

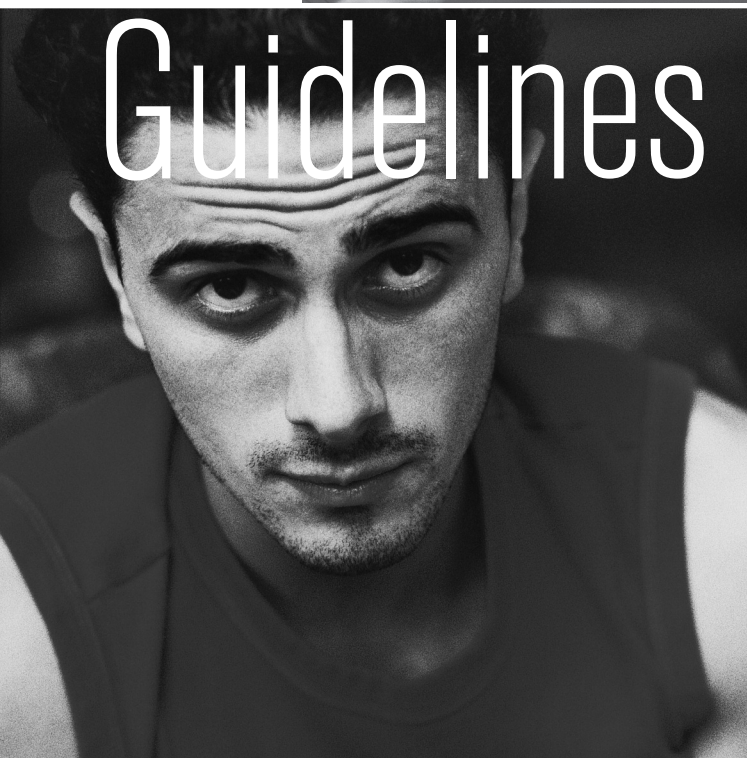
**MAC**

*Region II Male Involvement  
Advisory Committee*



Guidelines

for Male  
Sexual and  
Reproductive  
Health

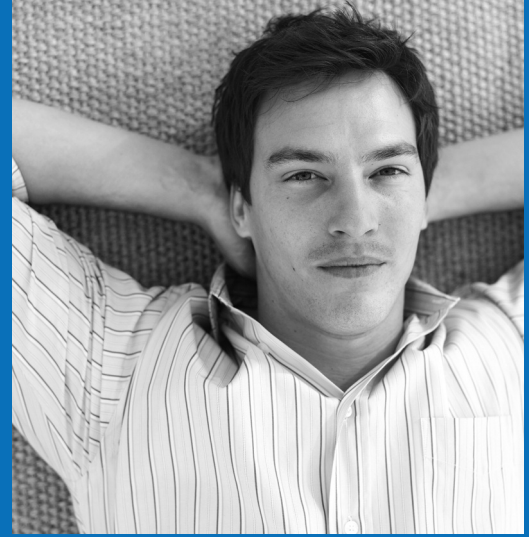


Services

2009 Edition



**A Tool for Family Planning Providers**



# Guidelines

“Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.”

(Sackett et al (1996, 71-72)).

This update to the **Male Guidelines for Sexual and Reproductive Health Services** includes current information on:

- Cancer Screening (Prostate, Testicular, Colorectal)

- HIV Education and Counseling and Testing

- Circumcision

- Self-Testicular Examination

# for Male Sexual and Reproductive Health Services



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## PREFACE

The Region II Male Involvement Advisory Committee (Region II MAC) was established in 1999 to serve as a forum for the exchange of information and discussion of issues related to males and male services in Title X funded programs in Region II. Under the guidance and leadership of the late Lucille Katz (Region II Regional Program Consultant for Family Planning) the Region II MAC brought together interested parties to address male involvement issues in the Region II Title X Family Planning Program. It was intended that the committee would use its findings to advise and make recommendations to the Region II DHHS Office of Family Planning. The membership of the committee was selected from:

- Public Health Service, Region II Office of Family Planning staff
- Individuals who were professionally associated with a Region II Title X grantee who had knowledge and or experience in issues related to male family planning services and a demonstrated interest in the goals and objectives of the Region II MAC
- Region II Title X Training Center grantee staff

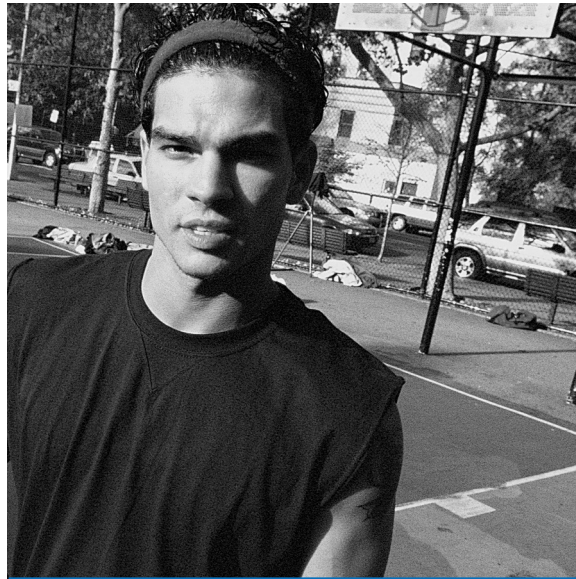
The committee's first task was to undertake a review of the status and availability of reproductive health services for males in the region. The committee found that male sexual health is largely misunderstood, and agencies were challenged to make it an integral component of the family planning service delivery system. Primary care providers rarely include inquiries about sexual health and few offer reproductive health services beyond a limited investigation for sexually transmitted infections. Furthermore, males rarely seek care for sexual health, and those who do usually find providers who are unfamiliar with the wide variety of issues that interfere with sexual performance or are related to sexual behaviors. However, it was clear that males have sexual and reproductive health needs and issues that not only affect their health and well being but also the health and well being of their sexual partners and their families. After reviewing the availability and status of male reproductive health services in Region II, the committee decided that providers in the region needed some guidance to define the scope of reproductive health services needed for males and to set standards for these services. These guidelines represent the first effort of this kind to bring together a wide range of prevention, health education and treatment issues related to male sexual and reproductive health.

The document you have before you is intended to be a resource that can be used in the development of clinical services for male clients. The guidelines are divided into three sections, which reflect the flow of services that should be provided in the typical clinical encounter. The first function is screening, during which the clinician collects information that not only defines the reason for the immediate clinical visit, but also identifies a list of other services needed by the male client. The Health Promotion/Education & Counseling section lists the range of educational and counseling services that should be presented, as appropriate, to all clients to achieve prevention of adverse outcomes related to sexual activity. Finally, the clinical diagnosis and treatment section identifies a number of common morbidities and discusses the best treatments.

Each of the items includes a statement of the “best practice” followed by a statement of the evidence or rationale that supports the best practice and finishes with suggestions for methods to implement the recommendation. These guidelines are intended to be comprehensive and to include all services that could be provided in the family planning clinical setting. However, the committee was acutely aware that it might not be possible to include these services in all family planning agencies. The committee recommends that the guide be used as a tool by an agency to develop an organizing structure, outlining the male services to be included in their program.

**Susan Moskosky, MS, RNC**

*Director, Office of Family Planning, Office of Population Affairs*



## ADVISORY COMMITTEE

# MALE REPRODUCTIVE AND SEXUAL HEALTH CLINICAL SERVICE GUIDELINES

### Male reproductive health services should include the following components

- **Screening:** Obtain a medical profile of every client. The profile should include; past medical history, history of present illness, family history, review of health behaviors, and so forth. Perform routine physical exam.
- **Health Promotion/Education & Counseling:** Evaluate client's risk and behaviors, give prevention educational information and discuss options with clients.
- **Clinical Diagnosis and Treatment:** Provide services as identified through screening.



# I. SCREENING

## ***Sexual and Reproductive History***

### **Pubertal Development**

#### **Best Practice**

Every adolescent male should be asked about his pubertal development, ideally covering different points in time corresponding to early, middle and late adolescence. Males should be asked about any concerns they may have about both the timing and rate of maturation. Additionally, specific issues relating to gynecomastia, height, facial/body hair and size of genitalia should be addressed.

#### **Rationale**

Youth initiate the pubertal process at different times than their peers or may progress at different rates. This may cause anxiety and worry. Also, they may be concerned that the appearance of breast tissue may represent a feminizing process, rather than a normal and often transient developmental occurrence. Elucidation of concerns, careful evaluation and appropriate counseling can be beneficial.

#### **Implementation**

Questions about pubertal development can be incorporated into a standardized questionnaire. Additionally, queries can be broached during the course of the physical examination.

### **Sexual Experience and Behavior**

#### **Best Practice**

All males should be routinely asked about their own sexual experiences.

The inquiries should include the following issues:

- continuation or reinstatement of abstinence
- age of initiation into sexual activity
- frequency of sexual activity
- partner number and selection
- sexual behaviors
- contraception
- use of prophylaxis against STI's
- sexual performance and dysfunction

#### **Rationale**

Males may be somewhat reticent volunteering information about sexual experiences, despite harboring fears and concerns. However, if the topic is broached in a confidential, nonjudgmental manner, they will frequently be relieved at having an opportunity to disclose concerns and trepidations. They are often receptive to obtaining information for themselves and their partners. Informed males can significantly contribute to facilitating their female partners' access to and use of contraceptive methods.

#### **Implementation**

In the waiting room, health educators can review basic topics that will be covered during the health visit. This "preview of coming attractions" may desensitize young men and prepare them for answering questions during the evaluation. A standardized self-administered questionnaire can also be used.

Every adolescent  
male should  
be asked about  
his pubertal  
development

## Pregnancy History

### Best Practice

All males should be asked if they have ever made a woman pregnant. If they have, they should be asked if the pregnancies were planned, what the outcomes were, what their feelings towards the outcomes are, and if they have intentions for more children.

### Rationale

Men have many feelings when a pregnancy occurs, and they are increasingly expected by society to be responsible for the children they father. Asking about involvement in pregnancy and parenting creates opportunities for men to express positive, negative, or ambivalent feelings about pregnancy outcomes. Asking about pregnancy also creates opportunities for men to become involved in planning future pregnancies. They may decide to use contraception if a pregnancy is not intended or have access to emergency contraception. Asking about pregnancy creates opportunities to identify reproductive health issues for which referrals might be needed. These issues include infertility evaluation, legal services, support services for fathers, paternity testing, HIV testing, and testing and treatment of STIs.

### Implementation

Questions about pregnancy can be included on a self-administered patient questionnaire. Providers should also include questions about pregnancy as part of a comprehensive sexual and reproductive health history.



