HEALTH EDUCATOR RESOURCES & OPPORTUNITIES GUIDE

Healthy Teen Network

Health Educator Resources and Opportunities (HERO) Guide
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U.S. ADOLESCENT AND YOUNG ADULT MEN (AYAM) HEALTH PROFILE

INTRODUCTION

Healthy Teen Network has assembled this profile of United States adolescent and young adult men (AYAM) as a quick-reference for individuals and organizations planning or delivering resources and services to the AYAM population. The profile draws largely from data sets generated by U.S. public agencies. It first establishes the size of the U.S. AYAM population and then reports the health status and socio-ecological conditions of this population. Information is grouped in the following subject areas: race and ethnicity; socioeconomic status; education status; alcohol, tobacco and other drug use; sexual and reproductive health; mental health; mortality and intentional injuries; and access to health care.

This profile considers "adolescents" to be people ages 10 through 19 and "young adults" to be people ages 20 through 24, unless the data set indicated otherwise.
People interested in developing AYAM profiles at the state or sub-state level may access the sources for this profile to determine whether sub-national data is available through the source.

NUMBER OF U.S. ADOLESCENT AND YOUNG ADULT MEN

Adolescents and young adults (men and women) comprise 21 percent of the population of the United States (Healthy People 2020, Adolescent Health).
In 2015, the total projected population of U.S. AYAM is 32,849,398. The U.S. AYAM population is projected to be distributed as follows:

- 10,474,531 ages 10-14 (32 percent of total projected U.S. AYAM population)
- 10,722,184 ages 15-19 (33%)
- 11,602,683 ages 20-24 (35%)

(United States Census Bureau, n.d.)

RACE/ETHNICITY OF U.S. ADOLESCENT AND YOUNG ADULT MEN

In 2013, there were 33,077,678 U.S. AYAM.

Among adolescent boys ages 10-14:

- 8,046,692 were White
- 1,718,248 were African American
- 2,432,029 were Hispanic

Among adolescent boys ages 15-19:

- 8,267,941 were White
- 1,788,137 were African American
- 2,367,336 were Hispanic

Among young adult men ages 20-24:

- 8,824,851 were White
- 1,932,258 were African American
- 2,458,793 were Hispanic

(WISQARS, 2013)

SOCIOECONOMIC STATUS OF U.S. ADOLESCENT AND YOUNG ADULT MEN

(Note: U.S. child poverty rates are not readily available disaggregated neither by gender of the child nor age of the child.)

In 2013, 11 percent of White children, 10 percent of Asian children, 30 percent of Hispanic children, and 38 percent of Black children were poor. (DeNavas-Walt, C., & Proctor, B., 2014)

In 2013 the median income for households maintained by a householder aged 15 to 24 years was $34,311 (DeNavas-Walt et al, 2014).

In 2014, unemployment rates for young adults (men and women) were as follows (Child Trends Databank, 2014):

- 28% of Black young adults
- 16% of Hispanic young adults
- 14% of White young adults

The July 2014 labor force participation rate for 16- to 24-year-old men was 63.2 percent. (BLS, 2014)

In July 2014, 25 percent of employed youth worked in the leisure and hospitality industry (which includes food services), and 19 percent worked in the retail trade industry. (BLS, 2014)

Among youth ages 16 through 24 who have not enrolled in school, young men have an employment rate of 68 percent. (Child Trends Data Bank, 2014)

Among youth ages 16 through 24 who have not graduated high school, young men have an employment rate of 48 percent. (Child Trends Data Bank, 2014).

EDUCATION STATUS OF ADOLESCENT AND YOUNG ADULT MEN

Between 2000 and 2012, the high school dropout rate of AYAM ages 16 through 24 declined from 12 to 7 percent. (Education, 2014)

In 2013, 81 percent of young men had completed at least a high school education. (Education, 2014)

ALCOHOL, TOBACCO, AND OTHER DRUG USE AMONG U.S. ADOLESCENT AND YOUNG ADULT MEN

In 2013, among students grades nine through 12, the prevalence of having ever drunk alcohol was 64.4 percent among White adolescent men, 59.8 percent among Black adolescent men and 69 percent among Hispanic adolescent men. (YRBS, 2014)

In 2013, 33.2 percent of White, 17.8 of Black, and 20.7 percent of Hispanic male students grades nine through 12 reported current tobacco use (cigarette use, smokeless tobacco use, or cigar use) (YRBS, 2014).

In 2013, 20.4 percent of White, 28.9 percent of Black, and 27.6 percent of Hispanic male students grades nine through twelve reported current use of marijuana (YRBS, 2014).

SEXUAL AND REPRODUCTIVE HEALTH

An estimated nine percent of adolescent men between the ages of 12 and 16 will become fathers before their twentieth birthday. (OAH, 2015)

In 2013, 12.4 percent of White, 37.5 percent of Black, and 16.5 percent of Hispanic male students grades nine through 12 reported having had sexual intercourse with four or more persons during their lives. (YRBS, 2014)

In 2013, 57.1 percent of White, 64.7 percent of Black and 58.3 percent of Hispanic male students grades nine through 12 reported having used a condom during last sexual intercourse. (YRBS, 2014)

The chlamydia rate for adolescent men ages 15 through 19 years was 803.0 cases per 100,000 n 2011 (CDC, 2011).

Young adult men ages 20 through 24 years had the highest rate of chlamydia (1,343.3 cases per 100,000 men) compared with other males. (CDC, 2011).

The gonorrhea rate for adolescent men ages 15 through 19 years was 248.6 cases per 100,000. (CDC, 2011)

Young adult men ages 20 through 24 years had the highest rate of gonorrhea (450.6 cases per 100,000 males) compared with other males. (CDC, 2011)

Gay and bisexual men ages 13 through 24 accounted for an estimated 19 percent (8,800) of all new HIV infections in the United States, and 72 percent of new HIV infections among youth in 2010. (CDC, 2015)

MENTAL HEALTH

In 2013, 19.1 percent of White, 18.8 percent of Black, and 25.4 percent of Hispanic male students grade nine through 12 reported feeling so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing some usual activities (YRBS, 2014).

In 2013, 11.4 percent of White, 10.2 percent of Black, and 11.5 percent of Hispanic male students grades nine through 12 reported seriously considering or attempting suicide during the prior 12 months. (YRBS, 2014).

5.6 percent of White, 3.0 percent of Black, and 5.7 percent of Hispanic adolescent men ages 12 through 17 had at least one major depressive episode within the year prior to being surveyed. (SAMHSA, 2015).

MORTALITY/UNINTENTIONAL INJURIES AMONG U.S. ADOLESCENT AND YOUNG ADULT MEN

In 2013, the mortality figure for AYAM ages 10-24 was 17,453. (WISQARS, 2013)
The leading causes of death among AYAM are unintentional injuries, suicide, and homicide. (CDC, 2011)

In 2013, 10.1 percent of White, 7.7 percent of Black, and 11.2 percent of Hispanic male students grades nine through 12 reported having made a plan about how they would attempt suicide. (YRBS, 2014)

In 2013, the homicide rate was 2.2 per 100,000 for White, 45.0 per 100,000 for Black and 11.7 per 100,000 for Hispanic adolescent men. (Child Trends Data Bank, 2015).

ACCESS TO HEALTHCARE

Between 2005 and 2011, only 63 percent of 18- to 25- year-old men had any type of insurance coverage. (Sommers et al, 2013)

78% percent of young adult men do not have a usual source of health care. 41 percent of young adult men have not visited a doctor in the past 12 months. (Bell, et al 2013)
28% percent of uninsured adult men are between the ages of 19 to 24. Of these young adult men, the uninsured percentage is 20 percent among Whites, 38 percent among Blacks, and 43 percent among Hispanics. (Wilson-Frederick et al, 2014)

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SUGGESTED PROFESSIONAL RESOURCES

Healthy Teen Network knows that health professionals are always hungry for more resources, but also that they often do not have enough time in the day to search for materials. As Healthy Teen Network developed the *Volt20: 20 Questions to a Healthy Future (http://www.volt20.com/)* resource, we uncovered a bounty of websites, reports, and instructional materials that would be helpful, either for expanding health professionals' own subject learning or for identifying online and print teaching tools (curricula, lesson plans, handouts, pamphlets) suitable for adolescents and young adults. We have sorted our curated list of resources by the 20 healthy future subjects covered in *Volt*20.

WHERE I LIVE: LIVING ARRANGEMENT

Community Planning – The American Planning Association (www.planning.org) has developed resources for educators and youth workers to engage youth in thinking and learning about their communities. (American Planning Association, 2015)

Healthy Homes – The U.S. Surgeon General has issued a call to action that describes the steps people can take now to protect themselves from disease, disability and injury that may result from health hazards in their houses. (U.S. Department of Health and Human Services, 2009)

Healthy Neighborhoods – The Robert Wood Johnson Commission to Build a Healthier America has issued a brief that examines the current state of knowledge about neighborhoods and their links with health. (Cubbin, 2008)

Healthy Neighborhoods – The Stanford School of Medicine Youth Science Program has developed a 10-lesson, experiential *Public Health Advocacy Curriculum* intended to teach students how conditions in their neighborhood affect their health and engage them in health-related advocacy efforts. The curriculum was created for high school classrooms but lessons can be modified for other populations and settings. (Stanford University, Stanford Medicine, 2015)

Neighborhood Safety – Child Trends (www.childtends.org) has issued a report on the connection between neighborhood safety and child and youth development. (Child Trends, 2013)

Runaway Prevention – The National Runaway Safeline (www.1800runaway.org) provides educational tools and promotional materials for schools and youth-serving agencies, including an

evidence-based, interactive, 14 module curriculum intended to educate young people about alternatives to running away as well as to build life skills so that youth can resolve problems without resorting to running away or unsafe behavior. (National Runaway Safeline, 2007)

RELATIONSHIPS AT HOME

Parent-Child Connectedness – *Parent-Child Connectedness: Implications for Research, Interventions and Positive Impacts on Adolescent Health* describes the many ways that parents matter in improving their teen children's odds for success. It provides a comprehensive review of the research literature, plus offers some practical insights. (Lezin, 2004)

