

Safer Sex Day: A Program to Reduce Risky Sexual Behaviors

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Abstract

Introduction: The negative consequences of risky sexual behavior among adolescents are well documented. There is a need for sexual risk reduction programs that are readily accessible to educators. Program overview: The goal of the Safer Sex Day program is to increase condom use by improving knowledge, skills and comfort discussing and using condoms. The program was developed using the 8 characteristics of effective curriculum based programs identified by Kirby. Program objective, preparation and materials needed are presented. Program implementation: Interactive methods are described step-by-step including brainstorming, group discussion, demonstrations, and other creative activities to discuss safer sex in an engaging and nonthreatening manner. Supporting research and discussion points are included. Methods for evaluating knowledge, attitudes and skills based on learner objectives are described. Discussion: This brief, research-based, interactive program has the potential to reduce sexual risk behaviors and the resulting negative consequences.

Keywords: Sexuality education, safer sex program, condom use, sexual risk reduction

1. Introduction

Risky sexual behaviors among youth are well documented. Approximately 65% of high school seniors report having had sexual intercourse, while an additional 15% report four or more sexual partners (Centers for Disease Control and Prevention [CDC] 2012). Of those who have had sex, 40% did not use a condom the last time they had sex. Additionally, 23-32% of middle school students report ever having sex in approximately half (7/16) of the 16 locations reporting Youth Risk Behavior School (YRBS) middle school data (Moore, Barr, and Johnson 2013).

The negative health consequences of these risky sexual behaviors are identified as national health priorities in *Healthy People 2020* (Office of Disease Prevention and Health Promotion 2011). Of the approximate 20 million new cases of sexually transmitted infections (STIs) each year in the U.S., over half occur among youth 15-24 (CDC 2014). In 2009, 39% of all new HIV infections were among young people aged 13-29 (CDC 2013). Additionally, more HIV infections occur among those 20-24 than any other group (CDC 2013). Finally, in 2009, the teen pregnancy rate was 66 per 1,000 women age 15-19, resulting in approximately 722,000 pregnancies to women under age 20 (The National Campaign to Prevent Teen and Unplanned Pregnancy [TNC] 2013).

Sexuality education programs to reduce these health risks are typically categorized as abstinence-only, abstinence-based, and comprehensive sexuality education.

Abstinence-only programs (or “abstinence-only-until-marriage”) focus on the importance of remaining abstinent, and only discuss contraception or condoms in regards to failure rates (Trenholm et al. 2007; Santelli et al. 2006). Abstinence-based programs (or “abstinence-plus” or “abstinence-centered”) stress the importance of abstinence but also include instruction on safer sex, condoms, and contraception (Goldfarb and Constantine 2011). Finally, comprehensive sexuality education contains a broad scope of topics and takes a positive view of sexuality (Goldfarb and Constantine 2011).

Abstinence-only sexuality programs have not been found to be effective (Trenholm et al. 2007). Effective programs are typically abstinence-based or comprehensive, and have been proven to reduce risky sexual behaviors. Such programs have been found to delay first sexual intercourse, reduce the frequency of intercourse, increase condom/contraceptive use, and reduce the number of sexual partners (Kirby and Lepore 2007; Sullentrop 2011; Alford 2008; Kohler, Manhart, and Lafferty 2008).

There is also overwhelming support for abstinence-based programs in schools. Numerous state and national studies show that the majority of the public not only support sexuality education, but also prefer both abstinence and condoms/contraceptives be taught (Barr et al. 2014, 2011; Eisenberg et al. 2008, 2009; Swenson 2008; Constantine, Jerman, and Huang 2007; Howard-Barr and Moore 2007; Bleakley, Hennessy, and Fishbein 2006; Ito et al. 2006; Yarber et al. 2005; National Public Radio 2004). National professional organizations and the medical community also support a more comprehensive approach to sexuality education (American Medical Association 2013; American Public Health Association 2006; American Psychological Association 2005; Klein 2005). Finally, both the *Healthy People 2020* and *Healthy Campus 2020* initiatives support efforts to improve the sexual health of adolescents and young adults with objectives specific to increasing condom use (American College Health Association, 2014; Office of Disease Prevention and Health Promotion, 2011).

