centered approach to healthy sexual behavior. Healthy sexual behavior is the goal, and a client-centered approach is the way to assist young men most effectively to achieve reproductive health for themselves and their partners. If a young man is concerned about HIV and is more likely to use a condom because of this issue, for example, then clinical, educational, and counseling services should be geared to HIV for that young man, and other services should have a secondary role.

"COLLABORATIVE partnerships among two or more experienced providers bear the greatest potential for organizing an array of services that will attract young men and meet their reproductive needs."

2. Set a minimum standard for clinical reproductive health services for young men. Organizations, by themselves or through collaboration, need to ensure a minimum standard of clinical reproductive health services that include preventive medical care for reproductive systems. Clinical services alone are not sufficient, but they are necessary to achieve the multiple objectives set forth in previous chapters. For a program to have any chance of success, education and community outreach must be directly linked to clinical services. For example, educating young men about the importance of STD testing and treatment must be accompanied by direct, easy access to culturally appropriate, confidential STD screening and treatment services.

3. Ensure meaningful community involvement with other service-based agencies. This recommendation involves the participa-

tion of at least one community-involved organization. Such organizations—which are not limited to not-for-profit, nongovernmental organizations—must be rooted in the community, have community trust, and have a long-standing relationship with young men in the community. Organizations that have traditionally served women's reproductive health needs may be interested in enhancing young men's reproductive health but may have trouble finding or reaching young men. Collaborating with community-involved organizations that hold the trust of young men provides a way to achieve the organization's goals while also benefiting young men. Moreover, community organizations may have special connections with young men who are considered hard-to-reach—such as those who are incarcerated, homeless, out of school, gay and bisexual, or in foster care—and who are most in need of reproductive health education and services.

Components of Collaborative Partnerships

Comprehensive reproductive health programs for young men should combine four channels of service delivery: educational services, individualized counseling, clinical care, and support services (see the discussion in chapter 2). It is unlikely that any single agency will be able to provide all four services adequately. Some agencies may be able to provide two or three of the four; others may be skilled in only one. In most instances, collaborative partnerships among two or more experienced providers bear the greatest potential for organizing an array of services that will attract young men, meet their reproductive health needs, and support them in making or maintaining healthy lifestyle choices. The working group recommends that collaborative partnerships be the framework for fashioning reproductive health programs for young men.

Collaborations in health promotion may involve many different types of organizations, including public health departments, managed care organizations, academic institutions, and community groups.[1] These organizations can be classified in many different ways, such as their reason for formation, their functions, the organizational structure, the services, the community actions, and the community changes.[2]

The working group has defined collaborative partnerships as a purposive relationship among partners committed to pursuing comprehensive reproductive health for young men where information and resources are shared for a common outcome; where activities, staffing structure, and relationships are modified to accommodate seamless service delivery and enhance program capacity for the benefit of the consumer; and where all partners mutually benefit, and share in risks, responsibilities, and rewards emanating from the collaboration.

A collaborative partnership among agencies to establish a reproductive health program for young men will minimally involve two agencies (at least one community-involved agency) that collectively deliver the four types of service delivery and include the necessary funding sources.

Collaborations may include other partners such as advisory and advocacy groups, parent and citizen groups, and local media outlets that build public awareness, enhance public knowledge and support of the programs, and potentially act as a source of recruitment and marketing.

The nature of the collaborative partnership among agencies to establish a reproductive health program for young men will vary from community to community and with the relative experience and

expertise of the agencies that form the collaborative relationship. Ideally, the four types of services (education, counseling, clinical care, and support services) are offered at the same location and at the same time. When the "one stop" location is not feasible, then strong and specific linkages to other service components become necessary.

Some programs may be jointly administered by the collaborating agencies. Other programs may best be served by having one lead agency that coordinates and manages the service components to create greater efficiency. Some partners in the collaboration (particularly the service providers and advisory groups) may be more visible on a regular basis, and others may choose a less visible role (such as a funder or a fiduciary agency). These administrative, programmatic, and funding relationships will vary to suit the needs and capabilities of the agencies involved.

Depending on the availability of other service programs in the community, reproductive health programs for young men should be creatively linked and complemented by collaborations with programs that traditionally serve young women and address their reproductive health needs. These links can range from partner referrals for STD care to couple communication workshops, to teen parenting programs, to mixed-gender sessions that explore male-female relationships. Similar links may be established with programs in the communities or schools that serve the parents, caregivers, and families of the young men.

What matters most in a collaboration is that the consumers—the young men—experience a seamless offering of services that address their individual needs, both medically and psychosocially.

"WHAT MATTERS most in a collaboration is that the young men experience a seamless offering of services."

Examples of Collaborative Partnerships

This section illustrates the concept of collaborative partnerships with three hypothetical examples of how collaborative partnerships might be formalized to combine education, counseling, clinical care, and support services for young men, and two examples of real collaborative programs (targeting other consumers, not solely males) that successfully incorporate multiple service components.

Hypothetical Examples

The first hypothetical example is a successful job training program in an urban neighborhood offered by a local nonprofit agency. The job training component constitutes a *support service* that is attractive to young men, and adding reproductive health services could further complement the success of the program. The nonprofit agency hosts a Title X service provider to provide a male-oriented *clinic session* several times during the week. The Title X services on-site include *education workshops* for the young men in the job training program, and *individualized counseling services* are offered along with *clinical services* as appropriate. Because the Title X provider also operates a traditional program in the community (primarily used by females), it can offer a place for female partners to be referred. The funding partners in this scenario are Title X, Medicaid, and the State Children's Health Insurance Program (SCHIP).

In a second hypothetical setting, a community health center wants to expand its capacity to provide reproductive health care to young men. It collaborates with a local community-based agency that offers AIDS/HIV outreach and prevention services along with other social

services. The health center arranges space for the agency to offer anonymous HIV testing at its center (a component of *clinical care* that complements the STD and other reproductive health services provided by the health center). The HIV staff is cross-trained on STD and pregnancy prevention topics so they can *educate and counsel* the young men they see and *link them to the clinical services* offered by the health center. The STD and pregnancy staff are cross-trained on HIV/AIDS. The young men can also access the *social services* available through the other programs of the AIDS/HIV outreach organization, such as education toward a high school equivalency degree (GED), mentoring programs, and recreational activities. The funding partners in this scenario are community health centers, Medicaid, and HIV/STD service agencies.

