Men’s Sexual and Reproductive Health Overview

Chapter Purpose and Objectives

This chapter provides basic information about men’s sexual and reproductive health issues, including:

- Sexuality
- Men’s sexual and reproductive anatomy and physiology
- Sexual dysfunction
- Sexual behaviors
- Sexual orientation
- Contraceptive methods
- Condoms
- Common sexually transmitted infections (STIs)
- Cancers of the reproductive system
- Infertility

Upon completion of this chapter, the participants should be able to:

- Identify sexual and reproductive health issues that men may be concerned about during counseling sessions
- Understand sexuality and its relation to reproductive health
- Demonstrate an understanding of the different types of sexual orientation
- Describe the range of sexual behaviors and their implications regarding men’s health
- Demonstrate familiarity with sexual and reproductive health terms
- Describe the basic anatomy and physiology of the male reproductive system
- Address common questions and concerns about male sexual dysfunction
- Provide comprehensive information about each contraceptive method that requires men’s active participation
- Describe how to use a condom correctly
- Describe some basic symptoms of common STIs in men and women and how they can be transmitted
- List ways to reduce the risk for transmitting or contracting STIs
- Understand the basic causes of infertility and what couples can do to improve their chances of having children
- Provide basic information to clients about prostate and testicular cancer
Training Tips for This Chapter

When counseling men, service providers should be very familiar with all the issues covered in this chapter. Therefore, before selecting the training activities for this chapter, assess the participants’ knowledge of and previous training in men’s sexual and reproductive health issues, and choose only those activities that cover significant gaps in their knowledge and training.

Training Time

10 hours, 5 minutes to 12 hours, 30 minutes, depending on the amount of time available and the participants’ knowledge and previous training. You may use the sample agenda on the next page to help plan your activities and time for this chapter.
<table>
<thead>
<tr>
<th>Training Content</th>
<th>Training Method</th>
<th>Estimated Time</th>
<th>Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction <em>(no corresponding content in the text)</em></td>
<td>Trainer presentation</td>
<td>5 minutes</td>
<td></td>
</tr>
<tr>
<td>Key Issues to Address in Men’s Sexual and Reproductive Health Counseling <em>(no corresponding content in the text)</em></td>
<td>Large-group activity: “Top 10 Men’s Reproductive Health Issues” Game Show</td>
<td>15 minutes</td>
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</tr>
<tr>
<td>Defining Sexuality <em>(pages 3.1–3.5 of the text)</em></td>
<td>Large-group activity: Understanding Sexuality</td>
<td>45 minutes</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation <em>(pages 3.4 and 3.16–3.17 of the text)</em></td>
<td>Brief lecture with discussion: Sexual Orientation</td>
<td>20 minutes</td>
<td></td>
</tr>
<tr>
<td>Men’s Sexual and Reproductive Anatomy and Physiology <em>(pages 3.5–3.13 of the text)</em></td>
<td>Small-group activity: Body Mapping OR Large-group activity: Penis Size OR Individual activity: Men’s Sexual and Reproductive Anatomy and Physiology Myths and Facts</td>
<td>45 minutes OR 5 minutes OR 30 minutes</td>
<td>Choose one of these activities.</td>
</tr>
<tr>
<td>Communicating with Clients about Sexual Anatomy and Behaviors <em>(page 3.5 of the text)</em></td>
<td>Large-group activity: Brainstorming Sexual Terms</td>
<td>20 minutes</td>
<td></td>
</tr>
<tr>
<td>Sexual Dysfunction <em>(pages 3.9–3.11 of the text)</em></td>
<td>Small-group activity: Sexual Dysfunction Case Studies</td>
<td>30 minutes</td>
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<tr>
<td>Common Sexual Behaviors <em>(pages 3.13–3.15 of the text)</em> and Health Considerations of Sexual Behaviors <em>(pages 3.15–3.16 of the text)</em></td>
<td>Large-group activity: Values about Sexual Behaviors</td>
<td>45 minutes</td>
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<tr>
<td>Training Content</td>
<td>Training Method</td>
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<tr>
<td>Sexuality Myths and Facts (pages 3.17–3.18 of the text)</td>
<td>Individual activity: Sexuality Myths and Facts</td>
<td>30 minutes</td>
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<tr>
<td>Common Client Concerns (pages 3.18–3.20 of the text)</td>
<td>Small-group activity: Common Questions Cards</td>
<td>30 minutes</td>
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<tr>
<td>Condoms (pages 3.21–3.27 of the text), Withdrawal (page 3.26 of the text), Vasectomy (pages 3.27–3.29 of the text), and Fertility-Awareness Methods (pages 3.29–3.30 of the text)</td>
<td>Small-group activity: Discussion of Male Methods</td>
<td>50 minutes</td>
<td></td>
</tr>
<tr>
<td>Condom Instructions (pages 3.23–3.25 of the text)</td>
<td>Large-group activity: Condom Steps OR Small-group activity: Practice Putting on a Condom Correctly</td>
<td>25 minutes</td>
<td>Choose one of these activities.</td>
</tr>
<tr>
<td>Men’s Role in Contraception (pages 3.30–3.31 of the text)</td>
<td>Small-group activity: Supporting and Hindering Contraceptive Use</td>
<td>30 minutes</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Infections (STIs) (pages 3.33–3.40 of the text)</td>
<td>Large-group activity: The STI Handshake</td>
<td>30 minutes</td>
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<tr>
<td>Common STIs (pages 3.33–3.35 of the text)</td>
<td>Small-group activity: Matching Game</td>
<td>45 minutes</td>
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<tr>
<td>Risk Factors for Transmitting and Contracting STIs (pages 3.36–3.38 of the text)</td>
<td>Large-group activity: Levels of Risk</td>
<td>30 minutes</td>
<td></td>
</tr>
<tr>
<td>Gender and STIs (pages 3.40–3.41 of the text)</td>
<td>Large-group activity: Discussion Topics</td>
<td>30 minutes</td>
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</tbody>
</table>
Sample Agenda (continued)

<table>
<thead>
<tr>
<th>Training Content</th>
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<th>Estimated Time</th>
<th>Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>STI Myths and Facts (pages 3.41–3.44 of the text)</td>
<td>Individual activity:</td>
<td>45 minutes</td>
<td></td>
</tr>
<tr>
<td>Cancers of the Reproductive System (pages 3.44–3.47 of the text), Infertility</td>
<td></td>
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</tr>
<tr>
<td>Sexual Dysfunction (pages 3.9–3.11 of the text), and Men’s Sexual and Reproductive Anatomy and Physiology (pages 3.5–3.13 of the text)</td>
<td>Large-group activity: Sexual Jeopardy</td>
<td>1 hour</td>
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</table>

**Advance Preparation**

- Determine which training activities will be used to present the content of this chapter, and prepare or gather any supplies needed for the activities you will be conducting (as described in the activity’s “Advance Preparation” section).
- Create flipcharts, as needed.

**Introduction**

Introduce this chapter by reading aloud the purpose and objectives provided on page 3.1 of this trainer’s resource book.
Key Issues to Address in Men’s Sexual and Reproductive Health Counseling

(no corresponding content in the text)

Training Activity: “Top 10 Men’s Reproductive Health Issues” Game Show

Objectives
1. To review the range of sexual and reproductive health issues that men may want to discuss during sexual and reproductive health counseling sessions
2. To help the participants identify the men’s sexual and reproductive health issues necessary to be an effective sexual and reproductive health counselor for men

Time
15 minutes

Materials
- 10 large index cards (or sheets of paper)
- Flipchart paper (or a chalkboard)
- Markers (or chalk and an eraser)
- Easel
- Tape

Advance Preparation
1. Develop a game-show board using a flipchart, an easel, and 10 large cards (or sheets of paper) with tape or using a chalkboard, chalk, and an eraser. Write each of the following top 10 men’s sexual and reproductive health issues on large index cards, 1 issue per index card:
   - Basic anatomy and physiology
   - Cancers of the reproductive system
   - Family planning
   - Genital hygiene
   - Infertility
   - Nocturnal emissions
   - Premature ejaculation
   - Sexual dysfunction
   - Sexual practices/sexuality
   - Sexually transmitted infections (STIs)/HIV/AIDS
2. Display the cards across a flipchart in one row. Cover the cards so the participants cannot see the issues at the beginning of the activity. Number the cards from 1 to 10.
Instructions

1. Divide the participants into three teams. Explain that the cards on the flipchart contain the top 10 issues that men may want to discuss during sexual and reproductive health counseling sessions. Point out that the ranking of these issues is not based on scientific evidence, but rather on anecdotal feedback from service providers who work with men.

2. Allow each team to take turns guessing which issues are among the top 10. Each team receives one point for a correct answer and a strike if the issue was not on the flipchart. Determine whether or not a team correctly identifies one of the top 10 issues by checking the teams’ answers against the list you used to prepare the index cards. After each team provides a guess, move on to the next team, whether or not the guess is correct. Continue playing the game until all the top 10 issues have been identified and all the index cards have been turned over. If a team gets three strikes, it is disqualified. The winner is either the team that correctly identifies all the top 10 issues or the team that correctly identifies the most issues.

3. After all the top 10 issues have been revealed, ask the participants to identify the issues that they think they need more information about in order to feel confident during counseling sessions. Try to ensure that the key issues that the participants identify are covered during the subsequent training activities in this chapter.
Training Activity: Understanding Sexuality

Objective
To help the participants gain an understanding of the broad concept of sexuality and the many areas of our lives that involve our sexuality

Time
45 minutes

Materials
• Flipchart paper
• Markers
• Tape
• Trainer’s Resource: The Four Components of Sexuality (page 3.9)

Advance Preparation
1. Write “Sex” and “Sexuality” in separate columns on a flipchart.
2. Draw the four components of sexuality (sensuality, intimacy and relationships, sexual identity, sexual health) provided on page 3.3 of the text on a flipchart. If the participants will do this activity in groups, cut out four large circles from a sheet of flipchart paper and write the four components of sexuality in the circles, one component per circle, to distribute to four groups of participants.

Instructions
1. Ask the participants what the term sex means to them. Allow them to share their thoughts, and record their responses in the “Sex” column on the flipchart.
2. Next, read aloud the following definitions of sex and sexual intercourse, and ask the participants for any comments on the definitions:
   • Sex: Sex refers to one’s biological characteristics—anatomical (breasts, vagina; penis, testes), physiological (menstrual cycle, spermatogenesis), and genetic (XX; XY)—as a male or female. Sex is also a synonym for sexual intercourse, which includes penile-vaginal sex, oral sex, and anal sex.
3. Ask the participants what the term sexuality means to them. Allow them to share their thoughts, and record their responses in the “Sexuality” column on the flipchart.
4. Next, read aloud the following definition of sexuality, and ask the participants for any comments on the definition:
   • Sexuality: Sexuality is an expression of who we are as human beings—a total sensory experience involving the mind and body. Sexuality includes all the feelings, thoughts, and behaviors of being male or female, being attractive and being in love, as well as being in relationships that include intimacy and physical sexual activity.
Sexuality begins before birth and lasts throughout the course of the life span. A person’s sexuality is shaped by his or her values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, spiritual selves, and all the ways in which he or she has been socialized. Consequently, the ways in which individuals express their sexuality are influenced by ethical, spiritual, cultural, and moral factors.