## Sexual Behavior of Men Who Have Sex with Men

### Best Practice

All males should be questioned about their sexual history and orientation during a comprehensive sexual and reproductive health history. Males should be interviewed in a manner that is accepting and normalizing of the full spectrum of sexual orientation and behavior. Males who identify as homosexual, bisexual, transgender, or “questioning,” should be asked about feelings of social acceptance or isolation. This especially applies to adolescent and young adult males who are in the process of “coming out.”

### Rationale

Sexual orientation is a part of the self-concept and has obvious implications for sexual experiences and behaviors. It refers to whether a person finds his primary emotional and sexual desire and fulfillment with members of the opposite sex, the same sex, or both. Unfortunately, homophobia and discriminatory practices still exist in American society. In some social settings men who identify as gay are able to openly express their sexuality; in others, fear of societal disapproval inhibits expression. Married men for example, may keep secret any extramarital sex with other men out of fear of social disapproval; others, such as recently incarcerated men, may have sex or have had sexual experiences with men while not self-identifying as homosexual. Obtaining an accurate history in a manner that normalizes same-sex sexual activity serves several purposes:

- Men feel accepted by their provider, regardless of their sexual orientation.
- Men who feel isolated or discriminated against because of their sexual orientation can be referred to appropriate support services.
- Appropriate screening tests, such as pharyngeal or rectal cultures, can be more accurately determined.

## Implementation

Self-administered instruments which include questions about sexual orientation may yield unreliable responses if administered before trust is established with a provider. If a self-administered instrument is used, the provider should still review responses with each patient. Questions about sexual orientation should be asked as part of the comprehensive sexual and reproductive health history during the initial medical exam. For example, “Have your sexual partners been female, male, or both?” Information about how to access services at GLBT community centers and health facilities should be available.

## Sexuality

### *Communications about Sexuality*

#### Best Practice

Each male should be asked about the frequency and nature of communication with sexual partners or persons with whom they have a close sexual relationship regarding reproductive health issues.

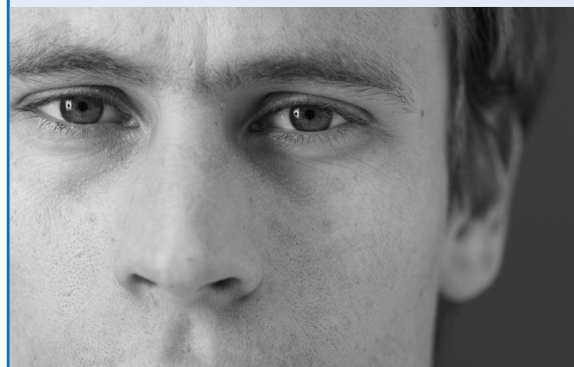
#### Rationale

Males demonstrate their involvement in sexual and reproductive health in many ways, including communicating with sexual partners. Talking about sexual issues requires complex skills that need to be taught and practiced. Unfortunately, interpersonal communication skills that enrich intimate relationships are not routinely or adequately taught in most schools. Providers can create brief teachable moments when communication skills are practiced. These interventions can increase men’s ability to communicate, to give and receive feedback, and be self-effacing during intimate situations.

#### Implementation

Questions that assess the level of interpersonal communications with sexual partners can be directly or indirectly asked on a self-administered form and explored more thoroughly during the exam, e.g., Have you and your current partner talked about using contraception? (direct). What method of contraception does your sexual partner use? (indirect). Providers should ask the following types of questions, tailoring their approach to the individual’s age, developmental level, and sexual experience: Do you talk with your partner about the need for and choice of contraceptive method and/or condoms? Do you and your partner communicate with each other about your sexual histories? How are preferences and differences regarding sexual activity negotiated? How do you and your partner decide how often to have sex or to express preferred forms of pleasuring? Providers can engage clients in brief role playing activities to assess skill level, and then teach and rehearse communication skills as needed; What could you say to your partner if you want to use a condom but they object? Let’s take a minute to talk about and practice other ways you might let them know what you want. Pamphlets about communication skills help introduce new ideas. They are most effective if reviewed with the provider. Waiting room group education can introduce new skills and normalize partner communication, making it a behavior practiced by other men. Here is one thing to say; “Many men have difficulty communicating with partners about condoms, but most can benefit from talking about these challenges together.” Interpersonal skills can also be developed through referral to individual and couple’s counseling.

**Sexual orientation is a part of the self-concept and has obvious implications for sexual experiences and behaviors**



## History of Hepatitis B and Hepatitis A Immunizations

### Best Practice

All adolescent and adult males should be asked about exposure to Hepatitis A and B, and/or receipt of vaccination. Depending on responses and risks, Hepatitis A and B vaccinations should be administered.

### Rationale

Significant morbidity can be attributed to viral hepatitis infections, particularly with respect to Hepatitis B. Individuals with Hepatitis B can also suffer from chronic liver disease, liver failure and possible death. Vaccines are available which can significantly reduce the prevalence of new infections. Hepatitis A and B vaccinations are required for all infants and children. Hepatitis B is required for all adolescents. Hepatitis A vaccines are recommended for males who have sex with males.

### Implementation

Ideally, vaccinations should be administered during early childhood as part of routine immunization series. If that opportunity has been missed, then attempts should be made to administer the vaccines to susceptible adolescents and adults during routine health evaluations. This may be achieved in your facility or by referral to community centers that provide free or low cost immunizations.

## Contraception and Prophylaxis

### Best Practice

All sexually active males should be asked about their knowledge of contraceptive methods in general, and specifically their own and their partner's contraceptive utilization. In the event that they have questions or concerns about contraceptive methods, males should be educated. If their partners are not using anything, males should encourage their partners to make a clinic appointment. In the interim, condom use should be encouraged with emergency contraception available as a back-up measure.

### Rationale

Males can be supporters or saboteurs in the contraceptive decision-making process. Additionally, an involved and informed male can facilitate access into reproductive health care for females.

### Implementation

Questionnaire or direct questioning.

## Sexually Transmitted Infection History

### Best Practice

All sexually active males should be asked about a past history of STIs. Additionally, they should be asked about symptoms of STIs. Many males may have had symptoms but refrain from seeking care due to fear, embarrassment, or transience of symptoms. Even if responses are negative, screening should be encouraged since many STIs are asymptomatic.

### Rationale

The high prevalence of STIs, particularly among youth, demands an aggressive approach on the part of providers. The availability of painless urine-based screening tests for gonorrhea and chlamydia should facilitate screening.

### Implementation

Standardized questionnaire; direct questioning during evaluation.

## Sexual Dysfunctions

### Best Practice

All men should be routinely asked if they are experiencing sexual dysfunction. Issues to include are an inability to obtain and maintain an adequate erection for satisfactory sexual activity (impotence, erectile dysfunction [ED]), premature or delayed ejaculation, loss of libido, painful intercourse, and also priapism, a prolonged painful erection not associated with sexual desire.

### Rationale

Sexual dysfunctions are characterized by difficulties in sexual desire, as well as in the psychological and physiological changes that occur during the sexual response cycle. Sexual dysfunction is a common event among both men and women. Male sexual dysfunction can stem from a number of causes: organic or psychological relationship issues, use of prescribed or illicit drugs, or a combination of these factors. Because of its sensitive nature, most men are reluctant to initiate conversations about sexual dysfunction unless prompted. Providers can normalize that occurrences of having difficulty getting or maintaining an erection happen to most men, and usually do not suggest an underlying problem. However, recurring problems with sexual functioning should be assessed for underlying physical, emotional, or relationship problems that require treatment.

### Implementation

Questions about sexual dysfunction can be included in a self-administered questionnaire. Providers should also ask about sexual dysfunction as part of a comprehensive sexual and reproductive health history during the initial and annual medical exam. Because of its sensitive nature, providers need to approach the issue of sexual dysfunction in a direct, empathetic, and nonjudgmental manner. For example, a provider could say the following; “Many of my male patients have questions about sexual functioning. Have you experienced any difficulties having sex that you’d like to discuss with me?”

## Body Image Concerns

### Best Practice

During routine health evaluations all males should be asked about satisfaction with their body image.

### Rationale

Males may be concerned about their appearance and may engage in potentially harmful practices to modify how they look. For example, taking diet pills to lose weight, excessive weight lifting or taking performance enhancing drugs such as steroids to achieve a chiseled physique.

### Implementation

Questions about body image can be included in a self-administered questionnaire. Providers should also ask about body image as part of the comprehensive health history taken during initial and annual medical exams as well as psychosocial and mental health screenings.



Ask about  
sexual  
dysfunction  
as part of a  
comprehensive  
sexual and  
reproductive  
health history



## Family and Peer Relationships<sup>1</sup>

### Best Practice

All male clients should be asked general questions about family and peer relationships to identify any stressful and/or positive relationships that might be affecting his reproductive health status. In the case of an adolescent it is important to establish the extent to which parents, other family members and/or peers might be involved in the patient's sexual and reproductive health decision making; in the case of an adult, the extent of the client's support systems and ability to form and maintain satisfying relationships. If appropriate, health guidance may be given to spouse/partners or parents/guardians of adolescents to help them respond appropriately.

### Rationale

The status of family and peer support systems impacts one's mental health, which in turn impacts one's reproductive health. Relationship difficulties may be a sign of the need for additional support, or may result in behaviors that negatively affect the client's sexual and reproductive health.

### Implementation

Male clients may not volunteer information concerning their family and peer relationships. However, if asked by a trusted and skilled caregiver, they may welcome the opportunity to share such information. Questions about family and peer relationships could be incorporated into a general psychosocial/mental health screen questionnaire: (for adolescents) Who lives with you? How do you get along with your family/friends? Has anyone moved in or left recently? Do you have enough privacy? If information is ascertained through direct questioning, client receptivity will be dependent on the sensitivity and skill of the interviewer. Thus, staff training in psychosocial assessment should be provided.

## Parenting Skills

### Best Practice

All males should be asked if they are a parent or plan on becoming a parent.

### Rationale

It is important for parents, especially first time parents or parents with children whose development is delayed, or those with children at risk, to understand their child's health and psychosocial issues. Additionally, parents need to understand the treatments advised or prescribed so they will be able to respond appropriately to the health or psychosocial needs of their child.

### Implementation

Providers should initiate conversation with their clients about any questions or concerns they might have related to parenting. Depending on the issue, they can clarify whether it is common or uncommon, provide information on an appropriate treatment, or give a referral if applicable.

## Violence and Aggression<sup>1</sup>

### Best Practice

All males should be questioned about the presence of aggression or violence in their lives.

### Rationale

Young males in comparison to females are more likely to commit acts of violence. These violent behaviors can threaten the males' own health and well-being, as well as the health and well-being of others. They may also have long-term consequences. When examining and counseling patients, health providers have the opportunity to screen patients for signs of violence and abuse. They may also provide information and counseling about the dangers associated with firearms, alcohol and drugs, and the effects of family, peer and media violence. Health providers have an opportunity to identify and help troubled or abused patients who are at risk of becoming victims or perpetrators.



