

The Other Half of the Equation: Serving Young Men In a Young Women's Reproductive Health Clinic

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CONTEXT: Efforts to improve reproductive health typically target women. Family planning agencies serving high-risk young women may be particularly suited to integrating young men in their health promotion efforts.

METHODS: In 2001, a family planning clinic in San Francisco serving primarily young women opened a male clinic as part of a male involvement program that includes education and outreach components. Client volume was assessed by reviewing billing data. New male clients completed questionnaires on their demographic characteristics, sexual and health-seeking behavior, and reason for clinic visit. Before and after the male clinic opened, female clients completed questionnaires assessing their satisfaction with services and their attitudes on males' being served at the clinic. Data were analyzed by using descriptive and chi-square statistics.

RESULTS: In the first year of the male clinic, the number of adolescent and adult male clients served at the facility increased by 192% and 119%, respectively, over the previous year. Among 110 males making first visits, 88% came for sexually transmitted disease testing or treatment. Three-quarters had learned of the clinic by word of mouth—from a sexual partner (37%), friend (29%) or sibling (6%)—rather than directly from outreach efforts. The proportion of female respondents very or mostly satisfied with their care was similarly high before (98%) and after (92%) the male clinic opened.

CONCLUSIONS: Increasing capacity within the female reproductive health model to serve males is feasible. To reach at-risk males, "in-reach" efforts with female clients may be as important as targeted outreach efforts.

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Rates of unintended pregnancy and sexually transmitted diseases (STDs) are high among U.S. adolescents and young adults.¹ Although young men represent half the equation, public health solutions have typically targeted young women, and the vast majority of resources for preventing unintended pregnancy and STDs are allocated to young women.² The public health community is increasingly acknowledging that promotion of good reproductive health among males is crucial to the reduction of reproductive health-related disease; however, no consensus exists on how to provide reproductive health services for male adolescents and young adults. Guidelines issued by the American Medical Association and the Society for Adolescent Medicine recommend reproductive health services for adolescents, but many providers do not offer these services in the context of general primary care.³ Although 71% of sexually active males aged 15–19 received a physical examination in the past year, only 36% discussed reproductive health topics (e.g., pregnancy and STD prevention) with a provider, and only 42% were tested for HIV or other STDs.⁴

Reproductive health services for male and female clients should aim to promote healthy sexual development, intimate relationships and responsible parenthood; prevent and control STDs, including HIV; and prevent unintended

pregnancy.⁵ Women often receive such care during routine gynecologic, prenatal and postpartum visits, which may include information on hormonal contraceptive methods and testing for STDs and cancer. Men, on the other hand, are typically offered reproductive health services only in the setting of STD clinics. Although gynecologic and family planning care are considered essential for women, male reproductive health is given considerably less attention. For example, of the more than 7,000 publicly funded U.S. clinics offering family planning services, 69% have at least one program devoted to outreach, education or services for teenagers, but only 39% routinely serve men.⁶

Few efforts to provide male reproductive health services in any type of clinical settings have been described. One reported approach is to carve out male services within the traditional setting of a family planning clinic.⁷ An example of this approach, described by Armstrong and colleagues, is the Young Men's Clinic in New York City, which provides comprehensive medical services (e.g., treatment for acute and chronic illness, general medical examinations and mental health services) while also focusing on reproductive health and psychosocial issues.^{*8} Moss and Sawyer have described another approach, in which a men's clinic was established at a multispecialty, university-based health center.⁹ Both of these reports were primarily descriptive, and the authors did not examine the impact of expansion of

*Ed. note: For more about the Young Men's Clinic, see page 220 of this issue.

services to males on existing clinical services and established female clients.

Agencies providing family planning services to adolescents and high-risk young women may be particularly suited to integrate services for young men into their health promotion efforts. Compared with pediatric and internal medicine practices, these agencies have greater experience serving populations at risk for unintended pregnancy and STDs; in addition, these agencies are already known in their communities. Nevertheless, the feasibility and potential impact of trying to integrate male services into the traditional female reproductive health care model remain unknown.