5. Explain that while many people often associate the term sexuality with the terms sex or sexual intercourse, it encompasses much more than that. To help the participants understand the complexity of sexuality, discuss four different aspects of sexuality.

Note:

- One way to present these four aspects is to use Figure 3-1, “The Four Components of Sexuality,” provided on page 3.3 of the text. Explain that each circle in this diagram represents one of the elements of sexuality. When all four circles are placed together, they suggest the total definition of sexuality. In this diagram, there is a space in the middle of the circles where the words “Values,” “Spirituality,” and “Culture” are written. These factors may all play a role in how an individual experiences the four components of sexuality.

- The information can be presented in many ways. The participants can be divided into four groups and each assigned a circle to define. Another alternative is to discuss the four aspects in a brief mini-lecture. Either way, make sure to cover the points about each element in the trainer’s resource on page 3.10.

6. After presenting this information, ask the participants to provide examples of how a person might enjoy each of the five senses in a sensual manner to demonstrate their understanding of each sense.

7. After discussing these four circles of sexuality, draw a fifth circle that is not connected to the other four. This circle is a negative aspect of sexuality and can prevent an individual from living a sexually healthy life. Say that this circle can “cast a shadow” on the four other circles of sexuality and describe it as follows:

- Using sexuality to control others: Generally, this component is not considered to be an aspect of sexuality but as something that can cast a shadow over a person’s healthy sexuality. Using sexuality to control others is not healthy. Unfortunately, many people use sexuality to violate someone else or get something from another person. Rape is a clear example of using sex to control somebody else. Sexual abuse and commercial sex work are others. Even advertising often sends messages of sex in order to get people to buy products.

8. Close the activity by discussing the questions below.

Discussion Questions

- Where is “sexual intercourse” included within the definition of sexuality? Does the term play a large or small role in the definition?
- How does culture influence the various circles of sexuality?
- Which circles of sexuality are very different between males and females? Do men and women experience sensuality the same way? Do men and women view relationships the same way? Do men and women have the same sexual health needs?
Sensuality. This is how our bodies derive pleasure. It is the part of our body that deals with the five senses: touch, smell, sight, hearing, and taste. When enjoyed, any of these senses can be sensual:

- **Touch**: Our entire bodies are sensitive to touch and pressure.
- **Smell**: Some species of animals emit pheromones, which are chemical substances that attract sexual partners. We may find some aromas, scents, or smells pleasurable and sexually arousing, too.
- **Sight**: This can play a role in our attraction to another individual. Our preferences for specific visual sights or erotic stimuli may vary by sex and from person to person.
- **Hearing**: Some people report that certain types of poetry, music, or other kinds of sounds can raise their level of sexual arousal. Sometimes, hearing specific phrases or the sound of someone’s voice may be arousing.
- **Taste**: Some people believe that certain foods may stimulate sexual arousal. For example, chocolate contains endorphins. These proteins can create a sense of calm and good feeling, thereby potentially making a person feel more relaxed for sexual activity.

The sexual-response cycle is also part of our sensuality because it is the mechanism that enables us to enjoy and respond to sexual pleasure.

Our body image is another part of our sensuality. Whether or not we feel attractive and proud of our bodies influences many aspects of our lives.

Our sensuality also involves our need to be touched and held by others in loving and caring ways. This is called “skin hunger.”

Fantasy is part of our sensuality, too. Our brain gives us the capacity to fantasize about sexual behaviors and experiences without having to act upon them.

**Intimacy and Relationships.** This is the part of sexuality that deals with relationships. Our ability to love, trust, and care for others is based on our levels of intimacy. We learn about intimacy from those relationships around us, particularly those within our families.

Emotional risk-taking is part of intimacy. In order to have true intimacy with others, a person must open up and share feelings and personal information. We take a risk when we do this, but intimacy is not possible otherwise.

**Sexual Identity.** Every individual has his or her own personal sexual identity. This can be divided into four main elements:

- **Biological sex** is based on our physical status of being either male or female.
- **Gender identity** is how we feel about being male or female. Gender identity starts to form around age 2, when a little boy or girl realizes that he or she is different from the opposite sex.
Our gender identity is at the core of how we feel about who we are. Some people are biologically male but internally female, and vice versa—these people may never feel comfortable living as defined by the sex they were born with.

If a person feels like he or she identifies with the opposite biological sex, he or she often consider himself or herself to be transgender. In the most extreme cases, a transgender person may have an operation to change his or her biological sex so that it can correspond to his or her gender identity.

- **Gender roles** are society’s expectations of how individuals should act based on their biological sex. Society has clear expectations about how males and females should behave. From the moment we are born, we are treated and expected to behave differently based on our biological sex.

- **Sexual orientation** is the final element of sexual identity. Sexual orientation refers to the biological sex that we are attracted to romantically. Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex). People often confuse sexual orientation and gender roles. For example, if a man is very feminine or a woman is very masculine, people often assume that these individuals are homosexual. Actually, however, the man and woman are expressing different gender roles. Their feminine or masculine behavior, respectively, has nothing to do with their sexual orientation. Homosexual men may be very feminine, very masculine, or neither. The same applies to heterosexual men. Also, a person may engage in same-sex sexual behavior and not consider him- or herself homosexual. For example, men in prison may have sex with other men but may think of themselves as heterosexual.

The range of sexual orientation, from heterosexuality to homosexuality, is a continuum. Most individuals’ sexual orientation falls somewhere along that continuum. While scientific studies have shown that individuals cannot change their sexual orientation at will, sexual orientation may change over time. Scientific research has also shown that individuals who have sex with members of their own sex can be just as emotionally healthy as those who have sex exclusively with members of the opposite sex.

**Sexual Health.** This involves our behavior related to producing children, enjoying sexual behaviors, and maintaining our sexual and reproductive organs. Issues like sexual intercourse, pregnancy, and sexually transmitted infections (STIs) are part of our sexual health.
Training Activity: Sexual Orientation

Objectives
1. To facilitate an understanding of the different types of sexual orientation
2. To examine societal attitudes about homosexuality
3. To clear up myths about homosexuality

Time
20 minutes

Materials
• Flipchart paper
• Markers
• Tape

Advance Preparation
No advance preparation is needed.

Instructions
1. Begin the session by asking the participants to define sexual orientation. Provide the following definition after the discussion:

   Sexual orientation refers to the biological sex that we are attracted to romantically. Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex).

2. Acknowledge that some of the participants might have strong values about a person’s sexual orientation. Tell the participants that you will respect every individual’s right to his or her opinion. However, sexual orientation is important to discuss to ensure that the participants do not make assumptions about their clients’ sexual activity and to ensure that they tailor their services and counseling to each individual client’s needs and behaviors.

3. Draw a line across the top of a sheet of flipchart paper. Label one side of the continuum “Heterosexual” and the opposite end “Homosexual.” Label the middle of the continuum “Bisexual.”

   Use this diagram to explain that the range of sexual orientation, from heterosexuality to homosexuality, is a continuum. Most individuals’ sexual orientation falls somewhere along this continuum. While scientific studies have shown that an individual cannot change his or her sexual orientation at will, sexual orientation might change throughout a person’s lifetime. So an individual’s orientation can move along the continuum as time passes.
4. Explain that a person’s sexual orientation is often confused with other aspects of his or her sexuality. For example, people often mistake sexual orientation with gender roles. To make this point, draw a second line below the first. Label one side “Masculine” and the other “Feminine.” Explain that gender roles are societal expectations of how men and women should act. Often, when a man acts in a feminine manner, he is assumed to be homosexual, but this may not be true because gender roles and sexual orientation are different. Explain that a person’s gender roles can also move across the continuum over time or can be based upon a given situation.

5. Another distinction to make is that a person’s sexual behavior does not always indicate his or her sexual orientation. To make this point, draw a third line below the other two. Label one side “Sex with men” and the other “Sex with women.” Explain that not all individuals who have had one or more sexual contacts with members of their own sex define themselves as homosexual or are considered to be homosexual by society. For example, some adolescent boys who experiment sexually with other boys (for example, masturbating in a group) and some men who have sex with other men in isolated settings, such as prisons, do not consider themselves and are not considered by others to be homosexual. In addition, individuals who engage in same-sex sexual activity might not be exclusively attracted to members of their own sex and might not wish to engage in sex only with members of their own sex. Indeed, some married persons engage in same-sex sexual activity outside of marriage and still consider themselves to be heterosexual. People who have sex with both men and women might consider themselves to be bisexual, homosexual, or heterosexual.

6. Conclude this activity by making the following points about sexual orientation. Give the participants an opportunity to discuss any of these points:
   • *Homosexuality is not a character defect or a mental illness.* Scientific research has shown that people who have sex with members of their own sex can be just as emotionally healthy as those who have sex exclusively with members of the opposite sex.
   • *Sexual orientation is not something a person can change at will.* No scientifically valid studies have indicated that people can change their sexual orientation by wanting to do so. However, an individual’s orientation might change over time.
   • *Homosexuality is different from transsexuality.* A person who feels that he or she was born into the body of the wrong sex is a transsexual. Being a homosexual has nothing to do with feeling that you are in the body of the wrong sex. Most homosexual men feel perfectly comfortable being male, and most homosexual women, or lesbians, feel perfectly comfortable being female.
   • *Children of homosexual or bisexual parents are no more likely to become homosexual or bisexual than children of heterosexual parents are.* No scientifically valid studies have indicated that this is likely to happen.
   • *Focus on risky sexual behaviors, not sexual orientation, when counseling clients.* When addressing a client’s concerns, giving a client health education or information, or providing services to a client, service providers must focus on the client’s sexual behaviors, not his or her sexual orientation. It is the behaviors—not the orientation—that put individuals, at risk for HIV infection and other STIs.
Men’s Sexual and Reproductive Anatomy and Physiology
(pages 3.5–3.13 of the text)

Training Activity: Body Mapping

Objective
To help the participants review and understand the anatomy and physiology of the male sexual and reproductive system

Time
45 minutes

Materials
• Flipchart paper
• Markers
• Tape

Advance Preparation
List on a flipchart the parts of the male sexual and reproductive system that the participants will include in their drawings, as follows:
• Bladder
• Penis
• Prostate gland
• Scrotum
• Seminal vesicle
• Testes
• Urethra
• Vas deferens

Instructions
1. Tell the participants that during this activity they will review the male sexual and reproductive system. Explain that they will find out how much they know about male anatomy.
2. Explain that they will be working in small groups to draw the male sexual and reproductive system. Display the names of the body parts that are listed on the flipchart and should be included in the drawings.
3. Divide the participants into groups of four or five. Distribute the flipchart paper and markers to each group. Give the groups 20 minutes to complete their drawings.
4. When the groups are finished, ask them to display their drawings on the wall. Ask the participants to walk around the room and take a close look at all the drawings.
5. After 10 minutes, reconvene the group and review Figure 3-2, which shows the external male genitals, provided on page 3.6 of the text, and Figure 3-3, which shows the internal male genitals, provided on page 3.7 of the text. Ask the participants to look at their drawings and discuss discrepancies.

