

EXECUTIVE POLICY PROPOSAL

THE AMERICAN MEN AND BOYS HEALTH, READINESS, AND OPPORTUNITY INITIATIVE

*A Five-Year National and Military Strategy for Health, Purpose, Family
Stability, Education, Work, and Force Readiness*

PREPARED FOR

President Donald J. Trump

President of the United States

The Honorable Pete Hegseth

Secretary of War

PREPARED BY

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July 22, 2026

Transmittal Letter

A formal request for presidential and departmental action

July 22, 2026

President Donald J. Trump

The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

The Honorable Pete Hegseth

Secretary of War
The Pentagon
Washington, DC 20301

Re: A National and Military Strategy for the Health, Readiness, and Opportunity of American Men and Boys

Mr. President and Mr. Secretary:

The United States has an opportunity to address a set of interlocking challenges affecting men and boys: preventable chronic disease, elevated suicide mortality, educational disengagement, social isolation, weak pathways from school to skilled work, inconsistent father involvement, and—in a clinically defined subset of men—hormonal or reproductive disorders. These are not separate problems. Together, they influence family stability, workforce participation, community safety, military recruitment, retention, and readiness.

The public discussion often reduces this agenda to testosterone. That is too narrow and medically risky. Testosterone matters when a man has consistent symptoms and properly confirmed biochemical deficiency; it should not be used as a cultural scorecard, a performance-enhancement shortcut, or a substitute for sleep, metabolic health, mental-health care, injury treatment, reproductive counseling, and disciplined training. Current professional guidance supports a careful diagnostic process and warns against indiscriminate screening or treatment of asymptomatic men (Bhasin et al., 2018; Endocrine Society, 2026; Mulhall et al., 2018).

This proposal therefore presents a broader and more defensible strategy: the American Men and Boys Health, Readiness, and Opportunity Initiative. It combines clinician-led male health care, military human-performance safeguards, suicide prevention, male-responsive education and career pathways, fatherhood and family support, high-quality mentorship, physical activity, vocational development, and rigorous federal evaluation. It also provides a practical pathway for implementing the Department's newly announced testosterone-deficiency screening initiative without creating overtreatment, infertility risk, privacy violations, or weak readiness metrics.

I respectfully request that you direct a 180-day interagency action plan; establish a White House Council on Men and Boys Health, Readiness, and Opportunity; authorize a five-year demonstration portfolio; and require an annual public scorecard that measures real outcomes rather than slogans. The Department of War can lead the military component through Total Force Fitness, the Periodic Health Assessment, military treatment facilities, and independent evaluation. Health and Human Services should lead the national clinical and public-health work, with Education, Labor, Veterans Affairs, Justice, the Environmental Protection Agency, Agriculture, and the Office of Management and Budget as core partners.

America should pursue strength with discipline, compassion with accountability, and innovation with evidence. A serious national strategy for men and boys will strengthen women and children as well, because healthier men are better able to contribute as fathers, husbands, sons, workers, mentors, neighbors, and service members.

Thank you for your consideration. I stand ready to support a detailed implementation plan, stakeholder briefings, pilot design, legislative language, and program evaluation.

Respectfully,

Brian C. Alston

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1 Executive Summary

A disciplined national response to a complex challenge

American men and boys do not face one single crisis, and no single hormone, program, or institution can solve the full problem. The evidence instead points to a portfolio of challenges that overlap: obesity and metabolic disease; sleep deficiency; mental distress and suicide mortality; uneven educational and career transitions; social disconnection; inadequate access to male-friendly preventive care; fatherhood and family strain; occupational and environmental exposures; and a subset of clinically significant reproductive or endocrine disorders.

The case for action is strong, but the strongest case is not built on sensational claims. One long-running U.S. cohort reported an age-independent decline in serum testosterone, yet the authors cautioned that the reasons were unresolved and national generalization was uncertain (Travison et al., 2007). A large meta-analysis found substantial declines in sperm concentration across multiple regions, but sperm count is not the same measure as testosterone and causal explanations remain contested (Levine et al., 2023). These signals justify better surveillance and research—not a presumption that every man needs testosterone treatment.

By contrast, several immediate burdens are well measured. In 2024, the U.S. suicide rate among males was nearly four times the female rate (Centers for Disease Control and Prevention [CDC], 2026a). Adult obesity affects roughly four in ten U.S. adults, including a large share of men, and obesity is associated with metabolic disease and can contribute to functional hypogonadism (CDC, 2024; Bhasin et al., 2018). Male high school completers were less likely than female completers to enroll immediately in college in 2022, reinforcing the need for stronger college, credential, apprenticeship, and career pathways rather than a college-only definition of success (National Center for Education Statistics [NCES], 2024).

The military has a distinct readiness interest. Obesity, sleep loss, musculoskeletal injury, traumatic brain injury, substance misuse, depression, and untreated endocrine disorders can impair performance. In July 2026, the Department of War announced an enhanced testosterone-deficiency screening protocol tied to human performance and readiness (U.S. Department of War, 2026a). That decision creates both an opportunity and a risk: it could identify service members with reversible or clinically important conditions, but poorly designed mass screening could produce false positives, unnecessary treatment, fertility harm, stigma, and unreliable readiness conclusions.

THE POLICY POSITION

Build a national men-and-boys strategy around health, competence, connection, responsibility, and opportunity. Treat testosterone testing as one carefully governed clinical tool—never as the strategy itself.

1.1 Proposed Mission

To improve the health, capability, connection, and contribution of American men and boys through evidence-based health care, safe military human-performance systems, strong educational and career pathways, responsible fatherhood, effective mentorship, physical activity, and measurable community support.

1.2 Five-Year Outcomes

- Reduce preventable male mortality and increase timely access to mental-health and substance-use care.

