nursing students
for sexual & reproductive health

Men's Sexual Health Toolkit

2017 Edition

Men's sexual health is an important issue in public health and primary care. Men are an underserved population when it comes to sexual and reproductive health care. Responsibility for pregnancy prevention and sexual health has been primarily targeted towards girls and women, neglecting a large section of the population. Men from other marginalized groups, including men of color, trans men, men who have sex with men, men with disabilities, urban and rural poor, as well as undocumented or non-English speaking men, often receive far less sexual health education and fewer services. As frontline health care workers, nurses are in a unique position to help directly remedy some of these health inequities.

A Word About Gendered Language and Health Research

Most research on the sexual health needs of men has focused on cisgender men, meaning people who were assigned male at birth and who identify as men. Some research has focused on trans men's needs and experiences and will be included in this document. The language used in health research generally uses terms such as males, females, girls, boys, men, and women without clarifying whether they intend this language to be inclusionary of trans experiences. Although when discussing the results of health research, we will use the language contained within the study, we do not do so to exclude trans experiences. When discussing issues of reproductive health care, it should be noted that not all women have the ability to become pregnant and not all men have the ability to cause a pregnancy, whether this is because they are trans or due to other factors. However this does not mean that they will not at some point in their lives become parents or that they do not require comprehensive sexual health care. Additionally, people may need access to sexual and reproductive health care specific to their reproductive anatomy who do not identify as men or women, as in folks who are genderqueer or non-binary. For more information, please see our **Trans Healthcare for Providers Toolkit**.

Defining Sexual Health

The World Health Organization defines sexual health as:

"...A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."

Sexual health is one important aspect of a person's life which is also affected by many other aspects of their life. This means it is critical to look at sexual health through an intersectional lens.

Intersectionality identifies that multiple, intersecting forms of oppression affect and impact a person in ways that are qualitatively different than any single form of oppression on its own. This means, for example, that a person who experiences gender-based oppression as well as race-based oppression has a different experience of both forms than a person who experiences one but not both.

Men's Sexual Health Disparities

Men are an underserved population for sexual and reproductive health services. At the time of writing, there is minimal guidance by national professional organizations as to how or which sexual and reproductive health services should be delivered to reproductive-aged men, as opposed to the guidelines that do exist for women's sexual and reproductive health care. There has been increased health care coverage for preventative sexual and reproductive health care, which means that it is likely that more men will be accessing services and care providers need to become equipped to deliver effective services. The National Survey of Family Growth found that 60% of men are in need of pregnancy prevention and planning services, referred to as preconception care. Higher prevalence of need was observed in men ages 15-29, living in urban settings, recent immigrants to the US, with high STI risk, and who were overweight/obese. Although 70% of the men in need reported accessing health services within the last year, few reported receipt of services which included STI/HIV testing or counseling. This is consistent with other studies which have found the health care providers consistently miss opportunities to deliver sexual and reproductive health care to men in need.

Men from other marginalized groups also report receiving fewer services related to their sexual health, specifically adolescent men of color in urban areas, trans men, and men with physical or cognitive disabilities. It should be assumed that men who belong to communities that experience other significant health disparities are also disproportionately impacted by a lack of sexual and reproductive health education and services.

Issues Impacting Men's Access of Sexual and Reproductive Health Care

A number of factors have been identified as internal and external barriers hindering men's access of sexual and reproductive health care.

Internal Barriers

Internal barriers refer to commonly internalized beliefs or fears that may make it more difficult for men to access sexual or reproductive health care and include social stigma, including fear of been seen accessing care, concerns about confidentiality, misinformation about and fear of

STI testing, lack of perceived need, and difficulty bringing up questions or concerns about sexual and reproductive health to their care provider.

Men may fear being seen accessing care and/or having community members find out they accessed care out of concern that it would damage their reputation, as considerable social stigma still exists for men accessing sexual and reproductive health services. Because these services have been predominantly targeted towards women, it may be presumed, for example, that a man would only access care for treatment of an STI. There is also a lot of common misinformation and/or outdated information about STI testing that can provoke fear and anxiety in men that may prevent them from seeking services. Additionally, they may not perceive that they need sexual or reproductive health care and so will self-select out of these services. Some men may also feel too uncomfortable or not know how to bring up questions relating to sexual health with their care provider.

Care providers' ability to mitigate some of these internalized issues may be limited depending upon the setting in which they are working. However, they can ensure that they bring up questions related to sexual and reproductive health with each patient that they work with. They can also assess to see if any of the above is a concern for their patients and ask if there are any ways they can help to lessen some of those anxieties.