6. After all the parts of the male sexual and reproductive system have been reviewed, facilitate a discussion by asking the questions below.

? Discussion Questions

- What was the group’s reaction as you drew the male sexual and reproductive system?
- Were there major discrepancies between your drawing and the diagrams in the text?
- What did you learn from drawing the male sexual and reproductive system?

Summary

Conclude the activity by reminding the participants that even though they have been working in the field of sexual and reproductive health, it is always valuable to review what they know. Tell them that most groups experience some kind of embarrassment or discomfort when they work on these drawings.
Training Activity: Penis Size

Objectives
1. To recognize that penis size is a common concern among men
2. To understand that penis size varies less when the penis is erect than when the penis is flaccid

Time
5 minutes

Materials
No materials are needed.

Advance Preparation
No advance preparation is needed.

Instructions
1. To illustrate variations in penis size, ask the participants to stand up and imagine that they are all flaccid, or not erect, penises.
2. Ask them to look around the room and notice the differences in heights of the other participants. Emphasize that the differences in height represent the differences in length of flaccid penises.
3. Ask the participants to sit down and imagine that they are now all erect penises. Ask them to look around the room and notice that the differences in height of people are not as great as they were before.
4. Emphasize that the differences in height here illustrate that when erect, most penises are similar in size. Smaller flaccid penises generally increase in size in a greater proportion than do larger flaccid penises.
5. Reiterate that some men may be concerned about how the size of their penis compares with that of other men. Men who see other men’s flaccid penises may think their penis is smaller or larger than other men’s, but when erect, most penises are about the same size (on average, between 12 and 18 cm, or 5 and 7 inches).
Training Activity: Men’s Sexual and Reproductive Anatomy and Physiology Myths and Facts

Objective
To help the participants review the myths and facts about men’s sexual and reproductive anatomy and physiology and correct any misinformation.

Time
30 minutes

Materials
- Pencils or pens
- Participant Handout 3-1: Men’s Sexual and Reproductive Anatomy and Physiology Myths and Facts (page 3.18)
- Trainer’s Resource: Men’s Sexual and Reproductive Anatomy and Physiology Myths and Facts Answer Sheet (page 3.19)

Advance Preparation
Make enough copies of Participant Handout 3-1: Men’s Sexual and Reproductive Anatomy and Physiology Myths and Facts to distribute to all the participants.

Instructions
1. Distribute the handout to the participants.
2. Ask the participants to complete the handout by reading each statement to themselves and writing the letter M (for myth) or F (for fact) in the space provided. Tell the participants not to spend a lot of time on each statement; if they are unsure of the answer, they should guess and move on to the next statement. Allow 10 minutes for completion.
3. Review the answers by calling on volunteers. Ask them to read aloud the statements and provide their responses and explanations. After each volunteer has responded, ask the other participants whether they agree with the response. Allow them to discuss their views.
4. Provide the correct answers, and clarify any responses by referring to the text.

Training Options
- Divide the participants into four groups, and ask them to work together on the statements before reviewing the answers.
- Begin the activity by asking one participant at a time to read aloud a statement, and then ask that participant and the larger group to respond.
- If time is limited, choose and read aloud select statements, and ask the participants to respond to them.
Men’s Sexual and Reproductive Anatomy and Physiology Myths and Facts

Review the statements below, and write the letter M (for myth) or F (for fact), as appropriate, in the space provided.

1. It is normal for a man to sometimes be unable to achieve or maintain an erection.
2. A man can urinate and ejaculate at the same time.
3. Morning erections can be the result of waking up from a deep sleep.
4. A longer penis is more likely to satisfy a woman than a shorter one.
5. Men are usually capable of holding back their ejaculations as long as they want.
6. Even as men get older, they still can have erections.
7. Just like women, most men are capable of having multiple orgasms.
8. Having sex too frequently can be harmful to a man.
9. A man can still reproduce into older age.
10. In men, ejaculation and orgasm are the same process.
11. Once a man has an erection, it is physically harmful to him if he does not ejaculate.
12. A man cannot impregnate a woman while she is menstruating (has her period).
13. You can tell how long a man’s penis is by looking at the size of his hands, feet, or nose.
14. The penis is a muscle.
15. A man’s penis grows longer with frequent use.
1. **It is normal for a man to sometimes be unable to achieve or maintain an erection.** (FACT)
   Sometimes a man can have difficulty achieving or maintaining an erection. This can result from such conditions as fatigue, illness, and nervousness, or can be a side effect of certain medications. This does not necessarily mean that something is physically or emotionally wrong with him. He will most likely be able to achieve and maintain an erection at another time.

2. **A man can urinate and ejaculate at the same time.** (MYTH)
   Although urine and semen are both expelled through the penis, a special muscle controls the flow of urine and semen. The body can expel only one or the other at a time.

3. **Morning erections can be the result of waking up from a deep sleep.** (FACT)
   The penis automatically becomes erect when a man is in a state of deep sleep. This happens regardless of whether or not he is dreaming or having a dream that is sexual in nature. In fact, a man can achieve an erection many times during the night. Sometimes men wake up in the morning from a dream and have an erection. This has nothing to do with the content of the man’s dream or his current sexual desire.

4. **A longer penis is more likely to satisfy a woman than a shorter one.** (MYTH)
   A woman’s vagina is most sensitive in the first third of its length. Therefore, many women report that the length of the penis does not affect their sexual stimulation or satisfaction during vaginal penetration.

5. **Men are usually capable of holding back their ejaculations as long as they want.** (MYTH)
   There comes a point during a man’s sexual response cycle where he is unable to hold back an ejaculation. This can sometimes be challenging to a couple who are relying on withdrawal as a method of contraception. But this does not mean that a man cannot control his sexual desires or urges or that he cannot stop sexual activity once he is sexually aroused.

6. **Even as men get older, they still can have erections.** (FACT)
   It may take longer for an older man to achieve an erection, but most older men can still achieve and maintain erections.

7. **Just like women, most men are capable of having multiple orgasms.** (MYTH)
   Most men can have only one orgasm during an act of sex and must wait through a period of time after ejaculation before they can have another orgasm.

8. **Having sex too frequently can be harmful to a man.** (MYTH)
   As long as a man is protected against STIs, engaging frequently in sex is not harmful.

9. **A man can still reproduce into older age.** (FACT)
   While women stop releasing eggs after menopause, many men produce sperm and can reproduce throughout their entire lives. However, men’s hormone levels and the amount of ejaculate they produce might decline as they get older.

(continued)
10. In men, ejaculation and orgasm are the same process. (MYTH)
   In men, orgasm is the muscular contraction of the pelvic muscles right before ejaculation, while ejaculation is the expulsion of semen through the penis. Although these two processes usually occur in tandem, they are indeed separate functions. It is possible for a man to have an orgasm without ejaculating, as well as for a man to ejaculate without having an orgasm.

11. Once a man has an erection, it is physically harmful to him if he does not ejaculate. (MYTH)
   While some men may claim this is true, achieving an erection or engaging in sexual activity without ejaculating is not harmful in any way.

12. A man cannot impregnate a woman while she is menstruating (has her period). (MYTH)
   Even when a woman is menstruating, it is possible for her to ovulate (release an egg) and become pregnant. However, a woman is most likely to become pregnant right after ovulation, which usually occurs in the middle of her menstrual cycle—not when she is menstruating.

13. You can tell how long a man’s penis is by looking at the size of his hands, feet, or nose. (MYTH)
   The size of a man’s hands, feet, or nose or any other body part bears no relation to the length of his penis.

14. The penis is a muscle. (MYTH)
   Although the penis is sometimes referred to as a muscle, it is more like a “sponge” that fills with blood.

15. A man’s penis grows longer with frequent use. (MYTH)
   Use has nothing to do with how long a penis might or might not become.
Communicating with Clients about Sexual Anatomy and Behaviors
(page 3.5 of the text)

➔ Training Tips for This Session

During this session:

• Explain to the participants that they may be uncomfortable discussing these terms. Emphasize that it is important to understand the meaning behind the common or slang terms because it is often the only frame of reference that male clients have. It is also important to introduce and use common or simpler non-medical terms when communicating with clients.

• If this material elicits laughter from the participants, you may want to bring it to their attention, mentioning how laughter can often help ease a tense situation. Men who come to health care facilities because of sexual or reproductive health concerns are often anxious or embarrassed, so humor may be appropriate in certain situations to lighten the mood and help the clients to relax. Remind the participants, however, that humor directed at the clients or their concerns will inevitably be counterproductive and that humor is not appropriate in every situation.

♦ Training Activity: Brainstorming Sexual Terms

Objectives

1. To become more comfortable with common or slang sexual terms that male clients are likely to use
2. To become familiar with common or slang terms that service providers may not have heard before

Time

20 minutes

Materials

• Flipchart paper
• Markers
• Pencils or pens
• Tape
• Participant Handout 3-2: Brainstorming Sexual Terms (page 3.23)
Advance Preparation
1. Write the terms “Penis,” “Vagina,” “Oral sex,” and “Penile-vaginal sex” at the top of four flipcharts, one term per flipchart. Display the flipcharts across a blank wall in a row.
2. Make enough copies of Participant Handout 3-2: Brainstorming Sexual Terms to distribute to all the participants.

Instructions
1. Tell the participants that during this activity they will review sexual anatomy and behaviors.
2. Distribute the markers to the participants, and ask them to write all the common or slang terms they know for each medical term on the corresponding flipcharts. Allow five to 10 minutes for completion.
3. Review the responses with the participants, and clarify any meanings of the common or slang terms.
4. Distribute the handout to the participants, and ask them to record the common or slang terms listed on the flipcharts on their handout. Tell them to keep the list to help them remember the terms.
5. Close the activity by discussing the questions below.

Discussion Questions
- Why do you think you were asked to perform this activity?
- Was this activity challenging for you? Why?
- Have you ever heard male clients use terms like these before? If so, how did you respond? If not, do you think it is likely that clients might use such terms at some point during a visit to your facility?
- Do you ever want to use terms like these with clients? If so, in which situations? Which terms would you use when talking to clients?
- Are you unfamiliar with any of the terms on the flipcharts? What other common or slang terms for other body parts or sexual behaviors do you feel are important to define?