- Improve metabolic health, sleep, physical activity, and functional fitness among men and boys.
- Increase successful transitions from high school into college, apprenticeships, technical credentials, military service, or employment.
- Strengthen father engagement, parenting capacity, and family stability without coercive or discriminatory policy.
- Expand access to screened, trained, and supervised mentors and coaches.
- Implement a safe, fertility-conscious, evidence-based military pathway for evaluating testosterone deficiency and related conditions.
- Create a durable federal measurement system that distinguishes health outcomes from ideology or political messaging.

1.3 Recommended Federal Architecture

Function	Lead
White House leadership	Establish a Council on Men and Boys Health, Readiness, and Opportunity chaired by the Domestic Policy Council.
Civilian health lead	Department of Health and Human Services, including CDC, NIH, HRSA, SAMHSA, and the Office of the Surgeon General.
Military co-lead	Department of War, through Personnel and Readiness, the Defense Health Agency, the services, and Total Force Fitness.
Opportunity partners	Departments of Education and Labor, Veterans Affairs, Justice, Agriculture, and the Small Business Administration.
Environment and research	Environmental Protection Agency, National Institute of Environmental Health Sciences, and occupational-health partners.
Accountability	Office of Management and Budget, independent evaluators, inspectors general, and an annual public report.

2 Decision Requests

Actions that can be authorized immediately

The following requests are designed for executive action while preserving congressional authority, professional medical standards, federalism, religious liberty, and individual rights.

Decision	Recommended Action
1. Issue a Presidential Memorandum	Direct a 180-day interagency plan for men and boys covering health, suicide prevention, education and work transitions, fatherhood, mentorship, military readiness, and research.
2. Establish a White House Council	Create a time-limited coordinating body with measurable objectives, public reporting, and representation from federal agencies, states, tribes, researchers, clinicians, veterans, parents, educators, employers, faith-based organizations, and youth.
3. Authorize Five-Year Demonstrations	Use competitive grants and existing authorities to test integrated state, tribal, local, and military-community models. Require control or comparison groups where feasible.
4. Direct a Safe Military Clinical Protocol	Require confirmatory testing, symptom assessment, fertility counseling, differential diagnosis, privacy protection, and treatment monitoring for the Department of War's testosterone initiative.
5. Launch the State of American Men and Boys Report	Publish a nonpartisan annual scorecard using health, education, employment, family, safety, and readiness metrics. Do not use average testosterone as a headline national performance target.
6. Submit a Legislative Package	After the 180-day review, submit narrow statutory requests for data linkage, demonstration authority, workforce funding, research, and appropriations where current authority is insufficient.

FIRST EXECUTIVE TEST

Any proposal that cannot explain its clinical safeguards, measurable outcomes, implementation authority, cost, and failure conditions is not ready for presidential approval.

3 The Problem: What the Evidence Supports

Separate measured burdens from hypotheses and rhetoric

3.1 Testosterone: Important, but Frequently Misused

Testosterone supports sexual function, bone density, muscle mass, erythropoiesis, and aspects of energy and well-being. However, symptoms such as fatigue, low mood, reduced performance, weight gain, and impaired concentration are nonspecific. They may reflect sleep apnea, depression, overtraining, traumatic brain injury, obesity, diabetes, medication effects, alcohol or opioid use, chronic illness, or relationship and occupational stress.

Professional guidelines therefore define hypogonadism clinically, not culturally. The Endocrine Society recommends diagnosis only when a man has consistent symptoms or signs and unequivocally, repeatedly low testosterone concentrations, confirmed with repeat morning testing (Bhasin et al., 2018). The American Urological Association similarly recommends two early-morning tests on separate days and treats 300 ng/dL as a reasonable diagnostic cut-off in the proper clinical context—not as a universal performance target (Mulhall et al., 2018).

In July 2026, the Endocrine Society stated that evidence remains insufficient for population-level screening of asymptomatic men and emphasized test accuracy, repeat measurement, and clinically appropriate treatment (Endocrine Society, 2026). This proposal adopts those safeguards.

3.2 Secular Trends: Signals Requiring Better Surveillance

A Massachusetts cohort observed lower testosterone levels in later calendar years even after adjusting for age and several health factors (Travison et al., 2007). This finding is important but should not be presented as proof of a uniform one-to-two-percent annual national decline. Cohort composition, assay methods, obesity, medication use, chronic disease, and other factors complicate interpretation.

Sperm concentration and total sperm count have also declined in pooled studies across several decades (Levine et al., 2023). That trend deserves attention because it may reflect reproductive, environmental, behavioral, or health changes. Yet sperm count, fertility, testosterone, masculinity, and military performance are different constructs. A responsible policy must not collapse them into one narrative.

3.3 Metabolic Health and Obesity

Obesity is one of the most actionable population-level risks. CDC estimates indicate that about 40 percent of U.S. adults had obesity during August 2021–August 2023, with similarly high prevalence among men and women (CDC, 2024). In men, excess adiposity is associated with insulin resistance, sleep apnea, inflammation, and lower circulating testosterone. Weight reduction and treatment of underlying conditions may improve endocrine function for some men without exogenous testosterone.

Military data also warrant attention. Defense health surveillance reported a marked increase in obesity prevalence among active-component service members between 2013 and 2023, with implications for injury, heat illness, chronic disease, retention, and deployability (Defense Health Agency, 2025). The readiness response should prioritize body composition, sleep, nutrition, training quality, recovery, and clinical care—not hormone levels alone.

3.4 Sleep, Recovery, and Circadian Health

Sleep is a foundational readiness input. A small laboratory study found that one week of restricting healthy young men to five hours of sleep per night reduced daytime testosterone by approximately 10–15 percent; its sample size was small, so the result should not be generalized as a precise population estimate (Leproult & Van Cauter, 2011). The stronger policy rationale for sleep is broader: sleep supports cognition, mood, physical recovery, injury prevention, and operational performance. The Army's Holistic Health and Fitness framework recommends approximately seven to nine hours of sleep for most adults and provides an existing platform for implementation (U.S. Army, 2026).

