Fourth Edition

Positive Images

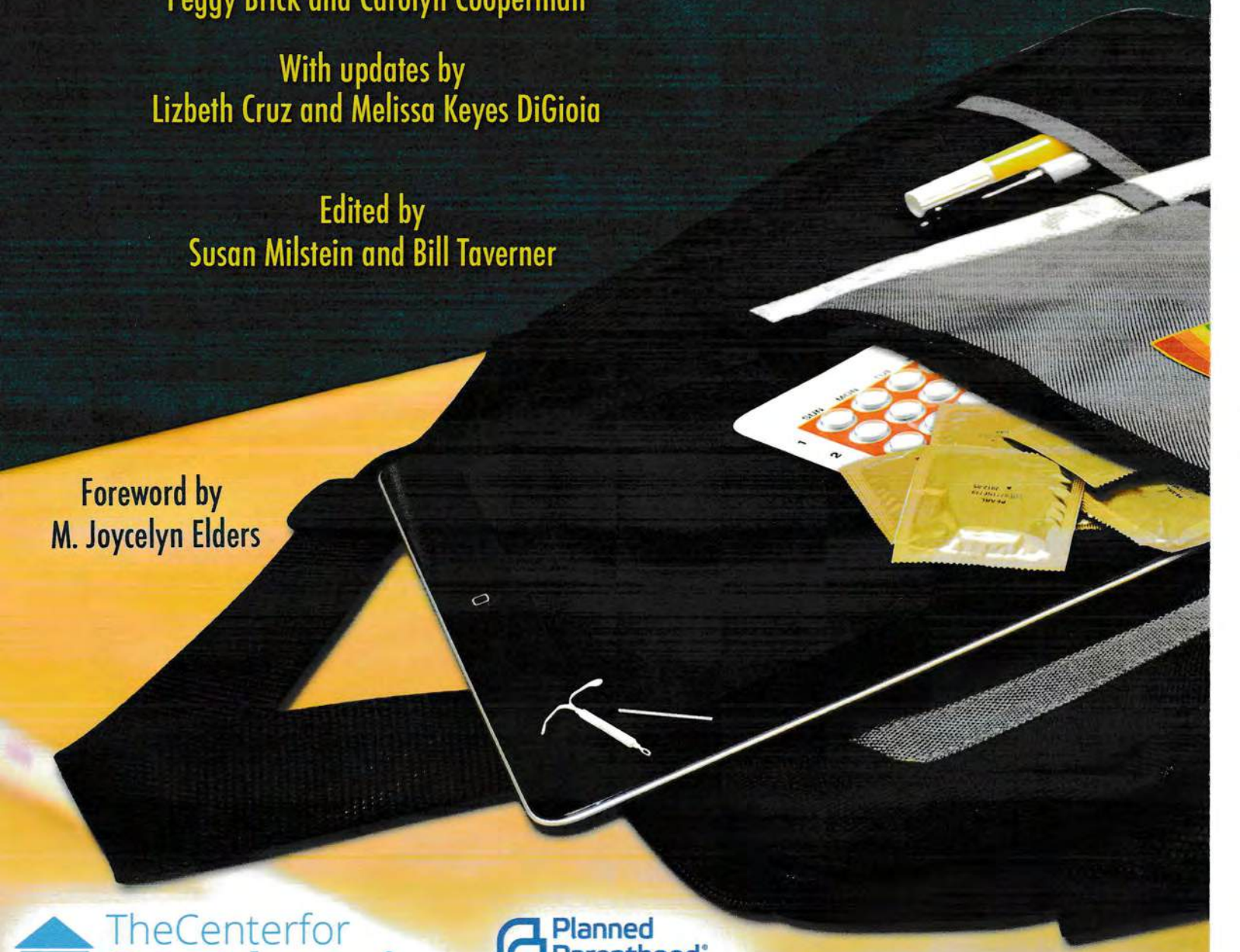
Teaching about Contraception and Sexual Health

By
Peggy Brick and Carolyn Cooperman

With updates by
Lizbeth Cruz and Melissa Keyes DiGioia

Edited by
Susan Milstein and Bill Taverner

Foreword by
M. Joycelyn Elders



TheCenterfor SexEducation

Planned Parenthood®
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Planned Parenthood of Northern, Central, and Southern New Jersey

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FOREWORD

By M. Joycelyn Elders, MD

What an excellent book to help people learn about adolescent sexual health! The updated fourth edition steers educators in a refined path that is improved and even more relevant and easy to use than the previous editions.

Sometimes we are so sensitive that our children might hear something that will harm them that we maintain a silence about their own sexual development. We all have sexual development; we just want our children to develop a healthy and wholesome attitude about their sexuality rather than a dysfunctional view. This book can help us as educators and parents to inform and guide them in healthy directions.

When children grow up believing that sex is dirty, sexual dysfunction is more likely to follow than when children grow up believing that sex is for pleasure and procreation when they are old enough to be respectful of themselves and their partner, responsible for the consequences, and to practice safe sex.

When generation after generation is uninformed of the facts of human sexuality, an ignorant society is created which wreaks havoc and heartbreak in people's lives.

Ignorance is not bliss. It is not bliss for a society that says, "Sex is dirty; save it for marriage." Are we saying that sex in marriage is dirty?

Ignorance is not bliss for more than 70 percent of our teens who are sexually active before reaching the age of 20. Ignorance solves no problems, is not enlightened, nor safe, nor just, nor kind. However, ignorance can be overcome by knowledge.

It is difficult for an entire society to learn that speaking forthrightly is not vulgar in itself; rather, it is merely expressing factual information in an unashamedly straightforward manner. We need to be delivered from our old inadequate ways of conversing and learn to speak with one another in new non-judgmental ways about sexual health and well-being.

Although many American people and even our US government sometimes tend to ignore it, adolescents have a fundamental human right to accurate and comprehensive sexual health information.

The lesson plans in *Positive Images* have content that reflects the latest in sexual health and explicit instructions for presentations to which adolescents can relate. So, both the content and style of presentations are solid, complete and effective.

Parents, teachers, clergy, sex educators and everyone who is around adolescents as well as adolescents themselves can benefit from having the actual facts. Sometimes we tend to rely on "beliefs" without the knowledge that facts provide. Beliefs are fine, but they do not replace factual information in the education of all our society.

Adolescents confront many issues as they mature into adulthood, not the least of which is their sexuality. No matter what adults say, the hormonal imperative says, "YES!" The sexual drive is not coolly reasoned away nor decreased by demanding it to be gone. Rather it is a normal part of the natural human body and human development.

While many American adults cringe at simply seeing the words "adolescent" and "sexuality" paired together, adolescent hormones proceed with their relentless takeover of youthful thought—and, often, action. Children and adolescents need to know what is happening in their bodies. When children experience puberty, natural intensification of sexual feelings soon follows. The median age of onset of puberty is 11.6 years, the mean age of initiation of sexual intercourse is 17 years, and the mean age of first marriage is 26 years.

It is vital that young people know that they are sexual beings from birth to death. They may be amazed to learn that their sexuality will last their entire lifetime. So, it occurs in stages of development which they can learn about and look forward to. If sexuality is taught as a normal developmental and aging process, then we can all relax a bit and just teach sexuality as we teach everything else that young people need to know as they prepare to become successful, well-adjusted and happy adults.

I like to remind adolescents and adult educators of the 3 P's of Sex — Procreation, Prevention and Protection — while remembering that sexuality is about much more than an act of sex.

The facts of sexual health for adolescents are important. However, to get these life-saving facts across to adolescents in ways to which they can relate is a trickier proposition, and I think this book pulls that off.

INTRODUCTION

In 1986 Carolyn Cooperman and Peggy Brick wrote *Positive Images*, a manual promoting "a new approach to contraceptive education." The lessons were designed to empower people to take control of their reproductive lives by providing learning experiences that encourage conscious decision-making and integrate contraceptive use into the ideology of love, relationships and sexuality. The authors' deep understanding of young people and their insight regarding how adults can support young people in their growth toward sexual health are an important part of this new edition.

Positive Images has been successful. Thousands of copies are in use throughout the United States, in Australia, Canada, England, Ghana, New Zealand, and Zimbabwe; thousands of educators have revised the way they teach about contraception; numerous agencies, schools and colleges have utilized our skill-based strategies in developing their own curricula, and Carolyn's innovative "Condom Lineup" has become a classic in HIV/AIDS prevention education. However, this positive approach to teaching about contraception remains atypical in a society that is reluctant to provide healthful alternatives to abstinence for young people.

This edition of *Positive Images* continues the tradition of creating positive images of contraception and of people who use it to have control of their lives and their futures. It includes abstinence from intercourse as a viable choice — for anyone at any time — and integrates that choice in developing the attitudes, values and skills that are crucial for making responsible decisions regarding sexuality throughout life.

This edition continues to address the social attitudes about sexuality that result in teenage pregnancy and abortion rates in the United States that are double those in other developed nations. It is based on the conviction that positive attitudes about one's own sexuality are fundamental to sexual health and essential to making self-enhancing decisions about one's own behaviors. It also addresses issues that are of increasing importance for the sexual health of young people in today's world: the fact that many teen pregnancies are fathered by adult men; the prevention of sexually transmitted infections, including HIV, which must be integrated into decisions about contraception; and the alarming growth of the world's population, which may impact on personal family planning decisions.

This manual is based on the conviction that young people have a right and a need to understand their sexuality. It provides opportunities for them to examine personal decisions within historical, social, and ethical contexts and promotes their development into sexually healthy adults.

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THE LESSONS

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PRINCIPLES FOR SEX EDUCATION

The new edition of *Positive Images* remains faithful to The Center for Sex Education's long-held principles for sex education. It is important for teachers using this edition to recognize these principles and act upon them, since they illustrate basic philosophical and pedagogical differences between comprehensive sex education and abstinence-only education. Educators who are mindful of these principles and examples will likely find additional ways to implement them as they teach the lessons.

1 **ALL PARTICIPANTS NEED AND DESERVE RESPECT.** This respect includes an appreciation for the difficulty and confusion of addressing sexual issues and a recognition of the constellation of factors that contribute to those issues. It means treating all persons, both young people and adults, as intelligent individuals who are capable of making decisions in their lives.

2 **PARTICIPANTS NEED TO BE ACCEPTED WHERE THEY ARE.** This means listening and hearing what people have to say, though we as educators might sometimes disagree. In general, we are much better off helping individuals explore the possible pitfalls of their attitudes rather than telling them what they ought to believe.

3 **PARTICIPANTS LEARN AS MUCH OR MORE FROM EACH OTHER AS FROM THE EDUCATOR.** Often, if we let people talk, allow them to respond to each other's questions and comments, and ask for others' advice, they feel empowered and take responsibility for their own learning. It is much more powerful for a participant to challenge a peer's belief or attitude than for the educator to do so.

4 **HONEST, ACCURATE INFORMATION AND COMMUNICATION ABOUT SEX IS ESSENTIAL.** For most of their lives participants may have received messages suggesting that sex is hidden, mysterious and something not to be talked about in a serious and honest way. Limiting what individuals can talk about and using vague terminology perpetuates the unhealthful "secrecy" of sex. Sexual information needs to be presented in an honest, accurate way.

5 **A POSITIVE APPROACH TO SEX EDUCATION IS THE BEST APPROACH.** This means moving beyond talking about the dangers of sex and acknowledging in a balanced way the pleasures of sex. It means associating things open, playful, and humorous with sexuality, not just things that are grave and serious. It means offering a model of what it is to be sexually healthy rather than focusing on what is sexually unhealthy.

6 **PEOPLE HAVE A FUNDAMENTAL RIGHT TO SEX EDUCATION.** They have a right to know about their own bodies and how they function. They have a right to know about any sexual changes that are occurring now and any others that may occur during their lifetimes. They have the right to have their many questions answered. People who have explored their own values and attitudes and have accurate information are in the best position to make healthful decisions about their sexual lives.

7 **GENDER EQUALITY AND GREATER FLEXIBILITY IN SEX-ROLE BEHAVIOR HELP ALL PEOPLE REACH THEIR FULL POTENTIAL.** This manual strongly advocates for the right of all people — regardless of their gender — to achieve their full human potential. Strict adherence to traditional gender-role behavior limits people's choices and restricts their potential.

8 **ALL SEXUAL ORIENTATIONS AND GENDER IDENTITIES MUST BE ACKNOWLEDGED.** The inclusive nature of these lessons recognizes that there are diverse sexual orientations and gender identities, and some participants may identify as lesbian, gay, bisexual, transgender, intersex or questioning. It is important to create an environment that recognizes the needs of these often isolated and invisible individuals. Teaching frankly about diverse identities can benefit everyone, as participants may have concerns or fears about their feelings and perceptions of their gender and/or sexual orientation.

9 **SEX INVOLVES MORE THAN SEXUAL INTERCOURSE.** Acknowledging this concept reminds participants that not only are there many ways to be sexual with a partner besides vaginal, oral and anal intercourse, but also that most of these other behaviors are safer and healthier than sexual intercourse.

OBJECTIVES FOR TEACHING ABOUT CONTRACEPTION AND SEXUAL HEALTH

After participating in these lessons, participants will be able to:

- Explain that the option not to engage in sexual behavior is a basic human right which an individual should be able to assert at any time in a relationship.
- Express comfort, knowledge, attitudes and skills needed to use contraception and safer sex if they decide to have intercourse.
- Develop positive attitudes about people who choose to have sexual intercourse but want to avoid pregnancy or abortion.
- Explain how contraception can be a way people gain control over their bodies, lives and futures.
- Assess whether they are at risk for an unplanned pregnancy or sexually transmitted infection (STI) and, if so, what they can do to reduce the risk.
- Build decision-making and communication skills needed to protect themselves and their partners.
- Develop the capacity to work cooperatively with a partner to assume responsibility for contraception and safer sex.
- Explain why condoms need to be used whenever one wants protection from sexually transmitted infections and pregnancy.
- Understand that taking care of one's reproductive health is an integral part of being a sexually healthy person.

CREATING A SUPPORTIVE ENVIRONMENT FOR LEARNING ABOUT SEXUAL HEALTH

A supportive group atmosphere and a supportive non-judgmental educator are essential for sexual health education. Participants may be nervous, cautious, even suspicious as they address this sensitive issue, which requires a serious examination of their own behaviors. Since much of the learning occurs during interactions among group members, educators need to be effective group facilitators, creating a safe, non-threatening environment in which people can talk openly and honestly about sexuality. The goal is to provide experiences that strengthen people's motivation and ability to take responsibility for their own sexual safety. A few basic interaction guidelines for educators include:

1. Establish "ground rules."

It is important that the educator help the group establish, and adhere to, clear guidelines for how the group will work together, so that everyone will feel safe and comfortable. If time allows, the educator can encourage participants to brainstorm their own ideas, with questions such as "What rules would you like to establish ...?" and "What should we expect from everyone ...?" The educator follows up with clarifying questions to help participants elaborate the ideas and take ownership of their ground rules. In a short session, the educator can post several of the most relevant time-honored ground rules (below), and ask for the group's agreement in carrying them out.

Key ground rules:

- Listen carefully.
- Respect people's right to express their own opinions, even if you disagree.
- Speak for yourself, not for others. Use "I" statements. For example "I believe that ... "
- Respect each other's confidentiality and privacy. Keep personal information in the group. (Rarely, an educator may need to break this rule if required by law or special circumstances.)
- Questions are welcome. There is no such thing as a "stupid" question.
- Every person has the right to pass on any activity or discussion.
- One person talks at a time. Avoid side conversations.
- Keep electronic devices turned off (and away).
- Think before you speak.
- No put downs. (No hurtful comments, looks, groans or gestures that would make anyone feel embarrassed, stupid or incompetent.)
- Share the time. Let everyone have an opportunity to speak, if they wish.
- Have fun!

Ground rules are sometimes called "group agreements" when working with adults. Here are some additional ideas for older groups:

- Assume good will.
- Listen to hear *and* understand ... not just respond.
- Limit side conversations.
- Speak from one's own experience.
- Use time thoughtfully and engage in your own way.
- Set your own boundaries for personal sharing.
- Use the language you currently have.
- Recognize participants are all in different places (personally and professionally).

Notes:

Ideas adapted with permission from many experienced educators and trainers, including Nora Gelperin, Maureen Kelly and Melissa Keyes DiGioia, and from Hedgepeth and Helmich.[1]

Images can enhance the fun, importance and retention of group guidelines and can be incorporated into a guessing game in a later session. Online sources of images include www.clipart.com and Google Images (www.images.google.com).

2. Use a Question Box.

Anonymous questions protect privacy and avoid embarrassment. A Question Box in a known but private place allows participants to submit concerns privately. Educators can also distribute small index cards and pencils, assuring anonymity, and ask everyone to write, even if it's only, "I do not have a question at this time." Educators may then approach each person to put questions in without anyone seeing what's on the cards. There is seldom a lack of questions in the box when a group is encouraged to learn about sexuality in this way. It's a good idea to wait a day before answering questions.

3. Encourage comfort and communication.

To the extent that it is in your control, try to ensure that the room is private and comfortable. Discourage interruptions that may distract and/or violate privacy. If possible, arrange chairs or desks in a circle or semi-circle so that participants can look at each other while talking. Balance the tone of the discussion so it is open, but not inappropriately personal for either the educator or the participants. Interactions that are humorous but not silly, fun but serious, can increase comfortable communication.

[1] Hedgepeth, E., & Helmich, J. (1996). *Teaching about sexuality and HIV: Principles and methods for effective education*. New York: New York University Press.

4. Pay attention to language.

Participants need to hear language they can understand. Sometimes using slang can be a very effective way to clarify information, as in "after the male **ejaculates,** or '**cums**.'"

Inclusive, gender neutral terms that do not imply everyone is heterosexual is critical. Examples such as, "A guy and his **partner** went to a party," rather than "a man and his **girlfriend** ...," or "What if a woman were going out with **someone** who wouldn't use protection?" rather than "with a **man** who wouldn't use protection?" or "What if a **man** refused to get tested at the same time as his partner?" are important for everyone to hear. Heterosexual individuals may not notice the difference but lesbian, gay, bisexual and transgender people will, and may feel safer than they might have otherwise.

It can be helpful to use sexual vernacular that is common among your participants. Phrases such as *hooking up* and *having sex* may assist you in meeting participants where they are. However, be aware that such language is often vague, and will need follow up clarification, e.g., "What do you think is meant by *hooking up*?"

5. Help participants think for themselves.

Education is supposed to help people **think,** not tell them what to do. The strategies in these lessons are designed to help people examine their own knowledge, attitudes, values and behaviors. Ideally, every response will demonstrate the educator's respect for the participant's potential to make healthful sexual decisions and build the self-efficacy needed to protect their sexual health. For educators to moralize or attempt to impose their own values is counterproductive. Here are some open-ended questions educators might ask:

- What do you think?
- What are some alternatives?
- What might/will happen if ...?
- What are the advantages? The disadvantages?
- What would you do?

6. Seek additional training in group facilitation.

It is important that educators who plan to teach about sexual health prepare themselves, especially if the above are new techniques for them. Professional development workshops can help them acquire the knowledge, attitudes and group facilitation skills needed to teach effectively. The American Association of Sexuality Educators, Counselors and Therapists lists upcoming trainings on their website, www.aasect.org. And each year, the CSE hosts a National Sex Ed Conference (see www.SexEdConference.com). Further, since sexual health information and recommendations may change, it is important for educators to keep themselves updated with respect to current data and resources.

HOW TO USE POSITIVE IMAGES

Scope of the Manual

The lessons in this manual are ***non-sequential*** so educators can select those most relevant to their participants. It is important to know that *Positive Images* is ***not a curriculum*** and is not intended to be taught from start to finish. This resource focuses on the comfort, knowledge, attitudes and skills required for a person to make responsible decisions about their sexual health. These materials can be used to ***supplement*** existing curricula in traditional academic or interdisciplinary settings, and the objectives and educational activities can be integrated into a variety of community settings.

How the Manual is Organized

Each lesson is designed to take approximately 45 minutes to one hour, but the actual time needed will depend on the group, on participants' prior knowledge and experience, and on the importance the educator wants to give the topic. A few of these lessons can be completed in less time, but with more thorough discussion, many may take longer. Each lesson includes:

Objectives: The major learning participants will acquire from the lesson, in measurable terms.
Rationale: A brief explanation of the importance of that particular lesson.
Materials: Items needed for the lesson, plus related handouts and educator resources.
Procedure: A step-by-step guide to teaching the lesson.

A Resources Section at the end of the manual includes: a chart of common STIs and their symptoms; a summary of STIs including advice on prevention and treatment; instructions on using condoms; a contraceptive options chart; and a resource list for finding more help. These resources can be distributed with many different lessons, and can also be used as standalone materials.

A note about the "Finding Help" resource: The media are full of tragic stories of individuals who have been overwhelmed with the problems they face. One of the most useful things any educator can do is to provide people with information about the many resources available to them. Encouraging individuals to get support when they need it, can make a tremendous difference in a person's life!

Selection of Lessons and Activities

Few educators will use ***all*** of these lessons. However, in order to understand the scope of sex education, it is recommended that all educators read through the entire material, particularly the rationales, to determine which lessons and activities will be most useful for the intended population.

As with all sex education materials, each activity needs to be carefully evaluated by the educator for its appropriateness in a particular community, with a particular group of participants at a particular

time. Since these lessons are designed for use with a variety of ages, genders, backgrounds, etc., all activities will not be appropriate for all groups.

Permission

We are often asked about permission for reprinting the lessons that appear in our publications, and we are pleased to have granted permission to a number of leading health organizations throughout the world. Written permission from The Center for Sex Education is required for copying any material in *Positive Images*, with the exception of handouts, which may be freely copied in print format and distributed to participants in educational settings.

Written permission from The Center for Sex Education is required for reprinting other material (e.g., complete lesson plans, educator resources, etc.), or to post any material, including handouts, electronically. Please contact Info@SexEdStore.com for further information.

HOW TO USE ROLE-PLAY

Rationale

Participants may know the "facts" about sexual health, safer sex and sexually transmitted infections (STIs), but unless they develop decision-making and communication skills for protecting themselves, they remain at high risk. Research suggests role-play is one of the most effective ways to develop the communication, negotiation and assertiveness skills essential for safer sex behaviors. Skill practice using role-play is an important part of any sexuality education effort, including the lessons in this manual, as it allows participants to apply what they have learned to real-life situations. If you ever have extra time in a given lesson, role-play is probably the best way to use it.

Benefits of Role-Play

Role-play helps participants:

1. Act out a wide variety of feelings and ideas without fear of judgment from others. Since they are "only acting," they can express and experience feelings and ideas that they often hide.

2. Try communicating ideas they may be reluctant to express in real life due to lack of confidence or knowledge, or to peer pressure.

3. Practice making decisions and identifying forces that influence decision-making.

4. Evaluate how they solve problems and deal with the consequences of their behaviors.

5. Increase their problem solving capabilities by generating alternatives.

6. Develop understanding and empathy for people who may have different experiences and opinions by acting as another person might in a particular situation.

7. Rehearse communication and assertiveness skills.

Before the Role-Play

1. Prepare yourself to facilitate the role-play. Think about your goals and decide how to organize the role-play to achieve those goals.

2. Be aware that role-play may trigger strong reactions in an individual who may suddenly realize that the situation or problem in some way applies to her/him. Consider how you will handle this without drawing undue attention to the participant; know what backup support you can call on for the person.

3. Prepare materials you need for the strategy you plan to use. "Character cards" describing each character are useful for getting started and large "character name tags" help participants stay in their roles and help the audience remember the "actors" are pretending to be someone else, not playing themselves.

4. Decide ***who*** needs to know ***what*** information about the role-play. What does the audience need to know about the situation? The characters? What do the characters need to know about each other? Are there any "secrets" that need to be maintained for the role-play to be effective?

5. If you have access to recording equipment, consider recording the role-play. Evaluate the pros and cons. Participants often like to see and hear themselves "on stage." They can examine their role-playing and get feedback from their peers. Consider how your group will benefit. Will role-play build or decrease participants' confidence? Can you arrange for smooth, trouble-free use of the equipment? If you do record the role-play, be sure that ***you,*** not participants, are fully in charge of the recording so it doesn't wind up on YouTube!

Simple Role-Play Strategies

Role-plays can be structured in a variety of ways, depending on the educator's skill and the group's level of functioning and willingness to participate. ***However,*** participants may have difficulty improvising at first. Using these ***simple*** strategies first can provide an opportunity for a person to develop communication skills in ways that are nonthreatening for both educators and participants. Establish ground rules that assure all group members will feel safe. Affirm and support participants as they develop these skills.

1. Ask two or three volunteers to act out a few written, realistic dialogues.

2. Ask ***pairs of volunteers*** to read or act out written realistic dialogues.

3. Give the participants several written "pressure lines" (e.g., "You would if you loved me ...") and ask them in pairs to write one-line responses. Ask participants to read ("role-play") responses back to you.

4. Have participants do the same as #3 above, but with pairs writing and role-playing their own responses.

5. Create a dialogue with the group. Give them the first line and ask them to suggest how each person could respond in turn. Write the dialogue on a board/flip chart paper. Then ask a volunteer to act it out with you.

6. Create another dialogue with the group. Ask two volunteers to read it aloud.

7. Divide participants into pairs. Distribute a magazine picture of a couple to each pair. Ask pairs to write the opening lines in an imaginary dialogue the couple could have as they begin a discussion about safer sex. Encourage pairs to develop an exchange of at least four statements and responses. Ask each pair to stand, one at a time, hold up their picture, and speak their dialogue to each other.

8. Divide participants into small groups and give each group a card describing a problem situation. Each group discusses its problem and possible strategies to deal with it. Next tell the group to select one of the strategies and write out a short role-play which they will then present to the entire group.

Steps to Effective Role-Plays

1. **Set ground rules.** Explain that role-play is a great way to think about situations people may experience sometime in real life and to practice handling tough problems. Tell participants the success of any role-play depends upon how well they follow the five simple ground rules below:

    a. People playing roles need to **act** and **think** like the character would in the given situation. Observers need to be quiet and attentive, unless they are assigned another task.

    b. Role-players should say what comes to mind, not think too much before speaking.

    c. No one should "put down" the role-players, or anyone else in the room. (Emphasize this rule.)

    d. Respect privacy and confidentiality. (Whatever a person has said, either inside or outside the group, is not identified by that person's name; no asking of personal questions is appropriate; speak for one's self only.)

    e. Have fun, but stay focused on the task.

2. **Organize the room comfortably.** Depending on the type of role-play you have chosen, consider setting up chairs at the front of the room, since participants usually feel more comfortable sitting than standing, at least at first. Make sure those observing can see and hear well.

3. **Identify the players.** You may ask for "impromptu" volunteers or ask someone to take on a role beforehand. No one should be forced to role-play, but often a little encouragement in advance works wonders. Pass out character cards or character name tags if needed.

4. **Set the scene.** Describe the situation. Make the issues between the characters clear. Then, draw a verbal picture of the location: "It's raining outside. You are sitting in the living room in front of the TV. Your mom is upstairs and ... "

5. **Help characters get into their roles.** Ask one or two questions that will help each player begin to talk as the character might, and think about how that person is feeling. For example, "Derek, tell me about yourself." "How do you get along with your parents?" "What's the problem you're having with your sister?" Spend at most a minute with each character.

6. **Get the role-players started.** Explain exactly where the situation is at this moment. "So, you've been discussing this issue and you're both getting really angry. It's all yours now, you two!"

7. **Pay attention to the audience as well as the role-players.** If someone seems to be getting upset (flushed, agitated, tearful, head down on desk), handle it in a way that protects and respects his/her privacy and works in your setting.

8. **If necessary, refocus the role-play.** If the role-players are struggling so much that nothing is being accomplished, stop the role-play for a moment. Acknowledge that sometimes role-play (or that particular situation) may be difficult to enact. Make a suggestion to the players or ask observers for a suggestion. Or, ask if a player would like to have someone else try one of the roles, and handle accordingly.

9. **Stop the role-play.** When the problem is resolved or when it seems a good time to discuss the scene, stop the role-play. Remember that debriefing and a follow-up discussion are **vital** parts of role-play, so be sure to allow sufficient time for them.

10. **Have the audience ask questions of the players with the players *remaining in character.*** Questions and comments from the audience will help everyone examine the behaviors and alternatives that might have been possible in the situation. Comments and questions should focus on what the player did as the character, ***not*** on how well s/he acted.

11. **Debrief the players.** Ask the players how they felt as their character in the role-play. What did they like or dislike about how they handled the problem? If the necessary trust level has developed in the group, ask how similar this situation is to those they have seen in real life. (Stress that no names should be mentioned.)

12. **Discuss the role-play.** The purpose of this discussion is to examine how the characters felt and behaved. It is ***not*** to evaluate the acting ability of the players. Discussion questions might include:

    a. What feelings do you have about any of the characters?

    b. What could any of the characters have done to improve the outcome of the situation?

    c. How do you think _____ felt when _____ (such a thing happened)?

    d. What do you admire about any of the characters?

    e. How difficult would this situation be to resolve in real life? Explain.

f. What did you learn from observing this role-play?

Ideas for More Complex Role-Plays

1. **Use *doubles***. Have a second participant stand behind each player and occasionally suggest an idea to the player. The player may choose to use or not use the suggestion.

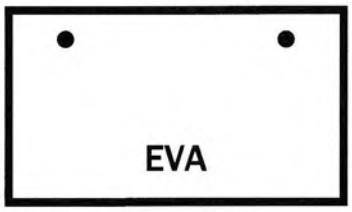
2. **Have role-players begin to act out a scenario.** At the point of highest tension, stop the action by saying, "***Freeze!***" Ask the audience how they think each of the characters is feeling. Ask for suggestions for resolving the conflict. Now have the role-players continue the role-play using one or more of those suggestions.

3. **Reverse *roles*.** At some point during the role-play, have players switch roles. For example, ask the female to become the male or the passive partner the assertive one, and vice versa. Restart the role-play.

4. **Use groups of three or four who will independently and simultaneously act out a situation.** Include an observer, and give participants points to be looking for in the interaction, as well as guidelines for their small-group discussion afterward. Allow enough time for enough role-plays so that each participant has the chance to play more than one role, including that of the observer.

5. **Use group-assisted and supported role-play.** It's useful to make character cards (large index cards to which information about one character is affixed) and character name tags (hung around character's neck during role-play).

Note:
Punch two holes at the top of each card. Cut about three feet of yarn for each card, pull the yarn through the holes and knot at both ends to create a name tag that fits loosely around the neck. (See example.)



a. Divide participants into small groups, explaining that each group will focus on one character in the role-play scenario. Give each group one of the role-play character cards and each individual a small index card. The group is to read the description and discuss how its character will act in the role-play. After about five minutes, ask the group to select one volunteer to take part in the role-play.

b. Tell the other group members that, as the role-play progresses, they are to write on their cards any suggestions they have for the actor from their group about what else he/she might do or say. At specified times they will be able to deliver these suggestions to their actor, who may choose to use the suggestions or ignore them.

c. Ask the actors to come forward. Help each get into his or her role by asking, "How are you feeling about the situation right now?" Tell the players to begin the scene. Let the role-play continue as long as it seems productive, but no more than 10 minutes.

d. Now ask the actors to return to their own groups to get more suggestions. A new person may assume the role at this time. Have the actors begin again, continuing the role-play. (Group members may also continue to make written suggestions to their actor.)

e. Stop the role-play in time to debrief the actors and help them get out of their roles. Ask each, "How did you feel in the role that you played?"

Discussion Questions:

a. What examples can you give of something a character did or said that ***encouraged*** communication? Something that ***discouraged*** communication?

b. Why might the characters not have talked about this situation sooner?

c. What would you recommend to the characters about future discussions of this situation?

SECTION 1
Teaching about Contraception

This section has 13 lessons for teaching about the many contraceptive choices available today. The lessons help participants examine basic facts, range of efficacy, risk and decision-making, as well as gender, sexual orientation and consumer literacy.

All Together Now:
Preventing Unplanned Pregnancy* and *Sexually Transmitted Infections

Protect Yourself:
The First Time and Every Time

High Risk, Low Risk, No Risk

Choices and Consequences
Making Decisions about Contraception

Contraceptive Dominoes

Contraception in Perspective:
A History of Birth Control

Magical Methods of Birth Control

Contraception: The Male Factor

How Could That Be?:
A Lesson about Identity, Behavior, Perception and Risk

Putting Contraception into Romance

Creating Positive Images:
Advertising for Contraception and Safer Sex

Getting It:
Consumer Skills for Contraception

Contraception through the Lifespan

ALL TOGETHER NOW
Preventing Unplanned Pregnancy *and* Sexually Transmitted Infections

Objectives

By the end of this lesson, participants will be able to:

1. Identify their personal feelings about the relative risks for unplanned pregnancy and sexually transmitted infections (STIs).

2. Compare the effectiveness of the major methods for protecting against unplanned pregnancy and STIs.

3. Explain ways to integrate preventing unplanned pregnancy with preventing STIs.

Rationale

Many teens want to protect themselves from an unplanned pregnancy as well as from STIs. Unfortunately, popular and highly effective methods of contraception like the Pill, patch and Depo-Provera® do not protect against STIs. Yet many young people who use a condom the first time they have vaginal intercourse stop using condoms when they begin using hormonal contraception, making themselves vulnerable to STIs. This lesson helps teens assess their own risk for pregnancy and STIs, by stressing the importance of preventing **both** unplanned pregnancy **and** sexually transmitted infections.

Materials

- Flip chart paper or board, index cards, markers and tape
- A set of large signs labeled as follows:
  - **EXCELLENT PROTECTION**
  - **SOME PROTECTION**
  - **NO PROTECTION**
  - **PREGNANCY**
  - **STIs**
- Two sets of cards, each set a different color, labeled as follows on both sets:
  - **ABSTINENCE**
  - **DIAPHRAGM**
  - **FEMALE CONDOM**
  - **IMPLANT**
  - **INJECTION (SHOT)**

- **IUC**
- **MALE CONDOM**
- **NO METHOD**
- **OUTERCOURSE**
- **PATCH**
- **SPERMICIDE**
- **THE PILL**
- **VAGINAL RING**
- **WITHDRAWAL**

(28 cards in total – 14 of one color, 14 of another color)

- Sample protection methods, pictures or pamphlets describing different methods
- **Handout: All Together Now: Preventing Unplanned Pregnancy *and* Sexually Transmitted Infections**
- **Contraceptive Options** chart (see Resources Section of this manual)

Procedure

1. Before the lesson begins, put the large signs on the wall or board in the format shown on the **Handout: All Together Now: Preventing Unplanned Pregnancy *and* Sexually Transmitted Infections.**

2. Give a blank index card to each participant. Put the following words/phrases on the board or on flip chart paper:

   PREGNANCY
   SEXUALLY TRANSMITTED INFECTIONS (STIs)
   HIV

   Ask participants to rank each on their index cards, as follows:

   1. The most difficult for you to deal with at this time in your life
   2. The second-most difficult
   3. The least difficult

   Discussion Questions:

   a. What are the reasons for ranking them the way you did?

   b. Are people you know more likely to be at risk for an unplanned pregnancy, an STI or HIV? Why?

   c. How much do people you know think about ways they can avoid all these risks? Explain.

3. Distribute the following:

   a. **Handout: All Together Now: Preventing Unplanned Pregnancy *and* Sexually Transmitted Infections.**

   b. **Contraceptive Options** chart (see Resources Section of this manual).

   c. The 28 cards (14 in one color; 14 in another color). If there are too few participants, some can take two or more; if there are too many participants, some can work in pairs.

4. Show participants the large signs on the wall that mark the continuum of protection from unplanned pregnancy, from **EXCELLENT PROTECTION** to **SOME PROTECTION** to **NO PROTECTION.** Note that the wall is set up like the chart on the handout, and that the lower the level of protection, the higher the risk.

5. Ask participants with **one** color of cards (e.g., blue) to use the **Contraceptive Options** chart to decide where on the **PREGNANCY** section of the continuum their method belongs. When they have decided, they should tape their cards in the correct place to show how well that method prevents **PREGNANCY**.

6. As the cards are being placed, ask participants who are seated to fill in the first section of their handouts.

   Discussion Questions:

   a. Does anyone disagree with the location of any of the methods? If you disagree, what is your reason? Where would you move the method on the continuum? *(If the group agrees with the change, move the card.)*

   b. What can decrease the effectiveness of a method? *(Possible answers: forgetting to take a pill; using an oil-based lubricant with a condom.)*

   c. What can make a method most effective? *(Possible answers: remembering to use the method every time; following directions for correct use.)*

7. Note that many methods have a range of effectiveness. For example, male condoms' effectiveness in preventing pregnancy ranges from 82% to 98%. Ask participants if they placed their cards based on the higher or lower rate listed. *(Explain the difference between "typical" and "perfect" use: A "perfect" user uses a method consistently and correctly; a "typical" user makes some mistakes, such as forgetting to take pills every day or not using a condom every time.)*

8. Ask participants with the other color of cards (e.g., yellow) to come forward and tape their method on the bottom part of the chart to show how well that method prevents sexually transmitted infections (STIs).

   Discussion Questions:

   a. Does anyone disagree with the location of any of the methods on the STI continuum? If you disagree, what is your reason? Where would you move the method on the continuum? *(If the group agrees with the change, move the card.)*

   b. Looking at the **PREGNANCY** (top) part and the **STIs** (bottom) part of the continuum, what conclusions do you draw? What questions do you have? *(Emphasize that some of the methods that work best at preventing pregnancy, like the Pill, do NOT protect against STIs. Others, like spermicides, could increase the risk of STIs.)*

9. Ask participants to complete the rest of their handouts, answering the final three questions at the bottom of the page. Emphasize that the handouts are confidential and will not be collected. Summarize by asking the following.

   Discussion Questions:

   a. Which two methods give the most protection against **both** pregnancy **and** STIs? *(Abstinence from any kind of sexual intercourse* and *condoms.)* Why might this be important to know? How would you explain these methods, and what makes them unique, to a friend thinking about contraceptive options?

   b. If someone had unprotected intercourse, what could she or he do to prevent unplanned pregnancy afterward? *(Get emergency contraception within 120 hours at a local pharmacy or clinic, by calling 1-800-230-PLAN or 1-888-NOT-2-LATE, or by visiting The Emergency Contraception Website at www.not-2-late.com.)*

10. Use any remaining time to review individual methods, referring to the **Contraceptive Options** chart, plus sample methods, pictures or pamphlets. Note that the chart includes all the methods that might be used throughout a person's life, but focus on the methods more commonly used by teens, such as abstinence, the Pill, condoms and injection.

Handout

All Together Now: Preventing Unplanned Pregnancy *and* Sexually Transmitted Infections

Directions: Place each method on the continuum below, twice: once for the protection it gives in preventing pregnancy, and once for the protection it gives in preventing STIs.

- **ABSTINENCE**
- **DIAPHRAGM**
- **FEMALE CONDOM**
- **IMPLANT**
- **INJECTION (SHOT)**
- **IUC**
- **MALE CONDOM**
- **NO METHOD**
- **OUTERCOURSE**
- **PATCH**
- **SPERMICIDE**
- **THE PILL**
- **VAGINAL RING**
- **WITHDRAWAL**

PREGNANCY	**EXCELLENT PROTECTION** (No Risk or Very Low Risk)	**SOME PROTECTION** (Some Risk)	**NO PROTECTION** (High Risk)
STIs			

Considering your own behavior now, where on the continuum of risk do you place yourself? (Check one box for each.)

	NO RISK or VERY LOW RISK	SOME RISK	HIGH RISK
For an unplanned pregnancy?			
For an STI?			

Do you want to change where you are on the continuum? _____**YES** _____**NO**

If yes, one thing you can do is:_____

PROTECT YOURSELF
The First Time and Every Time

Objectives

By the end of this lesson, participants will be able to:

1. Explore personal and societal attitudes related to sexual intercourse and identify how these attitudes affect contraceptive and safer sex behaviors.

2. Respond to statements expressing common attitudes about using contraception.

Rationale

Negative feelings and attitudes about having sexual intercourse and about the various contraceptive methods can discourage people from engaging in the behaviors needed to prevent unwanted pregnancies and disease. People become confused by contradictory messages, some which promote abstinence as the only moral choice and others that promote intercourse as essential for popularity, love and happiness. Unable to acknowledge their own sexual activity, they do not plan for protection but let intercourse "just happen." Embarrassment about getting and talking about contraception adds to the likelihood that people not use protection if they have intercourse. This lesson raises these issues and provides an opportunity to rehearse positive responses to excuses that often discourage the use of protection.

Materials

- Index cards for each participant
- **Handout: Excuses! Excuses! Excuses!**

Procedure

1. Introduce the lesson by stating that first sexual intercourse is generally a significant event in a person's life. Ask the group to brainstorm a list of responses to the following sentence stems: **A VIRGIN IS ...** and **A NON-VIRGIN IS ....** Review the lists for the negative and positive connotations. Identify specific words on the lists that stereotype a person or might make a person feel uncomfortable about being a virgin or a non-virgin.

2. Distribute one index card to each participant. Tell the participants that they should not write their names on the index cards. Ask them to imagine a person has just had intercourse for the first

time. On the card, they are to write down words describing how they think the person might be feeling. Give time for participants to complete. Then, collect the cards, shuffle them and redistribute. Have each participant read the card s/he now has aloud to the rest of group.

Discussion Questions:

a. Were these statements about first intercourse generally positive, negative or both?

b. Why might some people feel positive about having intercourse?

c. Why might some people feel negative about having intercourse?

d. What, in your opinion, does a person gain or lose at first intercourse?

e. How might having intercourse change a couple's relationship?

f. Were there attitudes expressed on the cards that might impact whether or not a contraceptive would be used the first time a person has intercourse? If so, what?

3. Note that there are many reasons why people fail to protect themselves the first time (or anytime) they have sexual intercourse. Participants are going to practice responding to some of the excuses people use to avoid using protection from unwanted pregnancy or sexually transmitted infections.

4. Divide the participants into small groups. Distribute the **Handout: Excuses! Excuses! Excuses!** Review the directions.

5. After all groups have completed the handout, read and discuss each of the responses in numerical order one at a time, having the different small groups read their responses to the entire group.