Fortunately, new federal funding initiatives through the U.S. Department of Health & Human Services, Office of Adolescent Health for evidence-based sexuality education programs are setting the stage for change (U.S. Department of Health & Human Services 2011). In the latest SIECUS overview of sexuality education programs in the U.S., they reported that 18 states have recently initiated legislation to include medically accurate, age-appropriate sexuality education if the schools offer sexuality education (SIECUS 2009). Additionally, the newly developed and published National Sexuality Education Standards provide support and guidance for sexuality content in grades K-12 (Future of Sex Education Initiative, 2013). With these recent initiatives, schools may be more likely to move from abstinence-only education to more abstinence-based education that includes information about contraceptive options and condom use as methods to reduce sexual risk.

However, there may be some disconnect in the sexual health risk reduction programs that educators have access to and what they are charged with teaching. Many of the evidence-based programs are commercially sold and costly which may be prohibitive for schools and non-profit agencies. Additionally, many programs are several sessions/hours long, which may not fit within an already overcrowded school curriculum or for groups only having a one-time presentation opportunity. Hence, this program was developed to fill this gap. It is brief and based on Kirby’s (2007) characteristics of effective curriculum-based programs. Of the characteristics, 8 focus specifically on the content of the curriculum itself. These 8 characteristics were carefully considered and incorporated when developing this program (See Figure 1).

Figure 1: Kirby’s 17 Characteristics and Application in the Safer Sex Day Program

| Kirby’s 17 Characteristics | Safer Sex Day |
|---|---|
| Focus on clear health <u>goals</u> - the prevention of STI/HIV, pregnancy, or both | <u>Goal:</u> To increase condom use through improved knowledge, skills and comfort discussing and using condoms. |
| Focus narrowly on specific types of <u>behavior</u> leading to these health goals (e.g. abstaining from sex or using condoms or other contraceptives) Give clear <u>messages</u> about these types of behavior, and address situations that might lead to them and how to avoid them | <u>Behavior:</u> Condom use <u>Messages:</u> Importance of using condoms, how to use condoms |
| Address sexual psychosocial <u>risk and protective factors</u> that affect sexual behavior (e.g. knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy) and changed them | <u>Risk/Protective Factors:</u> Knowledge about condoms, effectiveness, use; attitudes about the need to use condoms; self-efficacy to use condoms; perceived risk of not using a condom |
| Create a safe social <u>environment</u> for young people to participate | <u>Environment:</u> ice breaker and/or setting ground rules to help create a safe social environment |
| Include multiple <u>activities</u> to change each targeted risk and protective factor | <u>Activities:</u> Several activities/methods are included that involve participants and address various risk and protective factors. |
| Employ sound <u>teaching methods</u> that actively involve participants, help them personalize information, and aim to change targeted risk and protective factors | <u>Teaching Methods:</u> -Ice-Breaker/Ground Rules to increase comfort -Lecture and Presentation to provide factual information and risk information -Discussion and Questioning throughout lecture to elicit interaction and participant ideas -Brainstorming to get participants involved and coming up with relevant and realistic ideas -Demonstrations to add visual cues to reinforce lecture -Cooperative Learning to have participants work together and think critically -Skills Practice to reinforce information and demonstrations -Humor used throughout to reduce barriers and increase comfort |
| Employ activities, instruction methods, and behavioral messages <u>appropriate</u> for the culture, developmental age, and sexual experience | <u>Appropriateness:</u> Program well-received by college students of many ethnicities; can be modified for younger groups |
| Cover topics in a logical <u>sequence</u> | <u>Sequence:</u> Topics were designed to build on each other with knowledge provided first, followed by application of material through activities |

