Dr. Marcell: A pleasure to be here today to be able to share with you preventive male sexual and reproductive healthcare recommendations for clinical practice. For this talk I have nothing to disclose. By the end of my talk I hope you’ll be able to describe best practice recommendations for delivering preventive clinical sexual and reproductive health services for reproductive aged males.

 I want to start out by just talking about why we should involve males in sexual and reproductive health. First it’s important that we address males sexual reproductive health needs in their own right and to address both sides of the partnering equation including addressing health outcomes of both individuals needing to address direct benefits such as decreased infection transmission between partners as well as indirect benefits including shared health promotion practices.

 Studies also show that including males it’s critical partners and family planning can help ensure all pregnancies are planned and wanted as well as addressing men’s health needs to improve their capacity for parenting, fatherhood and child outcomes. In addition using sexually productive healthcare as a clinical hook can help address their other health needs. Many studies shows that providers defined here broadly, inclusive of parents, teachers as well as clinicians have demonstrated that on all of these individuals lack sufficient knowledge and skills in addressing sexual reproductive health specifically for males.

 In many countries males are not socialized around healthcare and especially sexual reproductive healthcare, specifically in this country as well. I’d like to spend just a couple of slides on expanding this background just highlighting what our male sexual reproductive health means and before I go into describing the recommendations from the guidance themselves.

 National data show that males have substantial sexual reproductive health needs and that many have multiple needs. We know that all males go through puberty and the maturation of the reproductive health system. Sexual identity formation is a normal task of adolescence. Although the majority identify as heterosexual, somewhere between 5 to 10 % of adolescence report same sex attraction or behaviors. Studies show that these populations may have additional health needs.

 The majority of males by age 18 to 19 report having had sex, are diagnosed with STDs between the ages of 15 to 24. That the majority have pregnancy prevention and family planning needs, given that the majority of children born to males under 18 report that this first child is unintended. Males in particular have limited knowledge about hormonal methods that are available for females and don’t necessarily even know how to use a condom correctly.

 The majority of males also have preconception health needs. We’ll talk a little bit more about this later, but this is defined as meaning that they intend to have a child at some point in their life. Males also experience comorbid behaviors such as alcohol and drug use that can lead to a lack of condom use, STD risk and unintended pregnancy. As well as sexual problems with primary issues typically related to sexual performance anxiety when younger or erectile dysfunction when older. Or secondary to medications like use of MSSRI or substance abuse or even condoms.

 Males also experience intimate partner violence, sexual violence, sexual reproductive health related cancers. Finally among males intending to have children, some have concerns about infertility, they may not even recognize medications that might impair their spermability for example, such as some anti-seizure medicine. Finally abnormal puberty findings are not uncommon, these include genetic conditions listed here as well as non-STD related issues such as gynecomastia, torsion, varicocele and acne.

 Early and late maturing males may also have other health needs related to negative health outcomes due to increased risk taking, mental health and substance use. As I mentioned earlier, sexual minority use might be an increased risk for mental health and substance abuse issues of not connected with supportive environments.

 In the context of all of these needs you may be surprised that few males report receipt of sexual reproductive healthcare. This slide focuses on the majority of studies that really focus on just assessing sexual health or STD and HIV receipt. Here you can see compared to females fewer males are report receipt of being assessed about sexual health or being ever tested for HIV or testing for HIV in the last year, as well as counseling on different issues inclusive of STI, HIV pregnancy, contraception as well as condoms.

 Within the context of this, however when asked if male adolescence or young adults in clinical settings want to talk about the following sexual reproductive healthcare services with their healthcare provider, we actually found that the majority say yes. More than 85% report they’re willing to talk about each topic. More interestingly the majority state they want their provider to bring up the topic. What accounts for the discrepancy in male’s sexual reproductive healthcare receipt. There are many issues and I can spend the entire hour just focusing on this.

 As clinicians some of the challenges we face in delivering sexual reproductive healthcare to males is that until now, no one national organization has outlined clinical standards of care for delivering sexual reproductive healthcare or even family planning services to males across the lifespan. In addition there’s really been a lack of research with males in the domain of sexual reproductive healthcare in clinical settings to inform such guidance. Existing guidance are guidelines are single-topic focused and have lacked a comprehensive sexual reproductive health framework.

 What constitutes sexual reproductive healthcare for males? I would like to spend the remainder of my talk on discussing recommendations from two related recently published guidelines. The first [ad 00:07:27] I’m mentioned and the second from the Male Training Center that aim to organize sexual reproductive healthcare services for all males inclusive of male adolescents. The first is the QFP that was published as the MMWR report earlier this year by the CDC and the OPA and the link is listed on the bottom of the slide.

