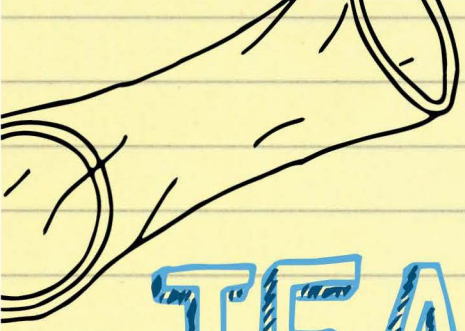
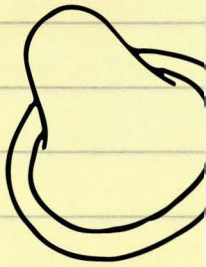


TEACHING SAFER SEX



ABRIDGED EDITION

10 Lesson Plans
Selected and Updated from
Teaching Safer Sex, 3rd Edition

BILL TAVERNER
EDITOR

TheCenterfor SexEducation

Planned Parenthood® Care. No matter what.
Planned Parenthood of Northern, Central, and Southern New Jersey

TEACHING SAFER SEX

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This manual was produced with generous support from the makers of LifeStyles condoms.

The Center for Sex Education is the national education division of Planned Parenthood of Northern, Central, and Southern New Jersey, Inc.

ABOUT THE EDITOR

BILL TAVERNER, MA, CSE, is the executive director of The Center for Sex Education and is the editor-in-chief of the *American Journal of Sexuality Education.* He is the author or editor of more than 75 publications, including teaching manuals and curricula, college readers, journal articles, chapters, lesson plans and other contributions in sexuality education.

Bill is the chief editor of the third edition of *Teaching Safer Sex,* which received the prestigious AASECT Book Award, given by the American Association of Sexuality Educators, Counselors and Therapists. He is the co-author of *Making Sense of Abstinence,* associate editor of *How I Got Into Sex … Ed,* and editor or co-editor of eight editions of *Taking Sides: Clashing Views in Human Sexuality.*

Bill served on advisory boards for a number of organizations, including the inaugural board for the graduate Sexual Health Certificate program at the University of Michigan, and on an advisory panel convened by former U.S. Surgeon General David Satcher to provide input on the development of a curriculum to help parents talk with their children about sex.

A trainer of thousands throughout the United States, who has twice advocated for sexuality education at U.S. Congressional briefings, Bill has received other national awards recognizing his leadership in sexuality education: the first Schiller Prize, given by AASECT for best workshop using interactive strategies; Planned Parenthood's Golden Apple Award for leadership in education; the *Sexual Intelligence* award, naming him "one of the country's pre-eminent sex educators, trainers, and sex education theorists"; the Academy for Adolescent Health's Social Justice Award for commitment to racial and social justice; and the AASECT Sexuality Educator Award.

LETTER FROM LIFESTYLES

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I thank the following organizations and people who contributed to the development and publication of *Teaching Safer Sex: Abridged Edition.*

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- Everyone at the **CSE** and **Planned Parenthood of Northern, Central, and Southern New Jersey (PPNCSNJ)**: Nick Beard, Triste Brooks, Ali Glaser and the PPNCSNJ Board of Directors, for support in producing many excellent teaching resources.

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INTRODUCTION

by Bill Taverner

More than 30 years ago, Peggy Brick wrote the first edition of *Teaching Safer Sex* with Catherine Charlton, Hilary Kunins and Steve Brown.[1] In a world that was still just beginning to understand HIV and AIDS, with much of the education focused on epidemiology of the disease and the function of T-cells, Brick et al. recognized the need for lesson plans that addressed the attitudes, skills and behaviors needed to protect one's sexual health. The authors recognized that epidemiological knowledge was incidental, and even unnecessary, for individuals wanting to prevent sexually transmitted infections. The lesson plans used interactive strategies to improve comfort with sexual language, to counter negative attitudes about condoms and condom users, and to create a new frame with which safer sex was portrayed in a positive, responsible way.

Peggy hired me in 1998 while she was finishing the expanded second edition, *The NEW Teaching Safer Sex.*[2] That was the first writing project Peggy and I worked on together. Though I added very little content to the final draft of that edition, I learned a lot that summer about how to make learning fun, interactive and meaningful. When I served as lead editor for the third edition in 2012,[3] Peggy wrote an enthusiastic and congratulatory introduction, which served as a guided tour to the 50 lesson plans in two volumes. Privately, Peggy admonished me that there were too many lessons! So I think she would be very happy with this abridged edition.

Peggy died on December 24, 2018. She is remembered as an internationally respected sexuality educator who was admired by her colleagues.[4] *Teaching Safer Sex: Abridged Edition* retains Peggy's vision, as well as philosophical and pedagogical characteristics of prior editions. The lessons are highly interactive, involve frequent discussion, and focus on the knowledge, attitudes and behavior needed to be successful in taking responsibility for one's sexual health. As I selected and edited the lesson plans for this edition,

Peggy's voice was frequently in my head. "Keep the Four Corners activity!" "That's way too much information!" "Why not combine the lessons?" I don't know that I always made the decision that Peggy might have made, but it did make me miss the rigorous debates we'd have that would help me think better.

The contributing authors to *Teaching Safer Sex: Abridged Edition* are terrifically talented and it was an honor to incorporate their creative ideas into this manual, which includes 10 carefully selected and updated lesson plans using a variety of pedagogical techniques — true/false handouts; paired, small group and large group discussion; kinesthetic activities; role play; games; independent research; and more, as participants explore a spectrum of considerations related to sexual health, and develop the knowledge, attitudes and skills to make safer decisions.

Many thanks to the makers of LifeStyles condoms for supporting this project and getting these lesson plans into the hands of sexuality educators.

CONTENTS

PRINCIPLES FOR SEX EDUCATION

Teaching Safer Sex: Abridged Edition 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 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 healthy decisions about their sexual lives.

2. **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.

3. **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.

4. **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.

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. **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 unhealthy "secrecy" of sex. Sexual information needs to be presented in an honest, accurate way.

7. **All sexual orientations, gender identities and gender expressions must be included.**

   Comprehensive sex education recognizes that there are diverse audiences, 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. All people have a right to achieve their full human potential.

8. **All sex education must be rooted in the concept of consent.**

Consent is a bedrock in all relationships, especially romantic and sexual relationships. The assumption of consent is woven into all quality sex education and it should also be taught deliberately and directly. This is especially important to counteract gender role socialization that sets the conditions for sexual violence to occur and a media culture that sends mixed messages about what comprises sexual consent.

9. Sex education must be sensitive to the needs of participants with histories of trauma.

Experiences of trauma, including sexual trauma, are very common in the U.S. population, so it is likely that any sex education group will have participants that are trauma survivors. Sex education can be healing or retraumatizing for survivors. Trauma-informed sex education aims to create a climate and teach knowledge that contradicts the exploitive dynamics of trauma.

10. 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.

GOAL AND OBJECTIVES FOR SAFER SEX EDUCATION

Goal

To help participants explore the many facets of safer sex and sexually transmitted infections, in order to support the health and well-being of themselves, their family, friends and acquaintances, and society at large.

Objectives

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.
- Describe the possible consequences of sexual intimacy, particularly when it involves vaginal, oral or anal intercourse, and describe the actions one can take to reduce the risk of unwanted consequences.
- Express comfort, knowledge, attitudes and skills needed to practice safer sex if they decide to have intercourse.
- Assess the risks involved in their own sexual behavior and set goals to make safer sex an integral part of their sexual lives.
- Develop the capacity to work cooperatively with a partner to assume mutual responsibility for safer sex.
- Speak up for actions that help protect the sexual health and well-being of others.

HOW TO USE THIS EDITION OF TEACHING SAFER SEX

Scope of This Book

This manual has 10 lesson plans presented in *nonsequential* order so educators can select those most relevant to their participants. It is important to know that this is *not a curriculum* for teaching about sexually transmitted infections (STIs) as it is not intended to be taught from start to finish. Rather, the manual seeks to enhance the field of safer sex education by providing a variety of engaging, up-to-date lessons.

This resource focuses on the comfort, knowledge, attitudes and skills required for a person to practice safer sex, and it is designed to encourage thoughtful sexual decision-making. These materials can be used to *supplement* existing curricula in traditional academic or interdisciplinary settings, or the safer sex objectives and educational activities can be integrated into a variety of community settings.

"Safer sex" includes any behaviors that reduce the risk of unwanted consequences of sexual activity, among them, unplanned pregnancy and sexual coercion, as well as the risk of STIs.

How This Book 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 plan includes:

Objectives: The learning and skills participants will have after participating in 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 book includes a summary of STIs, including advice on prevention and treatment, and instructions on using condoms. These resources can be distributed with many different lessons and can also be used as standalone materials.

Selection of Lessons and Activities

Few educators will use *all* of these lessons. However, in order to understand the scope of safer 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 sexuality 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 all material in *Teaching Safer Sex: Abridged Edition*, with the exception of handouts, which may be freely copied in print format and distributed to participants in educational settings.

THE LESSONS

DEFINING *SEXUAL HEALTH*

MASTURBATION:
A Safe, but Touchy Subject

STI BINGO

THE BIG IF

THE CONDOM LINEUP

SWIPING RIGHT:
Profile of a Successful Condom User

SAY WHAT?!?:
Communicating About Safer Sex

CHOOSING CONDOMS, CHOOSING LUBES

SECURING THE BACK DOOR:
A Guide to Safer Anal Sex

FRIENDS GETTING TESTED

DEFINING *SEXUAL HEALTH*

by Kirsten deFur, MPH

Objectives

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

1. Define the term *sexual health*.
2. Identify at least two indicators of sexual health.
3. Identify at least two things they can do to improve or protect their sexual health.

Rationale

The term *sexual health* can be interpreted in a variety of ways, and it is important to clarify the definition and determine how sexual health can be achieved on an individual basis. This lesson will allow participants to define *sexual health*, recognize its characteristics, and understand ways to improve and protect their sexual health.

Materials

- Paper for each group of participants
- Optional: two or three prizes for the winner of the brainstorm competition
- **Handout: Defining *Sexual Health***
- **Handout: How Do You Measure Sexual Health?**

Procedure

1. Introduce the activity by explaining that the term *sexual health* is frequently talked about on the news, in school and among health professionals, but it is rarely defined and is often left for interpretation.

2. Divide participants into groups of two or three. In their groups, ask participants to spend a few minutes writing down as many words as possible that come to mind when they hear the term *sexual health*.

3. Have the group read their lists aloud, one at a time. (Optional: Give a prize to the group with the most words.)

4. Next, ask each group to develop their own definitions of the term *sexual health*. Give them a few minutes to develop their definitions, and let them know they will be asked to share the definition with the larger group.

5. After about 10 minutes, have each group read their definition aloud.

   Discussion Questions:

   a. What similarities did you notice in the different definitions?

   b. What differences did you notice?

   c. What items from the different definitions do you think are most important to include in a definition of *sexual health*?

   d. Why is it important to understand what *sexual health* means?

   e. When might a person need to use the term *sexual health*?

   f. Some definitions might focus on preventing disease. What other parts of sexual health are important?

6. Pass out copies of the **Handout: Defining *Sexual Health***. Ask one of the participants to read the definition aloud. Explain that this is a working definition from The World Health Organization (WHO).[5]

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Discussion Questions:

a. What do you think about this definition? What parts strike you as important?

b. How does one become sexually healthy according to this definition?

c. What do you think it means that sexual health is "not merely the absence of disease, dysfunction or infirmity"?

d. Why is a "positive and respectful approach to sexuality and sexual relationships" important to sexual health?

e. How might a person have "pleasurable and safe sexual experiences" that are "free of coercion, discrimination and violence?" Are there any times when avoiding coercion, discrimination or violence may be beyond a person's control?

f. How easy or difficult do you think it is to achieve this definition of *sexual health*?

7. Pass out the **Handout: How Do You Measure Sexual Health?** Ask participants to work in pairs to complete the handout.

Discussion Questions:

a. Which part of the handout do you think adults talk about the most?

b. Which parts of sexual health might cause a person anxiety?

c. How can a person know if they are sexually healthy or not?

d. What can individuals do to affirm their decision to be sexually healthy?

e. What will you take away from participating in this activity?

Handout

DEFINING *SEXUAL HEALTH*

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity.

