

PLANNING FOR CHILDREN MODULE

HELPING COUPLES GET ON THE SAME PAGE
ABOUT IF OR WHEN TO HAVE MORE CHILDREN

BY PAMELA M. WILSON, MSW



ABOUT THE AUTHOR



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The Annie E. Casey Foundation



GUIDE TO USING PLANNING FOR CHILDREN MODULE

Unexpectedly bringing a new child into the family presents a serious challenge to low-income couples who are trying to attain family stability. In spite of that fact, few, if any, relationship or marriage education programs include a focus on pregnancy planning and prevention. This module was created to fill that void and provide a much-needed supplement to comprehensive relationship and marriage education programs. The overall goals of the module are:

- To promote the importance of timing pregnancies in order to reach family goals and achieve family stability.
- To enable couples to get on the same page (create a shared vision) about if or when to have another child and the use of contraception to achieve their vision.

The module was developed collaboratively in 2009 by the Center for Urban Families (CFUF), the Brookings Institution Center for Children and Families (CCF), The National Campaign to Prevent Teen and Unplanned Pregnancy (The National Campaign), and the Annie E. Casey Foundation (AECF). AECF funded this project and acknowledges that the findings and conclusions presented in this report are those of the author(s) alone, and do not necessarily reflect the opinions of the Foundation. The National Campaign also helped fund the project.

WHY FOCUS ON PREGNANCY PLANNING AND PREVENTION?

A look at statistics reveals that the United States is doing an inadequate job of preparing folks to plan and control when they have children. Shockingly, half of all pregnancies in the U.S. are unplanned. While we have been understandably concerned about teen pregnancy rates, it is also true that many adults experience unplanned pregnancies. The National Campaign reports that:

- 7 in 10 pregnancies to unmarried women in their 20s are unplanned.
- There are more than 1 million unplanned pregnancies to unmarried women ages 20-29.
- Two-thirds of unplanned pregnancies in this age group are to women in the lowest income brackets.¹
- Unplanned pregnancy is not just an issue for women who have never been pregnant before: 72% of all unplanned pregnancies to unmarried women in their twenties are to women who have already had at least one pregnancy.²

Unplanned pregnancy has serious consequences for the parents involved, as well as for their children. For example, there is reduced opportunity to pursue pre-conception care as well as care in-between pregnancies. Directly relevant to relationship and marriage education programs, among couples in a cohabiting relationship who had

an unplanned pregnancy resulting in a birth, one-third split up within two years of the child's birth. In addition, children born following an unplanned pregnancy are significantly more likely to have mothers and fathers who suffer from depression, relationship conflict, and poor relationship quality compared to children born following a planned pregnancy, controlling for background factors. Furthermore, unplanned pregnancy places both mothers and fathers at greater risk of educational hardship and failure to achieve education and career goals.³

Poor women are significantly more likely to face an unintended pregnancy than those who are better off, and rates of unplanned pregnancy have increased among low-income women in recent years.⁴ According to authors Kathryn Edin and Maria Kefalas, low-income women tend to place very high value on children and childbearing and they see “spacing pregnancies” to accomplish life goals as something middle class white women do.⁵

In a briefing paper on unmarried couples with children, Edin and England reported that:

- The more serious the relationship, the more likely the couple will have a pregnancy.
- Women who are ambivalent (think they would feel very glad about a pregnancy even though they don't want to have a child at this time) are less likely to use contraception.
- When individuals/couples say they don't want a pregnancy now, they often don't use contraception effectively.⁶

Attempting to influence such beliefs and norms is challenging, but critically important. Low-income couples who decide to attend relationship or marriage education programs are motivated to create a better life for themselves and their families. These settings therefore offer a “reachable moment” for addressing this issue within the context of the couple's relationship and to include men—the other half of the equation—in pregnancy planning. Most importantly, this module can help couples assess how unplanned childbearing affects their attempts to become financially stable and achieve other plans.

Although specifically tailored for low-income couples, the basic information and activities in the module are also relevant for couples from higher socio-economic backgrounds. Unplanned pregnancies occur in every income bracket and they can have powerful consequences for couple relationships. More than a quarter of pregnancies among married couples are unplanned. The rates are twice as high among cohabiting couples. Facilitators can adapt the materials to reflect their population, most specifically, by creating new case studies and scenarios.