The third hypothetical situation is in a rural setting. A Big Brothers Program wants to add reproductive health services for its teen and young adult mentoring program *(support services)*. The program contracts with an independently practicing nurse clinician to provide *clinical care*. Through the extension service of the state university's human sexuality (or social work) program, it secures a graduate-level intern to work at the center several days a week to provide *counseling* in conjunction with the *clinical care* component and at other times to offer *educational workshops* to young men, their mentors, and the young men's parents. The funding partners in this scenario are private foundations, Medical Assistance, SCHIP, and nominal patient fees.

Real Examples

Two actual collaborative partnerships are described below. One is a male reproductive health program. The other is an ongoing partner-

ship that developed from two demonstration projects. While the second collaboration addresses needs of women, it could be adapted readily to fit a service model for men. Both examples offer comprehensive reproductive health services and are currently operating as collaborative partnerships. These examples illustrate both the advantages of the collaborative relationship and the challenges faced by the organizations that use this strategy.

"THESE examples illustrate both the advantages of the collaborative relationship and the challenges faced by the organizations that use this strategy."

Teens on Track

Teens on Track (TNT) was established as a young men's reproductive health program in 1990 in Camden, New Jersey. The program's goal is to reduce teen pregnancy by offering young men a range of services that promote male responsibility in sexual decisionmaking and reproductive health care. From its inception, the program has had three components: an interactive, *educational* component; a recreational component; and a *clinical and counseling* component. Ongoing collaborating partners in the service program are Planned Parenthood of Southern New Jersey, the local YMCA, a community center, an after-school mentoring program, and a public housing development. From time to time, additional community centers, church youth groups, and schools also have collaborated.

Planned Parenthood (PP) is the lead agency and employs all program staff. The educational and recreational components are offered in community settings (the YMCA, community centers, and public housing). These settings provide space and staff to complement the PP staff during the hours the program is offered. In the case of the YMCA program, PP provides a stipend to use the recreational facilities (pool, game room, and basketball court). Planned Parenthood staff

present 30- to 45-minute *educational* sessions for young men before they participate in a recreational activity. A calendar of yearly activities is planned at each site, and the sites help promote and recruit participation of young men in the activities. The young men are not eligible to participate in the recreational activity unless they have participated in the educational program offered at the session.

During the initial nine months, the program offered only the educational/recreational component in order to build recognition and trust among the young men in the community. The male-only *clinical services* started during the 10th month of operation and offered sports physicals, screening and treatment for STDs, and condom distribution. The in-take and *counseling* at the clinic were provided by one of the field staff members who offered the workshops and directed the recreational programs in the community settings. The clinical component continues to operate on a walk-in basis, and female partners are seen during regular family planning sessions. The TNT program serves 1,200 to 1,300 young men each year in the educational/recreational component and 400 in the clinical component.

The men took longer to start using the clinical component at PP than the community educational/recreational program. In some instances, TNT staff transported the young men to ease the transition. In its early years, the community program targeted younger males (ages 10 to 14). As these young men matured, they gradually grew more comfortable with seeking the clinical component.

Funding for the program started with a three-year grant from a local foundation that was renewed for another three years. The free clinical services were reimbursed through insurance and Title X. After six years, the foundation required that PP obtain matching funds.

Other funding came from the New Jersey Department of Health, another foundation, and more recently a Healthy Start federal grant.

Relationships with the collaborating agencies were always good. Advance planning of the educational and recreational activities ensured that space was available and that the agencies could contribute their own staff support to the activities. The agencies were instrumental in publicizing the programs among the young men and recruiting their attendance. PP staff who developed relationships with the young men in the community took the lead in establishing the successful link to the clinical services where they provided the counseling, one-on-one education, and the introduction to the medical provider.

While working in the community, the PP staff felt pressure from the agencies and from young women about the absence of a TNT program for girls. In some instances, the PP staff attempted to run coed activities, but the high demand and the shortage of staff made it too overwhelming. The community agencies understood the particular need to reach out to young men because few program resources had been available for men and the need was great. But in this setting such resources did not exist for the girls either. Some community sites responded by developing activities for young women. The complement of the male and female services was more pronounced in the clinical setting. In fact, the male partners of the female family planning patients, in addition to the young men in TNT, were able to use the male clinic.

No formal outcome evaluation of TNT has ever been completed. But the financial sustainability of the program over a 10-year period is clearly laudable, and it has been achieved by the persistent efforts of the lead agency, PP of Southern New Jersey. The ongoing commitment

and continued growth of agency collaborators contribute to the success of the program services.

PHREDA and Project CARES

Two demonstration projects funded by the Centers for Disease Control and Prevention were designed to implement and evaluate approaches to reduce the perinatal transmission of HIV infection among hard-to-reach populations. The first demonstration project, PHREDA (1989 to 1991), integrated family planning services into 13 drug treatment programs.[3] The second project, Project CARES (1991 to 1997), integrated family planning services into five drug treatment programs, three homeless shelters, and two public housing developments.[4]

Collaborative partnerships were developed to facilitate the provision of family planning services in these nontraditional settings. The partnerships involved the Family Planning Council, the lead agency and a Title X grantee; the Philadelphia Department of Health Coordinating Office on Drug and Alcohol Abuse Programs; the Philadelphia Health Management Corporation, the nonprofit organization overseeing the Healthcare for the Homeless Program; and Resources for Human Development, a community-based health care agency that oversees services at the two public housing developments. Linking separate systems with distinct funding streams and separate administrative systems required careful planning, flexibility, cooperation, resources, and care. After the demonstration projects ended, the partnerships and most services continued.

Both demonstration projects targeted women in settings with HIV-related behavioral risks. The services included *individual counseling, educational group or individual sessions,* reproductive health *clinical*

"THE ONGOING commitment and continued growth of agency collaborators contribute to the success of the program services."

services, and referrals for additional *psychosocial support services* as needed. Although the services for males were not evaluated, the program components were available for and used by men in these settings. Feedback about the services was solicited from both men and women. For example, after the first year of services, men and women participated in focus groups aimed at learning about opinions and attitudes associated with barriers to using family planning services and contraceptives. Their opinions were helpful in adapting the services to better meet the needs of the men and women.

Sustaining the collaborative partnership required continuous effort. The common goals of preventing unintended pregnancy and HIV infection were agreed upon. Roles and fiscal responsibilities were defined. During the start-up period (8 months for one project and 12 months for the other), cross-training among staff from different agencies was conducted and communication paths were developed to provide more information about the target population and staff responsibilities. For example, words that mean one thing for family planning staff may mean something different to the target population, some of whom perceived family planning services as only for women and only to be used to plan for a family. Another example was the target population's difficulty in keeping scheduled appointments, which was resolved by making walk-in appointments the norm. Medical and confidentiality guidelines were mutually agreed upon to clarify what information could be shared or not shared across agency staff. Both start-up and ongoing planning and communication activities were necessary to develop a satisfactory working relationship.