Training Options
- Divide the participants into four groups, distribute a flipchart with one of the medical terms to each group, and ask the participants to complete the activity with the other members of their group. Reconvene the group when all the participants are done, and ask a participant from each group to report back to the larger group.
- Distribute the handout, and ask the participants to complete the activity individually.

In both cases, close the activity by asking the discussion questions.
Brainstorming Sexual Terms

Write some of the common or slang terms for the body parts and sexual behaviors that are discussed during the brainstorming activity to keep as a reference for working with male clients. If desired, write other body parts and sexual behaviors that you have heard of but for which you may not know either the medical or common or slang terms. Discuss these with the other participants to identify medical or common or slang terms for them.

<table>
<thead>
<tr>
<th>Medical Term</th>
<th>Common or Slang Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penis</td>
<td></td>
</tr>
<tr>
<td>Vagina</td>
<td></td>
</tr>
<tr>
<td>Oral sex (fellatio or cunnilingus)</td>
<td></td>
</tr>
<tr>
<td>Penile-vaginal sex (sexual intercourse)</td>
<td></td>
</tr>
</tbody>
</table>
Sexual Dysfunction
(pages 3.9–3.11 of the text)

Training Activity: Sexual Dysfunction Case Studies

Objectives
1. To understand the common causes of sexual dysfunction
2. To identify some key messages to provide to clients about sexual dysfunction

Time
30 minutes

Materials
Participant Handout 3-3: Sexual Dysfunction Case Studies (page 3.25)

Advance Preparation
Make enough copies of Participant Handout 3-3: Sexual Dysfunction Case Studies to distribute to all the participants.

Instructions
1. Distribute the handout to the participants.
2. Divide the participants into six groups. Assign one of the four case studies to each group. Ask each group to read the case study and then respond to the discussion questions about their case study. Ask each group to choose a reporter who will summarize the case study and present their findings to the larger group. Allow each group 10 minutes to discuss their answers.
3. Reconvene the group, and ask the reporters of each group to summarize the case study and present their findings to the larger group. Encourage the other participants to share any additional thoughts. Allow 25 minutes for completion.
4. Ask the participants to take note of how these examples of sexual dysfunction were addressed, and encourage the participants to apply the same problem-solving ideas to their own situations and facilities.
Participant Handout 3-3

Sexual Dysfunction Case Studies

**Case Study 1: Excessive Drinking**
Stephen is 35 years old. He has come to the clinic complaining of problems with achieving an erection. He reports that he has had this problem on and off for many years, and it seems to have happened with most of his sexual partners at one time or another. He also says that recently, he has been having more trouble achieving an erection. Stephen spends a lot of his free time drinking alcohol and has been going to bars on weekends more often because he is upset about his “sexual weakness.” When asked, he tells the service provider that he drinks heavily at the bars. He usually returns home drunk, at which time he cannot achieve an erection.

❓ Discussion Questions
- What could be causing Stephen’s sexual dysfunction?
- What would you ask or say to Stephen in order to help him with his problem?

**Case Study 2: Anticipation**
Tshepo is 65 years old. He has come to the clinic complaining of problems with achieving an erection. He reports that he has had this problem the last few years. He does not drink or take any medications, and he does not have any major medical problems. Tshepo says that when he cannot achieve an erection with his partner, he cannot think about other matters. Sexual encounters with his partner are now sources of stress, and he always worries whether or not he will achieve an erection. He is not always successful.

❓ Discussion Questions
- What could be causing Tshepo’s sexual dysfunction?
- What would you ask or say to Tshepo in order to help him with his problem?

**Case Study 3: Self-Imposed Stress**
Javier is 19 years old. He has come to the clinic complaining of problems with having sexual intercourse with his partner. He reports that they have had frequent physical contact, that his partner has often performed oral sex on him, and that he has no trouble achieving an erection or ejaculating during oral sex. Sometimes, however, Javier achieves an erection but then loses it immediately before he inserts his penis. He also sometimes loses his erection while putting on a condom. These experiences have been a great source of stress for Javier. Now, he becomes very nervous before trying to have sex with his partner.

❓ Discussion Questions
- What could be causing Javier’s sexual dysfunction?
- What would you ask or say to Javier in order to help him with his problem?
Case Study 4: Anxiety

Ram is 28 years old. He has come to the clinic complaining of problems with premature ejaculation. He reports that he has had this problem in the past, but it seems particularly troublesome in his current relationship. When having sex with his partner, he usually engages in sexual intercourse for less than a minute before he achieves an orgasm. Ram feels bad about this and is upset that his partner is not sexually satisfied. Now, he experiences high levels of anxiety about achieving an orgasm too early when he has sex. This seems to make the situation worse. He is looking for advice about what he can do to prevent premature ejaculation when he has sexual intercourse.

Discussion Questions

- What could be causing Ram’s premature ejaculation?
- What would you ask or say to Ram in order to help him with his problem?
Training Tips for This Session

During this session:
- Highlight that “sex” is often thought to refer to penile-vaginal sex only, and sexual behaviors can be defined much more broadly.
- Stop often and allow the participants to ask questions and raise concerns. Tell them that if a sexual behavior that is common in their community is not addressed, they should bring it to your attention so that the group can discuss its health implications.

Training Activity: Values about Sexual Behaviors

Objectives
1. To help clarify the participants’ personal values about the range of sexual behaviors that male clients may be likely to engage in
2. To help the participants understand the importance of not letting their personal values about certain sexual behaviors interfere with their professional duty to provide quality sexual and reproductive health services to male clients
3. To describe the range of sexual behaviors and their health implications

Time
45 minutes

Materials
- Large index cards (or sheets of paper)
- Paper
- Markers
- Pencils or pens
- Tape

Advance Preparation
1. Write the following statements on large index cards (or sheets of paper), one statement per card: “OK for me,” “OK for others,” and “Not OK.” Display the cards across a blank wall in a row, leaving enough space under each card so the participants can post the sheets of paper under each card.
2. Write each of the following sexual behaviors on a sheet of paper, one behavior per sheet:
   - Kissing
   - Masturbating
   - Manually stimulating your partner
   - Having penile-vaginal sex
   - Having oral sex
   - Having anal sex
   - Having oral-anal sex (rimming)
   - Placing objects in the rectum
   - Placing objects in the vagina
   - Placing devices on the penis to maintain a longer erection
   - Engaging in “dry sex”
   - Partially suffocating yourself or your partner before or during orgasm
   - Having sex in groups
   - Having sex with a member of the opposite sex
   - Having sex with a member of the same sex
   - Using objects when engaging in sex
   - Getting paid for sex
   - Having sex in public places
   - Being faithful to one partner
   - Having sex with as many partners as you want
   - Having sex with someone without his or her consent
   - Having sex with a person who is much younger
   - Having sex with a person who is much older
   - Having sex with children (pedophilia)
   - Having sex with your spouse
   - Having sex with people you do not know
   - Having sex with animals (bestiality)
   - Practicing sadism and masochism (becoming sexually aroused by providing or experiencing pain and/or humiliation)
   - Having telephone sex
   - Watching pornographic movies
   - Initiating sexual encounters
   - Telling someone a lie in order to have sex with him or her

3. Prepare strips of tape for posting the sheets of paper on the wall.
Instructions
1. Randomly distribute the sexual behavior sheets of paper to the participants, and ask the participants to write their personal responses—“OK for me,” “OK for others,” or “Not OK”—on the sheets. Tell them not to write their names on the sheets. Then ask them to place the sheets face down in a pile. Mix up the sheets. Allow five minutes for completion.

2. Ask the participants to pick up a sheet, take a piece of tape, walk up to the wall, and post the sheet under the appropriate category (“OK for me,” “OK for others,” or “Not OK”), according to what is written on it. Remind them to post the sheet in the category that is written on it even if they personally do not agree with it.

3. When the participants have posted all the sheets on the wall, ask them to look at the categories in which the different sheets were posted. Facilitate a discussion by asking the questions below.

4. Review each of the practices in “Safer Sex” provided on page 3.15 of the text. Allow time for any questions or discussion.

5. Ask the participants to consider the health implications of the range of sexual behaviors, making sure to focus the participants’ attention on the possibly harmful sexual behaviors, which have different levels of risk, provided on page 3.16 of the text.

¿ Discussion Questions
• Are you surprised by the categories in which some of the sheets were posted?
• How common are some of these behaviors in your country?
• How would you feel if you were told that some of the behaviors are “right” or “wrong,” based on the category in which they were posted on the wall?
• How would you feel if you engaged in a sexual behavior that is in the “Not OK” category?
• How do you think male clients might feel when service providers ask them about their sexual behaviors?
• How do you think service providers’ values, attitudes, and biases about certain sexual behaviors might affect their work?
• Which of these sexual behaviors poses obvious consequences for a male client’s health? Why?

() Training Option
If time is limited, read aloud the sexual behaviors provided on pages 3.13–3.16 of the text, and ask the participants to share the possible health implications of each one.
Sexuality Myths and Facts
(pages 3.17–3.18 of the text)

Training Activity: Sexuality Myths and Facts

Objective
To help the participants review the myths and facts about male sexuality and correct any misinformation

Time
30 minutes

Materials
• Pencils or pens
• Participant Handout 3-4: Sexuality Myths and Facts (page 3.31)
• Trainer’s Resource: Sexuality Myths and Facts Answer Sheet (page 3.32)

Advance Preparation
Make enough copies of Participant Handout 3-4: Sexuality Myths and Facts to distribute to all the participants.

Instructions
1. Distribute the handout to the participants.
2. Ask the participants to complete the handout by reading each statement to themselves and writing the letter M (for myth) or F (for fact) in the space provided. Tell the participants not to spend a lot of time on each statement; if they are unsure of the answer, they should guess or move on to the next statement. Allow 10 minutes for completion.
3. Review the answers by calling on volunteers. Ask them to read aloud the statements and provide their responses and explanations. After each volunteer has responded, ask the other participants whether they agree with the response. Allow them to discuss their views.
4. Provide the correct answers, and clarify any responses by referring to the text.

Training Options
• Divide the participants into four groups, and ask them to work together on the statements before reviewing the answers.
• Begin the activity by asking one participant at a time to read aloud a statement, and then ask that participant and the larger group to respond.
• If time is limited, choose and read aloud select statements, and ask the participants to respond to them.
Review the statements below, and write the letter M (for myth) or F (for fact), as appropriate, in the space provided.

1. ______  A man’s nipples are sensitive to sexual arousal.

2. ______  A man who has had sex with another man is a homosexual.

3. ______  A man can sexually assault his wife.

4. ______  Having sex too frequently can be harmful to a man.

5. ______  Only men masturbate.

6. ______  Masturbation is harmless.

7. ______  A man’s sex drive (need to have sex) is stronger than a woman’s.

8. ______  Men need to have sex in order to maintain good health.

9. ______  Alcohol makes it easier for men to become aroused.