BACKGROUND

The idea for the *Planning for Children Module* arose when Joe Jones, CEO of the CFUF was taking a low-income couple with him to testify at a briefing on Capitol Hill. This particular couple had been participating in CFUF's Building Strong Families (BSF) program, which is a comprehensive intervention that includes intensive case management as well as small group relationship education. In conversation en route to the briefing the couple informed a shocked Joe Jones that they were pregnant again. As the conversation continued, the couple acknowledged that the pregnancy was unplanned, that it would challenge their ability to get on their feet financially, and that they would have appreciated an opportunity to explore these issues in BSF. Mr. Jones later entered into a partnership with The National Campaign, CCF, and AECF to develop this curriculum module. Pamela Wilson, an independent consultant, was selected to author the module because of her background and experience with the target audience, relationship education programs, and family planning. The author gratefully acknowledges the staff, facilitators, and couples at CFUF for their role in developing the module.

NEEDS ASSESSMENT

We used multiple strategies to help inform the content of the module:

- An advisory committee meeting with family planning professionals, Dr. Vanessa Cullins and Michael McGee, as well as staff from CFUF, The National Campaign, and AECF. Michael McGee also served as family planning content specialist to the project and helped develop some of the facilitator resources.
- Focus group sessions with five couples who were currently attending CFUF’s BSF program.
- Interviews with key staff from The National Campaign and the BSF program, as well as with the couple who spurred the idea for this module.
- A review of the literature that revealed important information about barriers to using contraception among low-income women and couples.

These strategies were invaluable in helping shape the content of the module. Advisors clearly told us that the curriculum sessions alone would be insufficient to influence low-income couples to undertake pregnancy planning effectively. They strongly recommended that pregnancy planning become a focus within the more comprehensive program. Case managers would need to include the issue of pregnancy planning as they help couples assess their current family situation and establish goals to attain family stability. The focus groups steered us away from ambiguous language, such as “family planning,” which did not mean the timing and spacing of pregnancies to most participants. Focus group participants also provided us with attitudes, myths, language, and anecdotes to be incorporated into the sessions.

The module was pilot tested with couples from CFUF’s BSF program. They responded very favorably and gave important feedback and recommendations which were incorporated into the final version.

MODULE CONTENT AND FORMAT

The Planning for Children Module consists of three 2-hour sessions, which includes an optional introductory session on sexuality. The CFUF staff recommended including a session on sexuality because they had encountered some basic misinformation and discomfort about these issues with BSF participants. Please note, the session on sexuality contains language that some may consider direct and frank. The writing is intentional and designed to meet the needs of participants. This section may not be a good fit with all people and in all places and that is why this section is optional. Below are the activities and objectives for each of the three sessions:

Session 1: Let’s Talk About Sex (Optional)	
Newlywed Game	Identify the strengths and gaps in their couple communication about sexuality
Man/Woman Talk	Increase participants’ knowledge of and comfort with female and male sexual anatomy, physiology, and sexual response
Myth-Information Game	Distinguish between facts and myths about male and female sexuality and conception
Partner Conversations	Couples identify what their partner wants more and less of in their sexual relationship

Session 2: Planning for Children I	
In Their Shoes	Identify the impact of common obstacles encountered by low-income couples with children when they have unplanned pregnancies
Same-Gender Conversations	Explore gender-based attitudes about childbearing, dispel myths, and increase knowledge of male birth control methods and longer-acting female methods; describe ways that men can support the use of effective birth control
Partner Conversations	Identify whether they are or aren't actively trying to prevent pregnancy at this time

Session 3: Planning for Children II	
Myths & Facts About Birth Control	Differentiate between myths and facts about birth control
Case Studies	Identify some strategies for communicating/negotiating with their partner about contraception in tough situations
Partner Conversations	Partners formulate their plan for preventing or delaying pregnancy

MODULE FORMAT

This module has been designed to be respectful, interactive, engaging, relevant, and fun. Our experience has taught us that group sessions must not seem at all like school. They cannot be dry or boring and they must be respectful of the life experiences that participants bring to the program. These sessions work best when the facilitator is enthusiastic, sensitive, and welcoming.

In addition, because the program deals with the sensitive topics of sexuality and pregnancy planning, we pay careful attention to creating a safe and comfortable learning environment, so that participants will be able to participate without fear of being judged or ridiculed. It is vital that the facilitator be able to create this kind of environment in the group.

Each session ends with an opportunity for couples to sit together, knee to knee, and talk, so that by the end of the module they are on the same page with their vision and plan for timing and spacing any future pregnancies.

CHANGING BEHAVIOR

According to behavioral scientist Thomas Coates, there are six factors that contribute to and support any kind of behavior change:

1. Information regarding the need to change behavior.
2. Motivation to change.
3. Skills to initiate and sustain new behavior (both technical and social skills).

4. Feeling that change is possible...empowerment/self efficacy.
5. Supportive changes in community norms...peer group.
6. Policy structure changes that support educational efforts and new behaviors.