ABUSE AT HOME

Child Abuse and Neglect Reporting – *Mandatory Reporters of Child Abuse and Neglect* discusses laws that designate the groups of professionals that are required to report cases of suspected child abuse and neglect. Summaries of laws for all States and U.S. territories are included. (Child Welfare Information Gateway, 2014)

WHERE I LEARN & WORK: EDUCATION AND EMPLOYMENT ARRANGEMENTS

Career Exploration – The U.S. Department of Labor (www.dol.gov) offers resources for educators and youth workers to guide youth through career exploration. (U.S. Department of Labor, 2015)
Health Barriers to Learning – The Education Commission of the States has issued *Health Barriers to Learning and the Education Opportunity Gap*, an issue brief on the connection between health and students' motivation and ability to learn. (Basch, 2015)

RELATIONSHIPS AT SCHOOL AND WORK

Positive Social Skills – Child Trends (www.childtrends.org) has issued a fact sheet on *What Works for Promoting and Enhancing Positive Social Skills: Lessons Learned from Experimental Evaluations of Programs and Interventions*. (Bandy, 2011)

VIOLENCE AT SCHOOL AND WORK

School Violence – The U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (www.cdc.gov) has compiled school violence prevention publications and resources, including links to other federal agency resources, at http://www.cdc.gov/violenceprevention/youthviolence/schoolviolence/tools.html. (U.S. Centers for Disease Control and Prevention, 2015)

Teaching Tolerance – Teaching Tolerance (www.tolerance.org), a project dedicated to reducing prejudice, improving intergroup relations and supporting equitable experiences for children and youth has developed resources for educators and youth workers. (Teaching Tolerance, 2015)

HEALTH CARE ARRANGEMENT

Health Professions – The American Medical Student Association (www.amsa.org) has developed a *Teen Education and Careers in Healthcare* curriculum to introduce youth to the various health professions. While designed as a career exploration tool, educators and youth workers could also use this curriculum to educate youth about the health professionals they encounter in the health care system. (American Medical Student Association, 2015)

DISEASES

HPV Education – The U.S. Centers for Disease Control and Prevention (www.cdc.gov) has developed and compiled human papillomavirus (HPV) materials for health educators to use with their program participants. (U.S. Centers for Disease Control and Prevention, 2015)

National Health Education Standards – The National Health Education Standards establish, promote and support health-enhancing behaviors for students in all grade levels—from pre-kindergarten through grade 12. (U.S. Centers for Disease Control and Prevention, 2015)

EATING

Food and Nutrition Education – The U.S. Department of Agriculture (www.nutrition.gov) has developed and compiled resources for educators and youth workers to teach youth about food and nutrition. (U.S. Department of Agriculture, National Agricultural Library, 2015)

Food Deserts – Teaching Tolerance (www.Tolerance.org) has developed a lesson plan to teach youth about the causes, consequences, and solutions to food deserts. (A food desert is a geographic area where residents' access to affordable, healthy food options is restricted or nonexistent due to the absence of grocery stores within convenient travelling distance.) (Teaching Tolerance, 2015)

BODY IMAGE

Media and Body Image – Common Sense Media has developed *Children, Teens, Media, and Body Image: A Common Sense Media Research Brief,* which reviews existing research on traditional media as well as emerging research on digital and social media with regards to body image. (Common Sense Media, 2015)

MY IDENTITY: PERSONAL IDENTITY

Adolescent Development – The U.S. Department of Health and Human Services, Office of Adolescent Health, has developed an e-learning module on adolescent development. The module consists of four parts covering biological and brain development, cognitive development, identity and social development, and healthy youth development. (U.S. Department of Health and Human Services, Office of Adolescent Health, 2015)

Identity Development – The ACT for Youth Center of Excellence (www.actforyouth.net) has developed and compiled resources on youth identity development. (ACT for Youth Center of Excellence, 2015)

Identity Formation – *Identity Formation in Adolescence: Change or Stability?* (Klimstra, 2010)

LGBT Youth – The U.S. Substance Abuse and Mental Health Services Administration has published *A Practitioner's Resource Guide: Helping Families to Support Their LGBT Children*. (U.S. Substance Abuse and Mental Health Services Administration, 2014)

HOW I FEEL: EMOTIONS AND MOODS

Mental Health Community Solutions – The *Community Conversations about Mental Health* webpage provides information on holding a community dialogue that builds awareness and support around mental health issues. (U.S. Substance Abuse and Mental Health Services Administration, 2015)
Mental Health and Substance Abuse Programs Registry – The *National Registry of Evidence-based Programs and Practices* is a searchable online registry of more than 350 substance abuse and mental health interventions. (U.S. Substance Abuse and Mental Health Services Administration, 2015)

HOW ACTIVE I AM: PHYSICAL ACTIVITY

Physical Activity Guidelines – The U.S. Centers for Disease Control and Prevention (www.cdc.gov) has developed a *Youth Physical Activity Guidelines Toolkit* to highlight strategies that schools, families, and communities can use to support youth physical activity. (U.S. Centers for Disease Control and Prevention, 2015)http://www.cdc.gov/healthyyouth/physicalactivity/guidelines.htm.

Physical Activity Textbook – The U.S. Centers for Disease Control and Prevention has issued a textbook for *Promoting Physical Activity: A Guide for Community Action*. (U.S. Centers for Disease Control and Prevention, 2015)http://www.cdc.gov/physicalactivity/strategies/communityguide.html.

TOBACCO AND NICOTINE USE

Youth Tobacco Cessation Guide – The U.S. Centers for Disease Control and Prevention (www.cdc.gov) has issued *Youth Tobacco Cessation: A Guide for Making Informed Decisions*. (Milton, 2015)

Youth Tobacco Cessation Effective Practices – The Robert Wood Johnson Foundation (www.rwjf.org) has issued Helping Young Smokers Quit: Identifying Best Practices for Tobacco Cessation. (Robert Wood Johnson Foundation, 2012)

Youth Tobacco Cessation Resources – The U.S. Department of Health and Human Services has developed and compiled at www.teen.smokefree.gov free evidence-based resources to help teens quit smoking. (U.S. National Institutes of Health, 2015)

ALCOHOL USE

Alcohol Screening – *Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide* helps health care professionals quickly identify youth at risk for alcohol-related problems. (U.S. National Institutes of Health, 2015)

Substance Abuse Community Solutions – *Focus on Prevention* helps a wide range of groups and communities move from concerns about substance abuse to proven and practical solutions. (U.S. Substance Abuse and Mental Health Services Administration, 2010)

Substance Abuse and Mental Health Programs Registry – The *National Registry of Evidence-based Programs and Practices* is a searchable online registry of more than 350 substance abuse and mental health interventions. (U.S. Substance Abuse and Mental Health Services Administration, 2015)

DRUG USE

Substance Abuse Community Solutions – *Focus on Prevention* helps a wide range of groups and communities move from concerns about substance abuse to proven and practical solutions. (U.S. Substance Abuse and Mental Health Services Administration, 2010)

Substance Abuse and Mental Health Programs Registry – The *National Registry of Evidence-based Programs and Practices* is a searchable online registry of more than 350 substance abuse and mental health interventions. (U.S. Substance Abuse and Mental Health Services Administration, 2015)

Drug Abuse Education Resources – The National Institute on Drug Abuse has developed and compiled resources for educators and youth workers on drug abuse at www.drugabuse.gov. (U.S. National Institutes of Health, 2015)

SEXUAL ACTIVITY

HIV Prevention Programs Registry – The U.S. Centers for Disease Control and Prevention has compiled a *Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention*. (U.S. Centers for Disease Control and Prevention, 2015)

HIV Prevention and Care Resources – The National Resource Center for HIV/AIDS Prevention among Adolescents (https://preventyouthhiv.org) has developed and compiled resources on youth HIV prevention and care. (National Resource Center for HIV/AIDS Prevention among Adolescents, 2015)

Teen Pregnancy Prevention Programs Registry – The U.S. Department of Health and Human Services, Office of Adolescent Health has posted the *Teen Pregnancy Prevention Evidence Review*, a searchable online registry of programs with impacts on teen pregnancies or births, sexually transmitted infections, or sexual activity. (U.S. Department of Health and Human Services, Office of Adolescent Health, 2015)

MY INTIMATE RELATIONSHIPS

Adolescent Relationship Abuse Prevention – The U.S. Department of Health and Human Services, Family and Youth Services Bureau (http://www.acf.hhs.gov/programs/fysb) has issued a *Toolkit to Incorporate Adolescent Relationship Abuse Prevention into Existing Adolescent Pregnancy Programs*. (U.S. Department of Health and Human Services, Administration for Children and Families, 2015)

Teen Dating Violence Community Solutions – The Idaho Coalition against Domestic and Sexual Violence (www.idvsa.org) has launched the Our Gender Revolution campaign, including public service awareness materials and *A Guide to Get Teens Involved in Preventing Dating Violence*. (Idaho Coalition against Domestic and Sexual Violence, 2015)

Teen Dating Violence Prevention Curricula – Break the Cycle (www.breakthecycle.org) has developed *Love is Not Abuse* teen dating violence and abuse prevention curricula for high school-aged and college-aged students. (Break the Cycle, 2010)

GOING ONLINE: MEDIA ACTIVITY

Media Literacy Education – Media Power Youth (www.mediapoweryouth.org) has developed and compiled resources for teaching media literacy to youth. (Media Power Youth, 2015)
Media and Youth Violence – The U.S. Centers for Disease Control and Prevention (www.cdc.gov) has issued *Electronic Media and Youth Violence: A CDC Issue Brief for Educators and Caregivers*. (Hertz, 2008)

HOW I SPEND MY FREE TIME: FUN ACTIVITY

Leisure Time – The United Nations included a scholarly chapter on leisure time in its 2003 World Youth Report. (United Nations, 2003)

Recreation Services – The National Recreation and Parks Association (www.nrpa.org) has published a report on *The Rationale for Recreation Services for Youth: An Evidence-based Approach*. (Witt, 2010)

Youth Interest Exploration – The Thrive Foundation for Youth (www.stepitup2thrive.org) has issued tips for educators and youth workers to help youth discover their interests. (Thrive Foundation for Youth, 2015)

Youth Interest Exploration Resources – The Search Institute (www.search-institute.org) has developed *Igniting Sparks* curricula, available for purchase, to help youth tap into their unique talents and interests. Each *Igniting Sparks* kit offers age-appropriate lesson plans, posters, and other items that lead youth to identify their interests and collaborate with peers in developing their sparks. (Search Institute, 2015)

ADOLESCENT & YOUNG ADULT MEN'S HEALTH FOCUS GROUPS: FINDINGS AND RECOMMENDATIONS

BACKGROUND

American Sexual Health Association, Healthy Teen Network, Partnership for Male Youth, and School-Based Health Alliance collaborate through the *Young Male Well Visit Project* to increase adolescent and young adult men's (AYAM) access to and utilization of primary care, reproductive, and other health services, including immunizations from preventable diseases. Boys and young men are underrepresented in health care utilization. Through the Young Male Well Visit Project, the collaborating organizations seek to reverse this disparity by delivering AYAM-friendly educational materials to youth and their families, clinical materials for health care providers, and inclusion training to youth-supporting professionals and volunteers. The project's products and services will elevate the importance of health care to boys and young men, their parents, and other caring adults. The Young Male Well Visit Project was made possible (in part) by an independent grant from Merck.