External Barriers

External barriers are created by the care provider, the health care system itself, or any other social system which disproportionately impacts men's ability to receive adequate sexual and reproductive health care. External barriers include services predominantly directed towards women, accessibility and cost, lack of choice in care provider and lack of care providers from similar cultural background, and disrespectful treatment by care providers.

Care providers have a responsibility to provide culturally relevant, respectful care to the patients they work with. Care providers should endeavor to access training on working with communities they are not a part of and/or do not have very much experience working with. They should also be well versed in basic patient-centered sexual health counseling skills in order to be able to provide information and referrals as necessary. It is helpful to stay up-to-date on any community specific resources which may exist in their region of practice so that they may be able to provide appropriate referrals.

Specific Sexual Health Disparities and Issues

It should be noted that although we look at each of these populations individually, in reality, there is often overlap and intersection between them which will impact sexual and reproductive health and access to routine services.

Adolescents

Adolescent males are in particular need of sexual health education and services. Rates of STIs are increasing among adolescent men ages 15-24. Unintended pregnancy rates are also high among this age group. As such, it is especially important that care providers ensure that men or boys who are of this age group receive adequate sexual and preconception health services.

Men Ages 65+

Social stigma and ageist assumptions around the sexuality and/or the sexual practices of older people persist in our culture. This stigma can make it more difficult for older patients to ask their health care provider questions about sexual health and/or disclose their sexual health practices.

Some health care providers assume that their patients who are elderly are no longer sexually active or may assume that older patients are already informed about issues pertaining to their sexual health. However, it is vital that you never make assumptions about anyone's sexual practices or level of knowledge. Instead, respectful, intentional, and culturally-informed counseling skills can help you assess what information your patient may need and also create a safe space for your patient to disclose any relevant health information.

Rates of STIs among populations 65+ has been increasing. The CDC reported that between 2010 and 2014, rates of chlamydia infections increased by about 52 percent, syphilis infections rose by about 65 percent, and gonorrhea cases increased by more than 90 percent.

Some causative factors for this increase include longer life expectancy and higher quality of life well into the later years. 53% of people 65 and over report still having sex and 25% of those over 75 also report sexual activity. Many older baby boomers came of age before HIV and during the dawning of the birth control pill, as such they were not a generation raised to use condoms. In fact sexually active older adults have the lowest condom use compared to other age groups, according to the 2010 National Survey of Sexual Health and Behavior. Older adults are also less likely to talk with their health care providers about issues of sex and sexuality. A New England Journal of Medicine survey found that only 38% of men and 22% of women reported having discussed sex with a physician since the age of 50 years.

It is vitally important that health care providers make it easier for older patients to get the sexual health services by not waiting for their patient to bring up questions related to sexual health. Make sure that any older patients you work with are educated about sexually transmitted infections and how to use a condom correctly.

Erectile dysfunction in older men is a significant problem, affecting more than 75% of men over 70 years of age in the United States. Older men have an increased likelihood of

developing ED due to chronic disease, co-morbid conditions, and age-related changes. Research has demonstrated that while the prevalence and severity of ED increases with age, sexual desire often remains unchanged. Some lifestyle factors such as anxiety, alcohol, other medications or drugs, and relationship problems can worsen erectile function. Any conditions or behaviors which restrict blood flow also affect erectile function, such as smoking, high cholesterol, diabetes, high blood pressure, heart disease, and lack of exercise. Erectile dysfunction can also be an early sign of cardiovascular illness, so assessing for ED can be a useful preventative tool, especially in otherwise underserved populations.

Men of Color

Rates of STIs and HIV/AIDs, as well as unintended pregnancy are disproportionately high in communities of color, especially among African-American/Black and Latino/Hispanic populations. Native American/Indigenous communities are also often underserved. Social, economic, and cultural barriers can limit the ability of people of color, especially youth, to access sexual and reproductive health services. The sexual and reproductive health needs of men of color are often under-address and insufficiently understood in clinic settings. It is vital that men of color be able to access culturally relevant health services.

Care providers working with people from outside of their cultural background must prioritize accessing comprehensive intercultural skill building training in order to work effectively across cultures.

Men who Have Sex with Men

Men who have sex with men (MSM) refers to strictly to sexual behavior and does not necessarily reflect how someone self-identifies. An MSM patient may not identify as gay or bisexual and may identify as straight and/or their own particular identity. Regardless of orientation, is important not to assume the sexual practices of any patient.