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Source: World Health Organization. (2006). Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002. Geneva: World Health Organization.

Handout

HOW DO YOU MEASURE SEXUAL HEALTH?

1. Sexual health includes physical, emotional, mental and social well-being. Describe at least one example of each:

   - A sign that a person is ***physically*** well would be:

   - A sign that a person is ***emotionally*** or ***mentally*** well would be:

   - A sign that a person is ***socially*** well would be:

2. How might disease, dysfunction or serious illness affect sexual health?

3. What steps can a person take to develop positive and respectful attitudes about their sexuality and sexual relationships?

4. What steps can a person take to help respect, protect and fulfill sexual rights for themselves and others?

MASTURBATION
A Safe, but Touchy Subject[6]

by Bill Taverner and Sue Montfort

Objectives

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

1. Identify basic facts and common myths about masturbation.

2. Examine common attitudes and their own feelings about masturbation.

3. Explain why masturbation is a healthy and safe form of sexual expression, and a readily available and reliable part of a person's strategy for avoiding both sexually transmitted infections (STIs) and pregnancy.

Rationale

No teaching about "safer sex" is truly complete without including a discussion of masturbation as a **safe** method of protection from STIs, as well as from pregnancy. People of all ages are likely to have questions about masturbation. Websites that provide sexual information for teens, such as www.scarleteen.com and www.sexetc.org, report that masturbation is one of the topics that young people ask about most often. While young people and adults often report receiving strong messages about masturbation during adolescence, including those conveyed by silence, masturbation is rarely addressed except in the most comprehensive of sex education programs.

In a world of myths and misinformation, it is important for everyone to develop positive attitudes about a behavior in which most will engage at some point in their lives. This lesson will help participants examine common attitudes and beliefs about masturbation in a

nonthreatening, nonjudgmental manner. It also allows them the opportunity to consider, perhaps for the first time, just how valuable masturbation can be as a safe form of sexual expression and pleasure.

Materials

- Flip chart paper or board, markers and tape
- Several flip chart sheets labeled **MASTURBATION**
- A box of graham crackers and a box of corn flakes cereal
- Large and small index cards
- **Handout: Just the Facts!** (Write each statement on a separate sheet of paper and post around the room)
- Green and red stickers
- **Educator Resource: Answer Key: Just the Facts!**

Procedure

1. Before the class begins, post the statements from the **Handout: Just the Facts!** around the room.

2. Ask the group if they have ever heard myths about masturbation. Give as an example the myth that poor eyesight is caused by masturbation, and explain that this is one of many untrue things that people may have heard over the years. Say that today's lesson will focus on learning the facts about masturbation, including its usefulness as a safe sex practice.

3. Divide participants into small groups and distribute markers and a sheet of flip chart paper with the **MASTURBATION** heading to each small group. Invite participants to write down as many words as they can think of that mean the same thing as masturbation. Tell them to include words young children use, words adults use, slang words, etc. Allow about five minutes. Offer each participant a piece of graham cracker to munch on while they work.

4. As groups finish, have them post their lists on the wall. Ask for a volunteer from each group to read that group's list of words, beginning with *masturbation*.

   Discussion Questions:

   a. How did you feel about making these lists?

   b. Why do you think there are so many words for masturbation?

   c. How would you describe these words? Funny? Silly? Weird? Rude? Gross? Other?

   d. What do these words say about how people feel about masturbation?

   e. Which words can apply to all genders? Which words describe mainly male masturbation? Mainly female masturbation?

   f. Why do you think there are so few words describing female masturbation on these lists?

5. Note that researchers have actually found many words for female masturbation. Give a few examples that are appropriate for your group, e.g., *jill off; romance the rose; a little southern comfort.* Other languages have many words for masturbation, including different words for male and female masturbation. For example, one Japanese word for male masturbation, *senzuri*, means "one thousand strokes." And one word for female masturbation, *manzuri*, means "ten thousand strokes." Ask what the difference between those two definitions suggests.

6. Acknowledge that slang language about masturbation is quite binary, prioritizes males, and does not recognize that this is a behavior available to people of *all* genders.

7. Now, while participants are still in their small groups, say that we need to define clearly what we are talking about when we say the word *masturbation*. Give each group a large index card and ask them to decide who will write for the group. Tell them they will have about five minutes to come up with a definition of *masturbation*.

8. When the groups have finished defining *masturbation*, ask a representative from each group to read the group's definition. Jot phrases from each group's definition on the board / flip chart paper. Add additional phrases from the sample definition below, as necessary.

   Sample definition:

   > *Masturbation involves touching, rubbing or stroking one's **own** body for sexual pleasure. It could involve stimulation of the penis, clitoris, labia, vagina or breasts.*
   >
   > **Note:** Be prepared to discuss *mutual masturbation* (partners stimulating each other or stimulating themselves in the presence of each other).

9. Explain that throughout U.S. history, people have been very concerned with the supposed harms of masturbation. Hold up the boxes of graham crackers and corn flakes, and ask participants to guess what these products might have to do with masturbation. Listen to a few responses.

   Tell participants that these products were invented by Reverend Sylvester *Graham* and Dr. John Harvey *Kellogg,* respected U.S. authorities of the early and mid-1800s. They believed that masturbation caused health problems because a person's body lost some of its fluid. The plain taste of corn flakes and graham crackers (made without sugar or cinnamon in those days) was supposed to prevent the urge to masturbate. So there's another myth!

Discussion Questions:

a. What other myths have you heard about masturbation? (Be sure to include things like: causes hairy palms, nosebleeds, acne, warts, headaches, tender breasts, a bent penis, nail biting, epilepsy, feeble-mindedness, insanity, weakness, obsession with sex, etc.)

b. How do you think these myths got started?

c. Why do you think people are sometimes more uncomfortable discussing masturbation than other forms of sexual expression? (Explain that while people hear a lot of myths and misinformation about masturbation, the subject is still not talked about very much.)

10. Distribute small index cards and ask participants to write down one question a person might have about masturbation. Make sure to clarify that this is anonymous — participants should not write their names anywhere on the index cards.

11. When participants are finished, collect the cards to read through while they work on the next assignment. Tell them they will now check out some statements that will help them learn accurate information about masturbation, and these will likely answer some of the questions they've just written down. Note you will discuss their other questions after they've completed the next activity.

12. Distribute the **Handout: Just the Facts!** to each person and ask them to form pairs, giving each pair 13 green and 13 red stickers. Tell them to put a **GREEN** sticker on the statement cards they think are **TRUE** and a **RED** sticker on the ones they think are **FALSE**. They can record their decisions on their handouts as they circulate among the cards. (Alternatively, ask participants to complete the handout in pairs.)

13. Give them about ten minutes, then review answers with participants, referring to the **Educator Resource: Answer Key: Just the Facts!**

    Discussion Questions:

    a. Which facts surprised you?

    b. Which facts do you think are common knowledge?

    c. What connection do you see between the health benefits of masturbation and safer sex practices?

    d. What are the advantages and disadvantages of masturbation when it comes to safer sex?

    e. Do people often *think* about masturbation as practicing safer sex? Why or why not?

14. To conclude, ask participants to think back to the myths and misinformation about masturbation that were discussed earlier. Ask them to write down one thing that would be important to help people feel more comfortable about masturbation.

Handout

JUST THE FACTS!

Directions: Mark each statement **T** for true or **F** for false.

_____ 1. Many infants and young children discover that touching their genitals feels good.

_____ 2. Many people report masturbating during adolescence.

_____ 3. Masturbation can help people learn about their own bodies.

_____ 4. Masturbation usually involves deep vaginal penetration.

_____ 5. Masturbation always leads to orgasm.

_____ 6. Masturbation can make someone run out of sperm.

_____ 7. Masturbation may be an important part of a couple's sexual relationship.

_____ 8. Many married people masturbate.

_____ 9. Masturbation occurs in societies throughout the world.

_____ 10. Some families and religions oppose masturbation.

_____ 11. In the United States, education about masturbation can be controversial.

_____ 12. Too much masturbation can cause health problems.

_____ 13. Masturbation is an example of safe sex.

Educator Resource

ANSWER KEY: JUST THE FACTS![7]

1. **Many infants and young children discover that touching their genitals feels good.**

   TRUE. Masturbation, or self-pleasuring, is a common behavior throughout childhood. Research shows that children often begin touching their own genitals for the pleasurable feelings this touch brings around two months of age (and sometimes in utero) and the median age is between 1.5 and 2.7 years of age. Later in childhood, some children continue to masturbate, some begin to do so, and some stop and start again later. Young children may not understand the sexual meaning of masturbation, but they do learn from adults' reactions, which likely affect their future feelings about the behavior.

2. **Many people report masturbating during adolescence.**

   TRUE. During puberty, adolescents begin developing a strong sense of how their bodies function, including their sexual feelings and physical responses, and may begin masturbating more purposefully at this time. A national study found that 74% of males and 48% of females reported masturbating between ages 14 and 17.

3. **Masturbation can help people learn about their own bodies.**

   TRUE. Masturbation can help people learn how they like (and do not like) to be touched, how physical and emotional feelings are connected, and how they can reduce tension and stress. It can help people feel more confident with their bodies and less anxious during sexual interactions.

4. **Masturbation usually involves deep vaginal penetration.**

   FALSE. People report many different ways to masturbate. While some prefer vaginal penetration during masturbation, it rarely resembles vaginal intercourse. Most masturbate by gently

stroking the clitoris (the only body part whose sole purpose is sexual pleasure), the labia, vagina and/or the breasts, or by stroking the shaft of the penis.

5. **Masturbation always leads to orgasm.**

   FALSE. For people of all ages, masturbation can be a pleasurable activity whether or not it causes a person to reach the stage of arousal called *orgasm*, with its peak in blood pressure, breathing and heart rate, and rhythmic muscular contractions. A person can begin and stop masturbating whenever they wish; there is no goal or end point that a person *must* reach or *always* reaches.

6. **Masturbation can make someone run out of sperm.**

   FALSE. This myth has been a cause of much worry in the past. If ejaculation happens several times close together, the person may notice a slight decrease in the amount of *semen* (which is 99% of the fluid). However, there are still millions of sperm in the semen. A healthy person continues to produce millions of sperm in their testes daily from puberty throughout life. Likewise, masturbation does not affect fertility in the ovaries.

7. **Masturbation may be an important part of a couple's sexual relationship.**

   TRUE. Masturbation can play a positive role in a relationship when partners' orgasms occur at different times in a sexual experience. When couples have discussed masturbation, this communication can reduce the pressure one partner may feel about the need to provide satisfaction for the other partner. Couples might also choose mutual masturbation. Masturbation can also help when one person is busy, sick, tired, pregnant or simply not interested in being sexual with a partner at a given time.

8. **Sometimes married people masturbate.**

   TRUE. Many married people, people who live with their partners, and other people who have regular sexual partners masturbate, as do people without sexual partners and/or who live alone.

About 70% of people who are married masturbate at least occasionally. Researchers conclude that married people are not masturbating to make up for frustrations in their relationships, but as an additional means of enjoying their sexuality.

9. **Masturbation occurs in societies throughout the world.**

TRUE. Masturbation has been studied in many countries. Some research is old, some research is new. Research is typically differentiated by gender, and there are often differences between males and females, with males reporting higher rates of masturbation. The following table represents a few countries and the percentage of people who answered yes when asked if they had ever masturbated:

COUNTRY	MEN	WOMEN
Australia	58%	42%
Bangladesh[a]	42%	13%
China	45%	10%
Columbia	92%	43%
Croatia	n/a[b]	60%
Great Britain	95%	71%
Russia	65%	32%
Sweden[c]	99%	86%
Thailand	89%	n/a[d]
United States[e]	89-94%	72-85%

However, it is important to note that most of this research relies on self-reporting. Since not everyone is comfortable being honest when reporting about masturbation, some percentages may be different in reality.

[a] Undergraduate students were studied.
[b] Men were not included in this study.
[c] High school students were studied.
[d] Study was limited to men in the army.
[e] A range of ages was studied.

10. **Some families and religions oppose masturbation.**

    TRUE. Masturbation is not for everyone; some people will choose not to masturbate because of the beliefs and attitudes of their family, religion or culture, or because of their own beliefs and attitudes. In both the United States and in many other countries, attitudes and beliefs about masturbation can range from taboo to enthusiastic approval; however, attitudes are generally becoming more accepting of masturbation, at least for some parts of the life cycle.