### **Implementation**

Health guidance for violence and aggression should include the following: education and counseling to avoid or reduce the use of alcohol and other substances which impair judgment and can lead to violence or aggression; education and counseling to address and resolve interpersonal conflicts without violence; and education and counseling to avoid the use of weapons. Providers should ask “have you ever” questions on the following topics: fighting; school violence; weapons carrying; gang membership; arrest; incarceration; bullying; and victimization.

## **Emotional, Physical and Sexual Abuse<sup>1,2</sup>**

### **Best Practice**

All males should be screened annually for a history of emotional, physical, and sexual abuse.

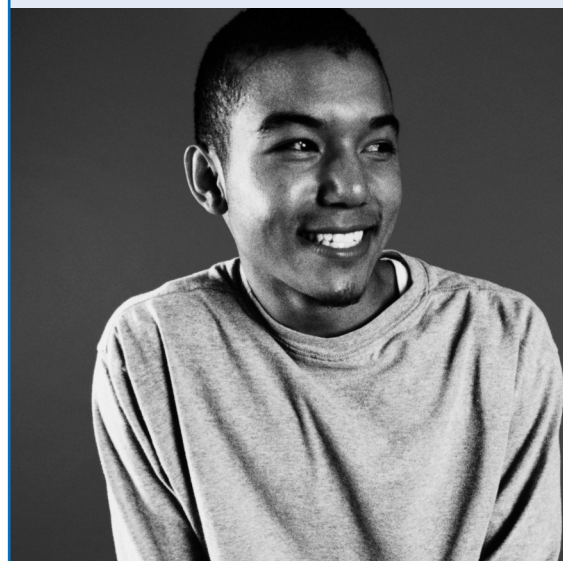
### **Rationale**

Adolescents victimized as children may experience a resurgence of fear and anger as prospects emerge for volitional sexual encounters. These emotions may interfere with the development of a normal sexual relationship. Teens who are ongoing victims of sexual abuse may present to the office or clinic with multiple STIs, as well as other problems. Adult male patients who were victimized as children may have a history of sexual dysfunction and/or abusive sexual relationships.

### **Implementation**

In recording a male patient’s sexual history, begin with general questions, gradually become more specific, then incorporate the following questions: Are you sexually active? Have you ever been sexually abused, raped, or engaged in any sexual activities against your will? In addition, inquire about age of first intercourse and number of current partners. Beginning intercourse at a very young age or a history of several partners should be red flags prompting closer inquiry into the patient’s psychosocial situation, including questions that explore the possibility of past or current abusive relationships. If abuse is suspected, the patient should be assessed to determine the circumstances around the abuse and the consequences, whether they are physical, emotional, and/or psychosocial. Health providers should be aware of state laws about the reporting of partner abuse or assault and issues regarding protecting the confidentiality of adolescent patients. Patients who report emotional or psychosocial sequelae should be referred to a mental health professional for evaluation and/or treatment. It is important to establish a sense of rapport and trust with the patient, especially with adolescents. Questions may be presented over several visits, allowing time to establish trust and credibility.

**Adult male patients who were victimized as children may have a history of sexual dysfunction and/or abusive sexual relationships**



## Depression<sup>3,4</sup>

### Best Practice

All patients should be screened for the presence of depression. Referral systems should be in place to assure accurate diagnosis, effective treatment and follow-up.

### Rationale

Depressive disorders can have far reaching effects on the functioning and adjustment of adults and adolescents. Depression disrupts the lives of the depressed persons and their families, and reduces economic productivity.<sup>3</sup>

An estimated six million men in the United States have a depressive disorder: major depression, dysthymia (chronic, less severe depression), or bipolar disorder (manic-depressive illness) every year.<sup>4</sup> Co-occurring mental and addictive disorders are common. In adolescents there is an increased risk for substance abuse and suicidal behavior associated with depression and nearly one in three adults who have a mental disorder in their lifetime also experience a co-occurring substance abuse such as alcohol or other drugs. Men are less likely than women to admit to depression, and doctors are less likely to diagnose and treat it. Alcohol or drugs often mask men's depression.

Depression typically shows up in men not as feeling hopeless and helpless, but as being irritable, angry, and discouraged.

### Implementation

The first step to getting appropriate treatment for depression is a good diagnostic evaluation/history by a clinician. A good diagnostic evaluation will include a complete history of symptoms: When did they start? How long they have lasted? How severe are the symptoms? Has the patient had them before and, if so, were they treated and how? The diagnostic evaluation should also include questions about alcohol and drug use, as well as thoughts about death or suicide. Further, a history should include questions about whether other family members have had a depressive illness and, if treated, what treatments they may have received and which were effective. Last, a diagnostic evaluation should include a mental status examination to determine if speech, thought patterns, or memory have been affected, as sometimes happens in the case of a depressive or manic-depressive illness.

*For Teens:* It is extremely important to establish a sense of rapport and trust with the patient. Assure the patient of confidentiality and privacy. A psychosocial inventory tool, such as BiHEADS\* should be used to assess the biopsychosocial status of young male patients. Questions may be presented over several visits, allowing time for the establishment of trust and credibility. If depression is identified, refer for ongoing counseling and/or treatment.

*For Adults:* A brief set of questions to ascertain presence of symptoms of depression; one-on-one follow up if symptoms are present; and referral for ongoing counseling and/or treatment.

\*BiHEADS is a biopsychosocial probe that stands for: (B) Body Image, (H) Home, (E) Education, (A) Activities, (D) Drugs, (S) Sex, Sexual Abuse, and Suicide.

## Suicide<sup>5</sup>

### Best Practice

Males should be screened annually about behaviors that indicate recurrent or severe depression, as well as risk of suicide. Screening for severe depression or suicidal risk should be performed on those who exhibit cumulative risk as determined by various risk factors (see Implementation). If suicidal risk is suspected, patients should be evaluated immediately and referred to a psychiatrist or another mental health professional. In severe cases the patient should be hospitalized. Non-suicidal patients with symptoms of severe or recurrent depression should be evaluated and referred to a psychiatrist or other mental health professional for treatment. See Depression section for more information.

### Rationale

Suicide is a complex behavior that can be prevented in many cases by early recognition and treatment of mental disorders. Men's risk of completed suicide is on average four and one half times higher than women's.<sup>5</sup> The rate of completed suicides among males was 19.2 per 100,000 compared to 4.3 for females. The 12-month average rate of suicide attempts among adolescent males in grades 9 through 12 was 2.1% compared to 3.1% among adolescent females. After age 70, the rate of men's suicide rises, reaching a peak after age 85 (age adjusted to the year 2000 standard population). At least 90% of people who kill themselves have a mental or substance abuse disorder, or a combination of disorders. Other risk factors include prior suicide attempt, stressful life events, and access to lethal suicide methods. Since suicide is difficult to predict, preventive interventions focus on risk factors.

### Implementation

Screening for depression or suicide risk should be performed. Look for symptoms of depression and/or ask: Have you ever been suicidal? Risk can be determined by declining school grades, chronic melancholy, family dysfunction, sexual identity issues, physical or sexual abuse, alcohol or other drug abuse, previous suicide attempt, suicide ideation, and suicide plans.

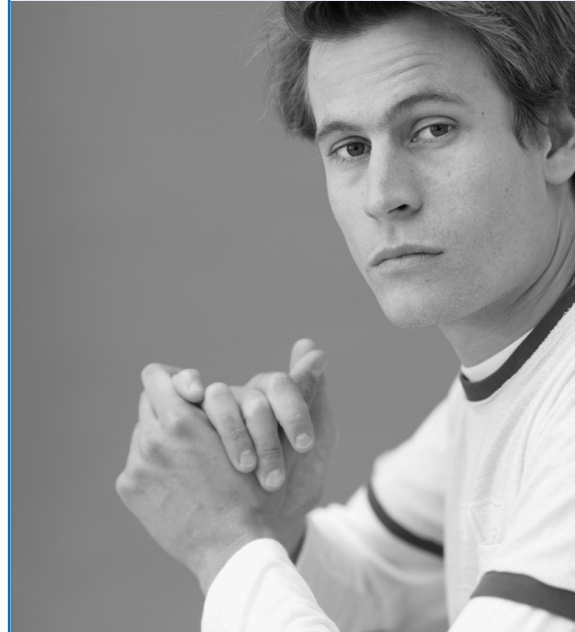
## Cancer Evaluation Screen

### Prostate Cancer<sup>6,7,8</sup>

#### Best Practice

Neither the United States Preventive Services Task Force (USPSTF) nor the American Cancer Society (ACS) supports routine testing for prostate cancer at this time. The ACS does believe that health care professionals should discuss the potential benefits and limitations of prostate cancer early detection testing with men, prior to screening and before any testing begins.

This discussion should include an offer for testing with the prostate-specific antigen (PSA) blood test and digital rectal exam (DRE) yearly. Men should actively take part in this discussion and decision by learning about prostate





cancer, and the pros and cons of early screening/testing and treatment. The guidelines for when this discussion should take place are as follows:

- Starting at age 50, for men who are at average risk of prostate cancer and have at least a 10-year life expectancy. After the discussion, those men who favor testing should be tested.
- Starting at age 45 for men at high risk of developing prostate cancer. This includes African American men and men who have a first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger than age 65).
- Starting at age 40 for men at even higher risk (those with several first-degree relatives who had prostate cancer at an early age).

If after this discussion a man asks his health care professional to make the decision for him, he should be tested (unless there is a specific reason not to test).

**The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine prostate cancer screening in men younger than age 75 years.**

**Grade: I statement**

The USPSTF found convincing evidence that prostate-specific antigen (PSA) screening can detect some cases of prostate cancer. In men younger than age 75 years, the USPSTF found inadequate evidence to determine whether treatment for prostate cancer detected by screening improves health outcomes compared with treatment after clinical detection. In men age 75 years or older, the USPSTF found adequate evidence that the incremental benefits of treatment for prostate cancer detected by screening are small to none.

The USPSTF found convincing evidence that treatment for prostate cancer detected by screening causes moderate to substantial harm, such as erectile dysfunction, urinary incontinence, bowel dysfunction, and death. These harms are especially important because some men with prostate cancer who are treated would never have developed symptoms related to cancer during their lifetime.

There is also adequate evidence that the screening process produces at least small harm, including pain and discomfort associated with prostate biopsy and psychological effects of false-positive test results.

**Rationale**

Other than skin cancer, prostate cancer is the most commonly diagnosed cancer in men. Over 30,000 men die of prostate cancer each year, making it the second leading cause of cancer death among American men. The disease primarily affects men over 40 years of age, with 80% of clinically diagnosed cases in men over 65. At all ages, African American men are diagnosed at later stages and die from the disease at a higher rate than white men.