AYA MEN FOCUS GROUP PURPOSE

As part of the *Young Male Well Visit Project*, Healthy Teen Network, a national adolescent health organization, and School-Based Health Alliance, a national association of school-based health centers and school health professionals, conducted focus groups with adolescent and young adult men (AYAM) to gather information from the intended beneficiaries of the project. We conducted the focus groups to gather information from AYAM of various races, ethnicities, and socioeconomic statuses about their attitudes on general health; sexual and reproductive health; sources of health information; and experiences with well visits.

METHODS

Healthy Teen Network and School-Based Health Alliance conducted 10 focus groups with a total of 68 AYAM ages 14 to 24 from May to July 2015. We recruited this convenience sample of participants from several community- and school-based programs with direct access to AYAM. School-Based Health Alliance recruited participants from their school-based affiliates in California, Georgia, and Maryland. Healthy Teen Network recruited participants from community-based organizations in Maryland and the District of Columbia.

The focus group discussions addressed the following topics: 1) young men's definition of health and well-being, 2) sources of health information, 3) attitudes about annual physical check-ups, 4) attitudes about sexual and reproductive health, including specifically the human papillomavirus vaccination. As part of the focus group discussion, we asked participants to provide feedback on a general health check-up checklist and to complete a brief survey. The survey included basic demographic questions and questions relevant to the checklist. This report will only share the results of the focus group discussion and demographic information of the participants.

The group discussion and survey were completely anonymous. We provided food and beverage to participants, as well as a $15 gift card. A private Institutional Review Board approved the study. Due to its low risk level, the IRB did not require us to obtain parental consent for the AYAM participation.

We recorded all focus groups with permission of participants and transcribed the discussion verbatim. We analyzed the focus group scripts to identify trending themes for each research topic. Although the transcripts differentiated the interviewer from the participant, it was very difficult to accurately identify each individual participant. Therefore, we analyzed each focus group as one unit.

RESULTS

We conducted a total of 10 focus groups, lasting an average of 44 minutes. Participants ranged from 14 to 24 years old, with a mean age of 16.9. Most participants (66%) were African American and most resided in urban/ city areas (75%). The level of mother's education (a proxy for AYAM socioeconomic status) varied among participants, but the majority reported that their mothers completed at least high school or GED (25%) or college education (27%). Of those reporting their sexual history, the majority (84%) reported ever having sexual intercourse. Participants 16 and younger were more likely not to have ever had sex than their older peers. Additionally, most participants (84%) reported having a primary care physician.

PARTICIPANTS' DEMOGRAPHIC DATA

Variables	Frequency (Percentage)
Age of Participants	
14	1 (1.5%)
15	13 (19.1%)
16	24(35.3%)
17	14 (20.6%)
18	9 (13.2%)
21	3 (4.4%)
22	1 (1.5%)
23	1 (1.5%)
24	2 (2.9%)
Participants' Race	
Black	45 (66.2%)
Latino	9 (13.2%)
White	3 (4.4%)
Other	11 (16.2%)
Mother's Education level	
Completed 8th grade	4 (6.0%)
Some high school	15 (22.7%)
Completed high school/ GED	17 (25.8%)
Some College	12 (18.2%)
Completed college degree	18 (27.3%)
Ever had sex	
Yes	53 (84.1%)
No	10 (15.9%)

The results from the focus groups' thematic analysis are organized below by the main topics of interest of the exploratory study.

YOUNG MEN HAD VARYING DEFINITIONS OF HEALTH AND WELL-BEING.

When asked about how they define "health", participants used words or phrases such as "hygiene", "being active/physically fit", "sports", "mental health", "exercise", "nutrition", "STDs", "pregnancy', "violence/gang involvement", "chronic disease such as asthma and diabetes", "lead paint contamination", "cigarette and marijuana smoking", "cancer", "HIV/AIDS", "stress", "PTSD/trauma", "alcohol use", "depression", and "drug use". Nutrition, being physically fit, STDs, and drug/alcohol uses were consistently reported across all focus groups as important health problems both among participants and their peers. Another recurring theme among the focus groups was hygiene. Most of the participants seemed concerned about the hygienic behaviors of their friends and their peers such as "not taking showers" and "brushing their teeth". Some focus groups reported violence and gang related activities and its repercussion on their environment and school. For some of the participants that played sports, concussion was a common concern for them and their friends.

INTERNET PREVAILS AS LEADING HEALTH INFORMATION SOURCE.

When asked about where they go to get health information, many participants initially indicated their health care provider. However, upon further probing, it became clear that the Internet is the first place they consulted whenever something is wrong with them or when they need specific answers to certain health questions. Many consider Google as the main site for obtaining health information. Participants were split on how they decide on websites to use while on Google; while some reported that they go on the first website that appears from their Google searches, others reported looking at 3-5 websites before deciding on what website to use. Though participants reported internet searches as their top primary source of obtaining health information, they were also very aware of the accuracy of the information they obtain from these sites. Participants said that they do not trust most of the information they get from Internet searches; therefore, they are more likely to go to their parents or health care providers for accurate diagnosis.

Family and Peers: Another main source of obtaining health information was through family members such as parents, grandparents, aunts, uncles, peers, and other older adults. Participants reported seeking additional advice from family members after their initial Internet searches to obtain specific answers or confirm the diagnosis suggested from their internet searches. Additionally, participants reported school/community health centers, books, and social media as other places they obtain health information. Though most participants reported the use of social media for obtaining health information, participants reported low trust level on the information obtained from social media. With family members, most participants were very comfortable talking to their mother about general health questions. On the other hand, participants are more likely to seek out men when looking for answers to sexuality questions. Many expressed seeking advice from peers that are either in similar situations or have gone through a situation similar to what they are currently facing.

Healthcare providers: Although participants place great importance and trust on the information provided by their physician or nurse, they do not have frequent contact time with them, and thus it is not a significant source of information. Participants said that their physician office would be the last place they go to if a symptom is severe. Most reported using the Internet to search and learn about their symptoms, confirm the symptoms with a parent, and then go to a clinic or physician's office for solutions.

Time spent seeking health information: The amount of time spent with each source depended on the severity of participants' symptoms. For example, participants reported spending as little as five minutes to over one hour while searching on Google for health information. Similar to above, reported time is also spent with family members based on severity of symptoms.

Comfort level: Participants reported that they are more likely to spend more time and talk with family members or other adults with whom they feel comfortable. Level of comfort was also determined by adults' rapport with them. Most said they would spend at least one hour with someone they feel has their best interests at heart. All focus groups reported that they are more likely to talk with people that are nonjudgmental towards them. In addition, the amount of time they will spend with these adults is dependent on how much they trust the adult and the information the adult is giving them. With family members, level of comfort was split. While some participants expressed that their parents are very uncomfortable talking to them about sexuality questions, others expressed feeling uncomfortable about talking to their parents about their sexual problems. For example, in all groups, participants reported feeling comfortable if the parents were giving advice rather than telling them not to have sex.

Mobile app for health information: When asked about their interest in using a health mobile app, participants were split on their interest. While some of the participants wanted an app to answer their questions, some expressed no interest in obtaining an app. Many expressed that they believe their personal information is not safe on an app and that it could easily be obtained by other people. Other participants expressed that though they might initially get the app if they are experiencing certain symptoms; they are more likely to delete the app once they get the information they need. However, participants who wanted the app expressed that they want apps that have guides and solutions to different STDs, chronic diseases, and life skills. In addition, participants said they are more likely to get an app that does not take too much storage space on their devices.

MOST PARTICIPANTS HAD A POSITIVE EXPERIENCE WITH PHYSICAL CHECK-UPS.

Participants in most focus groups were familiar with physical check-ups. Most participants reported going to physical examinations. Their participation rate in physical examinations ranged from going every few months, to every few years, to when something "was wrong". It was impossible to accurately confirm the frequency of receiving a standard check-up outside of sick visits. However, most participants felt these check-ups were important to maintain optimal health.

Many consider that other young men like themselves do not get regular check-ups because either they are lazy or they are afraid of what they can find out. These were recurring themes throughout most groups. Participants said they would motivate others to get regular physicals by telling them the importance of knowing more about their body. They would also encourage them by reminding them of the people who depend on them, if they have kids or parents they need to help. Participants

in multiple groups related personal experiences of people they knew who found out too late about a chronic condition.

Although participants are open to the idea of regular check-ups, all were clear on their expectations and what makes them feel comfortable in a visit. First, most focus groups reported that it is important to know the provider. Some participants have been to the same provider since they were born, others have developed a relationship with their providers over time. They say that building a relationship is crucial to open up and trust the provider. Having an honest, friendly, and caring provider is important to boost comfort levels. Moreover, they appreciate the time providers take in getting to know them, asking about their day, or their life, rather than just focusing on the visit.