In this article, we describe the implementation of a reproductive health clinic targeted at male adolescents (those younger than 20) and young adults that was established within a traditional family planning clinic for young women. By examining data that we collected before and after the opening of the male reproductive health clinic, we are able to assess the effects of such an initiative on both male and female clients.

MALE INVOLVEMENT PROGRAM

Overview and Setting

In July 2000, the New Generation Health Center (NGHC), a publicly funded affiliate clinic of the University of California, San Francisco, initiated a male involvement program that was designed to expand its capacity to involve adolescent males in reproductive health activities and to increase direct services provided to adolescent and young adult males, including individualized counseling, physical examinations, condom provision and STD testing. This three-year project has been funded by a grant from the California Wellness Foundation. The university's Committee on Human Research approved all research activities, and clients provided informed consent before completing study questionnaires.

NGHC, located in San Francisco, provides a comprehensive array of educational and community programs in addition to youth-specific family planning and STD services. Staffed by nurse practitioners and physicians, NGHC is open five days a week. It traditionally served female clients almost exclusively. NGHC provides confidential reproductive health services, including gynecologic examinations; HIV counseling and testing; diagnosis of and treatment for other STDs; contraceptive assessment and counseling, including for emergency contraceptives; and pregnancy testing and options counseling. Almost all clinical services are funded through the Family Planning, Access, Care and Treatment (Family PACT) program—a statewide program, sponsored by California's Office of Family Planning, that aims to increase access to family planning services for persons of low income. NGHC provides education and outreach at local high schools, public and community agencies, and street venues, and develops community links to enhance referrals and outreach efforts. NGHC also sponsors after-school activities, at two local middle schools, that offer girls alternative paths toward a sense of self-worth.

Outreach

A male peer educator program was established to increase outreach at two local high schools. The peer educator program identifies and engages young males, who in turn provide additional outreach, information and education to youths at the two target schools and in the community. The program is staffed by a full-time project coordinator and a part-time health educator. Additional administrative support for management of grant funds and project reporting is provided by the center manager.

In its first year (beginning July 2000), the project conducted a needs assessment,¹⁰ developed the curriculum for the peer educator training, and recruited and trained the first of two groups of peer educators. Each group of peer educators completed a 10-week training curriculum that was adapted from existing curricula. The curriculum focuses on developing peer educators' presentation skills and teaching them how to impart reproductive health knowledge and influence attitudes about males' roles in preventing STDs and unintended pregnancy. After completing their training, male peer educators worked with the project coordinator and conducted various activities designed to positively influence the reproductive health behavior of adolescent males and to increase awareness of the NGHC male clinic. In addition to completing training and outreach activities at the target schools, three peer educators remained on as paid clinic staff, performing outreach activities and working directly with the clinic.

In the second year of the project, the staff and peer educators conducted or participated in eight schoolwide events at the two target high schools (e.g., lunchtime events or activities, and school dances), reaching more than 900 students, and conducted 11 classroom or small group presentations to approximately 200 male students. In addition, at the midpoint of the second year, project staff and peer educators initiated monthly risk assessments and urine-based STD screenings at each school; a total of 139 males were screened at these sessions (which were held in the nurse's office during the lunch hour). Males who were screened were asked to follow up at the clinic to receive their test results and counseling.

Two of the peer educators remained on as paid staff at the end of the second year, doing clerical tasks to help make the clinic "male-friendly" and conducting waiting-room presentations. Under the supervision of the project coordinator, they also conducted direct one-on-one outreach efforts and distributed condoms on the streets (at after-school hangouts, recreation centers and community events). More than 2,900 male youths were contacted through these outreach efforts. All materials distributed included the NGHC clinic logo and information about the clinic.

The second group of peer educators was trained in the third year of the program; one of these young men was hired as a staff member. A total of 145 male peer educators were recruited over the three years of the project, and 61 completed the training.