Men who have sex with men often do not reveal their sexual behavior or orientation to their care provider. Lack of disclosure from the patient, discomfort or inadequate training of the care provider, micro-aggressions or perceived hostility from medical staff, and insufficient screening guidelines limit the provision of adequate sexual and reproductive health care to men who have sex with men.

Men who have sex with men are impacted by systems of oppression in addition to other life stressors, and may also lack adequate emotional and familial support. Recent trends also indicate an increase risk taking sexual practices, especially in younger populations. As a result of these and other issues, MSM are at increased risk of STIs, including HIV, anal cancer, as well as mental health issues, substance abuse, and eating disorders.

Care providers should be careful to ask questions about sexual orientation in a nonjudgmental manner, as well as addressing and maintaining confidentiality. Targeted screening for sexually transmitted diseases, depression, substance abuse, and other disorders should be performed routinely.

Trans men and Non-binary AFAB people

Trans men are people who were assigned female at birth (AFAB) but identify as men. Trans men may transition with use of hormones (testosterone) and/or gender confirmation surgeries. However, not all trans men want to, choose to, or are able to use the above methods and their gender identity should be respected regardless. It is best not to assume someone's gender identity and instead just ask how they self identify and/or what gender pronouns they use. For more information about trans issues and trans health, please see **Trans Healthcare for Providers Toolkit**.

Trans men are significantly less likely to seek the medical care that they need, especially related to sexual and reproductive health. Trans men need access to both STI screening, prevention, and/or treatment, and may need pregnancy prevention methods as well. Trans men are at risk for ovarian, cervical, and uterine cancer if they have not had surgery to remove these organs. This means that some trans men need a pap smear and pelvic exam. Discussing health issues pertaining to these reproductive organs and getting internal exams can be overwhelming, triggering to dysphoria and/or past trauma, or just generally uncomfortable. This can prevent many trans men from seeking the health care they need. As a health care provider, providing education to trans men who still have these organs around the importance of getting regular screening and making a safety plan in advance about how to navigate those exams will help patients get the care they need and deserve. Finding out what language a trans patient uses to refer to their body parts can also make a safer space for accessing sexual and reproductive health care.

Regardless of whether or not they've had top surgery on their chest, trans men also need breast cancer screening, including physical exams and mammograms. This is especially true if there is a family history of breast cancer. Again, a trans patient you're working with may not use the term "breast cancer" or "breast health." Find out how your patient refers to their body parts and use the language they use. Trans men, especially if they've had top surgery, may not be aware that they need to get regular chest health screenings, so providing this information is important.

Trans men who still have a uterus and ovaries can get pregnant, even if they're taking testosterone. Trans men who are having sex with a partner that could get them pregnant need to be informed of those and advised to use barrier methods. Other methods of preventing STIs such as dental dams and latex gloves should be advised as well. Be careful not to make assumptions about the sexual orientation or sexual behaviors of trans men you may work with. Instead, use sexual health counseling skills to assess behavior and risk level, as well as making a plan to prevent STIs and/or pregnancy.

Non-binary AFAB means someone who was Assigned Female At Birth but does not identify along the gender binary, as a man or a woman. Sometimes people use the term genderqueer, gender nonconforming, or Agender. Terminology around gender identity changes a lot and while nurses should make efforts to stay informed, this shouldn't be a barrier to providing good care. Instead, find out how an individual patient identifies and then respect this identity. Some non-binary AFAB folks may also identify as masculine, while others may identify as femme, or a mix of masculine and feminine, or not at all. Some may use hormones and/or surgery while others may not. Regardless, non-binary people still need STI screening and prevention, as well as safer sex education. If a patient has a uterus and ovaries, they also need a pap and pelvic exam. Some people may have the challenges or reservations about these exams as outlined above. If they are having sex with someone who could cause a pregnancy, they also need information about pregnancy prevention and a plan about which method is right for them.

Men with Disabilities

Disability, an umbrella term, can refer to physical, including visible and invisible disabilities, and cognitive or developmental disabilities. Care providers should ensure that patients with disabilities are provided with adequate sexual and reproductive health education.

There is a significant amount of ableist social stigma around disability and sexuality which adds additional barriers for people with disabilities seeking information about sexual health and healthy relationships.

Compounding this issue is that the rate of sexual violence against people with disabilities is very high, with some studies ranging as high as 83% of at least one experience of sexual violence over a lifetime. This, combined with ableist assumptions about disability and sexuality, can create a belief in some health care providers that people with disabilities, especially cognitive or developmental, are not capable of consenting to sex and that their partners are perpetrating abuse, even when it is explicitly stated otherwise by the person seeking sexual health services.