    Interestingly, the *written teachings* from each of the traditions of Judaism, Christianity, Islam, Buddhism and Hinduism do not hold single unanimous positions about masturbation, although *religious leaders* of the first four have historically discouraged the behavior. As a result, there has been, and continues to be, much debate about masturbation in some religious groups.

11. **In the United States, education about masturbation can be controversial.**

    TRUE. Although experts say that the topic of masturbation should be included in comprehensive sexuality education, in 1994 the United States Surgeon General, Dr. Joycelyn Elders, was fired after she said that masturbation "is something that is a part of human sexuality and … it's a part of something that perhaps should be taught," even though she clarified that she was advocating educating *about* masturbation, not teaching *how to* masturbate.

12. **Too much masturbation can cause health problems.**

    FALSE. Frequent masturbation does not cause health problems. Generally people stop when they feel sexually satisfied. To the contrary, research indicates that there may be many health *benefits* to masturbation, such as:

    - Reducing stress and tension
    - Avoiding sexually transmitted infections and unplanned pregnancy

- Relieving menstrual tension and cramps
- Making blood and hormones pump through the body faster, which helps the body produce cells better
- Helping prevent disease by increasing the flow of white blood cells and building up resistance to infections
- Strengthening muscles in the pelvic and anal areas
- Helping prevent breast cancer, prostate cancer and other prostate problems
- Strengthening the circulatory system

13. **Masturbation is an example of safe sex.**

TRUE. Masturbation has been described as "having sex with the only person whose sexual history you can trust completely." People cannot give or get a sexual infection or get pregnant just by masturbating, nor must they deal with another person's feelings, physical condition, timing, behaviors, etc. When a person chooses to masturbate instead of seeking an unknown partner, or one unwilling to use protection for sexual intercourse, or when a couple chooses to masturbate together if an infection is suspected, and/or they have no barrier protection available, they are choosing to enjoy sexual pleasure safely.

STI BINGO[8]

by Melissa Keyes DiGioia and Jessica Shields

Objectives

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

1. Name three examples of sexually transmitted infections (STIs).

2. List two ways that STIs can be transmitted.

3. Correctly name two prevention techniques people can use to eliminate or reduce their risk of contracting or spreading an STI.

Rationale

According to the World Health Organization, more than one million new STIs are acquired every day worldwide.[9] Participants need opportunities to learn and communicate about STIs. This game allows participants to review important information about STIs, including types, modes of transmission, and relevant prevention techniques.

Materials

- Flip chart paper or board
- Markers
- Pamphlets summarizing STIs (Can be printed or ordered from https://www.cdc.gov/std/healthcomm/the-facts.htm or ordered from https://www.etr.org/store/product/std-facts/)
- STI Bingo boards (Refer to the **Educator Resource: Making Bingo Boards** to make the boards ahead of time)
- **Educator Resource: STI Bingo Questions**
- Optional: Bingo cage (If you use a cage, be sure to remove all but numbers 1-28)

Procedure

1. Ask participants to name a few examples of sexually transmitted infections, or STIs, and record the responses on flip chart paper or board. Distribute the STI pamphlets and tell participants that they will play a game that will review facts about STIs. They can refer to the pamphlets throughout the game.

2. Distribute an STI Bingo board to each participant. Explain that everyone has a different bingo board. Note that the boxes contain words relating to STIs, such as the types of infections (bacterial, viral, etc.), the names of STIs, types of bodily fluids or ways to prevent STIs.

3. Tell participants that questions that relate to STIs will be read aloud. They will work together to correctly determine the answer to the question, which may be present in the boxes of the bingo board. Once a correct answer is provided, participants will mark off the answer with an **X** if it appears on their bingo boards. The first person to have five boxes crossed out that line up horizontally, vertically or diagonally should shout, "BINGO!" This person is the winner.

4. Use the **Educator Resource: STI Bingo Questions** to read the questions aloud**.** (Read the questions in numerical order or at random, have participants select question numbers, or use a bingo cage to choose a question number.) After each question is read, ask participants to provide an answer. Then give them a moment to find if the answer is located on their bingo boards. Provide the correct answer and be sure to record it on flip chart paper.

5. Continue the bingo game until the winner is determined. If the game ends quickly, explain that the next winner is the person with all the boxes on their bingo board crossed out.

Discussion Questions:

a. What bodily fluids can contain a sexually transmitted infection?

b. What types of infections can be cured by medicine?

c. What behaviors can expose a person to an STI?

d. What are some ways to avoid exposure to an STI?

e. Which ways of preventing STIs would you recommend for a friend? Why?

6. Write **#GYT** on the board or flip chart and ask participants if they have ever seen that hashtag. Ask for a few volunteers to guess what the hashtag might mean.

7. Explain that it means *get yourself tested*. Note that anyone can find out their STI status by getting tested.

8. Ask for a few more volunteers to share where a person might get tested. (Supplement ideas as needed, including doctor, health center and Planned Parenthood).

Educator Resource

MAKING STI BINGO BOARDS

1. Go to http://www.teach-nology.com/web_tools/materials/bingo/

2. Select the 5 x 5 bingo board size. Using the **Educator Resource: STI Bingo Questions**, type each of the answers (written in bold), into the open boxes (24 in all, assuming you will leave a FREE space).

3. Click on "FREE BINGO SPACE" to make the bingo board.

4. Print the board.

5. Click on "Shuffle Words" to make another bingo board, and print. Continue making different bingo boards to accommodate the number of participants.

   Note: There are 30 answers that can be used to create the bingo boards. As you make the boards, replace answers to increase the diversity of the boards.

Educator Resource

STI BINGO QUESTIONS

Below are questions to read aloud to the class. Questions can be read in numerical order or in whichever order you choose. Answers are written in bold.

1. This sexually transmitted virus can result in damage to the liver. **Hepatitis**

2. This sexually transmitted virus is named the human immunodeficiency virus. **HIV**

3. Before the invention of penicillin, Al Capone and Oscar Wilde died from advanced cases of this bacterial STI, which in its early stages can cause painless sores called chancres. **Syphilis**

4. Commonly referred to as crabs, these parasites attach to the pubic hair and can be cured by medicated shampoos, such as RID or NIX. **Pubic Lice**

5. This uncomfortable urethral symptom can be a motivator to get checked out. **Hurts to Pee**

6. This latex barrier prevents the spread of most STIs. **Condom**

7. This latex barrier is placed over the vulva or anus to provide some protection against STIs when engaging in oral sex. **Dental Dam**

8. There is a vaccine for this virus, which is the leading cause of cervical cancer in women. **HPV**

9. These two common bacterial STIs can be cured with antibiotics and sometimes have no signs and symptoms. **Gonorrhea and Chlamydia**

10. This fluid, given to a baby through breastfeeding, can transmit HIV. **Breast Milk**

11. This virus causes outbreaks of cold sores and genital blisters, and can be spread through oral, anal and vaginal sex. **Herpes**

12. People often do not know they have infections because they do not experience this. **Symptoms**

13. This term is used to describe the presence of genital blisters and cold sores caused by the herpes virus. **Outbreak**

14. These parasites live underneath the skin and can be passed through skin-to-skin contact. **Scabies**

15. This fluid can be transmitted through needle exchange, and can spread HIV and hepatitis. **Blood**

16. This fluid, released from the penis, contains sperm and can transmit STIs. **Semen**

17. This fluid, released from the vagina, can transmit STIs. **Vaginal Fluid**

18. A pre-exposure medication that people can take to prevent becoming infected with HIV. **PrEP**

19. In addition to sexual intercourse, HPV can be transmitted in this way. **Skin-to-Skin Contact**

20. This test is used to confirm a person is infected with HIV. **Blood Test**

21. This group of STIs caused by microscopic organisms can be cured by medicated lotions, shampoos or ointments. **Parasitic Infections**

22. This method of preventing pregnancy and infection involves avoiding oral, anal and vaginal sex. **Abstinence**

23. This syndrome, caused by HIV, occurs when the immune system is so weak that the body can't fight off other infections. **AIDS**

24. A post-exposure medication that people can take to prevent becoming infected with HIV. **PEP**

25. This group of STIs can be cured with antibiotics. **Bacterial Infections**

26. This group of STIs cannot be cured by antibiotics but can be treated with medicine. **Viral Infections**

27. These types of pregnancy prevention methods do not protect against STIs. **Hormonal Methods**

28. Behaviors such as having sex without protection, sharing needles, having multiple sex partners, and having sex with someone who has an STI are considered to be at this level of risk for STI transmission. **High Risk**

29. Behaviors such as having sex while using condoms or using dental dams are considered to be at this level of risk for STI transmission. **Low Risk**

30. Behaviors such as body massage, sharing silverware, showering together, and abstinence are considered to be at this level of risk for STI transmission. **No Risk**

THE BIG IF

by Peggy Brick, MEd

Objectives

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

1. Differentiate the risk for transmission of sexually transmitted infections (STIs) posed by a variety of sexual behaviors.

2. Describe the importance of partner choice as a factor in assessing one's risk for contracting an STI.

3. Discuss two ways that sexual orientation might affect safer sex practices.

4. Assess the difficulty of adopting different prevention behaviors and identify ways to overcome barriers to prevention.

Rationale

Misinformation about how STIs are transmitted is an important barrier to a person taking appropriate and effective precautions. Many people are uncomfortable talking about explicit sexual behaviors, and this discourages learning that is necessary for prevention. The risk continuum strategy used in this lesson helps participants overcome discomfort with sexual words, evaluate the relative risks of various behaviors, and compare modes of transmission. For many people, sexual orientation plays a role in their concern about sexual activity. This lesson provides an opportunity to discuss how sexual orientation may or may not impact the risk of STI transmission.

Materials

- Flip chart paper or board, markers and tape

- Two large signs, one labeled **HIGH RISK**, one labeled **NO RISK**
- **Educator Resource: Behavior Cards**
- **Handout: Risky Business**
- **Educator Resource: Sexual Partners Cards**
- **Handout: Playing It Safer**

Note: Use the two educator resources to create two sets of cards: one stack of Behavior Cards and one stack of Sexual Partners Cards. Using different-colored cardstock will make it easier to identify which is which.

Procedure

1. Write on the board or flip chart paper: **THE MORE YOU KNOW, THE SAFER YOU ARE**. Ask participants if they think this statement is true when it comes to sexually transmitted infections.

2. Hopefully, you will generate discussion about the difference between knowing something and acting on that knowledge. For example, people know that smoking is unhealthy; people know that a healthy diet is important; people know that it's unsafe to text while driving. But people don't always do what they know is healthy!

3. Write **IF** in big letters on the board or flip chart. Note that during this session participants will learn important information about personal safety regarding sexually transmitted infections, but the information will be useful only if (the "Big IF") people use the information in their own lives.

4. Make a long continuum on the wall using the **RISK** signs:

5. Divide participants into groups of five or six people and give each group one or more of the **Educator Resource: Behavior Cards**. Group members are to reach agreement about where on the continuum they should put each behavior in terms of the risk of transmission of an STI. Then one member is to tape each card in the proper place on the continuum.

6. After all cards are posted, ask the entire group to examine the cards on the continuum and recommend any needed changes. Continue discussion until everyone is satisfied with the location of all cards, or until the group has had an opportunity to express and understand the different opinions.

   Discussion Questions:

   a. When your group was deciding where to place each of your cards, what factors did you take into account?

   b. Do you think that sexual orientation changes the risk associated with any of these activities?

   c. What is the difference between a sexually transmitted *infection* (STI) and a sexually transmitted *disease* (STD)? *("STI" and "STD" are sometimes used interchangeably but there is some difference. An STI involves an infection that is treatable and often curable; an STI could lead to an STD, a more chronic condition.)*

7. Now distribute the **Handout: Risky Business** to each person. Ask participants to examine the handout and identify what further changes of card location are needed, again moving the cards as applicable.

8. Note that this risk continuum is assessing risk *if* one or both partners *is* infected. Therefore, a person must also assess risk in terms of partner selection. Distribute one or two of the **Educator Resource: Sexual Partners Cards** to each group. Instruct the groups to decide where they would "draw the line" in terms of the sexual behavior practices a person should require with each partner and put the card on the appropriate place on the risk continuum. Note that if neither partner has *any* infection, there is no risk!