"SUSTAINING the collaborative partnership required continuous effort."

The goals and objectives of the two demonstration projects were formally evaluated. Feedback to all partners on how the programs had

turned out was important for developing strategies for sustaining the programs. After the demonstration funding ended, considerable efforts were made to identify new funding sources. Leaders analyzed the programs to determine the costs associated with program services at each location and to identify which locations had the potential to sustain family planning services in these nontraditional settings. At the end of the demonstration project, the services were funded by Title X, Medical Assistance, and minimal patient fees.

Steps to Achieve Successful Collaborations

The advantages of collaborative partnerships are numerous. Partnerships pool resources, share risks, and increase efficiency; they can integrate and coordinate services; and they can build communities.[5] Partnerships benefit target populations by expanding the array of available services to meet their needs better.

The creation of a collaborative partnership requires numerous steps. These steps begin before the formation of the partnership and continue throughout its existence to ensure its ongoing success. Following are some of the steps:

- Obtain agreement among all partners on the overriding goals before entering into any partnership.
- Ensure that all partners agree on the approach, and respond to any criticism if controversial issues are involved.
- Discuss and agree on the financial, programmatic, and logistic responsibilities of each partner, and designate the lead agency if needed.
- Allow for a start-up time, which can vary from a month to a year or more, to work out details and ensure a smooth integration before

services are offered. Start-up activities might include the following:

- Learn more about the diverse needs (those based on language and cultural factors, for instance) of the target population.
- Provide orientation for staff of each agency in the partnership to inform them of the goals and objectives of the partnership, to respond to questions, to seek suggestions, to discuss expectations, and to generate staff support.
- Develop any necessary protocols such as confidentiality guidelines, service reimbursement procedures, and service and medical guidelines.
- Provide enough information and training to all staff to promote their comfort with the effort, increase their awareness, and enhance their understanding.

▸ Set regular times for meetings among staff of all partners in the collaboration to encourage ongoing communication, discuss ongoing activities, and resolve any issues.

▸ Obtain feedback from the population using the services, and be flexible in providing services so as to meet their needs better and obtain their trust.

▸ Provide periodic assessment of the status in meeting partnership goals and objectives through formal or informal evaluation.

▸ Modify partners' responsibilities as needed to meet changes in financial or service needs.

▸ Discuss partners' expectations of the program's long-term existence so that funding sources can be developed to further these expectations.

Additional steps will depend on the nature of the collaborative partnership and how it changes over the years.

Summary

Three guiding principles are necessary for effective and comprehensive reproductive health services for males: (1) promote a comprehensive, client-centered approach; (2) provide a minimum standard of clinical care; and (3) ensure meaningful involvement of the community. Through the framework of collaborative partnerships, these principles can be translated into seamless service delivery with four service delivery components: educational services, individualized counseling, clinical care, and support services.

Both hypothetical and real examples of collaborative partnerships illustrate the potential opportunities for communities to pool resources, obtain new funding, and enhance reproductive health services for young men.

Notes

[1] Baker, E. A., S. Homan, R. Schonhoff , and M. Kreuter. 1999. "Principles of Practice for Academic Practice/Community Research Partnerships." *American Journal of Preventive Medicine* 16 (3 Supplement): 86–93; and Nelson, J. C., H. Rashid., V. G. Galvin, J. D. Essien, and L. M. Levine. 1999. "Public/Private Partners: Key Factors in Creating a Strategic Alliance for Community Health." *American Journal of Preventive Medicine* 16 (3 Supplement): 94–102.

[2] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 1998. *Building and Sustaining Community Partnerships for Teen Pregnancy Prevention: A Working Paper.* Washington, D.C.: DHHS/ASPE. June.

[3] Armstrong, K., R. Kenen, and L. Samost, 199l. "Barriers to Family Planning Services among Patients in Drug Treatment Programs." *Family Planning Perspectives* 23 (6): 264–271; and Armstrong, K., L. Samost, and M. Bencivengo. 1992. "Integrating Family Planning Services into Drug Treatment Programs." In *Proceedings of the Community Epidemiology Work Group.* Bethesda, Md.: National Institute on Drug Abuse, pp. 548–559.

[4] Armstrong, K. 1998. "Women with High-Risk Behaviors." In *Family Planning Services for Special Populations.* Menlo Park, Calif.: Kaiser Family Foundation, pp. 25–28; and Cabral, R., C. Galavotti, P. Gargiullo, K. Armstrong, A. Cohen, A. Gielen, and L. Watkinson. 1996. "Paraprofessional Delivery of a Theory-Based HIV Prevention Counseling Intervention for Women." *Public Health Reports* 111 (1): 75–82.

[5] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 1998. *Building and Sustaining Community Partnerships for Teen Pregnancy Prevention: A Working Paper.* Washington, D.C.: DHHS/ASPE. June.

CHAPTER 6

FINANCING YOUNG MEN'S REPRODUCTIVE HEALTH PROJECTS

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The goal of previous chapters was to move from providing a limited set of health care services for young men in a clinical environment to enhancing reproductive health through broader community-oriented partnership approaches, involving both community-based organizations and health care providers.

One obstacle to establishing and maintaining male reproductive health programs is that—even though these programs may prevent longer-term and more expensive consequences of diseases—there are few clearly designated sources of funding for programs like these. No federal program has a mandate or mission to serve this particular population, although several programs, discussed in this chapter, are related and could contribute toward this objective. Discussions with program administrators confirm that—at least for now—reproductive health service programs for young men must cobble together multiple sources of funding. This is the current fiscal reality, even though it is inconvenient for program administrators because of the need for multiple grant applications and the fragility of these combined pro-

grams. Even if programs can obtain initial funding as demonstration projects, they face the eventual challenges of securing sustainable funding. Nonetheless, the funding barrier is not insurmountable. Communities across the nation have been able to create reproductive health service programs for young men, using ingenuity and the support of various funding agencies.[1]

How, then, do programs interested in enhancing the reproductive health of young men put together the funding necessary to meet the varied needs of young men, and where do they turn for this funding? Innovative strategies will be needed to secure and maintain sufficient funding to implement and sustain programs that target adolescent males and move closer to the reproductive health objectives outlined in chapter 2 and the collaborative strategies described in chapter 5. This chapter describes the strategies that existing programs must pursue to support reproductive health activities. It then explores some of the specific funding sources that are used for reproductive health and considers how these and other funding sources might be used to support reproductive health initiatives for young men.