10. ______  In a same-sex sexual relationship, one person usually takes the male role and the other takes the female role.
1. **A man’s nipples are sensitive to sexual arousal. (FACT)**
   Although men’s breasts and nipples are not often considered sexual, they are, in fact, sensitive to touch and sexual arousal. There is variation in nipple sensitivity among men, and nipple stimulation may or may not be perceived as enjoyable by a particular individual.

2. **A man who has had sex with another man is a homosexual. (MYTH)**
   Having a same-sex sexual experience does not mean a person is homosexual. Many people have sex with members of their own sex as a way of exploring their sexuality. What determines whether or not a man is homosexual are his feelings, not his sexual behaviors. Homosexual men feel primarily attracted to other men. Therefore, even if a man does engage in sexual activity with another man, that does not necessarily make him a homosexual or mean that he is necessarily or exclusively attracted to other men.

3. **A man can sexually assault his wife. (FACT)**
   Any time a man engages in sexual contact with his wife without her consent should be considered a sexual assault.

4. **Having sex too frequently can be harmful to a man. (MYTH)**
   As long as a man is protected against STIs, engaging in sex frequently is not harmful.

5. **Only men masturbate. (MYTH)**
   Both men and women masturbate.

6. **Masturbation is harmless. (FACT)**
   Masturbation does not cause harm to anyone of any age, unless an object is inserted into the vagina or anus in a harmful way.

7. **A man’s sex drive (need to have sex) is stronger than a woman’s. (MYTH)**
   Although it is often believed that men have a stronger sex drive than women, this is not the case. Sex drives vary from person to person, and both men and women can experience different levels of sex drive at different times.

8. **Men need to have sex in order to maintain good health. (MYTH)**
   It is normal and healthy for both men and women to have sexual feelings and a desire to express them, but neither men nor women need to have sex in order to be healthy.

9. **Alcohol makes it easier for men to become aroused. (MYTH)**
   Actually, alcohol has the opposite effect. Alcohol is a depressant. It decreases the flow of blood to the genital area, making it more difficult to have an erection and experience orgasm.

10. **In a same-sex sexual relationship, one person usually takes the male role and the other takes the female role. (MYTH)**
    In a same-sex sexual relationship, just as in an opposite-sex sexual relationship, both partners have the freedom to choose their gender roles and the roles they may play during sexual activity. There is no need for one person to always take the male role and the other to always take the female role.
Common Client Concerns
(pages 3.18–3.20 of the text)

Training Activity: Common Questions Cards

Objective
To practice answering common questions about men’s sexual and reproductive anatomy and physiology and sexual dysfunction

Time
30 minutes

Materials
Small index cards (or sheets of paper)

Advance Preparation
1. Choose five or more of the questions on pages 3.19–3.20 of the text.
2. Write the questions on small index cards (or sheets of paper), one question per card.

Instructions
1. Divide the participants into five groups, and randomly distribute one or two of the cards to each group.
2. Ask each group to imagine that a male client has asked the question on the card during a counseling session. Next, ask each group to decide how the service provider might respond in a way that meets the client’s needs. Allow each group five to 10 minutes to discuss their answer.
3. Reconvene the group, and ask a participant from each group to read aloud the group’s question and present their findings to the larger group. Encourage the other participants to share any additional thoughts.
4. Close the activity by discussing the questions below.

Discussion Questions
• How did you feel about answering some of these questions?
• What are some common themes of men’s concerns?
• How much information does a service provider need to give a male client about these concerns?
• What can a service provider do if he or she is not sure how to respond to a male client who has these concerns?
Training Options

- If time permits, you may wish to allow each group to come up with some of their own questions that male clients may have about sexual and reproductive anatomy and physiology and sexual dysfunction. Distribute blank index cards to each group, and ask each group to write their questions on the cards. You can collect the cards, shuffle them, and then randomly distribute them to the groups to work on.
- If time is limited, choose and read aloud select questions and ask the participants to respond to them.
Condoms, Withdrawal, Vasectomy, and Fertility-Awareness Methods
(pages 3.21–3.27, 3.26, 3.27–3.29, and 3.29–3.30 of the text)

While couples have many contraceptive methods to choose from, for the purposes of this training, only the methods that involve men’s direct participation—condoms, withdrawal, vasectomy, and fertility-awareness methods—are covered in detail. Later in the chapter, ways that men can play a supportive role in all methods of contraception are covered.

Training Tips for These Sessions

Note: In the text, the section “Condom Instructions” (pages 3.23–3.25) directly follows the section “Condoms” (pages 3.21–3.23). However, you may find it more useful to present the content about all four male methods first and then present the condom instructions, rather than following the order of content presented in the text.

During these sessions, highlight the following points about each method if they are not mentioned during discussion:

**Condoms**

- Use Figures 3-4 and 3-5, provided on pages 3.22 and 3.24–3.25 of the text, when describing how condoms work and their features.
- Tell the participants that during this activity they will be discussing and practicing the correct use of condoms after all four male methods have been described.

**Withdrawal**

- Use Figure 3-2, provided on page 3.6 of the text, when describing how withdrawal works.
- Emphasize that practice can help a man use withdrawal more effectively.
- Mention that withdrawal is more effective for partners who are familiar with each other’s sexual responses than for new sexual partners.
- Describe the options a couple has to reduce the risk of pregnancy if the male partner is unable to withdraw before ejaculation. Remind the participants that the man has an important responsibility to inform his partner that he ejaculated inside her because a woman may not always be able to tell that she has semen inside her vagina.

**Vasectomy**

- Use Figures 3-2 and 3-3, provided on pages 3.6 and 3.7 of the text, when describing how vasectomy works.
- Describe the differences between incisional and no-scalpel vasectomy.
- Remind the participants that vasectomy does not affect sexual functioning.

**continued**
Training Tips for These Sessions (continued)

Fertility-Awareness Methods

• Use Figure 3-3 on page 3.7 of the text when describing how fertility-awareness methods work.

• Remind the participants that all fertility-awareness methods are based on changes in fertility that occur during a woman’s monthly cycle.

• Remind the participants that most women have an egg available for fertilization only a few days out of the month. Therefore, the purpose of fertility awareness is to identify the time during a woman’s ovulation cycle that an egg is mostly likely to be present. Abstinence during that time can be an effective form of contraception.

• Inform the participants that some fertility-awareness methods are very simple and require nothing more than a calendar and a pen, while others require careful observations of the changes in a woman’s body that occur during her cycle. Remind the participants that whichever fertility-awareness method a client uses, he or she should always work with a family planning specialist; clients should not try to use this method on their own.
Training Activity: Discussion of Male Methods

Objective
To help the participants review basic information needed to counsel men about male methods of contraception

Time
50 minutes

Materials
No materials are needed.

Advance Preparation
No advance preparation is needed.

Instructions
1. Divide the participants into four groups. Assign one of the male methods of contraception—condoms, withdrawal, vasectomy, and fertility-awareness methods—to each group.
2. Ask each group to discuss the method by answering the following questions:
   – How does this method work?
   – What are the advantages and disadvantages of this method?
   – What might make couples want to use this method?
   – What might make couples not want to use this method?
   Allow 10 minutes for discussion.
3. Reconvene the group, and ask a participant from each group to report on their method to the larger group. Encourage the other participants to add any further information about the method if they desire. Allow 30 minutes for completion.
4. After each group finishes discussing their method, add any further information that the groups may have left out.
Condom Instructions
(pages 3.23–3.25 of the text)

➔ Training Tips for This Session

During this session:

• Tell the participants that in order for them to explain condom use adequately to clients, it is important that they have experience with putting on a condom correctly.

• Describe the additional information that clients need to know about the effective use of condoms. Emphasize what to do if a condom breaks or slips during sex.

• Highlight the fact that because breakage due to degradation is a common reason for condom failure, clients need to pay particular attention to lubricants that are safe and unsafe to use with condoms. Refer to the chart on page 3.27 of the text. Explain that “unsafe” means the lubricant will degrade the condom.

• Point out that condoms need to be stored properly to remain effective. A condom may be left in a wallet for a day, but it should not be kept there over an extended period of time.

💎 Training Activity: Condom Steps

Objectives
1. To examine the correct steps for using a condom
2. To identify places where people make mistakes using condoms

Time
25 minutes

Materials
• Large index cards (or sheets of paper)
• Markers
Advance Preparation
On large index cards (or sheets of paper), write each of the steps below, which partners need to follow to use a condom correctly. (Note: The steps are listed in the correct order.)
• Talk about condom use.
• Buy or get condoms.
• Store the condoms in a cool, dry place.
• Check the date made or expiration date.
• The man has an erection.
• Establish consent and readiness for sex.
• Open the condom package.
• Unroll the condom slightly to make sure it faces the correct direction over the penis.
• Place the condom on the tip of the penis.
• Squeeze the air out while leaving room at the tip of the condom.
• Roll the condom onto the base of the penis as you hold the tip of the condom.
• The man inserts his penis.
• The man ejaculates.
• After ejaculation, hold the condom at the base of the penis while still erect.
• The man removes his penis from his partner.
• Take the condom off, and tie it to prevent spills.
• Throw the condom away.

Instructions
1. Randomly distribute the index cards (or sheets of paper) to the participants.
2. Ask the participants to hold up their cards so that others can see them. Ask the participants to arrange themselves in the order that the steps should be in. If a participant does not have a card, he or she can help the others arrange themselves in the correct order. (If the group has fewer than 18 participants, ask the participants to place the cards on the floor in the order of first step to last.)
3. Close the activity by discussing the questions below.

? Discussion Questions
• What was challenging about this activity?
• Were you unsure of the order of any of the steps? If so, why? Could some of the steps have gone in more than one place?
• Do you think most people who use condoms follow these steps? Why or why not?
Training Activity: Practice Putting on a Condom Correctly

Objective
To demonstrate the correct use of a condom

Time
25 minutes

Materials
• Condoms
• Penis models

Advance Preparation
No advance preparation is needed.

Instructions
1. Split the participants into pairs. Ask each pair to practice demonstrating and explaining how to put a condom on a penis model correctly, using the instructions in Figure 3-5. Ask one member of each pair to act as the staff member and the other to act as the client. Tell the “clients” to ask questions if the instructions are vague or unclear. Allow 10 minutes for completion.
2. Reconvene the group when all the participants are done.
3. Close the activity by discussing the questions below.

Discussion Questions
• When demonstrating how to use a condom, what is the key information you need to impart to clients?
• What problems, if any, do you anticipate about demonstrating correct condom use with clients?