The purpose of this article is to present a brief, interactive, research-based program that could be used to help accomplish the goal of reducing risky sexual behaviors of youth. This program may be implemented in a variety of settings. Optimally, it could be included in a high school or college level personal health course as part of the sexuality education unit or in a sexuality education course. Incorporating it into a course would allow the instructor to address other important sexual risk content before presenting this program to enhance learner outcomes. The program could also be used as a stand-alone presentation in community or school settings, to train peer health educators and to carry out peer education, or to provide future health educators with teaching ideas they can in turn use with their audiences.

2. Program Overview

This program aims to cover key content related to safer sex. It first briefly reviews important ways to reduce sexual risk – abstinence, monogamy, communication, getting tested – but also recognizes the reality that these are not always 100% effective methods in practice. A few examples are scenarios such as – I thought oral sex was being abstinent, we were together for a year, I trusted him/her, I didn't know you could get it that way/we didn't even have sex. Next, methods to engage in 'safer sex' in a positive and non-threatening manner are presented. Through the use of demonstrations and humor participants are encouraged to get involved, ask questions and become more comfortable with talking about, handling and using condoms. Although the focus of this program is reducing STI risk, the safer sex behaviors presented also reduce risk for HIV and unintended pregnancy, so instructors may broaden the focus if they desire. The goal of this program is to increase condom use by improving knowledge, skills and comfort level with discussing and using condoms.

2.1 Objectives

By the end of this program, participants will: (1) define 'safer sex,' (2) list the proper steps in putting on a condom, (3) refute common myths about condoms, (4) believe it is important to use condoms if sexually active, (5) believe that there are few barriers to using a condom, and (6) demonstrate proper condom use on a model.

2.2 Preparation

If taught within the context of a high school/college personal health type course or sexuality education course, it is beneficial if instructors have previously discussed: adolescent sexual risk behaviors (e.g., CDC YRBS data); STIs (e.g., transmission); contraception/condom basics (e.g., what they are, effectiveness, where to get them); refusal skills and communication with a partner about condom and contraception use (for more information on these topics see: <http://www.cdc.gov/healthyyouth/yrbs/factsheets/index.htm>, <http://www.ashalsexualhealth.org/>, <http://www.plannedparenthood.org/>). If used for school health educator preparation, instructors should reinforce the importance of reviewing and adhering to school and district teaching policies about specific content requirements and parental notification or permission for students to participate in sexuality education. Instructors should practice all activities before teaching the education plan in order to make sure they are comfortable and able to do them correctly.

2.3 Time required

A minimum time period of 90-minutes is suggested. If the time period is shorter, instructors could choose to delete one or more of the demonstration activities and complete it in less time. If instructors have not had the opportunity to conduct the 'suggested activities' in this manuscript that would typically occur before condom use is addressed (such as 'ice breakers,' STI risk assessment, or transmission routes), the time period could easily be expanded to two or two and a half hours.

2.4 Materials

Instructors will need: 1) male condoms, preferably non-lubricated (1-2 for each participant, plus 12 more for the other demonstrations); condoms may be obtained free from a local health department or student health center; 2) 2 non-lubricated condoms blown up to a fairly good size and tied like balloons; 3) a water based lubricant; 4) an oil based lubricant such as petroleum jelly or baby oil; 5) a large clear bowl; 6) a gallon of water; 7) condom steps signs (put each step in Figure 3 on a separate sheet of paper in large font size); 8) grapefruit cut in half; 9) 4-5 firm bananas or cucumbers; 10) penis model (if available); 11) one cup each of hot and cold water; 12) dental dam; 13) saran wrap. Another option is to have participants bring their own condoms to help learn where to get them and reducing associated embarrassment.