Throughout the discussion sessions, participants in most groups expressed their interest in having accurate and complete information before and during their visit. They want to know what to expect from a visit, and why certain recommendations are important. For example, one group in particular wants information of a step-by-step process of a typical visit, so they are aware that they will be touched and their genitalia examined. Although some acknowledged that they receive some information, the touching aspect of a physical check-up was considered the most uncomfortable aspect of the visit. The vast majority of participants expressed a preference for female providers when it came to the physical examination. Most reported feeling uncomfortable being physically examined by providers who are men. However, many preferred providers who are men when it came to some health issues. According to them, providers who are men were more suitable to answer questions because they were men.

Participants expressed diverse opinions when it came to following providers' recommendations. Some believed they should always follow a physician's advice because the doctors knowledgeable; "that's what they went to school for" was a common assertion. There was a great deal of trust placed on the "doctor" title. However, many acknowledged that providers sometimes do not acknowledge their needs and make recommendations on medications, vaccinations or treatment without fully explaining the condition in a way they understand. Also, Maryland-area participants expressed divergent views of the medical establishment. While some fully trust the health care providers and community clinic staff, many distrust large medical institutions and believe these institutions conduct unethical research on uninformed patients.

PARTICIPANTS ACKNOWLEDGE THEY HAVE AN IMPORTANT ROLE IN THEIR SEXUAL AND REPRODUCTIVE HEALTH.

When asked about their role in the prevention of an unintended pregnancy or sexually transmitted infections, the majority of participants across focus groups acknowledged that they play a big role. As for protection, participants in most groups mentioned condoms as the primary form of protection. Many also mentioned the pull-out method (or withdrawal) as a form of pregnancy prevention. Only a few participants mentioned that as men they should ask their partners whether they are using some type of birth control method. Participants in most groups also mentioned that men should talk to their partners to see if they have any STI. A handful of participants mentioned going to a clinic to get tested.

KNOWLEDGE ABOUT HPV INFECTION AND THE VACCINE WAS LOW.

It was unclear participants' level of knowledge about HPV, the HPV vaccine and whether they had received it or not. When asked about HPV in general, most said that it sounded familiar, but they were not sure what exactly it was or the health impact of the infection. They had a similar reaction to the vaccine. Most groups reported knowing something about the vaccine, but upon asking further questions, it was likely that they were confusing the HPV vaccine with other seasonal vaccines. For example, participants reporting knowing about the vaccines also reported getting it every year at the start of the season, or getting a nasal spray, or getting it when they were born. After the group facilitators explained briefly what HPV is, most reported being motivated to get it. However, some groups were interested in some sort of incentive to get a vaccination, such as a gift card.

CONCLUSIONS

Focus groups were conducted with (AYAM) to gather information about their attitudes on general health; sexual and reproductive health; sources of health information; and experiences with well visits. Overall, all youth acknowledged that their primary source for obtaining information about their health is the internet even though they expressed distrust on the information they obtain from these sites; ultimately relying on their medical providers to provide them with accurate information.

However, exposure time with their medical provider is very limited to their routine annual well visit which generally lasts about 20 minutes. This, coupled with youth's willingness to sit down with medical professionals who are willing to educate them about their health, provides ample opportunities for medical professionals to create programs that will increase exposure time with these young men. Increased use of technology and social media by medical professionals and youth serving organizations in providing quick and accurate health information will prove beneficial in increasing health literacy among youths.

In regards to general sexual health, participants seemed knowledgeable about different STIs, condom use, pregnancy prevention and testing centers, but there is a limited knowledge on HPV disease as well as the HPV vaccine. Though most participants said they have gotten the HPV vaccination, it was unclear if it was the HPV vaccine or just other vaccines in general. After explaining what the HPV vaccine is and the diseases it prevents, there was a positive attitude among the participants in obtaining the vaccine. Low levels of knowledge was common among all focus groups; thus, health professionals and medical providers need to educate youth more about the vaccine and the health problems that may be prevented by it. Based on these observations, we recommend health care providers take into consideration the following health needs of young men.

Approach to health:

- When discussing health issues with young men, providers should use a more holistic approach and include discussion about nutrition, fitness, violence, substance use as well as sexual health.
- Young men appreciate comprehensive and complete information explained in simple language they can understand.
- Young men are more receptive to clinician's instructions when they build some rapport with the young men they serve.

Sources of Health Information:

- Young men greatly valued clinicians as a source of trustworthy information. Yet, they spend less than 30 minutes per year talking to a clinician. Clinicians should encourage open conversations during clinic visits and frequent clinical in-person or phone consults for other health issues.
- Given that young men most frequently consult online sources, clinicians may provide a list of vetted and trustworthy websites young men can visit for general health information.
- Also, clinicians may educate their young men patients on media literacy so they can better judge online sources of health information.
- Young men reported interest in health related apps. These apps should address relevant health topics and not take too much storage space.

Physical Examination:

- Although most participants went to annual check-ups, they all wanted additional education information about the visit. Clinicians should have available educational materials explaining what to expect from a physical and the importance of each aspect of the examination, including examination of genitalia, vaccines, and disease prevention.
- Young men reported that they are more likely to trust providers they have seen for many years. Clinician stability in a clinical setting is important to ensure continuity of care by the same person.
- Some young men reported feeling judged and rushed through the visit. Clinicians should strengthen their communication skills to build rapport and encourage trust with young men.
- Many young men had strong feelings about the gender of the provider. Many agreed that they feel more comfortable talking and being examined by a provider who is a woman. However, they preferred a provider who is a man if they had to talk about "men things." Providers should be aware of how their own sex can impact the level of comfort of their young men patients.

Sexual and Reproductive Health:

- Clinicians should use contact time with their patients to assess sexual health risk and emphasize healthy sexual behaviors, particularly condom use. Although most participants mentioned the condom as the main way they prevent pregnancies and STIs, some acknowledged that they do not use any protection or expressed myths regarding condom safety. Clinician can also educate about birth control used by people with uteruses, as young men reported very low knowledge on that subject.
- Young men reported low knowledge about different STIs. Clinicians should provide information about different STIs, mode of transmission, treatment or cure availability and communication strategies with partners.

- Most young men were not aware of HPV nor the vaccine. This vaccine was often confused with seasonal vaccines. Clinicians should provide information about vaccine schedule and a description of this vaccine in particular. Young men should be educated about the risks of HPV and the benefits of the vaccines for them and their future partners.

These focus groups provided general insights and overview on the health concerns of AYAM. Overall, there is a promising trend in young men's action towards their general health care either through seeking out the information themselves or talking to someone who will educate them about their health. Medical providers and other organizations that serve young men need to provide more opportunity for increased exposure time between young men and their medical providers. Finally, the use of technology in promoting health literacy is greatly needed and would prove beneficial to both the young men and the adults serving them.

Annotated Literature Review Regarding Adolescent and Young Adult Men's Access to and Utilization of Primary Care, Reproductive, and Other Health Services

Literature Review Methods Summary

Healthy Teen Network seeks to increase adolescent and young adult men's (AYAM) access to and utilization of primary care, reproductive, and other health services, including immunizations from preventable diseases. AYAM are underrepresented in health care utilization. Healthy Teen Network seeks to reverse this disparity by developing educational materials for youth, their families, clinicians, and other youth-supporting entities that provide health care to boys and young men.

Healthy Teen Network conducted a literature review on the following topics to evaluate where gaps can be filled in providing optimum and adequate healthcare for AYAM. We collected documents whose research or information focused on the following topics:

1. Rates of health insurance coverage among AYAM and effective strategies for enrolling AYAM in public and private health insurance.
2. Types of health care access points for AYAM.
3. Rates of AYAM's utilization of preventive health, primary health, reproductive health, and/or immunization services.
4. Causes of low uptake of AYAM's utilization of preventive health, primary health, and reproductive health and/or immunization services.
5. Evidence-based or promising approaches to encourage/increase AYAM's utilization of preventive health, primary health, reproductive health, and/or immunization services.
6. Effective preventive health, primary health, reproductive health, and/or immunization messages for AYAM.
7. Effective preventive health, primary health, reproductive health, and/or immunization messages for parents/family of AYAM.
8. Effective techniques for health screening and examination of and counseling with AYAM.

9. Effective techniques for parent dialogue with AYAM about health issues.

We used the following keywords for the search criteria: **"HEALTH," "CLINIC UTILIZATION," "MALE HEALTH," "COMMUNICATION METHODS," "EFFECTIVE HEALTH DISSEMINATION STRATEGIES," "MALE-FOUCUSED EVIDENCE BASED PROGRAMS," "REPRODUCTIVE HEALTH," "VACCINATION," "HPV," "ADOLESCENT HEALTH," "YOUNG MALE HEALTH," and "WELL VISITS."** We conducted a literature review using both the individual keyword as well as a combination of keywords. We used only free databases to obtain the articles that meet the criteria for our study questions. First, we searched these keywords in Google Scholar for a general overview of the literature. Second, we used PubMed to further search for articles. Lastly, we checked the references in the existing articles. There was no specific time span used as all articles were reviewed. We only reviewed articles that focused on young men between the ages of 10-24. We selected articles based on relevance to the research questions after reading each abstract.
Below are the documents we uncovered through our search. The summaries are pulled from the documents themselves.

Adelman, W., & Joffe, A. (1999). The adolescent male genital examination: What's normal and what's not. *Contemporary Pediatrics*-Montvale-, *16*, 76-92. Available at http://connection.ebscohost.com/c/articles/3931817/adolescent-male-genital-examination-whats-normal-whats-not.

This report "offers information on how pediatricians should conduct a genital examination on male adolescent patients. [Topics addressed include:] Reasons behind the importance of a genital exam; Where and how to perform the exam; Examination of the pubic area; Pearly penile papules; Scrotum and testis examination; [and] Scrotal lumps and bumps."