**Implementation**

Self-administered questionnaires completed prior to exam should include questions about family history of prostate cancer, past physical exams and prior PSA blood tests. Educational videos can be shown in the waiting room, and pamphlets distributed to inform men about the benefits and risks of early detection. Questions about family history of prostate cancer can also be included on the medical history form reviewed by the provider. If prostate cancer screening is not offered at a clinic site, patients should be referred to sources such as community health centers, and supplied with information about the costs.

## Testicular Cancer<sup>9,10,11</sup>

### Best Practice

Examination of the testicles should be a routine part of a regular physical exam for all men between 15 and 40 years of age for screening and diagnostic purposes beyond testicular cancer screening.

Each man should be informed that it is his decision as to whether to perform a testicular self-exam (TSE) monthly. Information and instruction on how to do a TSE should be accessible for all males.

### Rationale

Testicular cancer is uncommon, with just over 8,000 new cases in the U.S. each year. It is, however, one of the most common cancers in young men. It is treatable and often curable, especially if it is found at an early stage. White males have a higher incidence than African American males.

The recommendations for screening for testicular cancer differ particularly regarding the need for screening with a clinical exam. The American Cancer Society, as of 2006, recommends that a testicular exam be performed as part of a routine physical checkup. However, the US Preventive Services Task Force, found no evidence that screening with a clinical examination or testicular self examination is effective in reducing mortality from testicular cancer.

Both the USPSTF and the American Cancer Society state that there is no evidence to support testicular self-exams. ACS does not recommend TSE for men who do not have known risk factors. In 2004, the USPSTF restated their recommendation against routine screening for men without cancer symptoms. Given the low prevalence of testicular cancer, limited accuracy of screening tests and no evidence for the incremental benefits of screening, the USPSTF concluded that the harms of screening exceed any potential benefits.

Nevertheless, some doctors still recommend performing regular TSE. It is easy, painless, involves men in monitoring their own health, familiarizes them with normal testicular size and shape and creates opportunities for identifying unusual changes associated with STI's. The clinician may use the physical examination as an opportunity to teach and demonstrate a TSE. Charts, models, pictures, pamphlets, age appropriate handouts, cartoon graphics and videos can also be used to illustrate the simplicity of performing a TSE to male clients. The clinician may use these tools to increase the comfort level among males who might feel uncomfortable performing a TSE. However, since testicular self exam has not been sufficiently studied to show a reduction in death rate from this form of cancer, each man has the choice to decide for himself whether to perform monthly TSE. \*

### Implementation

Information and instruction on how to do TSE should be accessible to all males.

\*Although the USPTF notes that there is insufficient evidence to recommend for or against routine testicular cancer screening of asymptomatic men, by physical exam or TSE, since TSE is painless and easy to perform, it should be taught to all motivated males.



## Colorectal Cancer<sup>12,13</sup>

### Best Practice

Screen all males 50 years of age or older for colorectal cancer. Periodic fecal occult blood (FOBT) followed by further investigation in people with positive tests decreases colorectal cancer related mortality. Flexible sigmoidoscopy alone or in combination with FOBT is likely a beneficial screen.

### Rationale

Colorectal cancer is the third most commonly diagnosed cancer among men and women. The chance of survival five years beyond diagnosis is excellent if the disease is diagnosed at a very early stage. Unfortunately, men who are uninsured and who do not have a regular doctor or source of health care underutilize colorectal screening.

### Implementation

Questions about family history and prior screening for colorectal cancer can be added to a self-administered questionnaire completed prior to the clinical exam, and also included on the medical history form that is completed by the health care provider. Providers should encourage males age 50 and over to get screened. If screening is not offered at the provider's clinical site men should be referred to community health centers and other sources of care.



## Alcohol, Tobacco and Other Drug Use and Abuse (ATOD)<sup>14, 15, 16</sup>

### Best Practice

Each male client should be asked about his substance use. Specifically he should be questioned about use of cigarettes, alcohol, marijuana, cocaine/crack, inhalants, injected drugs and use of steroids. In addition, each male should be assessed for his knowledge and understanding of how cigarettes, alcohol and drugs affect his health and how they affect his reproductive health behaviors.

### Rationale

Cigarette smoking is the single most preventable cause of disease and death in the United States. Cigarette smoking is not only harmful to respiratory and cardiac health but also increases a man's risk of erectile dysfunction. Men who smoke 20 or more cigarettes daily have a 60% higher chance of erectile dysfunction than a man who has never smoked.<sup>14</sup> Every day an estimated 3000 adolescents start smoking and the vast majority of adult smokers started smoking before 18 years of age.<sup>15</sup> Alcohol and illicit drug use are associated with child and partner abuse; sexually transmitted infections, including HIV; teen pregnancy; and motor vehicle accidents.<sup>16</sup> Alcohol and drug use increase sexual risk taking behaviors and impact male sexual activity. Specifically, alcohol lowers testosterone and can cause difficulty with ejaculation; marijuana lowers sperm count; heroin lowers sex drive; cocaine weakens erection, deforms sperm and makes it harder to ejaculate; steroids shrink testicles, may cause breast development and interfere with sexual desire and performance.

### Implementation

These issues should be part of a self administered questionnaire that is given to each client prior to his clinical visit, and then discussed further with a provider. They may be included on the medical history form completed by the health care provider. Waiting room educational videos on ATOD Use and Abuse should be available. There should be a system for referrals to a social worker, to treatment programs, to twelve-step programs, and other support services.

**Cigarette smoking is the single most preventable cause of disease and death in the United States**

## Age-Appropriate Routine Physical Exam and Laboratory Testing<sup>17,18</sup>

### Best Practice

Each male should receive a basic physical exam and laboratory testing that is based on age and promotes the maintenance of both general and sexual health.

*Ages 13-18 years*

### Sexual health components

- Secondary sexual characteristics (Tanner's staging)
- Testicular exam
- Examination of penis
- Rectal examination as appropriate
- Prostate examination as appropriate

### Sexual health laboratory testing

- Chlamydia testing (oral, urethral and rectal, as indicated)
- Gonorrhea (oral, urethral, and rectal, as indicated)
- Syphilis (serology as indicated)
- HIV testing (as indicated)
- Urinalysis

*Ages 19 and above*

### Sexual health components

- Testicular exam
- Examination of penis
- Rectal examination as appropriate
- Prostate examination as appropriate
- Breast examination

### Sexual health laboratory testing

- Chlamydia testing (oral, urethral and rectal, as indicated)
- Gonorrhea (oral, urethral and rectal, as indicated)
- Syphilis (serology as indicated)
- HIV testing (as indicated)
- Urinalysis
- PSA as appropriate

### Rationale

Periodic health screening through physical examination and selected laboratory testing provide an opportunity to detect a number of medical conditions in an early, often asymptomatic phase, which permits treatment before significant morbidity develops. Practicing unprotected sexual intercourse, as well as having multiple partners place sexually active males at risk for HIV and sexually transmitted infections. Screening for STIs and HIV is recommended for all men at risk.

Additionally, during the physical exam young men may benefit from a clinician's reassurance that their physical maturation is normal.

### Implementation

Physical examination components can be added to the comprehensive exam form. Laboratory testing for STIs can be extended to male clients and provided on-site. Examiners must be trained to be proficient and comfortable in providing male genital examinations.

Each male should receive a basic physical exam and laboratory testing that is based on age and promotes the maintenance of both general and sexual health.



# II. HEALTH PROMOTION/ EDUCATION & COUNSELING

## Male Anatomy and Physiology

### Best Practice

Every male should have a basic understanding of male anatomy and physiology. This includes having knowledge of one's body and how it functions; the essential and accessory organs of the male reproductive system; the stages of male puberty; and how the male body undergoes both hormonal and physical changes. Subsequent to this instruction, male clients should be taught how to perform testicular self-exams and condom usage in an effort to involve them with regular health maintenance.

### Rationale

Men are often not involved in the healthcare system until a crisis occurs in their life. STI concerns such as painful urination cause panic that may bring a patient to a provider. The male client will be encouraged to seek out answers to questions and become involved with his own health maintenance. Males must learn how a body develops and functions in order to distinguish between healthy and unhealthy changes, and understand normal processes that occur during puberty.

### Implementation

This information can be presented to male clients during a group educational session. It can also be given at an individual patient-oriented male genital exam and physical. Demonstrations on performing a male genital self-examination, brochures, videos, and charts are also effective tools.

Every male client should have a basic understanding of male anatomy and physiology

Men are generally not involved in the healthcare system until a crisis occurs in their life

## Female Anatomy and Physiology

### Best Practice

All male clients should have a basic understanding of female anatomy and physiology. Each male client should have clear knowledge of both the accessory and essential organs that make up the female reproductive system. Male clients should be instructed in the female reproductive system, stages of female puberty, and the phases of the female menstrual cycle and associated hormonal production.

### Rationale

Male clients need to take responsibility in assuring that their female partners are protected from both pregnancy and STIs. By understanding female anatomy and physiology male clients will be able to assist their female partner in avoiding pregnancy, choosing a desired method of birth control, as well as STI protection. An added benefit of understanding a female's external and internal anatomy is the potential for the enhancement of sexual pleasure for the male and his partner.

### Implementation

This information can be presented to male clients during a group educational session or a private counseling session. Also, discussion can occur during couples counseling. Brochures, videos, and charts can be effective tools.

## Male Puberty

### Best Practice

All male clients should have a basic knowledge of the physical, sexual and emotional development that occurs during puberty and adolescence. Male clients need to understand that puberty is the period between childhood and adulthood when their bodies undergo remarkable physical and hormonal changes.

### Rationale

Young men can be self-conscious about their developing bodies. Therefore, male clients should be assured that bodily changes will occur at different ages for each of them, and that a delay cannot immediately be considered abnormal. Also, male clients need a comfortable environment in which they can seek answers to sensitive questions and be reassured that the physical, sexual and emotional changes they are experiencing are a normal part of the maturation process. Should an abnormality be identified, male clients should be referred to a specialist for a follow-up evaluation.

### Implementation

Most of this information can be presented to male clients during a group educational session. Health care providers should be trained to perform a patient-orientated male exam and physical. Brochures, videos, and charts can be effective tools. In addition, clients should have an opportunity to ask sensitive questions and obtain more information in a confidential setting.

## Female Puberty

### Best Practice

Male clients should have a basic understanding of the stages of female puberty and the physical, sexual and emotional development that occurs in females during these transitional times.