Note:
Be sure that participants move beyond the negative statements on the handouts and discuss how people can overcome these common attitudes that prevent the use of effective contraception. In terms of the statements about contraception not being "natural" or "losing feeling with condoms," allow student to consider the feelings and experiences of intercourse that are not interfered by contraceptive use (e.g., affection, skin contact, erection, lubrication, increased heart rate, orgasm, etc.) and the increased enjoyment many couples experience when they are relieved of anxiety about a possible pregnancy or risk of infection.

Discussion Questions:

a. How do you feel about the responses from members of the other groups?

b. What did you learn anything from doing this exercise?

c. Family planning professionals say it is particularly difficult for young people to determine the "safe time" of the month. Why is this so?

d. How might a contraceptive method with a high rate of effectiveness improve a couple's relationship? Explain.

e. Research indicates that lesbian and gay youth are at high risk for pregnancy. Why might this be?

f. How would pregnancy prevention options be similar for a same-sex couple? How would they be different?

Handout

Excuses! Excuses! Excuses!

Directions: Imagine that a couple is talking about having intercourse and planning for contraception. If one person said any of these statements, how might his or her partner respond? Take into account the fact that the couple cares about each other, and also wants to avoid pregnancy and sexually transmitted infections.

One person says: (Fill in what the **PARTNER** could say.)

1. "I'm embarrassed to go to a family planning clinic; someone I know might see me there!"

   _____

   _____

2. "I just finished my period; it's the safe time of the month."

   _____

   _____

3. "I don't need to use a condom with you. You're not the kind of person who would have an infection, and I'm safe."

   _____

   _____

4. "I'll pull out before I come. You'll be safe. I'd never do anything to hurt you."

   _____

   _____

5. "I hate condoms. It's like sex isn't real. I want to feel you, not the condom."

   _____

   _____

6. "I don't believe in using birth control. It's unnatural."

   _____

   _____

HIGH RISK, LOW RISK, NO RISK

Objectives

By the end of this lesson, participants will be able to:

1. Understand that within the young adult and adolescent population, a wide range of normalcy exists with regard to sexual behavior.

2. Identify the behaviors that put a person at risk for an unplanned pregnancy and/or sexually transmitted infection (STI).

3. Assess whether they are at risk for an unplanned pregnancy or STI.

Rationale

Most young people are curious about how their personal behavior compares with that of others in their own age group. Perception of peers' sexual behavior has been found to be an important factor influencing a young person's personal sexual behavior(s).[1] Other research indicates that young people commonly overestimate the extent of their peers' sexual experience.[2] Clearly, young people need a more accurate understanding of peer sexual behavior. This lesson supports the normalcy of a range of sexual expression and helps young people identify those behaviors that place an individual at risk for unplanned pregnancy and/or STI.

Materials

- Flip chart paper or board, markers and small blank sheets of paper
- **Handout: High Risk, Low Risk, No Risk**

Procedure

1. Begin the lesson by noting the normalcy of a variety of sexual behaviors. State that in any given group of young people, there will be different ways that people express themselves, including the choice that an individual makes about whether or not to have sexual intercourse.

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[1] Potard, C., Courtois, R., & Rusch, E. (2008). The influence of peers on risky sexual behavior during adolescence. *The European Journal of Contraception and Reproductive Health Care, 13(3),* 264-270.

[2] Martens, M. P., Page, J. C., Mowry, E. S., Damann, K. M., Taylor, K. K., & Cimini, D. (2006). Differences between actual and perceived student norms: An examination of alcohol use, drug use, and sexual behavior. *Journal of American College Health, 54(5),* 295-300.

6. Tell the participants that pregnancy can occur as the result of certain sexual behaviors. Write **HIGH RISK**, **LOW RISK**, and **NO RISK** on the board/flip chart. Explain that HIGH RISK behaviors are *very* likely to result in the possibility of pregnancy, LOW RISK behaviors are *somewhat* likely to result in the possibility of pregnancy, and NO RISK behaviors are *not at all* likely to result in the possibility of pregnancy. Ask participants to describe people who are at HIGH, LOW, or NO RISK for **unwanted pregnancy** by their sexual behaviors. List participant responses underneath the appropriately labeled category.

Note:
Since you are discussing risk of pregnancy in this section, "intercourse" refers to penile-vaginal sex.

Possible answers include:

HIGH RISK	LOW RISK	NO RISK
People who are undecided about whether to have sexual intercourse and are unprepared with a method of contraception.	People who have sexual intercourse and use a reliable method of contraception correctly with every act of intercourse.	People who abstain from intercourse and express their sexuality in other ways.
People who have intercourse and do not use contraception.		People who have outercourse (non-penetrative sexual behaviors such as holding hands, kissing, fondling, masturbation, etc.).
People who use contraception sometimes, but not always.		
People who use their method of contraception incorrectly.		

7. Again, write **HIGH RISK**, **LOW RISK**, and **NO RISK** on the board/flip chart. Tell the participants that contracting a sexually transmitted infection (STI) can occur as the result of certain sexual behaviors. Explain that HIGH RISK behaviors are *very likely* to result in the possibility of contracting an STI; LOW RISK behaviors are *somewhat likely* to result in the possibility of contracting an STI; and NO RISK behaviors are *not at all likely* to result in the possibility of contracting an STI. Ask participants to describe people who are at HIGH, LOW, or NO RISK for **contracting an STI** by their sexual behaviors. State that the examples should be different from those given above.

Note:
Since you are discussing STIs, "intercourse" must include penile-vaginal, anal, and oral intercourse.

Possible answers include:

HIGH RISK	LOW RISK	NO RISK
People who do not use a condom correctly with every act of intercourse.	People who use a condom correctly with every act of intercourse.	People who abstain from intercourse. People who are **certain** that they are uninfected who engage in sexual behaviors **exclusively** with each other.

Note Key Differences Between Risk of Pregnancy and Risk of STIs

- A person can get some STIs through kissing and other intimate contact.
- People who engage in sexual behaviors with people of the same sex can be at HIGH, LOW or NO RISK of contracting an STI, depending on their behavior.
- Nonoxynol-9, a key ingredient in spermicide, reduces the risk of pregnancy by destroying sperm cells. Frequent use of spermicide may contribute to vaginal irritation and damage to cells of the anal lining. Therefore, spermicide is not recommended as a risk-reduction method for STIs.
- It is extremely difficult to know whether or not one's partner is infected by an STI.

8. Emphasize that people can usually tell if they will have intercourse soon. Sometimes this is hard to admit to one's self, but when people think they might have intercourse and are unprepared with contraception, they are at high risk for unplanned pregnancy and sexually transmitted infections.

9. Write the following objective on the board/flip chart and discuss the meaning with the group:

TO AVOID UNPLANNED PREGNANCY AND STIs, EVERY PERSON WILL HAVE THE KNOWLEDGE AND SKILLS TO BE IN A "NO RISK" OR "LOW RISK" GROUP.

10. Distribute the **Handout: High Risk, Low Risk, No Risk.** Divide the participants into small groups. Review the handout and discuss any questions participants may have about completing it. Have participants complete the handout.

Note:
The handout gives a brief overview of variations in sexual behavior among adolescents. Current research indicates that less than half (46%) of high-school students have experienced sexual intercourse.

11. After a few minutes, reconvene the small groups. Use the discussion questions on the handout to have a conversation about the scenarios. Continue with the following discussion questions.

Discussion Questions:

a. What factors did you consider to determine a person's risk for pregnancy or STIs?

b. What are some reasons to not have intercourse? Are there other ways to express sexuality without intercourse?

c. Which individuals do you think are at least risk for unplanned pregnancy or an STI? Why? Greatest risk? Why?

d. What do you think a person needs to know in order to reduce the risk of unplanned pregnancy or STIs?

e. What can youth do to increase their knowledge and build skills to reduce the risk of unplanned pregnancy or STIs?

f. What do you recommend for people to reduce the risk of unplanned pregnancy or STIs?

Sources:

Centers for Disease Control and Prevention (2010). Youth risk behavior surveillance – United States, 2009. *Morbidity and Mortality Weekly, 59(SS-5).*

Centers for Disease Control and Prevention (2010). *Sexually transmitted infections treatment guidelines, 2010.* Atlanta, GA: Centers for Disease Control and Prevention.

Hatcher, R. A., Trussell, J., Nelson, A. L. Cates, W., Kowal, D., & Policar, M. S. (2011). *Contraceptive technology, 20th rev. ed.* Atlanta, GA: Ardent Media.

Handout

High Risk, Low Risk, No Risk

Directions: Read the following cases that describe sexual behaviors of students in a high school. In each box, write the person's risk category for **pregnancy,** and then their risk for **sexually transmitted infection. HI = HIGH RISK; LO = LOW RISK, NO = NO RISK**

FEMALES

Dana is just beginning to date. She doesn't like anyone well enough to consider having intercourse. ***Pregnancy risk____*** ***STI risk____***	Maria and her girlfriend have had sex a few times, and always use latex squares (a.k.a. "dental dams"). ***Pregnancy risk____*** ***STI risk____***
Lauren has not had intercourse. She may have intercourse in the future but only if her boyfriend uses condoms. ***Pregnancy risk____*** ***STI risk____***	Melissa has been in a close relationship for two years and has had intercourse frequently. She uses the birth control pill and her boyfriend uses condoms. ***Pregnancy risk____*** ***STI risk____***
Brianna knows she is a lesbian, but she goes out with Demitri, so people don't ask about her orientation. They've had sex — without a condom — a few times. ***Pregnancy risk____*** ***STI risk____***	Linda has had a boyfriend for one year. She feels they will have intercourse soon but has no plan for contraception. ***Pregnancy risk____*** ***STI risk____***
Alexis has intercourse regularly. She takes "the pill" every day. In the past she had an abortion. ***Pregnancy risk____*** ***STI risk____***	Katie has been having sexual intercourse for eight months without using contraception. ***Pregnancy risk____*** ***STI risk____***
Sandra has never had intercourse and thinks she would feel guilty about it if she did. ***Pregnancy risk____*** ***STI risk____***	Jasmine likes someone very much but does not feel ready for intercourse. She plans to wait until marriage. ***Pregnancy risk____*** ***STI risk____***

MALES

Andrew would like to meet a girl but is not sure how to do this. He feels it is important to know a girl before getting sexually involved. He has never had intercourse. ***Pregnancy risk____*** ***STI risk____***	Ken is more interested in school activities than having a sexual relationship. He has never had intercourse. He knows how to use a condom, just in case. ***Pregnancy risk____*** ***STI risk____***
Darnell's relationships have included heavy petting but not intercourse. He believes in abstinence. ***Pregnancy risk____*** ***STI risk____***	Bill has had intercourse that resulted in an unwanted pregnancy. The child was placed for adoption. His girlfriend now has the implant. ***Pregnancy risk____*** ***STI risk____***
Eric had intercourse once with a girl who used a female condom. He is not having intercourse at this time. ***Pregnancy risk____*** ***STI risk____***	Nick enjoys dating. He is not considering sexual intercourse at this time. ***Pregnancy risk____*** ***STI risk____***
Tyler has been having intercourse for the past four months without using contraception. ***Pregnancy risk____*** ***STI risk____***	Jack has intercourse once in a while. He uses withdrawal for contraception. ***Pregnancy risk____*** ***STI risk____***
Noah is attracted to men and women. He is dating but is not interested in sexual intercourse with anyone yet. ***Pregnancy risk____*** ***STI risk____***	Emilio has had intercourse with many different guys. He always uses a condom and uses it correctly. ***Pregnancy risk____*** ***STI risk____***

Discussion Questions:

a. What percentage of these students has not had intercourse yet?

b. How do the experiences of males and females compare? Is either group at greater risk?

c. What additional information might be helpful in assessing these students' risk?

d. Which student has the most difficult situation? Why?

e. Which student do you admire the most? Why?

CHOICES AND CONSEQUENCES
Making Decisions about Contraception

Objectives

By the end of this lesson, participants will be able to:

1. Identify the other decisions that become necessary once a couple has made the decision to have sexual intercourse.

2. Identify personal concerns that will influence contraceptive decision-making for an individual couple.

3. Demonstrate how to make contraceptive decisions in a variety of situations.

Rationale

Young people frequently engage in "magical thinking" or otherwise deny the possible consequences of the decision to have sexual intercourse. This lesson emphasizes the choices and consequences that are inescapable when a male/female couple makes the decision to have intercourse. It gives participants an opportunity to assess the considerations that go into making a decision about contraception. Working in pairs, participants experience decision-making with someone of the other gender and, hopefully, will be better able to communicate responsibly with a partner if and when the time comes to do so.

Materials

- Flip chart paper or board, markers
- **Handout: Decisions!**
- **Handout: Making Decisions about Contraception**
- **Contraceptive Options** chart (see the Resources Section of this manual)

Procedure

1. Distribute the **Handout: Decisions!** Note that every year in the United States nearly 750,000

women under the age of 20 become pregnant and must decide what to do about that pregnancy.[1] However, before a woman is faced with that very big decision, she and her partner have already made other important decisions. Ask participants to follow your charting of these decisions on the board/flip chart. Draw the chart, starting at the top. As you draw each step, tell them:

a. The first big decision, of course, is whether or not to have sexual intercourse. People who decide not to have penile-vaginal intercourse will not have to make a decision about an unplanned pregnancy.

b. Next, if a couple decides to have intercourse, they decide either TO USE CONTRACEPTION or they decide NOT TO USE CONTRACEPTION.

c. Then, if they had intercourse without using contraception, or used a condom that broke, or for any other reason they think they were not protected, the woman can decide, within 120 hours (5 days), to get EMERGENCY CONTRACEPTION — the sooner, the better.

d. If the woman finds out that she is pregnant, then she must decide whether to have a baby and be a parent; to have a baby and plan for someone else to raise the baby; or to have an abortion.

2. Ask participants to answer the three questions on the **Handout: Decisions!** Note that they will share their answers only if they choose to do so. Give them several minutes to think about the questions.

   Discussion Questions:

   a. Which of all these decisions would be most difficult? Why?

   b. What could be done to encourage more women to use emergency contraception so they might not have to make a decision about an unplanned pregnancy?

   c. Where on the chart do you think most people in this group (or school) are?

3. Use a random method to divide participants into male/female pairs. If there is not an even number of males and females, same-sex pairs can work together. Explain that they will be in these pairs only for this next exercise. Each pair will examine the six case studies involving possible intercourse and contraceptive use and discuss what advice they would give.

[1] Kost, K., Henshaw, S., & Carlin, L. (2012). *U.S. teenage pregnancies, births and abortions, 2008: National and state trends and trends by race and ethnicity*. New York, NY: The Alan Guttmacher Institute. Accessed at http://www.guttmacher.org/pubs/USTPtrends08.pdf

4. Distribute the **Handout: Making Decisions about Contraception** and the **Contraceptive Options** chart. Suggest that participants use the chart in deciding what contraceptive methods they might recommend. Do the first case study together to be sure participants understand the steps of the assignment.

5. When all pairs have completed the six cases on the handout, have the entire group discuss the cases. In evaluating the contraceptive method selected, ask the group if there was one "best" method for this particular couple or if other methods might be equally good.

   Discussion Questions:

   a. Do you predict that any of these couples will fail to protect themselves from an unwanted pregnancy? Why or why not?

   b. Which couple had the most difficult decision to make? Explain.

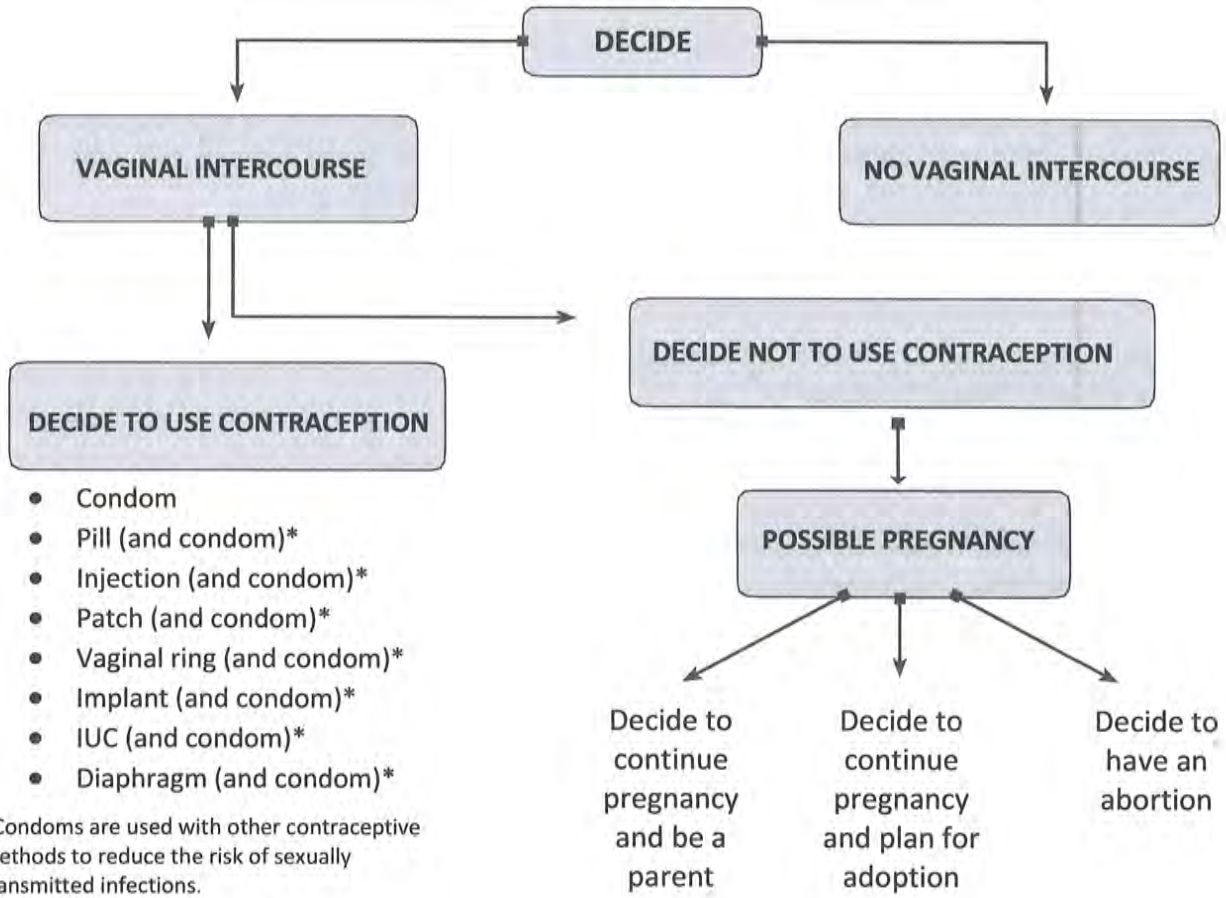
   c. Did any couple plan to do anything to prevent sexually transmitted infections (STIs), including HIV? Does everyone need to use a condom even if they're using another reliable contraceptive method? Explain.

   d. Did one person in your pair tend to make the decision for the couple or did both of you share it equally?

   e. What did you learn by doing this exercise?

Handout

Decisions!



- Condom
- Pill (and condom)*
- Injection (and condom)*
- Patch (and condom)*
- Vaginal ring (and condom)*
- Implant (and condom)*
- IUC (and condom)*
- Diaphragm (and condom)*

*Condoms are used with other contraceptive methods to reduce the risk of sexually transmitted infections.

If method fails, **DECIDE** to get emergency contraception within 120 hours (5 days)

Questions:

1. Which would be the most difficult decision? Rank the following from 1 (most difficult) to 4 (least difficult).

   ____Whether or not to have intercourse

   ____Whether or not to use contraception

   ____Whether or not to get emergency contraception

   ____Whether to have a baby and be a parent, select adoption, or have an abortion

2. Which of these four decisions are most people in this school or group currently dealing with?

3. If you (or your partner) became pregnant at this time in your life, what do you think you would do? What do you think you would do if you and your partner did not agree?

Handout

Making Decisions about Contraception

Directions: In each of the following cases, people are making decisions about intercourse and contraception. Discuss the situations with your partner, look at the **Contraceptive Options** chart and respond to the questions that follow.

1. Alicia and William have been going together for over a year. When they began to have intercourse, Alicia got "the pill." Then a month ago, they had a fight and decided not to see each other for a while. Alicia stopped taking the pill. But last night they got together, talked things over, and decided to continue with their relationship. Tonight, they are alone at William's and really want to start having intercourse again.

   What advice would you give?_____

   _____

   What contraceptive method would you recommend? _____

   Why?_____

   _____

2. For the past two months, David has been pressuring Lila to have intercourse. She just knows it will happen soon. But she'd rather wait to start having intercourse, which makes it hard for her to start talking about what kind of contraception to use.

   What advice would you give?_____

   _____

   What contraceptive method would you recommend? _____

   Why?_____

   _____

3. Marisa and Carla have been in love for more than a year. They haven't told anyone yet because they worry that some people may be disrespectful toward them. But someone started a rumor that Marisa was gay, so she went out with Derek to prove everyone wrong. She had intercourse without a condom, and now she's worried that she might be pregnant. She is also worried that Carla may find out about Derek and her.

   What advice would you give?_____

   _____

   What contraceptive method would you recommend? _____

   Why?_____

   _____

4. Orlando and Florey have been having intercourse once or twice a week for six months. They've been using "withdrawal," and it has seemed to work okay. Then two weeks ago, Florey's period was late. They worried that she was pregnant and vowed that they would never have unprotected intercourse again. Finally, Florey's period came. She wants to get a reliable method of contraception, but she's too embarrassed to go to a family planning clinic.

   What advice would you give?_____

   _____

   What contraceptive method would you recommend? _____

   Why?_____

   _____

5. Jerome respects his family's strong religious values, including their belief that intercourse should be saved for marriage. Jerome is dating Christina, and he cares for her a great deal. Christina had intercourse in a previous relationship and has been getting Depo shots. She thinks it's natural and right that she and Jerome should show their love for each other by having intercourse.

   What advice would you give?_____

   _____

   _____

What contraceptive method would you recommend? _____

Why? _____

_____

6. Yolanda and Paul have used a condom every time they have had intercourse in the last six months, but last night the condom leaked.

What advice would you give? _____

_____

What contraceptive method would you recommend? _____

Why? _____

_____

7. Jacob and Emma want to begin having sexual intercourse. Jacob is totally fine with other people knowing about this, in fact, he can't wait to tell his friends! Emma, on the other hand, doesn't want *anyone* to know about her personal business — her sexual behavior or her contraceptive choices. She needs a method that she can keep private.

What advice would you give? _____

_____

What contraceptive method would you recommend? _____

Why? _____

_____

CONTRACEPTIVE DOMINOES*

Objectives

By the end of this lesson, participants will be able to:

1. Identify three ways contraceptive methods work to reduce the risk of pregnancy.
2. Describe the instructions for correct use of three contraceptive methods.
3. Categorize at least one contraceptive method as being a barrier, behavioral, hormonal, intrauterine or surgical method.

Rationale

Declines in teen pregnancy rates are largely attributed to increased and improved use of contraceptives as well as a decrease in sexual activity.[1] Yet, recent data suggests that approximately 750,000 teenage women experience pregnancy in the United States yearly.[2] Young people need to know the facts about contraceptive methods, including abstinence, so they can make informed decisions about preventing pregnancy. Reviewing information about contraceptives is helpful so that young people can easily recall the knowledge they learned in order to use it correctly and consistently. *Contraceptive Dominoes* is a learning game that allows young people to apply information about contraceptive methods and abstinence.

Materials

- Contraceptive Dominoes (use **Educator Resource: Creating Contraceptive Dominoes)**
- **Educator Resource: Contraceptive Dominoes**
- **Handout: Contraceptive Dominoes Rules**
- **Contraceptive Options** chart (see the Resources Section of this manual)

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* Adapted from Shields, J. & DiGioia, M. K. (2012) *Game On! The Ultimate Sexuality Education Gaming Guide.* Morristown, NJ: The Center for Sex Education.

[1] The National Campaign to Prevent Teen and Unplanned Pregnancy (2012). *Fast facts: Teen pregnancy in the United States.* New York, NY: The Alan Guttmacher Institute.

[2] Santelli, J. S., Lindberg, L. D., Finer, L. B., & Singh, S. (2007). Exploring recent declines in adolescent pregnancy in the United States: The contribution of abstinence and increased contraceptive use. *American Journal of Public Health, 97*: 150-156.

Procedure

1. After reviewing the ground rules, explain that participants will be playing a game to apply basic facts about pregnancy prevention options called *Contraceptive Dominoes.* Distribute **Contraceptive Options** chart or other contraceptive pamphlets to participants and the **Handout: Contraceptive Dominoes Rules**.

2. Hold a sample Contraceptive Domino (see **Educator Resource: Creating Contraceptive Dominoes***)* for all participants to see. Explain that both sides of each domino will contain information about contraceptives. A domino side may contain the name of a contraceptive method, a type of contraceptive method, an instruction for correct use, a description of how a method works, or other relevant information about a contraceptive method. Review the **Handout: Contraceptive Dominoes Rules**.

3. Divide participants into small groups of two to six players.

4. Pass out Contraceptive Dominoes to each small group. Tell the participants to shuffle them, and then place them face down so that no one can see what is written to form the Dominoes Pile.

5. Direct the participants to start the game and follow the instructions for game play on **Handout: Contraceptive Dominoes Rules.** Disputes over domino matches may occur. The educator serves as arbiter for disputes. Players suggesting alternative domino matches should give a justification for a match.

6. Play the game until a winner is determined.

7. Once a winner has been determined, discuss the activity.

   Discussion Questions:

   a. What might someone consider when choosing a method to prevent pregnancy (e.g., side effects, cost, availability, personal values, age, etc.)?

   b. In what ways do contraceptive methods reduce the risk of pregnancy?

   c. Why might it be important to know *how* a method prevents pregnancy?

   d. What are some examples of directions to use a contraceptive?

e. Why do you think contraceptive methods are used incorrectly?

f. How might a person successfully follow the method's instructions for use?

Educator Resource

Creating Contraceptive Dominoes

Follow the instructions below to make one pack of Contraceptive Dominoes. Create as many packs as needed to accommodate group size. Generally, one pack is best used with two to six players.

Materials

- Cardstock paper
- Scissors/paper cutter
- **Educator Resource: Contraceptive Dominoes**

Creating the Contraceptive Dominoes

1. Photocopy each of the pages in **Educator Resource: Contraceptive Dominoes,** onto cardstock paper.

2. Cut along the dotted lines to form each domino. This will result in a domino with two statements facing opposite directions. Each page will yield 12 dominoes. After all the dominoes are cut, there will be 84 dominoes.

3. Shuffle and bind the Contraceptive Dominoes with a rubber band.

Variation

Increase or decrease the number of dominoes to address the contraceptive content needs of your audience. For example, if you notice that participants are having difficulty learning about hormonal methods, increase the number of hormonal contraceptive dominoes.

Educator Resource

Contraceptive Dominoes

Male condom	Barrier method	Spermicide	Thickens cervical mucus	Injection given by clinician	Emergency contraception	Implant	Blocks the sperm	Lasts for up to 10 years	Lasts for up to three months	Suppresses ovulation	Rod inserted underneath the skin
Hormonal method	Abstinence	Inserted inside the vagina	Alters lining of the uterus	Not reusable	Diaphragm	Intrauterine contraceptive	Barrier method	Lasts for up to three years	Makes sperm movement (motility) difficult	Inserted inside of the uterus	Fertility awareness – based methods

Changed weekly	Inserted inside the vagina	Withdrawal	Emergency contraception	Behavioral method	The injection
Taken daily	Placed on penis	Female condom	Reversible	Birth control pill	Tubal ligation
Requires prescription	Over the counter	Spermicide	Adheres to skin	The patch	The ring
Remains in vagina for 21 days	Must be used within five days after sexual intercourse	Permanent	Surgical method	Vasectomy	Observing, recording and interpreting the body's fertility signs

Male condom	The ring	Implant	Emergency contraception		
Fertility awareness–based methods	Female condom	Abstinence	Intrauterine contraceptive		
Outercourse	The injection	Diaphragm	The patch		
Withdrawal	Can be used safely with spermicide	Sterilization	Birth control pills		
Condom	Condom	Ways of being sexual without intercourse	Diaphragm		
Abstinence	Birth control pill	Female condom	The patch		

Changed weekly	Taken daily	Requires prescription	Remains in vagina for 21 days
Inserted inside the vagina	Suppresses ovulation	Over the counter	Must be used within five days after sexual intercourse
Blocks the sperm	Thickens cervical mucus	Requires prescription	Hormonal method
Spermicide	Reversible	Adheres to skin	Surgical method
Behavioral method	Method for females	Method for males	Clinician needed for fitting/ insertion
Not reusable	Permanent	Spermicide	Counting the days in the menstrual cycle to identify the fertile days

Hormonal	Barrier method	Blocks the sperm	Method for males	Behavioral method	Refraining from oral, anal or vaginal sex
Prevents fertilization	Method for females	Pulling out	Outercourse	Hormonal method	Ways of being sexual without intercourse
Suppresses ovulation	Thickens cervical mucus	Prevents fertilization	Can be used safely with a condom	Requires prescription	Birth control pill
Inserted inside the vagina	Comes in forms of foams, gels and films	Over the counter	Refraining from sexual intercourse during particular days of the menstrual cycle	Alters lining of uterus	The patch

Male condom	Birth control pill	Behavioral method	Diaphragm		
The ring	Female condom	The injection	Intrauterine contraceptive		
Emergency contraception	Female condom	Withdrawal	Birth control pill		
The patch	Fertility awareness–based method	Abstinence	Tubal ligation		
Condom	Birth control pill	The patch	Vasectomy		
The injection	Implant	Vasectomy	The patch		

Reduces the risk of sexually transmitted infections	Application required at time of intercourse	Fertility awareness–based method	Can be used safely with a condom	Ways of being sexual without intercourse	Permanent
Requires prescription	Over the counter	Pulling out	Reversible	Does not reduce the risk of sexually transmitted infections	Method for females
Can be used safely with a male condom	Must be used for a period of time in order to be effective	Hormonal method	Can be used safely with a condom	Reduces the risk of sexually transmitted infections	Surgical method
Behavioral method	Method for males	Refraining from oral, anal or vaginal sex	Possible age restriction for use	Over the counter	Blocks the sperm

Handout

Contraceptive Dominoes Rules

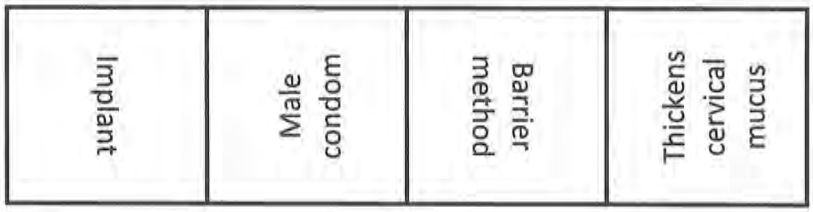
Each player will select eight dominoes from a Domino Pile. To start the game, the player whose birthday is closest to today will pick a domino from the Domino Pile and turn it face up for the players to see (**Figure 1**). Next, this player will try to use a domino from his/her hand to match the sides of the domino in play (**Figure 2**).

Figure 1: Domino in play

Either side can be matched

Figure 2: Player matched "Barrier method" to "Male condom"

Sides that are now open to be matched



Rules for Matches:

Side in play contains:	Use a domino in your hand that contains one of these:
Name of contraceptive	• Same name of contraceptive • Correct type of method • Correct description of how the method works • Correct directions for use • Relevant information that correctly applies
Type of contraceptive	• Same type of contraceptive • Name of contraceptive that correctly applies • Correct description of how the method works
Description of how the method works to prevent pregnancy	• Same description of how the method works • Name of contraceptive that correctly applies • Type of method that correctly applies
Directions for use	• Same directions for use • Name of contraceptive that correctly applies
Information about a contraceptive	• Same information • Name of contraceptive that correctly applies

Play will continue clockwise with the next player. The first player to eliminate all of his/her dominoes is the winner! If, at any time, a player cannot match a side in play, the player can select a domino from the Domino Pile to use during the turn. If, after three attempts, a match is still not possible, the player's turn is over. The player must hold onto any domino(es) not used during the turn and game play will resume clockwise with the next player.

CONTRACEPTION IN PERSPECTIVE
A History of Birth Control

Objectives

By the end of the lesson, participants will be able to:

1. Understand that throughout history people have made efforts to control their fertility.
2. Recognize that effective contraception technology is recent, and research to develop methods that are more effective and more acceptable still continues.
3. Address their own attitudes about overcoming obstacles to birth control.

Rationale

Few people are aware of the long history of human efforts to control fertility or of the long struggle to make contraceptive information and services available to people who want and need them. This lesson helps participants develop an awareness that throughout history attitudes and values about sexuality, as well as contraceptive technology, have affected the development, availability and use of birth control. The lesson makes participants aware that, although imperfect, the methods now available give people far greater opportunity to control their sexual and reproductive lives than ever before.

Materials

- Flip chart paper or board, markers
- **Handout: Contraception: The Continuing Revolution**
- **Educator Resource: What Would You Do?**

Note:
Ideally, the reading of **Handout: Contraception: The Continuing Revolution** would be completed by participants prior to the lesson, leaving more time for group discussion.

Procedure

1. Let participants work in pairs. Give them five minutes to list "The Ways Life Would Be Different If There Were No Contraceptives."

2. Ask each pair to give one item on their list as you write the items on the board/flip chart. Then, ask the following discussion questions.

   Discussion Questions:

   a. Given the responses listed, what are the benefits of access to contraceptive options?

   b. Which of the items on the list directly affect young people? How?

   c. Which of the items on the list do you think is the most significant? Why?

3. Distribute **Handout: Contraception: The Continuing Revolution** and ask participants to read.

   Discussion Questions:

   a. Which method of birth control has been used throughout recorded history and is still used today? *(Answer: Coitus interruptus or withdrawal)*

   b. Of the various methods used by people in early days, which methods might be somewhat effective? Why? Which would be completely ineffective? Explain.

   c. What is the reason many people in the United States became more interested in limiting the size of their families at the end of the nineteenth and beginning of the twentieth centuries? *(Answer: Industrialization — children, an economic advantage in an agricultural economy, became an increasing economic liability in an urban, industrialized economy.)*

   d. During the early 1900s upper- and middle-class families averaged only three or four children while the poor and working-class families continued to have large numbers of children. What might explain the difference in birth rates of women in different social classes?

   e. Throughout history, what factors have prevented people from controlling their reproduction? What factors have helped people control their reproduction?

4. Tell participants they will have an opportunity to examine their attitudes about the availability of contraception by pretending they live at different times in history. Explain that you will read a situation and give four possible alternatives. One corner of the room will represent each alternative. Participants will move to the corner that represents the option they would most likely select if they were confronted with this situation. Once they are in a corner, they should discuss their choice with others who made the same choice.

Facilitator should:

1. Read the situation found in **Educator Resource: What Would You Do?**
2. Identify the corner representing each option.
3. Give participants time to discuss their choices with others in their corners.
4. Let members of each corner share the reasons for their choices with the whole group.
5. Read the next situation.

5. After all the situations have been discussed, ask participants to return to their seats.

Discussion Questions:

a. What obstacles do you think people currently face when trying to access contraceptives?

b. What are some ways people can overcome these obstacles?

c. What rights do young people currently have regarding getting and using birth control? List these "rights" on the board/flip chart. Be sure they include:

   1. The right to say "no" when choosing not to have intercourse.
   2. The right to purchase contraceptives at the drug store.
   3. The right to receive confidential services at birth control clinics.

d. How might young people become more active in accessing reproductive health care?

Handout

Contraception: The Continuing Revolution

Thirty thousand years ago, a young woman stood in an African forest and tied three knots in a cord made from bark. In 1840 B.C.E. an Egyptian wife sent her slave to the river to collect crocodile dung she would use as a pessary (a substance inserted into the vagina to block sperm). In 1400 a Roumanian bride tucked three roasted walnuts in the bosom of her wedding dress. Each was practicing what she believed was contraception, an attempt to limit the number of children she would have.

Since prehistoric times, people have tried to control their fertility — how many children they would have and when they would have them. Their success was determined by their knowledge of reproduction, their attitudes and values about sexuality, and by contraceptive technology. Today, effective methods of birth control enable people to choose when and if they will have children in ways never before possible. This is an awesome revolution in the control that people, particularly women, have in determining how they will live their lives. The revolution continues.

The Long History of Abstinence and Coitus Interruptus

As soon as people realized that pregnancy resulted from ejaculation during intercourse, they tried to limit fertility by abstaining from intercourse or by coitus interruptus (withdrawal). In many cultures, custom determined when a couple should abstain, for example, (1) during menstruation, (2) for a year or more after childbirth, (3) on the anniversary of dead parents, (4) in the daytime, (5) during sunset, (6) at midnight, and (7) during an eclipse! Coitus interruptus was common in preliterate societies and is still used throughout the world, especially where more effective methods are not available.

Magical Thinking Dominates Early Methods

Early tribes tried a variety of birth control methods. Magical thinking was common: a young woman walked over a fresh grave; a man fashioned a special ring to wear during intercourse; women tied leather bags filled with herbs around their waists to ward off unwanted children. In Africa, potions were made from herbs, roots, the foam of a camel's mouth or the water used to bathe a dead person. Australian aborigines and other tribes made violent abdominal movements after intercourse to expel the semen. And Maori women in New Zealand placed a stone in the vagina with the belief they would become as sterile as the stone.

Other groups used methods that may have worked better. In some parts of Africa women used crushed roots or chopped grass as vaginal plugs. In Java the uterus was tipped in a painful process that caused sterility. In Guinea and Martinique lemon halves were used as cervical caps — an early diaphragm. And in Dutch Guinea, women inserted an okra-like seedpod into the vagina — a forerunner of today's condom.

Early Efforts in Egypt, Greece, Rome, Islamic Lands and India

The Egyptians, probably Cleopatra herself, used a mixture of crocodile dung, honey and gum resin to block the cervix. In India and Africa people used elephant dung, chopped grass and cloth. Greek and Roman medical writers reported a wide variety of methods including pessaries made from such materials as pomegranate, gallnut, myrrh, wine and pulp of dried figs. Sometimes additional actions were recommended: "The woman ought (at the moment of ejaculation) to hold her breath, draw her body back ... get up and sit down with bent knees ... and provoke sneezes ... then wipe out the vagina or drink cold water."

Islamic contraceptive medicine also advocated the sneeze: "... let the woman arise, sneeze and blow her nose several times and call out in a loud voice. She should jump violently backwards seven to nine paces ..." The woman could also apply drugs to the womb or "sit upon the tips of her toes and squeeze and rub her navel with her thumb." Pessaries were made from cabbage, pitch, gall, or animal earwax.

Other methods required the woman to lie passively during intercourse, or to rise quickly afterwards, or to avoid simultaneous orgasms. None were based on a scientific understanding of reproduction. None were effective in preventing conception. Through most of history, the majority of women rarely experienced a menstrual period because they were either pregnant or breast-feeding an infant throughout their reproductive lives.

Nineteenth Century Brings a Separation of Sex and Reproduction

The risk of pregnancy during intercourse was not significantly reduced until the late 1800s when the vulcanization of rubber made the condom and the diaphragm possible. The new technology contributed to the declining birth rate among the middle and upper classes that were able to afford the services of private doctors. This new ability to separate sex and reproduction had a profound effect on people's attitudes toward sexuality. However, most poor people did not have access to birth control information or services. They continued to suffer the consequences of unlimited childbearing.

Comstock Laws Outlaw Birth Control

The Comstock Law, passed by Congress in 1873, severely limited the availability of contraceptives in the United States. The law prohibited interstate mailing and transportation of birth control devices and literature, which it described as "every obscene, lewd, lascivious, indecent, filthy or vile article, matter, thing, device or substance and every article ... designed ... or intended for preventing conception."

Many states passed "little Comstock Laws," some of which continued to forbid the use of contraceptives until 1965 when the United States Supreme Court (*Griswold vs. Connecticut*) declared

that laws prohibiting the distribution of contraceptives violated the individual's right to privacy. The Griswold decision was an important victory for those who believe that decisions concerning people's reproductive lives should be made by individuals, not by the government.

Margaret Sanger Leads Fight for Birth Control

The Griswold decision was part of a long struggle by Americans to gain control of their reproductive lives. From before World War I, Margaret Sanger led a 25-year campaign to make contraception legal and accessible to all women. Sanger, a nurse, was angered by the suffering of poor women who were overwhelmed with constant childbearing. In 1916 she opened the first birth control clinic in a poverty-stricken section of Brooklyn and published *The Birth Control Review,* advocating the benefits of family planning:

> "Mothers!
> Can you afford to have a large family?
> Do you want to have any more children?
> If not, why have them?
> Do not kill, do not take life, but prevent. Safe, harmless information can be obtained of Nurses at 46 Amboy Street, Brooklyn.
> Tell your friends and neighbors. All mothers welcomed.
> A registration fee of 10 cents entitles any mother to this information."

Sanger, the clinic doctors, and other nurses were arrested and the clinic closed. But it was reopened and Sanger and her colleagues continued to educate, agitate and organize. A movement for reproductive rights was developed that continues today in organizations such as the Planned Parenthood Federation of America, whose root organization she helped create nearly 100 years ago.

World Population Explosion Adds Urgency to Birth Control Movement

By the mid-twentieth century the number of people on the planet was doubling every 40 years. Concern about the dangerous increase in the world's population, as well as concern for the quality of individuals, gave new importance to the birth control movement. By the 1960s the dramatic introduction of "the Pill" provided an almost 100% effective method for controlling conception. In the 1970s important improvements in the Pill greatly reduced its negative side effects.

For many couples, the threat of sexually transmitted infections, including HIV/AIDS, has revived the popularity of the condom. And although men wear them, over 50% of U.S. condom buyers are women. The most popular contraceptive method of all is sterilization, either tubal ligation or vasectomy, limited to people who have made a firm decision not to have any more children.