3.5 Mental Health, Suicide, and Social Connection

Male suicide mortality is a clear national concern. CDC reports that the male suicide rate in 2024 was nearly four times the female rate (CDC, 2026a). Men are also less likely than women to receive mental-health treatment, which may reflect stigma, service design, cost, access, symptom presentation, and help-seeking norms (National Institute of Mental Health [NIMH], n.d.). A men-and-boys strategy must make care easier to enter through primary care, workplaces, sports, veterans' services, faith communities, digital platforms, and crisis systems.

The strategy should avoid treating every form of male distress as an endocrine problem. Depression, trauma, substance use, grief, domestic conflict, financial pressure, loneliness, and moral injury require their own competent assessment and treatment.

3.6 Education and Pathways to Adult Competence

In 2022, 57 percent of male high school completers enrolled in college immediately after graduation compared with 66 percent of female completers (NCES, 2024). This gap should not be interpreted as proof that boys are inherently less capable or that college is the only valid outcome. It does show the need for multiple high-status pathways: four-year college, community college, military service, registered apprenticeships, technical credentials, entrepreneurship, public service, and direct employment with structured advancement.

Schools should use evidence-based supports—literacy intervention, attendance recovery, career exploration, tutoring, physical activity, project-based learning, behavioral health, and mentoring—rather than assuming one “male learning style” applies to all boys.

3.7 Fatherhood, Family Stability, and Mentorship

Longitudinal research supports the value of engaged fathering, especially direct, reliable interaction with children (Sarkadi et al., 2008). Policy should help fathers overcome barriers such as unemployment, unstable housing, incarceration, conflict, transportation, untreated mental illness, child-support complexity, and lack of parenting skills. It should not romanticize every household arrangement or pressure families to remain in unsafe relationships.

Youth mentoring can improve outcomes, but effects are typically modest and depend on relationship quality, duration, training, supervision, and program design (Raposa et al., 2019). Scaling mentorship without safeguarding, screening, and evaluation would be irresponsible.

3.8 Environmental and Occupational Exposures

Endocrine-disrupting chemicals can interfere with hormone signaling through multiple mechanisms, and exposure science supports continued research, biomonitoring, safer substitution, and risk communication (National Institute of Environmental Health Sciences [NIEHS], 2026). The evidence does not justify claiming that common consumer exposure is the sole or dominant explanation for population testosterone trends. Federal action should be chemical-specific, dose-aware, and grounded in toxicology and epidemiology.

Evidence at a Glance

Domain	What Is Well Supported	What Must Not Be Overstated
Clinical testosterone deficiency	Diagnosis requires symptoms/signs plus confirmed low levels; treatment can help appropriately selected patients.	A single low value does not establish disease; testosterone is not a universal vitality score.
Population trends	Some cohorts and reproductive studies show concerning secular changes.	The causes, magnitude, and national uniformity are not fully resolved.
Obesity / metabolic disease	High prevalence and strong links to health, readiness, sleep apnea, and functional hypogonadism.	Weight alone does not explain every case or justify stigma.
Sleep	Critical to cognition, mood, recovery, and performance.	One small sleep study does not establish a precise effect for every man.
Mental health	Male suicide mortality is high and treatment access is insufficient.	Distress should not be reduced to hormones or “weakness.”
Mentorship / fatherhood	Quality engagement can support youth development.	Unscreened or poorly supervised programs can harm youth.
Endocrine disruptors	Certain chemicals can affect endocrine function and merit research and regulation.	Broad claims about plastics or pesticides must not outrun chemical-specific evidence.

4 Strategic Principles and Guardrails

The standards that prevent a good idea from becoming bad policy

Principle	Operational Meaning
1. Health, not ideology	Define success through measurable health, safety, education, family, and readiness outcomes—not a preferred personality, political identity, or stereotype of manhood.
2. Clinician-led care	Screening and treatment decisions belong within licensed clinical practice, informed consent, laboratory quality standards, and professional guidelines.
3. Screening is not diagnosis	A screening result must lead to confirmatory testing and differential diagnosis—not automatic medication.
4. Fertility protection	Every reproductive-age patient must receive fertility counseling before exogenous testosterone. Testosterone monotherapy should not be used when preserving current or future fertility is a priority (AUA/ASRM, 2024).
5. Treat reversible causes	Address sleep apnea, obesity, diabetes, medication effects, opioid exposure, alcohol misuse, overtraining, under-fueling, depression, and other contributors before or alongside hormone therapy.
6. Privacy and non-discrimination	Hormone results must not become a simplistic basis for promotion, discharge, occupational exclusion, security clearance, school discipline, or public labeling.
7. Mission-relevant military standards	Judge performance through validated occupational requirements, deployability, injury rates, cognition, and mission outcomes—not testosterone targets.
8. Multiple pathways to adulthood	Value college, technical education, military service, apprenticeships, entrepreneurship, caregiving, and public service.
9. Family safety	Support father involvement and family stability while preserving protections for survivors of abuse, children, and vulnerable adults.
10. Local choice with federal accountability	Use state, tribal, local, military, and community innovation, but require clear safeguarding, fiscal controls, and outcome evaluation.
11. Religious liberty without coercion	Faith-based partners may contribute consistent with law, participant choice, and non-discrimination requirements.
12. Stop what does not work	Build sunset clauses, independent evaluation, and termination criteria into every major demonstration.

5 National Strategy: Seven Coordinated Pillars

A portfolio approach rather than a single-program campaign

Pillar 1 — Male Health, Prevention, and Reproductive Care

Create a visible, accessible male-health pathway that begins with primary care and does not force men to self-diagnose through social media, supplement advertising, or commercial hormone clinics.