People with disabilities need accurate information about sexual health and healthy relationships that is both useful and relevant to their lives. As a health care provider, it is your responsibility be be able to be provide information and/or resources and referrals for people with disabilities around issues of sexual health. It is also your responsibility to develop awareness about beliefs and assumptions you hold about disability and sexuality, identifying ways that these may impact your ability to effectively support your patients.

Adult Survivors of Childhood Sexual Abuse, Sexual Violence, and Intimate Partner Violence

Men are less likely to disclose histories of sexual abuse or intimate partner violence and are less likely to be routinely screened for it. However, it is important to be aware of this issue and some of the particular barriers that men often face.

Current statistics indicate that 1 in 5 girls and 1 in 6 boys experience some form of sexual abuse before the age of 18. This means that, whether or not they are aware of it, medical providers care for adult survivors of childhood sexual abuse routinely. For this reason, it is important that we not wait for patient disclosure to provide trauma-informed care. Trauma-informed practices should be incorporated as a normal, routine part of care provision, as has happened with universal precautions.

Traumatizing experiences during childhood are associated with specific health risks including PTSD, depression, alcohol and substance abuse, suicidality, and difficulty with intimate partner relationships. These may be the reason a patient seeks care or they may come up in the course of routine care. Additionally, patients who have experienced sexual violence of any kind may have particular triggers that come up during the course of care, given that medical care is often physically and/or emotionally vulnerable. For more information about triggers specific to medical care and information about supporting survivors of sexual and intimate partner violence in a health care setting, please refer to our **Sexual and Intimate Partner Violence Toolkit**.

Men experience higher rates of sexual and intimate partner violence than was previously believed. Screening questions, devised to screen women experiencing abuse or assault, may not reflect men's experiences of intimate partner violence and/or sexual abuse. It is estimated that 1 in 4 men will experience intimate partner abuse in his lifetime.

Current statistics estimate that 1 in 71 adult men experience some form of sexual violence. However, like all statistics pertaining to sexual and intimate partner violence, it is likely that the rates of violence are actually much higher. Additionally, men may be less likely to label or identify experiences of sexual violence, but this does not mean that they have not been harmed by these experiences. Many men must overcome considerable social pressures from masculinity culture to identify experiences of sexual violence and coercion. As with all survivor support, helping individuals identify how experiences made them feel and any impacts that they are still navigating is the first step in identifying experiences of sexual violence.

Men face considerable barriers when seeking services as adult survivors of childhood sexual abuse, sexual violence, and intimate partner violence. Although there is starting to be more movement towards making services more inclusive, many sexual and domestic violence agencies still have names that include women specifically in the title. Men may be afraid of being ill-received by these agencies and/or may assume that services for men do not exist. Many people that work in such agencies are women and some men may be uncomfortable discussing experiences of abuse with someone of another gender. It is important to assess for

any of these concerns and devise an emotional safety plan when referring male patients to support agencies or mental health workers.

Sexual Violence and Incarceration

Rates of sexual violence in prisons are very high, especially for youth incarcerated in adult prisons. Over 80,000 people are sexually assaulted per year while incarcerated, although this is believed to be an underestimation. Juveniles incarcerated in adult prisons are 5 times more likely to be sexually assaulted.

Men are incarcerated at higher rates than women and Black, Latino, and Native American men are incarcerated at staggeringly high rates. Native American men are incarcerated at a rate 38% higher than white men, Latino men 40% higher and Black men 50% higher. Despite making up much less of the general population, men of color constitute a much higher percentage of the prison population. For example, Black folks are about 14.3% of the total population, but 40% of the prison population. As rates of incarceration increase, it is estimated that 1 in 3 black men will be sent to prison.

It is important to consider incarceration through a lens of sexual health and reproductive justice. Incarceration is associated with a sequelae of health risks, including higher rates of HIV and Hepatitis C. These sexual health risks, as well as high rates of sexual violence, indicate that people who have been incarcerated may have an acute need for trauma-informed sexual and reproductive health care. Additionally, in smaller populations, like those disproportionately incarcerated, these health impacts can have far reaching effects in communities as a whole.