Training Options
• If penis models are not available, ask the participants to demonstrate on a substitute, such as a person’s index and middle finger. Remind them that when they teach clients, they should explain that even though they may be demonstrating condom use on a model or fingers, the condom needs to be used on a man’s penis in order to be an effective contraceptive.
• Some service providers and clients may be uncomfortable talking about or working with condoms. If you think it would be useful to conduct an activity to desensitize the issue, ask the participants to inflate (blow up) unlubricated condoms, and then ask a participant to put the condom over his or her hand or head. This is a good way to reduce anxiety and show the participants how strong condoms are. This activity also shows the participants that condoms can accommodate a large-sized penis.
Men’s Role in Contraception
(pages 3.30–3.31 of the text)

Training Activity: Supporting and Hindering Contraceptive Use

Objectives
1. To identify ways that men can support and hinder contraceptive use
2. To identify ways that service providers can help men play a supportive role in family planning

Time
30 minutes

Materials
• Flipchart paper
• Markers

Advance Preparation
Write the headings “Ways to Support Partner’s Contraceptive Use” and “Ways to Hinder Partner’s Contraceptive Use” on flipcharts, one heading per flipchart.

Instructions
1. Divide the participants into two groups. Tell the members of group 1 that they will be discussing ways that a man can support his partner’s use of a female method of contraception. Tell the members of group 2 that they will be discussing ways that a man can hinder his partner’s use of a female method of contraception.
2. Using a fishbowl process, ask the members of group 1 to sit in the middle of the room and discuss their topic loudly enough for the members of group 2 to hear it. Ask the members of group 2 to sit in a circle around group 1 and listen but not participate in the discussion. Allow 10 minutes for group 1 to discuss the topic. Then write their responses on the flipchart labeled “Ways to Support Partner’s Contraceptive Use.”
3. Next, ask the members of group 2 to sit in the middle of the room and discuss their topic, with the members of group 1 sitting around them and listening but not participating. Allow 10 minutes for group 2 to discuss the topic. Then write their responses on the flipchart labeled “Ways to Hinder Partner’s Contraceptive Use.”
4. Reconvene the group, and facilitate a discussion by asking the questions below.
5. Refer to pages 3.30–3.31 of the text, and mention any points that the groups did not discuss.
Discussion Questions

- Typically, how involved are men in decisions about contraceptive use in your local area?
- What can service providers do to help men use male methods of contraception and be more supportive of their partners’ use of female methods of contraception?

Training Tip

Make sure the participants have adequate time to discuss the last question. For this question, record the groups’ responses on a flipchart. Then ask the participants to identify the items on the list that service providers at their facilities are currently doing to involve men in contraceptive use. Mark an X next to those items. If the service providers are not doing certain items on the list, ask the group to consider what would be required to conduct those activities.
Sexually Transmitted Infections (STIs)
(pages 3.33–3.40 of the text)

Training Activity: The STI Handshake

Objectives
1. To help the participants understand the ways that sexually transmitted infections (STIs) are spread from one person to another
2. To help the participants understand how STIs can spread rapidly in a community through sexual partners

Time
30 minutes

Materials
- Small index cards (or sheets of paper)
- Markers
- Pencils or pens

Advance Preparation
1. Prepare enough small index cards (or sheets of paper) to distribute to all the participants.
2. Mark the cards as follows: Mark one card with an X, one third of the cards with a C, and one third of the cards with an N. Leave the rest of the cards blank.

Instructions
1. Randomly distribute one index card to each participant. Ask the participants to write their names on the top right-hand corner of the card. Tell them to hold onto the card throughout this activity.
2. Ask the participants to walk around the room, shake hands with five other people, and then sign each other’s cards. (If the group has fewer than 15 people, ask each participant to shake hands with only three other people.)
3. Tell the participants that once they have shaken hands with five other people, their card should contain five signatures. After the participants have completed their task, ask them to return to their seats.
4. Inform the group that this is an activity to demonstrate how quickly STIs can spread within a community. Review the definition of STIs and the information about how they are transmitted that are provided on page 3.33 of the text.

Sexually transmitted infections (STIs) are infections that can be passed from one person to another person by sexual contact, although in some cases some STIs can be transmitted by other means as well.
5. Ask the participants if STIs can be transmitted between two people who are uninfected. Acknowledge that STIs cannot be transmitted in this manner and that they can be transmitted only via an infected person.

6. Explain that for the purposes of this activity, one participant will represent a person who is infected with an STI. Remind the participants that this person does not actually have an STI but will act as if he or she does.

7. Ask the participants to look at their card and see if there is an X on it. Ask the person with the X card to stand up. Inform the person standing that for the purposes of the activity, you will say that he or she has an STI. Make the point that you cannot tell if someone has an STI simply by looking at the person. In fact, many individuals who have STIs do not even know that they are infected.

8. Next, ask the participants if STIs can be transmitted by shaking hands. Acknowledge that while STIs cannot be transmitted this way, for the purposes of this activity, you will say that shaking hands will represent having sex with another person. Therefore, the participants will have put themselves at risk for an STI with anyone with whom they shook hands.

9. Ask the participant with the X card to read aloud the names of the people who signed his or her card. Next, ask those people to stand up. Note that all the people who are standing may now be infected with the STI. Ask the people who are standing to read aloud the names of those with whom they shook hands; ask those people to stand. Continue to do this until all the participants are standing. If a person’s name has been called more than once, remind the participants that this person has put him- or herself at risk multiple times.

10. Now that all the participants are standing, ask them to see if they have an N on their card. Inform the group that everyone with an N on his or her card abstained and said “no” to sex, and, therefore, is not infected with the STI. Tell those individuals to be seated.

11. Next, ask the participants if they have a C on their card. Inform the group that everyone with a C on his or her card used a condom consistently and correctly every time they had sex, and, therefore, were protected from STIs. Tell those individuals to be seated.

12. Inform the participants that everyone who is still standing had unprotected sex and became infected with an STI. Ask the group to look around the room and count how many people have been infected with an STI. Tell those individuals who are still standing to be seated. Remind the participants that this is just a game and that STIs are not transmitted by shaking hands or signing someone’s card. Tell all the participants to be seated.

13. Facilitate a discussion by asking the following questions.

? Discussion Questions

- How many people were infected with an STI at the beginning of the activity? (Remind the group again that the person who had the X card is not actually infected with an STI.)
• How many people were infected with an STI at the end of the activity? Did the person who was originally infected directly infect every other person in the room?

• How does this activity help explain how STIs can spread so quickly in a community?

• Did anyone realize that he or she was infected before passing on the STI to someone else?

• Does anyone think that in real life STIs are often passed from one person to another without someone realizing that he or she is infected? Why is this?

14. Briefly review the section “Risk Factors for Transmitting and Contracting STIs,” provided on page 3.36 of the text.
Common STIs
(pages 3.33–3.35 of the text)

Training Activity: Matching Game

Objective
To help the participants understand the signs and symptoms of common sexually transmitted infections (STIs)

Time
45 minutes

Materials
• Small index cards (or sheets of paper)
• Markers
• Tape

Advance Preparation
1. Prepare three sets of differently colored small index cards (or sheets of paper) as follows:
   • Write on 10 cards of one color the name of each common STI listed in the chart provided on pages 3.34–3.35 of the text, one STI per card.
   • Write on 10 cards of another color the term “Signs and Symptoms” and list the signs and symptoms of each common STI listed in the chart provided on pages 3.34–3.35 of the text, one STI per card.
   • Write on 10 cards of a third color the term “Curable” on six cards and the term “Incurable” on four cards.
2. Prepare strips of tape for posting the cards on the wall.

Instructions
1. Display the index cards (or sheets of paper) with the names of the common STIs across a blank wall in a row.
2. Divide the participants into pairs. (If the group has more than 20 participants, divide the participants into groups of three.)
3. Randomly distribute the “Signs and Symptoms,” “Curable,” and “Incurable” cards to the pairs. Tell the participants that during this activity they will post the cards that they have in their hands on the wall under the corresponding STI. Explain that the cards of the one color indicate the signs and symptoms of the STI, and the cards of the other color indicate whether the STI is curable or incurable. Allow five minutes for completion.
4. Ask the participants to look at the wall and call out if they do not agree with the placement of any cards. Allow them to move the cards around, even cards they did not post, and ask them to explain their reason for moving the cards. When the participants are done, move the cards around, if needed, so that all the cards are placed correctly.
5. Review the correct answers by referring the participants to the chart provided on pages 3.34–3.35 of the text.
Risk Factors for Transmitting and Contracting STIs and Reducing Risk
(pages 3.36–3.38 and 3.37–3.41 of the text)

Training Tips for This Session

During this session:

- Review the risk factors provided on page 3.36 of the text. Explain that having multiple partners or having partners who have other partners can greatly increase the risk for STIs.
- Explain that sexual behaviors carry different levels of risk and that people can take precautions in order to reduce their level of risk.
- Describe the principle underlying the harm-reduction approach: to reduce risk as much as possible when avoiding high-risk behaviors will not or cannot be achieved.
- Describe the various safer-sex behaviors.

Training Activity: Levels of Risk

Objectives

1. To identify the level of HIV risk of various risky behaviors
2. To identify sexually pleasurable behaviors that are classified as low risk for HIV infection

Time

30 minutes

Materials

- Large index cards (or sheets of paper)
- Markers
- Tape

Advance Preparation

1. Write each of the following terms on colored large index cards (or sheets of paper), one term per card: “High Risk,” “Medium Risk,” “Low Risk,” “Very Low Risk,” and “No Risk.”
2. Write each of the following sexual behaviors (or other behaviors that are applicable to your area or client population) on cards, one behavior per card:
   - Abstinence
   - Masturbation
   - Performing oral sex on a man not using a condom, and having ejaculate in the mouth
• Performing oral sex on a woman not using a barrier
• Having penile-vaginal sex not using a condom
• Having penile-vaginal sex using a condom
• Hugging a person who has HIV infection/AIDS
• Deep (tongue) kissing
• Rubbing genitals together, unclothed, without penetration
• Dry kissing
• Manually stimulating a partner’s genitals
• Having sex with a monogamous, uninfected partner
• Performing oral sex on a man not using a condom, and not having ejaculate in the mouth
• Performing oral sex on a man using a condom
• Having anal sex using a condom
• Having anal sex not using a condom
• Performing anal-oral sex (rimming)
• Performing oral sex on a woman using a barrier
• Fantasizing

3. Prepare strips of tape for posting the cards on the wall.

Instructions

1. Display the level-of-risk cards (or sheets of paper) (“High Risk,” “Medium Risk,” “Low Risk,” “Very Low Risk,” and “No Risk”) high across a wall, and tell the participants that during this activity they will review the risks for contracting STIs, which is important for clients and service providers to understand.

2. Place the sexual-behavior cards face down in a stack. Ask the participants to choose a card and post it on the wall under the appropriate level-of-risk card with respect to the transmission of STIs.

3. Once the participants have posted all the sexual-behavior cards on the wall, ask the participants to review the categories in which the cards have been placed. Then ask for volunteers to state whether they:
   • Disagree with the placement of any cards
   • Do not understand the placement of any cards
   • Had difficulty placing any cards

4. Discuss the placement of select cards, particularly those that are not clear-cut in terms of risk or cards that are clearly misplaced. Begin by asking the participants why they think the card was placed in a certain category.