- Fund male-health demonstration clinics within community health centers, rural health systems, and tribal health programs.
- Integrate blood pressure, obesity, diabetes, sleep apnea, depression, substance use, sexual health, fertility goals, medication review, and symptom-triggered endocrine evaluation.
- Create a national clinician toolkit on testosterone deficiency, infertility, sleep apnea, opioid-related endocrine dysfunction, and fertility-preserving alternatives.
- Expand access to accurate laboratory testing through CDC-certified or equivalently standardized assays and quality-control requirements.
- Require transparent direct-to-consumer advertising standards for testosterone, “boosters,” peptides, and unapproved performance products.
- Fund comparative-effectiveness research on lifestyle treatment, weight management, sleep-apnea treatment, fertility-preserving care, and testosterone therapy.

CLINICAL SAFEGUARD

No federal program should promise to “raise testosterone” as its primary public-health outcome. The purpose is to identify disease, correct reversible causes, improve function, and protect fertility.

Pillar 2 — Military Human Performance and Ethical Hormone Care

Modernize Total Force Fitness by integrating endocrine care into a broader performance system. The Department of War should use its July 2026 screening initiative as a disciplined learning platform, not a mass-prescribing program.

- Embed screening within the Periodic Health Assessment and clinical care—not command-directed performance comparisons.
- Use standardized early-morning testing, repeat confirmation, symptom assessment, and evaluation of contributing conditions.
- Establish specialist pathways for traumatic brain injury, pituitary disease, opioid exposure, sleep disorders, infertility, and complex special-operations presentations.
- Provide fertility preservation counseling and access to reproductive specialists before exogenous testosterone when clinically relevant.
- Prohibit non-medical testosterone use for performance enhancement and strengthen detection of unapproved hormones and contaminated supplements.
- Measure readiness through validated outcomes: fitness, injury, deployability, cognition, sleep, retention, medical limitation days, and patient-reported function.

- Commission an independent evaluation before expanding any universal screening threshold or treatment policy.

Pillar 3 — Boys' Education, Physical Activity, and Career Pathways

Help boys succeed without lowering standards or reducing their future to one institutional path. Federal policy should support evidence-based interventions while respecting state and local control of education.

- Expand early literacy, high-dosage tutoring, chronic-absence intervention, and middle-school transition supports targeted by need.
- Increase daily movement and quality physical education, while accommodating disability and avoiding unsafe one-size-fits-all training.
- Fund project-based learning in engineering, agriculture, robotics, construction, health sciences, arts, and civic problem-solving.
- Build “multiple destination” high-school counseling that treats college, credentials, apprenticeships, military service, and employment as serious pathways.
- Expand dual enrollment, career and technical education, paid work-based learning, and registered apprenticeships.
- Recruit and retain more effective teachers, counselors, coaches, and mentors of diverse backgrounds, including men, without implying that only men can teach boys.
- Use school climate and discipline data to identify exclusion, disengagement, bullying, and unmet behavioral-health needs.

Pillar 4 — Men's Mental Health, Suicide Prevention, and Recovery

Design services around how men actually enter care. Many men will first disclose distress to a primary-care clinician, coach, pastor, peer, supervisor, veterans' representative, spouse, or crisis counselor rather than a specialty mental-health clinic.

- Expand same-day behavioral-health access in primary care, community health centers, military clinics, and veterans' services.
- Develop male-responsive public messaging that normalizes help-seeking without glamorizing stoicism or pathologizing masculinity.
- Train gatekeepers in workplaces, unions, sports, faith communities, colleges, apprenticeship programs, and firearm-owning communities.
- Integrate suicide-risk assessment, lethal-means safety counseling, substance-use treatment, and post-crisis follow-up.
- Expand trauma, grief, domestic-violence, anger-management, and relationship services that hold men accountable while offering a path to change.
- Use peer support as an entry point, not a substitute for licensed care when clinical risk is present.

Pillar 5 — Fatherhood, Family Stability, and Relationship Capacity

Support men in becoming reliable, safe, engaged fathers and partners. The federal role is to reduce barriers, strengthen skills, and protect children—not prescribe one family structure or minimize abuse.

- Expand evidence-based responsible-fatherhood and co-parenting programs tied to employment, parenting education, and child development.
- Provide navigation for child support, custody, reentry, housing, transportation, and benefits while preserving legal obligations.
- Offer relationship education, conflict de-escalation, communication, and domestic-violence prevention with survivor-centered safeguards.
- Create father-friendly prenatal, birth, pediatric, school, and family-service practices.
- Support father-child activities, reading, service, outdoor recreation, and skills development.
- Fund independent evaluations that measure child well-being, father engagement, safety, employment, and sustained participation.

Pillar 6 — Mentorship, Service, and Community Connection

Create a National Men and Boys Mentorship and Service Network built around quality, not raw enrollment. The objective is durable relationships, competence, and contribution.

- Use vetted mentors from veterans' groups, unions, trades, colleges, sports, businesses, civic organizations, and faith communities.
- Require background checks, child-protection policies, training, supervision, reporting channels, and clear boundaries.
- Prioritize small-group and team-based formats where one-to-one matching capacity is limited.
- Pair mentoring with real activities: tutoring, skilled trades, financial literacy, civic service, outdoor education, arts, entrepreneurship, and sports.
- Include intergenerational programs that engage older men while addressing isolation and transmitting skills.
- Pay for quality measures such as match duration, attendance, youth safety, goal attainment, and participant feedback—not just sign-ups.

Pillar 7 — Work, Purpose, and Economic Mobility

A credible strategy must connect health and character formation to productive opportunity. Purpose cannot be delivered by a slogan; it grows through responsibility, skill, belonging, and visible progress.

- Expand pre-apprenticeship and registered apprenticeship in construction, advanced manufacturing, energy, logistics, health care, information technology, public safety, and infrastructure.
- Create reentry-to-work pathways for justice-involved men, tied to treatment, housing, credentials, and employer partnerships.
- Provide small-business and entrepreneurship training with realistic market validation, financial coaching, and procurement access.
- Support employer practices that reduce preventable injury, sleep disruption, substance misuse, and untreated mental-health problems.
- Build service-year options that combine community contribution, training, mentorship, and education awards.