3. Implementation Procedures

If this group is meeting for the first time, or if an established group has not yet discussed sexuality topics, starting with a 'get to know you' activity and/or an ice breaker would be beneficial. This will help to increase participants' comfort levels when talking about sexual health and help to create a safe and comfortable environment. These activities can be as simple as having everyone break off several toilet paper squares or grab a handful of candy out of bag, and then individually share one fun fact about themselves with the group for each piece of paper or candy they took. If the goal is to also introduce the topic of sexual health, the instructor can create a list of statements related to sexual health.

Example statements include: was 12 or younger when they got their period; was 16 before they had their first kiss; respects men who are still virgins; knows someone who has an STI; knows someone who is LGBT; etc. Each participant would receive a copy of the list and be asked to find someone in the room who can sign by one statement. Participants can only sign others' paper one time. There should be fewer statements than participants. Other get to know you activities can be found through a web search or on professional health sites such as Advocates for Youth.

Are you at risk? An identified characteristic of effective programs is to address factors that affect participant sexual behavior such as perceived risk for acquiring STIs (Kirby, 2007). If STI risk has not already been addressed with this group, it is important to conduct a risk assessment activity. If this program is delivered within the context of a course, text books/teacher workbooks often include an STI or sexual health risk assessment. There are also online STI risk assessments, such as the STD Wizard (<http://www.stdwizard.org/>), that participants could complete before coming to the program, or could complete during the session using computers or a smart phone.

Another option for addressing perceived risk is to conduct a transmission activity. Every participant is handed a notecard. Proportionate to group size and risk level, cards should be labeled with a C (condom), A (abstinent), or S (STI). Participants are instructed to meet and sign the cards of about four other participants. Once the participants are seated, have all those with an S on their card stand. Tell them for the sake of this activity they have an STI. Then have anyone who has the signature of a standing participant to stand, and then repeat the process until all students who have a card signed by someone who had 'contact' with an STI are standing. Next ask all of those with an A on their card to raise their hand. Tell those participants they can sit because they chose to abstain from sex and therefore would not have gotten an STI. Next ask all of those with a C on their card to raise their hand. Tell those participants they can sit because they used a condom and would be significantly less likely to have acquired an STI. Have participants look around the room to see how quickly STIs can be passed. Ask participants if they think this risk is realistic among their group (eg., college or high students, age group). Ask them how they felt toward those who 'infected' them with an STI? Tell them you will further discuss how transmission routes and lack of symptoms can affect this type of scenario.

Next, have the group brainstorm ways to reduce the risk of STIs. Type them on an overhead or PowerPoint (PPT) slide, or write them on the board (hereafter referred to as PPT). After they have shared their ideas, add to them as necessary to complete the following list of STI risk reduction methods. Then go through each method listed for reducing risk and discuss the points described below. The discussion provides a rationale for the focus on condoms as a sexual risk reduction method (e. g., while the other methods are very important, their effectiveness depends largely on how individuals define or practice each, and they are best used in combination safer sex methods).

Abstinence - Ask the participants to define abstinence. Read a dictionary definition of abstinence ('abstention from sexual intercourse,' Merriam-Webster online 2011). Ask the participants the following: Are there other behaviors besides intercourse that put one at risk for STIs? Given this, what sexual behaviors do you consider to be abstinent? (Show list in Figure 2; remove risk levels for this discussion). There will be disagreement among participants; point out that this is okay. What is important is to know how your partner defines abstinence to help enhance communication about risk behaviors and safer sex. Discuss the following points: Abstinence is the only 100% effective way to prevent STIs as long as it is practiced 'correctly' (e.g., no behaviors that put one at risk for STIs). If one's definition of being abstinent includes that it is acceptable to engage in oral or anal sex, then s/he is at risk for STIs even though they consider themselves abstinent. Recent studies have shown that 98% of students' definitions of sexual intercourse include vaginal intercourse, while only 78% include anal intercourse and 20% include oral intercourse (Hans, Gillen, and Akande 2010). As long as one remains abstinent from all sexual risk behaviors (e.g., vaginal, oral, anal sex, even 'nudging' or genital-to-genital contact), then abstinence is a 100% effective method for preventing STIs.