Discussion Questions:

a. When your group was deciding where to place each of your cards, what factors did you take into account?

b. Would you be more concerned or less concerned if your partner had had sex with people of only one gender? Multiple genders? Why?

9. Ask the entire group to examine the location of cards and recommend any changes.

10. Write **U = U** on the board and ask volunteers to guess what it might mean. Add to the board **Undetectable = Untransmittable**. Explain that it means that HIV can only be transmitted if it is detectable. Note that medication today helps people keep viral loads down.

11. Distribute a copy of the **Handout: Playing It Safer** to each person/pair, noting that the list was adapted from one originally developed by a class of seventh graders.

12. Ask participants to write an **E** by the five easiest behaviors to accomplish, and a **D** by the five most difficult.

Discussion Questions:

a. Any questions about anything on the list?

b. Any items you disagree with? Anything you want to add to the list that relates to sexual health care?

c. Which behaviors do you think are most important?

d. What might make it difficult to follow any of the prevention recommendations?

e. What are some ways people can overcome these barriers to adopting prevention behaviors?

Educator Resource

BEHAVIOR CARDS

Anal intercourse with a latex condom	**Oral sex on a vulva using a dental dam**
Sexual fantasies	**Anal intercourse without a latex condom**
Oral sex on a vulva without protection	**Sharing needles or "works" while shooting drugs**

Donating blood	**Oral sex on a penis with a latex condom**
Sharing needles while piercing ears	**Dry kissing**
Oral sex on a penis without a latex condom	**Solo masturbation**
"Fingering" a vulva	**"Hand job" on a penis**

Taking showers together	**Flirting**
Having "dry sex"	**Touching a breast**
French/tongue kissing	**Holding hands**
Vaginal intercourse with a latex condom	**Getting drunk/high with your sexual partner**

Hugging someone with HIV or AIDS

Vaginal intercourse without a latex condom

Giving/getting a massage

Hugging your partner

Waiting to have intercourse

Wet kissing

Handout

RISKY BUSINESS[10]

This list describes the continuum of risk as it relates to HIV. However, recommendations for safer sex change frequently. Contact your local health clinic or AIDS organization for the latest information. It is important to note that all sexual behaviors described assume mutual consent in a nonabusive relationship.

NO-RISK SEXUAL BEHAVIORS	LOW-RISK SEXUAL BEHAVIORS	HIGH-RISK SEXUAL BEHAVIORS
• Sexual activities when both partners are monogamous, can trust each other, and have tested negative for HIV • Sexual fantasies • Massage • Hugging • Body rubbing • Dry kissing • Masturbation by oneself • Talking sexy • Watching sexy movies or pictures • Chatting online about something sexual • Showering together • Sexy touch of nongenital body parts	• Sexual activities when both partners are monogamous and can trust each other, but have not been tested • Wet kissing • Hand-to-genital touching • Vaginal intercourse with a condom and lubrication • Anal intercourse with a condom and lubrication • Oral sex on a penis with a condom • Oral sex on a vulva with a latex or plastic barrier	• Any sexual contact with blood • Vaginal intercourse without a condom • Anal intercourse without a condom • Oral sex on a vulva without a latex or plastic barrier • Oral sex on a penis without a condom, especially if semen gets in the mouth • Oral-anal contact • Any sexual contact that causes tissue damage or bleeding • Sharing sex toys

Educator Resource

SEXUAL PARTNERS CARDS

Directions: Copy and cut or write the phrases below on index cards. The suggested cards include a variety of gender expressions. Please feel free to modify, or add to the cards as you deem appropriate.

Female, has had sex with males	**Female, has had sex with other females**
Female, has had sex with partners of all genders	**Genderqueer person, has had sex with males**
Has not had sex	**Male, has had sex with partners of all genders**

Male, has had sex with other males	**Nonbinary person, has had sex with females**
Sexual history unknown	**Tested negative for STIs**
Tested positive for STIs, has been treated and cured	**Trans person, has had sex with males**

Handout

PLAYING IT SAFER

Directions: The following is based on a list created by a group of seventh grade students. Choose five recommendations that you think would be easy to follow and mark them with **E**, and choose another five recommendations that would be difficult to follow and mark them with **D**.

1. Abstain from sexual intercourse.
2. Be honest with partners about subjects that might be hard to discuss.
3. Choose sexual partners carefully.
4. Communicate assertively and often with your partner about protection.
5. Don't mix sex and drugs.
6. Enjoy outercourse (sexual closeness without vaginal, oral or anal intercourse).
7. Follow doctor's instructions if you become infected.
8. Have periodic tests for sexually transmitted infections.
9. Know sexual partner well; have a close, caring relationship.
10. Know when to use spermicides — they can protect against pregnancy, but can also cause irritation in the vagina, which makes it easier to transmit an STI.
11. Limit number of sexual partners.
12. Look for symptoms in yourself and your partner even though, more often than not, there are no symptoms.

13. Recognize that anyone, including you, could get a sexually transmitted infection.

14. Think carefully about your sexual values.

15. Use condoms that protect against both pregnancy and sexually transmitted infections (i.e., avoid condoms made of animal skin).

16. Use condom-safe lubricants during vaginal and anal intercourse.

17. Use latex squares or dental dams for oral sex on vulvas.

18. Wait to have intercourse until you are sure you can do so safely.

19. Wait until both partners receive negative test results before having vaginal, oral or anal intercourse. Then have intercourse only with each other.

20. What else?

THE CONDOM LINEUP[11]

by Carolyn Cooperman, MA, LCSW

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. 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.

> **Note:** The primary purpose of the "line-up" activity is to help participants feel comfortable talking about safer sex. Try to avoid getting bogged down in sequence precision. Indeed, other sequences might be successfully argued, as various steps might happen at multiple times. The point is not so much precision, nor to leave participants feeling encumbered that there are *so many* steps to remember, but that they emerge with strengthened confidence to talk with a partner and use this easy-to-follow method.

Materials

- Board or flip chart paper
- Tape
- Condoms: external and internal
- Samples of silicone- and water-based lubricants
- Twenty signs for "condom cards"; note the sequence but **do not number the cards**:

  1. DECIDE TO HAVE SEXUAL INTERCOURSE
  2. TALK ABOUT SAFER SEX
  3. BUY/GET CONDOMS
  4. CHECK EXPIRATION DATE
  5. AROUSAL (GETTING TURNED ON)
  6. ERECTION
  7. OPEN PACKAGE CAREFULLY
  8. INSPECT CONDOM
  9. PLACE DROP OF LUBE ON INSIDE TIP OF CONDOM
  10. HOLD CONDOM AT TIP TO LEAVE SPACE AT END
  11. PUT CONDOM ON TIP OF ERECT PENIS
  12. ROLL CONDOM DOWN TO BASE OF PENIS
  13. SMOOTH OUT AIR BUBBLES
  14. INTERCOURSE (VAGINAL, ANAL OR ORAL)
  15. EJACULATION
  16. BEFORE LOSING ERECTION, HOLD CONDOM AT BASE OF PENIS AND PULL OUT
  17. TAKE OFF CONDOM
  18. THROW CONDOM AWAY
  19. ENJOY THE GOOD FEELINGS
  20. REPEAT AS NECESSARY

- **Handout: Thinking More About the Steps**
- **Educator Resource: Thinking *Even More* About the Steps**
- 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.
- **Using Condoms** (One copy for each participant; see Resources section of this book)

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," "no dangerous side effects," and "good protection against STIs and 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 their card aloud.

9. Ask participants to tape their steps to the board or wall, in order, and then ask them to form small groups of about four participants each.

10. Distribute one copy of the **Handout: Thinking More About the Steps** to each small group and ask them to complete the handout, assigning one person per group to record on behalf of the entire small group.

11. Give participants about 10 minutes to complete the handout. Then ask for participants' attention and read aloud the **Educator Resource: Thinking Even More About the Steps**. After each answer, allow participants time to compare it with their group's answer to the question.

    Discussion Questions:

    a. What questions do you have about the items on the handouts?

    b. Which step do you think is easiest to follow? Explain.

    c. Which step might be difficult to follow? How could you make that step easier to follow?

    d. What differences would there be, if any, in the steps if intercourse …

        - involves two penises?
        - involves two vulvas?
        - includes oral sex with a penis?
        - includes oral sex with a vulva?
        - includes oral sex on the anus?

12. 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 an internal condom instead of an external condom, though the two should not be used at the same time due to excessive friction that can cause breakage. Demonstrate how the internal condom works. (The instructions are included in the package.)

13. 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.

14. 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.

15. 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.

16. Conclude by distributing a copy of **Using Condoms** (see Resources section of this book).

Handout

THINKING MORE ABOUT THE STEPS

Directions: Discuss the following questions, assigning one person to be in charge of recording responses for the group.

1. What is missing from this lineup before any sexual activity begins?

2. When should the expiration date be checked?

3. *Erection* is on the list. What does that mean? What's missing?

4. Why should you open the package carefully?

5. How do you "inspect" the condom, and what should you look for?

6. Why should a drop of lube be placed on the inside tip?

7. Why should space be left at the end?

8. What do you need to do if the condom is put on the tip of the penis inside out by mistake?

9. What is different if the penis is uncircumcised (i.e., if there is foreskin)?

10. Why should any air bubbles be smoothed out once the condom is on?

11. "Enjoy the good feelings" is one of the steps. Why is pleasure important?

12. Why should you hold onto the condom at the base of the penis and withdraw before the erection is lost?

13. How might using condoms be different if a person were drunk or high?

Educator Resource

THINKING *EVEN MORE* ABOUT THE STEPS

1. **What is missing from this lineup before any sexual activity begins?**

   Consent! People need to agree to any sexual activity in which they engage. Partners can check in with each other to make sure they still give their consent throughout the sexual encounter.

2. **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.

3. ***Erection* is on the list. What does that mean? What's missing?**

   Erection includes both penile and clitoral erection. Vaginal lubrication (or wetness) is also a sign of arousal that helps a person avoid feeling pain or discomfort during vaginal intercourse.

   Some people do not naturally lubricate very much, and therefore may need some extra lubricant. Lubrication is necessary for condoms not to break during anal sex and to increase pleasure.

   Note that a just because a person experiences arousal does not necessarily mean they consent to the activity. They still need to check in with each other.

4. **Why should you open the package carefully?**

   So you won't tear the condom.

5. **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, looks dry or cracked, then don't use it.

6. **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. Note that some condoms may already have enough lubricant, making this step unnecessary.

7. **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.

8. **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.

9. **What is different if the penis is uncircumcised (i.e., if there is 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.

10. **Why should any air bubbles be smoothed out once the condom is on?**

    So that it is less likely to break.

11. ***"Enjoy the good feelings" is one of the steps. Why is pleasure important?***

    Pleasure is a main reason people decide to have sex! It's important to remember orgasm for both partners. Although the penis should be withdrawn soon after ejaculation, the other partner's genitals could be stimulated by fingers, mouth, etc. until they feel satisfied.

12. **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.

13. **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.

SWIPING RIGHT
Profile of a Successful Condom User[12]

by Peggy Brick and Bill Taverner

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

1. Identify the qualities they would expect in a person with whom they would have an intimate relationship.

2. Describe the characteristics of a person who would be a successful condom user.

3. Evaluate their own personal qualities to determine whether they are a person a partner could rely on for a safe sexual relationship.

Rationale
Dating apps allow users to see a photo and profile of someone they might consider dating. A person might "market" personal characteristics they think will make them attractive to a potential partner, such as favorite activities and criteria for the ideal partner. Rarely, if ever, does anyone look for a partner who will be willing to practice safer sex. Given the current high risk rate of contracting a sexually transmitted infection, this lesson advocates an expansion of the definition of *sexual attractiveness* to include a person's willingness to communicate about and practice safer sex.

Materials
- Flip chart paper or board
- Index cards

- **Handout: What's Important to You?**
- **Handout: Profile of a Successful Condom User**

Procedure

1. Explain that during this lesson participants will be thinking about the personal characteristics they look for in a partner. Note that in this day of sexually transmitted infections, they may want to expand their definition of what makes a person sexually attractive.

2. Distribute the index cards and ask participants to list the major qualities they would look for in a partner. What makes a person attractive to them? After a few minutes, ask for volunteers to read several characteristics on their list. Write these on the board / flip chart paper.