- Measure earnings, retention, credential completion, advancement, and family stability—not only program enrollment.

6 Department of War Implementation Framework

A safe clinical and readiness model for testosterone-related screening

6.1 Strategic Objective

Identify service members with clinically meaningful testosterone deficiency or related health conditions, correct reversible causes, provide appropriate care, and generate valid evidence about readiness—without encouraging overtreatment, compromising fertility, or turning hormone values into personnel labels.

6.2 Recommended Clinical Workflow

Step	Required Standard
Step 1 — Eligibility and context	Use the Department's announced criteria as an initial operating policy, but allow clinician judgment. Explain that screening is a health assessment, not a fitness ranking or disciplinary test.
Step 2 — Initial laboratory test	Obtain total testosterone in the early morning, preferably fasting, using a standardized assay. Record sleep, shift work, acute illness, deployment status, recent strenuous exercise, and medication use.
Step 3 — Confirm an abnormal result	Repeat the early-morning test on a separate day. Do not diagnose deficiency from one result. Consider free testosterone or sex hormone-binding globulin when clinically indicated.
Step 4 — Assess symptoms and function	Evaluate sexual symptoms, fatigue, mood, bone health, muscle change, anemia, recovery, and patient-reported function. Avoid attributing nonspecific symptoms automatically to testosterone.
Step 5 — Identify causes	Review obesity, diabetes, sleep apnea, under-fueling, overtraining, opioids, glucocorticoids, anabolic agents, alcohol, pituitary disease, testicular disease, traumatic brain injury, and acute/chronic illness. Obtain LH, FSH, prolactin, and additional tests as indicated.
Step 6 — Discuss fertility and goals	Document current or future fertility intentions. Explain that exogenous testosterone suppresses spermatogenesis and may reduce fertility.
Step 7 — Treat the cause	Address sleep apnea, weight, metabolic disease, medication effects, nutrition, alcohol or substance use, mental health, and recovery. Refer to endocrinology, urology, reproductive medicine, sleep medicine, or TBI specialists when needed.
Step 8 — Consider testosterone therapy	Use only for symptomatic men with confirmed deficiency and no contraindication, after shared decision-making. Follow professional guidance on formulation, dosing, and monitoring.
Step 9 — Monitor safety and benefit	Track symptoms, testosterone level, hematocrit, blood pressure, prostate risk as age-appropriate, adverse events, fertility concerns, adherence, and objective function. Stop or revise treatment when benefits do not justify risks.
Step 10 — Protect records and	Limit access to clinical need-to-know. Prohibit automatic adverse personnel

Step	Required Standard
careers	action based solely on testosterone results or treatment status unless a validated, mission-specific medical standard applies.

6.3 Special Operations and “Operator Syndrome”

Special operations personnel may experience unusual combinations of blast exposure, traumatic brain injury, chronic pain, sleep disruption, intense training, repeated deployment, and neuroendocrine symptoms. These populations justify specialized multidisciplinary pathways and research. They should not be treated as representative of the entire force. A special-operations protocol should integrate neurology, endocrinology, sleep medicine, behavioral health, pain management, rehabilitation, and family support.

6.4 Military Pilot Design

Element	Recommended Design
Sites	Select diverse installations across services, including one special-operations site, one recruit-training site, reserve-component settings, and military treatment facilities with different laboratory capabilities.
Comparison	Use phased rollout, matched comparison sites, or another credible quasi-experimental design.
Population	Include men and women where clinically relevant; report sex-specific results. Do not assume female hormone health is outside readiness.
Outcomes	Diagnostic yield, false-positive rate, treatment rate, fertility counseling, adverse events, sleep-apnea diagnosis, metabolic treatment, patient-reported function, fitness, injury, deployability, and limited-duty days.
Time horizon	Minimum 24 months of follow-up before readiness conclusions; longer for fertility and cardiovascular safety.
Oversight	Independent clinical advisory board, human-subject protections, data safety monitoring, inspectors general, and publication of methods and results.
Expansion rule	Scale only if the pilot demonstrates net benefit, acceptable harm, operational feasibility, and cost-effectiveness.

6.5 Treatment Risk and Fertility Safeguards

The TRAVERSE trial found that testosterone therapy was noninferior to placebo for major adverse cardiovascular events in a selected population of middle-aged and older men with confirmed hypogonadism and elevated cardiovascular risk; some adverse events were more frequent in the testosterone group (Lincoff et al., 2023). In 2025, the Food and Drug Administration removed the boxed cardiovascular warning from testosterone labeling after reviewing the trial, while adding a class-wide blood-pressure warning and retaining limitations related to age-associated low testosterone (U.S. Food and Drug Administration [FDA], 2025). These developments support careful, indicated treatment—not casual prescribing.

For service members who want children, exogenous testosterone requires special caution because it suppresses gonadotropins and sperm production. Fertility goals must be documented before treatment, and alternatives or specialist referral should be considered (AUA/ASRM, 2024).

READINESS RULE

No commander should be told that “higher testosterone equals higher readiness.” Readiness is multidimensional and must be measured through validated human-performance and mission outcomes.

7 Governance and Interagency Responsibilities

Clear ownership, limited bureaucracy, transparent accountability

7.1 White House Council

Establish a White House Council on Men and Boys Health, Readiness, and Opportunity for an initial five-year term. The Council should coordinate—not duplicate—agency authority. It should publish priorities, approve shared metrics, identify legal barriers, align demonstrations, and issue an annual report.