 The second is the Male Training Centers or MTCs sexual reproductive healthcare recommendations. For clinical practice that was released about two weeks ago. Together these reports represent the first national guidance of its kind. Before I highlight content from both of these reports I’d like to walk you through the process we took in developing the guidelines. This begun when the OPA started planning the process to update the nation’s Title X clinical guidelines. At the time the Male Training Center was funded by the OPA to provide training support to the nation on men’s health. As part of our agenda, the MTC identified lack of clinical standards for men with a substantial gap in the field.

 As Sue mentioned already, we collaborated with the CDC and the OPA in updating the nation’s Title X clinical guidelines and used a parallel approach for developing guidance for men and women’s preventive clinical services. Guiding principles at the Male Training Center used in developing standards for male sexual reproductive healthcare included using an evidence informed approach. Where we examined professional organizations for recommendations across the lifespan and we relied on evidence based recommendations whenever possible. We also conducted additional systematic reviews for gap area and engaged experts in male health to inform the process, given the challenges that I described previously.

 As part of the QFP process, the Male Training Center convened a men’s health technical panel where we synthesized federal and professional medical recommendations based on IOM criteria in the institute of medicine for trustworthy clinical guidelines. We reviewed more than 40 screening services for males for more than 30 federal and professional medical associations. We got feedback from our members regarding the materials that we presented to them.

 This was then drafted and presented to the expert work group that was convened by the CDC over separate oversight process for the entire guidance. The expert work group used three type of criteria to consider core recommendation, consequences of recommendation and values and preferences. The CDC and OPA considered expert work group feedback to develop the final set of core recommendations to be included in the QFP for clinical services.

 For men’s health components of the guidance the follow seven decisions were made. The first is that we used the World Health Organization’s definitions of sexual reproductive health as a starting point for considering services to include for men. Here, the WHO’s framework and definition is quite broad and defines that sexual reproductive health is a state of physical, mental and social wellbeing and not merely the option for disease dysfunction or infirmity in all matters relating to the reproductive system, its functions and its processes.

 Using this framework we articulated clinical care goals for males and reviewed these goals with the technical panel members who provided us feedback. The final set of goals included preventing STIs and HIV. Again, this is focused on a clinical care setting preventing unintended pregnancy, reproductive health cancers, promoting sexual health and development. A reproductive life plan, preconception health, healthy relationships and behavior and reducing sexual problems and infertility. With the overall goal to increase lifespan and survival as well as quality life and ultimately access to clinical service and client satisfaction with these things.

 The additional decisions also included the following. I think we identified core services should include contraception, basic infertility, preconception health and STD services. The QFP is organized around these services. Third we identified that assessing a client’s reproductive life plan and a comprehensive sexual history were critical cornerstones for determining relevant services to deliver to population.

 Fourth we used hierarchical approach for providing each service given inconsistencies between organizations with the CDC at the top of the ladder. Next the US Preventive Services Task Force or the USPSTF. Then third if nothing is mentioned from the prior two, other organizations such as the Bright Futures from the American Academy of Pediatrics for adolescents and topic domain.

 Fifth, we identified other relevant services that were linked closely with family planning. Six we made recommendations against providing services that are shown to be ineffective or when potential harm outweighs the benefits that should no longer be provided. Finally in the QFP, recommendations for men’s health were integrated throughout rather than just listed as a separate section or treated as a special population.

 Since the goal of the male centers technical panel had a broader focus on men’s sexual reproductive healthcare content that was just not limited to family planning. The MTC document, the second document of the two summarizes the QFP recommendations for clinical preventive services, but also summarizes further deliberations by the panel for services to include. Then for each service it also provides additional tools and resources, regarding how to assess.

 Next I would like to walk you through the recommended services and highlight the services recommended by the QFP or the MTC as appropriate. This slide here highlights recommended history component and just to walk you through the slide. On the left the source of the recommendation has listed either the QFP or the MTC. On the right columns for ages to deliver services highlighting adolescents to the left, under 21, young adults in the middle ages or for individuals 25 or older.

 Some of the services that are recommended for the history components are directly linked to sexual reproductive health. Such as assessing a reproductive life plan, sexual health assessment, problems with sexual function, intimate partner and sexual violence and immunizations. While other services may appear to be more distally related but still overlap and meet the broader framework that I just described. Inclusive of alcohol and drug use, tobacco use and depression.

 Recommended physical exam components include measuring height, weight and BMI, blood pressure and performing an external genital exam amongst male adolescent. Recommended laboratory test components include, screening for Chlamydia, gonorrhea, syphilis and HIV for all male adolescents and young adults. Hepatitis C for older age population and the slide specifies the exact age range, as well as diabetes for adults.

 Finally, key sexual reproductive health counseling components include counseling on condoms with demonstration and practice, recommended by the MTC. STD and HIV, pregnancy prevention, preconception health, sexuality in relationships and sexual dysfunction is recommended by also MTC and infertility.