3. Explain that for a minute they are going to turn from thinking about a partner, to thinking about themselves. But you want them to expand the idea of sexual attractiveness and think about the characteristics they consider needed for a person to be a safe sexual partner.

4. Distribute the **Handout: What's Important to You?** and ask participants to complete the questionnaire. Note that it is completely confidential and will not be collected. It helps them think about where they draw the line regarding their own sexual safety and that of a potential partner.

5. After everyone is finished, discuss this exercise.

   Discussion Questions:

   a. Count your number of "not sure" answers. What does it mean if someone checks a lot of "not sure" answers?

   b. What did you learn from answering these questions?

c. What would you want to know about how a potential partner would answer these questions?

d. What is PrEP? (Explain that it stands for "pre-exposure prophylaxis." It is medication that prevents transmission of HIV.)

6. Explain that participants are going to imagine they are creating dating profile for an app, describing themselves as someone who takes responsibility for safer sex and is looking for someone who does the same. Read a few sample profiles from popular apps such as Tinder and Grindr. They should use the same brief styles, but focus on the qualities they have that would appeal to a reader who does not want to risk contracting a sexually transmitted infection. Ask them to turn their index card over and write 25 words or less.

7. When most participants are finished, ask for a few volunteers to read their profiles.

Discussion Questions:

a. How easy or difficult was it to write a profile that described you as a safe partner?

b. Do you think people value safety in writing dating profiles? Why or why not?

c. What would you do if you matched with someone who then seemed different than their profile once you met them?

d. What would you do if a person with whom you matched wasn't willing to practice safer sex?

e. How would you bring up safer sex in a conversation on a dating app? Would you bring it up before meeting? In person? What are the pros and cons of each option?

8. Ask participants to review the **Handout: Profile of a Successful Condom User.**

   Discussion Questions:

   a. Which items on the list do you think are unimportant?

   b. When people don't use condoms, which of these characteristics are they most likely to lack?

   c. Which of these characteristics would be the most difficult to develop?

   d. How would the characteristics of a successful latex barrier user be similar or different?

Handout

WHAT'S IMPORTANT TO YOU?

Directions: This questionnaire is confidential; it will not be collected. If you answer it honestly, it will help you think about where you draw the line regarding your sexual safety and that of your potential partner(s).

	AGREE	DISAGREE	NOT SURE
1. I would not have sexual intercourse until I am married.			
2. I would have intercourse only in a monogamous relationship. (I am sure neither of us has another partner.)			
3. I would not have intercourse without talking with my partner about protecting ourselves.			
4. I am willing to use safer sex.			
5. My partner needs to be willing to use safer sex.			
6. My partner needs to be willing to have "outercourse" rather than intercourse if we have no protection available.			

	AGREE	DISAGREE	NOT SURE
7. I would never have intercourse on the spur of the moment unless we had protection available.			
8. I would never have intercourse with anyone who shoots drugs.			
9. My partner would need to confirm they are HIV-negative with a test.			
10. If my partner or I were HIV positive, we would use a barrier or PrEP.			
11. I would not have intercourse with someone who has had many previous sexual partners.			
12. I would end any relationship if I found my partner had lied to me regarding their sexual history.			
13. I would end a relationship if my partner had intercourse with anyone else while they were going out with me.			

Handout

PROFILE OF A SUCCESSFUL CONDOM USER

A successful condom user is likely one who ...

- Feels positive about their own sexuality.
- Has decided to have sexual intercourse and feels good about that decision.
- Knows and believes that condoms are highly effective in preventing sexually transmitted infections and pregnancy, when used correctly and consistently.
- Does not want a pregnancy at this time of life.
- Is able to communicate with a partner about using condoms.
- Feels comfortable purchasing or getting condoms.
- Knows of the wide variety of condom types; if one isn't "right," they will try another.
- Knows the steps to successful condom use and has practiced on themselves or on a penis model.
- Has a cooperative partner.
- Knows there are many ways condoms can improve sex.
- Expresses thanks and affection to a cooperative partner after intercourse.

SAY WHAT?!?
Communicating About Safer Sex

By Allyson Sandak

Objectives

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

1. Demonstrate an understanding of passive, aggressive and assertive communication styles.

2. Increase their comfort in talking about safer sex with a partner.

3. Practice negotiating skills for safer sex.

Rationale

People may receive factual information about the proper use of safer sex methods such as condoms and dental dams. However, skills development is necessary to negotiate using such safer sex methods. Knowledge of safer sex methods does not automatically transfer to behavior — knowing how a condom works does not necessarily mean that one will use a condom and/or feel comfortable discussing condom use with a sexual partner. Skills development and self-efficacy (the belief that one is capable to put those skills into practice) are key components to social learning theory, which informs much of current comprehensive sexuality education.

Research indicates that pregnancy and sexually transmitted infection prevention programs that include skills development, including condom negotiation skills, have strong impact on teenagers' intention to use condoms.[13] This lesson will provide participants with an opportunity to develop comfort and skills around communicating assertively about safer sex.

Materials

- Flip chart paper or board, markers, pencils and tape
- **Handout: Speaking Up ... Without Putting Others Down**
- Six **Say What?** handouts (enough for each small group to have one)

Procedure

1. After reviewing the ground rules, let participants know that today's lesson is about sex, without informing them that the lesson is specifically about *communicating* about sex.

2. Write the following on the board or flip chart paper: Four-Letter Words that End in "K" and Have to Do with Sex

3. Ask participants to think of as many words that fit that topic, noting that they are allowed to use slang language during this activity. If a participant suggests *talk* as one of the words, explain that that was great and not many people think of that one. If participants do not list *talk* as one of the words, explain that there is one word missing from the list and write **TALK** on the board or flip chart paper.

   Discussion Questions:

   a. What does talking have to do with sex? What might people want to discuss regarding sex?

   b. Why is it important for people in relationships to talk about sexual behaviors and decisions?

   c. Why is it sometimes difficult for a person to talk with a partner about these topics?

4. Note that talking about sex allows people to discuss whether or not they want to have sex, what their limits and boundaries are, if they want to use protection, what they like sexually and what their sexual history is. Communication in general is also a key

component to a healthy relationship. Unfortunately, despite all these reasons, many people rarely think that talking has to do with sex, and communicating about this topic may not be very comfortable for people. The rest of the lesson will focus on communicating about sex.

5. Tape about 10 pieces of flip chart paper around the room. Ask participants to think of "pressure lines" that someone might use in an attempt to convince their partner to have sex without using protection. Record one pressure line on each sheet of flip chart paper. Extra flip chart paper can be posted if more pressure lines are generated by the participants.

   Discussion Questions:

   a. Was it easy or difficult to come up with these pressure lines? Why?

   b. How realistic are these pressure lines?

6. Note that communication skills can be useful if someone finds themselves faced with one of these pressure lines. Distribute **Handout: Speaking Up … Without Putting Others Down** and review the three styles of communication: passive, aggressive and assertive. Act out facial expressions, tone of voice, posture, etc.

7. Choose one of the pressure lines generated earlier by participants. Ask for a volunteer to come up with an aggressive response to this pressure line. Record the response on the flip chart sheet. Ask for a volunteer to come up with a passive response to this pressure line. Record the response on the flip chart sheet. Finally, ask for a volunteer to come up with an assertive response to this pressure line. Record the response on the flip chart sheet.

8. Ask participants:

Which response would be most effective at communicating about sexual boundaries in this situation?

After participants respond, explain as needed that passive and aggressive communication styles are extremes, while assertive communication is clear and direct and leaves little room for miscommunication.

9. Explain that participants will now have a chance to generate assertive responses to the other pressure lines. Divide participants into small groups of about four people. Distribute a marker to each group and ask them to stand up and go around to each piece of flip chart paper and write as many assertive responses they can think of to the pressure line on the flip chart paper. After about five minutes, ask for volunteers to read each list aloud.

   Discussion Questions:

   a. Was it easy or difficult to come up with assertive responses to the pressure line? Why?

   b. How realistic are these responses?

   c. What does this tell us about communicating assertively?

   d. How might this be useful to someone who is faced with a pressure line?

10. Tell participants they will have a chance to create a conversation between two people who have different ideas about what they want to do, or don't want to do, related to safer sex. Divide participants into small groups of about four people (different groups than the last activity) and give each group one of the six **Say What?** handouts. Tell participants that each handout has a different beginning statement, either by the person who wants to have unprotected sex or the person who wants to have protected sex. Read the directions on the handout aloud and allow about 10 minutes for groups to complete their scripts. Note

that they may find the pressure lines and assertive responses they generated useful at some point in the conversations they create.

11. After groups are finished, ask for one group to volunteer to read their script out loud. Continue with other groups as time permits. If groups are willing, and time permits, ask for groups to volunteer to act their scripts out.

Discussion Questions:

a. What was easy or difficult to create these conversations? Why?

b. How did it feel to have someone pressure you? How did it feel getting resistance to your request to use protection?

c. Was it easier to write a response for Person 1 or Person 2? Why?

d. Which statements in your conversation were assertive?

e. How well do you think someone can use this method in real life?

f. How does participating in activities like this affect your ability to communicate effectively in real life?

g. How did you decide upon the genders of the characters? How might the conversation be different if the genders were different than what you chose?

h. What advice would you give someone who is feeling pressured about sexual behaviors in a relationship?

Handout

SPEAKING UP … WITHOUT PUTTING OTHERS DOWN[14]

THREE WAYS TO COMMUNICATE

PASSIVE

Giving in and saying yes when you don't really want to. Not speaking up when you want something. Acting this way to be liked, to be nice or to not hurt the other person's feelings.

Speech: say nothing, lots of "ums"
Voice: soft, whining
Eyes: looking down, looking away
Posture: head down, body fidgeting

Example: You and your partner are making out. The other person starts to unbutton your pants. You don't want to go that far. But you don't say anything and let it happen.

What usually happens with PASSIVE communication?
You usually don't get what you want. The other person wins or you feel like you've been used.

AGGRESSIVE

Trying to get your own way or standing up for yourself by putting someone else down or violating that person's rights. Taking what you want. Threatening or forcing a person to give you something.

Speech: put-down words, just taking what you want
Voice: loud, cold, tense
Eyes: cold, staring, angry
Posture: stiff and rigid, hands on hips, finger-pointing

Example: Your partner starts to unbutton your pants. You don't want to go that far. You say, "Get off me, you stupid jerk."

What usually happens with AGGRESSIVE communication?
You may get what you want but the other person loses.

ASSERTIVE

Giving people an honest no to things you don't want. Asking straight for what you do want without putting them down. Not using other people or letting yourself be used.

Speech: honest, direct words
Voice: clear, firm, loud enough to be heard, but not too loud
Eyes: direct eye contact but not staring
Posture: relaxed, balanced, head and shoulders up

Example: Your partner starts to unbutton your pants. You say, "Stop. I like you, but I don't want to go that far."

What usually happens with ASSERTIVE communication?
You often get what you want. You keep your self-respect. You respect and don't hurt others.

Handout 1

SAY WHAT?

Directions: Read the scenario below and create a conversation between the two characters. Use assertive communication in your conversation.

Person 1 and Person 2 have been going out for a while and have had unprotected sex a few times. Person 1 has a friend who just found out they have herpes and now Person 1 is concerned about contracting a sexually transmitted infection too, in addition to getting pregnant. Person 1 wants to start using protection now, but Person 2 doesn't want to.

Person 1

I know we did it without a condom last time, but I think it's important for us to start using them now.

Person 2:

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_____

Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Handout 2

SAY WHAT?

Directions: Read the scenario below and create a conversation between the two characters. Use assertive communication in your conversation.

Person 1 and Person 2 have been going out for a while and have had unprotected sex a few times. Person 1 has a friend who just found out they have herpes and now Person 1 is concerned about contracting a sexually transmitted infection too, in addition to getting pregnant. Person 1 wants to start using protection now, but Person 2 doesn't want to.

Person 1:

We've both had sex with other people before. I'm freaked out about getting an STI.

Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Handout 3

SAY WHAT?

Directions: Read the scenario below and create a conversation between the two characters. Use assertive communication in your conversation.