Alexander, A. B., Stupiansky, N.W., Ott, M.A., Herbenick, D., Reece, M., & Zimet, G.D. (2014). What parents and their adolescent sons suggest for male HPV vaccine messaging. *Health Psychology*, 33(5), 448. Available at http://www.ncbi.nlm.nih.gov/pubmed/24588632.

"The purpose of this article was to identify the information parents and their adolescent sons deem important when making the decision to get vaccinated against human papillomavirus (HPV).
Method: Twenty-one adolescent males (ages 13 to 17), with no previous HPV vaccination, and their

parents were recruited from adolescent primary care clinics serving low-to middle-income families in a large Midwestern city. Dyad members participated in separate semistructured interviews eliciting the information participants felt would increase vaccine uptake and series completion via media and clinic-based sources. Interviews were recorded, transcribed, and coded using inductive content analysis. Results: Overall, participants felt fear-based messages would be most effective for increasing vaccination uptake through commercials. When describing clinic messages, parents and sons felt the most important component was a recommendation for vaccination from the health care provider (HCP). Additionally, parents desired more information about the vaccine from the HCP than the sons, including cost, number of shots, and time since the approval of the vaccine for males. Compared with the clinic message, the commercial message was a vector for vaccine awareness, whereas the clinic message was a source of vaccine information. Vaccine initiation messages should provide vaccine information and come from an HCP, whereas completion messages should remind the patient why they initiated the vaccine and can come from any medical staff. Conclusions: Family/individual-focused interventions should be tailored to message source, timing, and target audience. This information can be used to guide public health professionals in the development of interventions to increase vaccine uptake."

Barbour, D. (2015). Clinical Interventions to Improve Health Outcomes in Young Male Patients [PowerPoint slides]. Retrieved from http://s3-us-west-1.amazonaws.com/active-asap/documents/documents/000/000/041/original/Barbour_Improving_outcomes_in_males.pdf.

This presentation provides an overview of health gender disparities, men's health issues, and adolescent men's health issues. It also provides information about the Partnership for Male Youth, including its research, findings, tools, and current and future work.

Bell, D.L. (2003). Adolescent male sexuality. Adolescent Medicine Clinics, 14(3), 583. Available at http://www.ncbi.nlm.nih.gov/pubmed/15122162.

"Adolescence is a transition period between childhood and adulthood. During this time, the body develops into an adult and reproductively mature body. For many adolescents, it is the time of completion of high school, finding first jobs, leaving home, and beginning college. It is a stage to discover and establish an identity independent of the family. It is a time of exploration of romantic relationships, including the initiation of sexual relations. All adolescents are sexual beings whether

they are sexually active or not. Adolescents are often sexually active—a fact supported by data from many developed countries. Most adolescent males have their first sexual experience during their teenage years. Health care providers are not always comfortable addressing their sexual activity, however. Only one third of adolescent males report talking with their clinician about a reproductive health topic. It is essential for health care providers caring for adolescents to understand male sexuality during the teenage period. This article provides an overview of heterosexual adolescent male sexuality."

Bell, D.L., Breland, D. J., & Ott, M. A. (2013). Adolescent and young adult male health: A review. *Pediatrics*, 132(3), 535-546. doi:10.1542/peds.2012-3414 [doi]. Available at http://pediatrics.aappublications.org/content/132/3/535.

"Adolescent and young adult men's health receives little attention, despite the potential for positive effects on adult quality and length of life and reduction of health disparities and social inequalities. Pediatric providers, as the medical home for adolescents, are well positioned to address young men's health needs. This review has two primary objectives. The first is to review the literature on young men's health, focusing on morbidity and mortality in key areas of health and well-being. The second is to provide a clinically relevant review of the best practices in young men's health. This review covers male health issues related to health care access and the Centers for Disease Control and Prevention's Healthy 2020 objectives for adolescents and young adults, focusing on the objectives for chronic illness, mortality, unintentional injury and violence, mental health and substance use, and reproductive and sexual health. We focus, in particular, on gender-specific issues, particularly in reproductive and sexual health. The review provides recommendations for the overall care of adolescent and young adult males."

Cates, J.R., Diehl, S.J., Crandell, J.L., & Coyne-Beasley, T. (2014). Intervention effects from a social marketing campaign to promote HPV vaccination in preteen boys. Vaccine, 32(33), 4171-4178. Available at http://www.ncbi.nlm.nih.gov/pubmed/24886960.

"Adoption of human papillomavirus (HPV) vaccination in the US has been slow. In 2011, HPV vaccination of boys was recommended by CDC for routine use at ages 11–12. We conducted and evaluated a social marketing intervention with parents and providers to stimulate HPV vaccination among preteen boys. Methods: We targeted parents and providers of 9–13 year old boys in a 13 county NC region. The three-month intervention included distribution of HPV vaccination posters and brochures to all county health departments plus 194 enrolled providers; two radio PSAs; and an

online CME training. A Cox proportional hazards model was fit using NC immunization registry data to examine whether vaccination rates in 9–13 year old boys increased during the intervention period in targeted counties compared to control counties (n = 15) with similar demographics. To compare with other adolescent vaccines, similar models were fit for HPV vaccination in girls and meningococcal and Tdap vaccination of boys in the same age range. Moderating effects of age, race, and Vaccines for Children (VFC) eligibility on the intervention were considered. Results: The Cox model showed an intervention effect (ˇ = 0.29, HR = 1.34, p = .0024), indicating that during the intervention the probability of vaccination increased by 34% in the intervention counties relative to the control counties. Comparisons with HPV vaccination in girls and Tdap and meningococcal vaccination in boys suggest a unique boost for HPV vaccination in boys during the intervention. Model covariates of age, race, and VFC eligibility were all significantly associated with vaccination rates (p < .0001 for all). HPV vaccination rates were highest in the 11–12 year old boys. Overall, three of every four clinic visits for Tdap and meningococcal vaccines for preteen boys were missed opportunities to administer HPV vaccination simultaneously. Conclusions: Social marketing techniques can encourage parents and health care providers to vaccinate preteen boys against HPV."

Cates, J.R., Ortiz, R., Shafer, A., Romocki, L.S., & Coyne-Beasley, T. (2012). Designing messages to motivate parents to get their preteenage sons vaccinated against human papillomavirus. *Perspectives on Sexual and Reproductive Health*, 44(1), 39-47. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3306606/.

"Human papillomavirus (HPV) vaccine, licensed for use in 9- to 26-year olds, is most effective when given before sexual activity begins. HPV causes genital warts, is associated with several cancers, and disproportionately affects racial and ethnic minorities. Parents are typically unaware of the HPV vaccine for men; messages that might motivate them to get their pre-teenage sons vaccinated are unexplored. Methods: Messages promoting vaccination of pre-teenage boys were designed and tested in 2009 and 2010. Five focus groups were conducted with 29 black parents of 11-12-year-old boys, recruited through three churches and a middle school in North Carolina, and a racially diverse sample of 100 parents of 9-13-year-old boys in a university-based adolescent health clinic was interviewed. A constant comparison method was used to code transcripts and interpret themes. Chi-square and t tests or analyses of variance were used to assess differences in quantitative data. Results: Focus group parents knew little about HPV in males. Although concerned about safety and

cost, parents supported vaccination for their sons. They wanted to see racial diversity and both parents in motivational materials. In interviews, 89% of parents reported never having heard of the HPV vaccine for men. The largest proportion said that a message stressing the prevalence and possible consequences of HPV infection was the most motivating (32%); the design favored by the largest proportion (43%) showed two parents. Conclusions: Messages that may most motivate parents to get pre-teenage boys vaccinated against HPV focus on infection risk and include images of parents with their sons."

Chabot, M.J., Lewis, C., de Bocanegra, H.T., & Darney, P. (2011). Correlates of receiving reproductive health care services among U.S. men aged 15 to 44 years. *American Journal of Men's Health*, 5(4), 358-366. doi:10.1177/1557988310395007 [doi]. Available at http://www.ncbi.nlm.nih.gov/pubmed/21700668.

"Men have a significant role in reproductive health decision making and behavior, including family planning and prevention of sexually transmitted diseases (STDs).Yet studies on reproductive health care of men are scarce. The National Survey of Family Growth 2006-2008 provided data that allowed assessment of the predisposing, enabling, and need factors associated with men's receipt of reproductive health services in the United States. Although more than half (54%) of U.S. men received at least one health care service in the 12 months prior to the survey, far fewer had received birth control counseling/methods, including condoms (12%) and STD/HIV testing/STD treatment (12%). Men with publicly funded health insurance and men who received physical exam were more likely to receive reproductive health services when compared with men with private health insurance and men who did not receive a physical exam. Men who reported religion was somewhat important were significantly more likely to receive birth control counseling/ methods than men who stated religion was very important. The pseudo-R (2) (54%), a measure of model fit improvement, suggested that enabling factors accounted for the strongest association with receiving either birth control counseling/ methods or STD/HIV testing/STD treatment."

Davies, J., McCrae, B. P., Frank, J., Dochnahl, A., Pickering, T., Harrison, B., & Wilson, K. (2000). Identifying male college students' perceived health needs, barriers to seeking help, and recommendations to help men adopt healthier lifestyles. *Journal of American College Health*, 48(6), 259-267. Available at http://eric.ed.gov/?id=EJ609009.

"Seven focus groups at a university campus were formed to identify college men's health concerns, barriers to seeking help and recommendations to help college men adopt healthier lifestyles. Content analysis was used to identify and organize primary patterns in the focus group data. Results of the study revealed that the college men were aware that they had important health needs but took little action to address them. The participants identified both physical and emotional health concerns. Alcohol and substance abuse were rated as the most important issues for men. The greatest barrier to seeking services was the men's socialization to be independent and conceal vulnerability. The most frequently mentioned suggestions for helping men adopt healthier lifestyles were offering health classes, providing health information call-in service, and developing a men's center. Implications of the results are discussed."

Farrow, J.A. (2009). Male sexual health during adolescence and young adulthood: Contemporary issues. *Journal of Men's Health*, 6(3), 177-182. Available at http://www.sciencedirect.com/science/article/pii/S1875686709000682.