Another factor complicating the issue of sexual violence in prisons is that common US cultural attitudes often regard prison rape as a seemingly natural consequence of incarceration. Jokes like, “don’t drop the soap” remain commonplace, minimizing and trivializing the traumatic impact of sexual violence. Additionally, many Americans assume that sexual violence is chiefly perpetrated by other inmates, while current research indicates that inmates are more likely to be assaulted by staff of the prison itself.

Examining the causative factors of these high rates of incarceration and further consequences of mass incarceration is beyond the scope of this toolkit, but readers are encouraged to research this issue further. Incarceration is often ignored when discussing the impact of sexual violence in the US, but it is critical to develop an awareness of this issue as it constitutes a significant human rights and public health crisis.

It is important not to assume that any member of a population targeted by mass incarceration, such as men of color, has been previously incarcerated nor that any person who has been to prison was sexually assaulted while there. However this information should be used to widen your understanding of the impacts and prevalence of sexual violence and illustrate the vital necessity of trauma-informed care practices.

Understanding Men's Sexual Health Needs

Sexual History and Assessment

Preventative sexual and reproductive health history assessment includes:

- Making a reproductive life plan to determine family planning or preconception health needs or difficulty achieving pregnancy.
- A standard medical history including pregnancy and fatherhood status
- Additional visit-specific history components related to preconception health and basic infertility
- Comprehensive sexual health assessment (e.g., asking about sexual practices, partners, pregnancy prevention, protection from STDs, past STD history)
- Problems with sexual function
- Intimate partner and sexual violence

Taking a sexual and reproductive health history also includes services that may overlap and involve screening for:

- Alcohol and other drug use (alcohol and other drug use before and during sex may lead to lack of condom use, increasing risk for acquiring STIs/HIV and/or unintended pregnancy, as well as could cause problems with sexual function)
- Tobacco use (nicotine can impair male reproductive function)
- Depression (specific populations of men may be at increased risk for depression including those affected by other forms of oppression, those struggling with issues of sexual identity, experiencing stress during the coming-out process, experiencing a relationship break-up, or struggling with self-esteem, and certain classes of anti-depressants may lead to problems with sexual function)
- History assessment also includes vaccination history as pertaining to the past receipt of sexual and reproductive health-related immunizations (human papillomavirus (HPV) vaccine) (MTC, 2014)

Although reviewed in brief in this document, the Male Training Center for Family Planning and Reproductive Health's Preventive Male Sexual and Reproductive Health Care: Recommendations for Clinical Practice details guidelines for clinical practice in more depth and should be reviewed in tandem with this document.

Review Approach to Men's Sexual Health Exams for more comprehensive information about sexual health screening.

STI/HIV Prevention, Testing, and Treatment

Providing counseling, testing, and treatment for sexually transmitted infections is an important part of sexual health. As previously stated, health care providers often miss the opportunity to discuss men's concerns and needs around issues pertaining to sexual health during routine medical care. Care providers should not wait for patients to bring up questions about STI prevention and testing, but instead should take a proactive approach to discussing this with their patients, regardless of gender or orientation. For more general information about sexual health counseling, please review our Sexual Health 101 Toolkit.

Health care providers should also be able to educate patients about safer sex practices and risk reduction methods.

Resources detailing information about and prevention of sexually transmitted infections (STIs) are readily available from other sources. For the most current and accurate information, please see the Center for Disease Control. For a more thorough look at issues impacting and affecting nursing care and HIV/AIDS, please review our HIV/AIDS Toolkit and associated resources.

Condom Demonstration/Practice

From the Male Training Center:

"Offer male patients to view and practice condom demonstration:

For example, condom demonstration and practice should include steps for putting on (and removing) a condom including 1) pinching the tip of the condom, 2) rolling the condom down to base while leaving the tip pinched, 3) after ejaculation occurs, holding the condom at its base before withdrawing, 4) holding the condom at its tip and base and removing it from the penis, and 5) throwing it away. [86]

- Other teachable points include 1) checking the expiration date, 2) checking the package for air bubbles, 3) not opening the package with teeth or a sharp object, 4) using only water-based lubricants with latex condoms, and 5) not using spermicides (e.g., nonoxynol-9) since they can break down latex and increase susceptibility to STDs including HIV.
- Other points for discussion for optimal use include partners 1) discussing contraception methods in advance including who will purchase condoms; 2) latex allergies; 3) the type of condom used (ie, latex, polyurethane, lambskin) and condom characteristics (e.g., size, ribbed, lubricated, contain spermicides, etc.) and 4) try different condoms to find the one that fits and feels the best; condoms are available in different sizes and varying thickness."