Figure 2: Sexual Risk Behaviors for STIs

No Risk Behaviors

- Hugging, holding hands
- Masturbation / mutual masturbation (no contact with partner)
- Massage
- Phone sex / cyber sex
- Sex toys (not shared)

Low Risk/No Risk Behaviors

- Deep (tongue) kissing (no cuts; no contact with blood)
- Manual stimulation of another's genitals (no cuts; no contact with secretions, blood)
- Sharing sex toys (clean between partners, use a condom)
- Oral sex with a barrier (no contact with skin, secretions, blood)

Low Risk Behaviors

- Frottage (genital-to-genital contact without penetration)
- Vaginal sex with a condom (small risk of condom breakage; skin-to-skin contact)

Medium Risk Behaviors

- Anal sex with a condom (risk of condom breakage is greater; skin-to-skin contact)
- Oral sex without a barrier

High Risk Behaviors

- Unprotected vaginal sex (including withdrawal or used of hormonal contraceptives only)

Unprotected anal Sex

Instructors can expand this discussion/activity if time permits. First, show the list in Figure 2 on the PPT without the risk levels. Ask participants where they would draw a line separating where behaviors change from being considered abstinent behaviors to non-abstinent behaviors. Discuss the various views: non-risk behaviors (e.g., hugging, kissing, massage, etc.); 'grey area' – risk for STIs, but not pregnancy (e.g., oral sex, anal sex, touching partner's genitals, etc.) – classification might be based on an individual's personal /religious beliefs or on perception of risk; non-abstinent – most will say vaginal intercourse and anal intercourse. Stress the importance of knowing how they and their partner define abstinence in order to talk about risk behaviors.

Monogamy - Ask participants to define monogamy. Read a dictionary definition of monogamy ('the condition or practice of having a single mate during a period of time'; 'the practice of marrying only once during a lifetime', Merriam-Webster online, 2011). Ask participants how they define 'during a period of time' – what is the length of time one has to be with someone to be considered monogamous? Ask how many people they think practice 'serial monogamy' (e.g., one partner at a time, but several partners before a person gets married or over their lifetime). Discuss the following points: For some individuals the time period for a monogamous partner may be one week, for others three months or a year, and still for others it may be a lifetime. Practicing monogamy helps to reduce STI risk, but is not fail proof. It is important to know ones partner's sexual history.

Partner communication - Briefly review research (Kenyon et al. 2010; Zukoski, Harvey, and Branch2009) or remind participants of previous lecture(s) that show that partners with better communication are more likely to use safer sex practices, including condom use. Also discuss the following points: Previous studies have unfortunately shown that one of three people will say they don't have an STI when they know they do, just to have sex with a partner (Planned Parenthood 2011b). Another potential issue is that a partner may be honest and just not know that s/he has an STI (remind them that most people have no symptoms for a number of STIs). Getting to know a partner before having sex is key; empathy and trust in a relationship are critical to 'safer sex.'

Check yourself and get tested - Ask participants why checking themselves and getting tested for STIs is important. Discuss the following points: Individuals should know their bodies, in particular their genital region, so that they can regularly check for changes that might be indicative of an STI. Individuals should also get tested for STIs regularly if they are sexually active. People who know they are infected can get treated and take steps to make sure his/her partner doesn't get infected. They can also encourage their partner to get treatment if they have been infected.

3.1 Safer Sex Discussion

'Safer sex' behaviors: Tell participants: This is the focus of our presentation and it will be discussed in detail in a few minutes. All of the above steps are *very important* to reduce STIs. However, since only abstinence (practiced 'correctly') is 100% effective, it is critical that young people who choose to engage in sexual activity take the above steps, but also practice 'safer sex' behaviors.