The Need for Multiple Sources of Funding

Both clinical services and educational and counseling services fall under the umbrella of reproductive health services. *Clinical services* are usually provided by doctors, nurses, or other medical professionals in health care settings. They include screening and treatment for STDs, HIV/AIDS testing and counseling, and other physical exams. *Educational and counseling services* are provided by a more diverse set of staff, in a variety of settings such as community-based organizations, schools, or teen clinics. They can include mentoring programs,

group education and prevention sessions, individual counseling, and media campaigns. They may be linked to other support services needed by the young men, such as violence reduction, substance abuse prevention, and employment training.

All types of services are important to address young men's reproductive health needs successfully, but clinical and educational and counseling services are usually funded through different mechanisms. They may all be funded through direct public or private grants, but clinical services can also be paid for through insurance programs such as Medicaid. Nonclinical services, such as educational, counseling, and other preventive services, are generally covered only through grants and are not usually considered "reimbursable" services.

Because funding mechanisms for clinical and nonclinical services differ, and because funding in reproductive health has traditionally been categorical, programs that seek to address young men's reproductive health more comprehensively will need to seek funding from multiple sources. The specific source of funding that programs seek will depend on the health issue to be addressed, the type of service to be offered, and the service setting. Although competing for multiple sources of funding and fulfilling the administrative requirements of multiple funding sources is time-consuming and resource-intensive, most existing programs have had to adapt this strategy.

Programs that currently address both men's and women's reproductive health "package" multiple funding sources to provide the array of services their clients need. For example, a review of male involvement programs by the Urban Institute revealed that programs with clinical components were funded by multiple sources, including Medicaid and grants under Title V of the Social Security Act (Maternal

"COMMUNITIES across the nation have been able to create reproductive health service programs for young men, using ingenuity and the support of various funding agencies."

and Child Health Block Grants), Title X of the Public Health Services Act (federal family planning programs), and Title XX of the Social Security Act (Social Services Block Grants). Programs with an education or youth development component also relied on a combination of state and local public funds and private funds from foundations, church groups, corporations, and local agencies. Programs that primarily address women's reproductive health must also rely on multiple sources of funding. According to data compiled by the Alan Guttmacher Institute, almost half of public funding of family planning programs in 1994 came from Medicaid funds, 21 percent from Title X funds, 5 percent from Title V grants, 5 percent from Title XX grants, and 23 percent from state funds.[2]

"PROGRAMS that currently address both men's and women's reproductive health 'package' multiple funding sources to provide the array of services their clients need."

Organizations that seek to promote reproductive health among males, particularly in the special populations described in chapter 1, will likely be either organizations that already provide social or health services to males, or health care facilities that seek to attract and serve males. In either scenario, funding will be drawn not only from the public and private sources that have traditionally funded *health* services but also from sources that fund social and other services that males might need such as job readiness and training, educational enhancement, and violence/delinquency prevention services. This chapter discusses first the two major publicly funded insurance programs, Medicaid and the State Children's Health Insurance Program (SCHIP), and then several key grant programs, including Title X, Title V, and STD/HIV prevention programs of the Centers for Disease Control and Prevention (CDC). It then shows how community agencies can develop a funding base for male health projects and how funding agencies, public or private, can promote these projects.

Federal Health Insurance Programs

As insurance programs, Medicaid and SCHIP can reimburse the clinical component of male reproductive health services, including physician or clinic services, laboratory tests, prescription drugs, and counseling. But reproductive health services represent a minuscule fraction of these insurance programs' multibillion-dollar budgets. Thus, male health projects will need to maneuver within the rules and requirements of these vast insurance programs.

Medicaid

Medicaid is the largest source of public funds for reproductive health services in the United States. The majority of Medicaid recipients are women and children, and men are less likely to be eligible for program benefits. Teenage men under 19 years old may qualify for Medicaid coverage if they are children in welfare families, if they are "poverty-related" children, or if they have disabilities. Children's eligibility is discussed more in the section below on SCHIP. Young adult men may qualify if they are parents in welfare-type families or if they have disabilities.[3] A few states—such as Rhode Island, California, and Wisconsin, as well as the District of Columbia—have recently expanded eligibility to parents in families with incomes ranging from 100 to 200 percent of the federal poverty level (FPL), which is well above the traditional criterion for welfare. A few states—Tennessee, Hawaii, Minnesota, Oregon, and Washington—also provide services to low-income childless men, although they may have to pay a modest share of the insurance premiums. Oregon's Section 1115 waiver permits it to provide family planning services to both women and men whose

incomes are below 150 percent of the FPL, and other states are considering similar options.

Medicaid has a very broad medical benefit package and will cover services related to diagnosis or treatment of most diseases, including laboratory tests and prescription drugs, although states may impose limits. Family planning services are a mandatory component of state Medicaid programs, but states have some discretion in the specific services to be covered as family planning services. However, since the federal government provides 90 percent of the total cost of Medicaid family planning expenditures (much higher than the standard match rate), states have an incentive to cover broad services within family planning.

Medicaid may be especially useful in financing clinical reproductive health services for young men, but it will be less useful in funding educational and counseling services. Insofar as Medicaid is an entitlement, there are no inherent caps on the number of people who can be served or the costs of services provided to them, as long as people meet the eligibility criteria and the services are part of the benefit package.

Historically, Medicaid recipients could get services at a wide array of health care providers who were willing to take Medicaid reimbursements. This has changed with the steady growth of Medicaid managed care. Now a majority of Medicaid recipients—particularly nondisabled children and adults—are in a managed care plan that assigns each recipient a "primary care provider" who is supposed to be the source of medical care for most preventive and primary medical service. The primary care providers should be qualified physicians, such as family practitioners, internists, or general practitioners (or sometimes nurse practitioners or physician's assistants), who should be qualified to handle relevant clinical services such as STD or HIV test-

ing. However, they might not have as much expertise or level of awareness as some more specialized reproductive health clinics.

Primary care providers could make referrals to other clinics for male reproductive health services, particularly if they are in the same managed care network, but this is subject to the rules and authorization of each individual managed care plan. However, since many basic reproductive health services are considered primary care services, the primary care physician might have little incentive to make referrals to specialists for reproductive health needs. The situation may be more flexible in areas that use primary care case management (PCCM) systems in Medicaid, as opposed to capitated health maintenance organizations. The extension of Medicaid to families and parents involves use of Medicaid Section 1931 options. The extension of Medicaid to even childless adults involves Medicaid Section 1115 research and demonstration waivers. In Minnesota and Washington, the services are provided under special state-funded programs that operate like Medicaid, but without federal matching funds.