### Rationale

Young women are as self-conscious about their developing bodies as young men are. Male clients need to understand the physical and emotional differences between how males and females develop in puberty. Typically females develop earlier than males. Misinformation or lack of information is often responsible for males making inappropriate remarks and gestures. Such acts may negatively affect a female's self-image and transition into womanhood. Lack of information about a female's reproductive development could place both male and female partners at risk for pregnancy.

### Implementation

This information can be presented to male clients during a group educational session, couples counseling or a one-on-one counseling session. Brochures, videos, and charts can be effective tools.

## Normal Male Sexual Function and Physiology

### Best Practice

While sexual desire and activity is highly variable among individuals, every male needs to be informed about the anatomy and physiology of the male sexual response cycle. The five stages are desire, arousal, plateau, orgasm, and resolution. During the learning process males should have an opportunity to discuss questions, concerns, and myths about their sexual functioning.

### Rationale

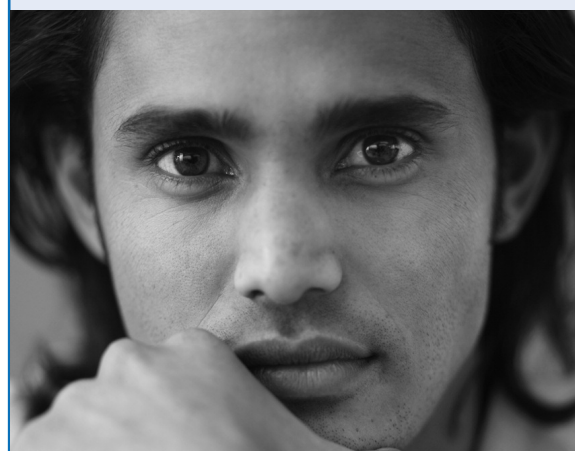
Sexual functioning is complex, involving environmental, physical, and psychosocial factors. Men visit health providers for preventive health care less often than women, and thus have few opportunities to obtain basic information about sexuality. Questions like these are not often answered:

Does size matter? Is it normal to masturbate? In American society, men are often expected to be all-knowing about sexual functioning, and thus may find it difficult to ask questions or raise concerns about sexual desire and performance. Providers need to proactively create teachable moments where men can ask questions and receive information about the psychological and physiological processes associated with sexual desire and response.

### Implementation

Providers should ask and offer information about sexual concerns during initial and annual visits so that these conversations become normalized. Providers should match their approach to the developmental level and sexual experience of each person: teach younger adolescent males about wet dreams and teach older males how to cope with changes in sexual functioning associated with health conditions and medications. Providers should tailor their educational interventions to individual's responses to questions about sexual functioning as elicited during the sexual history. A patient's dissatisfaction with their sex life would be an indication that the provider needs to offer guidance. Individual counseling or couple's counseling should be provided depending on individual situations. Referrals for further medical evaluation should be made if needed. Pamphlets about sexual functioning throughout the life cycle should be accessible in waiting areas and providers' rooms. Illustrative pictures of male anatomy should be used to enhance educational activities. When possible, age-appropriate videos about sexual functioning can be shown in waiting areas, preferably accompanied by educational discussions led by trained staff.

Men visit health providers for preventive health care less often than women, and thus have few opportunities to obtain basic information about sexuality



## Changes in Sexual Function and Physiology Over the Lifespan

### Best Practice

Men should be informed that changes in sexual functioning may be associated with the normal processes of aging, and that they are not abnormal.

### Rationale

Satisfying sexual activity can continue throughout the life cycle, but the aging process affects sexual responses and functions. Delayed erection reduced volume of ejaculation, longer refractory period, and so forth, are examples of possible complications caused by aging. Medical conditions associated with aging, such as prostate problems and hypertension, and medications associated with those conditions, are factors that can contribute to problems with libido and sexual functioning.

### Implementation

Providers should ask all males, especially older men and those with medical conditions known to be associated with sexual problems, about unwanted changes in sexual desire or response. When needed, basic information should be provided about the effect of medical conditions and medicines on sexual functioning. For example, some drugs that treat hypertension affect sexual function. Men need to be reassured however, that loss of interest in sex and problems with sexual functioning are not inevitable consequences of aging, and should be encouraged to discuss concerns with a health professional so that interventions can be arranged as needed. Written information should be provided when needed. Since problems with sexual functioning (such as erectile dysfunction and diminished interest in sex) can be associated with marital and other relationship problems, as well as other life stresses, medical and counseling referrals should be provided as needed.

## Impact of Alcohol, Tobacco and Other Drugs (ATOD) on Reproductive and Sexual Function and Development<sup>19, 20, 21, 22, 23, 24</sup>

### Best Practice

Each male client should be informed of the adverse physiological effects of substance use on sexual development and functioning. Emphasize the importance of responsible sexual behavior with drug and alcohol users, even infrequent users, as they are at higher risk for unprotected sex and STIs.

### Rationale

Males who abuse alcohol or drugs are more likely to initiate sex at a younger age, more likely to have unprotected sex, more likely to have sex with multiple partners, and more likely to contract sexually transmitted infections.<sup>19</sup>

### The following are some of the effects that have been reported in relation to ATOD use:

- *Alcohol*: Chronic heavy drinking can interfere with hormonal functions and sexual maturation in pubescent males, and cause sexual dysfunction and infertility in adult males.<sup>20,21</sup>
- *Tobacco*: Long-term, heavy use can contribute to erectile dysfunction.<sup>22</sup>
- *Marijuana*: Chronic use decreases sperm count, though effect appears to be reversible.
- *Cocaine/Amphetamines*: Prolonged use can cause erectile dysfunction.
- *Anabolic Steroids*: Long-term use can cause breast development and genital shrinking. Steroid abusers who share needles are at risk for contracting dangerous infections, such as HIV/AIDS, and Hepatitis B/C.<sup>23</sup>
- *Heroin/Oxycontin*: Highly correlated with HIV transmission due to needle sharing.

### Club Drugs<sup>24</sup>

- *MDMA (Ecstasy)*: High doses may lead to inability to regulate body temperature that then can lead to failure of the liver, kidneys, and the heart to work.
- *GHB (G, Liquid Ecstasy, Soap), Rohypnol (Rophies, Roofies), Ketamine (Special K, Vitamin K)*: Predominantly central nervous system depressants, often used in date rape. Delirium, amnesia, coma, and seizures are possible.





### **Implementation**

Male clients should be educated on predominant types of ATOD use and their physiological consequences on sexual function and development. Educational materials on ATOD use and abuse should be made available at the clinic.

## **Sexual Behavior of Men Who Have Sex with Men (MSM)<sup>25</sup>**

### **Best Practice**

Each male client, irrespective of sexual orientation or behavior, should be informed of the full spectrum of behavior and desire. Focus on normalizing the spectrum, including same sex, opposite sex, and solitary sex behavior and desires.

### **Rationale**

Young men who have sex with men have high rates of HIV infection due to high-risk sexual behavior. STIs transmitted through the exchange of bodily fluids are more easily transmitted during unprotected anal sex. Young men may perceive AIDS as a disease of older gay men and feel safe in having unprotected sex. Negative social and emotional factors are often associated with being gay: Many GLBTQ (Gay, Lesbian, Bisexual, Transgender, Questioning) teens experience feelings of severe isolation are two to three times more likely to attempt suicide than their heterosexual peers, and account for up to 30% of all completed suicides among teens.<sup>25</sup>

### **Implementation**

Male clients should be educated on the health risks that relate to specific sexual behaviors. All clients should be encouraged to protect themselves and to be tested for STIs. Providers should be prepared to answer questions and debunk myths regarding sexual orientation and the health risks involved in various types of sexual behavior. When discussing health risks, providers should relate them to sexual behavior rather than sexual orientation. Educational materials should be available and displayed in plain view in the clinic, along with other sexual health materials. Information about GLBTQ social and clinical services should be available.

## ***Contraceptive Education and Counseling***

### **Fertility Awareness Methods**

#### **Best Practice**

Each male client should be taught fertility awareness methods and questioned about his beliefs concerning responsibility for birth control, cooperation between partners, and control of sexual responsiveness. Specifically, can he effectively identify his female partner's fertile period? Does he agree with the concept of periodic abstinence? What if his partner says it is not a good time when he feels it is?

#### **Rationale**

The male client along with his partner must be committed to fertility awareness as the primary contraceptive method in order for it to be effective. Training is essential for couples using fertility awareness-based methods.

#### **Implementation**

This information can be presented to male clients during a group educational session or a private counseling session. Also, discussion can occur during couples counseling.

**Male clients  
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## Emergency Contraception

### Best Practice

Each male client should be questioned about his understanding of the process of fertilization and establishment of pregnancy. Also, he should be questioned regarding his need for post-coital contraception due to contraception failure or sexual spontaneity in relationships. Some ways to ask a male client include: Do you ever have unprotected sex? Have you ever had a condom break? Do you practice withdrawal as a form of birth control? Do you know how a pregnancy occurs?

### Rationale

Each male client must be instructed that emergency contraception is the only method a couple can use to prevent pregnancy after unprotected sexual intercourse or after a contraceptive “accident.” Male clients need to know that the window period in which emergency contraception must be taken to be effective is 5 days.

### Implementation

This information can be presented to male clients by providing a directory of resources, instructing uses of the Internet, or giving a toll-free telephone number. Discuss with female partner the option of obtaining a prescription to have on hand for emergencies.

## Condoms (Barrier Method)

### Best Practice

Each male client should be made aware that condoms are available for both male and female partners and that barrier methods provide protection from some STIs as well as pregnancy. He should also be informed and instructed in the correct usage and educated about any common misconceptions. The following questions will help address condom-specific issues: Do you know they make a condom for women? Have you ever used a male or female condom with your partner? Do you ever have trouble putting on a condom or have one break? Do you know it is recommended to use a condom during oral sex?

### Rationale

Each male client needs to know that condoms offer protection against some STIs, including HIV infection. In addition, barrier methods are essential when there are multiple partners or the sexual history of partners is not known.

### Implementation

Counseling and education in correct condom usage is essential. A clinician or counselor should first demonstrate proper application and removal to male clients by employing the use of a penis model and should then observe male client placement and removal of the condom from the model.

## Female Contraceptive Methods

### Best Practice

Each male client should be instructed in both female hormonal and female barrier methods of contraception. Male clients should be instructed about all major side effects or danger signals. Any misconceptions should be addressed. All male clients should be assisted in choosing a contraceptive method that will protect them and their partner from both pregnancy and STIs.

### Rationale

Male clients need to share responsibility in assuring that their female partners are using a contraceptive method correctly and consistently without fear. Male clients need to participate in choosing the best method of contraception and STI protection for himself and his partner. Teach males the proper use of female barrier methods and about female sterilization methods.

### Implementation

This information can be presented to male clients during a group educational session or a private counseling session. Also, discussion can occur during couples counseling. Brochures, videos, and charts can be effective tools.