When is it safe not to worry about STIs? Ask participants for their answers to this question. Add to their responses if necessary: 1) when both partners have practiced true abstinence from sex and IV drugs; or 2) when both partners get tested for STIs; both have negative test results, or get treatment if they have an STI; wait three to six months while engaging in no risk behaviors; and then both get tested again and have negative test results - then they are 'safe' to engage in a *monogamous* sexual relationship without worry of acquiring an STI.

Why focus on condoms? - Briefly review the following: Half of young people (1 in 2) will acquire an STI by age 25 (ASHA 2005); condoms greatly reduce the risk of STI infection if used correctly and consistently (CDC 2011); condoms greatly reduce the chance of unintended pregnancy (Planned Parenthood 2011a)- and a majority of Americans will use birth control in their lifetime, unless they choose to remain abstinent or are gay/lesbian, but the latter still need STI protection – so condoms will help reduce both STI and unplanned pregnancy – the only contraceptive that is good for both!

Why is it called 'safer sex' rather than 'safe sex'? - Briefly review transmission routes covered previously or from Figure 2. Remind participants: Although condoms are highly effective, they only protect what they cover. There is still a risk of STI transmission since STIs can be passed through genital-to-genital contact (areas not covered by a condom). There is also a small chance that the condom could break, which is most likely when they are used incorrectly (Planned Parenthood 2011a). If the session is a longer time period or within a course, make signs with the sexual risk behaviors listed in Figure 2. Pass the signs out to volunteers in the audience and have them come to the front of the room with their signs; have the remaining audience put the behaviors in order of risk, or in risk categories – e.g., no risk, low risk, high risk.

Safer oral sex - Following the discussion on transmission routes, reiterate the following: Unprotected oral sex (without using a condom or other barrier) puts both partners at risk for a number of STIs, whether they are giving or receiving genital stimulation. Discuss methods to reduce risk of STI transmission during oral sex (e.g., for the penis - male condoms designed for oral sex, often flavored; for the vulva or anus - condom cut open and unrolled to place across the area; Sheer Glyde dam or dental dam; non-microwaveable saran wrap). Show and pass around each item as it is discussed. Tell participants they may use these barriers with lubrication to improve sensitivity or food items to improve taste (non-oil based). The Sheer Glyde dam has been approved by the FDA for safer sex (Planned Parenthood 2011b). There is no information on effectiveness of these methods (CDC 2006).

3.2 Demonstration Activities

Steps for putting on a condom: Make signs for all the steps listed in Figure 3. Abbreviate or combine steps as needed to work with group size. Pass out the signs randomly to no more than half the group. Have the remaining participants in the audience put the signs in order and discuss any step that may need clarification or explanation (Oberneand McDermott 2010).

Figure 3: Steps for Putting on and Removing a Condom

- Get out condom, check expiration date, check package for holes (should be airtight).
- Carefully open condom wrapper (do not use teeth/fingernails).
- Remove condom from wrapper. Many have a small nipple-like tip at center of a latex ring.
- Place a couple of drops of water-based lubricant in tip of condom if desired.
- Squeeze tip between thumb and forefinger. This forces air out and leaves room for ejaculate (cum) later.
- Place condom on head of the erect (hard) penis.
- If uncircumcised, pull foreskin back before putting on condom. Once on, slide foreskin forward so more comfortable.
- Gently roll ring down the entire length of the erect (hard) penis. If the condom DOES NOT roll, throw it away and get new one. NEVER unroll and re-roll a condom before using it or flip it over once it has touched the penis.
- Smooth out any air bubbles. (Friction against air bubbles can cause condom breaks.)
- Use more water-based lubricant on outside of condom before having sex if desired.
- ***Sex***
- Pull out before the penis softens.
- Don't spill the semen — hold the condom against the base of the penis while you pull out.
- Remove the condom without spilling any semen.
- Throw the condom away.
- Wash the penis with soap and water before embracing again.