Under the federal "freedom of choice" provision, people in Medicaid managed care may still seek family planning services outside their managed care networks, such as at Title X family planning clinics, with some exceptions.[4] The interpretation of this provision is determined by each state's Medicaid agency, but it seems plausible that some reproductive health services for men (e.g., STD or HIV testing, but not treatment) could be defined as family planning services and therefore subject to the freedom-of-choice provision, even for men. But—in reality—this provision is not likely to be very useful for men, because most people, including patients themselves, do not usually think of men as getting "family planning." Even for women,

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these provisions have not been completely successful; Medicaid managed care patients are generally informed that they must seek care from their primary care providers first, and they usually are not aware of the exemptions for family planning.

Medicaid coverage may also be available to teenagers through school-based clinics or the early and periodic screening, diagnosis, and treatment (EPSDT) component of Medicaid.

State Children's Health Insurance Program (SCHIP)

SCHIP is a new, but potentially important, source of funding for reproductive health services for adolescent males. It was established in 1997 as Title XXI of the Social Security Act. The federal government allocates funds to states in the form of block grants to expand insurance coverage of uninsured children. States may expand Medicaid coverage for children, enroll uninsured children in separately administered SCHIP plans, or use a combination of these two approaches. As SCHIP coverage expands, it will become a mainstay for funding medical services for low-income teenagers along with Medicaid.

Through the combination of Medicaid and SCHIP, most teenagers under the age of 19 with net incomes under 200 percent of the federal poverty level are eligible for coverage (except for immigrants, who are ineligible if they entered the United States after August 1996). A few states set more restrictive eligibility criteria, but this is changing over time (those with income criteria set below 185 percent of poverty include Idaho, Louisiana, North Dakota, Ohio, Oregon, South Carolina, South Dakota, West Virginia, and Wyoming); older teenagers

are eligible for Medicaid or SCHIP with incomes up to 185 percent of poverty. In a few states, the income limits may be higher; for example, New Jersey sets its SCHIP income threshold at 350 percent of poverty.[5]

SCHIP programs are generally integrated with Medicaid programs or have similar basic operating structures. Primarily, they are insurance programs, generally using managed care plans to deliver services. Teenage males who have Medicaid coverage are generally eligible for a broad array of medical services, including STD or HIV testing and treatment and various forms of counseling and case management. When separate from Medicaid, the SCHIP benefit package may be narrower than the Medicaid package, but generally it still covers core clinical services such as the diagnosis and treatment of STDs or HIV or related medical counseling. Federal law does not require that SCHIP provide family planning services, but most states do offer these services.[6] Because most SCHIP programs use managed care, the range of providers is limited. Furthermore, the ability of youth to get care other than from their primary care providers may be limited, although state programs are often sensitive to the different needs of adolescents, such as a greater need for confidentiality.

Although insurance is the dominant mode of providing care under SCHIP, states have a limited option of funding services more directly through grants. Total funding for the direct services, administrative costs, and outreach may not exceed 10 percent of total SCHIP expenditures. Because of the high demands for administrative and outreach funds under SCHIP, there is only very limited potential for direct funding of health services through grants in SCHIP.

"SCHIP IS A *new, but potentially important, source of funding for reproductive health services for adolescent males."*

Federal Grant Programs

Grant programs generally offer much more flexibility in how the funds may be used, but they are limited with respect to the number of grantees and the size of the grants. Many of the programs discussed below have a public health focus, such as Titles X and V and the CDC programs. Others have a social focus, but permit or even encourage health components.

Title X Family Planning and Adolescent Family Life Programs

Title X of the Public Health Services Act is the only federal program dedicated primarily to family planning. It is administered by the Office of Population Affairs in DHHS. A great virtue of Title X funding is that grantees can use it flexibly for both clinical, educational, and counseling services for males. The disadvantage is that Title X funding is limited, and only certain organizations are approved as Title X recipient agencies.

The great majority of Title X funds go to family planning clinics, and the rest of the funds go to special programs such as male involvement initiatives. Title X funds are distributed to state agencies and other grantees, and states are required to use a portion of their Title X funds for adolescents. Seven in ten publicly funded family planning agencies, for example, have at least one special program to serve the needs of adolescent clients, and Planned Parenthood affiliates are especially likely (94 percent) to sponsor such programs.[7] An extremely small proportion of Title X funds distributed to family planning clinics are actually used for males, even though four in ten family plan-

ning agencies report that they serve men.[8] When men do seek reproductive health services through family planning clinics, some of the most popular services being provided are condom distribution at 93 percent of clinics, STD treatment at 86 percent, STD screening at 84 percent, and HIV testing at 79 percent.[9] Some other services that men obtain through family planning clinics are testicular cancer screening, prostate cancer screening, infertility counseling and treatment, phalloscopy, sports/work physicals, primary health care, and mental health services.[10]

Recently, Title X has funded male involvement programs as demonstration projects. These funds support demonstration projects to develop, implement, and evaluate program components to deliver family planning services and promote reproductive health among males. Nine of these programs are funded from the central office, and eight are funded through existing Title X grantees. These programs are based in a variety of settings, including clinics, social service agencies, and youth development organizations. They are testing a number of approaches for reaching and working with young men, including outreach, mentoring, peer education, support groups, academic skills building, and established health curricula.

The Adolescent Family Life program, like the Title X program, is administered by DHHS's Office of Population Affairs. This program funds two types of demonstration projects: those that provide care to pregnant and parenting teenagers, including male partners, and those that promote abstinence-based primary prevention programs. These grants may be approved for up to five years.

"A GREAT VIRTUE of Title X funding is that grantees can use it flexibly for both clinical, educational, and counseling services for males."

Centers for Disease Control HIV and Other STD Prevention Programs

"BECAUSE reduction of risky sexual behavior is a key strategy for the prevention of both HIV and other STDs, these programs are strongly interested in promoting responsible behavior."

The CDC administers grant programs to help control and prevent communicable diseases, such as HIV and other STDs. Because reduction of risky sexual behavior, including the promotion of condom use, is a key strategy for the prevention of both HIV and other STDs, these programs are strongly interested in promoting responsible behavior among men. In 1999, CDC spent approximately $650 million on HIV-related activities, including state and local prevention activities, a national public information network, education programs in the nation's schools, disease monitoring, and laboratory, behavioral, and epidemiologic studies designed to identify the most effective interventions to combat HIV.