 Before I review each of the recommended services in more detail I want to just review with you the services that are no longer recommended. These include; teaching about a testicular exam to specifically screen for testicular cancer. Then performing as a clinician a testicular exam again to specifically screen for testicular cancer. Likewise, screening for hernia and the following laboratories as screening test for gonorrhea among low risk population, hepatitis B among low risk population, hepatitis C for individuals not born between 45 and 65, for herpes simplex. For syphilis among individuals not at increased risk. Using a PSA for prostate cancer and conducting a screening urinalysis or a screening hemoglobin hematocrit.

 Now note this slide does reflect an update that isn’t incorporated into the final MTC document since it was just released by the USPSTF for to screen for hepatitis B in at risk adolescence and adults but not to screen among individuals who are at low risk. Then also there’s no recommendations were made for males in the following area since evidence is still being accumulated. This includes screening for trichomonas as well as human papillomavirus and anal cytology.

 Next I want to just walk you through each service and provide a little bit more detail about each. The guidance recommends asking about our patient’s reproductive life plan and intentions to have children in the next 12 months. The importance of this question is that really can help to prioritize appropriate services to deliver to an individual. For example, one can really focus on pregnancy prevention for individuals who are not planning to have a child in the next 12 months, or preconception health services for an individual who answers yes. Or to determine how best to bundle services and identify the appropriate services over a period of time for individuals who are ambivalent or unsure.

 We’ve not historically thought about preconception health for patients let alone for our male patients. I just wanted to take a moment to review the goal of preconception health in general and how to think about this for our male patients. The goal of preconception healthcare is to optimize health before conception and help reduce adverse maternal infant outcomes. More recently there has been for us to think about how to include males to be attuned to anticipatory fatherhood and help really minimize gender disparities and healthcare delivery.

 Specific benefits for men from preconception health include improving genetic and biological contributions to pregnancy as well as be involved in the planning and spacing of pregnancies. Really a lot of the components of preconception health for men represent men care. It has added benefits to just improve men’s overall health. For the male, especially younger males, preconception healthcare may just focus on taking additional history questions and educating about how to promote reproductive capacity. Use it as opportunity to help engage female partners in related preconception healthcare services. Based on ones history, provide additional counseling for potential behavior change as pregnant.

 The other cornerstone recommendation is to take a complete sexual health assessment. The guidance recommends using the 5 P’s approach. If you’re not familiar with the 5 P’s, this approach asks about practices, partners, pregnancy prevention, protection from STDs and past STD history. The MTC also recommends asking about problems with sexual function. The majority of males at some point will have some problems with sexual function. Adolescents it’s very uncommon for them to have performance anxiety. For individuals using condoms they may have issues with function related to lack of lubrication with condom use.

 Individuals on medications such as SSRIs might have changes in their libido and or actual performance issues. As I mentioned earlier, substance abuse is linked to multiple issues related to either lack of condom use or problems when having sex. It’s also important to understand the link between sexual dysfunction and underlying cardiovascular disease among men presenting with sexual dysfunction symptoms, especially if they’re 25 years or older.

 The MTC also recommends asking about intimate partner and sexual violence experience as well as engagement among males. Here it’s important to note that abuse has been shown to be bidirectional in relationships and that many individuals have a prior history of abuse. Certain population such as sexual minority males might be at higher risk for reporting abuse. Finally providers should comply with their state mandatory reporting guidelines regarding abuse. Each state or jurisdiction may have different mandatory reporting requirements. Resource sighted on this slide can provide you step by step links if you’re not already familiar with your state’s law.

 For example in the state of Maryland, even though there is a specific delineation when it is a crime if a minor has consensual vaginal intercourse with an older or younger partner. Clinicians are only mandated to report when the abusing individual is a caretaker of the abused individual. Learning about your own state laws can really help inform your practice about reporting.

 Next, the QFP and the MTC recommends to ask about alcohol, other drug, as well as tobacco use as I’ll show you on the next slide. Noting that there’s a substantial; overlap between drug use and negative sexual and reproductive health outcomes along with problems with sexual function as I mentioned earlier. As well as tobacco use and it’s in preconception health and potential infertility.

 The MTC document also provides example evidence based screening tools to screen for these areas, including the craft for alcohol and drug use in adolescents and the 5 A’s approach for tobacco use. Next it’s recommended to ask about the receipt of sexual reproductive health related immunizations such human papillomavirus HPV, hepatitis B virus HBV and hepatitis A virus HAV. The HPV vaccine is recommended for all males aged 11 to 26 with the minimum age to start at age 9. The guidance focuses on starting around age 11 to 12. With catch up between ages 13 to 21 for individuals who have not been previously vaccinated.