Person 1 and Person 2 have been going out for a while and have had unprotected sex a few times. Person 1 has a friend who just found out they have herpes and now Person 1 is concerned about contracting a sexually transmitted infection too, in addition to getting pregnant. Person 1 wants to start using protection now, but Person 2 doesn't want to.

Person 1:

We need to start using protection. Aren't you afraid of STIs?

Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Handout 4

SAY WHAT?

Directions: Read the scenario below and create a conversation between the two characters. Use assertive communication in your conversation.

Person 1 and Person 2 have been going out for a while and have had unprotected sex a few times. Person 2 has a friend who just found out they have herpes and now Person 2 is concerned about contracting a sexually transmitted infection too. Person 2 wants to start using protection now, but Person 1 doesn't want to.

Person 1:

What's the big deal? We've had sex without using protection before. What's gotten into you now?

Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Handout 5

SAY WHAT?

Directions: Read the scenario below and create a conversation between the two characters. Use assertive communication in your conversation.

Person 1 and Person 2 have been going out for a while and have had unprotected sex a few times. Person 2 has a friend who just found out they have herpes and now Person 2 is concerned about contracting a sexually transmitted infection too. Person 2 wants to start using protection now, but Person 1 doesn't want to.

Person 1:

You know I'm clean and I know you're clean. So there's nothing to worry about.

Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Handout 5

SAY WHAT?

Directions: Read the scenario below and create a conversation between the two characters. Use assertive communication in your conversation.

Person 1 and Person 2 have been going out for a while and have had unprotected sex a few times. Person 2 has a friend who just found out they have herpes and now Person 2 is concerned about contracting a sexually transmitted infection too. Person 2 wants to start using protection now, but Person 1 doesn't want to.

Person 1:

I'm so hot and it feels better without protection. Let's just do it.

Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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Person 1:

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Person 2:

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CHOOSING CONDOMS, CHOOSING LUBES

by Peggy Brick and Bill Taverner[15]

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

Condoms are not used consistently in the United States. Research shows that among people ages 15 to 44, between one-quarter and one-third of people reported using a condom during the past 12 months.[16] Some people may fear that to suggest using a condom is to suggest one's partner or oneself is 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. Participants examine and evaluate a variety of brands of condoms and personal lubricants; overcome the 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 ever decide to use condoms for protection against infection and unplanned pregnancy.

Materials

- Index cards
- A condom in a box, wrapped with special paper and a large bow
- **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**
- Variety of condoms (both internal and external) for each group, and variety of personal lubricants
- **Handout: Everybody Can … Make Condoms More Effective**
- **Handout: In Search of Condoms and Lubes**

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 people may have many different feelings about using condoms. 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 the attitudes of society in general? Explain.

c. Do you think there are differences in attitudes about condoms based on gender? (Note that many American young people express negative attitudes about condoms, regardless of their gender, 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 IUD, implant, patch, pill, ring or shot. 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.)

f. How can a person be "certain" their partner is not infected?

4. Distribute the **Handout: Condoms Work — When Used Consistently and Correctly**. Note that some people exaggerate the failure rate of condoms 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. Write on the board or flip chart paper: ***The problem is people — not condoms.*** Note that the last four statements in the handout address quality assurance for condoms. Explain that condoms are highly effective in preventing pregnancy and sexually transmitted infections when used *consistently and correctly* for *every* act of intercourse.

   Discussion Questions:

   a. Why is it important that the government regulate medical devices, such as condoms?

   b. Do you think condom use would increase if people understood how effective they are? Why or why not?

6. Divide participants into small groups and ask them to complete the **Handout: Everybody Can … Make Condoms More Effective**.

   Discussion Questions:

   a. Which of these solutions are people most likely to use? Which would be most difficult?

   b. How would you suggest we could get people to use condoms more effectively?

7. Note that it is important for people of all ages to know that condoms are highly effective in reducing the risk of both 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.

8. 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. Give each group a selection of external condoms, an internal condom and a selection of personal lubricants to evaluate. Give each person a copy of the **Handout: Choosing Condoms, Choosing Lubes**.

9. 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.

10. 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, and only silicone- or water-based lubricants (i.e., ***not*** oil-based) should be used.

11. 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?

12. 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[17]

Directions: There are many claims and counterclaims 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 reducing the risk of 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 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. Lubricants (lubes) that are **silicone-based**, **water-based** or **hybrid** (containing both silicone and water) 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, teen sexual activity does not increase. However, condom use does increase among teens who are **already** sexually active.

___ 9. When people use alcohol or other drugs, it reduces the likelihood that they will use condoms effectively.

___ 10. 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.

___ 11. The FDA-recognized standards assure that all condoms sold are of good quality, and provide requirements for length, width, thickness/thinness, strength and water leakage testing.

___ 12. Types of condom tests include air burst testing (how much air pressure they can sustain before bursting), dimensional testing (length, width, thickness), electronic testing, leak testing (ensuring they are free of weaknesses that could cause leakage), package intensity testing (making sure the package remains sealed) and tensile testing (condom strength).

___ 13. For electronic testing, every condom is pulled over a metal object and exposed to an intense electrical field. Since rubber does not conduct electricity, no electricity should reach the metal under the condom. If it does, it means a pinhole is present. Any condom failing this test is discarded.

___ 14. Numerous research studies confirm that the latex condom, when used correctly and consistently, significantly reduces the risk of contracting a sexually transmitted infection.

Handout

EVERYBODY CAN ...
MAKE CONDOMS MORE EFFECTIVE

Directions: When condoms don't work, it is usually because of some problem involving people, not the condom itself. Below are common "people problems." Propose a solution for each one.

THE PEOPLE PROBLEM	THE SOLUTION
1. A person finds it hard to talk with a partner about using condoms.	
2. A person is ready for intercourse, but doesn't have a condom.	
3. A person is ready for intercourse, has a condom, but NEVER used one before.	
4. A person finds it difficult to have to stop and open the condom package.	
5. A person uses an oil-based lubricant on the condom.	

THE PEOPLE PROBLEM	THE SOLUTION
6. A person uses their teeth to open the condom.	
7. A person has a condom, but is too drunk to use it.	
8. A person tries to put the condom on, but the penis goes limp.	
9. A person takes the condom off, but there is nowhere to put the messy thing!	
10. A person wants to use a condom, but it doesn't fit right.	
11. A person uses condoms, but only sometimes.	
12. Other?	

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

Material:

- ☐ Latex
- ☐ Polyisoprene
- ☐ Polyurethane

Packaging/Wrapping:

- ☐ Appealing to people of all genders and sexual orientations
- ☐ Appealing to a specific gender or orientation: _____
- ☐ Appealing to adults
- ☐ 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

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 Comments About This Condom:

_____

_____

Overall Rating of This Condom: *(circle one)*

5	4	3	2	1
Great!		**So-So**		**Terrible!**

Lubes[18]

Type:

- ☐ Oil-based*
- ☐ Silicone-based
- ☐ Silicone-water hybrid
- ☐ Water-based

Packaging:

- ☐ Appealing to people of all genders and sexual orientations
- ☐ Appealing to a specific gender or orientation: _____
- ☐ Appealing to adults
- ☐ Appealing to young people
- ☐ Difficult to open
- ☐ Easy to open
- ☐ Embarrassing
- ☐ Flip-top
- ☐ Interesting
- ☐ Packet
- ☐ Pump
- ☐ Screw-top
- ☐ Tube

Features:

- ☐ Long-lasting
- ☐ Natural oils
- ☐ Non-staining
- ☐ Numbing/desensitizing
- ☐ Odorless
- ☐ Safe with latex
- ☐ Tasteless
- ☐ Thick/heavy
- ☐ Thin/light

- ☐ Tingling
- ☐ Warming

* Oil-based lubricants are not recommended for use with latex condoms, since they can break down the latex.

Ingredients:

- ☐ Benzocaine**
- ☐ Chlorhexidine gluconate**
- ☐ Cyclopentasiloxane
- ☐ Dimethiconol
- ☐ Dimethicone
- ☐ Ethyl PABA**
- ☐ Glycerin**
- ☐ Lidocaine**
- ☐ Mineral oil*
- ☐ Nonoxynol-9**
- ☐ Petroleum
- ☐ Phenoxyethanol**
- ☐ Polyquaternium-15**
- ☐ Propylene glycol**
- ☐ Sugars** (e.g., glucose, honey, maltodextrin)
- ☐ Water

* Oil-based lubricants are not recommended for use with latex condoms, since they can break down the latex.
**Numbing or potentially irritating. Irritation could affect the skin, which could create problems in preventing STIs.

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 is the name of the place?

   _____

2. In what town/city?

   _____

3. Where were the condoms and lubes displayed?

   - ☐ Behind the counter
   - ☐ Locked
   - ☐ On the shelves
   - ☐ Elsewhere _____

4. Were they easy to find?

   - ☐ Yes
   - ☐ No

5. Why/Why not?

   _____

   _____

   _____

6. **What brand names and prices of condoms and lubes were 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:		

7. How would you feel purchasing condoms and lubes here?

   Check all the words that describe how you think you would feel.

- ☐ Afraid
- ☐ Ashamed
- ☐ Awkward
- ☐ Brave
- ☐ Comfortable
- ☐ Confident
- ☐ Eager
- ☐ Embarrassed
- ☐ Excited
- ☐ Frustrated
- ☐ Guilty
- ☐ Independent
- ☐ Indifferent
- ☐ Judged
- ☐ Mature
- ☐ Nervous
- ☐ Overwhelmed
- ☐ Protected
- ☐ Proud
- ☐ Responsible
- ☐ Scared
- ☐ Secretive
- ☐ Self-conscious
- ☐ Smart
- ☐ Worried
- ☐ Other:
  _____
  _____

SECURING THE BACK DOOR
A Guide to Safer Anal Sex

by Megan Andelloux

Objectives

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

1. Distinguish between facts and myths about anal sex.
2. Recognize the basic parts of anal and rectal anatomy.
3. Identify safer sex precautions that one might follow when engaging in anal sex behaviors.

Rationale

Anal sex is a common sexual behavior among Americans. More than 40% of American men aged 25-59 report having ever engaged in anal sex, as do 40% of women aged 20-49. Among younger Americans, about 20% of women aged 18-19 and 11% of men aged 20-24 report having had anal intercourse during the past year.[19]

However, due to the stigma associated with the anus and anal sex, as well as a lack of educational materials, many people do not know how to incorporate safer sex practices into anal sex. The result may be risky sexual decisions leading to trauma and/or infections. Since anal sex carries more health risks than other forms of intercourse, it is important that sexual health educators teach individuals about risk-reduction measures. In this lesson, participants dispel common myths about the anus and anal sex, and learn the facts about anal anatomy, as well as sexual health and sexual safety.

Materials

- Flip chart paper or board, markers and tape

- **Educator Resource: Myths and Image Ideas**
- Eight sheets of flip chart paper, numbered and with images, as directed in the **Educator Resource: Myths and Image Ideas**
- Condoms (both external condoms that go over the penis and internal condoms, which are condoms that can be worn inside the vagina or anus as a barrier during intercourse; an example of an internal condom is the FC2 condom)
- Latex glove (and non-latex [e.g., nitrile] glove, if available)
- Silicone-based lubricants (e.g., Überlube Luxury Lubricant and Swiss Navy Premium Silicone Lubricant)
- Copies (or projected display) of illustrations of the anatomy of the anus and rectum. The ideal sources are the illustrations in *Anal Pleasure and Health* by Jack Morin. Other illustrations can be found from reputable sources online, such as http://bit.ly/AnalAnatomyPic2
- A fresh orange, peeled (plus tissues or paper towels, for cleanup)
- **Educator Resource: Getting Behind the Facts**
- **Educator Resource: A Review of Rectal and Anal Anatomy**

Procedure

1. In advance of the class, follow the directions on the **Educator Resource: Myths and Image Ideas**. Post the numbered flip chart papers around the room, leaving enough space between papers for small groups of participants to crowd around.

2. Introduce participants to the focus of today's lesson: the anatomy of the anus, and safer anal sex. Explain that the group will start off by discussing myths that people may have heard about anal sex, and replacing those myths with factual information.

3. Point to the numbered sheets around the room and ask participants to approach each sheet on their own, observe the images, and *privately, without talking with anyone else,* write on the flip chart sheet what they think the images might suggest

regarding anal sex. Tell participants that they are not to write down their names next to their statements, nor identify others' statements by name. Let participants know that they are allowed to write down any idea, as long as it is something that they have heard, seen or wondered about that is related to today's subject.