During the third year, project staff repeated many of the

TABLE 1. Percentage distribution of respondents to a survey of men making an initial visit to a new male reproductive health clinic, by selected background characteristics, San Francisco, 2001–2002

Characteristic	% (N=110)
DEMOGRAPHIC	
Age	
≤19	50.5
≥20	49.5
Race/ethnicity	
Hispanic	34.3
Black	36.1
Asian/Pacific Islander	14.8
White	7.4
Other/multiracial	7.4
School currently attending	
Target high school	12.6
Other high school	14.6
College/vocational school	31.1
None	41.8
HEALTH-SEEKING BEHAVIOR	
Sees a physician for medical checkups	
Yes	40.1
No	59.9
Most recent visit for general examination	
≤1 year ago	48.0
>1 year ago	40.8
Never	11.2
Has ever been to an STD/family planning clinic	
Yes	16.5
No	83.5
Most recent visit for STD testing/treatment	
≤1 year ago	52.0
>1 year ago	27.6
Never	20.4
SEXUAL BEHAVIOR	
Currently sexually active*	
Yes	87.3
No	12.7
Number of partners in past three mos.†	
1	68.2
2	21.2
≥3	10.6
Frequency of unprotected intercourse†	
Never	29.2
Some of the time	48.3
Most of the time	10.1
Always	12.4
Frequency of condom use†	
Never	20.5
Some of the time	17.1
Most of the time	38.6
Always	23.9
Used a condom at most recent intercourse†	
Yes	44.2
No	55.8
Has ever gotten someone pregnant	
Yes	30.5
No	69.5
Total	100.0

*Defined as having had intercourse in the past three months. †Among those currently sexually active only. Note: Nonresponses are excluded from the valid percentages.

activities conducted in the previous year. In addition, they made a greater effort to reach out to teachers, who could ultimately allow peer educators to do more classroom presentations in the target schools.

Opening of the Male Clinic

To prepare for the clinic's opening in July 2001, staff performed several tasks. First, they completed a survey asking about whether they thought males should be served in the clinic, their concerns or reservations, their experiences serving male clients and their suggestions for ways of preparing the clinic and its staff. Second, clinic staff participated in a half-day workshop on providing services to males. Third, clinicians received training in performing sports physicals. Next, male peer educators evaluated the clinic for its male-friendliness. Male-friendly posters, educational materials and recreational games were added to the waiting room. Finally, before opening the clinic, male involvement program staff took inventory of other primary care resources available to male youths, contacted other providers to inform them about the new male clinic and developed a referral guide for the staff's clinicians and male clients. Although four providers in the vicinity of NGHC offer services tailored to teenagers, only one—a clinic linked to an alternative high school—offers primary care services targeting male youths.

Male clinic sessions are held on one-half day each week and are staffed by four (two male, two female) rotating adolescent medicine fellows and a female family nurse practitioner. As at other NGHC clinic sessions, a female clinic assistant is present; this person assembles client charts, shows clients to the examination rooms, measures vital signs and obtains blood samples. Two health educators (one male, one female) are available to conduct risk assessments and individualized counseling; one of these is the coordinator of the project, who was added specifically for the male clinic. Peer educators assist front-desk and clerical staff members, who would be present already because the clinic would normally be open during that time for drop-in pregnancy testing and counseling.

Services provided during the male clinic sessions include STD screening, counseling and treatment; diagnosis of and treatment for genitourinary conditions; HIV counseling and testing; and sports physicals. In addition, female partners of male clients can receive the full range of family planning services offered during regular clinic hours; female clients presenting for drop-in pregnancy testing during male clinic sessions are seen as time and staffing permit.

Study Measures

To assess whether the project increased direct services to males and to determine the effect of the project on female clients, information was obtained on the number of clients served, assessed according to clients' age and sex; health-seeking and sexual behavior of new male clients; and female clients' satisfaction with the clinic, given the addition of male services. Information on the number of clients served was obtained from billing data for the 12-month pe-

riods before and after the male clinic opened.