Male clients  
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## Pregnancy Options Counseling

### Best Practice

Each male client should be instructed and informed about all options available for management of an intended or unintended pregnancy.

### Rationale

Male clients need to take responsibility for their role in a pregnancy. The first step is for them to explore their level of knowledge, feelings, and perceptions regarding pregnancy options. To the extent possible, male clients should receive the necessary information alongside their partner as this will facilitate partner communication and foster the male's support for his female partner as the pair makes decisions about the pregnancy.

### Implementation

General information can be presented to male clients during a group educational session or a private counseling session. Also, discussion can occur during couples counseling. However, male clients must respect the right of their female partner not to give consent to joint options counseling. While efforts should be made to involve significant members in the woman's life, the choice to do so lies ultimately with the woman.

## STI Education and Counseling<sup>26</sup>

### Best Practice

Each male client should be questioned about the following: his knowledge of HIV and STIs; the presence of symptoms in self or partner; the existence of multiple sexual partners for self or partner; the treatment of either for an STI; and whether barrier methods are used.

### Rationale

Eight in ten adults living with AIDS in the U.S. are men; men's knowledge of effective measures for preventing STIs is sketchy; and few men know about genital herpes or that chlamydia can affect them.<sup>26</sup> Men need information and education about STIs/HIV, including how to avoid them, where to obtain and how to use condoms correctly, and how to talk about STIs/HIV with their partners. In addition, studies have shown that when men are provided with information about reproductive health, they are more likely to be supportive of their partner's family planning decisions.

### Implementation

These questions may be added to a clinical questionnaire that is given to each male client prior to the clinical visit. Alternatively, they may be included on the medical history form completed by the clinician. In both cases a skilled provider should review the information presented by the client in detail. An opportunity for questions and discussions must be offered. Condoms can be provided as well. Education can occur in a group setting.

## HIV Education and Counseling

### Best Practice

Reproductive health care settings are a critical conduit to HIV testing. HIV education, counseling, and voluntary testing should be offered to all patients. All male clients should be HIV risk assessed as a tool for risk reduction, not as a basis to offer testing.

### Rationale

According to the World Health Organization (2003), at least 75% to 85% of the 39.4 million HIV infections worldwide have been sexually transmitted. Prevention should take place on two levels. Examples of primary prevention would be: encouraging adolescents who are not currently engaged in sexual activity to remain abstinent; encouraging uninfected males to remain so by using condoms, avoiding injection drug use and the use of shared equipment, and by limiting their number of sex partners. An example of secondary prevention would entail advising infected male clients to practice safer sex techniques to protect themselves from co-infection and to protect their uninfected sex partners.

### Implementation

All male clients should be HIV risk assessed either by the provider asking specific questions as part of the medical history or by having the client complete a self-administered questionnaire prior to the exam. It is important to understand the client's literacy skills and cultural feelings. Questions concerning sexual behavior are sensitive issues for many clients. A substance abuse evaluation must be part of the risk assessment. Abuse of alcohol or drugs increases HIV risk because of potentially self-destructive risk taking. Teach skills as well as facts. Teach explicit safe-sex skills and instruct the male client to ask about and look for genital infections in their sexual partner. However, instruct clients to follow safe sex practices even if there is no visible sign of an infection.

## Circumcision, Genital Health and Hygiene

### Best Practice

Every male client, especially young males, should be made aware of the facts and myths about circumcision and the foreskin. Healthcare providers should feel comfortable in addressing penile-hygiene questions and concerns.

### Rationale

The debate regarding whether males should be left uncircumcised has been widely discussed in this society. Many people believe that a circumcised penis is cleaner than an uncircumcised one. Issues surrounding both viewpoints should be conveyed to clients, especially those who question either viewpoint. Recent studies conducted in Africa have shown that circumcision does decrease the risk of acquiring HIV for the male in high prevalence areas; however, it does not eliminate the risk. This research is not generalizable to the US population. In relationship to other STIs, the Population Council warns that little is known about the biological mechanism by which males are infected or the role of the foreskin in relation to infection. Proper hygiene is frequently noted as an important factor in preventing disease.

### Implementation

All males should be taught how to appropriately clean the penis and the proper bathing/hygiene requirements. Males should be directed to clean the penis skin and check for unusual bumps, discharges or burning. Also convey proper hygiene methods for the penis, as well as the use of hygiene products. Tell clients that attention given to penile hygiene is beneficial in detecting STIs. Uncircumcised males should be informed about: smegma, oily secretions which accumulate under the foreskin; balanitis, inflammation of the tip of the penis; and phimosis, the inability of the foreskin to pull down and expose the penis head during erections and intercourse.

If the client has questions, providers should be prepared to discuss the benefits and the liabilities of a circumcision decision.\* The provider should also be aware that cultural and societal expectations may be a factor in the client's circumcision decisions.

\*The benefits and liabilities of circumcision decisions were based on information provided by the Circumcision Resource Center. These "pros" and "cons" of circumcision were centered around several factors that included (1) pain (2) behavioral response (3) cleanliness (4) infections (5) cancer (6) sexually transmitted infections (7) foreskin function and size (8) male attitude and (9) cultural belief.



## Interpersonal Communication Skills on Sexual & Reproductive Behavior

### Best Practice

Providers should take advantage of opportunities during sexual histories and routine exams to become a resource for clients who have questions about relationships and sexuality. Clients should be encouraged to explore their values and beliefs about gender roles and stereotypes, and the impact of gender on sexuality. In addition talk about sexual expectations, communication and relationships. Information conveyed to clients should be age appropriate. Providers should also inform clients that there are many healthy ways to express sexual feelings that may not conform to traditional standards. Providers should have the aptitude to explain aspects of sexuality and relationships in both abstinence-only and comprehensive sexuality education models. Providers should impart accurate and nonjudgmental information that is age and experience appropriate.

### Rationale

Sexuality is a natural part of human life. Every individual has the right to obtain sexual health information and services in an open and nonjudgmental setting.

### Implementation

Providers should offer information about the positive, life-enhancing and pleasurable aspects of sexuality and relationships, as well as information about preventing unintended pregnancies and STIs. Providers may supplement their efforts through written materials such as pamphlets, guides, articles, and so forth. Providers must also realize there may be discordance between their own values regarding sexuality and relationships, and those of their clients. The provider must take the responsibility themselves to know any difference, as to avoid posing any barrier to the client's sexual and interpersonal relationship development.

## Cancer Screening<sup>27</sup>

### Breast Cancer

#### Best Practice

Every male client should be aware that breast cancer occurs in men as well as women. Educate men regarding risk factors: older age, family history of breast cancer, Klinefelter's syndrome or extra sex chromosome, gynecomastia or enlarged breasts, and testicular dysfunction. Men who are at risk should be instructed about the importance of prompt evaluation. They should be checking for any growth or changes in the chest or breast area.

#### Rationale

The American Cancer Society estimates that in 2005, breast cancer will be diagnosed in an estimated 1,690 men and more than 460 will die from it. Male breast cancer is rare, accounting for 1% of all diagnosed breast cancers. The average age of occurrence is 63 years. The presenting characteristics and treatments given for male breast cancer are very similar to female breast cancer. The BRCA2 gene has been implicated in male breast cancer and is often recognized as a potential cause. This occurs when there is a family history of a number of females or males with breast, ovarian, prostate or colon cancer. Men are usually diagnosed at a later stage than women because they are oft unaware of their risks and less likely to report any symptoms.

#### Implementation

Men who have risk factors such as family history of multiple females or males with breast, ovarian, prostate or colon cancer should be informed of their increased risk. Talk about the importance of reporting nipple inversion, breast lump, local pain, itching, pulling sensation and nipple discharge to their health care provider. Stress that early diagnosis and treatment is important in producing the best outcome. This information can be communicated using pamphlets and fact sheets.





## Prostate Cancer

### Best Practice

Every man should be informed of his risk for acquiring prostate cancer. Information should include risk factors for the disease, prevention measures, and screening recommendations.

### Rationale

Many factors place men at increased risk for prostate cancer. Some factors are beyond our control, but other factors can be affected by personal behavior. Risk factors for prostate cancer include: being older than 50, being African American, having a diet high in fat, being overweight, inactive, and having a family history of prostate cancer. Men should be aware of what measures can be taken to reduce their risk (see page 17-18).

### Implementation

Utilize appropriate health education materials to inform men of their risk. Discuss preventive behaviors: eating a diet low in fat and high in vegetables and fruits and getting at least 30 minutes of physical activity on most days. Achieve and maintain a healthy weight. Obtain a yearly PSA blood test. Start a digital rectal exam at age 50, or 40 if at high risk.

## Testicular Cancer

### Best Practice

Every man should be informed of testicular cancer risks. Information should include risk factors for the disease.

### Rationale

Testicular cancer risk has more than doubled among white Americans over the past 40 years but has remained the same for African Americans (see page 19).

### Implementation

Utilize appropriate health education materials to inform men of the risk factors for testicular cancer. They include: being ages 20-35, having an undescended testicle, and possessing family or personal history of testicular cancer. Information and instruction on how to do a TSE should be accessible to all males.





## Impact of Prescription and Over-the-Counter Medication on Sexual Function

### Best Practice

All male clients taking prescription or Over-the-Counter (OTC) medications should be informed of the potential side effects on sexual functioning pertaining to the medication in question. The provider should pay careful attention to the client's attitude regarding the medication and its potential side effects; if the provider suspects the client may not adhere to a needed medication, further discussion of the purpose of the specific medication is warranted, and alternative medications or interventions should be considered.

### Rationale

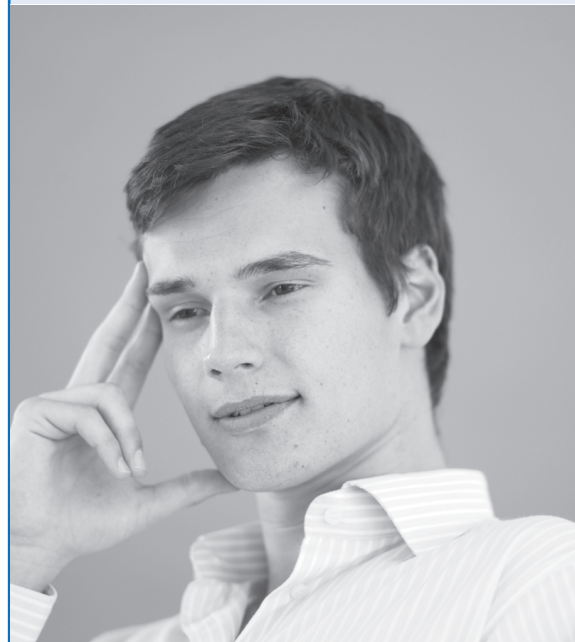
Many prescription and OTC drugs may affect male sexual functioning. Sexual dysfunction is commonly multifactorial. Below are listed some medications that may affect male sexual function. This list is neither comprehensive nor definitive.