Entity	Primary Responsibilities
Domestic Policy Council	Chair the Council; align health, education, family, workforce, justice, and community policy.
Department of Health and Human Services	Lead clinical standards, public health, suicide prevention, primary care, reproductive health, research, and community grants.
Department of War	Lead force health, human performance, military clinical pilots, family readiness, and veteran/active-duty mentorship partnerships.
Department of Veterans Affairs	Integrate mental health, suicide prevention, endocrine care, TBI, pain, substance use, family services, and veteran mentorship.
Department of Education	Support literacy, attendance, physical education, career pathways, school mental health, and evidence-based mentoring.
Department of Labor	Expand apprenticeships, credentials, reentry employment, worker safety, and employer partnerships.
Department of Justice	Support youth safety, reentry, violence prevention, mentoring standards, and evaluation.
EPA and NIEHS	Advance chemical-specific research, exposure surveillance, risk communication, and evidence-based regulation.
USDA	Support nutrition, rural health, outdoor programs, agricultural education, and cooperative-extension partnerships.
OMB	Review authorities, score costs, enforce performance requirements, and prevent duplicative grantmaking.
Independent Advisory Board	Include clinicians, researchers, veterans, fathers, mothers, youth, educators, labor, employers, faith leaders, tribal representatives, and survivor advocates.

7.2 Federalism and Community Partnership

States, tribes, territories, local governments, and communities should be able to select interventions that fit their populations. Federal funding should establish a common floor: evidence standards, child protection, civil rights, privacy, fiscal integrity, outcome measures, and independent evaluation. Programs may use male-

specific outreach or lawful male-only formats when justified, but the overall initiative must not deny services or opportunity on an unlawful basis.

7.3 Data Governance

- Use de-identified, minimum-necessary data and clear data-use agreements.
- Separate clinical records from program evaluation whenever possible.
- Prohibit sale or commercial use of participant health, genetic, reproductive, or mentoring data.
- Create a transparent data dictionary and publish limitations, missingness, and demographic differences.
- Require laboratory standardization and record assay method when comparing testosterone results.
- Allow independent replication and peer review while protecting privacy and national security.

8 Five-Year Implementation Roadmap

Sequence matters: establish safeguards before scale

Phase	Purpose	Key Actions
Phase 1: 0–180 days	Organize and protect	Issue presidential memorandum; establish Council; inventory existing programs; finalize clinical guardrails; design Department of War pilots; select core metrics; identify legal and budget authorities; publish public evidence brief.
Phase 2: 6–18 months	Pilot and build capacity	Launch military and civilian demonstrations; train clinicians and mentors; create laboratory-quality requirements; expand apprenticeship and school-pathway grants; launch mental-health access pilots; begin baseline data collection.
Phase 3: 18–36 months	Evaluate and refine	Release first annual report; compare pilot outcomes; correct implementation failures; expand only high-performing components; submit targeted legislation and budget requests; publish clinical and program toolkits.
Phase 4: 36–60 months	Scale what works	Scale validated models through formula or competitive grants; integrate successful military practices into standard policy; terminate ineffective programs; publish final five-year evaluation and recommendations for continuation.

8.1 First-Year Deliverables

- A presidential memorandum and charter for the White House Council.
- A federal evidence report distinguishing established facts, plausible risks, unknowns, and research priorities.
- A Department of War clinical protocol and independent pilot-evaluation plan.
- A national male-health clinician toolkit and patient decision aid.
- A model mentoring and child-safeguarding standard.
- A competitive notice for state, tribal, local, and community demonstration grants.
- A unified scorecard specification and baseline report.
- A preliminary legislative and appropriations proposal.

8.2 Demonstration-Site Model

Select a diverse portfolio rather than a single national prototype: urban and rural communities; tribal nations; regions with high suicide or overdose burden; communities with strong union or apprenticeship infrastructure; military-connected areas; and sites capable of rigorous evaluation. Each site should implement a locally chosen combination of at least three pillars and one shared measurement framework.

9 Illustrative Budget and Funding Strategy

A planning envelope — not a scored appropriation request

A credible national strategy requires resources, but it should first redirect and align existing programs. The following five-year planning range is illustrative and must be refined by the Office of Management and Budget and, where legislation is required, the Congressional Budget Office. Amounts exclude existing base funding already supporting primary care, schools, military health, workforce programs, and veterans' services.

Portfolio	Five-Year Range	Purpose
Council, data, and national evaluation	\$75–125 million	Interagency office, common data standards, annual reporting, independent evaluation, laboratory quality, and research coordination.
Civilian male-health demonstrations	\$225–350 million	Community health centers, rural/tribal sites, clinician training, reproductive health, sleep apnea, metabolic care, and mental-health integration.
Department of War pilots and clinical infrastructure	\$175–275 million	Laboratory standardization, clinical pathways, specialty referral, data systems, pilot evaluation, fertility counseling, and Total Force Fitness integration.
Education, CTE, apprenticeship, and service pathways	\$300–500 million	Competitive demonstrations, work-based learning, tutoring, career navigation, physical activity, and service-year pilots.
Fatherhood, family, mentoring, and community grants	\$175–300 million	Evidence-based fatherhood, relationship safety, supervised mentoring, service projects, training, and safeguarding.
Reproductive, endocrine, occupational, and environmental research	\$100–200 million	Longitudinal surveillance, exposure science, assay harmonization, treatment outcomes, fertility, and special-operations research.
Total illustrative five-year envelope	\$1.05–1.75 billion	Subject to authority review, offsets, scoring, and annual appropriations.

9.1 Funding Rules

- At least 10 percent of demonstration funding should support independent evaluation and data quality.
- No reimbursement for unapproved testosterone products, performance-enhancement prescribing, or supplements marketed with unsupported claims.
- Use milestone-based grants with continuation tied to safeguarding, enrollment quality, implementation fidelity, and early outcomes.
- Require cost-sharing where appropriate but protect rural, tribal, and high-poverty communities from unrealistic match requirements.
- Permit faith-based participation consistent with applicable law and participant choice.

- Sunset or redesign programs that fail predefined thresholds.