Current U.S. Efforts Focus on Adolescents

Current efforts at reducing unwanted pregnancies focus on adolescents. Teen pregnancy rates in the United States are at least double those in other developed nations; almost 750,000 American teens become pregnant each year. Most of these pregnancies are unplanned; about 25% end in abortion. Since adolescents themselves are the key to ending the tragedy of unwanted pregnancies, teens have begun to join campaigns seeking solutions. Major strategies of these nationwide efforts include:

1. Improving sexuality education in the schools.
2. Making contraceptives more easily available through school-based health clinics.
3. Encouraging parents to communicate with their children about sexual matters, including contraception.
4. Permitting advertising of contraceptives in the media.
5. Improving teens' hopes and expectations for their own future lives.

Contraceptive Options Today

Today, there are more contraceptive options available than ever before. Long Acting Reversible Contraceptives (LARCs) in the form of intrauterine contraceptives (IUCs) and implants lead the way in offering unprecedented efficacy in preventing pregnancy. Other new hormonal methods including patches, rings and injections expand options beyond the Pill. Condoms are available in a range of materials, textures and features. And, of course, abstinence remains a choice, just as it was in ancient times!

What will tomorrow's contraceptives look like, as scientists continue to develop new, as well as improved, barrier and hormonal methods?

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Educator Resource

What Would You Do?

Situation 1:
You live in ancient times. Your contraception choices are:

1. Crocodile dung, mixed to paste and inserted in vagina.
2. A magical or folk belief: rocking and jumping after intercourse.
3. Abstinence.
4. Doing nothing to prevent pregnancy.

Situation 2:
You live in 1920 and "Comstock Laws" prohibit information and services for contraception. Would you:

1. Advise people to get a method from a private doctor and use in secret?
2. Write a letter to the editor protesting the laws?
3. Join a protest march supporting Margaret Sanger's efforts?
4. Do nothing — support the status quo?

Situation 3:
You live in the present day and know that teens in the United States are at double the risk of pregnancy and abortion compared with teens in other developed countries. Would you:

1. Go to a Board of Education meeting advocating better contraception education in school?
2. Join a committee requesting the PTA to sponsor a workshop for parents on "Talking to Your Teenagers about Sex and Contraception"?
3. Join a committee advocating programs that encourage students to "Say No" to sex?
4. Do nothing?

MAGICAL METHODS OF BIRTH CONTROL*

Objectives

By the end of this lesson, participants will be able to:

1. Name at least three methods of birth control by participating in a large group brainstorm activity.

2. Categorize a list of methods as being either hormonal or barrier by participating in a large group discussion.

3. Demonstrate an understanding of birth control function, correct use, effectiveness, side effects, advantages and disadvantages by developing one magical method of birth control in small groups.

Rationale

Young adults often have questions about birth control methods — how they should be used, how they work to prevent pregnancy, and their possible side effects. Coincidentally, factors that may influence one's decision in choosing a contraceptive option include the advantages and disadvantages for use, side effects, effectiveness, and one's ability to use the method.[1] Providing youth with opportunities to better understand contraceptive options is essential for individuals to make decisions about contraceptives use. High school–aged and middle school–aged youth vary in their ability to hypothetically conceptualize a method's correct use and efficacy in preventing pregnancy. Activities that allow youth to consider possibilities and generate hypothesis are helpful in their ongoing cognitive development.[2]

Pop culture has seen an influx of magical themes in contemporary fiction, games and movies. This lesson builds on this growing genre of magical themes with participants creating fictional magical methods of birth control similar to traditional non-magical methods. As participants invent their magical method of birth control, they will consider how current *real* birth control methods assist in preventing pregnancy — enhancing their understanding of current contraceptive options.

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* This lesson was developed by Melissa Keyes DiGioia and Allyson Sandak. Allyson Sandak is the training and technical assistance manager for Answer.

[1] Hatcher, R. A., Trussell, J., Nelson, A. L., Cates, W., Kowal, D., & Policar, M. S. (2011). *Contraceptive technology, 20th rev. ed.* Atlanta, GA: Ardent Media.

[2] O'Donnell, A., Reeve, J., & Smith, J. (2007). *Educational Psychology Reflection for Action.* Hoboken, NJ: John Wiley & Sons, Inc.

Materials

- Markers (four different colors) and tape
- Flip chart paper and markers (enough for each small group to have one of each)
- Flip chart sheet labeled **NON-MAGICAL METHODS OF BIRTH CONTROL**
- A magician's hat or wizard's hat and accompanying props to be used to divide participants into small groups
    - Beaker
    - Parsley
    - Wand
    - Mask
    - Shield
- **Contraceptive Options** chart (see the Resources Section of this manual)
- **Handout: Sample Magical Method of Birth Control**
- **Handouts: Magic School Subject Descriptions** (one per group)
- **Handout: Magical Method of Birth Control**

Note:
This lesson should take place after a detailed review of the various birth control methods.

Procedure

1. To introduce the lesson, the educator should say, "Welcome to today's sex ed class at Magic School. Today's topic is pregnancy prevention." Referring to the flip chart labeled **NON-MAGICAL METHODS OF BIRTH CONTROL**, say, "First, let's discuss some examples of non-magical methods of pregnancy prevention."

2. Ask participants to raise their hands and name aloud as many methods they can think of. Record their responses on the flip chart labeled **NON-MAGICAL METHODS OF BIRTH CONTROL**. Supplement participants' list with methods found in **Contraceptive Options** as needed.

3. Remind participants that there are three main ways that non-magical methods of birth control work to prevent pregnancy:
    1. *Hormonal* – alters a female's body to prevent the release of an egg.
    2. *Barrier* – prevents sperm from coming in contact with the egg.
    3. *Surgical* – medical procedures to permanently prevent pregnancy.

    In addition, note that people sometimes choose to use *abstinence* (not having sexual intercourse) or *withdrawal* (pulling out) as behaviors to prevent pregnancy. Then write the word *Behavioral* next to *abstinence* and *withdrawal* on the initial brainstorm list using a colored marker.

4. Ask participants to identify two or three hormonal methods that are listed on the **NON-MAGICAL METHODS OF BIRTH CONTROL** flip chart sheet, and again circle these using a different colored marker. Repeat for barrier and surgical methods, again circling two or three methods with different color markers.

5. Distribute a copy of **Contraceptive Options** to each participant to use as a reference for the next activity.

6. Say, "Now that we have reviewed non-magical methods of birth control and how they work, for the rest of the class, we will spend time developing pregnancy prevention methods magicians might make/use. You will have the opportunity to work in small groups creating your own methods. Here is one example of a magical method some other witches and wizards have created."

7. Distribute the **Handout: Sample Magical Method of Birth Control** to each participant. Review all aspects of the handout with the participants.

8. Explain to participants that they will be divided into smaller groups that will study different types of magic. Create these groups by instructing participants to count off. Have participants sit with their groups. Once they are in their groups say, "Now the Magic Hat will tell you which magical subject you will study today."

9. To assign the magic study assignments to the small groups, walk around with the hat filled with props. Direct one person from each group to choose a prop from the hat without looking. Ask groups to guess which subject they are studying based on their prop. Use the following key to assign magic subjects based on props:

Potions	=	Beaker
The Power of Plants	=	Parsley
Spells	=	Wand
Metamorphosis	=	Mask
Magical Defense	=	Shield

Note:
The assignment of magic subjects can also be done without props, by having participants chose index cards with the name of the magic subject printed on them in advance. Alternately, they can also choose an index card with a drawing of the suggested prop.

10. Distribute the **Handout: Magic School Subject Descriptions** to each group so they can have some background information about their magic subject.

11. Explain to participants that they will create one magical method of birth control most relevant to their assigned magic subject. Say, "As you create your methods in your small groups, feel free to look back at the examples we just discussed, the **Contraceptive Options** handout, and the list of **NON-MAGICAL METHODS OF BIRTH CONTROL** we brainstormed earlier."

12. Distribute the **Handout: Magical Method of Birth Control** to each group while saying, "Non-magical methods of birth control include a patient information sheet. This explains many of the details of the product including directions and side effects. You will develop such a patient information sheet on this." Instruct them to complete all of the components of the handout.

13. Additionally, give each group a flip chart paper and marker and direct them to record the following: (1) magic subject (2) method name and (3) a picture of the method. Also explain that their flip chart papers will be posted so the other groups can see them.

14. Inform participants that they will have 10-15 minutes to complete this task. As groups are working, walk around to answer any questions, ensure groups are staying focused, provide the students with updates on how much time is remaining, and to assess the need for more time.

15. When groups are finished, have them post their flip chart papers and instruct them to select one participant to report back to the larger group about the method they developed. Allow time for all groups to report back.

    Discussion Questions:

    a. What was it like to do this? Ask participants to comment on what was easy and/or challenging about the activity and why.

    b. What is the value of including patient information material with birth control methods? What are some reasons why following directions is important?

    c. In what ways does a person impact the correct use of the method?

    d. Which of these methods do you think young witches and wizards might prefer? Why?

    e. How might this information be important in choosing a non-magical method of birth control? What else might a person consider (e.g., cost)?

    f. How is this useful in understanding non-magical methods of birth control?

Handout

Sample Magical Method of Birth Control

Magic Subject:	Spell
Method Name:	Spermo Expelleramus
Non-Magical Method Most Similar to:	Spermicide
Method Rate of Effectiveness:	79 - 95% effective if used correctly and consistently
Reasons for Possible User Error:	• Spell is not said correctly. • Spell is said after intercourse has already begun
Directions for Using the Method:	• Prior to sexual intercourse, flick wand and say, "Spermo Expelleramus!" • Uterus will glow to indicate if spell was performed correctly
How Method Works to Prevent Pregnancy:	Uterus shakes causing sperm to completely vanish and stops possibility of fertilization of an egg
Method Side Effects:	• Possible persistent uterine glow
Method Advantages:	• Able to use on the spot • Uterine glow indicates if spell was performed correctly • Cost effective
Method Disadvantages:	Could be used against someone without their prior knowledge

Handout

Magic School Subject Descriptions

THE POWER OF PLANTS

The Power of Plants teaches about plants, mushrooms and other naturally occurring items that have magical properties all by themselves, and can be used in conjunction with other ingredients or liquids to create potions.

POTIONS

Potions teaches about the magical fluids that are made from a variety of ingredients that are heated in a cauldron. For a potion to be effective, it has to be made with particular ingredients of varying amounts, at particular times during the potion-making process. A potion can be made in a short period of time, or may need time to develop.

METAMORPHOSIS

Metamorphosis teaches about the principles of the magic that allow objects to be changed into something else.

MAGICAL DEFENSE

Magical Defense teaches about protective magic. The magic may be in the form of hexes or curses that a person can cast to protect him/herself or to inflict harm upon others.

SPELLS

Spells teaches about how to cast spells to change how an object typically works. Spells might cause something to flash different colors, allow an object to levitate, or make a person laugh or dance. Spells do not cause people or objects to change, but merely to do something unexpected.

Handout

Magical Method of Birth Control

Magic Subject:	
Method Name:	
Non-Magical Method Most Similar to:	
Method Rate of Effectiveness:	
Reasons for Possible User Error:	
Directions for Using the Method:	
How Method Works to Prevent Pregnancy:	
Method Side Effects:	
Method Advantages:	
Method Disadvantages:	

CONTRACEPTION: THE MALE FACTOR

Objectives

By the end of this lesson, participants will be able to:

1. Examine their attitudes about the roles of males and females regarding contraception and safer sex.

2. Initiate a dialogue between males and females regarding responsibility for contraception and safer sex.

3. Develop a "Code of Ethics for Males" and a "Code of Ethics for Females" regarding contraception and safer sex.

Rationale

Almost 80% of males worldwide report ever having used a male condom, the only male barrier providing protection from sexually transmitted infections and pregnancy during intercourse. Males also report having used methods such as oral contraceptives, intrauterine devices and withdrawal with their partners to prevent pregnancy. Research indicates that a greater percentage of males make the decision to use a contraceptive method *with* a partner rather than either partner making the decision alone.[1] The male condom and other contraceptive options often require male support for proper application and use. Therefore, communicating about contraceptives can be useful for males and females alike. In this lesson, participants will explore attitudes males and females may have regarding contraception and safer sex. They will develop a "Code of Ethics for Males" and a "Code of Ethics for Females" regarding the responsibility for contraception and safer sex.

Materials

- Flip chart paper or board, markers
- Flip chart paper and markers for each group
- Index cards (yellow and green)
- **Handout: What's Your Opinion?** (If time is limited, have participants take this opinion survey in advance of the lesson, so you have time to tabulate the results.)

[1] Heinemann, K., Saad, F., Wiesemes, M., White, S., & Heinemann, L. (2005). Attitudes toward male fertility control: results of a multinational survey on four continents. *Human Reproduction, 20(2)*, 549-556.

Procedure

1. Note that people have many different opinions about sexual behavior, and about who is responsible for contraception. To assess the attitudes of people in this group, participants will have an opportunity to complete an opinion survey.

2. Distribute the **Handout: What's Your Opinion?** Tell the participants that they *will not* sign their names, but they *will* circle whether they identify as **"Female"** or **"Male"** so the surveys can remain anonymous. Then, the anonymous surveys will be tabulated to compare attitudes. Note that after the survey they will have an opportunity to explore the issues raised more fully. Give participants time to complete it.

3. Collect and ask someone to tabulate the surveys, separating male and female scores. (To obtain the "female score" on a question, add the answers to that question from all the "Female" surveys, then divide by the number of females. Use the same procedure using the "Male" surveys to obtain the "male score.")

4. Put the results in a table on the board/flip chart:

QUESTION #	FEMALE SCORE	MALE SCORE
1.		
2.		
3. *etc.*		

Discussion Questions:

a. Do the results give you any insight into the reasons why people who do not want to become pregnant don't use contraception? Explain.

b. What attitudes would need to change in order for people to use contraceptives correctly and consistently?

5. Tell participants they are going to use a favorite group strategy called a "fishbowl." Participants will form two circles, an inner circle and an outer circle. The inner circle will read and answer questions written on index cards, while the outer circle listens without comment. Participants have a right to pass or not provide a response. After all the recorded questions are answered, the inner circle and outer circle will switch places and repeat.

6. Explain that participants will write questions to use for the "fishbowl." The questions can be about the results of the survey — or anything else related to contraception. Distribute one yellow and one green index card to each participant. Note that questions for the males to answer will be recorded on the yellow index cards and questions for the females to answer on the green index cards. If they do not have any questions, they should write "No question" on both index cards. Tell participants that they should **NOT** write their names on the index cards.

7. After a few minutes, collect the cards from the participants. Separate the index cards by color and create a pile of index cards of the same color.

8. Direct the males to form a circle and the females to form an outer circle around the males.

9. Distribute the anonymous questions written on the yellow index cards to the male participants. Ask a participant within the inner circle to begin by reading one question aloud and encourage the inner circle participants to provide responses. Remind the participants in the outer circle to listen without comment to the responses. After the question is satisfactorily answered by the inner circle, continue with a new question. When all of the anonymous questions for the males have received responses, have males switch places with the females. Distribute the anonymous questions written on the green index cards to the female participants. Have the females repeat the process.

10. After the females finish responding to the questions, ask the group to make one large circle. Initiate a large group discussion between the males and females.

Note:
This is often a powerful experience and you may want to spend all remaining time facilitating the dialogue. However, at some point you need to get to the following activity, which is worth a full session if you have the time.

Discussion Questions:

a. How did it feel to provide responses openly? How did it feel to listen quietly to the responses?

b. What similarities and differences did you notice between the responses expressed by the males and females?

c. What, if anything, did you learn as a result of the activity? Explain.

d. Why was this activity important with regards to contraception and safer sex?

e. What is one thing from this activity that could be beneficial for others to know?

11. Note that previous research indicates about 70% of men *and* women believe that men need to play a greater role in making contraceptive choices.[2] Divide the participants into coed groups of five or six.

12. Give groups flip chart paper and markers. Ask half of the group to develop a "Code of Ethics for Males," and half a "Code of Ethics for Females," or guidelines for taking responsibility for avoiding unplanned pregnancies.

13. After about 15 minutes, ask the groups to report on their progress, noting the guidelines that they have reached.

Discussion Questions:

a. Do you think males or females have more power when making a decision about an unplanned pregnancy? Why might this be? *(Note that legally the woman has the final decision regarding whether to have an abortion or carry the pregnancy to term.)*

b. What feelings might a young man experience when a partner tells him she's pregnant?

c. What rights does a teen father have? *(They have the right to share equally in the child's physical custody and/or decision-making responsibilities.)*

Note:
For more information, visit U.S. Department of Health and Human Services Administration for Children & Families' Office of Child Support Enforcement http://www.acf.hhs.gov/programs/cse/

d. How can teen fathers be responsible when their paternity has been legally established? *(They can provide financial, physical and emotional support for the child, show up to scheduled court appointments and report any changes of address or employment.)*

Note:
For more information, visit your local office of child support.

e. What options do males have to prevent the possibility of an unplanned pregnancy? *(Abstain from sexual intercourse, use condoms, and support a partner's use of a contraceptive.)*

f. How would the codes be similar/different if the two partners were of the same gender?

[2] Kaiser Family Foundation (1997). *Another gender gap? Men's role in preventing pregnancy*. Accessed at http://www.kff.org/womenshealth/1252-index.cfm

Handout

What's Your Opinion?

Circle your gender: **Female** **Male**

Directions: Your answers are anonymous. Do **NOT** put your name on the paper. Circle the number that best represents your opinion.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Good sexuality education can help people grow up sexually happy and healthy.	1	2	3	4
2. Women should have the same sexual freedoms as men.	1	2	3	4
3. Men in a heterosexual relationship should make the first move.	1	2	3	4
4. Sexual faithfulness is part of a successful relationship.	1	2	3	4
5. A person can trust a partner to be honest about past relationships.	1	2	3	4
6. Women will always have primary responsibility for contraception and safer sex.	1	2	3	4
7. People should have sexual intercourse only if they are in love.	1	2	3	4
8. Sexuality education should stress the benefits of abstinence for teens.	1	2	3	4
9. If a teen woman gets pregnant, it's mostly her fault.	1	2	3	4
10. Most teens who become pregnant want to, consciously or unconsciously.	1	2	3	4
11. It's best if people younger than 17 do not have intercourse.	1	2	3	4
12. Having a baby makes a person feel important.	1	2	3	4
13. Comprehensive sexuality education can reduce the numbers of unplanned teen pregnancies.	1	2	3	4
14. If abortion were illegal, people would be more careful about using a reliable method of contraception.	1	2	3	4
15. I know the values I would teach my own children about sexuality.	1	2	3	4

HOW COULD THAT BE?
A Lesson about Identity, Behavior, Perception and Risk*

Objectives

By the end of this lesson, participants will be able to:

1. Explain the disparities between rates of unplanned pregnancy of lesbian, gay and bisexual youth, and heterosexual youth.

2. Describe the difference between identity and/or group connections and behavior, and ways that this distinction is important when it comes to sexual health.

3. Identify factors that may put lesbian, gay and bisexual youth at higher risk for unplanned pregnancy, and thus also sexually transmitted infections (STIs), than heterosexual youth.

4. Describe how people of all orientations can reduce their risk for unplanned pregnancy and STIs.

Rationale

Despite "conventional wisdom" that might indicate otherwise, lesbian, gay and bisexual (LGB) youth are at even greater risk for unplanned pregnancy than their heterosexual peers. And since unprotected sexual behaviors that may lead to unplanned pregnancy also put people at risk for STIs, LGB youth also face increased STI risks. This lesson provides an opportunity for participants to learn about this unexpected and complex lens through which to explore unplanned pregnancy and the risk for STIs. This lesson also provides participants with an opportunity to assess their own risk and provides information to encourage behavior change to increase intentional and protective safer sex choices when appropriate.

> **Note:**
> When teaching about risk factors for any group — teens, women, people of color; lesbian, gay, and bisexual people; transgender people, etc. — it is useful to share some information about resilience as well as risks. See, for example, procedure steps 6 and 7.

*Parts of this lesson were adapted from Taverner, B., Milstein, S., & Montfort, S. (2012). *Teaching safer sex, 3rd ed.* Morristown, NJ: The Center for Sex Education. This lesson was developed by Luca Maurer and Maureen Kelly. Luca Maurer, MS, is the program director of the Center for LGBT Education, Outreach & Services at Ithaca College; Maureen Kelly is the vice president for programming and communications at Planned Parenthood of the Southern Finger Lakes.

It is important to recognize that LGB adolescents may have different-sex *and* same-sex sexual partners. *All* safer sex lessons need to recognize the important distinction between sexual orientation and sexual behavior, and include LGB people in sexual health messages while not assuming their orientation predicts a specific set of behaviors. When participants leave the class after this lesson, they will be informed but also inspired to know that some simple changes — such as broadening safer sex messages to a behavior-based discussion rather than an identity-based discussion — can make a world of difference.

Materials

- Flip chart paper or board, and markers
- Copies of birth control facts, STI prevention information and general safer sex materials (one source for ordering these materials is ETR Associates, www.etr.org)
- **Educator Resource: Read Arounds** (prepare ahead of time by copying the resource and cutting each numbered sentence into individual strips)

Procedure

1. Introduce the topic by explaining that the group will be exploring safer sex, pregnancy prevention and sexually transmitted infection (STI) information through an interactive activity and group discussion.

2. Introduce or review the basic concepts of sexual orientation and sexual behavior:

   a. A ***heterosexual*** person is attracted to people of a different sex.

   b. A ***gay*** or ***lesbian*** person is attracted to people of the same sex.

   c. A ***bisexual*** person is attracted to people of different and the same sex.

   d. ***Sexual orientation*** is an identity label that describes WHOM a person is attracted to.

   e. ***Sexual behavior*** is WHAT a person does.

3. Write on the board/flip chart the following:

   HETEROSEXUAL PERSON **GAY OR LESBIAN PERSON**

   Ask the questions: ***Who do you think is at highest risk of unplanned pregnancy — a heterosexual person, or a gay or lesbian person? Why?*** (Note that most participants will identify heterosexual people as at greater risk for unplanned pregnancy.)

4. Explain that you will be examining what the research says about this shortly, but that first you need to review a few key points about ***sexual orientation*** and ***sexual behavior:***

    a. Sexual orientation and sexual behavior are NOT the same. Sexual orientation is an identity label that describes WHOM you are attracted to; a sexual behavior is WHAT you do.

    b. Although some people might hold inaccurate assumptions about in which specific sexual behaviors lesbian, gay and bisexual people might participate, the reality is that sex among lesbian, gay and bisexual people does not follow a prescribed set of behaviors. For example, anal sex is often incorrectly called "gay sex." Heterosexuals and bisexuals can and do have anal sex, too. People of all orientations participate in a wide variety of sexual behaviors regardless of sexual orientation.

    c. Having a lesbian, gay or bisexual identity is not a "lifestyle," it is an ***identity*** that is as varied and diverse as the people in that identity group.

5. Distribute a different statement to each participant from the **Educator Resource: Read Arounds.** Explain that each strip of paper has a fact about unplanned pregnancy and STI transmission. Have each participant read her or his strip aloud to the group. Ask participants to save questions or discussion for after all facts have been read.

    There are 20 facts on the educator resource. If the group has more than 20 people, some will not read a fact aloud; if the group has fewer than 20 people, some may read two or more facts aloud.

    Discussion Questions:

    a. Did any of these facts surprise you? Explain.

    b. Thinking back to the beginning of this lesson, why do you think we stressed the important difference between sexual orientation (WHOM you are attracted to) and sexual behaviors (WHAT you do)?

    c. What are some of the things you learned about during the activity that might be responsible for unexpectedly high unplanned pregnancy rates for lesbian, gay and bisexual youth?

    d. Despite these facts, most teen pregnancy programs are targeted at heterosexual participants only. What do you think educators should do to include lesbian, gay and bisexual people in pregnancy prevention and STI prevention lessons?

    e. How would you rate your school on inclusiveness and safety for lesbian, gay and bisexual people? Why do you think it matters to have a safe and inclusive school for lesbian, gay and bisexual youth? What kinds of things can you do to contribute to an inclusive and safe school environment?

f. What do you think are the most important messages to share with young people — of all sexual orientations — about preventing pregnancy and STIs?

g. How can people of all orientations reduce their risk for unplanned pregnancy and sexually transmitted infections?

6. Write on the board/flip chart:
   STRENGTHS **RESILIENCE**

   Ask, "What do these words mean?" and allow for a few volunteers to respond.

7. Explain that although the focus of this lesson has been about how stress and stigma might negatively affect some LGB youth and their safer sex decisions and behaviors, LGB youth may also develop unique **STRENGTHS.** Challenges (such as living in a mostly heterosexual world) can give people opportunities to practice their coping, creativity and community-building skills. LGB people may experience stressful situations, sometimes throughout their lives, yet most LGB people survive, in fact thrive, and are excellent examples of resiliency**. RESILIENCE** is the ability to overcome or be strengthened by experiences of challenge or adversity. As time permits, visit one of the following websites, or assign participants homework to visit:
   - www.familydiv.org/lovemakesafamily.php
   - www.glbthistorymonth.com
   - www.itgetsbetter.org

   Assign the following questions for homework, or ask in-class after the websites have been visited.

   1. In what ways are people who are LGB similar to people who are heterosexual? In what ways are people who are LGB different from people who are heterosexual?

   2. How do people on these websites demonstrate their resilience?

   3. What other questions about people who are LGB do you have?

   4. What is one thing you can do to help your friends and classmates — of any sexual orientation — find their strengths and build resilience?

Educator Resource

Read Arounds

Directions: Prepare ahead of time by copying this resource and cutting out each individual fact. Distribute one fact to each participant. Explain that each paper has a fact about unplanned pregnancy and STI transmission. Have each participant read her or his fact aloud to the group. Ask participants to save questions or discussion for after all facts have been read.

1. Lesbian, gay and bisexual (LGB) youth have a much higher risk of teen pregnancy — between two and seven times the rate of their heterosexual peers.

2. Some gay and lesbian teens may have sexual intercourse with different-gender partners as they explore their sexual orientation. In one study, gay male adolescents reported using condoms less often with female partners than with male sexual partners.

3. LGB youth report an earlier age at first intercourse, more sexual partners, and, somewhat surprisingly, higher pregnancy rates.

4. High rates of unplanned pregnancy among LGB youth are especially alarming in light of overall declining trends in teen pregnancy across North America in the last two decades.

5. Overall, bisexual or lesbian respondents were about as likely as heterosexual women to have had intercourse, but they had significantly higher rates of pregnancy.

6. In one study of teen parents in 9th and 12th grade, one in three teen fathers reported same- or mixed-sex sexual partners in the past year, as did one in eight teen mothers.

7. Another possible contributor to higher rates of teen pregnancy among LGB youth is having less access to supportive resources, such as feeling connected to family or at school. Disconnected youth may reach for caring connections through parenthood.

8. LGB young adults who experienced rejection by their families were nearly three and a half times more likely to have engaged in unprotected sexual intercourse.

9. Ongoing stigma and harassment may increase distress among LGB youth and cause risky coping behaviors that can lead to pregnancy.

10. LGB teens report similar frequency of intercourse as heterosexual teens.

11. Studies show LGB youth have lower contraceptive use than their heterosexual peers.

12. In one study, LGB youth were more likely to report HIV risk behaviors than heterosexual teens their same age.

13. People may engage in a number of strategies to either avoid or to cope with stigma. LGB youth may avoid disclosure, while simultaneously engaging in heterosexual dating and sexual behaviors as a form of "camouflage," to avoid being identified as lesbian, gay or bisexual, and being targeted for stigma.

14. Lesbian and bisexual youth who experience harassment and discrimination may choose pregnancy involvement as a way to deny their orientation.

15. Increased substance use and abuse as a way of coping with stigma can also lead to unplanned, and often unprotected, sexual behavior in LGB adolescents.

16. If sexuality education programs ignore the sexual health concerns of LGB youth, these teens may conclude that the information presented is irrelevant to their lives, and "tune out" important information about contraception and safer sex practices.

17. Risk for teen pregnancy remains higher for LGB teens compared to heterosexual peers. When teen pregnancy rates decreased overall, they actually increased for LGB teens. This suggests pregnancy prevention efforts aimed primarily at heterosexual teens have not been effective for sexual minority youth, whose reasons for pregnancy involvement may differ.

18. Among those who were sexually active, LGB youth reported more sexual partners, more alcohol use before last sex, and more pregnancy than heterosexual youth. However, LGB youth in schools with gay-sensitive instruction reported less of each of these than did LGB youth in other schools.

19. One study found that LGB youth in schools that had minimal or no gay-sensitive sexuality education had higher rates of teen pregnancy involvement than heterosexual teens and other LGB teens in schools with moderate to high levels of gay-sensitive education.

20. Reducing stigma for lesbian, gay, bisexual and questioning youth, and preventing the harassment and sexual violence they may be targeted for, could be important strategies for preventing unwanted teen pregnancies.

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PUTTING CONTRACEPTION INTO ROMANCE

Objectives

By the end of this lesson, participants will be able to:

1. Realize that popular images of romantic encounters rarely include discussion of, or use of, condoms and other contraception.

2. Incorporate discussion of contraception and condoms into a variety of romantic scenes.

Rationale

Although television, movies, books and magazines feature romance, rarely do these media feature a discussion about contraception and "safer sex." Popular ideas of romance provide few examples of protecting oneself from possible negative consequences of sexual intercourse.[1] This lesson helps participants imagine how couples can talk about contraception and include it as part of the language of romance.

Materials

- A variety of magazine ads picturing a male and female together
- Small blank "word balloon" shapes
- Tape
- **Handout: Putting Contraception into Romance**

Procedure

1. Ask participants to think of a romantic scene they've seen on television, in a movie, or in a video.

   Discussion Questions:

   a. Did the romantic scene include any discussion about the possibility of a pregnancy or a sexually transmitted infection?

   b. Do you recall any movie or television show where a couple makes a decision about using contraception? If so, what happened?

[1] Kunkel, D., Eyal, K., Finnerty, K., Biely, E., & Donnerstein, E. (2005). *Sex on TV 4.* Menlo Park, CA: Henry J. Kaiser Family Foundation.

c. What effect do you think the general absence of discussion about contraception in the media has on people?

2. Explain that this lesson will give participants an opportunity to think about how a couple could discuss contraception. Let participants divide into male/female pairs.

3. Give each pair the small blank "word balloon" shapes as well as a magazine ad showing a couple that is romantically involved. (Participants may have been assigned to bring ads from home.)

4. Tell the participants to create a brief conversation about using contraception featuring the couple in the magazine ad. They will write the words of each partner in the "word balloons" and adhere them to the ad.

5. After a few minutes, have each pair post their ad on the wall. Ask for volunteers to read the dialogue — with expression! (You may want to end the lesson here with discussion of the activity.)

6. Distribute the **Handout: Putting Contraception into Romance.** Review the instructions and stress that the conversations should be as realistic as possible.

   Note:
   Participants could complete this handout in pairs, in small groups, or as a take-home assignment, depending on the time available.

7. When handouts are completed, have participants share the dialogues they wrote with the rest of the group.

   Discussion Questions:

   a. How easy or difficult was it to develop the couple's conversation? Why?

   b. Overall, who seemed to begin the conversation? Why might this be?

   c. How likely do think it is that the couples will use contraception? Explain.

   d. How well did the couples communicate about contraception? What did they say that would facilitate contraceptive use?

e. Are there other ways a person might become more comfortable communicating about contraception and condoms? If so, what?

f. What strategies from this activity do you think you would want to remember to increase communication about contraception and safer sex?

Handout

Putting Contraception into Romance

Directions: Describe a romantic scene in which a couple communicates about how to protect themselves from pregnancy and/or sexually transmitted infections. Your description should include the following:

The Setting: Describe the place where the couple is having their conversation. Try to make it as vivid as possible so the reader can visualize the setting.

_____

_____

_____

Characters: Describe, briefly, each of the partners. Include their names, ages, personal characteristics and interests.

Partner A: _____

_____

Partner B: _____

_____

The Relationship: Tell how the couple met; how long they've known each other; and the present status of their relationship.

_____

_____

_____

Feelings about Intercourse: Tell how each partner feels about having intercourse at this time.

Partner A: _____

_____

_____

Partner B: _____

_____

_____

Feelings about Safer Sex: Tell how each partner feels about the possibility of getting and using condoms and/or contraception.

Partner A: _____

Partner B: _____

The Dialogue: Write a conversation between the couple in which they discuss the possibility of using contraception and/or condoms. There should be at least three quotations from each partner.

Partner A: _____

Partner B: _____

Partner A: _____

Partner B: _____

Partner A: _____

Partner B: _____

CREATING POSITIVE IMAGES
Advertising for Contraception and Safer Sex

Objectives

By the end of this lesson, participants will be able to:

1. Explain the advantages of contraceptive use by creating advertisements for contraceptive devices and safer sex.
2. Describe how advertising might influence the contraceptive and safer sex behavior of young people.
3. Evaluate when it is important to use a condom in addition to another method.
4. Describe the disadvantages that must be considered when choosing a particular method.

Rationale

Lower rates of teen pregnancy occur among countries that widely advertise birth control methods. Media is cited as a frequent source by young people for information about birth control. Experts suggest that media advertisements about contraceptives, safer sex and emergency contraception could decrease the rates of teenage pregnancy and reduce the number of abortions.[1] But there remains resistance among media sources to provide contraceptive and safer sex advertisements. In this lesson, participants will review information about contraceptives and safer sex in order to create much needed advertisements that are both appealing and accurate, and encourage condom use.

Materials

- Flip chart paper or board, markers
- Popular magazines
- Crayons, markers, scissors, paste, tape, paper
- Cards with one of each of the following words/phrases:

Abstinence	**Condom**	**The Pill**
Female condom	**Implant**	**Diaphragm**
Depo-Provera®	**IUC**	**Spermicide (creams, film, foams, gels)**

- **Contraceptive Options** chart (see the Resources Section of this manual)

[1] Strasburger, V. C. (2010). Sexuality, contraception, and the media. *Pediatrics, 126(3),* 576-582.

- Pamphlets describing contraceptive methods
- **Optional:** Sample ads demonstrating different advertising techniques.

Procedure

1. Begin the lesson by noting that in countries where contraceptives and safer sex are advertised openly in magazines and other media, there are lower rates of teen pregnancy. The advertisements help legitimize and normalize protective contraceptive/safer sex use among young people who have sexual intercourse. This lesson gives participants a chance to imagine the kinds of ads that might be used if public campaigns for contraceptives and safer sex became popular in the United States.

2. Explain that participants will work in small groups to create a magazine ad for a particular contraceptive method. Before dividing into groups, have participants brainstorm some of the methods that advertisers use to sell their products. List these techniques on the board/flip chart. (**Optional:** show sample ads.) The list should include:

Repetition	Association with celebrities
Snob appeal	Appeal to masculinity and femininity
Plain-folks appeal	Romantic appeal
Price appeal	Trendy (everybody is doing it)

3. Divide participants into groups of three to five and have each group select a card labeled with a contraceptive method. Give each group a copy of the **Contraceptive Options** chart plus pamphlets. Each group is to create an ad for the method listed on the card. The ad should be as attractive and convincing as possible, but it **MUST BE ACCURATE**. It cannot make any false claims for the method. The group should promote using condoms in addition to their birth control method (except for the "abstinence" and "condom" groups). In addition, somewhere on the ad they must describe the possible disadvantages of the method. A disadvantage for "spermicide," for example, might be "CAUTION: Frequent daily use of spermicides containing nonoxynol-9 may irritate vaginal tissue, which can contribute to an increased risk of HIV and other sexually transmitted infections." A successful ad will make people feel positive about the possibility of using a particular method, providing that the disadvantages are not unacceptable to them.

4. Let participants create ads. Leave 15 minutes at the end of the session for participants to display and discuss the ads and strategize how these ads could be used as part of an ongoing campaign to encourage contraception and safer sex practices. (The ads will have ongoing effectiveness if they remain posted on a bulletin board.)

   Discussion Questions:

   a. Was it easy or difficult to create positive images about any of these methods? Why?

b. Do any of the ads contain false claims for the product? How might false claims impact use of a contraceptive?

c. Do you think any of the ads have more appeal for some groups (age, sex, ethnicity) than for others? Explain.

d. How might the description of "disadvantages" impact people from using the contraceptive? Explain.

e. There has been considerable debate about advertising contraceptives and safer sex. What are the pros and cons of having ads for condoms and other contraceptives in the media?

f. How likely do you think it is that people will use condoms to prevent sexually transmitted infections in conjunction with another contraceptive used to prevent unwanted pregnancy? Explain.

g. What are some ways advertising companies could promote the use of condoms?

h. What are some ways, in addition to advertisements, that a person could learn more about contraceptives?

GETTING IT
Consumer Skills for Contraception

Objectives

By the end of this lesson, participants will be able to:

1. Explain why being able to obtain contraceptives is a critical part of becoming an effective user of contraception.

2. Report important information about various methods of contraception obtainable at a pharmacy, family planning clinic, and physician's office.

Rationale

A difficult step in becoming an effective user of contraception can be "going public," i.e., risking being seen obtaining a contraceptive and thus risking being identified as a person who is having intercourse. This lesson gives participants the responsibility for obtaining information about contraception and, in doing so, demystifies looking for contraceptives in a pharmacy or calling a family planning clinic or physician's office. This experience should help people feel more comfortable and competent should they need to obtain contraceptives for themselves.

Materials

- Flip chart paper or board, markers
- **Handout: Consumer Skills for Contraception**

Note:
This is a two-part lesson. Participants will need time to research information about local pharmacies, family planning centers and private physicians.

Procedure

1. List the following on the board/flip chart and ask participants to rank them on a piece of paper from **Most Difficult** to do to **Least Difficult** to do:

   BUY CONTRACEPTIVES AT PHARMACY
   GO TO FAMILY PLANNING CENTER
   TALK TO PARTNER ABOUT USING CONTRACEPTION

GO TO PRIVATE PHYSICIAN
ACKNOWLEDGE TO ONESELF THAT INTERCOURSE MIGHT HAPPEN AND CONTRACEPTION IS NEEDED

2. Ask several participants to share their ranked list.

   Discussion Questions:

   a. Which was the most difficult? Why? The least difficult? Why?

   b. How might acknowledging the possibility of having intercourse impact using contraception?

   c. How might an individual obtain contraceptives?

   d. What are some potential challenges to obtaining contraceptives?

   e. How might someone overcome these challenges?

3. Explain that in order to obtain contraceptives, one needs to know where to find them. Distribute the **Handout: Consumer Skills for Contraception**. Review the instructions on the sheet. Note that participants will work in small groups to learn about important details associated with obtaining contraceptives.

4. Divide participants into groups of three and let them plan strategies for obtaining the information. Ideally, the group will work together to gather the data so that everyone can learn how to utilize each facility or service. Give them a week or more to complete this assignment.

   Note:
   If you have a large number of participants, you may want to limit the number who will call a particular doctor's office. Perhaps you will want to request cooperation from some doctors in your community prior to this assignment.

5. A week or two later, or once participants have completed the **Handout: Consumer Skills for Contraception,** have groups share their findings.

   Discussion Questions:

   a. What were some of the feelings you had as you completed this assignment?

   b. How did people respond to your requests for information?

c. Were any of the locations particularly useful for youth? Why?

d. Did you have any problems that would discourage a person from getting contraceptives? If so, what were they? What are some ways individuals could overcome these problems?

e. What did you learn from doing this assignment?

Handout

Consumer Skills for Contraception

Directions: Before people can become effective users of contraception, they must obtain contraceptives at a pharmacy, family planning center, or physician's office. As you research the answers to the following questions, you will develop some of the consumer skills required to obtain contraceptives.

1. PHARMACY

Name of pharmacy visited:_____

Location:_____

List five varieties of condoms available, along with some characteristics and the price for each.

Brand Name	Characteristics	Price

List one brand name for each of the following, along with the number of items in a package or number of ounces. Include the price for each.

Brand Name	# in Package or # of Ounces	Price
Female condom:		
Contraceptive film, jelly, cream or foam:		
Personal lubricant:		

Does this pharmacy fill prescriptions for emergency contraception?_____

2. PLANNED PARENTHOOD/OTHER FAMILY PLANNING CENTER

Name of center nearest your home: _____

Address: _____

Phone number: _____

Website: _____

Directions to the center by car: _____

_____

_____

Directions to the center by public transportation: _____

_____

_____

Days and hours the center is open: _____

Average length of time of first visit: _____

Is a visit confidential? _____

Cost of first visit to the center to obtain contraceptives: _____

Cost at the center for:

Birth control pills (one-month supply)	$
12 condoms	$
A female condom	$
Depo-Provera injection	$
Birth control patch (one-month supply)	$
Birth control ring (one-month supply)	$
Birth control implant	$
IUC	$

Is emergency contraception available at this center? _____

3. PRIVATE PHYSICIAN

Name of physician contacted:_____

Address:_____

Phone number:_____

Website: _____

Directions to the office by car:_____

_____

_____

Directions to the office by public transportation:_____

_____

_____

Days and hours when appointments are available:_____

Is a visit confidential?_____

Cost of initial visit to obtain contraceptives:_____

Cost at the physician's office for:

Birth control pills (one-month supply)	$
12 condoms	$
Female condom	$
Depo-Provera® injection	$
Birth control patch (one-month supply)	$
Birth control ring (one-month supply)	$
Birth control implant	$
IUC	$

Is emergency contraception available at this physician's office?_____

CONTRACEPTION THROUGH THE LIFESPAN

Objectives

By the end of this lesson, participants will be able to:

1. Understand that contraceptive decision-making is an ongoing process that requires modification as life circumstances change.

2. Plan a contraceptive time line by applying their knowledge of different methods to changing life situations.

Rationale

Contraception may be neglected or discontinued when life circumstances change. For example, going away to college or breaking up with one's steady partner are stressful life situations that can increase vulnerability for unplanned pregnancy or sexually transmitted infections (STIs). This lesson involves participants in long-range contraceptive planning to establish the connection between life change and effective contraception. It also serves to reinforce knowledge of various options as participants take part in creative planning for contraception.

> **Note:**
> Before introducing this lesson, provide background information about the various methods of contraception.