The CDC funds prevention programs for high-risk populations through 65 state and local health departments; 22 national and regional minority organizations; 10 national business, labor, and faith partnerships; and 94 community-based organizations. Programs funded through state and local health departments must be designed according to the HIV Community Planning process, which mandates that responsibility for priority-setting be shared with representatives from communities for whom services are intended. HIV funding instructions also emphasize cross-program activities that integrate HIV, STD, and tuberculosis interventions, as well as HIV and substance abuse prevention and treatment, corrections, and education. CDC also has given attention to the severity of HIV in communities of color, as evidenced by one recent program announcement that allocates funds for community-based HIV prevention projects for African

Americans and another that announces funds for community-based efforts for gay men of color. Still another recent program announcement targets HIV prevention services, capacity building, and training and development for African American faith-based organizations. Because of their emphasis on community involvement, cross-program activities, and seeking out African American populations, CDC funds might prove promising for some community-based and faith-based organizations seeking to integrate reproductive and sexual health services into their programs.

Because of the intimate relationship between HIV and other STDs, HIV program funding instructions recommend efforts to increase access to STD diagnosis and treatment. In addition, CDC spent approximately $120 million on STD-related activities in 1999, including funding for comprehensive STD prevention systems, prevention of STD-related infertility, and a special initiative to eliminate syphilis. Although at present these funds are available only as continuation grants to previous grant recipients, the funds may be appropriate in the future for clinics that provide STD screening and treatment, as well as for community-based organizations that seek to increase STD awareness.

CDC maintains a searchable database of public and private sources of funding for HIV, STD, and tuberculosis prevention efforts, available at http://www.cdcnpin.org/db/public/fundmain.htm.

Title V/Maternal and Child Health Block Grant

Title V Maternal and Child Health Block Grants are distributed by DHHS's Health Resources and Services Administration to state health

departments for the purpose of improving maternal and child health. In principle, reproductive health services for adolescent males could be covered under Title V block grants, but this is subject to the plans authorized by each state health department. Typical recipient agencies are state and local health departments, but nonprofit health clinics or other providers may also receive funding.

Like Title X, Title V funds could be used for both clinical and educational services, but they are limited by the size of each state's maternal and child health budget and the rules established by each state health department. Title V funds might be particularly appropriate for programs in which male reproductive health services are part of a broader array of health programs for adolescents or children.

Community Health Centers

Under Section 330 of the Public Health Services Act, the Health Resources and Services Administration funds community health centers to provide a broad range of primary care services to people living in medically underserved areas. Although their focus is medical care, the health centers often provide a variety of related social or supportive services for their clientele. The great majority of health center users are either on Medicaid or uninsured. Because, as noted above, young adult men are not typically eligible for Medicaid, the community health centers might be particularly important providers for uninsured males. Community health centers often have multiple grants and also receive Title X, Title V, or CDC funds to provide family planning, maternal and child health, or STD services.

In many cases, community health centers may be ideal partners

for community-based organizations to provide preventive health services to young men. They are able to provide a wide array of health services that may be attractive to male patients, in addition to providing reproductive health services. Community health centers are nonprofit organizations and are required to have community-based boards of directors, so that they are inherently linked to community needs. A slight disadvantage may be that, because the health centers offer a broad array of primary care services, they are somewhat less focused on providing reproductive health services than other agencies such as family planning clinics.

The federal government also supports migrant health centers and programs providing health care for the homeless; these programs support primary care services for these more specialized populations. If there are special concerns for young men who are migrant workers or members of migrant families, or who are homeless or in homeless families, these health centers may also be important partners.

"COMMUNITY health centers may be ideal partners for community-based organizations to provide preventive health services to young men."

Ryan White Program

The Ryan White CARE Act is a categorical funding source that provides competitive grants and formula grants to areas with disproportionately high rates of HIV prevalence. It too is administered by the Health Resources and Services Administration. One of the components is Title IV, the Pediatric/Family AIDS Demonstration Program, which funds community-based projects for children, youth, women, and their families who are living with or at risk of HIV infection. (The other components of Ryan White primarily offer services for those who are already infected.) Many of the projects

"ALTHOUGH THE *main purpose of TANF funding is to provide cash assistance to needy families, it has the potential to fund reproductive health services for men too."*

funded under Title IV provide medical and/or psychosocial services for youth at high risk for HIV infection, such as minority youth in high-risk areas, runaways, homeless youth, injecting drug users, and gay youth, as well as youth who have already contracted HIV. Programs funded under Title IV of the Ryan White CARE Act use various methods to target youth at risk for HIV, such as early intervention, risk reduction counseling, case management, peer counseling, advocacy education, or primary care. Ryan White funds agencies and community programs that could directly target young men around issues of HIV prevention and care.

Ryan White program funds are particularly relevant for male reproductive health services, because they recognize the importance of preventing HIV in the community, and many community agencies have been funded to develop and implement novel approaches for services. Grantees typically realize that HIV and STD prevention, as well as other reproductive health services, are closely related, and that young men are an important target group for services. However, again, Ryan White grant funds are limited.

Social Services Block Grant

The Social Services Block Grant (SSBG) under Title XX of the Social Security Act is distributed by DHHS's Administration for Children and Families to state social service agencies for the purpose of encouraging individual self-sufficiency and reducing individuals' dependence on government. These block grants could potentially be used to fund reproductive health activities, but historically the use of these funds for family planning and related health purposes has

declined. SSBG funds might be particularly relevant when male reproductive health services are part of a broader social services program for youth, such as special programs for high-risk youth, foster care youth, or those involved in the child welfare system.

Temporary Assistance for Needy Families

Temporary Assistance for Needy Families (TANF) is the state block grant program that replaced the Aid to Families with Dependent Children (AFDC) program. Although the main purpose of TANF funding is to provide cash assistance to needy families, and to provide job training and related services, particularly child care, to welfare families, it has the potential to fund reproductive health services for men too. As a result of rapidly falling welfare caseloads, states are running surpluses in their federally allocated TANF dollars. Therefore funds may be available for reproductive health services. In addition, TANF legislation provides a $100 million annual bonus to be shared by the five states with the greatest reductions in their nonmarital birth rates. California, Michigan, Alabama, Massachusetts, and the District of Columbia were the first awardees.