Adverse effects on sperm production	Cytotoxic drugs, anabolic steroids, cimetidine (Tagamet for ulcers), sulfasalazine, spironolactone, opiates, and colchicines
Adverse effects on sperm function	Certain antibiotics (nitrofurans and macrolides, such as erythromycin) and calcium channel blockers used to treat hypertension (Captopril, Vasotec, nifedipine) which may affect the ability of the sperm to bind to and fertilize the egg.
Adverse effects on sexual performance	Antihypertensives that may impair sexual function (reserpine, methyldopa, and guanethidine), psychotropics that boost serotonin (SSRIs) may inhibit pleasure and ejaculation, antiepileptic drugs (AEDs) may contribute to decreased libido, potency, and fertility because of interaction with hormone-binding metabolism.
Other medications negatively associated with fertility	Antimalarials, tetracycline, amebicides, nitrofurantoin (for bladder infections), propranolol (Inderal), and barbiturates
Drugs that seek to enhance sexual	Dopamine may enhance sexual response. Sildenafil (Viagra) relaxes smooth muscle in the penis, facilitating erection. Vardenafil (Levitra) and Tadalafil (Cialis) enhance erections by increasing blood flow to the penis.
Other	Low Vitamin C levels may cause sperm to clump together. OTC Vitamin C, or diet changes can easily correct the problem.

### Implementation

During each physical examination male clients should be educated on the impact of prescription and OTC medications on sexual function. When medication is prescribed they should receive information about potential impact on sexual function.

Prescription and OTC medications can have adverse effects on sexual function and a negative effect on fertility



## Impact of Herbal Supplements on Sexual Function<sup>28</sup>

### Best Practice

All male clients taking herbal supplements, herbal medicines, homeopathic medicines, alternative medicines, or “all natural” medicines should be informed of the potentially adverse side effects of such medicines on sexual function.

### Rationale

A growing number of Americans are using herbal products for preventive and therapeutic purposes. The manufacturers of these products are not required to submit proof of safety and efficacy to the U.S. Food and Drug Administration before marketing. For this reason, the adverse effects and drug interactions associated with herbal remedies are largely unknown. Ginkgo biloba extract, ginseng, St. John's Wort, and ephedrine-containing herbal products have all been found to have adverse side effects or drug interactions. Additionally, because manufacture of herbals is not regulated, there may be adverse consequences due to impurities or varying potencies.

### Implementation

Male clients who report use of herbal supplements should be educated about what is known about the impact on sexual function.

## Impact of Environmental Factors on Sexual Function and Development

### Best Practice

All male clients should be informed about the potential impact of environmental factors on sexual function and development. Specifically, male clients trying to have children should be made aware of the environmental factors that can reduce fertility, including high temperatures and certain toxins.

### Rationale

Environmental factors can reduce fertility, especially anything that causes excessive heat in the scrotum, such as hot tubs, saunas, tight fitting underwear or pants, and strenuous exercise.

Environmental toxins that can lower fertility include: pesticides, insecticides, organic solvents, lead, ionizing radiation, heavy metals, polystyrene, xylene, benzene, mercury, Agent Orange, anesthetic gases, solvents, and other toxic chemicals. Environmental toxins that can interfere with the sexual development of the fetus or child include arsenic, lead, and also phthalates, the chemicals added to plastics and some insect repellents.

### Implementation

Male clients who complain of problems with sexual functioning or who are trying to have children should be informed of the potential impact of environmental factors on sexual function and development.



# III. CLINICAL DIAGNOSIS AND TREATMENT

Impotence is not an inevitable part of the aging process; the condition is treatable in all age groups

## **Impotence and Erectile Dysfunction<sup>29, 30</sup>**

### **Best Practice**

Health facilities should have either the ability to treat or to refer patients with cases of impotence or erectile dysfunction.

### **Rationale<sup>30</sup>**

Impotence and erectile dysfunction interfere with a man's sex life. Erectile dysfunction is common, the causes of which can generally be classified as either psychological or organic. Usually, erectile dysfunction is due to temporary psychological or emotional issues, and can be handled in a primary care setting where the provider should know how to counsel the patient or be able to refer to a mental health provider. If impotence or erectile dysfunction continues, the provider should look for possible organic causes. The majority of men with erectile dysfunction are thought to have an organic factor, the most common causes being related to alcohol consumption, the psychological aspects of anxiety, depression, self confidence, or relationship issues. Incidence of impotence rises with age: about 5% of 40 year-old and 20% of 65 year-old men experience impotence. Impotence is not, however, an inevitable part of the aging process; the condition is treatable in all age groups. Many of the conditions associated with aging—vascular disease, diabetes, cancer, as well as their treatments—may cause impotence. Side effects of common medicines are responsible for approximately one quarter of all cases. Occurrences can be due to hypertension drugs, antihistamines, antidepressants, and appetite suppressants.

### Implementation

The diagnosis of erectile dysfunction begins with an in-depth history to help define the degree and nature of the problem. The history should seek to identify common causal factors, such as aging, cardiovascular disorders, emotional problems, medication use, substance abuse, and physical injury. If the problem appears to be emotional, a nocturnal penile test should be given, then possibly followed with a referral to a therapist. If the cause of the problem is not immediately apparent, a general physical examination should be conducted, to include: blood pressure; peripheral circulation; examination of the breasts for gynecomastia; secondary sex characteristics; a genital examination to look for penile fibrosis, testicular atrophy, or bulbocavernosal reflex; and a rectal examination for prostate. Depending on what is suggested by history and general exam, one or more of the following lab tests may be required to identify disease or hormonal factors: plasma glucose, prolactin, free testosterone, luteinizing hormone; tests for follicle-stimulating hormone if testicular atrophy is suspected; for thyrotropin if hypothyroidism is suspected; and any other deemed appropriate.

Treatment of erectile dysfunction depends largely on diagnosis. Interventions related to specific risk factors may include: treatment for diabetes, treatment for substance abuse, and changing medications or hormone therapy. Psychological problems may require referral for therapy. Early detumescence should be treated with venous constriction. Other non-specific treatments that may be effective include: pharmacological, such as trial sildenafil/Viagra, trial yohimbine, phenolamine, and apomorphine; penile injections; penile implants; transurethral suppositories; and vacuum pump. Appointments for impotence should be given adequate time and resources to conduct an in-depth history and general exam, take blood and/or urine samples for lab work. Interventions should progress from least invasive to more invasive. Multiple follow-up appointments may be required if early interventions are unsuccessful.

## Premature Ejaculation

### Best Practice

Providers should be prepared to provide or arrange for the diagnosis and treatment of premature ejaculation.

### Rationale

Premature Ejaculation (PE) is the most common male sexual dysfunction, and is a source of frustration and concern for many men and their sexual partners. It can occur at any age, but is most common among younger, sexually inexperienced males. PE is a highly subjective and variable event, and defies simple definition. While some men are able to delay ejaculation for prolonged periods after the onset of arousal, others may ejaculate during foreplay before a full erection is even obtained. A commonly accepted understanding of PE however is that ejaculation occurs sooner than desired, and causes sexual frustration for the man and/or his partner. While it is the most common male sexual dysfunction, many men who experience rapid ejaculation are reluctant to seek help because of embarrassment and fear of being labeled as sexually inadequate. Providers need to sensitively, skillfully, and routinely initiate frank discussions about premature ejaculation and other sexual concerns with all male patients.

### Implementation

Successful treatment of premature ejaculation begins with a psychosocial and sexual history, since emotional and stress-related problems increase the risk of experiencing difficulties in all phases of the sexual response cycle. Anxiety and guilt about current and past sexual experiences should be carefully assessed, as well as other emotional problems. Discuss marital, relationship, employment, and school related stresses. While a clear organic cause of PE is not evident in most cases, a thorough medical history and physical examination should be performed to determine whether organic factors are present. These factors include neurological disorders, anatomical abnormalities, and alcohol peripheral neuropathy. Premature ejaculation is treatable



# Premature Ejaculation (PE) is the most common male sexual dysfunction

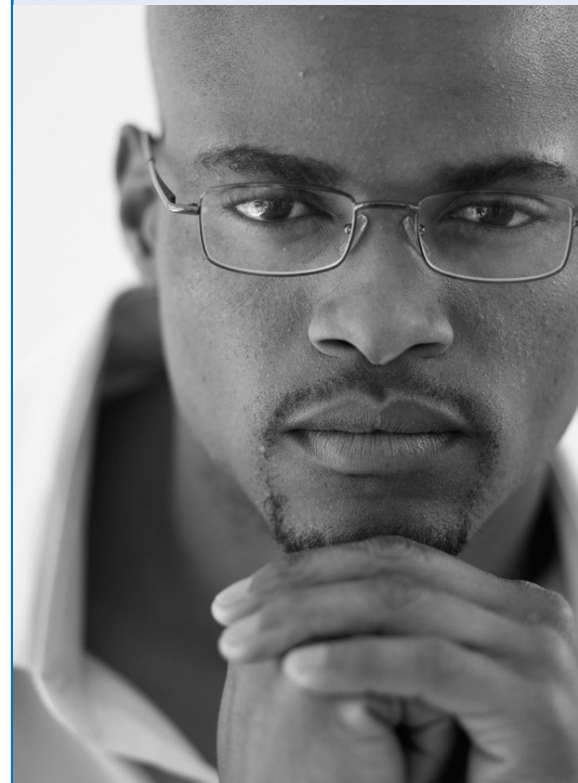
with behavioral adjustments, such as the “pause and squeeze” technique, as well as with pharmacological interventions. Low doses of antidepressants such as Paxil and Zoloft are effective and well-tolerated treatments to help delay ejaculation in men who do not have organic causes for rapid ejaculation. In some cases a single dose of Paxil or Zoloft taken 2-4 hours before intercourse helps delay ejaculation. Because of the sensitive nature of PE, privacy needs to be assured and time allotted for thorough assessment. Medical forms should contain questions about problems with sexual desire, erection and ejaculation so that accurate assessments of sexual dysfunction can be made. Medical manuals should be revised to include protocols for pharmacological treatment of rapid ejaculation. Staff should be trained to know how to take a thorough sexual history. Furthermore, using “normalizing” and “joining” responses may be helpful to reassure men that they are normal and to build hope; “Many men experience difficulties delaying ejaculation. We can work together to come up with some solutions that will help.” Providers might also consider asking about the following issues:

How does a male define premature ejaculation? Social and cultural norms about sexual performance often establish unrealistic expectations about how long ejaculation should be delayed after arousal or penetration, also known as ejaculatory latency time.