"The sexual health of young men is often neglected by health care systems that assume healthy developmental trajectories. Clinical morbidities and sexual concerns are not uncommon among sexually emerging young men. Sexually-transmitted infections, transient sexual dysfunction, and lack of screening for genitourinary abnormalities contribute to this morbidity. This article discusses common sexual issues and concerns of adolescents and young adult men encountered in a clinical practice devoted to men in this age group. The holistic model of care is described. Key issues and updated clinical approaches are discussed. Health care services and education focused on the sexual health of young men improves early detection of disease, prevents morbidity and promotes healthier sexual lifestyles."

Ford, C.A., Davenport, A.F., Meier, A., & McRee, A. (2011). Partnerships between parents and health care professionals to improve adolescent health. *Journal of Adolescent Health*, 49(1), 53-57. Available at http://www.ncbi.nlm.nih.gov/pubmed/21700157.

"Research on partnerships between parents and health care professionals (HCPs) to improve adolescent health is limited. In this study, we have developed an empirically derived framework to guide research in this particular area. Methods: We conducted a qualitative study using focus groups and in-depth semi-structured interviews. A total of 85 participants (51 HCPs, 17 mothers of patients of ages 1218 years, and 17 adolescents) were recruited from three free-standing adolescent health

clinics and five school-based health centers across North Carolina. We independently explored the perceptions of HCPs and mothers regarding the roles of parents, HCPs, and parent-HCP partnerships in preventing and addressing adolescent health problems. We then elicited feedback of adolescents on mother and HCP perceptions. We identified common and informative themes during content analysis using ATLAS.ti, and triangulated perspectives of HCPs, mothers, and adolescents to develop a framework for building parent-HCP partnerships to improve adolescent health. Results: A general framework emerged that conceptualizes both direct and indirect strategies for building parent-HCP partnerships. Direct strategies involve strengthening relationships and/or communication between parents and HCPs in both practice and community settings. Indirect strategies involve opportunities for HCPs to influence parent-adolescent relationships and/or communication within the context of adolescent visits. For example, HCPs can discuss the importance of parental involvement and monitoring with adolescents, encourage and facilitate parent-adolescent communication, and deliver tailored parental guidance while also respecting adolescents' desires for confidential health care when appropriate. Conclusions: Interventions that directly strengthen parent-HCP relationships and/or communication, and those that indirectly support parent-HCP partnerships within the context of adolescent health care, should be designed targeting health outcomes."

Goldenring, J.M., & Rosen, D.S. (2004). Getting into adolescent heads: An essential update. *Contemporary Pediatrics-Montvale-*, 21(1), 64-92. Available at http://www2.aap.org/pubserv/psvpreview/pages/files/headss.pdf.

"Provides information on the HEEADSSS psychosocial interview, or the assessment of the home environment, education, employment, eating, peer-related activities, drugs, sexuality, suicide or depression, and safety from injury and violence of adolescent patients in the U.S. History of HEEADSSS, originally known as HEADSS developed by physician Harvey Berman; [topics include:] Kinds of questions to ask adolescents; Factors to consider after the interview, including asking for feedback from patients."

Hagan, J.F., Shaw, J.S., & Duncan, P.M. (2008). Bright futures: Guidelines for health supervision of infants, children, and adolescents *American Academy of Pediatrics*: Elk Grove Village, IL. Available at https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx.

This document brings together "[…]recommendations for the top 10 areas of child development. Along with presenting the most up-to-date information on preventive screenings and services by visit, the Guidelines provide visit-by-visit anticipatory guidance for health care providers."

Hancock, J. (2004). Can mainstream services learn from male only sexual health pilot projects? *Sexually Transmitted Infections*, 80(6), 484-487. doi:80/6/484 [pii]. Available at http://sti.bmj.com/content/80/6/484.full.

"Over the past decade, a number of community-based sexual health projects aimed solely at young men have proved to be very successful at attracting young men into genitourinary medicine services. These projects are often short-term funded and under evaluated, so it isn't clear exactly how successful they are and why this might be so. These projects should be carefully evaluated and examined to elicit factors, either unique or common in nature, which could be utilized by mainstream sexual health services wishing to develop work with young men. There are many barriers to this happening in mainstream services, some being resource and time problems and others to do with values of staff and lack of quality training. The article looks at practical ways that working with men and the skills and confidence of staff can be improved in mainstream settings while recognizing that much of what needs to be done to support the needs of young men must take place in the planning and commissioning stage of services."

Kirzinger, W.K., Cohen, R.A., & Gindi, R.M. (2012). Health care access and utilization among young adults aged 19-25: Early release of estimates from the national health interview survey, January–September 2011. Atlanta, GA: Centers for Disease Control and Prevention, 1-10. Available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/Young_Adults_Health_Access_052012.pdf.

"This report provides preliminary estimates of access to and utilization of health care among young adults aged 19 – 25, using National Health Interview Survey (NHIS) data collected from January through September 2011."

Lanier, Y., & Sutton, M.Y. (2013). Reframing the context of preventive health care services and prevention of HIV and other sexually transmitted infections for young men: New opportunities to reduce racial/ethnic sexual health disparities. *American Journal of Public Health*, 103(2), 262-269. Available at http://www.ncbi.nlm.nih.gov/pubmed/23237172.

"Young Black males, aged 13 to 29 years, have the highest annual rates of HIV infections in the United States. Young Black men who have sex with men (MSM) are the only subgroup with significant increases in HIV incident infections in recent years. Black men, particularly MSM, are also disproportionately affected by other sexually transmitted infections (STIs). Therefore, we must strengthen HIV and STI prevention opportunities during routine, preventive health care visits and at other, nontraditional venues accessed by young men of color, with inclusive, nonjudgmental approaches. The Affordable Care Act and National HIV/AIDS Strategy present new opportunities to reframe and strengthen sexual health promotion and HIV and STI prevention efforts with young men of color."

Lindberg, C., Lewis-Spruill, C., & Crownover, R. (2006). Barriers to sexual and reproductive health care: Urban male adolescents speak out. Issues in Comprehensive Pediatric Nursing, 29(2), 73-88. Available at http://www.ncbi.nlm.nih.gov/pubmed/16772237.

"Risky sexual behaviors among adolescent males put them at risk for sexually transmitted diseases, HIV/AIDS, and unplanned fatherhood, yet few facilities in the United States provide focused sexual and reproductive health services to these young men. A general acknowledgement exists that the development of such services is needed, yet there is little research to guide providers in making existing services more attractive to young males and in developing new sexual health services for this population. Objectives: This research aimed to explore attitudes and perceptions of urban black male adolescents regarding the availability of and access to reproductive healthcare. Methods: Eighteen black male adolescents participated in three focus group discussions held in a central New Jersey city. Transcripts of the discussions were analyzed using the constant comparative method. Resulting categories were grouped into themes, which reflected the adolescents' perceptions and experiences. Member checks were used to verify findings. Results: The adolescents felt that obtaining sexual health services was a stressful experience fraught with both internal and external barriers. Internal barriers included a fear of stigma and a loss of social status, shame, and embarrassment. External barriers included disrespectful providers, a lack of privacy/confidentiality, and challenges in accessing and negotiating the health care system. The young males described an

idealized clinic environment as informal, welcoming, and respectful. Discussion and Conclusions: Providers should focus on improving the quality of care in existing clinics, particularly in the areas of access, privacy, and confidentiality, and on developing adolescent-friendly clinics focusing on men's services. Adolescents should be encouraged to visit clinics prior to an acute need for services. There also is a need for providers who are comfortable with and able to communicate with male adolescents."

Lohan, M., Aventin, A., Oliffe, J.L., Han, C.S., & Bottorff, J.L. (2015). Knowledge translation in men's health research: Development and delivery of content for use online. ***Journal of Medical Internet Research*****, 17(1), e31. doi:10.2196/jmir.3881 [doi]. Available at http://www.jmir.org/2015/1/e31/.**

"Men can be hard to reach with face-to-face health-related information, while, increasingly, research shows that they are seeking health information from online sources. Recognizing this trend, there is merit in developing innovative online knowledge translation (KT) strategies capable of translating research on men's health into engaging health promotion materials. While the concept of KT has become a new mantra for researchers wishing to bridge the gap between research evidence and improved health outcomes, little is written about the process, necessary skills, and best practices by which researchers can develop online knowledge translation. Objective: Our aim was to illustrate some of the processes and challenges involved in, and potential value of, developing research knowledge online to promote men's health. Methods: We present experiences of KT across two case studies of men's health. First, we describe a study that uses interactive Web apps to translate knowledge relating to Canadian men's depression. Through a range of mechanisms, study findings were repackaged with the explicit aim of raising awareness and reducing the stigma associated with men's depression and/or help-seeking. Second, we describe an educational resource for teenage men about unintended pregnancy, developed for delivery in the formal Relationship and Sexuality Education school curricula of Ireland, Northern Ireland (United Kingdom), and South Australia. The intervention is based around a Web-based interactive film drama entitled "If I Were Jack." Results: For each case study, we describe the KT process and strategies that aided development of credible and well-received online content focused on men's health promotion. In both case studies, the original research generated the inspiration for the interactive online content and the core development strategy was working with a multidisciplinary team to develop this material through arts-based approaches. In both cases also, there is an acknowledgment of the need for gender and

culturally sensitive information. Both aimed to engage men by disrupting stereotypes about men, while simultaneously addressing men through authentic voices and faces. Finally, in both case studies we draw attention to the need to think beyond placement of content online to delivery to target audiences from the outset. Conclusions: The case studies highlight some of the new skills required by academics in the emerging paradigm of translational research and contribute to the nascent literature on KT. Our approach to online KT was to go beyond dissemination and diffusion to actively repackage research knowledge through arts-based approaches (videos and film scripts) as health promotion tools, with optimal appeal, to target young men as an audience. Our findings highlight the importance of developing a multidisciplinary team to inform the design of content, the importance of adaptation to context, both in terms of the national implementation context and consideration of gender-specific needs, and an integrated implementation and evaluation framework in all KT work."