Family planning services are the only type of medical services that can be funded by TANF. Although the statute does not define "prepregnancy family planning services," many states have interpreted the term broadly to support a range of related activities.[11] TANF agencies do not need to contract directly with family planning services; they can subcontract with health departments to provide or fund services.

TANF funds have been used—to a limited extent—to fund educational, outreach, and training initiatives as well as clinic-based family

planning services.[12] Some states have used TANF funds for a youth development approach aimed at strengthening a variety of skills among at-risk youth. Several of these states have incorporated a male involvement or a male responsibility component. Others have focused primarily on young women, including recent mothers, using activities such as child care or second-chance homes. TANF funds are probably most appropriately considered when the program is concerned with a broader strategy of economic and skills development among low-income youth but is also interested in providing further access to clinical health services.

TANF also distributes grants to states to help them promote abstinence education programs. Organizations interested in a strong abstinence component for young men may be able to obtain funding from this new federal source, although the programs are often aimed at relatively younger children.

"SOME STATES have used TANF funds for a youth development approach aimed at strengthening a variety of skills among at-risk youth."

Other Categorical Grant Programs

One particularly important potential funding agency within DHHS is the Substance Abuse and Mental Health Services Administration (SAMHSA), which provides grants to prevent and treat drug and alcohol abuse and mental illness. SAMHSA has a special interest in AIDS prevention because of the well-known linkage between drug use and HIV transmission, as well as the broader correlation of high-risk behaviors, including substance use and STD/HIV behaviors, among youth.

Numerous other health, social, educational, and development-oriented grant programs are offered by DHHS and other federal agencies, including the Departments of Justice (violence prevention, high-

risk and incarcerated youth) and Labor (employment and training).

Table 6.1 summarizes other federal grant programs that might be relevant for male reproductive health programs. Although these programs do not focus on reproductive health services for young men, they target other health and social needs of youth, such as substance abuse, violence prevention, or job readiness, that may be correlated

Table 6.1 Other Federal Grant Programs That May Provide Funding Related to Young Men's Reproductive Health

Program Name	Federal Agency	Summary
Independent Living Program	ACF	Supports education and related programs to help young people make the transition successfully from foster care to adulthood, including prevention of early parenthood.
Community Services Block Grant	ACF	Provides funding to community agencies to provide services to low-income populations, including youth at risk, and summer youth employment programs.
Runaway and Homeless Youth Programs	ACF	Support programs to help serve runaway and homeless youth, including crisis intervention, counseling, and prevention programs.
Healthy Start	HRSA	Provides funds to community programs to reduce infant mortality and improve health of women, infants, and children. Some programs are aimed at teenagers, including sexual responsibility programs.
Healthy Schools, Healthy Communities	HRSA	Provides funds to support school-based health centers.
Youth Violence Initiatives	OJJDP	Provide funding to assist in prevention of violence among youth, including juvenile delinquency among high-risk youth.

ACF = Administration for Children and Families, DHHS. HRSA = Health Resources and Services Administration, DHHS. OJJDP = Office of Juvenile Justice and Delinquency Prevention, Department of Justice.

with young men's reproductive health needs. The community-based organizations that are grantees for these programs often serve high- and moderate-risk adolescents and young adults who also have preventive health needs. These other funding agencies can help provide a financial base for the education and social aspects of young men's reproductive health projects. In many cases, the social programs serve special populations who have specific and unique services needs, such as youth in foster care, runaways, youth in detention centers or on parole, and gay and bisexual youth.

State, Local, and Private Programs

Because of their diversity, it is not possible to list the state, local, or private programs that might be used to support male health programs. But it should be noted that most of the male health programs that the working group is aware of also rely on nonfederal funding sources, including charitable private foundations. The relatively short list here primarily reflects the gaps in the group's knowledge base, not the lack of importance of these nonfederal funding sources.

California has a noteworthy state-level initiative; the state's Office of Family Planning funds 23 male involvement programs. Although the settings in which these programs are implemented, the methods used to reach young men, and the additional funding sources used to support the agencies and programs vary, they all share the goals of encouraging male responsibility in pregnancy prevention and fatherhood. The California programs also have some common forms of implementation. Most of the agencies funded have a component that takes place in school, one-third have a component that is clinic-

based, and two-thirds have a community-based component that includes some combination of street outreach and after-school or church-based programs. Many of the programs also include components in juvenile or adult detention facilities. The male involvement programs are part of a much larger, relatively well-funded state initiative to promote family planning services in general.

Discussion

How Can Community Agencies Develop a Funding Case?

For organizations that are interested in developing programs of reproductive health services for males, particularly those that integrate educational and clinical services, the most reasonable approach will be to begin by seeking grant funding from one or more of the federal or state programs discussed above, from a private foundation, or from another community source. The virtue of grant funding is that it can provide a specified budget that can serve as a core around which other programmatic aspects can be developed and financed. Male reproductive health programs of the type discussed here are still novel and may appeal to funders as innovative demonstration programs that seek to resolve complex health and social problems with a multidisciplinary approach. In fact, some organizations that already have grant funding for certain programs may be interested in adding male reproductive health service components as an innovation to an existing grant.

To get grant funding, the organization must identify funders who appear receptive to its ideas and must be prepared to file applications,

including management plans and budgets. To do this, it should understand the prospective funders' rules, their funding priorities, and the grant application timetable. In most cases, funders periodically issue requests for applications or requests for proposals that describe their interests and the application process. Once a grant is received, the grantee should be prepared to evaluate how the funds are being used and write reports about the achievements of the program.

"FUNDERS NEED ***to promote a vision of how these services can be used in a complementary fashion to promote the health and well-being of all members of the community."***

Sometimes, funding agencies are not looking for new grantees, but only want to continue or expand services at existing recipient organizations. Current grantees might want to add male reproductive health programs as innovations to the current set of services offered. Even when funders are not looking for new grantees, outside organizations may find that it is possible to obtain funding through alliances with existing grantees. That is, the current grantee could get funding to offer male reproductive services that would be provided by the new organization. This is particularly relevant because grant funders are often interested in seeing evidence of community collaborations in their projects. Nonetheless, collaborative relationships pose a challenge, and organizations planning to partner need to have clear expectations about their respective roles and orientations (see chapter 5).