Are the male and/or his partner dissatisfied with the duration of intercourse? How sexually experienced is the male? How often does he have intercourse? Rapid ejaculation among younger males is often due to anxiety. Has the patient always had difficulty controlling ejaculation and feeling dissatisfied with the duration of intercourse, or has the onset of PE been recent? How pervasive is PE? For example, is ejaculation easier to control during masturbation than intercourse? Does the male ejaculate rapidly with every act of intercourse? Can he delay ejaculation with some partners more than with others?

Is PE really the problem or are erections poorly sustained so that they fade before orgasm is reached? In this case, the client likely suffers from erectile dysfunction (ED). Conversely, complaints of ED may mask PE, since loss of erection occurs rapidly after ejaculation.

Staff should also be trained to efficiently teach men and their partners behavioral methods to delay ejaculation. For example, in the “pause and squeeze” technique, the man or his partner briefly interrupts sexual activity when he senses an orgasm developing, and gently applies pressure just below the head of the penis. The technique is repeated until the man learns to delay ejaculation without applying pressure. Internal and external referral sources should be identified for men and couples who need longer interventions. Written materials, illustrations, and educational videos on PE should be available for men who desire additional information.





## Skin Lesions of the Genital Tract

### Best Practice

Providers should be prepared to diagnose and treat skin lesions of the genital tract. During the routine physical examination, each client should be assessed for the presence of any abnormal growths, itches, or skin changes in the genital area, as well as bleeding or irritation. This assessment should include the client's history of skin lesions and a thorough examination of the penis, scrotum, perineum, anus and pubic area. Careful consideration should be given to skin lesions that may be very small or occur inside of the anus. Clients should be made aware that skin lesions of the genital area are not necessarily indicative of sexually transmitted infections; however they can be part of a more serious problem. Any skin lesions present must be investigated to ensure that they are not of a serious type. Some associated conditions include pruritus ani (itching of the anus), eczema, folliculitis, tinea cruris (jock itch), intertrigo (rashes), genital herpes, genital warts (including those associated with HPV and syphilis), pubic lice and cysts.

### Rationale

Males who have skin lesions in the genital area may experience discomfort, embarrassment, low self worth, or interference with sexual functioning. A comprehensive examination must be completed for clients who may feel uncomfortable talking to the clinician or may be unaware that they have skin lesions.

### Implementation

During the examination any discomforts, abnormal growths or itches should be recorded in the client's records. If the lesions are sexually transmitted, information on ways in which the client can protect himself from acquiring further infections must be relayed. Clients should also be informed that some types of skin lesions may be difficult to detect and may warrant several different types of detection procedures. The client must be encouraged not to feel upset, angry or ashamed of themselves or their partners. An understanding of the prevention, treatment and management of skin lesions is most essential. Clients should also be encouraged to check themselves periodically for any type of skin lesions in the genital area.

## Other Reproductive System Disorders

### Best Practice

Reinforce the need for routine preventive health care, as well as the importance of obtaining prompt medical care when problems arise. Men should receive a comprehensive examination which includes: an assessment of presenting problem; a sexual and genitourinary history; a physical examination of abdomen and external genitalia; and, a collection of appropriate laboratory tests to rule out infection.

### Rationale

Men do not routinely access the health care system for an examination of their reproductive organs. During each visit to a health care provider, every effort should be made to not only confront the presenting problem, but also to provide an opportunity to discuss concerns about sexual activity and physical appearance. Disorders of the reproductive system include anatomical and physiological conditions, which become known through history, physical examination, and laboratory studies. Detection or suspicion of an abnormal condition may require prompt referral to a specialist for further assessment or treatment.

### Implementation

Stress the need for an examination by a clinician when signs and symptoms of illness develop. Educate about the value of having a physical examination that includes the genital region. Examine the abdominal and genital regions on a routine basis. Design clinical records to include a sexual and genitourinary history and physical examination. Provide an opportunity for men to ask questions. Employ leading statements such as, "Some men ask me whether or not what they are experiencing is normal."



## Diagnosis and Treatment for Hernias

### Best Practice

During the physical examination, each male should be assessed for the presence of a lump or swelling in the groin.

### Rationale

According to the National Center for Health Statistics, approximately 5 million Americans have hernias. In men, a hernia can develop in the groin, at the point where the spermatic cord passes out of the abdomen and into the scrotum. This is an inguinal hernia. A direct inguinal hernia creates a bulge in the groin area, and an indirect hernia descends into the scrotum. Hernias may occur more often in patients who are overweight, have a chronic cough, suffer chronic constipation, or endure prostatic hypertrophy, a condition characterized by strained urination. Treatment of these conditions may reduce the risk of developing a hernia. There may be a genetic predisposition to the development of hernias. An inguinal hernia can often be pushed back into the abdominal cavity. However, if it cannot be pushed back through the abdominal wall (reduced), the herniated bowel may become trapped in the inguinal ring (incarcerated), and its blood supply may be compromised (strangulated). Without treatment, the strangulated loop can become gangrenous, a life-threatening condition requiring immediate surgery. The surgery involves repositioning the loop of intestine and securing the weakened muscles in the abdomen. The outcome is expected to be good with treatment. Recurrence is rare (1-3%).

### Implementation

Assess the inguinal areas during the routine physical exam. Inform men that a tender lump in the scrotum or groin requires evaluation, as does groin pain aggravated by bending or lifting. Educate men who do heavy lifting or exercising of the risk for acquiring a hernia and the means by which to reduce that risk. Questions about personal history, current symptoms and occupation are important in assessing risk. Educate men on symptoms and risks for hernia and the importance of seeking prompt medical evaluation.

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## Varicocele

### Best Practice

During the physical examination, the testicles should be palpated to determine the presence of a varicocele. Men should be encouraged to report recurrent or constant discomfort or pain in the genital region to an urologist or primary care physician.

### Rationale

Varicoceles are found in 10 to 20% of men past the age of puberty. Varicoceles are enlargements of the veins that drain the testicles. They can develop in one testicle or both, but in about 85% of cases they develop in the left testicle. Most varicoceles are asymptomatic. However, some may cause pain or testicular atrophy, or a decrease in size of the testicle. Large varicoceles may be seen with the naked eye, while medium-sized ones are palpable on examination. Between 20% and 40% of all infertile males have varicoceles. The prevalence of varicocele is as high as 80% among men with secondary infertility, meaning those who have fathered a child but are no longer able to do so. A varicocele affects fertility due to the decrease in circulation of blood in the testicular area. The raised temperature may also impede production of new and healthy sperm. Surgery may be indicated for testicular atrophy, infertility, or because of size and discomfort related to the varicocele. Between 5 and 20% of men experience a recurrence.

### Implementation

Self-administered and medical history forms should include questions about infertility, whether the patient has been taught to do a testicular self-exam (TSE), and whether a medical provider has ever examined the patient's testicles. If the varicocele is asymptomatic, the symptoms mild, and infertility not an issue, the condition can be managed by wearing an athletic supporter or snug-fitting underwear to provide the scrotum with support.

## STI/HIV Diagnosis and Treatment

### Best Practice

Every facility should have the capacity to test for HIV and STIs. Treatment of common, uncomplicated STIs should be available on-site.

### Rationale

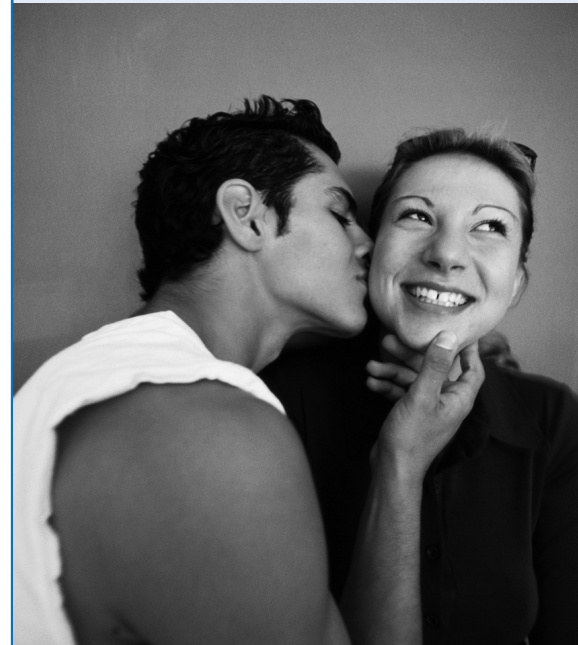
Untreated STIs result in spread of disease to sexual partners and damage to various other organ systems. Whenever possible, testing for the causative agent should occur in order to assure that proper treatment is provided.

### Implementation

Men presenting either with an exposure to STIs or symptoms of current infection should be provided immediate presumptive treatment. STI testing should be performed whenever possible to confirm the diagnosis. Testing, treatment, and follow-up should be based on current CDC Sexually Transmitted Disease Treatment Guidelines.



One in six couples  
face infertility  
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## Fertility Evaluation

### Best Practice

Each male should be questioned about his concerns regarding fertility; “Does he have any reason to believe that he may have difficulty fathering children?” “Does he believe he has ever been exposed to anything in his life that may make him sterile?” These questions could also be presented to the partner. Partners may have useful information and perspective.

### Rationale

One in six couples face infertility in the U.S. Male factors may contribute 30-40%. Testing the male is imperative in an initial evaluation. A physical and reproductive exam in conjunction with a semen analysis provides critical clinical information. Individuals from communities of color are less likely to be evaluated and treated for infertility concerns.

### Implementation

Evaluation of fertility concerns is part of a reproductive health history. Develop written instructions about semen collection and their transport to a laboratory. At each family visit, provide basic information about the prevention of infertility. Include fertility information for men seeking STI evaluation and treatment. The issue of fertility should be considered in women who are disappointed with negative pregnancy test results. Providers should consult with knowledgeable infertility providers when questions arise.

## Vasectomy

### Best Practice

When appropriate, vasectomy should be made available as a method of permanent male contraception. Although ejaculation and sexual pleasure is not impaired, the interruption of the vas deferens prevents passage of sperm into seminal fluid and female reproductive tract.

### Rationale

Vasectomy is a voluntary method of sterilization for males who are satisfied with the number of children they have and are not planning to father any more children. Vasectomy is intended to be a permanent method. Any adult male can choose to have a vasectomy; however, if a man is young or has no children, consideration should be given to using another method of contraception as to avoid regret in the future. Although surgical reversals of vasectomy are possible, the procedure is difficult and expensive, and the rate of success low.

### Implementation

An individual should discuss with a family planning doctor or counselor the benefits, side effects, and risks of having a vasectomy. One should be encouraged to consider the decision carefully and to discuss the decision with his partner. However, partner consent is not required for the procedure. Before a final decision is made, informational material should be provided for the client to take home.

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**Region II**





# Notes

# Notes