Materials

- Flip chart paper or board, markers
- **Handout: Lifeline of a Successful Contraceptor**
- **Contraceptive Options** chart (see the Resources Section of this manual)
- **Optional:** Pamphlets on the different methods of contraception

Procedure

1. Start by explaining that there are times during different life stages when a person is more likely to be at risk for unplanned pregnancy or sexually transmitted infections (STIs). List the following situations on the board/flip chart and discuss the possible links between the circumstances and contraceptive use:

   THE START OF A NEW RELATIONSHIP
   THE BREAKUP OF A RELATIONSHIP

A MOVE TO A NEW ENVIRONMENT (e.g., high school, college)
AFTER CHILDBIRTH
ILLNESS
A TIME OF STRESS (e.g., unemployment, death in family)
EARLY STAGES OF MENOPAUSE

2. Explain that by age 55, most women have completed menopause and are no longer fertile. Barring illness, male sperm production continues throughout the life cycle. Risk of infection with an STI must always be considered.

3. Divide the group into smaller groups, with no more than four participants in each. Distribute the **Handout: Lifeline of a Successful Contraceptor** and review the instructions. Each group should get a copy of the **Contraceptive Options** chart and pamphlets as reference material. Allow time for participants to complete the assignment and then have each small group present their lifeline to the entire group.

   Discussion Questions:

   a. How many years was the person in your lifeline concerned about contraception?

   b. Which method of contraception seemed most practical for first intercourse? Explain.

   c. How many different methods were used during this person's lifetime? Why?

   d. Will the responsibility for contraception be shared with the person's partner? If so, how?

   e. What do you think are some examples of good contraceptive habits?

Handout

Lifeline of a Successful Contraceptor

Directions: Your group is to make decisions about the contraceptive practices of an imaginary person, who successfully controls his or her fertility and reproductive health throughout life.

1. Decide whether this person is male or female. **Male_____** **Female_____**
2. Write **FIRST INTERCOURSE** at the age on the lifeline below when you decide it will occur.
3. Decide whether there will be one sexual partner throughout life or more than one. To indicate this, write **NEW RELATIONSHIP** on the line each time one occurs.
4. Decide if this person will have children. If so, write **BIRTH OCCURS** at point(s) on the line.
5. Identify at least two stressful times in this person's life when he or she should be extra careful about contraception. State what these are and place on line.
6. Using the **Contraceptive Options** chart, indicate the types of contraception that will be used in this person's life cycle. Contraception is used when pregnancy is not desired. (Condoms will also protect against sexually transmitted infections.) The contraceptive methods can change as life circumstances change. Draw arrows to show the amount of time using each method.

BIRTH 5 10 15 20 25 30 35

40 45 50 55 60 65 75+

SECTION 2
Methods, Methods, Methods

This section includes lessons that zone in on particular types of contraceptives: abstinence, long acting reversible contraceptives (LARCs), condoms, insertive methods and emergency contraception. Participants learn key information about these methods, and how to develop skills for successful use.

So What's an "Abstinence" Anyway?

Hey, Mom? Hey, Dad? (Hey ... Gram?)
Can We Talk about Abstinence?

Introducing LARCs

On a LARC

Deciding on a LARC?

What a Difference!
Comparing Hormonal Methods of Contraception

The Condom Lineup

Condom Talk:
Practice Makes Perfect

Choosing Condoms, Choosing Lubes

"Down There":
How to Use an Insertive Method

Emergency Contraception:
For Emergency Use Only!

SO WHAT'S AN "ABSTINENCE" ANYWAY?*

Objectives

By the end of this lesson, participants will be able to:

1. Define abstinence.
2. Identify what makes abstinence work, and identify the factors that can cause abstinence "user failures."
3. Examine the important role of active decision-making when it comes to choices about abstinence.

Rationale

Throughout the United States, abstinence is being promoted as the only 100% effective method for avoiding an unwanted pregnancy and sexually transmitted infections, including HIV. In actual use, however, abstinence often fails, i.e., people who intended to be abstinent have sexual intercourse — often without using either a condom or another contraceptive. This lesson helps participants think about what it takes to make abstinence work — and what they would need to do if they were going to choose abstinence as the way to protect themselves from unwanted consequences of sexual intercourse.

Materials

- Flip chart paper or board, markers
- A clear, hard plastic ball or heart that can be opened. These are often used for ornaments and are commonly found in craft stores.
- Slips of bright colored paper
- **Handout: So What's an "Abstinence" Anyway?**
- **Contraceptive Options** chart (see the Resources Section of this manual)

* Basche, F., & Terrell, A. (1995). So what's an abstinence, anyway? *Family Life Educator, 13(2).* Reprinted with permission from ETR Associates, Scotts Valley, CA. All rights reserved.

Procedure

1. Introduce the term "abstinence" by asking participants, "What is the best method to use to prevent pregnancy or sexually transmitted infections (STIs)?" Someone will likely answer "abstinence." Ask how effective abstinence is, and see if anyone says 100%. If so, ask why.

   Discussion Questions:

   a. What different kinds of things do people commonly abstain from? *(Responses may include: alcohol, candy, other foods, sex, smoking, voting.)*

   b. Why might a person decide to abstain from a behavior? *(Responses may include: to avoid negative consequences, to follow their personal or religious values, to make a point, to protect their health, or because they are not interested in the activity.)*

2. Explain that we are going to explore the meaning of ***sexual*** abstinence. Distribute the **Handout: So What's an "Abstinence" Anyway?** and read the directions to the first section aloud. Ask participants to complete the top section of the handout individually.

3. Next ask participants to pair up with another person and complete the second section of the handout, circling ***only*** the behaviors they ***BOTH*** can agree on. When each pair is finished, they should join another pair and complete the third section, circling ***only*** the behaviors ***all four*** can agree on. (If necessary, read the instructions aloud each time.)

4. Now bring the entire group together and ask several participants to give their definition(s) of sexual abstinence.

   Discussion Questions:

   a. What, if any, major disagreements did you have?

   b. Which behaviors have a risk of pregnancy? Sexually transmitted infections? Other risks?

   c. What did you learn from doing this activity?

5. Note that people may have very different definitions of what sexual abstinence means. For the purpose of this next activity, sexual abstinence means a conscious decision to not have intercourse: oral, anal or vaginal.

6. Now ask the group about the effectiveness of abstinence in preventing ***pregnancy.*** Distribute the **Contraceptive Options** chart and explain contraceptive effectiveness rates. Discuss "typical" and "perfect" user rates. Tell participants abstinence ***can*** be 100% effective ***if*** used perfectly every time, but what if it's ***not*** used perfectly every single time? Explain that all contraceptive methods have failure rates, mostly based on human error. People sometimes forget to take pills, or are late changing a patch, don't use a condom every time, or use it incorrectly causing it to leak or break. Promises or pledges of abstinence can also "break" if not followed consistently.

7. Tell participants that to learn how to use any contraceptive, they must know what it is and how it works. Many people have seen a condom or a pack of pills. Ask participants (rhetorically):
   - Has anyone ever seen an "abstinence"?
   - What does it look like?
   - How does it work?

8. Show the empty abstinence ball or heart. Say, "I happen to have an abstinence here" or, "It's hard to talk about something that you can't see, so I brought one." (If your abstinence is heart-shaped, mention to the group that abstinence doesn't have to mean lack of love, or of intimacy, romance, sensuality or eroticism.)

   Say, "As you can see, this abstinence is empty. An empty abstinence is like any empty promise — it doesn't work very well."

9. Ask participants to think of things that make abstinence work. Distribute a small strip of colored paper to each participant. Ask each to write one idea on the paper and put it into the "abstinence" as it is passed around. Ask for volunteers to say what they wrote as you write the items on the board/flip chart. Talk briefly about each item by asking how each contributes to the effectiveness of abstinence, and what it takes for a person to develop that attribute.

   Concepts may include:

• Assertiveness • Being able to identify sexual situations • Being able to talk to each other • Believing that pregnancy and/or infection can happen to you • Commitment • Having other alternatives • Information	• Knowing what your values are • Knowing what the consequences are • Partner cooperation • Positive vision for the future • Self-control • Self-esteem • Shared values

10. Ask what makes abstinence "break" or fail to work. Remove one item, such as "assertiveness," from the ball. Ask what would happen if a person had ***all*** the other items in the abstinence ***except that one.*** Have several volunteers take out other items, one at a time. Discuss in the same way for a few of the other items (e.g., "What if a person couldn't identify possible sexual situations?" "What if a person wasn't able to talk with his/her partner?" etc.). Conclude by asking, "What if two partners had different definitions of what abstinence means?"

11. Ask what other factors might cause abstinence to fail. *(These could include alcohol/drug use, partner pressure, threat or force.)* Explain that deciding to use "an abstinence" is similar to deciding to use ***any*** contraceptive or safer sex method.

    Discussion Questions:

    a. What if a person doesn't feel comfortable using abstinence?

    b. What if a person's partner doesn't want to use abstinence? How could a couple work it out?

    c. What are the possible "side effects" of using abstinence?

    d. What if a person doesn't use it every single time?

    e. If a person is abstaining from intercourse, what other behaviors could they engage in?

12. Ask participants for ways a person can make ***sure*** abstinence works, if that is their contraceptive or safer sex method. As you write their suggestions on the board/flip chart, introduce the following ideas into the discussion:

    a. **Don't leave your abstinence at home, or in health class, or in church, synagogue or mosque.** Keep it on hand with you at all times. Pills won't prevent a pregnancy if they're not taken every day; condoms can't protect you from an STI if they never make it out of a wallet or purse. Abstinence won't work if you don't use it.

    b. **Take out your "abstinence" every once in a while and think about it.** Review your reasons for choosing abstinence. How well is it working? What are its strong points? Its weak points?

    c. **Decide when and under what circumstances you will stop abstaining.** When you reach a certain age? When you are in a long-term committed relationship? Married?

    d. **Think about what you will decide when abstinence is no longer the right choice for you.** You will need to choose another method to protect against an unplanned pregnancy or a sexually transmitted infection.

Handout

So What's an "Abstinence" Anyway?

1. Imagine someone has decided to be ***ABSTINENT.*** According to your own definition of "abstinence," circle the following sexual behaviors you believe a person can engage in and ***still be ABSTINENT.***

Holding hands	Deep kissing	Anal intercourse
Dry kissing	Vaginal intercourse	Showering together
Mutual masturbation	Masturbation	Sexting
Reading erotic literature	Oral intercourse	Massage
Cuddling naked	Talking sexy	Body painting

2. Find a partner and discuss the list with your partner. Circle below ***only*** the behaviors you ***both agree*** a person can engage in and ***still be ABSTINENT.***

Holding hands	Deep kissing	Anal intercourse
Dry kissing	Vaginal intercourse	Showering together
Mutual masturbation	Masturbation	Sexting
Reading erotic literature	Oral intercourse	Massage
Cuddling naked	Talking sexy	Body painting

3. With your partner, find another set of partners. Again, circle ***only*** the behaviors ***all four of you agree*** a person can engage in and ***still be ABSTINENT.***

Holding hands	Deep kissing	Anal intercourse
Dry kissing	Vaginal intercourse	Showering together
Mutual masturbation	Masturbation	Sexting
Reading erotic literature	Oral intercourse	Massage
Cuddling naked	Talking sexy	Body painting

4. Examining your final list, have your group **define** *abstinence*.

_____

_____

HEY, MOM? HEY, DAD? (HEY ... GRAM?) Can We Talk about Abstinence?*

Objectives

By the end of the lesson, participants will be able to:

1. Explore how parents, guardians or other adults feel about abstinence.
2. Compare how social norms and pressures related to abstinence and sexual decision-making may have changed over the years.
3. Identify behaviors that encourage and discourage communication, by role-playing and preparing for an interview with a trusted adult.

Rationale

This lesson is designed to help young people begin a dialogue about abstinence with their parents, guardians or other trusted adults. Communicating about abstinence acknowledges the important role that parents and other adults play in the comprehensive sex education of their children. Prior discussion and role-play in class will enhance participants' ease and skill in talking with adults about abstinence and sexual decisions.

> **Note:**
> Since participants will need time to interview a parent (or other trusted adult), this lesson requires two sessions to complete.

Materials

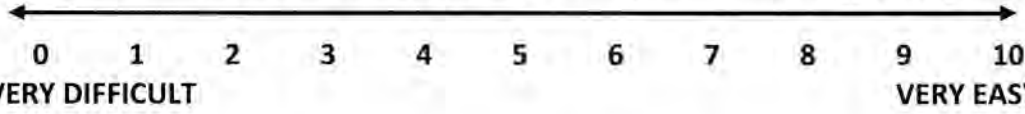
- Flip chart paper or board, markers and index cards
- **Worksheet: An Interview about Abstinence**

* Parts of this lesson were adapted from Taverner, B., & Montfort, S. (2005). *Making sense of abstinence. Lessons for comprehensive sex education.* Morristown, NJ: The Center for Sex Education.

Procedure

First Session

1. Draw a continuum on the board/flip chart from 0 (VERY DIFFICULT) to 10 (VERY EASY)



2. Distribute an index card to each participant and ask them to think about how easy or difficult it would be to talk with parents or another adult about abstinence. Have them mark their responses on the index cards. Ask for a few volunteers to share the number they wrote down and their reasons.

3. Now ask participants to brainstorm the advantages and disadvantages of a person's talking with a parent or other trusted adults about abstinence and sexual intercourse. Jot their responses on the board/flip chart.

4. Explain to participants that after this session they will interview a parent, guardian or other trusted adult about abstinence and sexual decision-making. The purpose of the interview is to learn how abstinence was discussed and handled during the adult's adolescence and to understand how those experiences influenced the adult's feelings and attitudes about the issue today.

5. Distribute the **Worksheet: An Interview about Abstinence** and ask participants to work in pairs. One will play the Adult, the other the Interviewer. Note the importance of ***listening*** to the response to each question and using that response in asking the next question. Let the "interview" continue for 10 minutes or so.

6. Ask pairs to switch roles, and repeat the interview.

   Discussion Questions:

   a. How similar or different were the two interviews your pair conducted?

   b. How might it be different actually interviewing an adult?

   c. What could you do to make this interview go smoothly?

d. What are some of the difficulties you might encounter in conducting your interview? How would you deal with those problems?

e. What other questions do you have before doing your own interview?

7. Give participants a few days to interview their parent, guardian or trusted adult and to complete the **Worksheet: An Interview about Abstinence.**

Note:
Some young people may be unable to complete this assignment with their parent(s) or guardian(s). Give them the opportunity to complete the assignment with another trusted adult such as an aunt, uncle, grandparent, coach or member of the clergy.

Second Session

1. After participants have had a few days to complete the assignment, ask them to bring their interview **Worksheets** to class.

2. Use the following ice-breaker to help participants think about their interviews. Ask participants to form a circle. Read each of the following statements aloud, and ask them to move to the center of the room if the statement applies to them. Ask participants in the center of the circle to discuss the statement briefly.

Move to the center of the room if...

- ...you completed this assignment the same night it was assigned.
- ...you waited until last night to complete the assignment.
- ...you found this assignment easy to do.
- ...you had difficulty completing this assignment.
- ...you were surprised by the responses of the person you interviewed.
- ...you found the adult you interviewed more nervous than you were.

3. Divide participants into small groups. Write the following discussion questions on the board/flip chart and ask the groups to discuss their answers.

Discussion Questions:

a. How did you feel about your interviews?

b. How common was sexual intercourse among teens when the adults you interviewed were young? Did people wait until marriage? How does this compare with today?

c. Did people learn about abstinence in school when the adult you interviewed was your age?

d. What were the adults' definitions of abstinence? How were they similar or different?

e. What advice did the adults give?

4. To conclude the lesson, ask participants to return to the larger group and ask them what they learned from their interviews, and from their discussions. Ask for ideas about other questions they might want to ask a parent, guardian or trusted adult. Ask how they would feel about talking again about sexual issues with the adult they interviewed.

Handout

An Interview about Abstinence

Directions: To find out how abstinence was discussed and how people felt about it in the past, interview your parent, guardian or other trusted adult by asking the following questions. **DO NOT** write your name or the name of the adult you are interviewing on this worksheet.

Age of person interviewed (optional) _____

1. When you were my age, was teen sex a big issue? At what age did people usually begin having intercourse?

_____

_____

_____

_____

2. Were people expected to abstain from sexual intercourse until marriage? Was this true for both men and women? What happened when people discovered someone had had intercourse?

_____

_____

_____

_____

3. Did schools teach about abstinence? Did adults talk about it? What messages did they give?

_____

_____

_____

_____

4. How do you define abstinence? What is ***not OK*** for an "abstinent" person to do? What ***is OK?***

5. Do you think it is easier or more difficult for a teen to abstain from intercourse today than it was when you were young? Why?

6. What advice would you give to a teen who is thinking about whether to abstain or to have intercourse? What advice would you give to a teen who has decided to have intercourse?

INTRODUCING LARCS*

Objectives

By the end of this lesson, participants will be able to:

1. Name the three long-acting reversible contraceptives (LARCs).
2. Identify how long each LARC provides contraceptive protection.
3. List the function of LARCs in general and for each specific LARC.

Rationale

As young people begin to have sexual intercourse, it is important for them to learn about the contraceptive options available to them and the ways they work so that they can make informed decisions about their sexual health. Long-acting reversible contraceptives (LARCs) are highly effective. They are far more effective than short-term reversible contraceptives such as the Pill, the ring, the patch and condoms.[1] Because they are highly effective, LARCs should be considered a viable alternative to short-term contraceptives. This lesson provides participants with the information required to make a decision about whether LARCs are appropriate for them or their partners.

Materials

- Markers, tape
- Three sheets of unlabeled newsprint hanging on the walls
- **Handout: What's a LARC?**
- **Handout: LARC Details**
- **Educator Resource: LARC Facts**

Procedure

1. Explain that this lesson will discuss LARCs, or long-acting reversible contraceptives, including information about what they are, how they work, and what the benefits are. Before you begin discussing the details, break down the term LARC for your participants.

*This lesson was developed by Karen Rayne, PhD, founder, Unhushed. For more information, please visit www.unhushed.net.

[1] Winner, B., Peipert, J. F., Zhao, Q., Buckel, C., Madden, T., Allsworth, J. E., & Secura, G. M. (2012). Effectiveness of long-acting reversible contraception. *New England Journal of Medicine: 366(21).*

Ask the participants if they know what contraception is. If someone offers an incorrect definition, clarify that contraception is something that prevents conception, or sperm fertilizing an egg, which is the first step in pregnancy.

Reversible contraception means that it can be stopped, unlike permanent contraceptive methods (such as a vasectomy or a tubal ligation).

Long-acting contraception means that it lasts more than just one time (unlike condoms) or for just one day or week (unlike the Pill, the patch, and the ring).

2. Ask participants if they know the names of any long-acting contraceptive methods. If they do, write one on each piece of newsprint. Write both brand names (Implanon®, ParaGard® and Mirena®) and the type of LARC (implant and intrauterine device, or IUC), matching them as appropriate.

   If the participants do not name all three LARCs, add the missing ones, including both the typical brand names and the types of LARC they represent. See the **Educator Resource: LARC Details,** for information.

3. Ask the participants what they have heard about LARCs. They might have preconceived notions about LARCs, either specifically or generally, and it is important to know what these are in order to address them. You will reinforce students' accurate knowledge and correct their misunderstandings in the next two steps.

4. Tell participants that there are two categories of LARCs: hormonal and non-hormonal. Pass out the **Handout: What's a LARC.** Ask each participant to turn to his or her neighbor and discuss two types of contraception listed. They should star points that are new to them.

5. Pass out the **Handout: LARC Details,** which provides information about each of the LARCs (what it is, how long it is effective, what it costs, how it works). Ask participants to contribute each point of the three points and write them on the newsprint under the types of LARCs at the same time. Address the participants' prior knowledge that they shared as you discuss each LARC.

6. Divide cards from the **Educator Resource: LARC Facts** among the participants and provide a roll of tape near each of the pieces of newsprint. Ask the participants to decide which cards apply to which LARCs based on the **Handout: What's a LARC?** and then tape the cards to the newsprint, using each other as well as their handouts as resources.

Discussion Questions:

a. What are the advantages and disadvantages of LARCs compared to other potential contraceptive options like condoms or the Pill?

b. Some have argued that Depo-Provera® — an injection in the arm that provides contraceptive protection for three months — is a LARC, too. Do you think it should be included or not? Why or why not?

c. Why would it be a good idea to use a condom along with a LARC?

Handout

What's a LARC?

Directions: Below is a general description of the ways hormonal and non-hormonal LARCs work and affect one's body. Use the information below to figure out which of the pieces of information your instructor gives you applies to which LARC.

LARC = Long-Acting Reversible Contraceptive

Different kinds of LARCs work in different ways. Some are hormonal, and some are non-hormonal. Understanding the basics of how contraception works will help you understand LARCs more completely.

Hormonal contraception uses the hormone progestin or a mix of estrogen and progestin to stop a woman's ovaries from releasing an egg every month. Adding hormones to a woman's reproductive system creates changes, such as stopping her period or making it more regular, potential weight changes, reduced acne, and more. The hormones used in LARCs can be taken while breastfeeding and pregnancy can occur immediately after removal.

Hormonal LARCs include implants (Implanon® and Nexplanon®) and the intrauterine contraceptive Mirena®.

Non-hormonal contraception uses means of preventing fertilization of the egg other than altering a woman's hormonal balance so that she does not release an egg. One example of a non-hormonal contraceptive is a condom, which works as a barrier between the sperm and the egg by catching the sperm. Non-hormonal contraception LARCs change the makeup of uterine fluids resulting in weakened sperm strength and prevention of fertilization. Non-hormonal contraception does not affect breastfeeding or future fertility.

The intrauterine contraceptive ParaGard® is a non-hormonal LARC.

All LARCs are highly effective, regardless of which kind they are.

Handout

LARC Details*

LARC type	Brand name	What is it?	Is effective up to...	Costs...	How it works
Non-hormonal intrauterine contraceptive (IUC)	ParaGard®	Small plastic and copper T-shaped device inserted into the uterus	10 – 12 years	$500 - $1,000 to have it inserted	Changes the makeup of uterine fluids resulting in weakened sperm strength and prevention of fertilization.
Hormonal intrauterine contraceptive (IUC)	Mirena®	Small plastic T-shaped device with low levels of hormones inserted into	5 years	$500 - $1,000 to have it inserted	Thickens cervical mucus keeping sperm out of the uterus, reduces sperm survival, and decreases the lining of the uterus.
Contraceptive implant (hormonal)	Implanon®, Nexplanon®	Progesterone-only hormonal implant (matchstick-sized) placed	3 years	$400 - $800 to have it implanted	Keeps eggs from being released, thickens cervical mucus to keep sperm from entering the uterus, and decreases the lining of the uterus.

* All information gathered from www.PlannedParenthood.org.

Educator Resource

LARC Facts

Directions: Copy and distribute the statements below and distribute one to each participant (or several to each participant, if it is a smaller group). Note that most of the statements are repeated, since they apply to more than one LARC.

Can become pregnant quickly after removal.	**Can become pregnant quickly after removal.**
Can become pregnant quickly after removal.	**Can be used while breastfeeding.**
Can be used while breastfeeding.	**Can be used while breastfeeding.**
Offers effective, long-lasting pregnancy prevention.	**Offers effective, long-lasting pregnancy prevention.**
Offers effective, long-lasting pregnancy prevention.	**Use is not visible to others.**
Use is not visible to others.	**Use is not visible to others.**
Does not change women's hormone levels.	

ON A LARC

Objectives

By the end of this lesson, participants will be able to:

1. Define long-acting reversible contraceptives (LARCs), and give two examples of LARCs.
2. Dispel common myths about IUCs.
3. Explain some non-contraceptive benefits of LARCs.

Rationale

About half of all pregnancies are unintended and close to half of all unintended pregnancies lead to abortion. In reflecting on these rates, Robert A. Hatcher, editor of *Contraceptive Technology,* the most authoritative reference book on contraception, quotes Albert Einstein, who famously said, "Insanity is doing the same thing over and over and expecting different results." Hatcher says that when it comes to teen pregnancy prevention, it's time we stop doing the same thing over and over. He recommends a new educational emphasis on long-acting reversible contraceptives (LARCs) — methods that can be used for extended periods of time. LARC methods such as intrauterine contraceptives (IUCs) and implants require minimal action on the part of the user, and thus have typical use effectiveness rates that are much higher than other contraceptive methods.

Materials

- Flip chart paper or board, and markers
- **Handout: IUC? IUD? Here Are Some Common Myths**
- **Handout: Pregnancy Prevention and More**

Procedure

1. Write the word **LARK** on the board/flip chart vertically, and ask if anyone has ever heard the expression, "on a lark." Ask for a few volunteers to suggest what the phrase might mean.

2. Explain that "on a lark" usually means "carefree," "spontaneous," and "without planning." Ask participants if they thing these meanings apply to sexual behaviors.

Discussion Questions:

a. Do you think sex should be "on a lark"? Why or why not?

b. What are some benefits of sex being carefree, spontaneous and without planning?

c. What are some risks?

3. Note that while some people might enjoy spontaneous sex, one of the drawbacks of sex being "on a lark" is that it doesn't give time for a person to make plans to prevent pregnancy. Replace the **K** in **LARK** on the board/flip chart with a **C** and ask if anyone has ever heard of LARCs.

4. Explain that LARC stands for "long-acting reversible contraceptive." Write each word next to the appropriate letter, and ask what each part means

Long Acting	It works for a long time. Several years, in fact.
Reversible	You can stop using it if you want to have a pregnancy, or if you want to begin using a different method.
Contraceptive	It works as a contraceptive to prevent pregnancy.

5. Explain that there are two main types of LARCs: IUCs and implants. First we are going to discuss IUCs, which stands for "intrauterine contraceptives". Explain that people may also know them as IUDs, in which "D" stands for "device". Ask what people have heard about IUCs or IUDs.

6. Explain that an IUC is a contraceptive method that is inserted into the uterus by a doctor, and provides very effective, long-term protection against contraception. Although it is highly effective, there are still some myths and misunderstandings about IUCs that we will bust now.

7. Distribute the **Handout: IUC? IUD? Here Are Some Common Myths**

Discussion Questions:

a. Which myths have you heard before?

b. Which myths do you think others might believe?

c. Why do you think there are so many myths about IUCs?

d. What reasons might a person not wanting a woman to use an IUC?

e. How might an IUC be a good choice?

8. Remind participants that the other kind of LARC is the implant, which is surgically placed under the skin. Like the IUC, the implant is highly effective in preventing pregnancy. In fact, LARCs are much more effective than other hormonal methods – pills, patches and rings – because there is no room for user error. You can forget to take a pill; you can't forget your implant or IUC.

9. Ask participants to name the method that should be used with a LARC to prevent sexually transmitted infections. *(Answer: condoms.)*

10. Divide participants into small groups, and explain that not only are LARCs highly effective in preventing pregnancy, they also have many non-contraceptive benefits. Distribute the **Handout: Pregnancy Prevention and More** and ask participants to imagine they are health care providers learning about LARCs for the first time. In their groups, they are to decide on five non-contraceptive benefits that they would want their patients to know about LARCs.

    Discussion Questions:

    a. Which non-contraceptive benefits did you want your patients to know about?

    b. Which non-contraceptive benefits did you think your patients would think are not important?

    c. As a health care provider, which LARC impressed you the most? Why?

    d. How do you think you would feel asking your doctor or health care provider about LARCs?

11. Conclude by asking for several volunteers to state the most important thing they learned in this class.

Handout

IUC? IUD? Here Are Some Common Myths

Directions: Intrauterine devices or contraceptives (IUDs or IUCs) are among the most effective contraceptives around. And yet, misinformation abounds. Here are some of the most common myths about IUCs/IUDs. Put a star next to any myth you've heard before. Circle any that you think others might actually believe.

1. **Myth: IUCs cause abortions.**
   Reproductive health organizations throughout the world, as well as reproductive health textbooks, strongly state that IUCs do not disrupt an implanted pregnancy, and therefore do not cause abortion.

2. **Myth: IUCs cause cancer.**
   Not only is this untrue, the hormonal IUC called Mirena® prevents endometrial cancer. The copper IUC called ParaGard® prevents both endometrial and cervical cancer.

3. **Myth: Women can't use IUCs if they have fibroids (non-cancerous tumors in the uterus).**
   For most women with fibroids, this is not true. In fact, Mirena can be used to *treat* bleeding and pain in women with fibroids.

4. **Myth: IUCs cause infections.**
   There is a very small risk of infection (0.1%) at the time the IUC is put in place, and two weeks following. However, women using Mirena have a lower risk of pelvic infection compared to women who don't use an IUC.

5. **Myth: Women need to wait until they have a baby before they can begin using an IUC.**
   Both the World Health Organization (WHO) and the Centers for Disease Control (CDC) have said the IUC is a good choice for birth control for women who have not had a baby.

Handout

Pregnancy Prevention and More

Directions: Long-acting reversible contraceptives (LARCs) have lots of *non-contraceptive* benefits. Imagine you are a health care provider learning about LARCs for the first time. Choose five non-contraceptive benefits that you would want your patients to know about.

ParaGard® IUC
Effective for 10-12 years

- ☐ 10 times less likely to have an ectopic pregnancy (pregnancy outside of uterus)
- ☐ Probable protection against endometrial cancer
- ☐ Possible protection against cervical cancer

Mirena® IUC
Effective for 5-7 years

- ☐ 90% less menstrual blood loss and prevention of anemia
- ☐ Prevention and treatment of endometriosis
- ☐ Decreased menstrual pain and cramping
- ☐ Prevention and treatment of endometrial cancer and hyperplasia (overproduction of cells)
- ☐ Decreased bleeding
- ☐ About 10 times less likely to have an ectopic pregnancy
- ☐ About a 50% protective effect against pelvic inflammatory disease

Implants
Includes Implanon® and Nexplanon® (effective for 3-4 years) and Jadelle® (effective for 5 years)

- ☐ Decreased menstrual and ovulatory cramping or pain
- ☐ Decreased number of days of bleeding
- ☐ Protection against anemia (not having enough healthy blood cells)
- ☐ Decreased risk for ectopic pregnancy

One other benefit to all LARCs is that since they are so effective in protecting against pregnancy, there is a decreased risk of needing to make a decision about abortion.

DECIDING ON A LARC?*

Objectives

By the end of this lesson, participants will be able to:

1. List three factors to consider when choosing a method of birth control.

2. Explain the difference between long-acting reversible contraceptives (LARCs) and other methods of contraceptives.

Rationale

When used correctly and consistently, contraceptive methods provide protection against pregnancy. However, nearly half (48%) of unintended pregnancies result from contraceptive failure.[1] Long-acting reversible contraceptive (LARCs) — methods that can be used over relatively long periods and which do not require user adherence — tend to be associated with lower pregnancy rates.[2] Such methods, like the intrauterine contraceptive (IUC) and implant have a higher efficacy rate, partly because they are inserted by a clinician and the user has very little to do over the course of use, thereby eliminating user error for longer periods. In this lesson, participants will have the opportunity to examine LARCs as a viable contraceptive option.

Materials

- Flip chart paper or board, markers, index cards and tape
- Three large signs, each labeled with a heading:
  EFFECTIVE (70-89%), **VERY EFFECTIVE (90-98%),** and **MOST EFFECTIVE (99% AND HIGHER)**
- A set of large cards, each with one label as follows:

DIAPHRAGM	**MALE CONDOM**
FEMALE CONDOM	**PATCH**
FERTILITY AWARENESS METHOD	**PILL**
IMPLANT	**RING**
INJECTION	**SPERMICIDE**
IUC – MIRENA	**WITHDRAWAL**
IUC – PARAGARD	

- **Educator Resource: DECIDING ON A LARC?**

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* This lesson was developed by Jessica Shields, Sexual Health Educator/Trainer, Planned Parenthood of Central and Greater Northern New Jersey.

[1] Hatcher, R. A., Trussell, J., Nelson, A. L., Cates, W., Kowal, D., & Policar, M. S. (2011). *Contraceptive technology, 20th rev. ed.* Atlanta, GA: Ardent Media.

[2] Ibid.

- **Contraceptive Options** chart (see the Resources Section of this manual)

Procedure

1. Before the lesson begins, hang the signs, leaving a large space between each, on the wall or board in the following hierarchal order:
   EFFECTIVE (70-89%)
   VERY EFFECTIVE (90-98%)
   MOST EFFECTIVE (99% AND HIGHER)

2. Ask participants to name some things a person may want to consider when choosing a contraceptive option. Give, as an example, *memory:* will a person be able to remember to take a pill every day? Write responses on the board/flip chart. Other responses may include: comfort, likeability, understand how to use it, affordable, safe, acceptable side effects, fits within lifestyle/value, partner's thoughts, effectiveness. (Add these to the list, as appropriate.)

3. Explain that today we are going to have an opportunity to compare the effectiveness rates of contraceptive methods. Note that when examining effectiveness rates, there is a **perfect** and **typical** rate. Explain that a perfect rate means that the user is using the method correctly and consistently whereas with a typical rate the user sometimes makes mistakes.

4. Ask participants to work together in pairs. Distribute a **Contraceptive Options** chart to each participant, and one contraceptive card to each pair.

5. Have participants note the large signs on the wall. Explain that these signs categorize the contraceptive methods as being either **EFFECTIVE, VERY EFFECTIVE** or **MOST EFFECTIVE.**

6. Using the **Contraceptive Options** chart, each pair is to decide on which sign their card belongs: **EFFECTIVE, VERY EFFECTIVE** or **MOST EFFECTIVE.** They will then place their cards in the appropriate location, based on **perfect use.**

   Discussion Questions:

   a. How easy or difficult would it be to use a method perfectly?

   b. What do the **MOST EFFECTIVE** methods have in common?

7. Explain that these methods were placed in a category based on the **perfect** effectiveness rate. However, many methods have a range of effectiveness. Ask participants to move their cards based on **typical** rates of effectiveness.

   Discussion Questions:

   a. Which cards moved? Which stayed in the same place?

   b. Why would some stay in the same place? (Explain that long-acting reversible contraceptives (LARCs) have the same perfect and typical use rate, because, since they are inserted by the physician, there is little a person can do to make a mistake.)

   c. What can cause a method to be less effective?

   d. Why is it important to understand the difference between perfect and typical effectiveness?

   e. Why would a person choose to use a condom along with a LARC?

   f. Which methods would you recommend to a friend? Why? Which ones would you not recommend? Why?

8. Divide participants into groups consisting of no more than five people and distribute a scenario to each group from the **Educator Resource: DECIDING ON A LARC?** (If there are a large number of participants, you can distribute multiple copies of each scenario.)

9. Tell the groups that they are to read their scenario, then recommend two contraceptive methods that their character may want to use and state a reason for which the character may want to use each method. Instruct groups to record their responses on an index card.

10. After about 10 minutes, have the small groups report back to the large group and discuss.

    Discussion Questions:

    a. Was it difficult or easy to recommend a method for your character? Why?

    b. What did you consider when you chose a method for your character?

    c. What can your character do to use the method you recommended perfectly?

    d. What do you think should be the most important factor in choosing a method of birth control?

Educator Resource

DECIDING ON A LARC?

Directions: Below are the scenarios. Copy and cut along the lines so each group has a scenario.

Amy and Jordan have been dating for over a year, and recently began talking about having sexual intercourse. Both want to protect against pregnancy, and Amy wants to decide on a method before they get busy. She wants a method that is easy to use, doesn't come in the form of a pill (because she doesn't like swallowing pills), and is highly effective.

Maria is 18 and about to leave for college. She hasn't had sexual intercourse yet, but is thinking that she might do so while she is at college, or maybe later when she goes to law school. Since she will be away, she wants a method that lasts at least through college and does not require frequent visits to the pharmacy, since there isn't one on campus.

Latisha and William had their first child about two months ago. They want to start having intercourse again but need to decide on a method of birth control. They want to have their next child in three years. They would like a method that is effective, very easy to use, and with little to remember, since caring for an infant is time consuming.

Arianna wants to use a method of birth control that is effective and easy to use. Most importantly, she wants a method that is highly discreet — one that her friends, family and even boyfriend won't know about; so, the method can't be found at her home. She has no problems getting to the local clinic or doctor.

WHAT A DIFFERENCE!
Comparing Hormonal Methods of Contraception

Objectives

By the end of this lesson, participants will be able to:

1. Identify the characteristics of each of the currently available hormonal contraceptives.

2. Describe the personal characteristics that would make an individual a good or a poor candidate for use of a particular hormonal method.

3. Discuss the fact that these highly effective methods of contraception do not protect against sexually transmitted infections (STIs), including HIV.

Rationale

Although hormonal contraceptives are highly effective, rumors and misinformation about them can prevent young women from making educated decisions regarding their use. Unwarranted fears may discourage use, and, in the case of the Pill, lead to poor compliance. On the other hand, lack of knowledge about side effects may lead to dissatisfaction after a method has been initiated.[1] This lesson presents the facts about hormonal contraceptives and leads to the recognition that each woman needs to examine her own feelings in order to evaluate the advantages and disadvantages of a particular method as a possible choice for herself. This also includes building awareness that hormonal methods alone do not provide protection against STIs.

Materials

- Flip chart paper or board, markers and tape
- 6 sheets of flip chart paper, each labeled with one hormonal method: **The Pill, Patch, Ring, Depo-Provera, Implant, Mirena®**
- **Handout: What a Difference! Comparing Hormonal Methods of Contraception**
- **Answer Sheet: What a Difference! Comparing Hormonal Methods of Contraception**
- **Contraceptive Options** chart (see the Resources Section of this manual)
- **Optional:** Pamphlets describing each hormonal method

[1] Trussell, J., Nelson, A., Cates, W., Stewart, F., & Kowal, D. (2007). *Contraceptive technology, 19th ed.* New York, NY: Ardent Media.

Procedure

1. Write the words **THE PILL, PATCH, RING, DEPO-PROVERA, IMPLANT,** and **MIRENA** on the board/flip chart.

2. Ask participants what they've heard about each of type of contraceptive. Jot down one or two responses under each contraceptive.

3. Review the recorded responses for each contraceptive pointing out examples of accurate and inaccurate statements. Note that just like the responses provided, there are many rumors about each method — some true, some not. Today they will review characteristics of each of the hormonal contraceptives.

4. Distribute **Handout: What a Difference! Comparing Hormonal Methods of Contraception**. Review the instructions.

5. Divide into groups of four or five participants. Provide each group with copies of the **Contraceptive Options** chart and contraceptives pamphlets if available. Tell the groups that they will have a few minutes to come to consensus on their answers for the **Handout: What a Difference! Comparing Hormonal Methods of Contraception.**

6. Bring the whole group together and distribute the **Answer Sheet**. Review and discuss any participant questions. Explain that an individual's experience using hormonal contraceptives can vary. It is important that an individual consults a clinician in order to use a hormonal contraceptive and to discuss any side effects. Note the additional column on the handouts called "Important to You?" Ask participants to think about how important each of the items on the list is to them and to check those items.

7. Divide participants into six small groups. Distribute one of the flip chart papers labeled with a hormonal contraceptive to each small group.

8. Explain that in order for hormonal contraceptives to effectively prevent unintended pregnancy, they must be used correctly and consistently. Participants will write down characteristics a woman would possess that would make her a good candidate to use the method listed on the flip chart paper correctly and consistently. Provide the example that for THE PILL a woman would need to be able to remember to take the Pill every day. Recommend they refer to the **Answer Sheet** and the contraceptives pamphlets to help them develop their list.

9. After about 10 minutes, tape the flip chart papers to the wall.

Discussion Questions:

a. What are the characteristics of a woman who would use each method effectively?

b. What similarities and differences do you notice between the lists?

c. If someone asked you which hormonal method was "best," what would you respond? *(Answer: It depends! The woman and her health care provider need to consider many factors regarding the individual woman.)*

d. How can a male partner share responsibility with a woman who chooses any one of these methods?

e. Though these very reliable methods of contraception prevent pregnancy, sexually active individuals can still be at risk for sexually transmitted infection. Why might this be so?

f. How reasonable is it for a couple to use a condom to reduce the risk of sexually transmitted infections in addition to using a hormonal contraceptive? Explain.

Handout

What a Difference!
Comparing Hormonal Methods of Contraception

Directions: Women now have a variety of hormonal methods of birth control. Check the statements that are true of each method, and then check the statements that are important to you.

	THE PILL	PATCH	NUVARING®	DEPO-PROVERA®	IMPLANT	MIRENA®	Important to you?
1. Is a very reliable method of birth control.							
2. Women must get it from a health care provider.							
3. Inhibits ovulation so eggs are not released.							
4. Must be taken every day.							
5. Requires an injection by a health care provider.							
6. Is prescribed by a doctor after the client has been checked to be certain the method is okay for her.							
7. Requires insertion and removal by a health care provider.							
8. Lasts for five years.							
9. Menstrual periods are likely to be irregular.							
10. Likely to increase appetite, which may lead to weight gain.							
11. Weight can be controlled by exercise and moderate diet.							
12. When this method is stopped, the woman becomes fertile within two to six weeks.							
13. When this method is stopped, it usually takes nine to ten months before fertility returns.							
14. Reduces the chance a woman will become anemic by reducing menstrual flow.							

	THE PILL	PATCH	NUVARING®	DEPO-PROVERA®	IMPLANT	MIRENA®	Important to you?
15. Reduces the risk of benign breast disease.							
16. Is much more effective in preventing pregnancy than the Pill when used correctly and consistently.							
17. A woman using this method should call her health care provider immediately if she has any symptoms that worry her.							
18. A woman using this method must use a condom if she wants to avoid possible infection with an STI or HIV.							
19. More expensive in the beginning, but least expensive in the long run.							
20. This method is less risky to a healthy woman than a pregnancy.							