 There is a permissive vaccine recommendation for males aged 22 to 26. Actually a specific straight forward recommendation for vaccinating individuals at risk or increased risk groups including young men who have sex with men MSM or individuals who are immune-comprised. Hepatitis B vaccine is recommended for males aged under 19 and all adults who are at increased risk as defined on this slide. Hepatitis A vaccine is recommended for persons at risk as defined on this slide.

 Lastly from the history components, it’s recommended to ask about depression and here to note the substantial overlap of depression risk with certain populations including sexual minority. As part of the depression screening guidance it’s also recommended to ask about suicide risk among individuals who are at increased risk or who are demonstrating symptoms of depression. Regarding the physical exam components it’s recommended to measure height, weight and calculate BMI as least annually and refer individuals who are at increased risk over obesity for appropriate interventions. To check blood pressure at least annually among adults as well as adolescents.

 To conduct an external genital exam among adolescents to document normal growth and development using sexual maturity ratings for hair and testicles as well as to examine for other common normal findings, such as hydrocele, varicocele and signs of STD. This part of the exam is also recommended among adults for individuals who have concerns related to infertility. Regarding laboratory tests Chlamydia screening is recommended using urine based non-nucleic acid amplification tests also called NAATs for all at risk males under 25 years old as defined on this slide and or in prevalence of high problems communities.

 To re-screen males who test positive for Chlamydia for re-infection at three months. Gonorrhea screening is recommended for at risk males and using the same NAAT approach. Very often this test is linked with Chlamydia so it’s sometimes challenging to de-link the test, because the cost might be the same. Here too, re-screening males for re-infection at three months is recommended. More frequent screening may be indicated for males who are having sex with other men or who have multiple or anonymous sex partners.

 The CDC also recommends for young men who have sex with men who had sex in the last year or two screen at least annually all sights of exposure. Using the urine test for men reporting insertive sex, the rectal swab for men reporting receptive anal sex and pharyngeal swab for men reporting receipt of oral sex.

 Syphilis screening is recommended for at risk males using the RPR or VDRL and at risk is defined on this slide. Some labs are actually using different screening strategies and starting with the ELISA or EIA treponema screening test, rather than the non-treponema RPR or VDRL. You could be familiar with the screening approach your lab is taking and tests that they’re using.

 Each of these screening is recommended for all persons aged 13 to 65 at least once with repeat annual testing based on risk as defined on this slide. Here two test types are available, the rapid test and the serology test. Rapid tests still are just third generation tests, but serology tests are available as third and fourth generation tests. As part of the recommendations it’s recommended by the CDC to provide opt-out screening approaches to notify that the test is performed as part of general medical consent, unless that patient declines. Regarding the test type the study show that adolescents prefer rapid test and that this test approach helps ensure 100% of clients receive the results.

 Hepatitis C screening is recommended for all persons born between 1945 and ’65. Then finally, diabetes screening is recommended for asymptomatic adults who have sustained blood pressure greater than 135 over 80 regardless of being on treatment or not. The QFP and MTC guidance on laboratory testing and screening focuses on screening tests. For individuals who test positive for an STD or who are presenting with signs or symptoms about an STD and need a diagnostic test, please refer to the CDC, STD treatment and HIV prevention and treatment guidelines for any additional diagnostic test information as well as for treatment information.

 Moving on to key counseling components. The MTC recommends counseling and condoms and providing opportunities for demonstration and practice. The MTC guidance document highlights the teaching steps for putting on and removing a condom as well as other teachable points to include as part of this skills based counseling. As well as what a partner should discuss for optimal use. The bottom line is that condoms come in multiple type, sizes and thicknesses and clinical settings should make a wide variety of condoms available for patients and allow them to choose the types of condoms that they want to use.

 In our clinical setting for example, we’ve developed our condom closet and a cart given how our setting is set up to walk patients or bring to patients so that they can choose the types of condoms that they’re interested in. We’ve been able to for a low cost, not much cost, get at least 10 to 15 different manufacturers and more than 20 to 25 different types of condoms inclusive of lubrication and dental dams and female condoms so that all patients inclusive of males have a wide variety of options available for them.

 If you’re not already aware at least in the US as a clinician you can write a prescription for condoms for some insurances and specifically Medicaid across the nation. The QFP also recommends counseling and STD HIV risk reduction as well as counseling about access to HIV pre-exposure prophylaxis and post-exposure prophylaxis as appropriate. An example of how STD/HIV risk reduction looks like is two separate 20 minute clinical sessions one week apart, where the first sessions focuses on assessing a patient’s personal risk, barriers to risk reduction and identification of a small risk reduction step within one week.