Lynne, S. T., Graber, J. A., Nichols, T. R., Brooks-Gunn, J., & Botvin, G. J. (2007). Links between pubertal timing and delinquency among urban youth. Journal of Adolescent Health, 40(2), 181. e7-181. e13. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2744148.

"The goal of this study was to evaluate underlying mechanisms of the association between early pubertal timing and both aggression and delinquency among a sample of minority males and females from an urban community. Methods: The association between perceived early pubertal maturation and aggressive or delinquent behaviors for African American and Latino males and females (n = 1366) was examined, as well as pathways between early maturation and these negative outcomes longitudinally across 6th, 7th, and 8th grades. Results: Early maturers reported higher mean levels of both aggression and delinquency at all time points regardless of gender or ethnicity. Associating with delinquent peers in 6th grade fully mediated the association between early maturation and both aggression and delinquency at all time points. Early maturers did not differentially associate with greater numbers of delinquent peers in either 7th or 8th grade. Conclusions: These results provide valuable information regarding at-risk groups and inform future intervention efforts."

MAC Region II Male Involvement Advisory Committee (2005). Guidelines for Male Sexual and Reproductive Health Services [Guidebook]. Retrieved from http://www.columbia.edu/itc/hs/medical/residency/peds/new_compeds_site/MaleReproductiveHealth.pdf.

This document "is intended to be a resource that can be used in the development of clinical services for men. 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 men. 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."

Marcell, A.V., Allan, E., Clay, E.A., Watson, C., & Sonenstein, F.L. (2013). Effectiveness of a brief curriculum to promote condom and health care use among out-of-school young adult males. *Perspectives on Sexual and Reproductive Health*, 45(1), 33-40. Available at http://www.ncbi.nlm.nih.gov/pubmed/23489856.

"Out-of-school black males aged 15–24 have higher levels of sexual risk-taking than in-school black males of the same age. However, few sexual risk reduction curricula are focused on out-of-school male youth. Methods: A sexual and reproductive health intervention conducted at a Baltimore youth employment and training program in 2008–2010 was evaluated in a study involving 197 youth aged 16–24 from a predominantly black population. Ninety-eight participants received three one-hour curriculum sessions on consecutive days; 99 served as controls. At baseline and three months later, participants completed a survey assessing demographic characteristics and various knowledge, attitude and behavior measures. Regression analysis with random effects was used to assess differences between intervention participants and controls in changes in outcomes over time. Results: In analyses adjusting for baseline characteristics, intervention participants showed greater improvements in outcomes between baseline and follow-up than did controls. Specifically, a man who received the intervention was more likely than a control man to report increases in knowledge of STDs and health care use (odds ratio, 1.6 for each), frequency of condom use (1.8), use of lubricant with condoms (23.6), communication with a provider about STDs (12.3) and STD testing (16.6).

Conclusion: These findings suggest the potential benefits of integrating safer-sex and health care information into a sexual and reproductive health curriculum for out-of-school male youth."

Marcell, A.V., Bell, D.L., Lindberg, L.D., & Takruri, A. (2010). Prevalence of sexually transmitted infection/human immunodeficiency virus counseling services received by teen males, 1995–2002. *Journal of Adolescent Health*, 46(6), 553-559. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872777.

The purpose of this study was "To examine whether improvements have been made in the delivery of sexually transmitted infection and/or human immunodeficiency virus (STI/HIV) counseling services to teen males. Methods: Analysis was performed using the 1995 National Survey of Adolescent Males (N = 1,729, response rate = 75%) and the 2002 National Survey of Family Growth (N = 1,121, response rate = 78%), which are two nationally representative surveys of 15-19-year-old males. Main outcome measure included discussion about STIs/HIV with a doctor/nurse. Weighted bivariate and multivariate Poisson regression analyses examined the association of outcome measures and survey year among males engaging in various types of sexual behaviors (e.g., varying partner numbers, higher risk sex) unadjusted and adjusted for sociodemographic and health care access factors. Results: In 2002, STI/HIV counseling receipt in the past year was reported by one-third of males who reported three or more female partners, anal sex with female partners, or oral/anal sex with male partners. Only 26% of males reporting high-risk sex (e.g., sex with prostitute, person with HIV, or often/always high with sex) reported STI/HIV counseling receipt. Overall, no improvements were found between 1995 and 2002 in STI/HIV counseling, even after controlling for sociodemographic and health care access factors. Conclusions: Mechanisms are needed to raise the importance of STI/HIV counseling services among sexually active male teens as well as to improve health care providers' delivery of these services."

Marcell, A.V., & Ellen, J.M. (2012). Core sexual/reproductive health care to deliver to male adolescents: Perceptions of clinicians focused on male health. *Journal of Adolescent Health*, 51(1), 38-44. Available at http://www.ncbi.nlm.nih.gov/pubmed/22727075.

"Male adolescents experience adverse sexual/reproductive health (SRH) outcomes, yet few providers deliver male SRH care. Given the lack of evidence base for male SRH care, the purpose of this study was to examine perceived importance in delivering SRH care to male adolescents among clinicians focused on male health. Methods: Seventeen primary care clinicians focused on male

health, representing pediatricians, family physicians, internists, and nurse practitioners, were individually queried about male adolescents' SRH needs and perceived importance to screen/assess for 13 male SRH services using a case scenario approach varying by visit type and allotted time. Results: Participants were highly consistent in identifying a scope of 10 SRH services to deliver to male adolescents during a longer annual visit and a core set of six SRH services during a shorter annual visit, including (1) counseling on sexually transmitted infection/HIV risk reduction, including testing/treatment; and assessing for (2) pubertal growth/development; (3) substance abuse/mental health; (4) nonsexually transmitted infection/HIV genital abnormalities; (5) physical/sexual abuse; and (6) male pregnancy prevention methods. Participants did not agree whether SRH care should be delivered during nonannual acute visits. Conclusions: Despite lack of data for male SRH care, clinicians focused on male health strongly agreed on male SRH care to deliver during annual visits that varied by visit type and allotted time. Study findings provide a foundation for much needed clinical guidelines for male adolescents' SRH care and have implications for education and training health professionals at all levels and the organization and delivery of male SRH services."

Marcell, A.V., Matson, P., Ellen, J.M., & Ford, C.A. (2011). Annual physical examination reports vary by gender once teenagers become sexually active. ***Journal of Adolescent Health*****, 49(1), 47-52. Available at http://www.ncbi.nlm.nih.gov/pubmed/21700156.**

"Few sexually active male adolescents receive sexual and reproductive health (SRH) services. To understand this, we examined the association between sexual behavior status and physical examination of the adolescents over time. Methods: We conducted longitudinal cohort analysis of the National Longitudinal Study of Adolescent Health with 9,239 adolescents who completed the baseline school (1994/1995) and wave 2 (1996) follow-up surveys approximately 1.5 years later (retention rate = 71%). The logistic regression models were fitted with random effects to estimate individual odds of reporting a physical examination in the past 12 months at follow-up, compared with baseline, stratified by sexual behavior status and gender, and adjusting for sociodemographic and healthcare access factors. Results: In all, 34.5% of male and 38.2% of female adolescents reported experiencing vaginal intercourse by follow-up, and 22.4% of male and 24.7% of female adolescents reported first experiencing intercourse during the study period. Among sexually active adolescents, about half reported having annual physical examinations and one-fifth reported not having any physical examinations. Among female adolescents, baseline to follow-up examination reports significantly increased in the following: sex initiators (adjusted odds ratio [OR] = 2.09, 95% confidence

interval [CI] = 1.662.64); those reporting sex at both times (OR = 2.16, CI = 1.513.09); and those reporting no sex either time (OR = 2.47, CI = 2.003.04). Among male adolescents, baseline to follow-up examination reports significantly increased in those reporting no sex either time (OR = 1.57, CI = 1.261.96) and showed increasing trends in sex initiators (OR = 1.27, CI = .921.76). Discussion: A majority of sexually active adolescents report annual physical examinations over time. Providers should not miss opportunities to deliver evidence-based SRH to sexually active adolescents. Future efforts are needed to increase access of all adolescents to SRH services."

Marcell, A.V., Wibbelsman, C., Seigel, W.M., & Committee on Adolescence. (2011). Male adolescent sexual and reproductive health care. Pediatrics, 128(6), e1658-76. doi:10.1542/peds.2011-2384 [doi]. Available at http://pediatrics.aappublications.org/content/early/2011/11/22/peds.2011-2384.

"Male adolescents' sexual and reproductive health needs often go unmet in the primary care setting. This report discusses specific issues related to male adolescents' sexual and reproductive health care in the context of primary care, including pubertal and sexual development, sexual behavior, consequences of sexual behavior, and methods of preventing sexually transmitted infections (including HIV) and pregnancy. Pediatricians are encouraged to address male adolescent sexual and reproductive health on a regular basis, including taking a sexual history, performing an appropriate examination, providing patient-centered and age-appropriate anticipatory guidance, and delivering appropriate vaccinations. Pediatricians should provide these services to male adolescent patients in a confidential and culturally appropriate manner, promote healthy sexual relationships and responsibility, and involve parents in age-appropriate discussions about sexual health with their sons."

Mulye, T.P., Park, M.J., Nelson, C.D., Adams, S. H., Irwin, C.E., & Brindis, C.D. (2009). Trends in adolescent and young adult health in the United States. *Journal of Adolescent Health*, 45(1), 8-24. Available at http://www.ncbi.nlm.nih.gov/pubmed/19541245.

"This review presents a national health profile of adolescents and young adults (ages 10-24). The data presented include trends on demographics, mortality, health-related behaviors, and health care access and utilization, as well as the most significant gender and racial/ethnic disparities. Although the data show some improvement, many concerns remain. Encouraging trends—such as decreases in rates of homicide, suicide, and some measures of reproductive health—appear to be leveling off or, in some cases, reversing (e.g., birth and gonorrhea rates). Large disparities, particularly by

race/ethnicity and gender, persist in many areas. Access to quality health care services remains a challenge, especially during young adulthood. Policy and research recommendations to improve health during these critical periods in the lifespan are outlined."