Answer Sheet

What a Difference!
Comparing Hormonal Methods of Contraception

	THE PILL	PATCH	NUVARING®	DEPO-PROVERA®	IMPLANT	MIRENA®	Important to you?
1. Is a very reliable method of birth control.	✓	✓	✓	✓	✓	✓	
2. Women must get it from a health care provider.	✓	✓	✓	✓	✓	✓	
3. Inhibits ovulation so eggs are not released.	✓	✓	✓	✓	✓	✓	
4. Must be taken every day.	✓						
5. Requires an injection by a health care provider.				✓			
6. Is prescribed by a doctor after the client has been checked to be certain the method is okay for her.	✓	✓	✓	✓	✓	✓	
7. Requires insertion and removal by a health care provider.					✓	✓	
8. Lasts for five years.						✓	
9. Menstrual periods are likely to be irregular.				✓	✓	✓	
10. Likely to increase appetite, which may lead to weight gain.				✓	✓		
11. When this method is stopped, the woman usually becomes fertile within two to six weeks.	✓	✓	✓		✓		
12. When this method is stopped, it usually takes nine to ten months before fertility returns.				✓			
13. Reduces the chance a woman will become anemic by reducing menstrual flow.	✓	✓	✓	✓		✓	
14. Reduces the risk of benign breast disease.	✓						

	THE PILL	PATCH	NUVARING®	DEPO-PROVERA®	IMPLANT	MIRENA®	Important to you?
15. Is much more effective in preventing pregnancy than the Pill when used correctly and consistently.					✓	✓	
16. A woman using this method should call her health care provider immediately if she has any symptoms that worry her.	✓	✓	✓	✓	✓	✓	
17. A woman using this method must use a condom if she wants to avoid possible infection with an STI or HIV.	✓	✓	✓	✓	✓	✓	
18. More expensive in the beginning, but least expensive in the long run.					✓	✓	
19. This method is less risky to a healthy woman than a pregnancy.	✓	✓	✓	✓	✓	✓	

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THE CONDOM LINEUP

Objectives

By the end of this lesson, participants will be able to:

1. Identify factors that influence effective condom usage.
2. Describe the steps of correct condom use.
3. Demonstrate increased comfort with initiating conversation about safer sex and condom use.

Rationale

All too often education about condom use fails to address the many factors essential for correct and consistent use. The active involvement of participants in this lesson is designed to relieve their anxiety about using condoms by increasing their confidence in condoms as a reliable form of contraception and protection against sexually transmitted infections (STIs). The popular "Condom Line-Up" activity and follow-up discussion addresses how to use a condom correctly, and the "Opening Lines" exercise addresses the difficulty teens may have starting a discussion with a partner about using a condom.

Materials

- Condoms: male and female
- Samples of glycerine, silicone and water-based lubricants
- Twenty signs for "condom cards," labeled in the following sequence:
    - **DECIDE TO HAVE SEXUAL INTERCOURSE**
    - **TALK ABOUT SAFER SEX**
    - **BUY/GET CONDOMS**
    - **CHECK EXPIRATION DATE**
    - **AROUSAL (GETTING TURNED ON)**
    - **ERECTION**
    - **OPEN PACKAGE CAREFULLY**
    - **INSPECT CONDOM**
    - **PLACE A DROP OF LUBE ON THE INSIDE TIP OF THE CONDOM**
    - **HOLD CONDOM AT TIP TO LEAVE SPACE AT END**
    - **PUT CONDOM ON TIP OF ERECT PENIS**
    - **ROLL CONDOM DOWN TO BASE OF PENIS**
    - **SMOOTH OUT AIR BUBBLES**
    - **INTERCOURSE (VAGINAL, ANAL OR ORAL)**
    - **EJACULATION**

  - **BEFORE LOSING ERECTION, HOLD CONDOM AT BASE OF PENIS AND PULL OUT**
  - **TAKE OFF CONDOM**
  - **THROW IT AWAY**
  - **ENJOY THE GOOD FEELINGS**
  - **REPEAT AS NECESSARY**
- Pictures from magazines of couples who seem to be having an intimate conversation. Be sure to include varied ethnic and age groups as well as some same-gender couples.
- **Handout: Using Condoms** (see Resources Section of this manual)

Procedure

1. Introduce the lesson by stating, "Today we will be talking about condoms for protection during vaginal, oral and anal intercourse." Explain that condoms have been used by millions of couples for hundreds of years.

2. Write the following heading on the board or flip chart paper: **REASONS PEOPLE CHOOSE CONDOMS**. Brainstorm a list of ideas, making sure to include concepts such as "easy to find," "not expensive," "male's role in preventing pregnancy," "no dangerous side effects," "good protection against sexually transmitted infections and unplanned pregnancy if used consistently and correctly."

3. Introduce "The Condom Line-Up" by telling participants they can have some fun showing what they know about condom use.

4. Shuffle "condom cards" so they are not in the proper order and distribute to participants. Each participant will have one card, unless the group is small, in which case participants can receive more than one.

5. Explain that the cards, when put in the correct order, show the steps for how to use condoms correctly.

6. Instruct participants to hold the cards and line themselves up shoulder to shoulder with each other, in the correct order, from left to right. (Or if there are more cards than participants, ask them to tape the cards in the correct order on the wall.)

7. After participants have put the cards in line, ask the whole group if the order of cards should be changed.

8. Once everyone agrees on the order, have each participant read his or her card aloud.
   Discussion Questions:

   a. When should the expiration date be checked? *(When the condoms are bought and, if the condom is not new, check it again before having intercourse.)*

   b. Erection for a male is on the list, but what female response is missing? (*Vaginal lubrication [or wetness] is a sign a woman is aroused. Without lubrication, a woman may feel pain or discomfort during vaginal intercourse and the condom is more likely to break, because there is more friction. Some women do not naturally lubricate very much, and therefore may need some extra lubricant. Extra lubrication will be needed if a couple engages in anal intercourse.*)

   c. Why should you open the package carefully? *(So you won't tear the condom.)*

   d. How do you "inspect" the condom, and what should you look for? (*Do NOT unroll the condom before putting it on the penis. Look at the rolled condom for obvious tears. If the condom sticks to itself, or looks dry or cracked, then don't use it.)*

   e. Why should a drop of lube be placed on the inside tip? *(To make the penis feel more sensitive. Remember not to use too much lubricant or the condom may slip off the penis, and remember not to use oil-based lubricants, which will damage the condom.)*

   f. Why should space be left at the end? *(To catch the semen [or "cum"]. If no space is left, the semen may leak out of the base or the condom may break.)*

   g. What do you need to do if the condom is put on the tip of the penis inside out by mistake? *(Throw it away because some semen may have gotten on the tip. If the semen contains something infectious, the condom would be exposed to it.)*

   h. What is different if the man is uncircumcised (if he has a foreskin)? *(Be sure the foreskin is pulled back* ***before*** *putting the condom on. If the foreskin isn't pulled back completely before the condom is on, it will stretch the condom at the tip and increase the chance of breaking.)*

   i. Why should any air bubbles be smoothed out once the condom is on? (*So that it is less likely to break.)*

   j. Ejaculation is on the list. What else is missing? *(Orgasm for the other partner. Although the penis should be withdrawn soon after ejaculation, the other partner's genitals could be stimulated by fingers, mouth, etc. until s/he feels satisfied.)*

   k. Why should you hold onto the condom at the base of the penis and withdraw before the erection is lost? *(To prevent the condom from slipping and semen spilling anywhere near the vagina, mouth or anus.)*

l. How might using condoms be different if a person were drunk or high? *(Difficult to remember or coordinate the steps. Having intercourse in the dark might also make it difficult to follow the steps.)*

9. Ask what the differences are, if any, in the steps if intercourse ...

   a. Is between two men.
   b. Is between two women.
   c. Includes oral sex on the male.
   d. Includes oral sex on the female.
   e. Includes oral sex on the anus.

10. Note that latex squares ("dental dams") are available for oral sex on the vulva or on the anus. Note also that during vaginal intercourse, some couples might choose to use the female condom instead of the male condom, though the two should not be used at the same time due to excessive friction that can cause breakage. Demonstrate how the female condom works. (The instructions are included in the female condom package.)

11. Tell the group that for many people, starting to talk with a partner about using condoms can be the most difficult part. Ask participants to find another person to work with, and give each pair a card with a magazine picture of a couple.

12. Explain that they will have five minutes to write the first two lines of an "opening conversation" this couple could use to begin talking about safer sex or about using a condom. If there is time, the dialogues can be written on "balloons" of white paper, glued to the pictures, and posted on the wall.

13. When the pairs of participants are ready, have them stand, one pair at a time, holding up their card. Ask them to say to each other the dialogue they have written.

14. Conclude by distributing a copy of **Using Condoms** (see Resources Section of this manual).

CONDOM TALK
Practice Makes Perfect*

Objectives

By the end of this lesson, participants will be able to:

1. Identify feelings people have about using condoms.
2. Describe ways that help a person become more comfortable talking about condom use with a partner.
3. Apply negotiating skills for condom use.
4. Describe how condoms can be a positive component of safer sex.

Rationale

There are numerous reasons why people do not use condoms: they may be unfamiliar with them; be embarrassed to talk with a partner about using them; or believe negative myths that convince them not to use condoms. This activity gives participants a chance to confront possible barriers to condom use and to respond to these barriers. After participants have had a chance to develop condom dialogue competence, they get to practice their skills and increase their condom efficacy. Finally, negative ideas about condoms are confronted by giving participants a chance to brainstorm all positive reasons to use them.

Materials

- Flip chart paper, tape
- Markers, enough for each participant

Procedure

1. Tape about 12 pieces of flip chart paper around the room. Brainstorm reasons why people ***don't*** use condoms, writing each reason on a separate piece of flip chart paper. Extra flip chart paper can be posted if there are more reasons generated by the group. Give one or two examples of

* This lesson was developed by Louise Yohalem, a former associate director of education for Planned Parenthood of Greater Northern New Jersey.

how people could respond if a partner gave one of these reasons. Then ask participants to walk around the room writing down responses to each reason. Have volunteers read responses aloud when group has finished writing.

2. Participants now have an opportunity to utilize the responses they have written on the flip chart paper in role-plays. Divide the group into pairs. Ask pairs to decide who will be number 1 and who number 2. First, tell the people who are number 1 to convince number 2 to wear a condom. Person number 2 should use as many excuses as possible to resist having the condom put on. Person number 1 can use the responses from the brainstorm to overcome the partner's resistance. When the first person in the couple has succeeded in convincing his/her partner to wear a condom, they switch roles.

3. When all have finished playing both roles, ask for volunteers to share their role-plays with the whole group. When all who want to share their role-plays have had a chance, process the activity using the following questions.

   Discussion Questions:

   a. How did it feel to try to talk your partner into using a condom?

   b. What arguments worked? Did anyone find a special technique that worked?

   c. Was anyone unable to convince a partner? What could a person do if the partner won't comply? What would ***you*** do in real life if this happened?

   d. Did this activity increase your comfort with condoms? Why or why not?

4. Sum up the lesson by pointing out that it is possible to overcome barriers to communicating about using condoms and also to overcome myths about how condoms spoil intercourse. Remind participants that effective communication goes beyond one-line catchy responses; this activity is meant to provide an opening to further dialogue. Ask group to brainstorm all the ways that condoms ***improve*** intercourse. (Possible responses include: take away anxiety; reduce fear of pregnancy and/or sexually transmitted infections; improve communication; can be part of foreplay; add variety; make intercourse last longer; "colorful"; help to relax; etc.)

   Note:
   If this lesson is the only condom lesson you will be using, be sure to demonstrate how to use one correctly. Consider distributing **Using Condoms** from the Resources Section at the end of this manual.

CHOOSING CONDOMS, CHOOSING LUBES*

Objectives

By the end of this lesson, participants will be able to:

1. Describe common feelings and attitudes about the meaning of using a condom.
2. Identify the most recent data regarding the effectiveness of condoms.
3. Evaluate a variety of brands and types of condoms and personal lubricants.
4. Recognize a variety of locations to find condoms and personal lubricants.

Rationale

Too many people resist using condoms when they would be of great benefit. Some people fear that to suggest using a condom is to suggest one's partner or oneself is promiscuous or infected. In this lesson, participants confront the issue of talking with a partner about condom use, and in addition, reflect on the impact negative attitudes may have on a couple's ability to protect themselves correctly and consistently. Participants examine and evaluate a variety of brands of condoms and personal lubricants; overcome common aversion to touching condoms; learn there are many different types of condoms and lubricants (if one is not satisfactory, try another); and become confident as consumers should they decide to use condoms for protection against infection and/or unplanned pregnancy.

Materials

- Index cards
- A condom in a box, wrapped with special paper and a large bow
- Variety of different male condoms, one female condom for each group, and variety of personal lubricants
- **Handout: Condoms Work — When Used Consistently and Correctly**
  Note:
  The answers to this handout are based upon the latest research data as this manual goes to press. If you find information that contradicts our answers, evaluate your resource, and if you are convinced that the data are scientifically accurate, change the test.
- **Handout: Choosing Condoms, Choosing Lubes**
- **Handout: In Search of Condoms and Lubes**

*Parts of this lesson were adapted from Taverner, B., Milstein, S., & Montfort, S. (2012). *Teaching safer sex, 3rd ed.* Morristown, NJ: The Center for Sex Education.

Procedure

1. Hold up the box and tell participants it contains a really great and thoughtful gift a person can give a sexual partner. Open and show the condom. Ask why a condom is a great gift.

2. Distribute index cards to each participant. Note that despite increased discussion about condoms, people still have many different feelings about using them. Ask participants to write on their cards how they imagine they would feel if they were involved in a relationship and, before intercourse, a partner took out a condom and suggested they use it. Explain that their responses are anonymous.

3. Collect cards and read them out loud. Discuss participants' responses, and the following questions.

   Discussion Questions:

   a. Did the comments strike you as mostly positive? Or mostly negative? Why do you think they were mostly negative (or mostly positive)?

   b. Do you think the comments are representative of society in general? Explain.

   c. Do you think there are differences in attitudes about condoms between males and females? (Note that many American males and females express negative attitudes about condoms, especially when compared to European teens. Ask why that might be.)

   d. Note that health care professionals advise couples to use a condom in addition to another method of contraception, such as the Pill, Depo-Provera®, the patch or the diaphragm. Why?

   e. Given the facts of life in American society today, who are the only people who do not need to use condoms? (People who are abstaining from sexual intercourse and people who are in a mutually monogamous relationship with a partner they are certain is not infected with a sexually transmitted infection.)

4. Distribute the **Handout: Condoms Work — When Used Consistently and Correctly.** Note that there is controversy about the effectiveness of condoms. Some people exaggerate the failure rate in the hope that they will persuade young people to abstain from intercourse. Participants will have a chance to check what they believe is true about condoms with the facts. Ask them to select a partner and work together to complete the handout. When everyone is finished, explain that ***ALL answers are true***. Discuss any questions.

5. Note that it is important for people of all ages to know that condoms are all tested for breakage and slippage, and that they are highly effective in reducing the risk of both sexually transmitted infections (STIs) and pregnancy. It is also important to know that everyone can benefit from lubricants to increase sexual pleasure and decrease friction, which may be painful and/or irritating.

6. Say that to be sure everyone is familiar with the wide variety of condoms and lubes available, they're going to have a chance to evaluate some of those products. Divide participants into small groups (five or fewer is best). Give each group a selection of male condoms, a female condom, and a selection of personal lubricants to evaluate. Give each person a copy of the **Handout: Choosing Condoms, Choosing Lubes.**

7. Read the directions aloud and tell participants that each person is to evaluate either one condom or one lubricant, completing the appropriate side of the handout. They will have about 10 minutes to complete their evaluations, and then compare and discuss their individual evaluations to see which condom and which lube got the highest ratings.

8. After groups have finished discussing their evaluations, ask for volunteers from some groups to briefly report their ratings and reasons to all participants. Note that condom brands and types are a matter of personal tastes and comfort. Stress that only condoms manufactured from latex, polyisoprene (synthetic latex) or polyurethane should be used, and only silicone, glycerine or water-based lubricants (i.e., ***not*** oil-based) should be used.

9. Conclude the lesson by asking each group to report which condom and which lube received the highest ratings and why.

   Discussion Questions:

   a. What similarities do you notice about how different groups rated the different condoms and lubes? What differences did you notice?

   b. Why is it important to be able to evaluate condoms and lubes? Why is it important to be aware of differences in condoms and lubes?

   c. What advice would you give to someone who was choosing condoms and lubes?

10. Follow up: Distribute and review the **Handout: In Search of Condoms and Lubes.** Give participants several days to do their research. Discuss any questions they have.

Handout

Condoms Work — When Used Consistently and Correctly

Directions: There are many claims and counter-claims about the effectiveness of condoms. Decide if you think each statement is true or false and write **T** (True) or **F** (False) in front of each statement.

____ 1. Latex condoms are up to 98% effective in preventing pregnancy when used correctly and consistently.

____ 2. When used consistently and correctly, latex condoms are highly effective in preventing transmission of HIV, and reduce the risk of other sexually transmitted infections (STIs).

____ 3. "Consistent" condom use means using a new condom every time.

____ 4. If condoms do slip or break, it is usually due to the condom being used incorrectly, rather than the quality of the condom itself.

____ 5. Reasons why condoms might slip or break include fingernail tears, keeping them in hot places, using oil-based lubricants, and not withdrawing the penis right after ejaculation.

____ 6. **Silicone, glycerine** and **water-based** lubricants (lubes) do not damage latex condoms, but **oil-based** lubricants such as hand lotions and petroleum jelly do.

____ 7. Using spermicides with condoms is not recommended for preventing STIs.

____ 8. Studies have shown that when condoms are available at schools and clinics, teen sexual activity does not increase. However, condom use does increase among teens who are **already** sexually active.

____ 9. Latex, polyisoprene (synthetic latex) and polyurethane condoms marketed in the United States must meet high standards set by the U.S. Food and Drug Administration (FDA). Therefore, color, shape and packaging are all a matter of personal choice and do not impact effectiveness.

____ 10. When people use alcohol or other drugs, it reduces the likelihood that they will use condoms effectively.

Sources:

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Handout

Choosing Condoms, Choosing Lubes

Directions: By yourself, check all descriptions that apply to the condom packaging, wrapping and features, or to the lube packaging, ingredients and features. When finished, discuss your findings with your group.

Condoms

Name: _____ **Material:** _____

Packaging/Wrapping:

- ☐ Appealing to men
- ☐ Appealing to women
- ☐ Appealing to young people
- ☐ Difficult to open
- ☐ Difficult-to-read expiration date
- ☐ Easy to open
- ☐ Easy-to-read expiration date
- ☐ Embarrassing
- ☐ Eye-catching
- ☐ See-through
- ☐ Other: _____

Features:

- ☐ Colored
- ☐ Contour fit
- ☐ Extra-thick
- ☐ Extra-thin
- ☐ Extra-lubricated
- ☐ Extra-sensitive
- ☐ Flavored
- ☐ Larger tip
- ☐ Larger-fitting
- ☐ Lubricated with: _____
- ☐ Odorless
- ☐ Non-lubricated
- ☐ Ribbed
- ☐ Snugger-fitting
- ☐ Studded
- ☐ Tipped
- ☐ Twisted tip
- ☐ Unique shape
- ☐ Vibrating ring
- ☐ Other: _____

Other Comments about This Condom:

_____

_____

Overall Rating of This Condom: (circle one)

5	4	3	2	1
Great!		**So-So**		**Terrible!**

Lubes

Name: _____

Packaging:

- ☐ Appealing to men
- ☐ Appealing to women
- ☐ Appealing to young people
- ☐ Difficult to open
- ☐ Easy to open
- ☐ Embarrassing
- ☐ Other: _____
- ☐ Flip-top
- ☐ Interesting
- ☐ Packet
- ☐ Pump
- ☐ Screw-top
- ☐ Tube

Ingredients:

- ☐ Benzocaine*
- ☐ Cyclopentasiloxane
- ☐ Dimethiconol
- ☐ Dimethicone
- ☐ Ethyl PABA*
- ☐ Glycerine*
- ☐ Other: _____
- ☐ Lidocaine*
- ☐ Mineral oil
- ☐ Nonoxynol-9*
- ☐ Petroleum
- ☐ Phenoxyethanol*
- ☐ Water

*Numbing or potentially irritating. Irritation could affect the skin, which could create problems in preventing STIs.

Features:

- ☐ Flavored
- ☐ Long-lasting
- ☐ Natural oil-based
- ☐ Non-staining
- ☐ Numbing/desensitizing
- ☐ Odorless
- ☐ Petroleum-based
- ☐ Safe with latex
- ☐ Other: _____
- ☐ Silicone
- ☐ Tasteless
- ☐ Thick/heavy
- ☐ Thin/light
- ☐ Tingling
- ☐ Warming
- ☐ Water-based with glycerine
- ☐ Water-based without glycerine

Other Comments about This Lube:

_____

_____

Overall Rating of This Lube: (circle one)

5	4	3	2	1
Great!		**So-So**		**Terrible!**

Handout

In Search of Condoms and Lubes

Directions: Find a place that sells condoms and lubes. Answer the following questions about your journey in search of condoms and lubes.

1. **What was the name of the place?**

   Name of store, health center or physician _____

   Town/city _____

2. **Where were the condoms and lubes displayed?**

   ☐ Not on display ☐ Behind the counter ☐ On the shelves

   ☐ Elsewhere _____

3. **If in a store, were they easy to find?** ☐ Yes ☐ No

4. **Why/Why not?** _____

5. **Brand names and prices of condoms and lubes available**
   List two brand names of condoms available, and two brand names of lubes available. Indicate the quantity available per package (i.e., number of condoms or ounces of lube) and price.

Brand Name	Quantity	Price
Condom 1:		
Condom 2:		
Lube 1:		
Lube 2:		

6. **How would you feel purchasing condoms and lubes from this place?**
   Check all the words that describe how you think you would feel.

☐ Anxious	☐ Excited	☐ Responsible
☐ Comfortable	☐ Guilty	☐ Safe
☐ Confident	☐ Independent	☐ Secretive
☐ Confused	☐ Relaxed	☐ Tense
☐ Embarrassed	☐ Relieved	☐ Other _____

"DOWN THERE"
How to Use an Insertive Method

Objectives

By the end of this lesson, participants will be able to:

1. Examine knowledge and attitudes that could affect a person's ability to use contraceptives that require inserting something into the vagina.
2. Explain the anatomy of the vagina and how insertive methods fit and work inside the vagina.
3. Consider ways a person could learn how to use insertive methods.

Rationale

Anyone who has demonstrated vaginal methods of contraception has witnessed negative responses to the idea of inserting a contraceptive device. For many, the vagina is unknown territory and the idea of touching the genitals in order to use an insertive method (including the female condom, diaphragm, cervical cap or spermicide) is very uncomfortable. This lesson utilizes a "bingo" game to initiate discussion about the knowledge and attitudes that could affect a person's ability to use these methods. A diagram helps participants understand exactly how to use insertive methods.

Materials

- Samples and, if possible, pamphlets describing the different insertive contraceptive methods (female condom, diaphragm, cervical cap, spermicide and NuvaRing®)
- **Handout: "Down There" Bingo**
- **Educator Resource: "Down There" Bingo**
- **Handout: How to Use an Insertive Method**
- **Contraceptive Options** chart (see the Resources Section of this manual)
- **Optional:** Pamphlets describing these methods

Procedure

1. Distribute the **Handout: "Down There" Bingo.** Explain that some people don't use the methods of contraception that require the insertion of a device or a cream into the vagina because they have negative feelings about that area of the body and about touching it. The group is going to participate in an activity that will examine some of their own attitudes about the

female genitals, often named only "down there." Ask them to look through the statements on the handout and decide which ones they could sign as true for themselves. Read the instructions on the handout emphasizing that they must ask the question aloud to someone, not just hand the paper to someone.

2. After about 10 minutes, ask everyone to sit down and check how many signatures they have.

   Discussion Questions:

   a. How did you feel doing this activity?

   b. Which of the statements did you feel a little uncomfortable asking?

   c. Which of the statements were hard to get signatures for?

   d. How might a woman's negative attitudes about her genitals affect her ability to use contraceptives, such as the NuvaRing, diaphragm or vaginal film?

3. Divide participants into groups of four or five. Give each group five copies of the **Handout: How to Use an Insertive Method** and the **Contraceptive Options** chart, plus pamphlets if available. Ask groups to complete the handout.

4. Review the handout with the entire group. Emphasize that while all of these insertive methods are designed to prevent pregnancy, many offer limited or no protection against sexually transmitted infections (STIs). Any method containing or using spermicides could make the risk of STIs and HIV greater.

   Discussion Questions:

   a. Why might a woman select a contraceptive method that is inserted into the vagina?

   b. What are the benefits of each of these methods?

   c. Why is it important for a woman to practice using each of these methods on her own before using it for intercourse?

   d. Under what conditions might a couple choose to use each of these methods?

Handout

"Down There" Bingo

Directions: Move around the room, find someone and ask, "Are you someone who ... *(complete the question)*." If the person says yes, ask him/her to sign on the line in that box. No one may sign more than one of your statements. The winner is the person with the most signatures when the exercise ends.

ARE YOU SOMEONE WHO ...

... learned the correct names for the genital organs when you were a small child? _____	... knows someone who feels comfortable using tampons? _____	... has had a pelvic exam? _____	... knows what a vulva is? _____
... has seen a cervical cap? _____	... has heard that the vagina is dirty or smelly? _____	... wishes you knew more about the clitoris? _____	... can describe a difference between male and female condoms? _____
... knows how many openings a woman has "down there"? _____	... knows why a diaphragm can't get lost in the vagina? _____	... knows how long the average vagina is? _____	... feels a little uncomfortable doing this activity? _____
... knows what must be used with the diaphragm to make it an effective barrier? _____	... knows the body part inside the vagina that feels like the tip of a nose? _____	... was taught when you were little that it's not okay to touch your genitals? _____	... believes that if a woman does not bleed the first time she has intercourse, she is not really a virgin? _____

Educator Resource

"Down There" Bingo

Although many of the statements on the bingo handout involve attitudes or experiences, a few are fact based. Answers for fact-based statements are in italics.

... learned the correct names for the genital organs when you were a small child? *Penis, vulva, etc.*	... knows someone who feels comfortable using tampons?	... has had a pelvic exam?	... knows what a vulva is? *External female sexual organs (mons, labia, clitoris, Bartholin's glands, urethra and vaginal opening)*
... has seen a cervical cap?	... has heard that the vagina is dirty or smelly? *Myth because the vagina is self-cleaning*	... wishes you knew more about the clitoris?	... can describe a difference between male and female condoms? *E.g. where and when it is worn**
... knows how many openings a woman has "down there"? (*Vagina, urethra, anus*)	... knows why a diaphragm can't get lost in the vagina? *It can always be retrieved; cannot pass through cervix*	... knows how long the average vagina is? *Three to four inches*	... feels a little uncomfortable doing this activity?
... knows what must be used with a diaphragm to make it an effective barrier? *Spermicide*	... knows the body part inside the vagina that feels like the tip of a nose? *Cervix*	... was taught when you were little that it's not okay to touch your genitals?	... believes that if a woman does not bleed the first time she has intercourse, she is not really a virgin? *Myth*

*The male condom is worn over the erect penis just before intercourse begins; the female condom can be inserted in the vagina in advance.

Sources:

Hatcher, R. A., Trussell, J., Nelson, A. L. Cates, W., Kowal, D., & Policar, M. S. (2011). *Contraceptive technology, 20th rev. ed.* Atlanta, GA: Ardent Media.

Herbenick, D. (2009). *Because it feels good: A woman's guide to sexual pleasure and satisfaction.* New York, NY: Rodale.

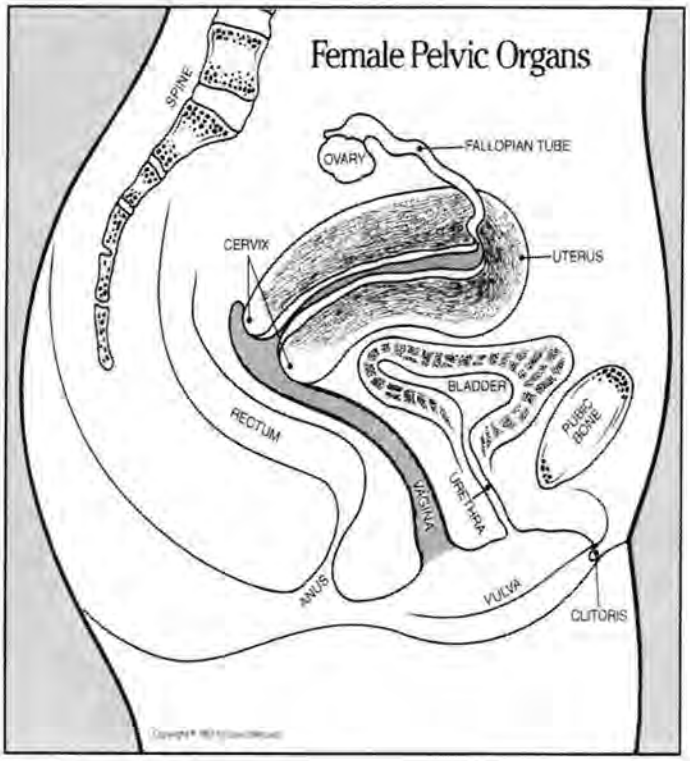
Handout

How to Use an Insertive Method

Directions: Use a separate handout for each of the following methods: female condom, diaphragm, cervical cap, spermicide and NuvaRing®. Record your answers to questions 1-3 on the back of the handout.

METHOD:_____

1. What prevents this method from getting lost inside the body?
2. Why does the uterus have an opening?
3. How does this method work to prevent a pregnancy or sexually transmitted infections?
4. Draw this method in the proper location in the vagina.
5. What could a person do to learn how to use this method? Rank order the following from 1 (most useful) to 8 (least useful).
6. What prevents this method from getting lost inside the body?
7. Why does the uterus have an opening?
8. How does this method work to prevent a pregnancy or sexually transmitted infections?



9. Draw this method in the proper location in the vagina.
10. What could a person do to learn how to use this method? Rank order the following from 1 (most useful) to 8 (least useful).

_____Get a pamphlet with diagrams and explanations.
_____Use a mirror to locate the opening of vagina.
_____Buy one in a drugstore and practice using.
_____Get advice from someone who already uses the method.
_____Practice using tampons to become familiar with inserting something into the vagina.
_____Go to a clinic or doctor for instructions.
_____Practice with a group of friends.
_____Other_____

EMERGENCY CONTRACEPTION
For Emergency Use Only!

Objectives

By the end of this lesson, participants will be able to:

1. Describe basic facts about emergency contraception.
2. Evaluate three situations where emergency contraception is a possible choice.
3. Rehearse calling a health care provider regarding the possibility of using emergency contraception in a particular situation.

Rationale

Although emergency contraception has been available in the United States for several decades, many people do not know that it is available as an alternative to possible pregnancy when a contraceptive fails or was not used. Some family planning experts state that utilizing emergency contraception could prevent many unintended pregnancies.[1] This lesson serves to introduce participants to the facts and allows them to examine situations in which a woman/couple might consider requesting the use of emergency contraception.

Materials

- **Handout: "We Used a Condom ... But ... "**
- **Handout: "We Meant to Use a Condom ... But ... "**
- **Handout: "He Forced Me and He Didn't Use a Condom!"**
- **Handout: The Facts about Emergency Contraception**

Procedure

1. If possible, have chairs or desks arranged in three circles. As participants enter room, divide them in a random fashion and direct each to one of the circles.

[1] Trussell, J., Nelson, A., Cates, W., Stewart, F., & Kowal, D. (2007). *Contraceptive technology, 19th ed.* New York, NY: Ardent Media.

2. Distribute one of the following to each group: **Handout: "We Used a Condom ... But ... "; Handout: "We Meant to Use a Condom ... But ... "** and **Handout: "He Forced Me and He Didn't Use a Condom!"** Explain that participants should read the situation on their group's handout and then complete the sheet, first listing all the alternatives the person has and then selecting the alternative the group thinks is best.

3. After about 10 minutes, ask a reporter from each group to explain their situation and the alternative they selected. Ask the entire group to identify the similarities of the three situations. *(Answer: Each of the women does not want to be pregnant at this time in her life and has had unprotected intercourse within the last 24 hours.)*

4. If no one has already mentioned emergency contraception, note that this is an option that each of these women has. Distribute the **Handout: The Facts about Emergency Contraception.** Ask groups to read it and decide whether or not emergency contraception would be a good option for the woman in their case study.

5. After about five minutes, discuss.

   Note:
   Be sure to emphasize the fact that this is an emergency method and should not be used as a routine contraceptive.

   Discussion Questions:

   a. What questions might your person want to ask before deciding to use emergency contraception?

   b. How quickly would the person in your case study have to act?

   c. What are the chances the person in your case study will act quickly enough?

   d. In your situation, what role could the male partner play in taking action to prevent pregnancy?

6. Ask for two volunteers. One will play the person in one of the scenarios calling a doctor or family planning center to inquire about getting emergency contraception. The other will play a health care professional responding over the phone. (Be certain that the "professional" gives accurate answers and emphasizes that if the woman wants to use emergency contraception, she must begin using it within 72-120 hours of intercourse.)

7. Inform participants about age restrictions for over-the-counter purchase of emergency contraception, state-specific guidelines for emergency contraception availability, and any other current developments in access to emergency contraception. Visit www.plannedparenthood.org or www.not-2-late.com to provide updated information for your location.

Handout

"We Used a Condom ... But ... "

1. This is what happened:

   Janine and James have been going together for over a year. They've been having intercourse for six months now, and they've used a condom every time. They chose condoms because condoms protect against both pregnancy and sexually transmitted infections. At first they experimented with different types of condoms and finally selected the type they liked best. They had never had a problem until last night. They were out of their usual brand and found an old one in the glove compartment of the car. It broke just after ejaculation. Both Janine and James want to finish school; neither wants to have a baby at this time in their lives.

2. What can Janine and James do? List all their alternatives.

3. Given these alternatives, what's your advice?

Handout

"We Meant to Use a Condom ... But ... "

1. This is what happened:

   Kisha and Tyrone have been going together for over a year. They've been having intercourse for six months now, and they've used a condom every time. They chose condoms because they're good protection against both pregnancy and sexually transmitted infections. At first they experimented with different types of condoms and finally selected the type they liked best. They had never had a problem until last night when they'd had a couple of beers — well, more than a couple. And, they didn't have a condom with them. So, they had intercourse without a condom for the first time. Both Kisha and Tyrone want to finish school; neither wants to have a baby at this time in their lives.

2. What can Kisha and Tyrone do? List all their alternatives.

3. Given these alternatives, what's your advice?

Handout

"He Forced Me and He Didn't Use a Condom!"

1. This is what happened:

   Last night Maria was out with the friend of a friend. It was very exciting, but also a bit scary, because Anthony was six years older than she. Maria did her best to seem sophisticated, and the evening seemed to go quite well. Anthony talked about a lot of interesting things and she listened. Then, when she thought he was taking her home, he stopped the car and pulled her towards him, kissing her and touching her breasts. She wasn't sure of what to do or what to say. She didn't want him to think she was immature, so she didn't ask him to stop. He held her down and forced her to have intercourse. When they got to her house, Maria quickly got out of the car without saying a word.

2. What can Maria do? List all possible alternatives.

3. Given these alternatives, what's your advice?

Handout

The Facts about Emergency Contraception

EMERGENCY CONTRACEPTION (EC):

- EC is a woman's second chance to PREVENT pregnancy. It is used when the prevention of pregnancy by use of ongoing contraception or abstinence doesn't "pan out" either because the method was not used or there was a contraceptive accident or mishap. Examples of contraceptive accidents or mishaps include a broken condom, wrong pills taken, IUD expulsion, failure to withdraw before ejaculation, or forgetting to pack birth control method for a trip.

- The copper IUC (intrauterine contraception) is the most effective EC method — it reduces the risk of pregnancy by more than 99 percent if it's placed in the uterus by a trained health care provider within five days of unprotected sex.

- Ulipristal acetate (UPA), a pill prescribed for EC, reduces the risk of pregnancy by up to 85% and works just as well on any day if taken up to five days after unprotected sex. But in very overweight women, it may not work at all.

- Progestin EC, one or two pills depending on brand, can be bought over the counter depending on the purchaser's age. It reduces the risk of pregnancy by 75%-89% if taken within the first three days after unprotected sex. It is less effective the more time passes and may not work four or five days after sex. Also, in overweight women, it may not work as well. In very overweight women, it won't work at all.

- Emergency contraception pills prevent ovulation (no egg is released from the ovary), delay ovulation, or thicken the cervical mucus so sperm cannot reach the egg, if the egg is released. The copper IUC causes inflammation that affects sperm movement and is toxic to sperm, thereby preventing fertilization.

- EC is intended for emergency use only, if the pill version is used; unlike the copper IUC (ParaGard®), EC pills are not considered an ongoing method of contraception.

- EC does not affect a woman's ability to get pregnant in the future.

- EC does not cause or increase the risk of birth defects.

EMERGENCY CONTRACEPTION OPTIONS:

Copper IUC (ParaGard®) – the most effective emergency contraception option. The copper IUC is also one of the most effective ongoing contraceptive methods. It is inserted into the uterus, is more than 99% effective, and prevents pregnancy for up to 12 years.

Ulipristal acetate packaged pill (ella®) – a pre-packaged dose of one pill that is FDA approved for use within five days of unprotected intercourse.

Progestin EC (levonorgestrel-only) packaged pills – a pre-packaged dose of one or two pills that is FDA approved for use within three days of unprotected intercourse. Options include:

Plan B One-Step® (one pill)
Next Choice One Dose™ (one pill)

Next Choice™ (two single pills taken 12 hours apart)
Levonorgestrel Tablets (two single pills taken 12 hours apart)

Combined estrogen and progestin oral contraception pills – are no longer pre-packaged, are not as effective as all other emergency contraction methods, are associated with more side effects, and so, only should be used if nothing else is available. It is a specific combination of two, three, four or five prescribed oral contraceptive pills taken 12 hours apart within 72 hours. The number of pills taken depends on the dose of each pill used.

KEEP IN MIND ABOUT EMERGENCY CONTRACEPTION:

- In the form of a copper IUC, is the most effective second chance at preventing pregnancy; ulipristal acetate is next best; progestin EC pills are third best at preventing pregnancy but may be more accessible because of over-the-counter status.

- Should be started as soon as possible after unprotected intercourse. Research indicates that progestin EC pills can still be effective when started up to five days after unprotected intercourse, but progestin EC pills are not as effective as ulipristal acetate when more than three days past unprotected intercourse. Recent research shows that progestin-only pills won't work in very overweight women and are much less effective than ulipristal acetate in overweight women. Ulispristal acetate may not be effective in very overweight women. The effectiveness of the IUC is not affected by weight.

- Progestin EC can be obtained over the counter for those ages 17 or older. A court decision April 5, 2013 by Judge Edward Korman in *Tummino v. Hamburg* may result in over-the-counter progestin EC availability, regardless of age. More recently, on April 30, 2013, the FDA approved Plan B One-Step® over-the-counter availability for those 15 and older, with proof of age. A prescription is required for ulipristal acetate regardless of age.

- Can cause side effects such as nausea, breast tenderness, abdominal pain and/or irregular bleeding.

- Pills do not require a woman to have a pelvic exam or a pregnancy test when unprotected intercourse occurred no more than five days beforehand.

- Pills are provided by some clinicians during a woman's regular visit so she can take them immediately in case of a contraceptive mishap or emergency.

For further information or to locate a provider near you access www.plannedparenthood.org or http://ec.princeton.edu or call:

1-888-NOT-2-LATE **1-800-230-PLAN**

Sources:

Alan Guttmacher Institute (2004). *Facts in brief: Contraceptive use*.

Bracken, M. B. (1990). Oral contraception and congenital malformations in offspring: a review and meta-analysis of the prospective studies. *Obstetrics and Gynecology, 76:* 552-557.

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International Consortium for Emergency Contraception (Feb. 2013). Clinical summary: Emergency contraceptive pills. Accessed April 17, 2013 at www.cecinfo.org/custom-content/uploads/2013/03/ICEC-Clinical-Summary-2013.pdf

International Consortium for Emergency Contraception and International Federation of Gynecology and Obstetrics (FIGO) (Mar. 2012). Mechanism o f action: How do levonorgestrel-only emergency contraception pills (LNG ECPs) prevent pregnancy? Accessed April 17, 2013 at www.cecinfo.org/custom-content/uploads/2012/12/ICEC_FIGO_MoA_Statement_March_2012.pdf

SECTION 3
Teaching about Sexual Health

This section explores the confusing and complex world in which we gain information about sexual health for ourselves, and encourages critical thinking about the world around us. Participants learn basic information about their bodies, reproductive and sexual health, and how to access services.

Mixed Messages:
Growing Up In a Sexually Confusing Society

Sexuality through the Lifespan

Sex Ed on the Web:
In Search of Accurate Sexuality Information on the 'Net

Making the Parent Connection:
Encouraging Communication within the Family

Handling Horny:
Savvy about Sexual Response

What's Your Advice?
Adult Male–Teen Female Relationships

It's Your Body:
Understanding Reproductive Health

Positively Pregnant:
Prenatal Care: The Difference It Makes

It's Your Right:
How to Access Reproductive Health Services

A Place for Us All

Sex Ed Trivia

MIXED MESSAGES
Growing Up in a Sexually Confusing Society*

Objectives

By the end of the lesson, participants will be able to:

1. Explain that sexual behaviors and attitudes are learned.
2. Analyze the messages about sexuality that they receive from a variety of sources.
3. Identify some of their own current beliefs and values regarding sexuality.

Rationale

Youth growing up in contemporary society are confronted with a variety of contradictory and confusing messages about how they should act as sexual persons. This lesson is designed to help participants realize that people must examine the messages they are receiving and then make conscious decisions regarding their own beliefs and behaviors.

Materials

- Flip chart paper or board, markers
- Large **SOURCE CARDS** with one label each: **Friends, School, Advertising, Parents, Myself, Internet, Television/Videos, Religion, Books/Magazines, Music**
- **Handout: Sources Tell Me ...**

Procedure

1. Write on the board/flip chart:

   SEXUAL BEHAVIORS AND ATTITUDES ARE LEARNED

2. Note that while hormones are important in creating the potential for human sexual responses, how people actually behave sexually is determined largely by the society in which they grow up. Each society teaches its children and young people how they should act as males and females;

* Parts of this lesson were adapted from Taverner, B., & Montfort, S. (2005). *Making sense of abstinence: Lessons for comprehensive sex education.* Morristown, NJ: The Center for Sex Education.

how their bodies should look; who can touch them and under what conditions; what's okay and not okay in relationships, and many other values regarding their sexuality.