Pregnancy Prevention

Care providers should not wait for patients to bring up questions about pregnancy prevention, but should ensure that men in relationships in which pregnancy is possible have all of the information they need about pregnancy prevention including non-hormonal, such as condoms, vasectomy, and withdrawal, and hormonal methods, such as long-acting reversible methods, combination methods, and emergency contraception.

Consent and Healthy Relationships

Men's experiences of sexual violence and/or intimate partner abuse often goes unreported. Men across a spectrum of identities often face greater barriers to disclosing abuse experiences, but it can be particularly difficult for men who hold other marginalized identities, such as trans men, men with disabilities, and men of color. Many people, including care providers and patients, assume that men cannot be abused and may miss signs of unhealthy or abusive relationships. Care providers should be careful to screen all of their patients for abuse and not make assumptions about abuse histories based on gender.

Sexual and Reproductive Dysfunction

It's important to assess for common sexual function issues and provide appropriate information and referrals. Some issues may occur more commonly in older men, although some may occur in younger men as well. Some common issues include erectile dysfunction, premature ejaculation, pain with ejaculation, pelvic pain, testicular pain, urinary tract issues, hematospermia, and concerns about fertility.

Review **Approach to Men's Sexual Health Exams** for further information on screening for sexual and reproductive functioning issues.

Erectile Dysfunction

According to the Minority Health Institute, all men 25 years and older should be asked about erectile dysfunction, regardless of sexual dysfunction complaints because it can indicate occult systemic vascular disease and should prompt an aggressive assessment for cardiovascular risk. Erectile Dysfunction is defined as, "the inability to achieve or maintain an erection sufficient for satisfactory sexual performance," according to the American Urological Association.

Infertility

Care providers should be able to assess for concerns about fertility and/or difficulty conceiving and make appropriate referrals for screening and treatment.

Preconception Counseling

Preconception counseling focuses on prevention strategies implemented before conniption of a first or subsequent pregnancy to improve pregnancy and infant outcomes. It involves developing "high reproductive awareness" i.e. a reproductive life plan to figure out what steps are needed to prevent unintended pregnancy and/or optimize health prior to a desired pregnancy. Typically preconception care has been targeted towards women of reproductive age and little is currently known about the extent to which men in the US are in need of preconception care.

A recent data analysis of men aged 15-44 in the National Survey of Family Growth 2006-2010 estimated that about 60% of men in the US are in need of preconception care, with some groups have more elevated need. These groups include men age 15-29, men living in urban settings, men who are in school versus not in school (regardless of working status), not in a co-residential union (versus married or cohabiting, recent immigrants to the US, men who had never had a child, overweight or obese men, men who reported binge drinking, and those who have high risk of STIs.

This study also found that men reported general interest in improving pregnancy outcomes, including improving paternal health before pregnancy, but demonstrated little knowledge about risks factors that could impact paternal or fetal health.

Preconception care requires increasing men's access to related education, awareness, outreach, and clinical services. It includes risk assessment, social history, risk behaviors, nutrition, mental health, physical health and laboratory medicine, health promotion, and clinical and psychosocial interventions.

Conversations related to pregnancy prevention should also access for need for preconception care if a man is hoping or planning to become a father. Concerns about fertility should also be addressed in these conversations.

Resources

- http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf
- https://www.ncbi.nlm.nih.gov/pubmed/25739683
- https://www.ncbi.nlm.nih.gov/pubmed/16772237
- http://www.advocatesforyouth.org/publications/publications-a-z/2302-the-reproductive-and-sexual-health-of-young-men-of-color
- http://www.thetaskforce.org/static_html/downloads/resources_and_tools/ntds_report_on_health.pdf
- http://www.berkeleywellness.com/self-care/sexual-health/article/seniors-sex-and-stds
- http://www.siecus.org/index.cfm?fuseaction=Feature.showFeature&featureID=1947
- http://safersex4seniors.org/faq/
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2426743/
- http://safersex4seniors.org/assets/SS4S_How_to_Talk_with_Your_Doctor_about_Sex.pdf
- http://www.aafp.org/afp/2004/0501/p2149.html
- https://www.cdc.gov/ViolencePrevention/pdf/NISVS_Report2010-a.pdf
- https://www.prisonpolicy.org/reports/rates.html
- http://www.sentencingproject.org/doc/publications/inc_hispanicprisoners.pdf
- https://www.thenation.com/article/why-americans-dont-care-about-prison-rape/

Suggested Reading

Alexander, Michelle. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness.* , 2010. Print.