5. Ask the participants to look at the behaviors in the “Low Risk,” “Very Low Risk,” and “No Risk” categories, and explain how this information may affect the kinds of information they provide to clients. Emphasize the idea that some pleasurable sexual behaviors are of low, very low, or no risk.
6. Ask the participants to look at the behaviors in the “High Risk” category. Explain that because many clients will continue to engage in those behaviors even when they know the risks involved, it is important to provide all clients with information about how to reduce their risk for STIs while engaging in these behaviors.

7. Describe the principles of harm reduction and safer sex, and ask the participants how harm reduction applies to sexual behaviors. Emphasize:
   - The messages a health care worker would want to give a client about any particular sexual behavior (while the issues can be complicated, clients should receive a simple message before leaving a facility)
   - That risk depends on the context of the behavior or other factors, including gender; whether or not the partner is infected; whether or not the person is the “giver” or “receiver” of the sexual behavior; and the difficulty of knowing whether or not one’s partner is infected
Gender and STIs
(pages 3.40–3.41 of the text)

Training Activity: Discussion Topics

Objective
To help the participants understand how gender issues can affect the transmission of HIV and other STIs

Time
30 minutes

Materials
No materials are needed.

Advance Preparation
No advance preparation is needed.

Instructions
Facilitate a discussion by asking the participants the questions below. Consult the text to correct any misinformation about each question if needed.

- Physical differences between women and men
  - How are women’s bodies more physically vulnerable to contracting STIs than men’s bodies?
  - Why are women’s bodies less likely to present STI symptoms?

- Socially constructed expectations of male behavior
  - What is it about men and expectations about sexual behavior that make men vulnerable to STIs?
  - What impact does this have on women’s vulnerability to STIs?
  - Why may men be less likely to seek out proper diagnosis and treatment for STIs?

- Power imbalances between men and women
  - How can an imbalance of power between men and women make it harder for women to protect themselves from and seek treatment for STIs?
  - How does this imbalance of power affect:
    - Condom negotiation?
    - Condom use?
    - Sexual decision making?
    - Partner notification of STI infection?
Training Option

To conduct this activity as a small-group activity, divide the participants into three groups and assign one of the three discussion topics to each group. Ask each group to discuss the topic and then write their responses on a flipchart. Allow each group 10 minutes to discuss the topic. Reconvene the group, and ask a participant from each group to read aloud the discussion topic and report their responses to the larger group. Encourage the other participants to share any additional thoughts.
Training Activity: STI Myths and Facts

Objective
To help the participants review the myths and facts about sexually transmitted infections (STIs) and correct any misinformation

Time
45 minutes

Materials
• Pencils or pens
• Participant Handout 3-5: STI Myths and Facts (page 3.54)
• Trainer’s Resource: STI Myths and Facts Answer Sheet (page 3.55)

Advance Preparation
Make enough copies of Participant Handout 3-5: STI Myths and Facts to distribute to all the participants.

Instructions
1. Distribute the handout to the participants.
2. Ask the participants to complete the handout by reading each statement to themselves and writing the letter M (for myth) or F (for fact) in the space provided. Tell the participants not to spend a lot of time on each statement; if they are unsure of the answer, they should guess or move on to the next statement. Allow 10 minutes for completion.
3. Review the answers by calling on volunteers. Ask them to read aloud the statements and provide their responses and explanations. After each volunteer has responded, ask the other participants whether they agree with the response. Allow them to discuss their views.
4. Provide the correct answers, and clarify any responses by referring to the text.
Training Options

- Divide the participants into four groups, and ask them to work together on the statements before reviewing their answers.
- Begin the activity by asking one participant at a time to read aloud a statement, and then ask that participant and the larger group to respond.
- If time is limited, choose and read aloud select statements, and ask the participants to respond to them.
### Participant Handout 3-5

#### STI Myths and Facts

Review the statements below, and write *M* (for myth) or *F* (for fact), as appropriate, in the space provided.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>________</td>
<td>1. A man cannot transmit a sexually transmitted infection (STI) if he withdraws before ejaculation.</td>
</tr>
<tr>
<td></td>
<td>2. It is possible to get an STI from having oral sex.</td>
</tr>
<tr>
<td></td>
<td>3. A monogamous person cannot contract an STI.</td>
</tr>
<tr>
<td></td>
<td>4. If you have an STI once, you become immune to it and cannot get it again.</td>
</tr>
<tr>
<td></td>
<td>5. You can become infected with more than one STI at a time.</td>
</tr>
<tr>
<td></td>
<td>6. You cannot contract AIDS by living in the same house as someone who has the disease.</td>
</tr>
<tr>
<td></td>
<td>7. You can always tell if a person has an STI by his or her appearance.</td>
</tr>
<tr>
<td></td>
<td>8. Condoms reduce the risk of contracting STIs, including HIV.</td>
</tr>
<tr>
<td></td>
<td>9. A person infected with an STI has a higher risk of contracting HIV.</td>
</tr>
<tr>
<td></td>
<td>10. STIs are a new medical problem.</td>
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<tr>
<td></td>
<td>11. Herbal treatments are effective in curing STIs.</td>
</tr>
<tr>
<td></td>
<td>12. People usually know that they have an STI within two to five days of being infected.</td>
</tr>
<tr>
<td></td>
<td>13. Abstinence is the only 100% effective safeguard against the spread of STIs.</td>
</tr>
<tr>
<td></td>
<td>14. It is possible to get some STIs from kissing.</td>
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<tr>
<td></td>
<td>15. Youth are particularly vulnerable to STIs.</td>
</tr>
<tr>
<td></td>
<td>16. Anal sex is the riskiest form of sexual contact.</td>
</tr>
<tr>
<td></td>
<td>17. Special medicines can cure HIV infection.</td>
</tr>
<tr>
<td></td>
<td>18. HIV is a disease that affects only sex workers and homosexuals.</td>
</tr>
<tr>
<td></td>
<td>19. HIV can be transmitted from one person to another when sharing needles for drugs.</td>
</tr>
<tr>
<td></td>
<td>20. A man can be cured of an STI by having sex with a girl who is a virgin.</td>
</tr>
</tbody>
</table>
1. **A man cannot transmit a sexually transmitted infection (STI) if he withdraws before ejaculation. (MYTH)**
   Withdrawal does not eliminate the risk of STIs. Pre-ejaculatory fluid from the penis can contain infectious organisms, and organisms on the skin of a man’s genitals can be transmitted to another person.

2. **It is possible to get an STI from having oral sex. (FACT)**
   The person performing and the person receiving oral sex are at different levels of risk. The person receiving oral sex is at risk only if his or her partner has an open sore or ulcer in the mouth or on the face. The person performing oral sex is at high risk if he or she has an open sore or ulcer on the lips or face or if he or she has ejaculate or vaginal fluids in the mouth. To protect against STIs, an individual should always use a latex or plastic barrier, such as a male condom, female condom, or dental dam, when having oral sex.

3. **A monogamous person cannot contract an STI. (MYTH)**
   Individuals who are faithful to their partner may still be at risk for STIs if their partner engages in sexual activity with other people. In addition, individuals who are currently monogamous with their partner may have contracted an STI from someone else in the past; therefore, they may have an STI without knowing it and/or without telling their current partner.

4. **If you have an STI once, you become immune to it and cannot get it again. (MYTH)**
   Contracting an STI does not make a person immune to future infections. If a person is treated and cured but his or her partner(s) is not treated, the cured person can get the infection again. The cured person can also get the infection from another partner. Repeat infections can put people at risk for damage to the genital tract (e.g., scarred fallopian tubes) or chronic infection (e.g., chronic pelvic inflammatory disease [PID]).

5. **You can become infected with more than one STI at a time. (FACT)**
   A person can have more than one STI at the same time. For example, more and more people are now contracting chlamydia and gonorrhea together.

6. **You cannot contract AIDS by living in the same house as someone who has the disease. (FACT)**
   HIV, the infection that causes AIDS, is transmitted through exposure to infected blood and other infected body secretions. Living in the same house with someone who is HIV-infected does not put those in contact with him or her at risk unless they share items that have been exposed to the infected person’s blood or genital secretions (e.g., through the use of shared toothbrushes, razors, or douching equipment).

7. **You can always tell if a person has an STI by his or her appearance. (MYTH)**
   Sometimes, STIs produce no symptoms or no visible symptoms. In fact, many people have STIs for long periods of time without knowing that they are infected. In addition, no type of person is immune from STIs. People of different races, sexes, religions, socioeconomic classes, and sexual orientations all contract STIs.

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_continued_
8. **Condoms reduce the risk of contracting STIs, including HIV. (FACT)**
   After abstinence, latex condoms are the most effective way to prevent STIs, including HIV infection. However, latex condoms are not 100% effective. Some groups have reported inaccurate research suggesting that HIV can pass through latex condoms, but this is not true. In fact, laboratory tests show that no STI, including HIV, can penetrate latex condoms.


9. **A person infected with an STI has a higher risk of contracting HIV. (FACT)**
   Both ulcerative STIs (those that cause sores) and nonulcerative STIs increase the risk for transmitting and contracting HIV. Ulcerative STIs increase the risk for HIV infection because the ulcers provide easy entry into the body via the HIV virus. Nonulcerative STIs may enhance HIV transmission for two reasons: They increase the number of white blood cells in the genital tract, and genital inflammation may cause microscopic cuts that can allow the HIV virus to enter the body.

10. **STIs are a new medical problem. (MYTH)**
    STIs have existed since the beginning of recorded history. Evidence of medical damage caused by STIs appears in ancient writings, art, and skeletal remains.

11. **Herbal treatments are effective in curing STIs. (MYTH)**
    Antibiotics are the only proven effective treatment for bacterial STIs, which include chlamydia, gonorrhea, and syphilis. Currently, no cure exists for viral STIs, which include genital warts, hepatitis, herpes, and HIV. Often, clients who receive STI care from nonmedical personnel believe that their STI has been treated, but this is not so. This misconception prevents them from getting adequate treatment, which puts their health and the health of their partner(s) at great risk.

12. **People usually know that they have an STI within two to five days of being infected. (MYTH)**
    Many people never have symptoms, and others may not have symptoms for weeks or years after being infected.

13. **Abstinence is the only 100% effective safeguard against the spread of STIs. (FACT)**
    Abstinence from sex is the best way to prevent the spread of STIs. However, latex condoms are the next best option. When used consistently and correctly, these condoms prevent the transmission of STIs very effectively.

14. **It is possible to get some STIs from kissing. (FACT)**
    It is rare but possible to get syphilis through kissing if the infected person has chancres (small sores) in or around the mouth. Kissing can also spread the herpes virus.

15. **Youth are particularly vulnerable to STIs. (FACT)**
    STIs are disproportionately higher among young people than adults for both biological and behavioral reasons. The highest reported cases of STIs are among young people.
(ages 15 to 24). In developed countries, two-thirds of all reported cases of STIs occur among those under age 25.