Condom use- Now reinforce the steps for proper condom use using a penis model to demonstrate (or a firm banana or cucumber works well if a model is not available). Some penis models have the availability to demonstrate ejaculation. If this model is available, condom removal can be shown, as well as how ejaculate covers the penis, and sometimes the hands, (using the included 'ejaculate' a UV light will show where the ejaculate is) in order to stress the importance of proper washing before coming in contact with a partner's penis again. Ask participants to follow along by applying the condom to their fingers (the pointer finger and middle finger together work well for this). For instructors who have not been trained in sexuality education, there are some good demonstration videos available online (Planned Parenthood 2011a).

Condom sensitivity- Before the program starts, place the two halves of the grapefruit, a glass of ice water and a glass of hot water on a table at the front of the room. While participants still have the condoms on their fingers, ask them to come up to the front of the room and feel each of the three substances (e.g., hot water, cold water and grapefruit). After participants have made their way through the line ask them what they think the purpose of this activity was. Tell participants that a common complaint about condoms is the decreased sensitivity. This activity shows that one can still feel temperature and texture while using a condom. Point out that the penis is even more sensitive than the fingers and that lubrication can help enhance these feelings.

Condom lubrication - Display a list of lubricants that are safe for use with latex condoms (e.g., water-based lubrications such as Astro Glide, KY, Wet, etc.) and those that are not (e.g., oil-based lubricants such as baby oil, Vaseline, sun tan oil, etc.) and discuss why they are or are not recommended- water-based lubricants can help increase sensitivity and make sex more enjoyable; oil-based lubricants can damage condoms (Planned Parenthood 2011a). Take out the two blown up non-lubricated condoms. Ask two outgoing participants to volunteer in a demonstration of why it is important to use water-based lubricants. Hand each participant one of the blown up condoms. Put a good amount of oil-based lubricant on one condom and water-based lubricant on the other. Ask participants to use their hands to rub the lubricant into the condom vigorously. Warning! - The condom with the oil-based lubricant will pop. Summarize that this is an example of how the oil breaks down the condom. Have paper towels or baby wipes available for participants to wipe their hands.

Condom size and durability - Take out the large bowl, a non-lubricated condom and the gallon jug of water. Place the opened, unrolled condom over the top of the opened milk jug. While holding the condom on the jug over the bowl, turn the jug upside down so that the water starts filling up the condom. Instructors may need to squeeze the jug to get the water to completely move into the condom.

Explain to participants that this demonstration shows that size shouldn't be an issue with condoms (e.g., they can accommodate a gallon of water!) and refutes myths participants made have heard about condoms breaking or not being durable (e.g., they can hold a gallon of water!). Some brave participants and instructors have then picked up the tied-off condom and held it up over the bowl to show the durability of the condom.

Condom races - The final activity is condom races. Have five or so firm bananas or cucumbers. Ask for five pairs of participants (depending on group size) to come to the front of the room to demonstrate proper condom use. Tell them that it is a race to see which team can finish putting on the condom correctly (following all steps described in the previous activity) the fastest. Give one partner a banana and the other an unopened condom. Instruct the participants to watch the pairs to make sure they do not make any mistakes. Give them a mark, set, go. Time the race. After they all finish, make sure the fastest pair did not make any mistakes (common mistakes include not checking the date or for leaks in the package; ripping the condom open with teeth or long nails; forgetting to pinch the tip; sloppy pulling off of the condom, etc.). Congratulate the winner (the quickest with no mistakes). Tell participants how long 'using' the condom took (usually only seconds), and discuss how condoms do not have to be a major interruption of sexual activity. Discussion may include how to make condom use part of foreplay, sexual intercourse and romance.

Another variation of the race is to break the group up into teams. One participant is the observer and each of the others must put on and take off the condom correctly before passing it to the next team member. If a team member misses a step, the observer makes them do it again before passing the banana/model to the next member. To make it even more challenging, the team members can be blind folded. This relay race has shown to be effective in increasing condom confidence/self-efficacy and skills (Elkins et al. 1998; Hayden 1993).