New male clients were asked to complete a comprehensive questionnaire on demographic information, health-seeking behaviors, reasons for coming to the clinic, and sexual behaviors and attitudes. Clients were told that completion of the questionnaire, which they received along with registration materials, was optional.

Beginning in June 2001, during designated 2–3-week periods every four months, all female clients visiting NGHC were asked to complete a questionnaire asking about their satisfaction with services they received and their attitudes toward male clients' being served at the clinic. Responses from female client satisfaction surveys administered before and after the male clinic opened were compared by using chi-square statistics.

RESULTS

Clinic Volume

In the year before the male clinic opened, NGHC served 2,034 clients; 57% were younger than 20, and 6% were males. During the first year of the male clinic, the number of male adolescent and adult clients served increased by 192% and 119%, respectively, and the number of female clients served increased by 10%. In all, 322 individual male clients visited the clinic at least once that year, representing 13% of the total patients served at NGHC. The increase in the number of male adults served occurred primarily in the first six months after the clinic opened (163% growth); the rise in male adolescents served was greater during the second half of the year (120% growth) than during the first half (44% growth). Eighty-three percent of males served in the first year were seen during male clinic hours. On average, nine male clients and six female clients were seen during each weekly male clinic session. The number of clients seen during an average male clinic session (15–16) was similar to the number seen during other NGHC sessions. Of the clients seen during male clinic sessions, 40% were female; this proportion is relatively low compared with that seen during other sessions, 95%.

Male Clients

The mean age of the 110 new male clients who completed a questionnaire was 19.4 years (range, 14–24). Most (70%) were Hispanic or black (Table 1). Fifty-eight percent were students (in high school, college or vocational school). While outreach efforts yielded only modest results, with 13% of new male clients coming from the target high schools, the proportion of males coming from any other high school was substantially smaller. Forty percent of males reported having a physician or place to go for general health care services; 48% had been seen by a health care provider for a general physical examination in the previous year. Eighty-four percent had never visited an STD or family planning clinic; half had sought STD services in the past year.

Of the 87% of respondents who reported having intercourse in the past three months, 89% had had one or two sexual partners during that time. Most males (93%—not

TABLE 2. Percentage distribution of respondents to a survey of men making an initial visit to a new male reproductive health clinic, by characteristics pertaining to their use of the clinic

Characteristic	%
How found out about the clinic*	
Sexual partner	37.3
Female friend	19.1
Male friend	10.0
Sibling	6.4
Peer educator	7.3
Program outreach	6.4
Teacher or school counselor/nurse	5.5
Sports coach	3.6
Flyer/other information at school	5.5
Telephone directory	4.6
Other	10.9
Reason for coming to the clinic*	
STD testing or treatment	88.2
Condoms	20.9
Sports physical	7.3
Job/school physical	3.6
Annual physical	2.7
Information on birth control	1.8
Immunization	1.8
Other	9.1
Decision to come to clinic	
Made alone	49.5
Made with someone else	47.4
Determined mostly by another person	3.1
Came with someone else	
Yes	50.9
No	49.1
Any male friends used clinic	
Yes	23.0
No	41.0
Do not know	36.0
Current or previous partner used clinic	
Yes	42.0
No	36.0
Do not know	22.0
Preferred sex of health care provider	
Female	21.2
Male	20.2
Either	58.6
Total	100.0

*Sum of percentages for this variable exceeds 100% because respondents were permitted to give more than one answer. Note: Nonresponses are excluded from the valid percentages.

shown) disagreed with the statement “I would feel happy if I got someone pregnant now.” Among those who had been sexually active in the previous three months, 23% had had unprotected sex all of the time or most of the time, and 48% had had unprotected sex some of the time. More than half (56%) of sexually active males reported not using a condom at their most recent sexual encounter. Nearly a third of all respondents (31%) reported ever getting someone pregnant.