 The second session focuses on the prior week’s behavioral change, successes and barriers. Providing support for changes made. Identifying other barriers and facilitators to change and developing a longer term plan for risk reduction. The QFP recommends counseling for pregnancy prevention and that this should include counseling about male methods as well as female methods, inclusive of emergency contraception to male patients. Unfortunately not all states allow clinicians to provide emergency contraception in advance to a male patient to use with his partner, but some states do. For those of us who are not able to do that, we can at least educate our male patients about how EC works and it’s availability, since they may know best if a condom has slipped or broken.

 The QFP also provides extensive guidance and how to provide patient centered contraceptive services and highlights as part of this to address the 4 C’s. Choice, correct use, consistent use, continued use or switching. To discuss effectiveness. To ensure understanding of side effects and use the teach back method approach. To involve the partner in the plan and plan for a follow-up. It also promotes the use of dual protection that is use of an effective method to prevent against pregnancy, plus a condom to prevent against infection.

 The MTC recommends counseling on sexuality in relationships especially for male adolescents. This includes providing support to males who can be dealing with issues of sexuality that can affect their psychosocial and physical health. As well as providing support to adolescents in general and how to have healthy relationships. The MTC document provides example tools to use for each. The MTC also recommends counseling males who are experiencing problems with sexual function and sometimes these are manageable on our own. Sometimes we might need to refer to a multi-disciplinary team if it is more complex.

 If you’re not already aware Montorsi and colleagues published algorithms and guidance on how to best evaluate and treat sexual dysfunction. The QFP recommends counseling males about preconception health as I discussed previously and finally recommends counseling males about infertility, especially those who have concerns. Recommendations for workup for a male who has concerns as follows; for a couple who is attempting to conceive should have an evaluation for infertility if pregnancy fails to occur within one year of regular unprotected sex.

 An evaluation should be conducted before one year if the male infertility risk factors such as history of bilateral cryptorchidism are known to be present. Female infertility risk factors such as advanced female age or suspected or the couple questions the male partner’s fertility potential.

 With my final minutes I would like to walk you through ways in which you can think about bringing this guidance together in your clinical practice. This first scenario is a 15 year old who is at your clinic for a routine physical. He states because you’ve asked, he does not intend to have children in the next 12 months, but that he has a sexual partner. What clinical preventive, sexual reproductive health services do you want to provide him?

 This table presents one way to think about how to organize or bundle services for this patient. Under contraception you should be taking a comprehensive sex history and provide appropriate contraceptive counseling. Under STD services, conducted genital exam, screen for STDs as per recommendations and provide counseling on STD/HIV risk reduction. Given he’s here for a routine physical under related preventive health services, address additional history components and appropriate counseling and sexuality in relationships and or sexual dysfunction.

 What about if the same 15 year old came in for an acute visit, what types of clinical preventive services could you think about providing to him that day? One way of thinking about this is what might take minimal clinician time such as conducting the same day STD/HIV screening. Have them make a follow-up appointment to address his sexual and reproductive health more fully as described on the prior slide.

 The second scenario is a 25 year old who presents to your clinic for a work physical and he shares that he and his partner are planning to start a family in the next year. For this patient you could focus on his preconception health needs and also ensure his partner is connected to preconception care. You may also need to provide STD services depending on his risk factors after conducting a complete sexual health history as well as any other relevant preventive health services for him.

 Then this final third scenario is a 21 year old who presents with concerns about STD contact and symptoms but states he’s unclear about his reproductive life plan. For this patient besides addressing his actual STD symptoms and need for treatment because of his contact, you might need to address other relevant STD/HIV screening needs and provide him with relevant services that best address his ambivalence related to his reproductive life plan. That might include a combination of contraception, family planning services as well as preconception health services.

 In summary, I hope you have a better understanding that males have substantial sexual reproductive health needs as well as understand how the QFP and MTC used in evidence informed approach to make recommendations for the delivery of clinical preventive sexual reproductive healthcare to males. One of the strings of this guidance is its integrated approach for men’s health that addresses adolescent development, mental health, drug use, relationships and sexuality.

 During the process we identified a number of gaps in the clinical guidance on male sexual reproductive health as well as the dearth of research in the domain of men’s sexual reproductive healthcare to inform evidence based recommendations. Although recommendations and some of the areas by an expert panel may be on the lower end of the evidence ladder, they can have merit and be useful in context when high quality evidence is lacking. The procedures used to develop them are explicit and transparent.

 With these limitations in mind, this guidance either QFP and MTC defines, though for the first time of course, sexual reproductive healthcare services to deliver to males. We hope that it can help you organize and bundle sexual reproductive health services for your male patients as well as service a foundation for standards of sexual reproductive healthcare to deliver to males in the US and support you to do this effectively and efficiently. I’d like to thank my colleagues at the Male Training Center, at the office of population affairs and the CDC for all of their time and assistance on this project as well as all of our members of men’s health technical panel.

 This final slide just shows again some of the websites and PDF links for the guidelines I discussed during this talk today.