16. **Anal sex is the riskiest form of sexual contact. (FACT)**
   Anal intercourse carries a higher risk of HIV transmission than other types of sexual contact. During anal sex, the penis can tear the mucous membrane of the anus, which provides the virus with an entry point into the bloodstream.

17. **Special medicines can cure HIV infection. (MYTH)**
   Currently, there is no cure or vaccine for HIV infection. Some drugs can slow down the production of the virus in an infected person, but these drugs are expensive and difficult to access.

18. **HIV is a disease that affects only sex workers and homosexuals. (MYTH)**
   Anyone can become infected with HIV. A person’s risk for HIV is not related to the type of person he or she is, but rather to the behavior he or she engages in.

19. **HIV can be transmitted from one person to another when sharing needles for drugs. (FACT)**
   Sharing needles during injectable drug use carries a very high risk of HIV transmission. Infected blood is easily passed from one person to another via an infected needle or other equipment used to prepare or inject drugs.

20. **A man can be cured of HIV by having sex with a girl who is a virgin. (MYTH)**
   Some people believe this misconception, but it is not true. Virgins do not have any power to heal HIV-infected individuals. There is no way to cure HIV once a person is infected.
Training Activity: Sexual Jeopardy

Objective
To offer the participants a fun, nontraditional format in which to learn about men’s sexual and reproductive health

Time
1 hour per game

Materials
- Flipchart paper (or a chalkboard)
- Markers (or chalk and an eraser)
- Easel
- Tape
- Trainer’s Resource: “Sexual Jeopardy” Game Questions and Answers (page 3.60)

Advance Preparation
1. Create a “Sexual Jeopardy” board using flipchart paper, an easel, and markers or using a chalkboard, chalk, and an eraser. See the diagram below for an example of the “Sexual Jeopardy” board.

Example of a “Sexual Jeopardy” Board

<table>
<thead>
<tr>
<th>Men’s Sexual and Reproductive Anatomy and Physiology</th>
<th>Sexual Dysfunction</th>
<th>Infertility</th>
<th>Cancers of the Reproductive System</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
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</tbody>
</table>

2. Decide which four categories will be included in the “Sexual Jeopardy” game. Six categories that cover information that is addressed in the text have been developed for this manual: “Men’s Sexual and Reproductive Anatomy and Physiology,” “Sexual Dysfunction,” “Infertility,” “Cancers of the Reproductive System,” “STIs,” and “Contraception.” You can develop other categories and questions as you see fit.
3. Write the four categories that you have decided to include from the six categories listed in the Trainer’s Resource: “Sexual Jeopardy” Game Questions and Answers (pages 3.60–3.63).

**Instructions**

1. Explain to the participants that during this activity they will play a game called “Sexual Jeopardy,” which is based on a popular television game show in the United States called “Jeopardy.” Unlike the television game show, this game discusses issues around sexual and reproductive health.

2. Explain that each category has a list of five questions. The easier questions are worth fewer points (the easiest is worth 100 points), and the more difficult ones are worth more (the hardest is worth 500 points).

3. Divide the participants into two teams. Explain that the team members should discuss their answer together, and then have a spokesperson present it. Any other answers that other team members shout out will not be accepted. Ask each team to designate a spokesperson for the team.

4. Take turns giving each team an opportunity to select from the board. Allow the team to select categories and question values from the board, by consensus—for example, “I’ll take ‘Sexual Dysfunction’ for 300, please.” Ask the question. If the team answers correctly, it is credited with the points. If the team answers incorrectly, it loses half the points. For example, if a team answers a 300-point question incorrectly, it will lose 150 points.

5. Continue until all the questions are answered. The winner is the team with the most points.

6. After all the questions have been answered, you can opt to provide a “Final Jeopardy” question. Present this question to both teams. Each team develops its own answer quietly, so the other team cannot hear it. Both teams also decide how many points they want to risk on their answer. The team can bet as little or as much as it wishes. Remind the teams that if their answer is incorrect, they will lose all the points they bet, not just half of them! The winner is the team with the most points after the “Final Jeopardy” question.

7. After finishing the game, remind the participants that everybody ends up winning because they are all having fun and learning important information at the same time.
“Sexual Jeopardy” Game Questions and Answers

Men’s Sexual and Reproductive Anatomy and Physiology

100 Name the male organs that produce sperm. . . . Testes/testicles

200 On average, do males or females take longer to move through the sexual-response cycle (from excitement to orgasm)? . . . Females

300 True or false: Is it normal for young men, especially teenagers, to have spontaneous erections that occur for no reason at inconvenient times of the day? . . . True

Note to the Facilitator
This is a common occurrence during puberty and will occur less often as teenagers get older.

400 What percentage of a man’s ejaculation is actually sperm? (a) 1%; (b) 10%; (c) 50%; (d) 75%? . . . (a) 1%. The remainder is fluid produced by the seminal vesicle, the Cowper’s gland, and the prostate gland.

500 The average number of sperm in an ejaculation is: (a) 1,000; (b) 100,000; (c) 1 million; (d) 200 million. . . . (d) 200 million

Sexual Dysfunction

100 True or false: Excessive alcohol use can cause a man to have difficulties with sustaining an erection. . . . True

Note to the Facilitator
Alcohol is a depressant drug and chemically acts to slow down, reduce, or stop the physical processes necessary for sexual arousal and orgasm. In men, alcohol can inhibit arousal, reduce erectile capacity, and slow or eliminate ejaculation and orgasm.

200 Premature ejaculation is: (a) having an orgasm before you are age 12; (b) a man having an orgasm before he wishes to ejaculate; (c) a man not being able to ejaculate; (d) arriving for a date before the partner is ready to go out . . . (b) a man having an orgasm before he wishes to ejaculate

300 Name two steps a man can take to help prevent premature ejaculation. . . . Wear a condom; masturbate before intercourse; change to a less stimulating position during intercourse; use the start/stop technique: stop sexual stimulation when near the brink of orgasm, then start again after the ejaculatory feeling subsides, use the “squeeze” technique: gently squeeze the tip of the penis and hold for several seconds
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3.61

Erectile failure is the inability to sustain or maintain an erection. Name three possible causes of erectile failure. . . . Stress, fatigue, short-term illness, alcohol consumption, psychological factors (such as anxiety), old age (decreased sex drive), medication, injury

500

Name two treatments that a man can receive for erectile failure. . . .

Viagra (a recently approved drug that helps men achieve an erection by increasing blood flow to the penis); penile injections (a drug is injected into the penis, which causes a temporary erection); a penile pump implant (a pump is placed inside the man’s penis along his urethra); a vacuum pump that is placed over the penis

Infertility

100

True or false: Infertility problems are always caused by a problem with the woman’s reproductive system. . . . False. Approximately 30% of infertility cases are caused by a problem in the man’s reproductive system, and another 20% of the cases are caused by a problem in the functioning of both the man’s and the woman’s reproductive system.

200

True or false: Failure to properly treat some sexually transmitted infections (STIs) may lead to infertility in both men and women. . . . True. Infertility can be caused by some STIs that, if left untreated, can cause damage to the fallopian tubes and vas deferens; chlamydia and gonorrhea are the STIs most likely to cause infertility.

300

Name three possible causes of infertility in men. . . . Illness (such as the flu or the mumps) can decrease the production of sperm; STIs; environmental toxins; alcohol and drug use; smoking; varicoceles (damaged or enlarged veins near the spermatic cord); congenital problems; chromosomal defects; hormonal insufficiency

400

Name three steps a man can take to help prevent infertility. . . . Avoid stress; avoid alcohol, drugs, and smoking; check medications that may affect fertility; wear loose-fitting undergarments; take zinc; get antioxidants (from fruits, vegetables, and grains); avoid environmental toxins; use condoms to prevent STIs

500

Name three ways a doctor can diagnose male infertility. . . . Sperm analysis, blood tests to check for hormonal imbalances, X-rays to look for damage and blockage of the vas deferens, postcoital tests to check the compatibility of the man’s sperm with the woman’s cervical mucus

Cancers of the Reproductive System

100

Name the two most common types of cancers of the reproductive system among men. . . . Prostate cancer, testicular cancer

200

What age group is at highest risk for testicular cancer: (a) men age 20 to 34; (b) men age 35 to 50; (c) men age 51 to 70? . . . (a) men age 20 to 34

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300 Name the two screening mechanisms for prostate cancer. . . . *Digital rectal exam, prostate specific antigen (PSA) test*

400 How often should a man conduct a testicular self-exam? . . . *Once a month*

500 Name three symptoms of prostate cancer. . . . *Frequent trips to urinate, especially at night; urgent need to urinate; difficulty beginning and stopping the flow of urine; dribbling; hesitant and thin stream of urine; sensation that bladder is not emptied; inability to urinate; involuntary loss of urine (incontinence); lower back pain; blood in the urine (rare)*

**STIs**

100 Name two signs that a man has gonorrhea or chlamydia. . . . *A burning sensation when the man urinates, discharge from the penis*

200 True or false: Women are more likely than men to acquire an STI from any single act of unprotected penile-vaginal sex. . . . *True. Semen remains in the vagina for an extended amount of time after sex; this increases the opportunity for infection. In addition, the interior wall of the vagina is more vulnerable to cuts or tears that could easily transmit STIs than the penis, which is less vulnerable because it is protected by skin.*

300 Identify four parts of a man’s body that can be infected with an STI. . . . *Genitals, mouth, anus, eye*

400 How long must people wait after possible infection until a blood test will tell them if they were infected? . . . *Three months; this is how long it takes for blood to develop antibodies to the HIV infection, which is what an HIV test looks for to determine whether someone is HIV-infected.*

500 Name three STIs with no known cure. . . . *HIV/AIDS, genital herpes, genital warts (warts can be removed but might grow back), hepatitis B*

**Note to the Facilitator**

Any STI that is a virus cannot be cured. Viruses continue to live in a person’s body throughout his or her life.

**Contraception**

100 Name two methods of family planning that men can use. . . . *Condoms, vasectomy, not having sex, periodic abstinence, withdrawal*

200 Name the only method of family planning aside from abstinence that can prevent most STIs. . . . *Condoms*

300 Name four methods of family planning that are designed for women to use. . . . *The pill, Depo-Provera, Norplant implants, diaphragm, IUD, female condoms*

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*continued*
What type of material should a condom be made of so that it does not allow HIV to pass through it? . . . \textit{Latex or polyurethane (plastic)}

\textbf{Note to the Facilitator}
Animal-skin condoms have small openings in the material that a virus can pass through.

Name three advantages of a man using vasectomy as his choice of family planning. . . . \textit{It is something a man can use; it is a simpler operation than a tubal ligation (female sterilization); it is very effective; it is permanent; there are no side effects; it is inexpensive; it is a fairly short procedure}

\textbf{Final Sexual Jeopardy Question}
Name three body fluids that can transmit HIV from one person to another. . . . \textit{Blood, semen, vaginal fluid, breast milk}