Nearly three-quarters of males had learned about the clinic by word of mouth—37% from a sexual partner, 29% from a friend and 6% from a sibling (Table 2). School sources from which they had heard of the clinic included teachers, counselors or nurses; coaches; and flyers or information at school. Fourteen percent of males had heard about the

clinic from a peer educator or through program outreach efforts.

Most first visits (88%) were for STD testing or treatment; 21% of first-time clients came to obtain condoms. Half of clients made the decision to come to the clinic with someone, and half actually came to the clinic with someone. Twenty-three percent reported that a male friend had visited the clinic; 42% said that a current or former sexual partner had been to the clinic. When asked about their preference for having a male or female health care provider, more than half (59%) reported having no preference, and responses among the rest were fairly evenly divided.

Female Client Satisfaction

Satisfaction surveys were completed by 51 female clients before the opening of the male clinic and 356 after. All females surveyed before the male clinic opened (100%) and almost all of those surveyed after (99%) rated the quality of services they received at NGHC as good or excellent. In addition, most females were very or mostly satisfied overall with the care they received (98% before, 92% after). Both before and after the opening of the male clinic, all females said that if they were to seek help again, they would definitely come back, and said that they would recommend the program to a friend in need of help. In the first year of the male clinic, only 12% of females reported being bothered by the presence of male clients at the clinic; this proportion was not significantly different from that objecting to the presence of males before the male clinic opened (6%).

DISCUSSION

The male clinic sessions successfully increased the number of male clients served at NGHC, in particular adolescents. The increase in male clients served was not at the expense of female clients, however, as the number of female clients increased modestly in the year following the opening of the male clinic. Although the program successfully reached its target population—adolescents—the growth in the number of adult male clients was initially greater than that among adolescents. The relatively rapid increase in the number of adult males seen may have been generated in response to the extended number of clinic hours devoted specifically to provision of male services; the increase in the number of male adolescents seen may have been more in response to outreach efforts, which intensified during the first year of the male clinic. Adolescent males may be more reluctant than older males to seek reproductive health care services because of developmental and confidentiality issues, and therefore more intensive efforts may be necessary to attract them.

Because NGHC's male involvement program held its outreach activities at high schools, these outreach efforts could not be restricted to their intended audience of sexually active adolescent males (i.e., female students or males who are not sexually active may have been included in outreach activities) and thus may not have represented the most efficient possible strategy. However, this approach represents

by far one of the most convenient opportunities for reaching sexually active adolescent males.

Our findings are consistent with an overall trend in growth of reproductive health services for males in California, although NGHC experienced greater growth: From 2000–2001 to 2001–2002, the number of male reproductive health clients served statewide through the Family PACT program increased by 33%, compared with 158% at NGHC.¹¹

The expansion of services to male clients did not appear to affect the level of satisfaction among female clients, which remained high. Although 40% of clients served during male clinic sessions were female, the overall character of the male clinic was in sharp contrast with that of other sessions, in which male clients rarely were present.

The male involvement program at NGHC reached a high-risk population, a substantial proportion of whom were adolescents. Direct outreach to a target population and increased capacity most likely played significant roles in expanding service provision to male clients. The clinic also implemented a targeted outreach program designed to bring males from two local high schools and the neighboring community to the clinic. As a result, the proportion of male clients attending a target high school was greater than that attending any other high school (although only 27% of male clients attended any high school). However, despite the program's outreach efforts, nearly three-quarters of new male clients learned of the male clinic sessions through other persons, especially sexual partners. Thus, "in-reach" efforts targeting female clients may be a cost-effective way to bring male clients to family planning clinics.