3. Draw a stick figure on the board or on a new page of flip chart paper. Draw a question mark **(?)** inside the face of the stick figure. Ask participants, "What are the different sources of information about sexuality in the United States?" List responses around the stick figure drawing.

4. Divide participants into small groups of three or four, and distribute one **SOURCE CARD** and a copy of the **Handout: Sources Tell Me ...** to each group. If you have a small number of participants, some groups may work on two sources.

5. Ask each group to list all the messages they can think of that their source might say about *sex*. Encourage participants to identify as many messages as they can, writing each message as a short quote. (For example, the **INTERNET** might say, "Sex is available 24 hours a day!"; or **RELIGION** might say, "Don't have sex unless you're married!") Give groups about 10 minutes to write their source lists.

6. Ask each group to decide upon the top three messages that best represent its source, and to mark these messages with a star. Ask each group to choose one person who will represent them (or two people if the group worked on two sources).

7. Tell participants they will now have an opportunity to learn about sex from society's different sources. Ask source representatives to put on their source cards and, with their group's source list in hand, make sure that all participants hear their source's messages. Tell them to be creative and persuasive in delivering their messages to everyone in the room.

8. After a few minutes, ask source representatives to be seated.

Discussion Questions:

a. How did your group decide what *sex* meant?

b. How did it feel to listen to all these messages? To give the messages?

c. Which messages did you hear most clearly? Which were most influential?

d. Which messages (or sources) were most helpful? Why?

e. Which sources were not helpful? How could these sources become more helpful?

f. Which messages would apply only to heterosexual individuals, if any? Explain.

g. If you plan to have children in the future, what messages would you want to give your children?

h. What advice would you give to someone trying to make a sexual decision while faced with all this confusion?

Handout

Sources Tell Me ...

Directions: There are many sources of sexual information in a society. Write down the name of the source your group is considering, and list all the things that this source might say about *sex*.

SOURCE:

When it comes to sex, this source says:

"_____"

"_____"

"_____"

"_____"

"_____"

"_____"

"_____"

"_____"

"_____"

"_____"

"_____"

SEXUALITY THROUGH THE LIFESPAN

Objectives

By the end of the lesson, participants will be able to:

1. Describe how sexuality develops and changes throughout the lifespan, from birth to death.
2. Explain that sexuality includes all our attitudes, values and behaviors related to being male or female.
3. Understand that outercourse (sexual intimacy without intercourse) is a possible option for expressing sexual feelings without risk of pregnancy.

Rationale

In today's society, when people use the word *sex* they are usually referring to intercourse. As young people internalize this message from their environment, they may feel pressured to experience intercourse as an affirmation of their sexuality. By examining ways humans express their sexuality throughout the lifespan, participants can broaden their understanding of their own sexual experience.

Materials

- **Handout: Human Sexuality Is ...**
- **Handout: Sexuality through the Lifespan**

Procedure

1. Note that humans are sexual beings from before birth until death.

   Discussion Questions:

   a. What questions do young children ask about sex?

   b. What play activities do young children create to find out about their sexuality?

   c. Can you remember anything you were curious about regarding sexuality when you were a child?

2. Divide the participants into small groups and distribute **Handout: Human Sexuality Is ...** and **Handout: Sexuality through the Lifespan.**

3. Review the handouts with the entire class. Tell the groups that they will work together to reach consensus in completing the assignment.

4. After a few minutes, redirect the small groups to form a large group discussion. Begin by asking volunteers to comment on the questions at the bottom of the **Handout: Human Sexuality Is ...** Then, ask the following discussion questions:

   Discussion Questions:

   a. How is sexuality in childhood similar to sexuality in old age? How is it different?

   b. What stage are you in? How does sexuality in the stage you are in compare with sexuality in other stages of the lifespan?

   c. Which stage of the lifespan seems most exciting? Why?

   d. Explain that the word *outercourse* is used to describe intimate sexual relations without intercourse. Describe some possible forms of outercourse, such as holding hands, kissing, fondling, and masturbation.

   e. What are some ways individuals can develop positive attitudes about their own sexuality?

   f. What could parents and other caregivers do to help their children develop positive attitudes about their own sexuality?

Handout

Human Sexuality Is ...

Directions: Human beings are sexual from birth to death. Sexuality, however, changes throughout the lifespan as a person grows and develops. Place a check in the column that indicates the times in the lifespan in which each of the following needs or behaviors might occur.

Human Sexuality is...	Early Childhood Birth–3 years	Late Childhood 4-8 years	Early Adolescence 9-11 years	Adolescence 12-18 years	Young Adult 19-30 years	Adult 31-45 years	Adult 46-64 years	Adult 65+ years
1. Love								
2. Touch and affection								
3. Sense of being male or female								
4. Curiosity about body differences								
5. Need for friends								
6. Erections								
7. Lubrication of vagina								
8. Possibility of orgasm								
9. Possibility of masturbation								
10. Menstruation								
11. Sperm production								
12. Awareness of attraction to members of same sex, different sex, or both								
13. Possibility of intercourse								
14. Possibility of outercourse (kissing, touching, etc.)								
15. Possibility of pregnancy or impregnating								
16. Possibility of contraception and "safer sex" decisions								

Human Sexuality is...	Early Childhood Birth–3 years	Late Childhood 4-8 years	Early Adolescence 9-11 years	Adolescence 12-18 years	Young Adult 19-30 years	Adult 31-45 years	Adult 46-64 years	Adult 65+ years
17. Flirting								
18. Possibility of beginning or ending a relationship								
19. Need for independence								

1. **Which stage in the lifespan seems most exciting?**
2. **Write the letter "P" next to the items that are pleasurable.**
3. **Write the letter "C" next to the items that involve choices and decision making.**

Handout

Sexuality through the Lifespan

EARLY CHILDHOOD (Birth to 3 years)
Learns about love and trust through touching and holding
Sucking (need for oral satisfaction)
Boys: erections of penis
Girls: vaginal lubrication
Possibility of masturbation
Gender identity develops (child knows "I am a boy" or "I am a girl")
Sex role conditioning (boys and girls are treated differently)
Exploration of own body (hands, feet, genitals, etc.)
Toilet training
Curiosity about differences between boys' and girls' bodies
Curiosity about parents' bodies

LATE CHILDHOOD (4-8 years)
Childhood sexual play (e.g., "playing doctor")
Sex role learning: how to behave like a boy or girl
Learns sex words ("bathroom vocabulary")
Asks questions about pregnancy and birth
Begins to distinguish acceptable and not-acceptable behavior
Possibility of masturbation
Becomes modest about own body
Media influences understanding of male/female family roles

EARLY ADOLESCENCE (9-11 years)
Puberty begins (growth of genitals, breast development, etc.)
Possibility of masturbation
Closeness of same-sex friends
Possibility of body exploration with others
Possibility of menarche

ADOLESCENCE (12-18 years)
Pubertal changes occur
Menstruation or sperm production
Possibility of masturbation
Pleasure from kissing and petting
Greater awareness of being attracted to people of same sex, opposite or both
Possibility of sexual intercourse or outercourse
Possibility of pregnancy or impregnating
Possibility of contraception and "safer sex" decisions
Strong need for independence

YOUNG ADULTHOOD (19-30 years)
Possibility of intercourse or outercourse
Possibility of mate selection (homosexual or heterosexual)
Decision making about partnerships, marriage, family life and careers
Possibility of masturbation
Possibility of pregnancy, childbirth and parenting
Possibility of contraception and "safer sex" decisions
Possibility of ending a relationship

ADULT (31-45 years)
Possibility of intercourse or outercourse
Possibility of mate selection (homosexual or heterosexual)
Maintaining relationships (sexual and non-sexual)
Possibility of masturbation
Possibility of parenting responsibilities (sex education of own children)
Possibility of pregnancy and childbirth
Possibility of contraception and "safer sex" decisions
Possibility of grandparenting
Possibility of ending a relationship

ADULT (46-64 years)
Menopause
Possibility of grandparenting
Possibility of intercourse or outercourse
Possibility of mate selection
Possibility of masturbation
Possibility of contraception and "safer sex" decisions
Possibility of divorce or death of a loved one

ADULT (65 to Death)
Body still responds sexually, but more slowly
Possibility of grandparenting
Need for physical affection
Possibility of intercourse or outercourse
Possibility of masturbation
Possibility of mate selection
Possibility of death of a loved one

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SEX ED ON THE WEB
In Search of Accurate Sexuality Information on the 'Net*

Objectives

By the end of the lesson, participants will be able to:

1. Compare the quality of three websites designed to provide information about sexuality for teens.

2. Identify questions regarding sexuality of concern to teens and evaluate answers to those questions found on the three websites.

3. Recommend strategies for assessing the reliability of information about sexuality they research online.

Rationale

Although many adults are concerned about the messages about sex young people are getting on the Internet, some websites are designed for teens and provide an invaluable resource for helping them access information vital to their sexual health and well-being. It is important for teens to know these reliable sites are available to them when they have questions about sexuality. And, since many sites are not reliable, it is also important that they become critical viewers of any site where they seek to learn about sexuality. This lesson introduces three responsible sites and encourages young people to evaluate carefully the information they are receiving from the Internet.

> **Note:**
> Since participants will need time to research information on the Internet, this lesson requires two sessions to complete.

Materials

- Flip chart paper or board, markers and index cards
- Computers with Internet access
- **Handout: Navigating the 'Net**
- **Handout: Savvy Sexual Health Information Websites for Teens**

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* Thanks to Jillian Kandrach and Kim Jack Riley for their help in developing this lesson.

Procedure

1. Put the following continuum on the board/flip chart.

0	1	2	3	4	5	6	7	8	9	10
Dangerous										**Wonderful**

Ask participants to evaluate the Internet as a place to get information about sex. Where would they put their evaluation on the continuum?

Discussion Questions:

a. Where did you place your evaluation on the continuum? Why?

b. How do you determine if information you receive from a website is credible?

c. What are the advantages of using the Internet to investigate sexuality topics? Disadvantages?

d. What can you do to find sexual health–related websites on the Internet?

2. Write the names of three sexual information websites on the board/flip chart:

www.plannedparenthood.org/info-for-teens/
www.scarleteen.com
www.sexetc.org

If working with Spanish-speaking participants, use these websites:

www.plannedparenthood.org/esp/
www.ambientejoven.org
www.quierosaber.org

3. Ask participants if anyone knows any of these Internet websites. Explain that these three sites were designed specifically to address teens' concerns about sexuality. They are going to compare the three sites by searching for answers to questions they think are of particular interest to young people. Give each participant an index card and ask them to write an important question regarding sexuality. Emphasize that the questions will be anonymous — no one will know which question any individual wrote.

4. Collect the cards and examine them quickly; eliminate any that are inappropriate for the project.

5. Distribute the **Handout: Navigating the 'Net.** Put the question cards into a container and have participants select, at random, a question to research. Review the handout, explaining that they are to compare the quality of the answers to their question on each of the sites. Give them a specific time when the assignment will be due. Note that if an answer is not available, they can ask the website to provide one!

6. On the due date, ask several volunteers to report their findings.

   Discussion Questions:

   a. Which website(s) did you like best? What did you like about it?

   b. Which website did you find most helpful in answering your question?

   c. How easy or difficult was it to find the answer on the website? Why?

   d. How could you check the accuracy of the answer(s) you received at the sites?

   e. What are some other resources that could be useful to get sexual health information?

7. Distribute the **Handout: Savvy Sexual Health Information Websites for Teens.** Ask participants whether they know other sites they believe are reliable sites for sexuality information.

Handout

Navigating the 'Net

Directions: Write the question about sexuality you are researching. Visit three sexual health information websites, chosen from the **Handout: Savvy Sexual Health Information Websites for Teens**. Then record your evaluations for each website on the chart.

What question are you researching? _____

	Website #1:	**Website #2:**	**Website #3:**
How well did this website answer your question?	_____Not at all _____Somewhat _____Completely	_____Not at all _____Somewhat _____Completely	_____Not at all _____Somewhat _____Completely
What organization sponsors this website?			
What did you like/ dislike about this website?			
What feature did you like best about this website?			
Would you visit this website again? Why?			

Handout

Savvy Sexual Health Information Websites for Teens

Websites in English

- **www.plannedparenthood.org**
  A website by Planned Parenthood Federation of America

- **www.scarleteen.com**
  A website for teens and twenties

- **www.goaskalice.columbia.edu**
  A question-and-answer website by Columbia University's Health Education program

- **www.pamf.org/teen/sex/**
  A website by the Palo Alto Medical Foundation, provides information about sexual health

- **www.sexetc.org**
  Sex ed by teens for teens, published by Answer

- **www.guttmacher.org**
  The Alan Guttmacher Institute, providing translated up-to-date research on reproductive health issues

- **www.cdc.gov**
  The Centers for Disease Control and Prevention, providing the latest information and research sexual health and wellness in the United States

- **www.teenshealth.org**
  A website for teens by The Nemours Center for Children's Health Media

- **http://ec.princeton.edu**
  The Emergency Contraception Website, operated by the Office of Population Research at Princeton University and the Association of Reproductive Health Professionals

- **http://amplifyyourvoice.org/youthresource/health-topics**
  YouthResource is a project of Advocates for Youth and is for lesbian, gay, bisexual and transgender youth.

Websites in Spanish

- **www.plannedparenthood.org/esp/**
  A website by Planned Parenthood Federation of America

- **www.ambientejoven.org**
  A website for lesbian, gay, bisexual and transgender youth by Advocates for Youth

- **www.quierosaber.org**
  A website by the American Sexual Health Association

- **www.nlm.nih.gov/medlineplus/spanish/birthcontrol.html**
  A website by the National Institutes of Health, MedLine provides information about sexual health and other health-related topics

- **www.positive.org/DiQueSi/index.html**
  A website by the Coalition for Positive Sexuality

- **www.cdc.gov/spanish**
  A website by The Centers for Disease Control and Prevention, providing the latest information and research sexual health and wellness in the United States

- **www.teenshealth.org/teen/centers/spanish_center_esp.html**
  A website for teens by The Nemours Center for Children's Health Media

- **http://ec.princeton.edu/es_index.html**
  The Emergency Contraception Website, operated by the Office of Population Research at Princeton University and the Association of Reproductive Health Professionals

MAKING THE PARENT CONNECTION
Encouraging Communication within the Family

Objectives

By the end of the lesson, participants will be able to:

1. Identify reasons why parents do not talk with their children about sexuality and contraception.

2. Identify behaviors that encourage and discourage adolescent–parent communication.

3. Discuss whether communication between parents and their children would help develop responsible sexuality and discourage unwanted pregnancy and infection.

Rationale

Research consistently indicates that most parents do not talk openly with their children about sexuality.[1] Communication can be especially difficult during the adolescent years when teens are establishing independence from their families — sometimes through sexual activity. Yet studies show the importance of parent–child communication because youth are more likely to delay sexual intercourse, use contraception, and have fewer sex partners when parents communicate about sexuality.[2] This lesson helps participants examine family communication about sexuality and explore ways to initiate discussion on sexual issues.

Materials

- Flip chart paper or board, markers
- Index cards: Large, with copy of description of one role-play character on each
  Small, for each participant
- **Handout: Making the Parent Connection**
- **Handout: Role-Play Characters**

[1]Martino, S. C., Elliott, M. N., Corona, R., Kanouse, D. E., & Schuster, M. A. (2008). Beyond the "big talk": The roles of breadth and repetition in parent-adolescent communication about sexual topics. *Pediatrics, 121(3):* 612-618.

[2] Schuster, M. A., Corona, R., Elliot, M. N., Kanouse, D. E., Eastman,K. L., Zhou, A. J., & Klein, D. J. (2008). Evaluation of talking parents, healthy teens, a new worksite based parenting programme to promote parent-adolescent communication about sexual health: Randomised controlled trial. *British Medical Journal,* 337-345.

Procedure

1. Start discussion by noting that it is important that parents talk about sexuality with their children, but that many parents find this difficult. Ask participants why it is difficult for many parents to talk with their children about sexuality.

2. Ask participants to brainstorm the reasons why it would be advantageous for parents to talk about sexuality, including contraception and safer sex, with their children. (Write the reasons on the board/flip chart as participants suggest them.)

   Discussion Questions

   a. What are some ways teens can initiate conversations about sexuality with parents?

   b. What are some critical sexuality topics parents and teens should be discussing?

   c. What are some suggestions you have for teens and parents to talk about sexuality? List suggestions on the board/flip chart.

3. Tell participants that they are going to do a new kind of role-play to explore family communication about sexuality. Then, divide the participants into four groups.

4. Give each group a card describing one member of the family from the **Handout: Role-Play Characters.** Explain that each group will read the description and discuss how the character will act in a role-play of the current crisis in the household. After about five minutes, ask the groups to select one volunteer to take part in the role-play.

5. Distribute small index cards to the remaining group members. State that during the skit, group members can write a suggestion on the index card and deliver it to the actor from their group. (Actors may choose to use the suggestion or ignore it.)

6. Tell the actors to come forward. Help each get into the role by asking: "How are you feeling about the situation in your family right now?" Then, let the players begin the scene.

7. Let the scene continue as long as it seems productive. After about 10 minutes, let the actors return to their own group to get more suggestions. A new person may assume the role at this time if the group so chooses.

8. Let actors return to the "stage" and continue the role-play. (Group members can continue to make written suggestions to their actor.)

9. Stop the role-play in time to debrief the actors and help them get out of their roles. Ask each actor, "How did you feel in the role that you played?"

   Discussion Questions:

   a. What examples can you give of something a family member did or said that encouraged communication? Examples of something that discouraged communication?

   b. Should this family have started talking about sexuality sooner? Explain.

   c. Ask the actors who played the Mother and Father why they might have been reluctant to raise the topic.

   d. What would you recommend to individual family members concerning future communication about sexual issues?

Note:
This lesson suggests one possible situation for a role-play examining family conversation about sexuality and contraception. However, we recommend that you adapt it to fit situations familiar to your own group. Refer to **How to Use Role-Play** (page xxii) for additional recommendations.

Follow-up Activities

1. Have participants complete and discuss **Handout: Making the Parent Connection**. If feasible, have participants take a copy of the handout home for a parent to complete. Provide an opportunity for participants to discuss parents' answers and how young people and parents might begin to communicate about sexuality.

2. Write a dialogue in which a mother discovers a condom in her son's jeans. Have volunteers read their dialogues to the group.

3. Write a dialogue in which a teen talks to a parent about the possibility that the teen will have intercourse soon.

4. Have participants, for homework, ask parent(s) how and from whom they would have liked to learn about sexuality, and how and from whom they actually learned. Discuss answers next time the group meets.

Handout

Making the Parent Connection

Directions: People have different opinions of the role parents should have in talking with their children about sex. What do you think? Check whether you agree strongly, agree, are not sure, disagree or disagree strongly with each of the following statements.

YOUNG PEOPLE WOULD MAKE MORE RESPONSIBLE DECISIONS ABOUT SEX IF:	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly
1. Parents began talking with their children about sexuality in early childhood.					
2. Family discussion about contraception and safer sex started no later than seventh grade.					
3. Parents encouraged abstinence and did not talk about contraception and safer sex at all.					
4. Parents helped young people understand about sexual responsibility by sharing information about their own early sexual responsibilities.					
5. Parents discussed the pros and cons of different contraception and safer sex methods with their daughters.					
6. Parents discussed the pros and cons of different contraception and safer sex methods with their sons.					
7. Parents discussed going to a doctor or birth control clinic with a daughter involved in a relationship that seems likely to lead to sexual intercourse.					
8. Parents discussed purchasing condoms with a son/daughter involved in a relationship that seems likely to lead to sexual intercourse.					
9. Parents offered to help their son/daughter pay for contraception and condoms if the young person is having intercourse.					
10. Parents did not talk about intercourse at all since talk encourages young people to have intercourse.					

YOUNG PEOPLE WOULD MAKE MORE RESPONSIBLE DECISIONS ABOUT SEX IF:	Agree Strongly	Agree	Not Sure	Disagree	Disagree Strongly
11. Parents felt proud when their teenager took responsibility for using condoms and another reliable method of contraception.					
12. Parents expressed their views (perhaps favoring abstinence) but encouraged use of contraception, including condoms, if son/daughter decided to have intercourse.					
13. Families discussed sexual orientation in an understanding and accepting way.					

Handout

Role-Play Characters

Mother, 44

Your daughter, who is only 17, has been going out with a man, 22 years old, who is a good friend of your son. You're worried that they are having intercourse, though you hope not. You believe that older men often pressure girls to have intercourse before they are really ready. You know you should talk to your daughter about the possibility of a pregnancy and the importance of using contraception. However, you really want to encourage her to say "no." Last night you discussed the matter with your husband, and you agreed to bring the subject up at dinner tonight.

Father, 46

Your daughter, who is only 17, has been going out with a man, 22 years old, who is a good friend of your son. You're worried that they are having intercourse, though you hope not. You believe that older men often pressure girls to have intercourse before they are really ready. You know you should talk to your daughter about the possibility of a pregnancy and the importance of using contraception. However, you really want to encourage her to say "no." Last night you discussed the matter with your wife, and you agreed to bring the subject up at dinner tonight.

Daughter, 17, High-School Junior

For three months now, you've been going out with a man, 22 years old, who is a good friend of your 20-year-old brother. You like him a lot, and you've been spending more and more time alone together. You think he wants to have intercourse, but you're nervous about it. You would be happy to keep the relationship just the way it is now, but you don't think he will be. Last night you overheard your parents talking, and you know they plan to talk with you about your relationship at dinner tonight.

Son, 20

For about three months, your sister, a 17-year-old high-school junior, has been dating your friend, who is 22 years old. Their relationship seems to be getting serious, and while you haven't talked to your friend about it, you suspect he wants them to have intercourse. It's hard for you to imagine your little sister having intercourse, but your friend is a great guy, and you think it's a good relationship. You heard your parents talking about discussing this relationship at dinner tonight.

HANDLING HORNY
Savvy about Sexual Response*

Objectives

By the end of the lesson, participants will be able to:

1. Increase awareness of the physical aspects of sensuality and sexual response.
2. Recognize the role the senses play in sexual response.
3. Understand that sensual feelings are present throughout life.
4. Identify ways to handle sexual feelings that are consistent with one's values, including personal definitions of abstinence.

Rationale

Since sexual feelings are present throughout life, learning to identify one's own sexual responses can help young people manage them, and make decisions to help themselves avoid unplanned pregnancy and sexually transmitted infections. Whether teens' conscious decisions are to be abstinent or to engage in sexual intercourse, understanding and valuing their bodies increases the likelihood that they will implement their decisions in effective and healthy ways.

This lesson, in contrast to those sometimes found in abstinence-only programs that promote simplistic slogans (like "Just Say No" or "Put a lock on it"), helps normalize natural sexual responses for young people and build skills for recognizing and handling sexual responses. Research shows that for young women, in particular, validating experiences of sexual desire and expectations of sexual pleasure in relationships increases the likelihood that they will delay intercourse for the "right person" and the "right time," and use contraception if they begin to have intercourse.[1]

Materials

- Flip chart paper or board, markers and tape
- Sheet of flip chart paper with the following questions written on it.
    1. Which of these physical changes are easy for a person notice in him/herself?

* Parts of this lesson were adapted from Taverner, B., & Montfort, S. (2005). *Making sense of abstinence: Lessons for comprehensive sex education.* Morristown, NJ: The Center for Sex Education.

[1] See, for example, Thompson, S. (1995). *Going all the way: Teenage girls' tales of sex, romance, and pregnancy.* New York, NY: Hill and Wang.

2. Which of these physical changes are easy to notice in another person?
3. What emotional changes might a person feel when these physical changes happen?
4. What thoughts might a person have?

- **Handout: What's Going on Here?**
- **Educator Resource: So, Now What? Scenarios for Managing Sexual Arousal** for making **AROUSAL SCENARIO CARDS.** Provide each small group of participants with one scenario written on a large index card.

Procedure

1. Begin by saying that today's lesson focuses on sexual arousal or being "horny," and how these feelings might affect people's sexual decisions. Ask if anybody knows where the word "horny" comes from? Take guesses. Explain that the term comes from the belief in some cultures that drinking ground-up rhinoceros horn increases a person's sexual desire.

   Discussion Questions:

   a. Why might a person want to use a substance to make himself/herself horny?

   b. Do you think this would work? (*Some substances may cause a placebo-like effect; if the user **thinks** something will work, it may, to some degree.*[2])

   c. What might be some risks in using a substance like this? (*Being disappointed when it doesn't work, giving someone a substance without their knowing, becoming addicted.)*

2. Lead a limited brainstorm with the question, "So, how do people ***know*** they're 'horny' anyway?" Write answers on the board/flip chart.

3. Note that we need to talk first a little bit about pleasure in general in order to understand how "horny" happens. Write the five senses (see, smell, hear, taste and touch) on the board/flip chart and note that they can greatly affect sexual arousal. In fact, the senses are important throughout our lives. For example, research has demonstrated that the way an infant is touched and handled affects how her/his brain develops, including the pleasure centers of the brain.[3] Ask participants to think of another sense memory — besides touch — from their own childhoods.

   Discussion Questions:

[2] Francoeur, R. T. (1997). *The complete dictionary on sexology.* New York, NY: Continuum Press.

[3] See, for example, Prescott, J. W. (1989). "Affectional bonding for the prevention of violent behaviors: Neurological, psychological, and religious/spiritual determinants" in Hertzberg, L. J. et al (eds). *Violent Behavior: Assessment and Intervention.* New York: PMA Publishing Corp.

a. How many of you thought of a sense memory that was pleasurable? Not pleasurable?

b. Which were especially strong sense memories? Ask for a few volunteers to share their memories about different senses.

4. Mention that ***now*** we can move on to looking a little more closely at ***sexual*** pleasure and the physical changes of sexual arousal, which are important signals for people to be able to identify if they want to understand how their bodies work physically.

5. Post the sheet of flip chart paper with the questions, and distribute the **Handout: What's Going on Here?** Ask participants to read this handout, which describes the physical changes of sexual arousal, on their own. They are to ***circle*** the physical changes of sexual arousal a person could easily ***notice*** and answer the questions posted on the board on the back of their handouts.

   Discussion Questions

   a. What items did you circle that a person could notice in her or himself? In another person?

   b. What feelings might a person have about sexual arousal? *(Note the variety of both positive and negative feelings a person might have about sexual arousal, depending upon their experiences as they go through life.)*

   c. What thoughts or questions might a person have about sexual arousal?

6. Continue by asking participants to think about some of the specific things that might be the very beginnings of sexual arousal or "turn ons." So, other than rhino horn, what could make a person feel horny? (Give an example or two, such as the smell of a certain cologne; a certain type of hair; a romantic song.) Ask for volunteers to name something from the senses that could trigger sexual arousal. Write these items on the board/flip chart.

   Discussion Questions:

   a. Which senses appear on this list?

   b. Which ones could be especially powerful turn-ons?

7. Note that a great variety of possible turn-ons exist. What is sexually arousing for a person may change at different points in their lives and varies from one individual to another. Explain that it is also important to think about what to do about sexual arousal when a person's decision is to not have oral, anal or vaginal intercourse.

8. Divide participants into small groups and distribute flip chart paper, a marker and one of the scenario cards from the **Educator Resource: So, Now What? Scenarios for Managing Sexual Arousal** to each group. Instruct each group to choose a recorder, discuss their scenario, and write down five choices a person has when they are turned on, but have decided to abstain from intercourse.

9. As participants begin working, write on the board/flip chart:

   What are five things your teen could do to handle being "horny"?

   Allow about 10 minutes. When most are finished, ask the groups to decide and star which of their five alternatives is the best. Then ask a volunteer from each group to tape the group's list on the wall. When all lists are posted, ask the whole group to notice similarities and differences between the lists while the volunteer from each group reads that group's scenario aloud.

   Discussion Questions:

   a. Comparing the lists, what do you notice?

   b. Which suggestions do you think would be best? Why?

   c. Which suggestions would be easier to follow? More difficult?

   d. How likely is it that the teen on your card would follow your advice? Why?

   e. What else might affect how a person handles being turned on in these situations?

   f. How do you think people might feel talking about having sexual responses? Why? (*Note that the timing of sexual feelings might not always be ideal — privacy may not be available, the person might also feel pressured about their decisions, or feel guilty, or a person's body may not continue to respond sexually.*)

10. To conclude the lesson, write the following on the board/flip chart, and discuss briefly:

    FEEL ... ACT ... (THINK)
    or
    FEEL ... THINK ... ACT

Discussion Questions:

a. Which do you think is a better way to handle sexual arousal?

b. What is the difference between **FEELING** and **THINKING**?

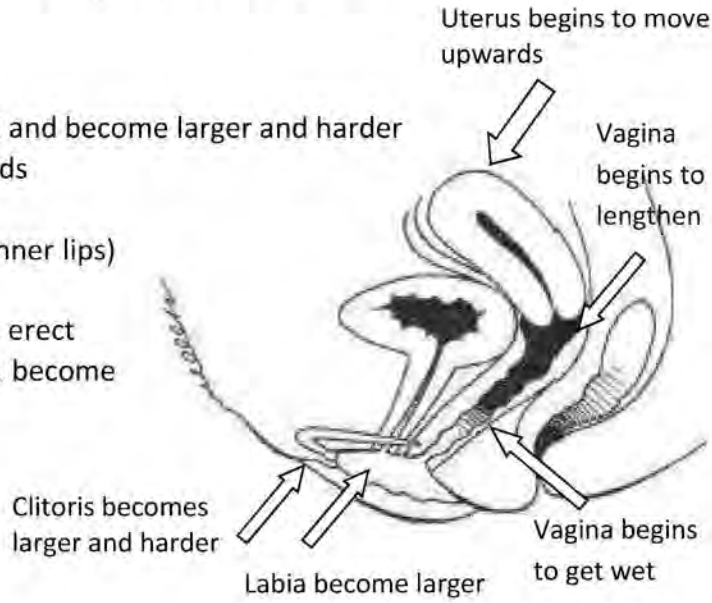
c. Why do you think the **THINK** is in parentheses in the top one? *(Note that when a person **FEELS** and **ACTS** first, s/he may or may not **THINK** later!)*

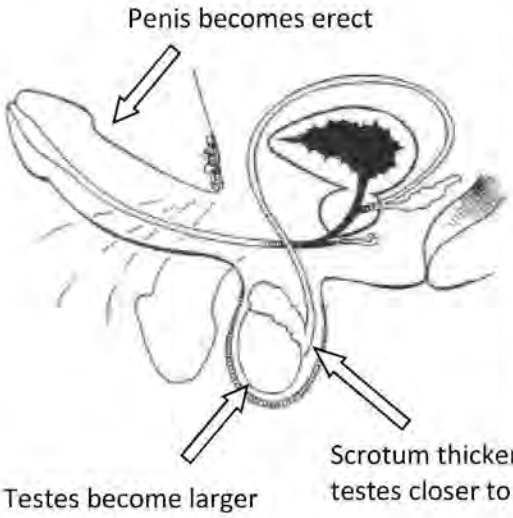
Handout

What's Going on Here?

EXCITEMENT RESPONSES IN FEMALES

- Increased blood flow causes clitoris to swell and become larger and harder
- Vagina lubricates (becomes wet) and expands
- Labia becomes darker in color
- Labia majora and labia minora (outer and inner lips) flatten and spread apart slightly
- Breasts increase in size and nipples become erect
- Some parts of the body, such as the chest, become red in some females (called "sex flush")
- Muscle tension increases
- Heart rate begins to increase
- Blood pressure begins to rise





EXCITEMENT RESPONSES IN MALES

- Increased blood flow causes penis to become erect
- Scrotum thickens and becomes more tense
- Testes elevate slightly within scrotum
- Scrotum pulls testes closer to the body
- Nipples become erect in some males
- Muscle tension increases
- Heart rate begins to increase
- Blood pressure begins to rise
- Some parts of the body, such as the chest, become red in some males (called "sex flush")

Illustrations by Daerick Gross, Sr.

Sources:

Kelly, G. (2005). *Sexuality today: The human perspective.* Cambridge, MA: McGraw-Hill.

Masters, W., & Johnson, V. E. (1966). *Human sexual response.* Boston, MA: Little, Brown and Company.

Educator Resource

So, Now What? Scenarios for Managing Sexual Arousal

1. **John** has decided to abstain from oral, vaginal and anal intercourse. He realizes he's feeling very turned on by a scene in the video he and his partner have been watching.

2. **Kim** has made a decision to abstain from oral, vaginal and anal intercourse. She notices she's feeling very aroused by the sexy thoughts she's having while her partner is giving her a sensuous backrub.

3. **Carlos** has made a decision to abstain from oral, vaginal and anal intercourse. He is with his new partner. He's getting very "hot" listening to the song he and his last partner fooled around to.

4. **Amy** has made a decision to abstain from oral, vaginal and anal intercourse. She loves the cologne her partner uses and the taste of their long kisses. Tonight they've been lying together and kissing for ages and she's feeling very horny.

5. **Lisa** has made a decision to abstain from oral, vaginal and anal intercourse. All evening she and her partner have been dancing close every time there's a slow song on their favorite CD. Hearing and feeling her partner's heavy breathing on the back of her neck, Lisa is getting very aroused.

WHAT'S YOUR ADVICE?
Adult Male–Teen Female Relationships*

Objectives

By the end of this lesson, participants will be able to:

1. Examine their attitudes regarding relationships between couples in which there is a significant difference in age.

2. Summarize research indicating that males over 20 years old may be responsible for many "teen" pregnancies, as well as for the high rate of sexually transmitted infections among teen females.

3. Assess the reasons older males might choose to have sexual relationships with teen females and the reasons teen females might choose to have sexual relationships with older males.

4. Decide what advice they would give to someone involved in an adult–teen relationship.

Rationale

The difficulty the nation has had in reducing teen pregnancy rates may be due, in part, to the fact that intervention efforts have assumed those pregnancies were the result solely of peer-to-peer relationships. In fact, many "teen" births are fathered by adult men. In addition, teen females have a high rate of sexually transmitted infections as compared with their male peers, suggesting that adult male–teen female relationships may also be implicated in disease transmission. This lesson examines the issue of relationships in which adult males are having sexual intercourse with teen females. It encourages participants to evaluate those relationships and give advice about them.

Materials

- Flip chart paper or board, markers
- Four pieces of flip chart paper, each with one of the statements below written on it:
  - **Why teen girls go out with older men**
  - **Why older men go out with teen girls**
  - **Why adults worry when teen girls go out with older men**
  - **How teen boys feel when teen girls go out with older men**
- **Handout: Adult–Teen Relationships: What Are the Facts?** (and **Answer Key**)

* Parts of this lesson were adapted from Montfort, S. & Brick, P. (2007). *Unequal partners: Teaching about power and consent in adult–teen and other relationships.* Morristown, NJ: The Center for Sex Education.

- **Handouts:**
  - **What's Your Advice ... To "Girl in Love"?**
  - **What's Your Advice ... To "My Friend's Friend"?**
  - **What's Your Advice ... To "Confused"?**
  - **What's Your Advice ... To "Stay or Go"?**

Procedure

Note:
Before using the **Handout: Adult–Teen Relationships**, complete the ages for items #9 and #10 according to your state's sexual offense laws (see http://aspe.hhs.gov/hsp/08/sr/statelaws/report.pdf for state-by-state statutory rape laws).

1. Draw on the board/flip chart:

   OK----------??----------NOT OK

2. Explain that participants will be discussing relationships where one partner is much older than the other. Ask them to draw the diagram. Then, ask them to think about a sexual relationship in which a high-school sophomore girl is going out with a 22-year-old man. How do they feel about the fact that he is an adult, seven years older than his teen partner? Put an **X** on the continuum.

3. Ask for several volunteers to say where they placed themselves on the continuum and why. Jot down descriptive words in the appropriate place on the continuum.

4. Distribute the **Handout: Adult–Teen Relationships: What Are the Facts?** and ask the participants to complete it in pairs. When everyone is finished, give the correct answers, one by one. (See the **Answer Key**, which reflects current data.) As you discuss #9 and #10, ask participants why they think these laws exist. What is necessary for a person to be able to agree to a sexual behavior freely and safely?

5. Divide the participants into four groups and give each group a sheet of flip chart paper with a "statement." Instruct each group to list ***all*** the reasons they can think of in response to the statement on their sheet.

   After 10 minutes, ask the groups to post their sheets.

Discussion Questions:

a. What observations can you make from viewing these lists?

b. Do you agree with adults who are concerned about these relationships? Explain.

c. What is your advice to older men? To teen girls? To teen boys?

6. Depending on your group, ask the participants to work again in their small groups, in pairs, or individually. Distribute equally among participants the two **Handouts: What's Your Advice ... To "Girl in Love"?** and **... To "My Friend's Friend"?** Ask the participants to write an "Advice Column" response to the letters on their handout.

   Note:
   If you wish to expand the lesson to relationships between teen boys and adult women, and same-sex relationships, use the additional **Handouts: What's Your Advice ... To "Confused"?** and **...To "Stay or Go"?**

7. To conclude, ask one or two groups, pairs or individuals to read their columns to the entire group.

Handout

Adult–Teen Relationships: What Are the Facts?

Directions: Mark each statement below **T** for True or **F** for False.

_____1. The majority of teenagers who have sexual intercourse do so with partners close to their own age.

_____2. Many babies born to 15-year-old teens are fathered by males 20 or older.

_____3. The younger a girl is when she first has sexual intercourse, the more likely it is that she does not agree to it, and does not want to do it.

_____4. The "age of consent" to sexual intercourse is the same in every state.

_____5. The closer in age a teen girl and her sexual partner are, the more likely she is to use contraception the first time she has sexual intercourse.

_____6. A teen girl is less likely to be exposed to a sexually transmitted infection (such as HIV/AIDS) by a partner three or more years older than by a partner closer to her own age.

_____7. The younger a teen mother is, the greater the age gap is likely to be between her and her baby's father.

_____8. Half of fathers aged 20 or older whose infants are born to 14- to 17-year-old girls have completed fewer years of school than is expected for their age.

_____9. In our state, it is against the law for a person under ____ years old to have sexual intercourse.

_____10. In our state it is against the law for a person _____ years old to have sexual intercourse with a person ____ years old (Or: ____, or more years older) even if the younger person consents to it.

Answer Key

Adult–Teen Relationships: What Are the Facts?

__T__ 1. The majority of teenagers who have sexual intercourse do so with partners close to their own age.

__T__ 2. Many babies born to 15-year-old teens are fathered by males 20 or older.

__T__ 3. The younger a girl is when she first has sexual intercourse, the more likely it is that she does not agree to it, and does not want to do it.

__F__ 4. The "age of consent" to sexual intercourse is the same in every state.

__T__ 5. The closer in age a teen girl and her sexual partner are, the more likely she is to use contraception the first time she has sexual intercourse.

__F__ 6. A teen girl is less likely to be exposed to a sexually transmitted infection (such as HIV/AIDS) by a partner 3 or more years older than by a partner closer to her own age.

__T__ 7. The younger a teen mother is, the greater the age gap is likely to be between her and her baby's father.

__T__ 8. Half of fathers aged 20 or older whose infants are born to 14- to 17-year-old girls have completed fewer years of school than is expected for their age.

__*__ 9. In our state, it is against the law for a person under ____ years old to have sexual intercourse.

__*__ 10. In our state it is against the law for a person _____ years old to have sexual intercourse with a person ____ years old (Or: ____, or more years older) even if the younger person consents to it.

*** State-specific information.**

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Handout

What's Your Advice ... To "Girl in Love"?

I'm 14 and I'm going out with a 21-year-old man. I think he loves me, and I ***know*** I really love him. He treats me really nice. But my parents don't want me to go out with him — just because he's older! They want me to stop seeing him. What should I do?

Your response to "Girl in Love":

Handout

What's Your Advice ... To "My Friend's Friend"?

My roommate is dating a 16-year-old girl. It makes me very uncomfortable because he's 21. I think it may be illegal for an adult to have sex with someone under 18. Can he be arrested? Anyway, I don't know what he sees in such a young kid. Do you think there's something wrong with him? Should I do anything about this?

Your response to "My Friend's Friend":

Handout

What's Your Advice ... To "Confused"?

I'm 15, almost 16. One of my mom's friends is coming on to me all the time. She has always been a close friend of the family and I like her a lot ... but is this normal? I'm very confused, and my mom doesn't even seem to notice.

Your response to "Confused":

Handout

What's Your Advice ... To "Stay or Go"?

I'm 15 years old, and my parents kicked me out when I told them I was gay. Now I am living with my 20-year-old boyfriend. He takes care of me, but a lot of times he gets pushy and demanding. I think I should leave him, but I don't know where to go.

Your response to "Stay or Go?":

IT'S YOUR BODY
Understanding Reproductive Health*

Objectives

By the end of this lesson, participants will be able to:

1. Identify common reproductive health concerns of young people.
2. Discuss basic information about female and male reproductive health care.
3. Talk about reproductive health issues.

Rationale

Young people are often anxious about whether their bodies are normal or healthy but find it difficult to talk about their concerns. This is particularly true of the sexual and reproductive parts of their bodies. We believe that sexual health and reproductive health are integral parts of overall health. Therefore, in discussing reproductive health, we are being inclusive of sexual health. Sexually healthy people need to know how to care for themselves and what services health care professionals can provide for them. This lesson provides basic personal and professional sexual and reproductive health care information and aims to increase young people's comfort in discussing sexual and reproductive health care and potential concerns sexual and reproductive parts of their bodies.

Materials

- Flip chart paper or board, markers and tape
- Index cards in two different colors, with the common reproductive health questions on one color and the answers on the other (See **Educator Resource: Reproductive Health Question and Answer Cards**)
- Charts, diagrams, and/or models of male and female sexual anatomy
- **Handout: It's The Truth: The Facts about Personal Reproductive Health Care for Males**
- **Handout: It's The Truth: The Facts about Personal Reproductive Health Care for Females**
- **Handout: A Maintenance Checklist for Penis Owners**
- **Handout: A Maintenance Checklist for Vagina Owners**

* This lesson was developed by Sue Montfort and Joan O'Leary, former Planned Parenthood educators.