This module has the potential to address all of these factors:

1. The module provides simple information about methods of contraception, dispels myths, and provides a strong rationale for actively planning or preventing pregnancy.
2. Couples can increase their motivation to actively prevent pregnancy at this point in their relationship by engaging in experiential activities that help them confront their ambivalence and that dramatize the impact of unplanned childbearing.
3. Couples work on the skill of communicating with each other about pregnancy planning. If case managers also take on this issue, they can refer couples to family planning agencies in the community who can provide them with the technical skills for using contraception effectively.
4. When participants hear peers in the group discuss their positive experience with a contraceptive method, they begin to feel that change is possible...that they could also use a method successfully.
5. When a cohesive relationship or marriage education group buys into the importance of timing pregnancies in order to accomplish family goals, they become their own supportive peer group.
6. By including a focus on pregnancy planning in case management, organizations can provide couples with ongoing institutional support and assistance that extends beyond the two or three group sessions.

At the end of the module, couples create a “family plan” that outlines their goals with respect to spacing and timing any future pregnancies as well as actions both partners will take to reach these goals. Case managers can play a critical role in helping couples follow through with their plans, just as they would with other goals identified by couples in their caseloads.

USING THE MODULE

The ideal strategy for using this module is to incorporate the sessions into a comprehensive program that includes case management, such as Building Strong Families. Programs can decide whether or not to implement the optional session on sexuality.

Other uses for the module include:

- Stand-alone relationship or marriage education programs: Facilitators in these programs might decide to use all or part of the module in their program. We encourage you to build partnerships with family planning agencies in the community so you can make referrals and follow-up appropriately.
- Family planning programs: In our research prior to designing the module, we were unable to find materials specifically aimed at low-income couples. We hope that family planning educators will find new ideas and strategies for working with low-income women and their partners.

Regardless of the nature of your particular program, it will be important to ensure that facilitators are prepared to facilitate these sessions in a nonjudgmental fashion and with comfort and skill. They will need to have basic information about sexuality, conception, and birth control. They will need to be able to educate in an informal and lively fashion without conveying their personal values or biases. For all of these reasons, it is important to choose facilitators who already have these skills or to provide specialized training to facilitators in the areas of sexuality

and family planning. Facilitators also need adequate preparation time to study and digest the procedures involved in conducting the module activities effectively.

ADDRESSING PREGNANCY PLANNING WITHIN CASE MANAGEMENT

The following strategies are considerations for case managers who want to address pregnancy planning in their work with couples:

- As a part of your assessment process, ask questions to find out how couples feel about having additional children in the near future:
 - Do you plan to have any additional children? If so, when would be a good time for this to happen. (Next 1-2 years? 5 years?)
 - How would bringing another child into the family affect you financially? How would it affect your relationship? Your ability to complete other goals?
 - How would you feel (happy or upset) if you got pregnant before you were ready?
 - Are you using any birth control right now? If yes, how is that working out? If no, would you be interested in getting more information about birth control?
- Build partnerships with family planning providers in your community so that you can make referrals and follow up appropriately.
- Get training on family planning and contraception. Ideally, case managers and facilitators can attend any training on sexuality and contraception at the same time.
- Follow up with couples after they have completed their “family plan” in which they establish goals and action steps for spacing and timing any future pregnancies. Work with them over time to help ensure that they follow through with their plan.

A FINAL WORD

We hope that you will decide that “planning for children” is an important issue to include in your relationship or marriage education program. As you use the module, we welcome your comments, feedback, and suggestions. While it was carefully developed based on available information and experience, as well as valuable input from program staff and participants at CFUF, the module has not yet been evaluated and, as such, should be considered an early version. We hope to do some assessment in 2010. In the meantime, we are making this version available to the field and plan to use any feedback we receive in future revisions. Please email your comments to communications@thenc.org with “Planning for Children” in the subject line.

If you are interested in receiving training to conduct this module, contact Pamela Wilson at pamwilson@comcast.net or the Center for Urban Families (CFUF) Training and Technical Assistance Department at 410-367-5691, ext 1380. CFUF will also be providing training on this module as part of the *Blueprint: A Guide to Family Stability & Economic Success* curriculum. For more information about working with low-income individuals and couples, visit the Center for Urban Families’ website at www.cfuf.org. For more information about preventing unplanned pregnancy, visit The National Campaign’s website at www.TheNationalCampaign.org.