Like the clients of the Young Men's Clinic described by Armstrong and colleagues, the males visiting NGHC came primarily for STD testing and treatment, and a large proportion reported engaging in behaviors associated with high risks for STDs and unintended pregnancy.¹² To meet the needs of the male family planning client, clinics should not only be capable of performing all forms of STD testing but also be prepared to provide risk assessments and counseling about reducing the risk of unwanted pregnancy. Although the majority of sexually active adolescent males receive general physical examinations, only a small minority receive reproductive health services (i.e., counseling about pregnancy and STD prevention and testing for STDs).¹³

While one could argue that male reproductive health services consist essentially of STD screening and treatment, and that trying to incorporate males into the female reproductive health model may not be appropriate, this approach may be beneficial. For example, teenagers who have discussed STDs with a medical professional are more likely than others to also discuss these topics with their sexual partners.¹⁴ Moreover, reproductive health counseling with a medical professional, even for a short time, may increase contraceptive knowledge and use among young men.¹⁵ As such, a model that incorporates comprehensive reproductive health education and counseling into STD testing and treatment may result in improved reproductive health outcomes for young men and their partners.

Our findings demonstrate that family planning agencies that serve females can play a role in increasing reproductive health services to males, outside of the STD clinic model. In general, limited funding precludes most family planning agencies from offering services to males; however, when funding expands, as it did in California, agencies should seek appropriate models for expanding and providing services to males. We have described an example of a successful strategy for reaching adolescent and young adult males. However, our data on male clients served and satisfaction among female clients may not be representative of all NGHC clients, because only those who agreed to complete questionnaires were assessed.

The overall project added not only male-friendly clinical services but a peer educator program to provide targeted outreach in two local high schools. Staffing the male clinic required the addition of roughly 0.3 full-time equivalent (FTE) clinician staff and 0.3 FTE counseling staff and administrative support.* Revenue generated by billing for counseling and clinical services provided covers only a fraction of the cost of caring for adolescent and high-risk clients, both male and female. Some services the clinic offers to attract males, like sports physicals, are not reimbursed by the state, and the clinic must absorb these costs; however, by seeing some female clients during male clinic hours, NGHC was able to minimize the potential losses in revenue.

The peer education program and outreach activities required the addition of at least 2.1 FTE staff; some of that staff time was required for administrative support to fulfill financial and reporting obligations of the grant that funded the male clinic.† It is difficult to determine which aspects of the overall project were responsible for the observed increase in the number of male clients served, and it may be difficult to reproduce NGHC's experience exactly. The peer education program was a high-intensity activity, requiring, at a minimum, a dedicated 1.0 FTE (for the coordinator and part-time health educator) and involving a relatively small number of adolescent males—61 over three years. However, the outreach activities of the project staff and hired peer educators involved a relatively low level of intensity, requiring roughly 0.8–1.1 FTE (for the peer educators and project coordinator), but reached a larger number of males—approximately 3,000 in year two of the program. A better understanding of which components of the outreach efforts were most effective in bringing males to the clinic would be important in determining the cost-effectiveness and sus-

*The following positions composed the additional clinician staff time required to operate the male clinic: nurse practitioner, 0.2 FTE; physician fellow, 0.1 FTE. The following additional counseling and administrative staff were also needed: clinic assistant, 0.1 FTE; peer educators, 0.1 FTE total; and the project coordinator, serving as a health educator, 0.1 FTE. Two existing staff positions, a health educator (0.1 FTE) and a clerical, front-desk worker (0.1 FTE), were used for the male clinic; these staff were available prior to the opening of the male clinic for drop-in pregnancy testing and counseling.

†The following positions accounted for the additional staff time: two peer educators, 0.3 FTE total for outreach activities; project coordinator, 0.4 FTE for peer education and at least 0.5 for outreach; part-time health educator, 0.6 for peer education; and the center manager, 0.3 for grant administration.

tainability of such programs. Although the peer educator aspect was instrumental in allowing NGHC's male involvement program to develop a close relationship with the targeted schools, we believe that the male clinic could be sustained with funding of less staff (0.5–1.0 FTE), by eliminating the peer education component and concentrating more on general outreach in the schools and community.

For this program, grant funding was essential for developing capacity (i.e., training staff) and meaningful collaborations with the schools and other providers in the community. Because conducting a peer education program requires a high-intensity effort, it would be more cost-effective to hire staff who are already trained as peer educators and can work with males in a larger group of target schools. Given the low yield from outreach efforts to the two targeted schools, the NGHC male involvement program is now shifting its efforts to expanding outreach to the community, by working with community-based organizations that serve male youths.