Procedure

1. Tell the group the session will address concerns that many teens have regarding their reproductive or sexual health. Write "**MALE CONCERNS**" on the board/flip chart and ask the group to brainstorm common concerns, worries, or questions that many males have about the "sexual parts of their bodies." Repeat for "**FEMALE CONCERNS**."

   Discussion Questions:

   a. Which male concerns have to do with sexual health? Which with sexual responsiveness? Sexual attractiveness? Repeat for female concerns.

   b. Is there a difference between the focus of male and female concerns? If so, why?

   c. How can people find out if they should get help from a professional for a sexual health concern/problem?

2. Distribute **Handout: It's The Truth: The Facts about Personal Reproductive Health Care for Males** and **Handout: It's The Truth: The Facts about Personal Reproductive Health Care for Females.** Ask participants to read through the lists and see if the handouts address any of the concerns they listed. Discuss any questions.

3. <u>REPRODUCTIVE HEALTH ISSUES QUESTION/ANSWER MATCH</u>

   a. Tell participants that they're going to have a chance to find answers to some common questions about reproductive and sexual health problems.

   b. Distribute one question or answer card to each participant. (Store question and answer cards in pairs until you know the number needed for your group. Shuffle the order of the question and answer cards before you begin the activity.)

   c. Explain that participants each have either a question card or an answer card. Their job is to find the person in the room holding the best match to their own card. Demonstrate by doing an example with one student.

   d. Tell participants they will have five minutes to find their match, and they should remain with their match until the activity is completed.

   e. After everyone has found a match, ask each pair to read their question and answer to the group, one at a time. If the group believes the match is accurate, the pair sits down, and the entire group adds information or asks questions about that issue. If someone questions the accuracy of the match, ask that pair to move to a specified section of the room until all of the pairs have reported.

f. When all of the pairs have read their cards, have participants with the questionable matches reread their cards and others provide the correct match for any that were paired incorrectly.

Discussion Questions:

a. How did it feel to do this activity?

b. What did you learn from doing this activity?

c. What do you think might be particularly useful for individuals to know? Why?

d. What other reproductive or sexual health issues would you like to know more about?

4. PERSONAL REPRODUCTIVE AND SEXUAL HEALTH CARE

Distribute copies of the **Handout: A Maintenance Checklist for Penis Owners** and **Handout: Maintenance Checklist for Vagina Owners** and ask participants to complete the appropriate handout. Assure them that it is completely confidential and will NOT be collected.

Discussion Questions:

a. Which recommendations surprised you?

b. Which recommendations do many people NOT follow? Why?

c. Which recommendations do you think might be particularly important to follow?

d. What are some ways individuals can follow these recommendations?

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Handout

It's the Truth:
The Facts about Personal Reproductive Health Care for Males

It is COMMON for ADOLESCENT MALES to:

- Be at a different stage of physical development from peers of the same age.
- Have a temporary increase in breast size.
- Have breast swelling or tenderness, or a sore spot under nipple(s).
- Have a flaccid (soft) penis length of 1 inch to 5 inches.
- Have an erect penis length from 4 inches to 7 inches.
- Have a penis that becomes erect at any angle, and may curve to the right or left.
- Believe (incorrectly) that penis size is crucial to proper sexual functioning.
- Have an ache in the testicles after prolonged sexual arousal (which will go away by itself).
- Have one testicle larger and hanging lower than the other.
- Have their testicles hang closer to or further from the body, depending upon temperature changes, stress or sexual arousal.
- Be "normal" with either a circumcised or uncircumcised penis.
- Have a whitish, cheesy substance (smegma) under foreskin, if uncircumcised.
- Have a pimple or hairs on the penis.
- Have genital hair that differs from other body hair.
- Have a natural, healthy genital odor.
- Have frequent erections, due to sexual arousal, stress, general excitement or sometimes for no apparent reason.
- Wake up in the morning with an erection.
- Have erections without ejaculating.
- Sometimes lose an erection.
- Masturbate occasionally, frequently or not at all (with no resulting physical harm).
- Have approximately one teaspoon of milky fluid come out of the penis (ejaculate, "cum," wet dream) when sexually aroused, or while sleeping.
- Be unable to urinate at the same time they ejaculate.
- Have occasional, short-lived itching around testicles and/or inside thighs.
- Feel a thickening or ridge (epididymis) in the top back portion of the testicle.

It is UNCOMMON but POSSIBLE for ADOLESCENT MALES to:

- Get breast cancer.
- Get testicular cancer.
- Have hernias.
- Have foreskin adhere to the penis (uncircumcised male).

SIGNS of POSSIBLE PROBLEMS for ADOLESCENT MALES include:

- Brown, red, yellow, green, gray or strong-smelling fluid coming from the end of the penis.
- Discharge from the nipple.
- Burning during or more frequent urination.
- Blister, or open, persistent sore spot around the penis, testicles, anus; or non-tender but open lesion in genital or anal area.
- Sharp pain in the testicles that lasts more than a few minutes.
- Undescended testicle (any time after age 2).
- A lump in the testicle that wasn't there before and stays in place for several weeks.
- Mild to moderate pain in the testicle or groin that doesn't go away in a day or two.
- Persistent itching around testicles, inside thighs, or in anal area, even after use of cornstarch or over-the-counter medications.

Handout

It's the Truth:
The Facts about Personal Reproductive Health Care for Females

It is COMMON for ADOLESCENT FEMALES to:

- Be at a different stage of physical development from peers of the same age.
- Have breasts of slightly different sizes and shapes.
- Have occasional lumps in their breasts.
- Have breast swelling and tenderness just before their menstrual periods.
- Have nipples that turn in instead of out, or hair around the nipples.
- Have occasional clear or milky discharge from the nipples.
- Have a natural, healthy genital odor.
- Have genital hair that differs from other body hair.
- Have cramps before and/or during their periods.
- Have a "regular" menstrual cycle length between 21 and 35 days.
- Have a total menstrual discharge equal to approximately 1/2 cup (4 to 6 tablespoons of blood plus other fluids and some tissue).
- Have irregular menstrual periods.
- Have wetness in the vaginal area when sexually aroused.
- Masturbate occasionally, frequently or not at all (with no resulting physical harm).
- Have varying amounts of clear to cloudy discharge from the vagina, as part of their monthly cycle or with antibiotics, birth control pills or pregnancy.
- Have hymens of different thickness, with different natural openings (rarely completely covering the opening).
- Have their hymens stretched during routine physical activities like gymnastics (therefore no connection to virginity).
- Have labia, breasts and nipples of various sizes, shapes and skin tones.

It is UNCOMMON but POSSIBLE for ADOLESCENT FEMALES to get:

- Cysts or fibroids in the breast.
- Breast cancer.
- Cervical or uterine cancer.
- Ovarian cysts.
- Uterine fibroids.

SIGNS of POSSIBLE PROBLEMS for ADOLESCENT FEMALES include:

- A nipple that used to stick out suddenly turns in.
- A breast lump that wasn't there before stays for several weeks.
- A discharge from the nipples that is gray, green, yellow, brown or has some pus or blood in it.
- Unusually heavy or smelly vaginal discharge.
- General pelvic pain.
- Suddenly irregular periods.
- An unusually late period.
- Unusual, severe or long-lasting cramps (more than three days).
- Non-period time bleeding or cramps.
- Pain or burning when urinating.
- More frequent urinating than usual.
- A persistent blister, open sore or non-tender lesion in the genital or anal area.
- Pain during intercourse.
- Itching and/or burning sensation in the vaginal or anal area.

Educator Resource

Reproductive Health Question and Answer Cards

Questions	Answers
1. What are some reasons a woman might get a pelvic exam?	She's 21 and hasn't had one before It's been a year since she's had one Her vaginal discharged has changed To see if she's pregnant
2. How often should a man examine his testicles?	Once a month
3. What is the name of the special instrument health care providers use for a female pelvic exam?	Speculum
4. What percent of females infected with gonorrhea have no symptoms?	80%
5. What percent of females infected with chlamydia do not know that they have it?	75%
6. What are some symptoms a person **might** have due to a sexually transmitted infection?	Slight fever Rash Discharge from penis/vagina Painful sore
7. What are some early signs of pregnancy?	Missing a menstrual period Sore breasts Nausea or upset stomach
8. In (your state), who has the right to give a minor (someone younger than 18) permission to have a sexual health exam or a test for a sexually transmitted infection?	Nobody
9. What are some ways a health professional determines if a person has a sexually transmitted infection?	Visual exam of genital area Culture lab test Exam of cells under microscope Blood test

10. What factors increase a female's chances of getting pelvic inflammatory disease, which may limit her ability to become pregnant in the future?	Having been infected with gonorrhea Having many different partners Beginning intercourse before age 18
11. What factors increase a female's risk of getting cervical cancer?	Smoking Beginning intercourse before age 18 Infection with HPV (human papillomavirus) Infection with HIV
12. What health benefits besides pregnancy protection can condoms provide?	Reduced risk of cervical cancer Reduced risk of acquiring a sexually transmitted infection
13. Why is prenatal care important?	To increase the chance of having a healthy baby To protect the mother's health
14. What behaviors put a pregnant female and/or her fetus at risk?	Smoking Drinking alcohol Using drugs Poor Diet
15. What choices does a person have for dealing with an unintended pregnancy?	Adoption Abortion Single parenthood Married parenthood
16. When may a sexual health care provider contact a minor's parent or guardian?	Only in the event of a medical emergency when the patient needs additional specialized care.
17. Why is it risky for people to take care of a reproductive health problem by themselves?	They may take an at-home test incorrectly They may make diagnosis difficult by using the wrong medication Home remedies may not work
18. What does it mean when medical information is "confidential"?	Unless there is an emergency, no one other than medical staff will see or talk about information in a person's medical file without the person's permission
19. What are some reasons why some teens don't go to a sexual health provider?	Embarrassed Partner doesn't want them to go Afraid family will find out

Handout

A Maintenance Checklist for Penis Owners

Directions: This is confidential. **DO NOT** sign your name. Check the appropriate box to indicate if you do or do not follow the recommendation, or if the item is not appropriate for you at this time.

	YES	NO	N/A
1. Change underwear daily.			
2. Wear loose (not tight-fitting) pants and cotton underwear.			
3. Use athletic supporter or cup for sports or other vigorous activities.			
4. Wash genital area daily; if uncircumcised, pull foreskin back to clean smegma (white cheesy substance) from under it.			
5. Dry genital area well after bathing, swimming, etc.			
6. Check testicles for changes, unusual lumps.			
7. Understand the function of pubic hair (to hold pheromones, natural scents that affect attraction.)			
8. If you decide to shave pubic hair (or if a doctor orders it), use care.			
9. Talk with partner about reproductive and sexual health issues.			
10. Check self and partner visually for signs of sexually transmitted infections.			
11. Understand that many sexually transmitted infections don't have visual symptoms.			
12. Don't engage in sexual activities that can result in bleeding or skin breakage.			
13. Wash body parts or objects before inserting in own, or sexual partner's body.			
14. Always use contraceptive methods correctly (according to package instructions or health care provider's advice).			
15. Use condoms and/or latex squares along with other birth control methods for sexual activities in which there is contact with a partner's body fluids.			
16. Make appointment for routine physical exam at least once a year or whenever you suspect a problem.			
17. Ask questions and give honest information to sexual health care provider.			

Handout

A Maintenance Checklist for Vagina Owners

Directions: This is confidential. **DO NOT** sign your name. Check the appropriate box to indicate if you do or do not follow the recommendation, or if the item is not appropriate for you at this time.

	YES	NO	N/A
1. Wear cotton or cotton-crotched underwear/pantyhose.			
2. Avoid wearing thongs and tight-fitting pants.			
3. Change underwear daily.			
4. Wash genital area daily and dry well.			
5. Wipe from front to back after a bowel movement.			
6. Do not douche, or use feminine hygiene sprays, bubble baths, deodorized menstrual pads and/or tampons.			
7. Check breasts and genitals for changes, including unusual lumps.			
8. Understand the function of pubic hair (to hold pheromones natural scents that affect attraction).			
9. If you decide to shave pubic hair (or if a doctor orders it), use care.			
10. Use the least absorbent tampons and change tampons and pads regularly. (Recommendations vary, but many experts say about every four to eight hours.)			
11. Use a pad rather than a tampon for at least eight hours of every day, preferably at night.			
12. Ease menstrual cramps with a heating pad, warm baths, exercise or over-the-counter pain medications. (For severe cramps, consult a physician.)			
13. Talk with partner about reproductive and sexual health issues.			
14. Check self and partner visually for signs of sexually transmitted infections.			
15. Understand that many sexually transmitted infections don't have visual symptoms.			

	YES	NO	N/A
16. Don't engage in sexual activities that can result in bleeding or skin breakage.			
17. Wash body parts or objects before inserting in own, or sexual partner's body.			
18. Always use contraceptive methods correctly (according to package instructions or health care provider's advice).			
19. Use condoms or latex squares (along with other birth control methods) for sexual activities in which there is contact with a partner's body fluids.			
20. Make appointment for routine physical exam at least once a year or whenever you suspect a problem.			
21. Have first pelvic exam by age 21, or whenever you suspect a problem.			
22. Ask questions and give honest information to sexual health care provider.			

POSITIVELY PREGNANT
Prenatal Care: The Difference It Makes*

Objectives

By the end of this lesson, participants will be able to:

1. Review the importance of early prenatal care for the health of both the mother and the baby.
2. Describe the early signs of pregnancy.
3. Name at least two places a young woman can turn to get help regarding a pregnancy.

Rationale

Receiving early and ongoing prenatal care, maintaining a healthful diet, and avoiding smoking and toxins such as alcohol and illicit and over-the-counter drugs are recommended as means to having a healthy pregnancy and baby. Pregnant teens may not get adequate help regarding their pregnancies because some deny their pregnancy for many months; others are fearful of telling their partners and/or their parents; and still others do not realize that their own health and that of the fetus (should they choose to carry to term) is helped by early and consistent prenatal care. As a result, pregnant teens are at greater risk of giving birth prematurely, giving birth to a baby with low birth weight, or other health problems.[1] This lesson seeks to empower young women to identify a possible pregnancy, get help from people they trust in making decisions about a pregnancy, and access appropriate community resources.

Materials

- Flip chart paper or board, markers
- Large cards for **STEPS TO A HEALTHY PREGNANCY** (with each step printed on a card):
    1. **Have preconception check-up**
    2. **Talk to partner**
    3. **Talk to good friend**
    4. **Talk to mother/father/other trusted adult**
    5. **Get a pregnancy test**

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*This lesson was developed by Louise Yohalem, a former associate director of education for Planned Parenthood of Greater Northern New Jersey.

[1]March of Dimes. (2009). *Teenage pregnancy*. Accessed at http://www.marchofdimes.com/medicalresources_teenpregnancy.html

6. **Make a decision regarding abortion, adoption, marriage, single parenting**
7. **Begin regular prenatal care with a private doctor, midwife or family planning clinic**
8. **Stop smoking**
9. **Stop drinking any alcohol, including wine and beer**
10. **Eat healthful food — including milk, fruit and vegetables, and grains**

- **Handout: Pregnancy: A Case Study**
- **Handout: The Difference It Makes: The Importance of Prenatal Care**

Procedure

1. Ask participants to BRAINSTORM all the benefits for a woman who identifies her pregnancy early and knows where and how to get help. List ideas on the board/flip chart. *(They may include: gets to decide whether or not to have a baby; can talk it over with people she knows and trusts; can get early prenatal care; baby less likely to have fetal alcohol spectrum disorders (FASDs), to be underweight or sickly; mother less likely to become sick; able to get help if there are problems with the pregnancy.)*

2. Stress the importance of getting help, and telling someone she trusts. Ask participants why, with all the advantages noted on the board, some girls do not get this help. Accept their answers.

3. Note that two reasons why young women do not get help with a pregnancy are they are not sure whether or not they are pregnant, or they may be denying the pregnancy. Ask participants what is the FIRST signal a woman and her partner have that she may be pregnant. Put on the board/flip chart:

UNPROTECTED VAGINAL INTERCOURSE

Note that a woman who has unprotected vaginal intercourse is AT RISK for pregnancy. Draw 10 stick figures on the board/flip chart.

Ask: If these figures represent women who have intercourse without using any protection for a year, how many would get pregnant? Put guesses on the board. Note that nine out of 10 would. Circle nine of the figures.

4. Ask for OTHER signs of pregnancy and list on board/flip chart. *(Tender breasts, no menstrual period or a light/different period; general feeling of tiredness; changing hunger patterns.)*

5. Ask for 10 volunteers to come to the front; give each one a **"STEPS TO A HEALTHY PREGNANCY"** card. Ask them to imagine they are a young woman who thinks she might be pregnant. Tell the class to put the volunteers with cards in the best order for steps one should take to assure a healthy pregnancy.

   Discussion Questions:

   a. Which step(s) would be the hardest to do? Why?

   b. Why is it important for a woman to get support as soon as she thinks she may be pregnant?

   c. If, after talking with people she trusts, a woman decides to continue her pregnancy, what help does she need to be sure her baby is born as healthy as possible?

6. Explain that participants are going to have a chance to think about all the people who may be responsible for helping ensure a healthy pregnancy. Distribute the **Handout: Pregnancy: A Case Study.** Tell participants that you will read the story out loud. As you read, participants should rank the people from: #1 (the person who acted MOST responsibly) to #5 (the person who acted LEAST responsibly). After you finish reading, repeat the directions and give all participants a minute to rank the individuals in the story. Then, divide participants into groups of five or six and ask them to reach consensus on the ranking by trying to convince each other of the reasons for their own ranking.

7. After seven or eight minutes, bring the whole group back together for further discussion.

   Discussion Questions:

   a. Did your group reach consensus? What did you agree or disagree about?

   b. What advice would you like to give Isabella? Aaron? Any other character?

   c. Where could a couple go to check out whether or not they were pregnant?

   d. How could a couple find an adoption referral agency? An abortion provider? A prenatal care health provider?

8. Distribute **Handout: The Difference It Makes: The Importance of Prenatal Care.** Ask participants to take the test in pairs — quickly. **After five minutes, tell them that ALL the answers are TRUE!**

9. Put on board/flip chart: **"The most important thing to remember about this lesson is...."** Let five or six participants finish the sentence orally.

Sources:

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Strandberg-Larsen, K., Grønboek, M., Andersen, A. M., Andersen, P. K., & Olsen, J. (2009). Alcohol drinking pattern during pregnancy and risk of infant mortality. *Epidemiology, 20(6):* 884-891.

Handout

Pregnancy: A Case Study

In October, **Isabella** missed her period. Since she was only 15, a sophomore in high school, and she had missed her period before, Isabella didn't think much about it.

In November, Isabella still didn't get her period. She told her girlfriend **Sandy**, and Sandy said, "That happens to all girls our age. Don't worry." Isabella felt relieved. "Missing your period is perfectly normal," she repeated to herself.

By early December, Isabella had trouble sleeping. She wondered, "What if I'm pregnant? Maybe I should buy one of those home pregnancy tests at the drug store? ... But someone might see me ... Who can I talk to? I've got to talk to my mom ... She'll kill me ... What am I thinking?! ... I've got to talk to her." The next night Isabella tried to talk to her **mom**. She said that she knew a girl at school who thought she might be pregnant. Her mom said, "I don't know what's wrong with kids today. I'm glad I raised you properly so I don't have to worry about that sort of thing with you." Isabella didn't say anything else.

In January, Isabella began her health class. She was wearing baggy sweaters and sweatpants instead of her usual jeans. Isabella was glad they would be learning about pregnancy and birth control. She thought she might even speak with **Mr. Jones**, her health teacher. Mr. Jones began his lecture on teen pregnancy by saying, "Getting pregnant as a teenager is a very stupid thing to do! Teens are having sex before they're ready." Isabella's heart sank. She heard nothing for the rest of the period and left quickly as soon as the bell rang.

In mid-February, Isabella got up her courage and texted **Aaron**, her former boyfriend. "I might be pregnant." There was a long delay before Aaron texted back, "Not me. We were together a LONG time ago." Isabella immediately called him and started to cry. Aaron tried to calm her down and came up with a plan. "Listen, I don't know about what you're saying, but I'll pick you up at 4 p.m. behind the cafeteria tomorrow to go to the clinic, and we'll see what they say." With shaking hands Aaron hung up the phone. "Pregnant? Me, a father? I can't be." The next day at 4 p.m., Aaron was playing basketball at the school gym. He remembered he was supposed to meet Isabella, but he kept playing. He would call her next week, or some other time, he thought. Isabella waited for Aaron for two hours and then went home and cried herself to sleep.

In March, Isabella woke up one morning with some pain on her lower right side. It hurt every time she urinated — which she had to do often. She had no idea what could be causing her so much pain so she ignored it.

In mid-April, the pains became more general and very severe. Not knowing what else to do, Isabella went to the hospital emergency room where they discovered that she was in labor, her cervix fully dilated. She gave birth to a very premature baby (28 weeks), who was put on a respirator. The doctors are unsure whether this baby will ever walk or have a normal life. Isabella was treated for a urinary tract infection, a known cause of premature labor.

Each person in his or her own way has affected the outcome of this pregnancy. Rank them below on a scale of 1 to 5, with 1 being the person you believe has acted in the MOST responsible way (not to blame for the negative outcome) to 5 being the person you believe has acted in the LEAST responsible way.

_____ Isabella _____ Sandy _____ Mom _____ Mr. Jones _____ Aaron

Handout

The Difference It Makes: The Importance of Prenatal Care

Directions: Put a **T** (True) or **F** (False) in front of each statement.

_____1. A medical check-up before pregnancy may benefit a woman and the baby she later conceives.

_____2. Prenatal alcohol consumption can lead to miscarriage, newborn death, and the number one cause of preventable developmental disabilities, fetal alcohol spectrum disorders.

_____3. An untreated sexually transmitted infection in a pregnant woman can cause disabilities and physical defects in her child.

_____4. Babies born to women who smoke are more likely to have a low birth weight and lung problems.

_____5. Pregnant teens can get prenatal care without parent/guardian approval.

_____6. Early prenatal care is important for the health of the mother and may prevent miscarriage and birth defects.

_____7. Babies weighing under 5½ pounds at birth and premature babies (born before 36 weeks) are more likely to die as infants or have future health problems.

_____8. Pregnant women need to gain 25-30 pounds so that they and their babies will have enough vitamins and other important food elements to be healthy.

_____9. Alcohol, tobacco and drugs are more dangerous to the fetus than to the mother.

_____10. The sooner the mother-to-be stops using drugs or alcohol during her pregnancy, the greater the chance of having a healthy baby.

_____11. A woman is more likely to have a healthy baby if she begins healthful eating and exercise, as well as quitting smoking, drinking and drug use before she gets pregnant.

_____12. Fathers-to-be can contribute to healthy pregnancies by adopting healthful habits, like not exposing a pregnant woman to harmful second-hand smoke.

IT'S YOUR RIGHT
How to Access Reproductive Health Services*

Objectives

By the end of this lesson, participants will be able to:

1. Identify common concerns about using sexual health services.
2. Identify situations in which sexual health services would be helpful.
3. Explain how to find and get to appropriate sexual health services in their community.

Rationale

Young people frequently lack the knowledge, experience and comfort level to access health care services. This lesson increases their familiarity with family planning services, often their entry point for other health care. They need to develop the skills required to find, contact and negotiate with agencies, institutions or individuals that provide sexual health care. This lesson breaks down some of the barriers that may prevent a person from accessing the health services s/he needs.

Materials

- Flip chart paper or board, markers and tape
- **TO GO OR NOT TO GO?** signs, each with one statement:
  - **GO FILL A PRESCRIPTION**
  - **GO GET CONDOMS**
  - **GO TO DOCTOR OR CLINIC FOR CONTRACEPTIVES**
  - **GO TO DOCTOR OR CLINIC FOR STI/HIV TESTING**
- **STEPS TO REPRODUCTIVE HEALTH CARE** cards (with one step per index card). Note the correct sequence:
  - **IDENTIFY THE NEED OR PROBLEM**
  - **FIND OUT WHERE TO GET HELP**
  - **FIND OUT WHEN YOU CAN GO**
  - **DECIDE HOW TO GET THERE**
  - **EXPLAIN YOUR NEED OR PROBLEM**
  - **MAKE AN APPOINTMENT**
  - **GET READY TO GO**

*This lesson was developed by Sue Montfort and Joan O'Leary, former Planned Parenthood educators.

  - **GO TO APPOINTMENT**
  - **FILL OUT ANY FORMS**
  - **VISIT WITH CLINICIAN**
  - **GET INSTRUCTIONS OR TREATMENT PLAN**
  - **ASK QUESTIONS**
  - **SCHEDULE FOLLOW-UP VISIT (IF NEEDED)**
  - **PAY (IF NECESSARY)**
- **Handout: Finding Sexual Health Care**
- **Educator Resource: Profile Cards** (Use images of young people and attach them with each profile to a large index card.)
- **Finding Help: A Resource List** (see the Resources Section at the end of this manual)
- **Educator Resource: Discussion Triggers for Accessing Health Care Steps**

Procedure

1. Explain that this lesson will help participants learn about getting sexual health care whenever in their lives they might need it. Ask the group to brainstorm a list of places to go for sexual health care, and write their answer on the board/flip chart. *(Answers might include Planned Parenthood or other family planning clinics, STI/HIV testing sites, adolescent clinics, health department, hospital, prenatal clinic, gynecologist, urologist, etc.)*

   Discussion Questions:

   a. Who would you feel most comfortable asking about sexual health care?

   b. What do you know about the services offered at each of the places listed? *(Provide additional information as necessary.)*

   c. Why might women go to a family planning clinic?

   d. Why might men go to a family planning clinic?

2. Post the **TO GO OR NOT TO GO?** signs in four corners of the room. Acknowledge that people may have different feelings about going for sexual health care services. Ask participants to stand by the sign that describes the ***most difficult*** thing to do. Allow a few minutes for them to talk with others also standing by that sign about their reasons for making that choice. Then process briefly with the following discussion questions:

   Discussion Questions:

   a. Why did you choose that action as most difficult?

   b. What could make that action easier?

c. Why might a person need to get that type of service?

3. Divide participants into small groups. Have each group assign a recorder. Give each group the **Handout: Finding Reproductive Health Care,** one or more of the **Profile Cards,** the handout **Finding Help: A Resource List,** and a directory (or brochures) for local health services. Review the directions on the handout and allow about 10 minutes for completing this task.

4. Get the whole group's attention and ask for the recorder for each group to report briefly on their profile character's situation and their answers to the handout questions. Encourage responses from other participants as well.

   Discussion Questions:

   a. What parts of your character's situation were the easiest to figure out?

   b. What were the most difficult?

   c. What qualities would *you* look for in a person or agency that might help you with your sexual health?

5. Note that some people may avoid getting sexual health care because they don't know the steps that are involved; this next activity will help us think more about what usually happens when a person wants to get sexual health care. Shuffle the **STEPS TO SEXUAL HEALTH CARE** cards so they are not in order, and distribute one to each participant. (If the group is small, give participants more than one card.)

6. Tell participants to tape the cards on the wall in the order in which these actions would occur when a person is getting sexual health care, from the ***first step*** to the ***last step.***

   Discussion Questions:

   a. Which cards were difficult to place? Why?

   b. Which step cards would any of you put in a different place along the lineup? Why?

   c. Which of these steps in getting sexual health care might be easier to do? More difficult to do? Why? What could make difficult steps easier?

   d. What should people do to make their reproductive health care appointment most effective?

Note:
Choose questions from the **Educator Resource: Discussion Triggers for Accessing Health Care Steps** to expand the discussion about individual steps, as necessary, and as time permits.

7. To conclude, ask the group, "What tips would you give a friend who was considering going for her/his first visit?"

Handout

Finding Sexual Health Care

Directions: As a group, discuss the questions below. Choose a recorder to write down your responses.

1. What is "your" character worried about?

   _____

   _____

2. What might concern your character about getting the sexual health care she or he needs?

   _____

   _____

3. Whom could your character talk to about this concern?

   _____

   _____

4. Where *could* your character go to get help?

   _____

   _____

5. What are two questions your character might want to ask about his or her sexual health care?

   a. _____

   b. _____

Educator Resource

Profile Cards

Directions: Put the teen situations **IN BOLD** on the profile cards. The possible problem and places where a teen could go for help are written next to each situation. Educators may wish to change names to ones that are more appropriate to their groups or to avoid names of participants in the group.

1. **Randall just found out that his former sexual partner used to share needles with other people.**	Possible risk of HIV and other sexually transmitted infections (STIs). Randall could get tested at an HIV testing site, or other STI clinic.
2. **Jennifer's period is almost two weeks late. She's been having sexual intercourse with Tony for three months without using any method of birth control.**	Possible pregnancy. Jennifer could get a pregnancy test at a family planning clinic or private doctor's office.
3. **Andrew has noticed a large pimple-like sore that hurts a lot on the head of his penis.**	Likely genital herpes. Andrew could go to an STI clinic, family planning clinic, or private doctor's office to get examined, and treated, if necessary.

4. Eduardo sees a yellowish discharge from his penis and feels a burning sensation when he urinates.	Likely sign of an STI. Eduardo could go to an STI clinic, family planning clinic, or private doctor's office to get tested and possibly treated.
5. William's condom broke during intercourse with Denise last night. She does not want a pregnancy.	Possible risk of pregnancy and STI. Denise could call right away to get emergency contraception, or she and William could discuss this at a family planning or STI/HIV clinic, or with a teacher or school nurse.
6. Laura has recently noticed a pink raised area near the opening to her vagina. It doesn't hurt, but it seems as if it's getting bigger.	Likely genital warts. Laura could get a checkup at an STI clinic, family planning clinic, or private doctor's office.
7. When Maureen had sexual intercourse with her new partner, Jamal, last night, he said he would pull out in time, but he didn't.	Possible risk of pregnancy and STI. Maureen could discuss this at a family planning or STI/HIV clinic, or with a teacher or school nurse, or call immediately about emergency contraception.

8. Jeffrey's girlfriend just told him her period is three weeks late, but she thinks it will come any day now.

Likely pregnancy. Jeffrey could discuss this with a teacher or school nurse, or at a family planning clinic. Offering to go with his girlfriend might encourage her to get help sooner, and help them think about the decisions that are ahead.

9. Karen had oral sex with her boyfriend several times. He just told Karen he had intercourse with another woman, without using a condom. Karen doesn't have any symptoms of STIs.

Possible STI. (Often, STIs have NO symptoms.) Karen could go to an STI clinic, family planning clinic, or private doctor's office to get examined, and treated, if necessary.

10. Sarah's breasts hurt and she feels lumps on the sides of both of them.

Possibly normal since there are lumps on both breasts. Sarah could get, and learn to do, a breast examination at a family planning clinic or private doctor's office.

11. Soo Li just did a home pregnancy test and it was positive. She wants to be sure her baby gets a healthy start.

Likely pregnancy. Soo Li could go to a family planning or prenatal clinic, or to an obstetrician, to get a confirming pregnancy test and continuing prenatal care.

12. One day, while taking a shower, Michael notices a lump or thickening of skin behind his left testicle.

Likely normal, but could indicate testicular cancer. Michael could get it checked out at a family planning clinic or urologist's office.

13. Tanya has such heavy menstrual periods that she wears two tampons and a pad so she won't stain her clothes. Her best friend told her that going on the Pill would make her periods lighter.

Likely normal. Tanya could discuss this at a family planning clinic, with her private doctor, or the school nurse.

14. Sam has had a small sore lump under his left nipple for some time.

Likely normal. Sam could discuss this with his private doctor, or at a family planning clinic.

15. Brenda's boyfriend Joey loses his temper a lot. Last week he slapped her in the face when he saw her talking with another guy from class. Last night, he insisted on having sex with her, even though she was tired and didn't want to.

Abusive relationship, possible sexual assault. Brenda could discuss her situation with a school staff person, or women's health/crisis center.

Educator Resource

Discussion Triggers for Accessing Health Care Steps

- **FIND OUT WHEN YOU CAN GO**
  1. What dates and times are best for YOU?
  2. When is the CLINIC or OFFICE open? (Weekdays? Weekends? Times?)

- **DECIDE HOW TO GET THERE**
  1. Will you take a bus? Train? Walk? Get a ride from a friend? Other?
  2. Do you need directions?

- **MAKE AN APPOINTMENT**
  1. What might you want to ask?
  2. Are services confidential? How do you want to be contacted?
  3. What is the cost? (How might using insurance affect confidentiality?)
  4. Is it important to you whether the clinician is female or male?
  5. Do they have someone that speaks your language?
  6. Do you need to bring anything to the visit (a date book, menstrual record, information about your concerns, etc.)
  7. What do you need to do if you can't keep your appointment?

- **GET READY TO GO**
  1. What do you need to do to get ready? (Write out questions? Get someone trustworthy to go with you? Gather anything needed for visit?)

- **GO TO APPOINTMENT**
  1. Why might a person not go to a health care visit, even though they've made an appointment?
  2. How can a person get support?

- **FILL OUT ANY FORMS**
  1. What kind of information might the health care staff need to know?
  2. Why do people receiving health care need to sign consent forms?
  3. What might be helpful to know about one's medical history? Family history?
  4. Why is it important to be honest in providing information?

- **VISIT WITH CLINICIAN**
  1. What could be helpful to do during an exam? (Be sure the staff knows if the exam is your first one, talk about feelings, ask questions, ask for explanations.)

- **GET INSTRUCTIONS AND TREATMENT PLAN & ASK QUESTIONS**
  1. What medications are needed? How will you get them?
  2. How can you find out test results?
  3. Do you need a follow-up appointment?
  4. What behaviors do you need to do, or avoid, to stay healthy?

A PLACE FOR US ALL*

Objectives

By the end of this lesson, participants will be able to:

1. Describe, in their own words, the importance of family planning and what it means to them personally.

2. Identify some of the key relationships between family planning and other important global issues (e.g., poverty, environmental protection, sustainability, health and human rights).

Rationale

Family planning is an essential human right. It delivers immeasurable rewards to families and communities around the world. By enabling individuals to choose the number and spacing of their children, family planning has allowed women, and their children, to live healthier, longer lives. It may lift nations out of poverty, decrease infant mortality and maternal deaths, and is one of the most effective means of empowering women.[1] "The State of World Population Report 2012" says that governments, civil society, health providers and communities have the responsibility to protect the right to family planning.[2] Other rights and global issues such as education, negative impacts on economy, the environment, and regional development efforts are also connected to family planning.[3] This lesson attempts to illustrate those important connections to family planning through an experiential process.

Materials

- Flip chart paper or board, markers and tape
- Assorted items for "Making the Connections" exercise: rope or string, chocolates, spare change, two flashlights, a candle, a match, black cloth or paper
- **Educator Resource: What Does Family Planning Mean?**
- **Educator Resource: Important Websites**
- **Educator Resource: Quotes for the Presenter**

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* This lesson was developed by Tim McLeod and other Community Health Educators from Planned Parenthood of the Great Northwest.

[1] United Nations Population Fund (2012). Additional investments in family planning would save developing countries more than $11 billion a year. Accessed at http://www.unfpa.org/public/home/news/pid/12601

[2] United Nations Population Fund (2012). The state of world population report 2012. Accessed at http://www.unfpa.org/public/home/publications/pid/12511

[3] World Health Organization (2013). Family planning fact sheet No. 351 May 2013. Accessed at http://www.who.int/mediacentre/factsheets/fs351/en/

Procedure

1. Divide the full group into smaller groups of three to four participants. Distribute cards with one segment of the **Educator Resource: What Does Family Planning Mean?** to each small group.

2. Ask groups to fill out their cards, giving them these prompts:
   "When you think of family planning, what are some words or phrases that come to mind?"
   "Pick your group's top three words or phrases and write these on the card."
   "Please allow each person in your group to contribute a word or phrase."

3. After all groups have finished their cards, call to the full group. Ask one person from each small group to read the three words on their card aloud. Ask participants if they think people should have a ***right*** to information and ***access*** to the words that are read.

4. Read the following definition of family planning, drafted in Cairo, Egypt, and informed by 179 nations around the world.

   Family Planning is when all couples and individuals have the right to decide freely and responsibly the number and spacing of their children, and have access to the information, education, and means to do so.

5. Explain that many people around the world and even in the United States still lack information and access to these services and that we may have a role in changing this inequity. Explain that in this lesson we will explore the following questions:

   Discussion Questions:

   a. What is family planning? What does it mean to us personally?

   b. What are some of the relationships between family planning and poverty? Environmental protection? Sustainability? Health and human rights?

   c. How does knowledge about family planning help in understanding the relationships between it and other important global issues?

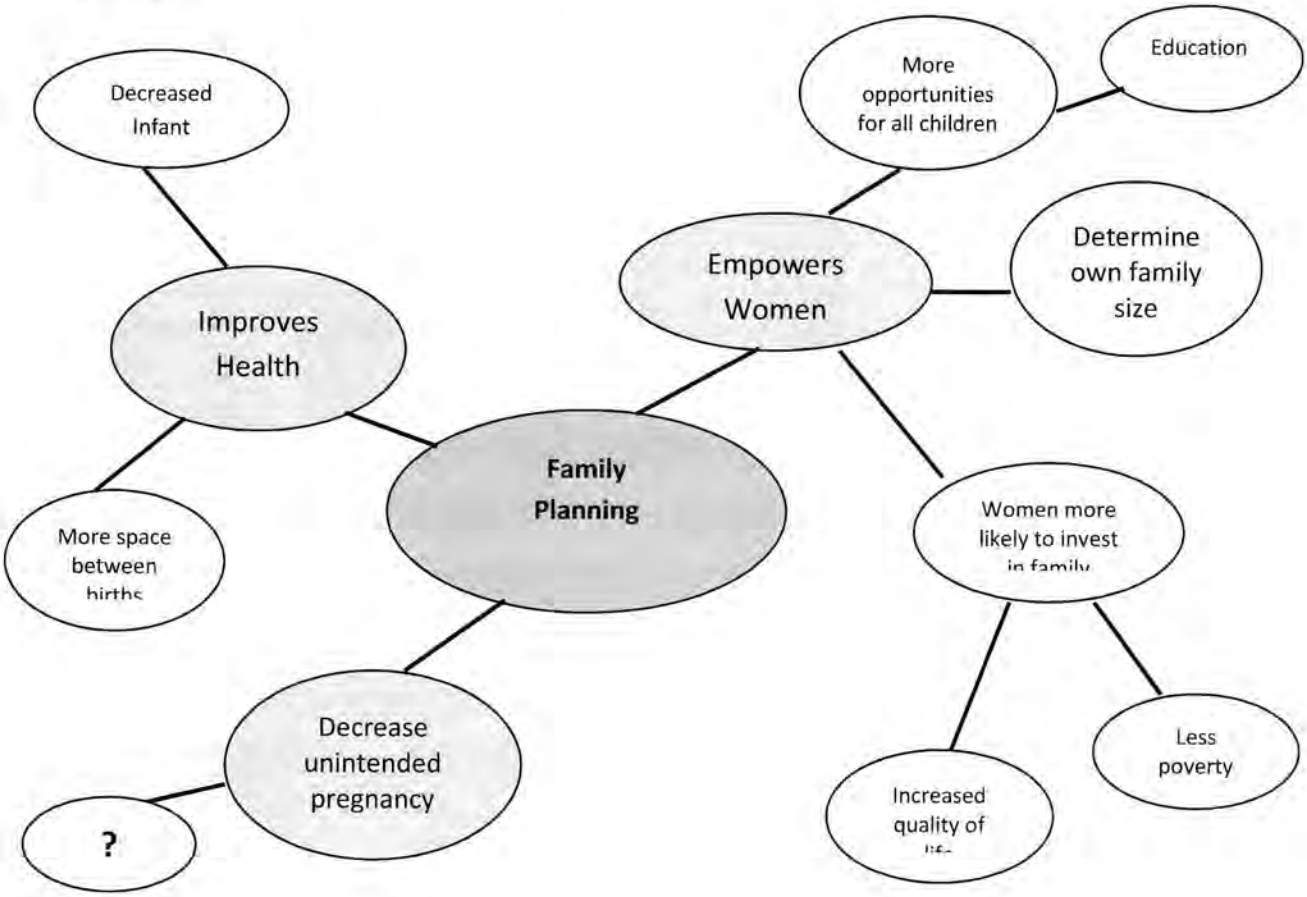
6. In the center of a the board/ flip chart draw a bubble with the words **FAMILY PLANNING** written in the center of the bubble. Explain to the group you are going to collectively create a "mind map," or a visual of how family planning can impact individuals, families and communities.

7. Ask the group for one benefit that may stem from family planning, for example, family planning "empowers women." Write this answer in its own bubble. Then connect it to the center by drawing a line to both. *(See example below.)*

8. Clarify each phrase that is added to the mind map, with questions, such as "*How* are women empowered?"

9. Give each subsequent response its own bubble. If other benefits arise from a given answer given write these down and keep the map going.

10. Continue this process, returning back to the central theme of family planning as needed or as ideas arise.



Note:
Each map created will be unique depending on the knowledge of the group. Facilitators should not worry about knowing all of the possible benefits of family planning. If useful, here are some evidenced-based statements that facilitators may use to help flesh out each map:

- Increasing access to family planning could prevent up to 30% of all maternal deaths and 20% of newborn deaths.

- Research suggests that women are more likely than men to use financial assistance to benefit their children and families.

- Family planning is essential to securing the well-being and autonomy of women.

- Family planning reduces HIV rates.

- Current contraceptive use will prevent 218 million unintended pregnancies in developing countries and, in turn, will avert 55 million unplanned births, 138 million abortions (of which 40 million are unsafe), 25 million miscarriages and 118,000 maternal deaths.

11. Using different-colored rope or string, measure and cut appropriate lengths for **AFRICA, ASIA, LATIN AMERICA,** and **UNITED STATES**, using the guide below. Explain that the lengths represent the comparative land areas of each region, not the shape of each region. Lay these area regions on the floor around the room (or taped to the walls) and label if desired.