10 Performance Measurement and Public Accountability

Measure the outcomes the nation actually needs

10.1 National Scorecard

Domain	Core Measures
Health	Obesity and severe obesity; diabetes control; blood pressure; sleep-apnea identification and treatment; physical activity; preventive-care use; substance-use treatment; self-rated health.
Mental health and safety	Male suicide mortality and attempts; crisis follow-up; treatment initiation and retention; overdose mortality; domestic and community violence; firearm-safety interventions where appropriate.
Education	Literacy and math recovery; attendance; graduation; immediate postsecondary enrollment; credential completion; CTE participation; apprenticeship entry; disciplinary exclusion.
Work and opportunity	Employment, earnings, credential attainment, apprenticeship completion, retention, promotion, entrepreneurship survival, and reentry employment.
Family and relationships	Father-child contact and engagement; parenting skill; co-parenting quality; child support compliance; family safety; relationship conflict and domestic-violence outcomes.
Mentorship and community	Mentor screening and training; match duration; attendance; participant safety; youth goal attainment; volunteer retention; service hours; social connection.
Military readiness	Deployability; physical fitness; injury; sleep; behavioral-health access; limited-duty days; retention; medical evacuation; diagnostic yield; adverse events; fertility counseling; patient-reported function.
Clinical testosterone care	Proportion with repeat confirmatory testing; symptom documentation; cause evaluation; fertility counseling; specialist referral; appropriate treatment; monitoring; discontinuation when ineffective or unsafe.
Equity and access	Outcomes by age, race/ethnicity, geography, disability, veteran status, income, and rural/urban location, with careful interpretation and privacy safeguards.

10.2 Measures That Should Not Be Used as Stand-Alone Success Metrics

- Average national testosterone level.
- Number of testosterone prescriptions.
- Number of boys placed in male-only programs.
- Number of mentors recruited without quality or duration measures.
- Gym memberships or program sign-ups without health and retention outcomes.

- Marriage rates without safety, stability, and child well-being measures.
- Military fitness scores without injury, retention, deployability, and occupational validity.
- Public-relations reach, impressions, or slogans as substitutes for behavior and outcomes.

10.3 Evaluation Standards

Every major program should have a published theory of change, baseline, implementation measures, outcome measures, demographic analysis, adverse-event monitoring, and a predetermined decision rule for continuation, revision, or termination. Randomized designs should be used when ethical and feasible; otherwise, use strong quasi-experimental methods. Public reports should disclose limitations and null results.

11 Risks, Objections, and Mitigation

Stress-testing the proposal before implementation

Risk	Failure Mode	Mitigation
Medical overtreatment	Broad screening creates false positives and commercial pressure to prescribe.	Repeat testing; symptoms required for diagnosis; specialist referral; utilization review; audit commercial conflicts; publish treatment and adverse-event rates.
Fertility harm	Exogenous testosterone suppresses sperm production.	Mandatory fertility discussion; documented reproductive goals; specialist access; alternatives when appropriate; follow-up.
Politicization of medicine	Hormone levels become a proxy for ideology, masculinity, or loyalty.	Independent clinical governance; professional guidelines; privacy rules; no command or school ranking by hormone values.
Stigma and discrimination	Men with low testosterone, mental illness, disability, or poor fitness are labeled as weak.	Person-first communication; disability and civil-rights compliance; confidential care; focus on function and treatment.
Exclusion of women and girls	The initiative is perceived as zero-sum or hostile to existing programs.	State clearly that targeted support responds to specific male outcomes and does not reduce legal rights or necessary services for women and girls.
Unsafe mentorship	Rapid scaling exposes youth to abuse, exploitation, or boundary violations.	Background checks; training; supervision; two-adult practices; reporting; audits; survivor-informed safeguarding.
Weak evidence	Programs are scaled from anecdotes or ideology.	Competitive pilots; independent evaluation; sunset clauses; public methods; peer review; stop-loss criteria.
Unfunded mandates	Schools and communities receive requirements without capacity.	Voluntary demonstration grants; realistic administrative funding; local flexibility; phased implementation.
Environmental overreach	Broad chemical bans are adopted without dose- or chemical-specific evidence.	NIEHS/EPA review; biomonitoring; substitution analysis; risk-benefit assessment; targeted rulemaking.
Fragmented bureaucracy	New council duplicates existing offices.	Five-year sunset; small coordinating staff; agency inventory; shared metrics; OMB oversight; consolidate duplicative grants.
Privacy and data misuse	Sensitive health, fertility, and youth data are exposed or commercialized.	Minimum-necessary data; de-identification; access controls; contractual

Risk	Failure Mode	Mitigation
		bans on sale; breach response; independent audit.
Readiness misinterpretation	Testosterone is treated as a proxy for combat performance.	Use validated occupational outcomes; clinical data remain clinical; no personnel action based solely on a level or diagnosis.

11.1 The Hard Questions

- What exact outcome improves, by how much, and by when?
- What evidence supports the intervention for this population?
- What harm could the program cause, and how will it be detected?
- Who is accountable when results are poor or data are manipulated?
- What authority permits the action, and what requires legislation?
- What existing program should be consolidated, redirected, or stopped?
- How will the strategy protect fertility, privacy, civil rights, and family safety?
- What result would justify ending the program?

12 Conclusion

Strength through health, competence, connection, and responsibility

America should take the challenges facing men and boys seriously without accepting weak science, simplistic cultural narratives, or careless medical intervention. The country needs strong men—but strength must be defined broadly and responsibly: physical health, emotional regulation, moral courage, competence, service, accountability, family commitment, and readiness to contribute.

The American Men and Boys Health, Readiness, and Opportunity Initiative offers a practical path. It builds on institutions that already exist; targets measurable burdens; expands opportunity; treats clinically significant testosterone deficiency appropriately; protects fertility and privacy; supports military readiness; strengthens fathers and families; and creates the data needed to learn what works.