If they can obtain grant funding, the programs should be arranged so that clinical services are paid for by Medicaid, SCHIP, or private health insurance programs where possible, to stretch their grant funds. If the organization is in an area where Medicaid is primarily fee-for-service, it must be able to submit medical bills in the authorized fashion. As noted earlier, though, managed care has become the dominant force in Medicaid and SCHIP. If the organization is a contracted health care provider in Medicaid/SCHIP managed care net-

works, it may be able to get reimbursed directly for services on an fee-for-service basis. If not, it should try to develop medical referral systems so that its clients can obtain the relevant medical diagnostic or treatment services from their Medicaid/SCHIP primary care providers or other contracted network providers. To do this, the organization needs to understand the insurance coverage of its clientele and the managed care networks that exist in its community.

How Could Governments or Private Funders Encourage Male Reproductive Health Services?

As argued earlier in this chapter, a critical first step in the development of programs to promote young men's health services is getting one or more core grants that can be enhanced by other funding sources such as Medicaid or SCHIP. Funding agencies, whether they are public or private, that want to promote male reproductive health services need to ask how they can encourage community agencies to develop programs like those discussed in this report.

Funders can influence the development of these programs by encouraging them through grant activities. It might not be necessary (or even desirable) to develop new types of public or private programs to offer these services; a large number of categorical health and social services programs that can be adapted are already in existence. Most grant announcements issued by governments or foundations, however, indicate priority areas where they encourage applicants to develop new initiatives. For example, grant announcements could say that they would favor applicants who develop initiatives for integrated clinical

and educational/social reproductive health services for young men. Both Title X family planning and the state of California fund male involvement programs by designating them as priority areas within the broader rubric of existing programs, but they have limited funds.

An unavoidable issue with categorical grant programs is that, ultimately, they all have limited funding. The demand for funds almost always outstrips the available money. Thus, designating one type of service as a priority might be viewed as undercutting support for other services. Funders should ensure that dollars used to support services for young men are not viewed as funds taken away from women's or children's services, or that funds spent on health are funds not spent on job training. Instead, they need to promote a vision of how these services can be used in a complementary fashion to promote the health and well-being of all members of the community.

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APPENDIX

TOPIC	SOURCE	ORGANIZATION
Coalitions and Community Involvement; Teen Pregnancy Prevention	*Communities Responding to the Challenge of Adolescent Pregnancy Prevention*	Advocates for Youth (202) 347-5700 http://www.advocatesforyouth.org
Community Building	*Community Building Chronicles*	The Coalition of Community Foundations for Youth (800) 292-6149 http://www.ccfy.org
Fatherhood Initiatives	FatherLit Database	National Center on Fathers and Families (215) 573-5500 http://www.ncoff.gse.upenn.edu
Financing	*Tapping TANF: When and How Welfare Funds Can Support Reproductive Health or Teen Parent Initiatives*	Center for Law and Social Policy (CLASP) (202) 328-5140 http://www.clasp.org
Peer Health Education	Peer Education Clearinghouse	Advocates for Youth (202) 347-5700 http://www.advocatesforyouth.org
School Health Education; AIDS Prevention	*Guidelines for Effective School Health Education to Prevent the Spread of AIDS*	Centers for Disease Control
Teen Pregnancy Prevention	*Involving Males in Preventing Teen Pregnancy*	The Urban Institute (202) 833-7200 http://www.urban.org
Teen Pregnancy Prevention	*Get Organized: A Guide to Preventing Teen Pregnancy*	The National Campaign to Prevent Teen Pregnancy (202) 261-5655 http://www.teenpregnancy.org
Teen Sex	*When Teens Have Sex: Issues and Trends—a KIDS COUNT Special Report*	The Annie E. Casey Foundation (410) 547-6600 http://www.aecf.org

CONTENT	ORDERING INFORMATION
This five-volume series encourages and assists communities to address adolescent sexuality in a balanced and realistic manner. The five volumes are *Mobilizing for Action; Building Strong Foundations, Ensuring the Future; Designing Effective Family Life Education Programs; Improving Contraceptive Access for Teens;* and *Linking Pregnancy Prevention to Youth Development*.	To order: http://www.advocatesforyouth.org/publictions/ PRODUCTS.HTM or call (202) 347-5700
The Coalition of Community Foundations for Youth (CCFY) is a network of over 135 community foundations in communities across the United States dedicated to securing improved conditions for children, youth, and families. *Community Building Chronicles* is the Coalition's bimonthly publication focused on building strong communities for children, youth, and families.	To read the latest issue on the Internet: http://www.ccfy.org/toolbox/index.htm
The FatherLit database, coordinated by the National Center on Fathers and Families (NCOFF), is a compilation of citations, annotations, and abstracts for over 8,000 basic and policy research publications on fathers, families, and child welfare.	Available at http://www.ncoff.gse.upenn.edu/database/index.html
This paper describes the availability of roughly $3 billion in unspent federal TANF funds and provides guidance to advocates and agency administrators seeking to tap these funds for pregnancy prevention and teen parent initiatives. The paper discusses what can and cannot be done under the law and describes what states are already doing with TANF and state Maintenance-of-Effort funds to prevent pregnancy.	Available at http://www.clasp.org/pubs/teens/reproductive_healthtanf_teens.htm or call (202) 328-5140
The Peer Education Clearinghouse contains a national database with descriptions of and details about adolescent reproductive and sexual health peer education programs and provides technical assistance, research articles, and referrals.	For more information: http://www.advocatesforyouth.org/peered.htm
These guidelines have been developed to help school personnel and others plan, implement, and evaluate educational efforts to prevent unnecessary morbidity and mortality associated with AIDS and other HIV-related illnesses. They provide information for planning and implementing appropriate and effective strategies to teach young people about how to avoid HIV infection.	Available at Internet: http://www.cdc.gov/nccdphp/dash/aids.htm
Involving Males in Preventing Teen Pregnancy, a guide for program planners, presents compelling evidence that young men should be involved in teen pregnancy prevention efforts, and offers models of how to do so.	To order: call toll-free (877) 847-7377
Get Organized is a practical manual for people at the state and local levels who are interested in taking action to prevent teen pregnancy in their communities. A three-volume, 17-chapter publication, it covers a lot of ground—from strategies for collecting basic data and reaching out to religious leaders, to practical advice about how to raise money and to conduct program evaluation. The three volumes are *Focusing on the Kids; Involving the Key Players;* and *Making It Happen*.	To order: http://www.teenpregnancy.org/campub.htm or call (202) 261-5655
When Teens Have Sex, patterned after the Foundation's annual KIDS COUNT Data Book, provides key indicators of adolescent health and sexual behavior state by state, discusses the issues, and describes some promising programs that are helping young people make responsible decisions.	Available at http://www.kidscount.org/kidscount/teen/index.htm or call (410) 547-6600

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