Africa	15 feet, 8 inches
Asia	20 feet
Latin America	11 feet, 3 inches (this includes both Central and South America)
United States	5 feet

Note:
These measurements and ratios used here and for the rest of this activity are rough estimates. They are meant to illustrate basic land ratios, population densities between regions, relative wealth indicators, food, low-value staples and luxuries, energy consumption, and numbers of people living with HIV/AIDS. Dependent on adjusted GDP, border disputes and other factors, these aspects will of course fluctuate. Sources are listed at the end of the activity.

12. Now ask participants to volunteer and stand within (or next to) these "regions."

Note:
This illustration of population density is based on 18 participants. If teaching a very small group, have participants take turns representing the density in each region (e.g., send six participants to the African region, then eight to the Asian region, etc.). If teaching to a very large group, simply ask for volunteers to stand in specific regions and have others observe the process.

Africa	6
Asia	8
Latin America	3
United States	1

13. Ask participants what they think the people standing in each region represent.

14. Explain that this is a rough regional population expressed as a percentage of the world's *total* population. So, if we were to imagine that the world had 18 people, this is how they would be distributed in these regions. Note that current actual world population (as of 2013) is just over 7 billion people.

15. Explain that we will now take a closer look at some specific countries within these geographical regions. Give participants standing within regions amounts of money as follows:

China	$0.83
Mexico	$0.12
Nigeria	$0.03
United States	$1.56

Ask participants what they think this represents. After a few guesses, explain that the money distribution represents a rough comparison of wealth between these countries, specifically gross domestic product (GDP), a unit used to compare wealth in each nation. (There is a more detailed explanation of GDP below.) Explain that the money distributed to each region shows the GDP for four different countries: China, Mexico, Nigeria and the United States.

16. Note the actual GDPs of each nation. Explain that you distributed the money based on dividing the actual GDP by $10 trillion.

China	$8.25 trillion
Mexico	$1.163 trillion
Nigeria	$272.6 billion
United States	$15.65 trillion

Note:
GDP is a term used to describe the economic health of a country and to gauge a country's standard of living. This term is sometimes debated. Critics argue that a nation's overall productivity is not necessarily related to the standard of living.

Discussion Questions:

a. What do you notice as you look at the distribution of wealth, or the population size of each region?

b. What thoughts or feelings would you like to share?

17. Distribute a number of small chocolates as follows:

Africa	3
Asia	5
Latin America	2
United States	9

18. Ask participants what they think the chocolates represent. (They are also free to eat their chocolates if they wish!)

19. Explain that the chocolates represent a very rough comparison of food consumption. Low-income countries spend a greater portion of their budget on food than middle- and high-income countries. We must acknowledge that consumption varies within a country, but we are looking at a country's food consumption overall.

    Discussion Questions:

    a. What do you notice about the distribution of food?

    b. What thoughts or feelings would you like to share?

20. Distribute to the regions as follows:

China	a large flashlight
Mexico	a small candle
Nigeria	a match head
United States	a large flashlight

21. Ask participants what they think these objects represent. Explain that they represent a rough comparison of annual energy consumption.

China	100.881 quadrillion BTUs
Mexico	7.284 quadrillion BTUs
Nigeria	0.720 quadrillion BTUs
United States	98.041 quadrillion BTUs

Note:
BTU is defined as the quantity of heat required to raise the temperature of one pound of liquid water by one degree Fahrenheit at the temperature at which water has its greatest density. Another way to look at energy consumption is within the context of a nation's "ecological footprint" and "ecological deficit."

Discussion Questions:

a. What do you notice about the different levels of energy consumption in the different regions?

b. What thoughts or feelings would you like to share?

22. Distribute the following number of black squares (use a piece of cloth cut in squares, or simply black paper). Lay these pieces on the ground in each region near the feet of the participants.

Africa	22 squares
Asia	5 squares
Latin America	2 squares
United States	1 square

23. Ask participants what they think these objects represent. Explain that they illustrate a rough representation of the number of people living with HIV/AIDS in the following regions.

Africa	more than 22 million people
Asia	5 million people
Latin America	1.5 million people
United States	1.1 million people

24. Note that on a global level, at the end of 2010, an estimated 34 million people were living with HIV, with 1.6-1.9 million deaths from AIDS and 340,000-450,000 children newly infected with HIV.

Discussion Questions:

a. What do you notice about the different rates of people living with HIV and AIDS around the world?

b. What thoughts or feelings would you like to share?

25. Ask participants to return to their original seats. Let them know that this large group reflection is a time for them to share a little about their experiences.

Discussion Questions:

a. What was this experience like for those of you in the U.S. region? Latin America? Asia? Africa?

b. Is there anything that surprised you while doing this exercise? Explain.

c. Is there anything that was challenging about this activity?

d. Which global issues that we examined — population, wealth distribution, food distribution, energy or HIV — did you care most about? Explain.

e. What are some of the connections you can draw between family planning and the global issues and trends we just examined?

f. How might family planning assist in addressing the issues you care about?

26. Thank participants for their comments, ideas and participation. Acknowledge that these are complex topics and answers will continue to unfold. Write on the board/flip chart:

Family planning is a basic human right.

Ask for a few volunteers to share what they think that means. Conclude by reading this quote by former UN Secretary General Kofi Annan. You may read additional quotes from the **Educator Resource: Quotes for the Presenter,** as time permits.

> ***"The world must advance the causes of security, development and human rights together, otherwise none will succeed. Humanity will not enjoy security without development, it will not enjoy development without security, and it will not enjoy either without respect for human rights."***

Sources:

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www.cia.gov/library/publications/the-world-factbook
www.eia.gov
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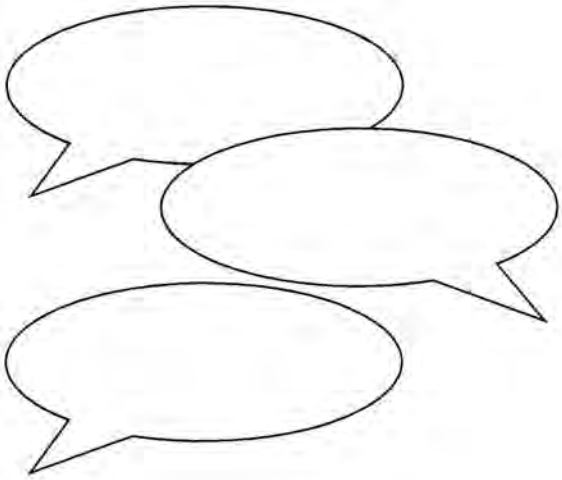
www.hhs.gov
www.nationalatlas.gov
www.un.org/popin/icpd2.htm
www.unaids.org
www.unfpa.org
www.who.int
www.womenandchildrenfirst.org
www.worldstat.info
www.worldsavvy.org

Educator Resource

What Does Family Planning Mean?

Directions: Copy and cut up the sheet below as needed. Paste one section each onto index cards to distribute to your small groups.

What are three words **you** would use to describe the term ***family planning***?



What are three words **you** would use to describe the term ***family planning***?

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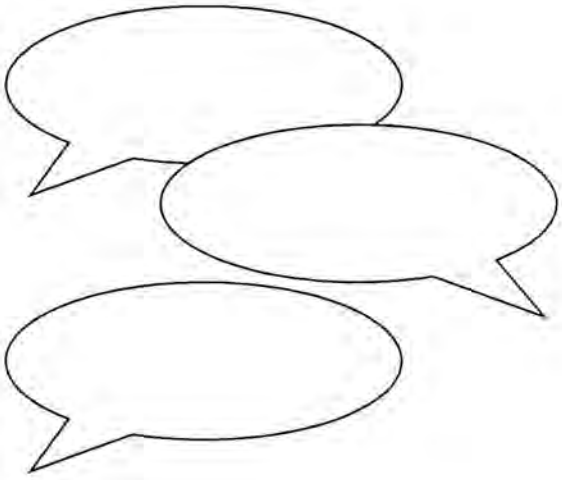

What are three words **you** would use to describe the term ***family planning***?

Educator Resource

Important Websites

The websites listed on this page offer excellent information about a number of topics relevant to this lesson, including:

- Connections between population dynamics and social/economic progress
- Gender equity
- Global policies and relevant issues such as the United Nations Millennium Development Goals and the "Cairo consensus"
- Human rights advocacy
- HIV/AIDS prevention, treatment and care
- International Conference on Population and Development
- Maternal and child health
- Reproductive rights and family planning

The International Planned Parenthood Federation (IPPF)
www.ippf.org
IPPF works in 172 countries to empower the most vulnerable women, men and young people to access life-saving services and programs, and to live with dignity.

International Women's Health Coalition (IWHC)
www.iwhc.org
IWHC supports the right of women worldwide to a just and healthy life.

United Nations Population Fund (UNFPA)
www.unfpa.org
UNFPA advocates for a world where every pregnancy is wanted, every birth is safe and every young person's potential is fulfilled.

Educator Resource

Quotes for the Presenter

Directions: Use the following quotes at the end of the lesson, or space them throughout the lesson when it seems relevant.

"The world is like a table. Twenty percent live on the table and eighty percent survive underneath it. Our work cannot be to move a few from under the table, or vice versa. Our task is to move the table, to change its position if necessary, and all to sit together around the table."

Jean-Bertrand Aristide, 2002
Haiti's first democratically elected president

"If we don't change our direction we're likely to end up where we're headed."

Chinese proverb

"As the young leaders of tomorrow, you have the passion and energy and commitment to make a difference. What I'd like to really urge you do is to have a global vision. Go beyond your country; go beyond your national boundaries."

Ban Ki-moon, Secretary General of the United Nations
In a message given on International Youth Day, 2010

"There is a striking kinship between our movement and Margaret Sanger's early efforts. Our sure beginning in the struggle for equality by nonviolent direct action may not have been so resolute without the tradition established by Margaret Sanger and people like her."

Rev. Martin Luther King, Jr., 1966
On the death of Margaret Sanger, founder of Planned Parenthood

"We need to defend the interests of those whom we've never met and never will."

Jeffrey D. Sachs, 2011
American economist

SEX ED TRIVIA*

Objectives

By the end of the session, participants will be able to:

1. List two facts about contraception and sexual health care.

2. Ask a question regarding the various prevention methods.

Rationale

The Sexuality Information and Education Council of the United States (SIECUS) says there are many important issues to discuss when addressing sexual and reproductive health. Some topics that are included among these important issues are contraception, condoms, emergency contraception, health care and sexuality. Based on a popular game show format, *Sex Ed Trivia* reviews basic information about hormonal methods, barrier methods, condoms and sexual health care. It gives the educator an opportunity to reinforce key facts and clarify areas of confusion.

Materials

- Index cards
- Markers
- Game board (use **Educator Resource: Creating Sex Ed Trivia**)
- **Educator Resource: Question Cards**

Procedure

1. After reviewing the ground rules, explain to participants that they are going to play a game that will test their knowledge about abstinence, contraception and sexual health care.

2. Divide participants into teams of two to four players. Give each team an index card and ask them to create a team name and write it on the card.

3. Assign teams their order of play: 1st, 2nd, 3rd, etc.

* This lesson was originally developed by former Planned Parenthood sexual health educator Joan O'Leary, and was adapted with assistance from former intern Jessica Millevoi. It most recently appeared in Shields, J. & DiGioia, M. K. (2012). *Game On! The Ultimate Sexuality Education Gaming Guide.* Morristown, N.J.: The Center for Sex Education.

4. Explain the game board (use **Educator Resource: Creating Sex Ed Trivia**) and method of play:

    a. In the pre-determined order, each team will select a category and point-value question.

    b. The facilitator will then read the question from the selected category/point value.

    c. The team will have a maximum of two minutes to reach a consensus and provide an answer.

    d. If the team answers correctly, it is awarded the point value of that question. The facilitator may encourage the other teams to give additional information regarding the question and add/clarify any additional information.

    e. If the answer is incorrect, no points are awarded and that category/point value is "dead" and may not be selected again. The facilitator will give the correct answer.

5. Play the game. Use **Educator Resource: Question Cards** to determine if a question is answered correctly. Continue until all the categories/point values have been selected. The winning team is the one with the highest number of points when play is ended.

6. Once a winner is determined, ask the following.

    Discussion Questions:

    a. What are some things people should keep in mind when obtaining sexual health care?

    b. What are some things to consider when choosing a method of contraception?

    c. What questions should a person ask a sexual health care provider when getting a method of contraception?

Educator Resource

Creating Sex Ed Trivia

The following is needed to create the ***Game Board, Topic Cards*** and ***Question Cards*** for **SEX ED TRIVIA**.

Materials:

- 30 index cards
- Markers, tape
- **Educator Resource: Question Cards**
- Tri-fold display board

To Make the Game Board:

1. Make the Topic Cards. Write <u>one</u> of the following topics on the front of an index card: *condoms, hormonal methods, other methods, personal sexual health care, reproductive health services.* This will result in five Topic Cards.

2. Make the Question Cards. Use **Educator Resource: Question Cards.** On one side of an index card, write a question. Flip over the index card and write the point value that corresponds with that question. Repeat for each question. This will result in 25 Question Cards.

3. Tape the Topic Cards to the tri-fold display board. Tape the questions, with point value facing the audience, in numerical order underneath the appropriate heading.

Educator Resource

Question Cards

CONDOMS:

Point Value	Question	Answer
10	What material is being used to make some of the newer condoms?	• Polyisoprene • Polyurethane (plastic)
20	What are two reasons condoms are sometimes lubricated?	• Decrease breakage • Increase comfort and pleasure
30	When must a male condom be placed on an erect penis or a female condom inserted into the vagina?	Before any contact with partner's genital area
40	What must a person do with a condom before withdrawing the penis from his partner?	Hold onto the rim of the condom to prevent its slipping or leaking
50	Name three advantages of using condoms.	• Can be purchased in any drug store • Few side effects • May make intercourse last longer • May help maintain erection • May help prevent many sexually transmitted infections, including HIV • Reasonably priced • Very effective in preventing pregnancy when properly used

HORMONAL METHODS:

Point Value	Question	Answer
10	What type of contraceptive is placed under the skin of a woman's arm and works for three years?	Implant
20	How long does a contraceptive injection provide protection against pregnancy?	Three months
30	What are two possible benefits of using birth control pills?	• High rate of effectiveness (91%-99.9%) • Offers some protection against ovarian cysts, ovarian and uterine cancer • May lessen menstrual cramps • Regulates menstruation
40	What are two ways hormonal methods work?	• Prevent eggs from leaving ovaries • Cause cervical mucus to thicken, preventing sperm from entering uterus
50	Name two situations when a doctor might prescribe emergency contraception.	• Condom broke • Forgot to take a birth control pill • Sexual assault

OTHER METHODS:

Point Value	Question	Answer
10	How do barrier methods of contraception work?	Prevent sperm from reaching and fertilizing an egg
20	What are two barrier methods inserted into the vagina to cover the cervix?	• Diaphragm or cervical cap • Female condom
30	If people want to be 100% sure to avoid a pregnancy, what should they do?	Consistently abstain from vaginal intercourse
40	What is one contributing factor to withdrawal (pulling out) being less effective in preventing pregnancy?	• Partner may lack self-control • Neither partner wants to do it • Waiting too long to withdraw penis from vagina
50	What does "IUC" stand for?	Intrauterine contraceptive

PERSONAL SEXUAL HEALTH CARE:

Point Value	Question	Answer
10	At what age should a female begin to have a routine pelvic exam?	Age 21; maybe sooner if experiencing a medical problem
20	State two major reasons why some young people do not use contraception.	• Cost of contraceptive • May not know how to use • May not know where to obtain • Partner doesn't want to use
30	What is the name of the recommended self-exam that males may perform?	Testicular self-exam
40	Name two reasons a young person may need to go to a reproductive health care provider.	• Pelvic/urological exam • Prevent pregnancy/STIs • Sexual assault • STI/pregnancy testing • Yearly checkups
50	Name two physical symptoms of a sexually transmitted infection.	• No symptoms at all • Abdominal pain • Bump/sore/itching in genital area • Painful urination • Skin discoloration • Slight fever • Vaginal/urethral discharge

REPRODUCTIVE HEALTH SERVICES:

Point Value	Question	Answer
10	Name two types of local reproductive health care providers.	• Family planning center • Hospital-based clinic • Names of local providers • Planned Parenthood • Private doctor • State/County health department
20	How could a young person get information about a reproductive health care provider?	• Ask a family member • Check the Internet • Talk to a friend • Talk to the school nurse
30	What does it mean when a reproductive health care service is "confidential"?	The patient's medical information will not be released to anyone unless there is an emergency, or by explicit permission by the patient
40	What are two reasons a young person might not go to a reproductive health care provider?	• Afraid parents would find out • Afraid to call for an appointment • Doesn't know where to go • Never been to a health care provider without a caregiver • No money to pay
50	Name two factors to consider when choosing a reproductive health care provider.	• Confidentiality • Cost • Location • Type of services

RESOURCES SECTION

This section has a number of handouts that may be used in conjunction with a number of different lessons, or as standalone materials. Included in this section find:

Common Sexually Transmitted Infections

Sexually Transmitted Infections: A Summary

Using Condoms

Contraceptive Options

Finding Help: A Resource List

COMMON SEXUALLY TRANSMITTED INFECTIONS

Viral Infections

Hepatitis B

How It's Spread	Possible Symptoms	Treatment
Vaginal, anal or oral intercourse; sharing needles with someone who has Hepatitis B	Can sometimes have no symptoms Flu-like feelings and tiredness Jaundice (yellow skin) Fever, headache, joint aches	There is no cure for Hepatitis B; treatment is advised as soon as a person might have been exposed
How to Avoid	**Possible Effects**	
Avoid sexual intercourse or use condoms; early vaccine	Some people recover completely, others cannot Liver damage or liver cancer Pregnant woman can pass to fetus Death	

Herpes

How It's Spread	Possible Symptoms	Treatment
Vaginal, anal or oral intercourse; skin-to-skin contact with someone who has herpes	Can have no symptoms Painful blisters Flu-like feelings	There is no cure for herpes; medication can decrease healing time
How to Avoid	**Possible Effects**	
Avoid genital skin-to-skin contact; avoid sexual intercourse or use condoms	Recurrent outbreaks of blisters Pregnant woman can pass to fetus Easier infection with HIV/AIDS	

HIV/AIDS

How It's Spread	Possible Symptoms	Treatment
Vaginal, anal or oral intercourse; sharing needles with someone who has HIV/AIDS	Early HIV rarely has symptoms Weight loss or tiredness Flu-like feelings Diarrhea White spots in mouth AIDS has symptoms of serious illness such as pneumonia, cancers	There is no cure for HIV/AIDS; medications can help with symptoms and prolong life
How to Avoid	**Possible Effects**	
Avoid sexual intercourse or use condoms; needle sharing; blood contact; breast feeding	Cannot be cured Increased susceptibility to illnesses Can cause illness and death Pregnant woman can pass to fetus or baby during breastfeeding	

HPV

How It's Spread	Possible Symptoms	Treatment
Vaginal, anal or oral intercourse; skin-to-skin contact with someone who has HPV	Small bumpy warts on genitals or anus Itching or burning around genitals Genital or cervical cell changes that may not be visible to the naked eye	There are vaccines, but no cure for HPV; medications alleviate some symptoms; warts can be surgically removed; immunity may develop over time in many individuals
How to Avoid	**Possible Effects**	
Avoid genital skin-to-skin contact; avoid sexual intercourse or use condoms; early vaccine	Warts may go away on their own, or grow and spread Can lead to cancers (of cervix, vulva, penis, anus, throat) Pregnant woman can pass to fetus	

Bacterial Infections

Chlamydia

How It's Spread	Possible Symptoms	Treatment
Vaginal, anal or oral intercourse with someone who has chlamydia	Can have no symptoms Abnormal discharge or bleeding from penis or vagina Burning or pain when urinating Pain in abdomen (belly) or swollen, tender testicles	Cured with antibiotics
How to Avoid	**Possible Effects**	
Avoid sexual intercourse or use condoms	Infections in pelvis Damage to reproductive organs Infertility Pregnant woman can pass to fetus Easier infection with HIV/AIDS	

Gonorrhea

How It's Spread	Possible Symptoms	Treatment
Vaginal, anal or oral intercourse with someone who has gonorrhea	Can have no symptoms Thick discharge from penis or vagina Burning or pain when urinating or having bowel movement Pain in abdomen or swollen, tender testicles	Cured with antibiotics
How to Avoid	**Possible Effects**	
Avoid sexual intercourse or use condoms	Infections in pelvis Damage to reproductive organs Infertility Skin disease, heart trouble, arthritis, blindness Pregnant woman can pass to fetus Easier infection with HIV/AIDS	

Syphilis

How It's Spread	Possible Symptoms	Treatment
Vaginal, anal or oral intercourse with someone who has syphilis	Can at times have no symptoms Painless sores on mouth or genitals Rash Flu-like feelings	Cured with antibiotics
How to Avoid	**Possible Effects**	
Avoid sexual intercourse or use condoms	Heart disease Brain or nerve damage Blindness Infertility Pregnant woman can pass to fetus Death	

Parasitic Infections

Pubic Lice	How It's Spread	Possible Symptoms	**Treatment**
	Sexual intercourse; contact with infested bedding, clothing, upholstered furniture	Intense itching in genitals or anus Mild fever Feeling run down Irritability Lice or small egg sacs in pubic hair	Cured with over-the-counter medication and thorough cleaning
	How to Avoid	Possible Effects	
	Limit the number of intimate sexual contacts	Itching begins about five days after infestation No long-term effects	
Scabies	How It's Spread	Possible Symptoms	**Treatment**
	Sexual intercourse or skin-to-skin contact with someone who has scabies	Intense itching usually at night Small bumps or rash on penis, buttocks, breasts, thighs, navel	Cured with over-the-counter or prescription medication
	How to Avoid	Possible Effects	
	Limit the number of intimate sexual contacts	May take several weeks to develop No long-term effects	
Trichomoniasis	How It's Spread	Possible Symptoms	**Treatment**
	Sexual intercourse or skin-to-skin contact with someone who has trichomoniasis	Yellow or green discharge from vagina or penis Burning or pain when urinating	Cured with antimicrobials
	How to Avoid	Possible Effects	
	Avoid sexual intercourse or use condoms	Symptoms are uncomfortable Men can get infections in prostate gland Can cause problems during pregnancy	

SEXUALLY TRANSMITTED INFECTIONS: A SUMMARY

What are STIs?

Sexually transmitted infections, or STIs, are also sometimes called sexually transmitted diseases (STDs).

STIs are infections that are spread through sexual contact with certain body parts (the penis, vagina/vulva, anus, mouth and throat).

STIs caused by bacteria or parasites ***CAN be cured*** with medicine, such as antibiotics. These infections include:

- Chlamydia
- Gonorrhea
- Syphilis
- Pubic lice (crabs)
- Trichomoniasis ("trick")

STIs caused by viruses ***CANNOT be cured*** with medicine yet, but they can be treated to reduce the symptoms and make the infected person more comfortable. These infections include:

- Hepatitis B (can be immunized against)
- Herpes
- HIV/AIDS
- HPV (can be immunized against)

How Can I Tell If I Have an STI?

Sometimes you can tell if you have an STI and sometimes you cannot.

- In many people, especially women, the STI **does not cause any symptoms.**
- The symptoms may be inside the vagina or the anus, where they cannot be seen.

Symptoms that Women MIGHT Have

- Sores in or around vagina/vulva, anus or mouth
- Irregular growths, bumps or blisters in genital area
- Discharge from vagina that *smells* different than usual
- Discharge from vagina that *looks* different than usual
- Itching of vagina, vulva or anus
- Pain when urinating or having a bowel movement
- Pain during or after intercourse
- Unusual vaginal bleeding or spotting after intercourse
- Pain in lower abdomen (belly)
- Pain or swelling in groin
- Rash

Symptoms that Men MIGHT Have

- Sores on or around penis, anus or mouth
- Irregular growths, bumps or blisters in genital area
- Discharge from penis
- Itching around penis or anus
- Pain when urinating or having a bowel movement
- Pain or swelling in groin
- Rash

What Should I Do if I Think I Might Have an STI?

Call Planned Parenthood, or your doctor, local STI clinic or health department.

You need to see a health care provider if you have:

- Any symptoms of an STI.
- Vaginal, anal or oral intercourse with someone who might have an STI.
- Any sexual contact of your penis, vagina/vulva, anus or mouth with someone who might have an STI.

What Can Happen if I Don't Get Tested and Treated for an STI?

- You can give an STI to your sexual partner(s).

- If they aren't treated, STIs can lead to serious health problems, including:
  - Other infections that can damage your reproductive organs.
  - Liver damage, heart disease, skin disease, arthritis, blindness, brain damage, cancer.
  - Infertility (not being able to have children).
  - Death.

- A mother who has an STI can give it to her fetus during pregnancy, or to her baby during birth or breastfeeding.

- Having any STI makes it easier to get HIV. (HIV can pass more easily through the sores or breaks in the skin caused by most STIs.)

How Can I Protect Myself and My Partner(s) Against STIs?

The surest way to prevent STIs is not to have sexual intercourse or any direct contact with body fluids that might be infected (blood, semen and vaginal fluid) and infected skin.

If you choose to have intercourse and want to reduce your risk of getting an STI:

- Have just one partner who does not have any STIs, has sexual contact only with you, and does not use injection drugs.

- Use protection every time you have intercourse or any sexual contact with a person's penis, vagina/vulva, anus or mouth. The options are:
  - A male latex condom with a ***water***-based lubricant.
  - A male polyurethane (plastic) or polyisoprene (synthetic latex) condom for people who are allergic to latex.
  - A female condom.
  - A latex glove to protect during hand-genital contact.
  - A latex square or dental dam to protect during oral sex.

- Avoid using spermicides — they do not protect against STIs but can irritate the skin, and make it easier to pass along an STI. Douching can also irritate the vagina.

What if My Partner Says She or He Doesn't Have an STI?

- Not everyone tells the truth about having an STI.

- Not everyone who is infected knows it.

- A person can have STIs for months or years without knowing it.

USING CONDOMS

If you decide to have intercourse, correct use of a condom is the only way to reduce the risk for you and your partner against both STIs and unplanned pregnancy.

Getting Condoms

- Anyone, no matter what age, has a legal right to buy condoms at any drug store or clinic.
- Check the expiration date on the package so the condoms will keep for a long time.
- Buy some lubricant, especially if the condoms are not already lubricated. ***Do not use oil-based lubricants*** such as Vaseline, baby oil or massage oil. They will make the condom break! ***Do use water-based lubricants, or those made with silicone or glycerine.*** They are usually available in drugstores, near the condoms.
- Try different kinds of condoms to find out which is the best for you and your partner.
- If either partner is allergic to latex, use condoms made of polyurethane (plastic) or polyisoprene (synthetic latex).
- Feel good about buying condoms. You are protecting yourself and your partner.

Storage

- Keep condoms nearby so you can use them ***every*** time you have intercourse.
- Keep condoms in a cool, dry place until you need them. The heat of a car, wallet or back pocket can dry out the condoms, making them easier to break.

Getting Ready

- If you have never used a condom, or you don't feel comfortable using one, you can practice putting a condom on a model or even your fingers.
- Men who masturbate can practice on themselves or a couple can try it together.

Putting It On

- Check the freshness of the pack by feeling for the air bubble.
- Take the rolled condom out of the package. Gently tear the condom package down one edge.
- Be careful not to break the condom by using teeth or fingernails to open the package.
- Use only one condom at a time. Do ***not*** use two condoms at once.
- You can put a dab of lubricant on the tip of the penis or inside the tip of the condom to make the penis feel more sensitive.
- Pinch the air from the tip of the condom, and hold on to the tip with one hand as you roll the condom all the way to the base of the penis with the other hand.
- If the erection is lost while you are doing this, relax! It is normal and can usually be taken care of by the partners together.
- When both partners participate, putting on the condom can be part of lovemaking.

Taking It Off

- Soon after ejaculation (coming) and before the penis becomes soft, hold the condom at the base of the penis and pull out from inside partner.
- Keep the used condom away from your partner's body and your body.
- If semen spills on either of you, wash it off.
- Wrap the condom in tissue and throw it away.
- Do not use the same condom again.

CONTRACEPTIVE OPTIONS

Non-Permanent Methods

	How It Works	Advantages	Disadvantages	Effectiveness*
Abstinence not engaging in oral, vaginal and anal intercourse	Eliminates the chance for pregnancy to occur naturally.	No physical side effects. Nothing to purchase. Can be used anytime. Excellent protection from STIs. Private.	Requires commitment and self-control by both partners. Social pressures. Many people fail to use protection when abstinence ends.	Perfect use: 100% Typical use: unknown, depends on user
Condom — Male latex, polyurethane or polyisoprene sheath worn over the penis during intercourse	Provides a physical barrier so sperm cannot meet up with an egg.	Excellent protection from STIs. Inexpensive, available over the counter. May help delay ejaculation. Male involvement.	May leak or break if used incorrectly. May interfere with spontaneity.	Perfect use: 98% Typical use: 82%
Condom — Female polyurethane or nitrile condom placed inside the vaginal canal	Provides a physical barrier so sperm cannot meet up with an egg.	Good protection from STIs. Available over the counter. Alternative for people with latex allergies. Can be inserted up to eight hours before intercourse.	Requires high level of comfort with one's body. May be difficult to insert. May become dislodged during intercourse. May interfere with spontaneity.	Perfect use: 95% Typical use: 79%
Diaphragm/ Cervical Cap rubber or silicone cup placed inside the vagina to cover the cervix and the opening to the uterus	Provides a physical barrier so sperm cannot meet up with an egg; used with spermicide.	Can be inserted in advance of intercourse. Can remain in place for multiple acts of intercourse (diaphragm: 24 hours, cap: 48 hours). No hormones.	Requires high level of comfort with one's body. May be difficult to insert. Requires fitting by clinician. Limited STI protection possibly made worse from addition of spermicide. Effectiveness of cap is lower for women who have already given birth.	Perfect use: 94% for diaphragm and 91% for cap Typical use: 88% for diaphragm and 84% for cap
Fertility Awareness Method techniques used to determine the most fertile days of a woman's cycle in which intercourse will not occur or another method is used	Reduces the chance for pregnancy to occur naturally.	Nothing to purchase. Allowed by some religions that prohibit the use of other methods.	Requires commitment. No intercourse for much of menstrual cycle. Very difficult to be effective if periods are normally irregular. No protection against STIs.	Perfect use: varies by method Typical use: 75%
Implant progesterone-only hormonal implant (matchstick-sized) placed under skin on the inside of the upper arm	Keeps eggs from being released, thickens cervical mucus to keep sperm from entering the uterus, and decreases the lining of the uterus.	Continuous protection against pregnancy for three years. Nothing to apply/insert at time of intercourse. Private.	Minor surgical procedure. Irregular menstrual bleeding. Possible weight gain/loss. May be seen under the skin. No protection against STIs.	Perfect use: 99+% Typical use: 99+%

	How It Works	Advantages	Disadvantages	Effectiveness*
Injection (Depo-Provera®) progesterone-only hormonal injection given every 12 weeks	Keeps eggs from being released, thickens cervical mucus keeping sperm out of uterus, and decreases the lining of the uterus.	Continuous protection against pregnancy for three months. Nothing to apply/insert at time of intercourse. Menstruation stops for over half of women (may or may not be an advantage). Private.	Requires injection by doctor. Must remember to get the shot regularly. Possible side effects: irregular periods, weight gain, headaches, temporary bone thinning. Return to fertility may take several months after stopping method. No protection against STIs.	Perfect use: 99+% Typical use: 95%
Intrauterine Contraceptive (IUC) (Mirena®) small plastic T-shaped device with low levels of hormones inserted into the uterus	Thickens cervical mucus keeping sperm out of the uterus, reduces sperm survival, and decreases the lining of the uterus.	Continuous protection against pregnancy for five years. Nothing to apply/insert at time of intercourse. Low level of hormones may reduce menstrual cramps and bleeding. Private.	Must be inserted and removed by clinician. Rare, but serious health risks (uterine expulsion or perforation, pelvic inflammatory disease). No protection against STIs.	Perfect use: 99+% Typical use: 99+%
Intrauterine Contraceptive (IUC) (ParaGard®) small plastic and copper T-shaped device inserted into the uterus	Copper and inflammation affect sperm movement and are toxic to sperm, thereby preventing fertilization	Continuous protection against pregnancy for 10 years. Nothing to apply/insert at time of intercourse. No hormones, so is an alternative for women who cannot use hormonal methods. Private.	Must be inserted and removed by clinician. Heavier periods. Rare, but serious health risks (uterine expulsion or perforation, pelvic inflammatory disease). No protection against STIs.	99% or more Weight does not change effectiveness.
No Method having penile/vaginal intercourse without using any pregnancy prevention method	N/A	Nothing to purchase.	No protection against pregnancy. No protection against STIs.	15%
Patch (Ortho Evra®) hormonal patch applied to the body weekly; hormones are absorbed through the skin	Prevents eggs from being released and thickens cervical mucus to keep sperm out of the uterus.	Continuous pregnancy protection for one month. Nothing to apply/insert at time of intercourse. Ability to become pregnant returns quickly after stopping method.	Must be prescribed by a doctor. Must remember to replace patch weekly, then no patch for the fourth week. Visible – worn on the skin, only one color offered. No protection against STIs. Not recommended for women over 198 lbs.	Perfect use: 99+% Typical use: 92%

	How It Works	Advantages	Disadvantages	Effectiveness*
The Pill oral pill containing hormones taken daily	Prevents eggs from being released and thickens cervical mucus to keep sperm from entering the uterus.	Continuous pregnancy protection for one month (some pills act longer). Nothing to apply/insert at time of intercourse. More regular, shorter periods. Ability to become pregnant returns quickly after stopping method.	Must be prescribed by a doctor. Must remember to take daily. Possible side effects: nausea, breast tenderness, weight gain/loss. Rare, but serious health risks include blood clots, heart attack, and stroke (risks are higher for smokers over 35). No protection against STIs.	Perfect use: 99+% Typical use: 91%
Ring (NuvaRing®) plastic ring infused with hormones inserted into the vagina; hormones are absorbed through vaginal tissue	Prevents eggs from being released and thickens cervical mucus to keep sperm out of the uterus.	Continuous pregnancy protection for one month. Nothing to apply/insert at time of intercourse. Ability to become pregnant returns quickly after stopping method.	Must be prescribed by a doctor. Must remember to remove ring for one week after being in place for three weeks. Requires high level of comfort with one's body. No protection against STIs.	Perfect use: 99+% Typical use: 91%
Spermicides chemical gel, foam, cream, tablet, suppository or film placed inside the vagina no more than one hour before intercourse	Prevents sperm and egg from meeting by killing sperm upon contact.	Available over the counter in a variety of forms. Can add lubrication.	Must be inserted close to each act of intercourse, but no longer than one hour prior. May cause allergic reaction. Possibility of irritation that could facilitate STI transmission.	Perfect use: 82% Typical use: 72%
Withdrawal withdrawal of the penis before ejaculation during vaginal intercourse	Prevents sperm and egg from meeting.	Nothing to purchase. No hormones. Available in any situation. Male involvement.	Dependent on male partner. Requires great control. May affect pleasure. No protection against STIs.	Perfect use: 96% Typical use: 72%

Emergency Contraception

	How It Works	Advantages	Disadvantages	Effectiveness
Copper Intrauterine Contraceptive (IUC) (ParaGard®) small plastic and copper T-shaped device inserted into the uterus	Copper and Inflammation affect sperm movement and are toxic to sperm, thereby preventing fertilization	Most effective emergency contraception method. Can be inserted up to five days after unprotected intercourse. Can continue to use as long-term, ongoing contraception for up to 12 years.	Requires insertion by a health care professional skilled in ParaGard® IUC insertion.	99% or more Weight does not change effectiveness.
Emergency Contraception Pills — Ulipristal Acetate (UPA) (ella®) one pill taken up to five days after unprotected intercourse	May keep the ovary from releasing an egg; delays release of the egg; thickens cervical mucus to keep sperm from entering the uterus. Emergency contraception will not end a pregnancy.	UPA is more effective than Progestin EC up to five days after unprotected intercourse.	May cause nausea, vomiting, breast tenderness and irregular bleeding. Not for regular use. No protection against STIs. UPA may not work in very overweight women.	Depends on timing and medication. UPA is consistently effective each of five days after unprotected intercourse. It reduces the risk of pregnancy up to 85%.
Emergency Contraception Pills — Progestin EC one or two pills optimally taken up to three days after unprotected intercourse	May keep the ovary from releasing an egg; delays release of the egg; thickens cervical mucus to keep sperm from entering the uterus. Emergency contraception will not end a pregnancy.	Available over the counter, depending upon age.	May cause nausea, vomiting, breast tenderness and irregular bleeding. Not for regular use. No protection against STIs. It is less effective in overweight women and won't work in very overweight women.	Depends on timing and medication. Progestin EC is more effective the sooner it is taken after unprotected intercourse. At its best, it reduces risk of pregnancy 75%-88% within three days of unprotected intercourse. It is much less effective more than three days after unprotected intercourse.

Permanent Methods

	How It Works	Advantages	Disadvantages	Effectiveness*
Sterilization without Incision (Essure®) nonsurgical procedure implants into each fallopian tube a small insert which develops into a tissue blockage	The body's natural tissue grows around and through the inserts blocking sperm and egg from meeting.	Permanent protection against pregnancy. Nonsurgical and can be done in doctor's office. No hormones. Nothing to apply/insert at time of intercourse. Private.	Requires in-office procedure. Irreversible. No protection against STIs. Usually available only to older adults or those who have already had children. Can be costly due to post-insertion imaging to make sure the tubes are blocked. Takes three months to take effect.	Perfect use: 99+% Typical use: 99+%
Tubal Ligation surgically cutting or blocking the fallopian tubes	Prevents the sperm and egg from meeting.	Permanent protection against pregnancy. Nothing to apply/insert/take. Private.	Requires surgery. Reversal has relatively low success rate. No protection against STIs. Usually available only to older adults.	Perfect use: 99+% Typical use: 99+%
Vasectomy surgically cutting or blocking the vas deferens	Prevents sperm from entering the ejaculatory fluids.	Permanent protection against pregnancy. Nothing to apply/insert/take. Male involvement. Private.	Requires in-office procedure. Reversal has relatively low success rate. No protection against STIs. Usually available only to older adults.	Perfect use: 99+% Typical use: 99+%

***Perfect use rate** refers to the effectiveness of a method for someone who is using it consistently and correctly. **Typical use rate** refers to the effectiveness of a method for someone who does not necessarily use it correctly and consistently (e.g., missing pills, using oil-based lubricant with a condom, going in late for injection, etc.). If a method is 99% effective, 99 women in 100 having sexual intercourse regularly for one year are expected **not** to become pregnant. If a method is 15% effective, 15 women in 100 having sexual intercourse regularly for one year are expected **not** to become pregnant.

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FINDING HELP: A RESOURCE LIST

Whatever your situation, you never need to be alone. If you need information, guidance, support or just a caring person to talk to, all you need to know is where to look.

Depending on whom you feel most comfortable with, you can go to a/an:

- Parent/guardian
- Other relative
- Friend
- Neighbor
- Doctor
- Teacher/professor
- Guidance counselor
- Coach
- Health department
- Nurse
- Religious/spiritual advisor
- Peer counselor/educator
- Family planning clinic
- Youth program adult
- Other trusted adult

If you have questions or concerns about the following issues, you can contact:

Alcohol/Drugs Substance Abuse Hotline 1-800-662-4357 www.samhsa.gov/treatment	Dating Violence Break the Cycle National Dating Abuse Helpline 1-866-331-9474 www.loveisrespect.org	Eating Disorders National Eating Disorders Association 1-800-931-2237 www.nationaleatingdisorders.org
HIV/AIDS National AIDS Hotline 1-800-CDC-INFO www.aids.gov www.thebody.com	Pregnancy Planned Parenthood Health Center Hotline 1-800-230-PLAN www.plannedparenthood.org	Runaway Hotline National Runaway Switchboard 1-800-RUN-AWAY www.1800runaway.org
Sexual Assault and Abuse Rape, Abuse & Incest National Network Hotline 1-800-656-HOPE www.rainn.org	Sexual Orientation LGBTQ Hotline 1-800-850-8078 www.thetrevorproject.org www.itgetsbetter.org	Sexually Transmitted Infections Planned Parenthood 1-800-230-PLAN www.plannedparenthood.org American Social Health Association 1-919-361-8488 www.ashastd.org
Suicide National Suicide Prevention Lifeline 1-800-273-8255 www.suicidepreventionlifeline.org	Unprotected Sexual Intercourse Planned Parenthood or EC Hotline *(Within 120 hours of intercourse!)* 1-800-230-PLAN 1-888-NOT-2-LATE http://ec.princeton.edu www.plannedparenthood.org	

For LOCAL hotlines and helpful agencies, search with an online browser such as Google by entering keywords for the issue you need help with, combined with the name of your town or county (e.g., "HIV/AIDS Morristown NJ" or "Sexual Assault Morris County NJ"). You can also search locally at www.yellowpages.com.

Local information can also be found in your telephone book yellow pages or in the Community Services Numbers in front of the white pages.

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"What an excellent book to help people learn about adolescent sexual health!"

— M. Joycelyn Elders, MD
15th U.S. Surgeon General

"*Positive Images* is a valuable resource for any educator looking to implement interactive and fun approaches to teaching about contraception and sexual health."

— Leslie M. Kantor, MPH
Vice President, Education
Planned Parenthood Federation of America

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International Sexuality Consultant

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— Al Vernacchio, MSEd
Author
For Goodness Sex

"Sex educators will love this book! The authors take a positive approach to sexuality that goes beyond just a list of the risks involved and they discuss the pleasures and joys that sexuality can involve. The broad acceptance of viewpoints will allow students to more fully understand different sexual feelings and views and the different choices that they and others may make in the area of contraception and sexual health. I highly recommend this book — teachers who use it will make a significant difference in the lives of their students."

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Professor Emeritus of Sociology
University of Minnesota

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