National Adolescent and Young Adult Health Information Center (2014). A Guide to Evidence-Based Programs for Adolescent Health: Programs, Tools, and More [Guidebook]. Retrieved from http://nahic.ucsf.edu/download/evidence-based-program-guide/.

This guide provides an inventory of landing pages/organizations with compilations of evidence-based and promising adolescent health practices.

Neinstein, L., Lu, Y., Perez, L., & Tysinger, B. (2013). The new adolescents: An analysis of health conditions, behaviors, risks, and access to services among emerging young adults. Available at http://www.usc.edu/student-affairs/Health_Center/thenewadolescents/doc/TheNewAdolescents_Final_Locked.pdf.

"This report examines the health risks facing the nation's 34.6 million emerging young adults, a group defined as young people aged 18–25."

New York City Department of Health and Mental Hygiene, Young Men's Initiative. Best Practices in Sexual and Reproductive Health Care for Adolescents [Guidebook]. Retrieved from http://www.nyc.gov/html/doh/downloads/pdf/ms/adolescent-sex-best-practices-online.pdf.

"These recommendations set forth the best practices for sexual and reproductive health care for adolescents in New York City."

Ott, M. A. (2010). Examining the development and sexual behavior of adolescent males. *Journal of Adolescent Health*, 46(4), S3-S11. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2858917.

"A careful examination of young men's sexuality by health professionals in pediatrics, primary care, and reproductive health is foundational to adolescent male sexual health and healthy development. Through a review of existing published data, this article provides background and a developmental framework for sexual health services for adolescent boys. The article first defines and provides an overview of adolescent boys' sexual health, and then discusses developmentally focused research on the following topics: (1) early romantic relationships and the evolution of power and influence within

these relationships; (2) developmental "readiness" for sex and curiosity; (3) boys' need for closeness and intimacy; (4) adopting codes of masculinity; (5) boys' communicating about sex; and (6) contextual influences from peers, families, and providers. This article concludes by examining the implications of these data for sexual health promotion efforts for adolescent males, including human papillomavirus vaccination."

Physicians for Reproductive Health (2015). Adolescent-Friendly Health Services [PowerPoint slides]. Retrieved from http://prh.org/teen-reproductive-health/arshep-downloads/.

"This module identifies barriers to health care access faced by adolescents, describes elements of adolescent-friendly health services, and utilizes the HEEADSSS model of patient interviewing."

Physicians for Reproductive Health (2015). Male Adolescent Reproductive and Sexual Health [PowerPoint slides]. Retrieved from http://prh.org/teen-reproductive-health/arshep-downloads/.

"This module discusses misconceptions around male sexual health and how they affect health care delivery, identifies male-friendly health services, [and] demonstrates how to take a male-focused sexual health history and recognize male genital concerns."

Rafferty J.A., Barbour D. (2015). The importance of close relationships for the health & wellbeing of boys & young men [PowerPoint slides]. Available by request to barbour@patnershipformaleyouth.org

Reiter, E.O., & Lee, P.A. (2002). Delayed puberty. Adolescent Medicine Clinics, 13(1), 101. Available at http://www.ncbi.nlm.nih.gov/pubmed/11841958.

"Normal puberty is a time of life and a process of development that results in full adult maturity of growth, sexual development, and psychosocial achievement. Delayed puberty describes the clinical condition in which the pubertal events start late (usually > +2.5 SD [standard deviations] later than the mean) or are attenuated in progression. The differential diagnosis includes syndromes of low gonadotropin production, usually constitutional delay of growth and maturation associated with chronic disease, but also an array of gene-mediated disorders, and syndromes of primary gonadal dysfunction with hypergonadotropic hypogonadism, including Turner and Klinefelter syndromes, and a group of acquired and genetic abnormalities. Diagnostic assessment and varied therapeutic

modalities are discussed. The issues of androgen or estrogen therapy are important to assess, and growth hormone treatment remains a difficult dilemma."

Rickert, V.I., Auslander, B.A., Cox, D.S., Rosenthal, S.L., Rickert, J.A., Rupp, R., & Zimet, G.D. (2014). School-based vaccination of young US males: Impact of health beliefs on intent and first dose acceptance. Vaccine, 32(17), 1982-1987. Available at http://www.ncbi.nlm.nih.gov/pubmed/24492015.

"Little is known about adolescent males and their parents with respect to intent and first dose uptake of the human papillomavirus (HPV) vaccine outside of primary care settings. The purpose of this study was to evaluate potential predictors of parental intent to vaccinate (study was conducted in November 2010-December 2012) and of first dose uptake of HPV vaccine among a sample of young adolescent males, 11-15 years of age, who received care at a school-based health center (SBHC). We also examined intent as a potential mediator of the relationships between predictors (health beliefs and perceived spousal agreement) and vaccination. Slightly more than half (n=135 of 249) of parents reported an intention to vaccinate and 28% (n=69) of males received their first dose of the HPV vaccine. Two of three health beliefs were significantly associated with both intention and uptake as was perceived spousal agreement. We found intention to vaccinate was a partial mediator between the perceived benefits of HPV vaccine and first dose acceptance. We also determined that intent was a strong mediator between both general immunization benefits and perceived spousal agreement and first dose uptake. While vaccine uptake was lower than expected, particularly considering that many barriers to vaccine initiation were eliminated because of the SBHC setting, this rate is higher than in traditional settings. After controlling for intent, only perceived benefits of the HPV vaccine remained a significant predictor of first dose acceptance."

Robinson, M., & Robertson, S. (2010). Young men's health promotion and new information communication technologies: Illuminating the issues and research agendas. *Health Promotion International*, 25(3), 363-370. doi:10.1093/heapro/daq022 [doi]. Available at http://heapro.oxfordjournals.org/content/25/3/363.abstract.

"The article examines the use of newer, interactive information and communication technologies (ICTs) in young men's health promotion (HP), drawing on gender theory, HP research, and evidence on young men's Internet usage. The focus is on highlighting an agenda for research in terms of emerging issues. New forms of social media ICT (for example 'web 2'-based on-line social networking

sites, micro-blogging services, iPhones, and podcasts) have the potential to enable young men to engage with health information in new and interesting ways. Given concerns about young men's engagement with health services, innovative ICT formats, particularly using the Internet, have been tried. However, issues persist around surfing 'addiction,' quality control, and equal access. Approaches to HP using new ICTs offer distributed control over information content and quality and a lay social context for accessing information. Online communities can potentially legitimize young men's participation in discourses around health, and support sustained engagement. The article discusses how this could support young men to re-conceptualize healthy choices in the context of masculine imperatives and responsible citizenship if specific conditions are met (for trusting engagement) and risks addressed (such as commercial disinformation). The skill requirements for young men to engage effectively with new ICTs are explored, focusing on health literacy (HL). It is predicted that social marketing approaches to HP for young men will increasingly include new ICTs, making specific requirements for HL. These approaches may appeal narrowly to hegemonic masculinities or broadly to multiple masculinities, including those historically marginalized. Recommendations are made for future research."

Sonenstien F. (Editor) (2000). Young Men's Sexual and Reproductive Health [Guidebook]. Retrieved from http://webarchive.urban.org/UploadedPDF/410027.pdf.

The publication describes why the time is right for an initiative promoting young men's sexual and reproductive health, why it is so important, how it might be done, and how the U.S. Department of Health and Human Services can help make it happen.

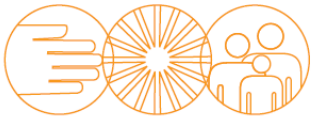
Teichman, J., Sea, J., Thompson, I.M., & Elston, D.M. (2010). Noninfectious penile lesions. *American Family Physician*, 81(2), 167-174. Available at http://www.aafp.org/afp/2010/0115/p167.html.

"Family physicians commonly diagnose and manage penile cutaneous lesions. Noninfectious lesions may be classified as inflammatory and papulosquamous (e.g., psoriasis, lichen sclerosus, angiokeratomas, lichen nitidus, lichen planus), or as neoplastic (e.g., carcinoma in situ, invasive squamous cell carcinoma). The clinical presentation and appearance of the lesions guide the diagnosis. Psoriasis presents as red or salmon-colored plaques with overlying scales, often with systemic lesions. Lichen sclerosus presents as a phimotic, hypopigmented prepuce or glans penis with a cellophane-like texture. Angiokeratomas are typically asymptomatic, wellcircumscribed, red or blue papules, whereas lichen nitidus usually produces asymptomatic pinhead-sized, hypopigmented

papules. The lesions of lichen planus are pruritic, violaceous, polygonal papules that are typically systemic. Carcinoma in situ should be suspected if the patient has velvety red or keratotic plaques of the glans penis or prepuce, whereas invasive squamous cell carcinoma presents as a painless lump, ulcer, or fungating irregular mass. Some benign lesions, such as psoriasis and lichen planus, can mimic carcinoma in situ or squamous cell carcinoma. Biopsy is indicated if the diagnosis is in doubt or neoplasm cannot be excluded. The management of benign penile lesions usually involves observation or topical corticosteroids; however, neoplastic lesions generally require surgery."

Westwood, M., & Pinzon, J. (2008). Adolescent male health. *Paediatrics & Child Health*, 13(1), 31-36. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2528816.

"Although adolescent males have as many health issues and concerns as adolescent females, they are much less likely to be seen in a clinical setting. This is related to both individual factors and the health care system itself, which is not always encouraging and set up to provide comprehensive men's health care. Working with adolescent boys involves gaining the knowledge and skills to address concerns such as puberty and sexuality, substance use, violence, risk-taking behaviors, and mental health issues. The ability to engage the young male patient is critical, and the professional must be comfortable in initiating conversation about a wide array of topics with the teen boy, who may be reluctant to discuss his concerns. It is important to take every opportunity with adolescent boys to talk about issues beyond the presenting complaint, and let them know about confidential care. The physician can educate teens about the importance of regular checkups, and that they are welcome to contact the physician if they are experiencing any concerns about their health or well-being. Parents of preadolescent and adolescent boys should be educated on the value of regular health maintenance visits for their sons beginning in their early teen years."



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