Speaker 1: Great. Thank you Dr. Marcell. At this time we’d like to take some questions from our participants. Just a reminder, please submit your questions in the Q&A window on the right side of your screen. You may need to click the triangle next to Q&A to open the window. Our first question says; I’m at pediatric adolescent HIV or primary care office. We do routine triple site STI screening and have found a lot of positives versus just checking urine. Our other providers doing triple site testing, we are also seeing an increasing in [inaudible 00:42:22] in younger … I think it gets cutoff. Sorry.

 Dr. Marcell?

Dr. Marcell: You don’t have the cutoff part?

Speaker 1: The question is around …

Dr. Marcell: Routine triple site testing. As I walk through for the laboratory screening section for individuals that are reporting engagement in sex and different sites routine screening, which they’re describing triple sites screening of [inaudible 00:43:06] anus and urine is recommended and should be the standard. We’re hoping that promoting it as part of a larger picture as opposed to these individual recommendations that sometimes get lost will help people see the bigger picture of services to provide to male.

Speaker 1: Thank you. Another question. Also how are the guidelines incorporating MSM and LGTB use? Finally, diabetes based on BP and not BMI.

Dr. Marcell: The first question is guidelines incorporating LGBT and MSM?

Speaker 1: Yeah.

Dr. Marcell: The Male Training Center guidance as I mentioned has a broader scope to think about sexual reproductive health services broadly. It doesn’t specifically single out LGBT populations versus other populations. It’s really talking about holistically an individual who is either a biological male or identified as male of how to provide relevant services to them. That’s for the first part of the question. Then the second one about diabetes screening.

Speaker 1: Yeah, diabetes based on blood pressure not BMI.

Dr. Marcell: The guidance by the USPSTF actually focuses on diabetes screening based on blood pressure and not BMI. Maybe I’m not clear about what the actual question is.

Speaker 1: I think it was just following that questions about guidelines incorporating, previous. I think it was just a move on there. The person that answered that question could clarify, that would be great and we can come back to it. What are some ways to incorporate these guidelines more fully into a primary care clinic, how do support providers?

Dr. Marcell: That’s a great question and I think it’s not the intention of the guidance per se to think about everything that you have to so at one visit, that these are hopefully opportunities to health educate our male patients about all of the different domains around sexual reproductive healthcare. The services that are recommended depending on their age or risk category and really think about how to prioritize, what services to deliver at initial visit and potentially at subsequent visits. To really think about it as a clinical hook for service delivery or to bundle at this part of maybe a sexual health visit.

Speaker 1: Thank you. Our next question; we see very few males coming in for services in our Title X family planning clinics. How can we better engage them to seek our services?

Dr. Marcell: That’s a great question and I know Sue can also speak to this a little bit. There’s a number of research initiatives at the office of population affairs have funded that have resulted in great evaluation work, that initially has shown, use your existing female clients to outreach to their partners and males in their lives. Help educate them about these individuals sexual reproductive health needs and why it’s important to address them. That’s really a great in-reach approach and maybe Sue can speak to some of the other types of evaluation work that’s been done and some of the other effective methods to engage.

Sue: This is Sue. The last round of male research projects that we funded through the population affairs involved three pronged approach that involved changing the environment within the service [sites 00:48:41] themselves as well as training all staff, not just clinical staff but all staff to help it be a more welcoming environment. Also doing outreach and clinic promotion and clinical services where folks actually knew what services should be provided. In many of the cases it really did result in … They did significant outreach within the community to make sure that the community was aware that there were services being provided.

 I would say that without some efforts like that folks probably aren’t just going to walk in and ask for services. If its consorted effort made it really did show that it can make a significant improvement. In fact in many of the cases it not only increased the number of males and the proportion of males but also the number of females that were receiving services also increased. The efficiency of those service sites increased. It actually had some very positive results and David may want to talk too, a little bit about male community practice that’s available on the FPNTC website that actually folks could join.

 I think some of those strategies that might help with being able to engage more males and services within your service life. That particular activity I think could be helpful to you if you’re interested.

David: Sure. I think also before we end, Cardea who’s helping sponsor this webinar will actually have some information about to join that. As Sue said and Arik alluded to as well, one of the most important parts of being able to attract males, first of all is actually letting them that actually they can attend these clinics. Often the typical family planning clinic also has a female related name to it, either women’s health center or pregnancy counseling center. Something related to that and it helps them to know that the services provided there are appropriate for them as well.

 Then again, it goes back to understanding who your clients are, understand who the population and community are. You all know your clients better than anyone. However it’s also important to know what your clinicians themselves also, what are their views and what are their attitudes towards all of the clients that they have? What are the misunderstandings that they may have? One of the questions that came up was with regards to macho attitude, that’s also trying to understand maybe what are the attitudes and why do they come across as being macho.