4. Allow about 10 minutes for participants to move around the room, and give them a two-minute warning when time is almost up. Encourage them to write down any final thoughts they have and return to their seats.

5. Thank participants for their written remarks. Tell them they'll now listen to the different thoughts that people wrote about what the pictures suggested regarding anal sex. Remind participants clearly and firmly that *no one is to identify* who wrote what *on any of the sheets, including themselves.*

6. Next, ask for eight volunteers, who will each read aloud the statements written on *one* of the numbered sheets while the rest of the whole group listens. At the conclusion of *each* sheet review, thank the volunteer for reading, and ask the whole group, "Out of everything you've just heard, what do *you* think these pictures were intended to represent?" Then read the appropriate myth from the educator resource.

   Discussion Questions:

   a. Have you heard this myth before?

   b. Why do you think some people might believe it is true?

7. Respond to each myth by reading factual information from the **Educator Resource: Getting Behind the Facts** before moving on to the next flip chart sheet. Proceed in the same fashion until all the numbered flip chart images and statements have been examined and questions have been answered. Conclude the activity with the following discussion questions.

Discussion Questions:

a. How common do you think these beliefs are?

b. What was surprising about these myths?

c. How might a person *feel* about the anus, or about anal sex, if they believed these myths to be true?

d. Why might a person decide to engage in anal sex?

e. How could a person engage in anal sex safely?

8. Explain that before a person can learn ways to engage in safer sex, they need to understand how the body is structured, so our next step will be to learn about anal and rectal anatomy.

9. Distribute illustrations of anal and rectal anatomy, or display an image via projector. Using the **Educator Resource: A Review of Anal and Rectal Anatomy**, explain the anatomy referring to the illustrations for clarity. Explain that you will also be using an orange to give a more 3-D illustration of the body parts discussed.

Discussion Questions:

a. What new information did you find most interesting? Explain.

b. Why is it important to understand anal and rectal anatomy?

c. Which anatomical structures would you like the group to discuss further?

10. Note that now that the class has covered basic anatomy, it's time to discuss safety. Ask participants why they think it is important to practice safer sex during anal sex. After a few volunteers share their thoughts, note that safer sex can help prevent the transmission of sexually transmitted infections. Explain that if a

person is engaging in anal sex, using a condom every single time is important for their safety and health.

11. Invite participants to call out types of condoms that can be used. Be sure to clarify only latex, polyisoprene (synthetic latex) and polyurethane condoms have been shown to prevent transmission of infections. The internal condom is made of polyurethane as are select brands of external condoms.

12. Show some examples of condoms. Note that latex gloves may be used for protection when fingers penetrate the anus, and that non-latex gloves (e.g., nitrile gloves) are available for people with latex allergies.

13. Explain that lubrication is also an important part of safer anal sex. Since neither the rectum nor the anus makes its own lubrication, friction can occur, weakening both the skin and the condom. Since the rectal tissue is thinner than the tissue found in the mouth or vagina, it is more likely to tear with friction. *This is why lubrication is essential when engaging in anal sex.* Note that research suggests *silicone-based* lubricants are the safest type of lubricant to use during anal sex because they do not irate the delicate rectal tissue. Hold up some examples of silicone-based lubricants.

14. Note that water-based lubricants may also be used for anal sex, but stress that oil-based products, numbing agents and items treated with nonoxynol-9 should be avoided since they have been shown to increase the transmission of infections and harm the body, causing trauma to the rectum.

15. Ask participants why they think you spent a full lesson talking about the anus and anal sex. Allow a few volunteers to share their thoughts.

16. Ask participants to write down one new bit of information they learned that they found interesting. Ask for a few more volunteers to share what they wrote down.

Educator Resource

MYTHS AND IMAGE IDEAS

Directions: Below are eight myths about anal sex. Number eight sheets of flip chart paper and affix each one with images that are appropriate for that myth. Images can be easily found using search engines like Google Images or magazines. Number each flip chart sheet, but do NOT include the statements.

1. **Engaging in anal sex will cause people to lose control of their bowels.**

   Possible images: Adult diapers, a sitting stool, a picture of someone who looks like they have to go to the bathroom.

2. **The rectum is an exit only.**

   Possible images: EXIT sign, STOP sign, or OFF RAMP highway sign.

3. **Anal sex will cause the anus to stretch out or develop hemorrhoids.**

   Possible images: A person ripping their shirt off, earlobe being stretched, pulling on a pair of socks, a belt having to be loosened, hemorrhoid medicine.

4. **Anal sex is painful for the receiver.**

   Possible images: A face grimacing in pain, someone falling and hurting themselves, a teardrop, thought bubbles filled with exclamation points.

5. **Only gay men engage in anal sex.**

   Possible images: Two men holding hands, hugging, cuddling or being affectionate.

6. **Having anal sex always leads to HIV or other sexually transmitted infections (STIs).**

   Possible image: Red AIDS ribbon.

7. **Having anal sex keeps one's virginity.**

   Possible images: A cherry, a pledge form, an abstinence slogan.

8. **Anal sex should be a surprise.**

   Possible images: Someone sneaking up behind another person, a person with a surprised expression.

Educator Resource

GETTING BEHIND THE FACTS[20]

This resource includes detailed information in response to common myths about anal sex.

1. **Engaging in anal sex will cause people to lose control of their bowels.**

   MYTH. Some people believe that if you allow something into the rectum, it will make the sphincter muscles weaker, thus making a person more likely to lose control of their bowels. This is not true. What is happening is a person is relaxing the sphincter muscles enough to allow something into the body. Relaxing the sphincter is like letting your arm hang limp at your side. You haven't lost any strength. If need be, you can still lift a pile of books with the same amount of strength you had before. Like all muscles, the anal sphincters tend to lose tone and function as we age. A person can help counteract this by regularly doing Kegel exercises.

   Many individuals also believe that if they engage in anal sex, their partner will defecate on them. Feces are not normally stored in the rectum, which is where anal sex takes place. When stool moves into the rectum it causes an urge to defecate. There may be some feces left in the rectum from earlier bowel movements, which can easily be cleaned out by using an enema with warm water, well ahead of time.

2. **The rectum is an exit only.**

   MYTH. Though we typically associate the rectum with passage of stool *out* of the body, there are many times of our lives where the anus is an entrance *into* the body as well. For example, taking a baby's temperature or giving certain medications. When a finger, penis or sex toy enters the rectum, all of the nerve endings there can make it pleasurable, provided this is what a person wants, and they are sufficiently relaxed. Some people, however, do not

want anything to enter into their rectum and because it is their body, they can rightly claim *their* rectum to be "exit only."

3. **Anal sex will cause the anus to stretch out or develop hemorrhoids.**

   MYTH. The anus will almost never stretch out or develop hemorrhoids if a person learns how to relax the anal muscles and keep them toned with Kegel exercises. The anus has two sets of sphincters in it, which prevent stool from leaking out the bottom of the rectum. When cared for properly, with lots of lubrication and remembering to stop if penetration becomes painful, one's sphincters will last a lifetime.

   When a person develops hemorrhoids, it is usually not due to anal sex. According to the book *Anal Pleasure and Health,* the three most common causes of hemorrhoids are straining to have a bowel movement, chronic muscle tension stored in the anus and pressure on the pelvic muscles from pregnancy.

4. **Anal sex is painful for the receiver.**

   MYTH. Pain during anal sex is the body's defense mechanism signaling that the anus is not sufficiently relaxed. If a person experiences pain, they should stop the behavior and take some deep breaths. Breathing gives a person the chance to collect their thoughts and bodily reactions, and promotes relaxation. If a person begins to feel uncomfortable or wants to stop engaging in the behavior, they have every right to stop whenever they want to. Healthy anal sex should feel pleasurable, not painful.

   If a person does experience pain, it may be the result of friction. Since the rectum does not make its own lubrication, it is important to use plenty of commercially made lubrication during *every* anal sex act. Lack of adequate lubrication is often the most common reason people experience pain or injury during anal sex.

5. **Only gay men engage in anal sex.**

   MYTH. Anal sex is a common sexual behavior among Americans. According to a national study, more than 40% of American men aged 25-59 report having ever engaged in anal sex, as well as 40% of women aged 20-49. These figures include people of *all* sexual orientations.

6. **Having anal sex always leads to HIV or other sexually transmitted infections (STIs).**

   MYTH. Having anal sex (or oral or vaginal sex) does not automatically transmit HIV or other STIs. *Having unprotected anal sex with someone who is already infected with HIV (or other STIs)* could result in contracting an infection. This is an important distinction. HIV and other STIs do not magically appear during sexual contact — they can only be transmitted when one person is already infected.

   Usually you cannot tell if a person has an infection just by looking at them. Many infections do not have symptoms, and transmission is possible when a person "looks fine" but is really infected.

   If one partner *is* infected, anal sex does have a higher risk of transmission than oral or vaginal intercourse. The chance of transmission is greatly reduced if a condom is always used for anal intercourse. When using latex condoms, avoid oil-based lubes, since these can break down the latex. This is not a concern with non-latex condoms, including the external condom (also known as FC-2).

7. **Having anal sex keeps one's virginity.**

   MYTH. **Some** people think that anal sex doesn't "count" as "real" sex. *Webster's Dictionary* defines *virginity* as "the state of never having had sexual intercourse." So what is *sexual intercourse?* The same dictionary defines it as "sexual contact between individuals involving penetration."

Many people who have experienced anal sex would describe it as involving both sexual contact and penetration — of a penis, or fingers, or other objects. Since "virginity" means different things to different people, the question is how do *you* define *virginity*? Does it mean never engaging in oral, anal or vaginal sex? Does it mean avoiding kissing and other sexual behaviors too?

Whether a person thinks of anal sex as involving virginity or not, it's important to be clear about it with one's partner to ensure both people are on the same page. It's also important to be clear with one's doctor, to ensure the appropriate tests (and treatment, if needed) are given.

8. **Anal sex should be a surprise.**

MYTH. **Anal sex should never be a surprise.** Surprising someone by engaging in *any* sexual behavior without consent is illegal, and could lead to charges of sexual assault or rape. Sex without consent can also cause serious damage to body and mind. In order to have safer, consensual sex, a person needs to be fully aware of what is going to happen to them before an act takes place. It is very important that both partners desire the sexual activity and that they give their bodies time to adjust to new behaviors and sensations.

Educator Resource

A REVIEW OF ANAL AND RECTAL ANATOMY

This resource includes glossary-style explanations of rectal and anal anatomy, including italicized instructions for using a freshly peeled orange to help illustrate the different body parts. See the Materials section of this lesson for recommendations of illustrations to distribute or project.

Anus — where waste leaves the body or where insertion takes place during anal sex.

> *Hold up the peeled orange. Place your finger where the stem used to be located.*

Explain this area represents the anus. Note that the anus has two structures that prevent waste from being expelled from the body unintentionally and prevent things from going into the rectum unintentionally.

External sphincter — is located closer to the outside of the body.

> *Hold up the peeled orange and with the pad of your finger, as though you are ringing a doorbell, gently push inward where the stem used to be.*

Explain that a person can control the external sphincter. When a person feels the need to defecate, the external sphincter is relaxed to "allow the bowels to be emptied." The external sphincter can cause pain if something is irritating it or trying to push it open when a person does not want it to open. Pain is the body's way of saying something is wrong.

Internal sphincter — is located about an inch inward from the anus.

> *Hold up the peeled orange, and with the pad of your finger, push inward about an inch into the orange.*

The internal sphincter is an involuntary muscle that a person has no control over. When the muscle relaxes, a signal is sent to the brain letting a person know it's time to defecate.

Rectum — once the sphincters have been cleared, the rectum is penetrated.

> *On an anatomical chart, point to where the rectum lies (the pouch below the* S *shape).*

The rectum is on average five inches long. Note that feces are not stored in the rectum unless someone needs to defecate.

Pubo-rectal sling — is a group of muscles that hold back gas and feces. The pubo-rectal sling is normally stimulated when feces or gas is traveling out of the body.

> *Show on chart.*

When air or feces come in contact with the pubo-rectal sling, it makes individuals aware that they might have to defecate. It can be stimulated during anal sex, which sometimes causes individuals to panic, thinking they are going to defecate on their partner. This sensation will pass after about 10 seconds.