3.3 Summary

End the program by showing a list of the 'top 10 lame reasons' for not using a condom (one at a time) and refuting them with the information provided in parentheses, which are from the discussion and activities done during the program (and/or previous lectures on STI transmission and symptoms; condom types, effectiveness; sexual communication with a partner, etc.). Do not include the information in parentheses on the PPT slide. Before refuting each myth, ask participants to come up with a response for a partner who used each excuse. Then add to their responses.

- 10 – It looks so big and shiny, the glare will hurt my eyes! (Just for fun!)
- 9 – They break too easily and don't work anyway. (They hold a gallon of water! They can endure vigorous friction - lubrication demonstration. Discuss testing performed on condoms to ensure durability, and cite studies on risk reduction rates for STIs.)
- 8 – They are too hard to find. (Remind participants where they can get free condoms locally, and the low cost of buying them at the store.)
- 7 – They spoil the mood. (Remind participants how quickly and easily condoms can be put on as part of sex foreplay - condom race.)
- 6 – I'm allergic to rubber. (Remind participants of various types of condoms: latex, polyurethane, lambskin (pregnancy prevention only).)
- 5 – Sex doesn't feel as good. (Remind participants of grapefruit, water feeling demonstration; condoms are not a shield of armor!)
- 4 – If you loved me, you wouldn't ask me to. ('If you loved me, you wouldn't ask me NOT to.' Remind participants of importance of communication.)
- 3 – I don't have any diseases. (Are you sure? Most STIs lack symptoms.)
- 2 – I have great control. (Why would you want to interrupt? And there are also too many 'oops' ... !!)
- 1 – I can't find one that fits. (It 'fits' a gallon of water! There are many brands and sizes)

Discuss the following with participants: They now know how to refute just about any excuse for not wanting to use a condom! Participants need to make up their mind that they will engage in 'safer sex', practice and be prepared. When we laugh about something it helps to make us feel more comfortable with those sensitive topics (Kher, Molstad, and Donahue 1999). Hopefully through the demonstrations and engaging the group, participants are now more comfortable with condoms, or at least have an 'ice breaker' story to share with partners when engaging in 'the talk' – the 'safer sex' talk that is! Be sure to provide participants with a handout or other resource with the contact information for local health services to access condoms and STI testing and treatment.

3.4 Assessment Procedures

Depending on the setting and purpose of the education provided, instructors can verbally quiz the group, develop a short pre-post survey, or incorporate questions into a test to assess the learning objectives. For the written survey/test participants may be asked to: define/recognize 'safer sex' behaviors; list/recognize the steps for putting on a condom in order; identify true/false statements about condom use and effectiveness; indicate agreement level with statements about the importance of using condoms if sexually active and the barriers/benefits of using condoms. For those interested in longer-term impact, include questions on behavioral intentions to use condoms. The instructor can assess participant demonstrations of putting on a condom correctly during the activities, or at the end of the program.

4. Discussion

STI rates among young people in the U.S. are at unacceptably high levels. Reducing the risk of acquiring STIs requires that young people start using sexual risk reduction behaviors. This includes a number of behaviors such as abstinence, monogamy, partner communication, getting tested for STIs, and using condoms. This program has evolved over the past 20 years, and incorporates various research based teaching methods, research on sexual risk behaviors, and instructor experience. Although some of these specific demonstrations have been described elsewhere (Fennell 1993; Hayden 1993), the combination of activities and use of engaging participants, along with including recent research, following guidelines for evidence-based curriculum, and an introduction and conclusion that summarize the various risk reduction strategies and their importance make this program unique. Young adults have responded extremely well to this program – they get involved, ask a lot of questions, laugh a lot, and overall seem very comfortable with and interested in learning about safer sex. The potential implications are to help reduce sexual risk behaviors and the resulting negative consequences among young people.

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