 Often what we found in the preliminary research and even through some of the evaluation, the macho attitude actually went down very quickly after the understanding was there that the clinicians that you all out there are there to help. You actually have information and services that are really directed at providing these services to the men that come in.

Speaker 1: Thanks David. Can you talk more about why teaching about self testicular exam is no longer recommended?

Dr. Marcell: Yes, absolutely. The USPSTF back I think in 2004 reviewed the evidence for screening for testicular cancer, both using teaching about it as a tool and conducting the physical actual exam by clinicians as a screening tool. They recommended against routine screening for testicular cancer in asymptomatic males as a de-recommendation. They just didn’t see any evidence that it was effective in reducing mortality from testicular cancer. That in screening absence the current treatments provided are favorable health outcomes. They’ve updated the guidance and the review again. I think it was 2011.

 Still reaffirmed this de-recommendation, low prevalence of testicular cancer, limited accuracy of screening test and no evidence for incremental benefits of screening. Some of their past discussions about this is a note that clinicians should be aware that patients who present with symptoms of testicular cancer are frequently misdiagnosed initially as having epididymitis, testicular trauma or hydrocele or other benign disorders. Despite the reading that harms actually outweigh the benefit and part of the harms is increased cost with un-needed ultrasounds, other radiology tests.

 There’s been no specific study that has truly assessed that those harms are associated with screening. That is based on the systematic reviews by the USPSTF that it’s a de-recommendation against screening, with the caveats as clinicians that if somebody is coming in with a symptom to ensure that it’s part of your differential diagnosis so that it’s not misdiagnosed initially.

 Our guidance really focuses on the importance of conducting an external general exam for a host of other types of issues. Ranging especially among adolescents from documenting and progress and development, screening for visuals, STI symptoms, for other normal and abnormal abnormality that might have gone undiagnosed until adolescence or he picked up until somebody should start puberty.

Speaker 1: Were you finished?

Dr. Marcell: Yeah, I’m finished.

Speaker 1: Thanks. Our next question. Does the guidance address the sexual and reproductive health disparities that are seen in communities of color?

Dr. Marcell: We’re hoping that this guidance will help close the disparities in healthcare we see across all population of men and help the clinical community understand the importance of addressing sexual reproductive healthcare for male adolescents, young adults and adults, which right now has received very limited attention.

Speaker 1: Thank you. I know the outreach has been addressed in some of the other questions, but there is another question about it. Any suggestions for community outreach to males? Dr. Marcell.

Dr. Marcell: I’m happy to defer to David and Sue but I guess I’ll answer this from the perspective of the clinician audience. I think clinicians we can do a better job and hopefully this guidance can help support you packaging materials that are culturally and population sensitive to the populations that you work with. To share what is sexual reproductive health for males across the life span and pertinent to the populations you work with. If it’s younger populations like adolescents to help parents understand why males through adolescence still have needs to see the doctor. We know that healthcare use declines from adolescence into adulthood for males.

 There are still important reasons for males to stay connected with the healthcare system and specific services that are highly effective described by the guidance to deliver to them. Likewise in adulthood, even outside of family planning settings, to use it as opportunity to talk with your female patients, to help share it with their husbands, likewise their children or adolescents, young adults. That we can really help educate everybody about what it means to appropriately deliver sexual reproductive healthcare to males.

Speaker 1: Thank you. Our next question. Is there grant money that set up these services for males?

Dr. Marcell: Many of these services should be already covered under standard health insurance plan. Depending on where you work and if you are able to provide maybe a little bit more detail about your type of work setting, if it’s a free clinic or a community clinic, that’s not an FQHC, etcetera, I can provide a little bit more specific feedback. The majority of these services should be covered under individual’s health insurance plan if not all of them.

Sue: If we could just add to that from OPA. What Arik said is absolutely correct. The other piece of this is that, for a number of years within the Title X program we did award some supplemental funds for helping folks to get started with incorporating males to a greater degree than what they were doing. At this point it’s an expectation that all Title X service sites, and I can’t speak to outside of the Title X system, but at least within the Title X system, there aren’t additional grant money that will be given to anybody. It is an expectation that any place that’s serving females is also making services available to males on the same basis.

 Meaning that if they’re low income males that services have to be provided on a sliding fee schedule for males that are seeking services. There are considerable resources now to help you with knowing what those services should include where in the past that has been gaps. Our resources and there’s the training centers and folks that can help with providing technical assistance. There are not additional grant money for that purpose within Title X.

Speaker 1: Thank you. Our next question. What do you think can be done to demonstrate to men who often do not seek services that they should have a healthcare checkup?