Colon — feces are stored in the colon. The colon is located beyond the rectum, approximately six inches in. The colon is shaped like an *S*.

> *Show on chart.*

The colon is not a straight tube like many people think, and usually is not penetrated during sexual contact.

FRIENDS GETTING TESTED[21]

by Peggy Brick and Bill Taverner

Objectives

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

1. Evaluate the proposition that if a friend's behaviors put them at risk, a real friend will try to prevent the danger.

2. Identify possible responses they might have when a friend is at risk.

3. Apply different ways of taking action to reduce a friend's risk.

Rationale

Most sexuality education focuses on the individual's responsibility for self and partner. However, by acknowledging the vital role of peers in determining a person's attitudes and behaviors, many educators now use peer education effectively. Yet, young people are seldom urged to be proactive regarding a friend's risky sexual behaviors, as they are in safety campaigns such as those regarding alcohol use, e.g., "Friends don't let friends drive drunk." This lesson encourages young people to consider whether a true friend needs to take a role in discouraging risky sexual behavior that could lead to a sexually transmitted infection or an unplanned pregnancy. The lesson concludes with a review of the important steps needed for getting tested and seeking treatment, if needed.

Materials

- Flip chart / board, markers
- Four signs labeled with one number each, **1**, **2**, **3** and **4**
- **Educator Resource: What's a Friend to Do?**
- **Handout: Steps for Getting Tested**

- **Educator Resources: Thinking More About the Steps to Getting Tested**

Procedure

1. Put the following statement on the board:

   A true friend will try to stop unsafe sexual behavior of a friend.

   Ask participants to take a position regarding the statement, and raise their hands if they agree, fold their arms if they are not sure, or turn their thumbs down if they disagree.

2. Ask participants why they took different positions. Write key reasons on the flip chart or board.

3. Explain that they will have a chance to think about particular situations and decide what they might do if a friend were at risk. Post the signs **1**, **2**, **3** and **4** around the room and explain that you will read a variety of scenarios to them and they will move to the part of the room that best describes what they would do.

4. Continue by conducting the activity described in the **Educator Resource: What's a Friend to Do?**

   Note: Do as many scenarios as time permits, or choose situations that are most relevant to your group.

5. Ask participants to be seated.

   Discussion Questions:

   a. How did examining specific situations affect your thinking about whether a friend needs to intervene?

   b. Are there any other choices that are better than those that were read? Explain.

c. What other situations can you think of where a person might help prevent a friend's unsafe sexual behavior? (*Write these on the flip chart or board.*)

d. What have you heard about PrEP and PEP? *(Explain that PrEP is medication taken before a person has been exposed to reduce the risk of transmission of HIV; PEP can be taken after a person thinks they might have been exposed.)*

e. What do you think about "combination methods" (e.g., combining PrEP with condoms?)

6. Note that often, a person doesn't act because they are afraid of being rejected by the friend. Or, the friend might attack them for some of the person's own behavior they think is unsafe. Explain to participants that you are going to give them a chance to practice addressing several situations through role-play so they will be better prepared if they ever want to help a friend.

7. Depending on your group, you may give participants a particularly relevant situation to role-play; use a situation in the **Educator Resource: What's a Friend to Do?**; or ask them to think of a situation that would be interesting to role-play.

8. Set up the role-play. Ask for two volunteers. Ask which participant wants to role-play as the friend who wants to help, and who will role-play as the friend in danger. Ask questions to help each player get into their roles, such as the following:

a. Ask the friend at risk:

- What is your name?
- Are you worried you may be at risk for STIs?
- What can you tell me about your partners?
- Are you using any precautions?

b. Ask the helping friend:

- What is your name?

- Exactly why are you concerned about your friend's behavior?
- What do you think you will do?

9. Let them begin their dialogue. After three or four minutes, or when the scene seems finished, stop the role-play. While the actors stay in their roles, let group members ask questions about the scene.

10. As time permits, repeat the role-play with other situations and other participants.

11. Distribute the **Handout: Steps to Getting Tested** and ask participants to work in pairs, deciding which steps would be easy or hard to follow.

    Discussion Questions:

    a. Which of these steps in getting tested might be easier to do? Why?

    b. Which steps are most difficult? Explain.

    c. What advice would you give a friend to make a particular difficult step easier?

        Optional: As time permits, you may ask pairs to form small groups to discuss ideas for making the difficult steps easier.

    d. How is a sexual health checkup similar different from a general health checkup? How is it similar?

    Note: Use the **Educator Resource: Thinking More About the Steps to Getting Tested** to elaborate on individual steps, as necessary, and as time permits.

12. To conclude, ask:

    What advice would you give a friend who was thinking about getting tested?

Educator Resource

WHAT'S A FRIEND TO DO?

Directions: Read each situation and the corresponding four choices, directing each participant to move to the corner of the room that represents the choice they think they'd make. Allow time to discuss their choices with others in each corner. Then ask each corner to report briefly to the larger group, before proceeding to the next situation.

A. **Your best friend is dating someone you know has herpes. You know the partner has not told your friend and they are not using a condom or any other precautions. You:**

1. Tell your friend about the partner having herpes.
2. Give your friend condoms and tell your friend everyone should use them.
3. Give your friend a pamphlet on herpes and say everyone needs to be careful these days.
4. Do something else.

B. **Your friend has gonorrhea but currently has no symptoms. They are in a relationship and have not told the partner about the infection. You:**

1. Tell your friend's partner; if they won't take the initiative to protect their new partner, you will.
2. Tell your friend that both of them must get treated even if there are no symptoms.
3. Tell your friend they must tell their partner.
4. Do something else.

C. **Your friend sends you a picture of someone's penis or vulva with symptoms of an STI, claiming it was someone you both know.**

1. Delete it and tell your friend not to send you that kind of stuff anymore.

2. Forward it to the person who it supposedly is and let them know what's being said behind their back.

3. Print out a copy for the health teacher or guidance counselor, with an anonymous note about the rumor being spread.

4. Do something else.

D. **Your friend is living with HIV and wants to continue having a happy sex life. You:**

1. Offer emotional support and encouragement.

2. Give them some condoms.

3. Tell them about PrEP, medication their partners can use to significantly decrease the chance of infection.

4. Do something else.

E. **Your friend is having sex with a lot of partners. If a partner doesn't want to use condoms, your friend doesn't push it. You:**

1. Tell your friend's partners about these promiscuous behaviors.

2. Explain to your friend the risks involved with this kind of behavior.

3. Give your friend some pamphlets about STIs and hope your friend will read them.

4. Do something else.

F. **Your friend drinks a lot at parties, and you've seen your friend leave with someone they hardly know. You:**

1. Try to set up a buddy system, agreeing that you'll leave parties together.

2. Talk to your friend about risky behaviors when they are sober.

3. Discuss the issue with other friends and decide together what to do.

4. Do something else.

Handout

STEPS TO GETTING TESTED

Directions: Circle **E** if the step is easy, and **D** if the step is difficult. For the steps that are difficult, explain what makes it so.

STEP	EASY/ DIFFICULT	WHAT MAKES THIS STEP DIFFICULT?
1. Identify the need or problem.	**E** **D**	
2. Find out where to get help.	**E** **D**	
3. Find out when you can go.	**E** **D**	
4. Decide how to get there.	**E** **D**	
5. Explain your need or problem.	**E** **D**	
6. Make an appointment.	**E** **D**	

STEP	EASY/ DIFFICULT	WHAT MAKES THIS STEP DIFFICULT?
7. Get ready to go.	E D	
8. Go to appointment.	E D	
9. Fill out any forms.	E D	
10. Visit with clinician.	E D	
11. Get instructions or treatment plan.	E D	
12. Ask questions.	E D	
13. Schedule follow-up visit (if needed).	E D	
14. Pay (if necessary).	E D	

Educator Resource

THINKING MORE ABOUT THE STEPS TO GETTING TESTED

IDENTIFY THE NEED OR PROBLEM

- What needs might a person have to see a doctor?
- How might you know there is a problem?

EXPLAIN YOUR NEED OR PROBLEM

- Who would you feel comfortable talking with about the issue before you set up an appointment?

FIND OUT WHERE TO GET HELP

- How will you search for the health center?

FIND OUT WHEN YOU CAN GO

- What dates and times are best for YOU?
- When is the health center open? (Weekdays? Weekends? Times?)

DECIDE HOW TO GET THERE

- Will you take a bus? Train? Walk? Ride from a friend? Ride share?
- Do you need directions?

MAKE AN APPOINTMENT

- How will you reach them? Phone? Online scheduler? App?
- What might you want to ask?
- Are services confidential? How do you want to be contacted?
- What is the cost? (How might using insurance affect confidentiality?)
- Is the gender of the clinician important to you?
- Do they have someone that speaks your language?
- Do you need to bring anything to the visit?
- What do you need to do if you can't keep your appointment?

GET READY TO GO

- What do you need to do to get ready?
- Will you write out questions?
- What do you need to gather for the visit?
- Do you have money if the health center charges a fee?

GO TO APPOINTMENT

- What trustworthy friend or adult might go with you?
- Why might a person not keep their appointment?
- How can a person get support?

FILL OUT ANY FORMS

- What kind of information might the health care staff need to know?
- Why do people receiving health care need to sign consent forms?
- What might be helpful to know about one's medical history? Family history?
- Why is it important to be honest in providing information?

VISIT WITH CLINICIAN

- 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 OR TREATMENT PLAN AND ASK QUESTIONS

- What medications are needed? How will you get them?
- How can you find out test results?
- Do you need a follow-up appointment?
- What things do you need to do, or avoid, to stay healthy?

PAY (IF NECESSARY)

- Does the health center charge a fee?
- Do they charge on a sliding scale (i.e., based on a person's ability to pay?)

RESOURCES

This section has handouts that may be used in conjunction with the lessons, or as standalone materials. Included in this section are:

SEXUALLY TRANSMITTED INFECTIONS — A SUMMARY

USING CONDOMS

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 or 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, the STI does not cause any symptoms.

- The symptoms may be inside the vagina or the anus, where they cannot be seen.

Possible symptoms

Symptoms might appear on the anus, mouth, penis, scrotum, vagina or vulva. People often have no symptoms.

- Sores
- Irregular growths, bumps or blisters
- Discharge from the vagina that *smells* different than usual
- Discharge from vagina that *looks* different than usual
- Discharge from penis
- Itching of anus, penis, vagina or vulva
- Pain or swelling in groin
- Pain during or after intercourse
- Pain in lower abdomen
- Pain when urinating or having a bowel movement
- Rash
- Unusual vaginal bleeding or spotting after intercourse

What should I do if I think I might have an STI?

Call Planned Parenthood (1-800-230-PLAN), 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
- Someone who is pregnant with an STI can give it to their fetus during pregnancy, or to their 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?

The surest way to prevent STIs is not to have sexual intercourse or any direct contact with body fluids (blood, semen and vaginal fluid) that might be infected or with 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 latex condom with a *water-* or *silicone*-based lubricant, or water/silicone-based hybrid
  - An external polyurethane (plastic) or polyisoprene (synthetic latex) condom for people who are allergic to latex
  - An internal 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 they don'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 will 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, those made with silicone, or water-silicone hybrids. 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.

- A person or couple can practice using a condom during masturbation.

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 your partner.
- Keep the used condom away from your partner's body and your body.
- If semen ("cum") spills on either of you, wash it off.
- Wrap the condom in tissue and throw it away.
- Do not use the same condom again.

ENDNOTES

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THE CONDOM LINEUP

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SWIPING RIGHT: PROFILE OF A SUCCESSFUL CONDOM USER

[12] The original lesson plan by Peggy Brick was titled "Personals: Portrait of a Successful Condom User" when it appeared in prior editions of *Teaching Safer Sex.* It is adapted with permission.

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SAY WHAT?!? COMMUNICATING ABOUT SAFER SEX

[14] Adapted with permission from multiple Center for Sex Education publications, including *Making Sense of Abstinence* and *Streetwise to Sexwise.*

CHOOSING CONDOMS, CHOOSING LUBES

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FRIENDS GETTING TESTED

[21] The original lesson plan by Peggy Brick was titled "What's a Friend to Do: Exploring the Role of Friends in Promoting Safer Sex" when it appeared in prior

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