There is growing recognition of the importance for society of male involvement in improving reproductive health outcomes. This program had the primary goal of increasing males' access to reproductive health care services through education and outreach. To effectively engage males in teenage pregnancy prevention efforts, program planners must also consider other models, involving schools and communities, that address the range of issues pertinent to male youths, including school graduation, vocational and career development, and violence.¹⁶

REFERENCES

1. Ventura SJ, Mathews TJ and Hamilton BE, Teenage births in the United States: trends, 1991–2000, an update, *National Vital Statistics Reports*, 2002, Vol. 50, No. 9; and Centers for Disease Control and Prevention (CDC), *Sexually Transmitted Disease Surveillance 2000*, Atlanta: CDC, 2001.
2. Sonenstein F et al., *Involving Males in Preventing Teen Pregnancy: A Guide for Program Planners*, Washington, DC: Urban Institute Press, 1997.
3. American Medical Association (AMA), Elster AB and Kuznets NJ, *AMA Guidelines for Adolescent Preventive Services (GAPS): Recommendations and Rationale*, Baltimore: Williams & Wilkins, 1994; Emans SJ et al., Society for Adolescent Medicine position paper on reproductive health care for adolescents, *Journal of Adolescent Health*, 1991, 12(8):649–661; and Blum RW et al., Don't ask, they won't tell: the quality of adolescent health screening in five practice settings, *American Journal of Public Health*, 1996, 86(12):1767–1772.
4. Porter LE and Ku L, Use of reproductive health services among young men, 1995, *Journal of Adolescent Health*, 2000, 27(3):186–194.
5. Sonenstein FL, ed., *Young Men's Sexual and Reproductive Health: Toward a National Strategy (Getting Started)*, Washington, DC: Urban Institute Press, 2000.
6. Frost J and Bolzan M, The provision of public-sector services by family planning agencies in 1995, *Family Planning Perspectives*, 1997, 29(1): 6–14.
7. Schulte MM and Sonenstein FL, Men at family planning clinics: the new patients? *Family Planning Perspectives*, 1995, 27(5):212–216 & 225.
8. Armstrong B et al., Involving men in reproductive health: the Young Men's Clinic, *American Journal of Public Health*, 1999, 89(6):902–905.
9. Moss DJ and Sawyer RG, Experiences with a clinic for young men, *Adolescent Medicine*, 1996, 7(1):27–34.

...family planning agencies that serve females can play a role in increasing reproductive health services to males, outside of the STD clinic model.

10. Marcell AV, Raine T and Eyre SL, Where does reproductive health fit into the lives of adolescent males? *Perspectives on Sexual and Reproductive Health*, 2003, 35(4):180-186.
11. Center for Reproductive Health Research and Policy, University of California, San Francisco, Family PACT (Planning, Access, Care, Treatment) program report, graphic summary 2001/02, Center for Reproductive Health Research and Policy, San Francisco, 2002.
12. Armstrong B et al., 1999, op. cit. (see reference 8).
13. Porter LE and Ku L, 2000, op. cit. (see reference 4).
14. Kaiser Family Foundation, Music Television (MTV) and Teen People, *What Teens Know and Don't (but Should) About Sexually Transmitted Diseases: A National Survey of 15 to 17 Year-Olds*, Menlo Park, CA: Kaiser Family Foundation, 1999.
15. Danielson R et al., Reproductive health counseling for young men:

what does it do? *Family Planning Perspectives*, 1990, 22(3):115-121.

16. Sonenstein FL, 2000, op. cit. (see reference 5); and Center for Reproductive Health Research and Policy, University of California, San Francisco, Young men moving forward: California's male involvement program—a teen pregnancy prevention program for males, Center for Reproductive Health Research and Policy, San Francisco, 2002.

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