Dr. Marcell: This is a huge cornerstone of the type of research that I do. I think the first place to start is really address their knowledge. Here in Baltimore where I work and I focus predominantly my work in research with adolescents and young adults, most just don’t know where to go. They don’t know what’s available to them. Like Sue mentioned earlier, they don’t know their clinics, maybe because of their name or maybe related to stigma are places … Because of their name are places that they can go to, to get confidential services or low cost services if they’re uninsured. Because of stigma there may be places that they don’t feel comfortable walking in to, like an STD clinic because of what that might mean if they’re seen by others in their community.

 Likewise they may not know of other clinical settings that they can go to get appropriate sexual reproductive health related care. I think starting with knowledge is critical on intervention study that we conducted here in Baltimore, was one hour sessions, three days in a row. It was a replication of a study that some colleagues of mine conducted in New York City here in Baltimore that we adjusted to be culturally relevant to the population. Here we were really surprised that knowledge was such a major influence.

 Knowledge changed drastically in the intervention compared to the controlled group and influenced care receipt in ways that typically as researchers you need to change attitude or self efficacy around behaviors and not knowledge. That knowledge is typically assumed to be there and that there’s no need to make substantial changes across our control and intervention groups. Less than 20% knew about any settings to go for a confidential services or sexual reproductive health services and that increased to greater than 85% in our intervention group compared to staying the same in the control from baseline.

 I think knowledge is power and you’ve got to make it known that the services are available, that you are available to provide those services and work on creating structural changes within your clinical settings to ensure that your setting is male friendly. Then I think you’ll be surprised to see how much that can help shift the whole system. I think as I mentioned at the beginning of our talk, much of our systems are set up to not socialize male in healthcare seeking and or sexual reproductive healthcare in particular.

 We really have to work at the middle level, at the [inaudible 01:04:25] level to help shift that and working with individuals themselves, but potentially others in their lives like parents and wives and partners to really help make that shift is critical.

Speaker 1: Thank you. Next question. Are test other than VDRL or RPR, which were mentioned, recommended for syphilis?

Dr. Marcell: As I mentioned typically RPR/VDRL has been the standard first line, but some labs are using the EIA treponema test as a first line. I don’t think it’s a universal recommendation to change RPR as a screening test. I think if you’re not aware, if your lab has a particular screening protocol that they actually when you send a test might be doing the EIA treponema test. I would recommend talking with your co-lab or the labs that you work with to find out what is their approach so that you can be in line with what they’re using and order it correctly if there needs to be a change. Sometimes it’s sufficient to order the RPR and behind the scenes they use the two tier screening approach that’s inclusive of the EIA treponema test.

Speaker 1: Thank you. We have another question. Are any changes anticipated any time soon in the evidence behind any of the recommendations? In other words, are there any specific recommendations where the evidence is lacking or laid, which might shift greater research?

Dr. Marcell: That’s a great question. The USPSTF, the United States Preventive Services Task Force as I mentioned in May made an update to hepatitis B which prior to that was non-conclusive recommendation. They actually found sufficient evidence to recommend hepatitis B screening for individuals, for adolescents and young adults as I described in my talk who are at risk, but not among individuals who are low risk. They reaffirmed guidance counseling for STD/HIV behavior change just in the past couple of days and I think in the last week that was just published.

 They also reaffirmed the insufficient evidence at the USPSTF level for screening for Chlamydia and gonorrhea for males. Both the QFP and the MTC guidance is using CDC recommendations as first tier and are recommending screening males under the age of 25 who are at risk for Chlamydia and gonorrhea. I’m not aware of any other core pending areas, for example in some of the domains that the MTC made recommendations about, because so far I’m not aware of any reviews by the US Preventive Services Task Force to fill in guidance in some of those areas. I’m not aware of that. Any of those are topics that are actually being reviewed.

 There’s always the opportunity if you’re interested or maybe this can help to stimulate systematic review in some of these areas that could help further provide support or potentially make a change of what our expert panelists helped us provide guidance on in some of these areas that they deemed to be critical for considering as part of a broader framework of sexual reproductive healthcare for males.

Speaker 1: Thank you so much. Looks like all the questions have been answered we’ve received. I just want to check in with the panelists. We’ll give another chance for participants to send in any last questions. I also want to check with our panelists to see if they have any closing comments or remarks before we continue.

Dr. Marcell: Well, I’m just grateful to have the opportunity to share with you a report, like I said I hope that it helps to continue to stimulate this discussion and provide a broader framework and guidance to improving the quality of services to deliver to our male patients in the domain of sexual reproductive healthcare.

Speaker 1: Thank you so much. I just wanted to remind participants too that we have a webinar coming up also "Caring for Adolescent and Young Adult Males Tools for Clinicians", on Thursday October 16th, 3 to 4 PM eastern n the webinar they’ll talk more about our communities and practice. You can register for that webinar by going to the NTC website. Then I also want to remind folks that the report preventive male sexual and reproductive healthcare recommendations for clinical practice is available for download at the Male Training Center website.