The most important decision is not whether the federal government can launch another campaign. It is whether the government will impose the discipline required to align medicine, education, work, family, community, and military readiness around outcomes that matter. This proposal recommends that discipline.

RECOMMENDED PRESIDENTIAL MESSAGE

America will help men and boys become healthier, more capable, more connected, and more responsible—through high standards, real opportunity, strong families, sound medicine, and measurable results.

Appendix A — Clinical Testosterone Decision Pathway

Operational reference for military and civilian demonstration sites

Decision Point	Proceed When	Do Not Proceed When
Initiate evaluation	Symptoms/signs suggest deficiency; high-risk clinical condition; or authorized screening protocol with informed explanation.	The sole reason is a desire for performance enhancement, bodybuilding, or a nonspecific promise of “optimization.”
Initial test	Early-morning total testosterone using a reliable assay; patient is not acutely ill when feasible.	Timing, acute illness, shift work, or laboratory method makes interpretation unreliable without adjustment.
Confirm	A separate early-morning test is also low.	Only one test is low or values are inconsistent without further evaluation.
Diagnose	Symptoms/signs and consistently low testosterone are both present, with appropriate clinical judgment.	Low number without symptoms, or symptoms without confirmed biochemical deficiency.
Determine cause	LH/FSH and other testing, history, examination, medication review, and relevant specialty assessment clarify primary, secondary, or functional causes.	Treatment is started before considering pituitary/testicular disease, sleep apnea, obesity, opioids, medication effects, under-fueling, or acute illness.
Address fertility	Reproductive goals are documented and the patient understands suppression of spermatogenesis.	Fertility is desired but counseling, alternatives, or referral have not occurred.
Treat	Benefits, risks, contraindications, alternatives, monitoring, and stopping rules are documented.	There is no confirmed indication, informed consent, monitoring capacity, or safe plan.
Monitor	Symptoms, laboratory levels, hematocrit, blood pressure, adverse effects, prostate considerations, fertility concerns, and objective function are reviewed.	Treatment continues despite absent benefit, unsafe laboratory change, serious adverse effect, or patient preference to stop.

Clinical framework informed by the Endocrine Society and American Urological Association guidelines. Local policy must be reviewed by licensed clinicians and legal counsel.

Appendix B — First 180-Day Action Agenda

A practical executive sequence

Timing	Action
Days 1–15	Issue presidential memorandum; name chair and agency leads; freeze any expansion of testosterone treatment protocols until safeguards and evaluation design are approved; preserve clinically necessary care.
Days 16–45	Inventory federal male-health, fatherhood, mentoring, workforce, military, veterans, education, suicide-prevention, and endocrine-research programs; identify duplication and authority gaps.
Days 31–60	Convene clinical panel; publish interim Department of War guardrails; specify assay, repeat testing, symptom assessment, fertility counseling, privacy, and referral requirements.
Days 46–90	Select national scorecard; establish baseline; issue data-governance standards; create independent advisory and evaluation boards.
Days 61–120	Release demonstration grant concepts; identify military pilot sites; publish mentoring safeguarding standard; begin clinician and program-leader training.
Days 91–150	Finalize budget and legislative options; negotiate data-sharing agreements; launch public education emphasizing health and responsible care, not hormone hype.
Days 151–180	Deliver interagency action plan to the President; announce pilots; publish evidence report, implementation dashboard, and first-year milestones.

Appendix C — Draft Presidential Directive

Proposed memorandum language for legal and policy review

Memorandum for the Heads of Executive Departments and Agencies

Subject: Coordinating Federal Action to Improve the Health, Readiness, and Opportunity of American Men and Boys

American men and boys contribute to the strength of our families, communities, economy, and national defense. Many are thriving, but preventable health burdens, suicide, educational disengagement, weak career transitions, social isolation, family strain, and gaps in preventive care require focused and disciplined action. The Federal Government must respond with sound science, high standards, local partnership, and measurable results.

By the authority vested in me as President by the Constitution and the laws of the United States of America, I hereby direct the Assistant to the President for Domestic Policy to coordinate a 180-day interagency action plan on the health, readiness, and opportunity of American men and boys.

Section 1. Policy

It is the policy of the executive branch to improve health, reduce preventable mortality, expand educational and career pathways, strengthen responsible fatherhood and family safety, support evidence-based mentorship, and enhance military readiness. Testosterone testing and treatment shall remain clinician-led, evidence-based, fertility-conscious, and subject to privacy and non-discrimination safeguards.

Section 2. White House Council

There is established a White House Council on Men and Boys Health, Readiness, and Opportunity, chaired by the Assistant to the President for Domestic Policy. Membership shall include the heads, or their designees, of relevant departments and agencies. The Council shall coordinate existing authorities, recommend targeted legislative action, and publish an annual report.

Section 3. Department of War Action

The Secretary of War shall ensure that testosterone-deficiency screening and treatment protocols use reliable assays, repeat confirmation, symptom assessment, evaluation of underlying causes, fertility counseling, appropriate referral, treatment monitoring, and independent evaluation. Hormone results shall not be used as a stand-alone proxy for readiness or as the sole basis for adverse personnel action.

Section 4. Demonstrations and Evaluation

Within available authority and appropriations, agencies shall develop time-limited demonstrations with common metrics, child and participant safeguards, independent evaluation, and termination criteria. The Office of Management and Budget shall review proposed funding and duplication.

Section 5. General Provisions

This memorandum shall be implemented consistent with applicable law and subject to the availability of appropriations. It does not create any right or benefit enforceable at law or in equity against the United States, its agencies, officers, employees, or any other person.

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APA-style source list

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Document note: The title “Secretary of War” is used as the authorized secondary title established by Executive Order 14347; the statutory office remains Secretary of Defense unless Congress provides otherwise. This proposal is a policy document, not individualized medical advice. All legal, medical, and budgetary details should be confirmed with official sources.