REFERENCES

1. National Campaign to Prevent Teen and Unplanned Pregnancy. *Briefly - Unplanned Pregnancy Among 20-Somethings: The Full Story*. (May 2008) Retrieved from <http://www.thenationalcampaign.org/resources/pdf/briefly-unplanned-pregnancy-among-20somethings-the-full-story.pdf>
2. National Campaign to Prevent Teen and Unplanned Pregnancy. *DCR Report (Data, Charts, Research): Section B*. (2009) Retrieved from <http://www.thenationalcampaign.org/resources/dcr/>
3. National Campaign to Prevent Teen and Unplanned Pregnancy. *Briefly - Unplanned Pregnancy Among 20-Somethings: The Full Story*. (May 2008) Retrieved from <http://www.thenationalcampaign.org/resources/pdf/briefly-unplanned-pregnancy-among-20somethings-the-full-story.pdf>
4. Finer, L.B. & Henshaw, S.K. (2006). Disparities in rates of unintended pregnancy in the US: 1994 and 2001. *Perspectives on sexual and reproductive health*. (38)2: 90-96. Retrieved from <http://www.guttmacher.org/pubs/psrh/full/3809006.pdf>
5. Edin, K. & Kefalas, T. (2005). *Promises I can keep: Why poor women choose motherhood before marriage*. Berkeley & Los Angeles, CA: University of California Press.
6. England, P. & Edin, K. (September 2007). *Unmarried couples with children: Why don't they marry? How can policy-makers promote more stable relationships? A briefing paper prepared for the Council on Contemporary Families*. Retrieved from <http://www.contemporaryfamilies.org/subtemplate.php?t=briefingPapers&ext=unmarriedcouples>

LET'S TALK ABOUT SEX

GOAL FOR THIS SESSION

To increase couples' knowledge of and comfort with their own sexual bodies and to encourage open communication about sexuality.

OBJECTIVES

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

1. Identify the strengths and gaps in their couple communication about sexuality.
2. Communicate with comfort about their own genitals, sexual response, and conception.
3. Separate facts from myths about sexual anatomy, physiology, conception, and male/female sexual relationships.
4. Identify what their partner wants more and less of in their sexual relationship.

SESSION-AT-A-GLANCE

Activities & Sequence	Objectives <i>Couples taking part in the activity should be able to...</i>	Time	Materials <i>FR = Facilitator Resource H = Handout</i>
Newlywed Game	Identify the strengths and gaps in their couple communication about sexuality	25 min.	<ul style="list-style-type: none"> • Newlywed Game Questions (FR) • Answers Ready to Copy (FR) • Prize for Winning Couple
Woman/Man Talk about Sex	Increase participants' knowledge of and comfort with female and male sexual anatomy, physiology & sexual response	35 min.	<ul style="list-style-type: none"> • Woman to Woman Outline (FR) • Man to Man Outline (FR) • Female & Male Sexual/Reproductive Systems (FR) • Female External Genitals (H) • Journey of the Sperm and Egg (H)
Myth-Information Game	Distinguish between facts and myths about male and female sexuality and conception	30 min.	<ul style="list-style-type: none"> • Sexuality—Myth or Fact (FR)
Partner Conversations	Identify what their partner wants more and less of in their sexual relationship	30 min.	<ul style="list-style-type: none"> • Our Relationship (H)

NEWLYWED GAME

Purpose: To have couples identify the strengths and gaps in communicating about sexuality.

Materials: *Newlywed Game Questions and Answers Ready to Copy*; Prize for the winning couple

Time: 25 minutes

Facilitator Notes:

1. This session is an optional component of the *Planning for Children Module*. The entire module is designed to be incorporated into a more comprehensive program on relationships. If you want to offer this session to your participants but feel uncomfortable or ill-prepared, you might invite an educator from Planned Parenthood or a similar agency to lead the session.
2. If you are using this session in an already cohesive group, you will still need to set the stage and create a comfortable atmosphere for discussing the sensitive topic of sexuality. If you are using this with a group that is not already cohesive, then it will be even more important to create some ground rules. Your tone right from the outset will be invaluable in creating a warm and open learning environment.
3. *The Newlywed Game* is designed to energize participants, help them release any anxiety, and get warmed up to participate in the session. To make the cards for the game, take the facilitator resource, *Answers Ready to Copy*, to your local copy center and have it copied onto card stock. You might want to use a different color card stock for the answers to each question. Make enough copies so that you have a set of all the possible answers to each question for every participant. Once you have your answers duplicated on card stock, cut the answers into strips so you can distribute them to participants (to be placed on their laps) during the game.
4. Obtain a desirable prize for the winning couple—something like a restaurant or movie theatre gift card, or whatever your program can afford. If you don't have a budget for this, you might create an attractive award for the “sexiest couple” in the group.

Procedure:

1. **Welcome and Stage Setting (5 minutes):** Welcome participants and let them know that today's session will be on the topic of sex and sexuality. Make the following points:
 - We're going to ask you to talk about how you learned about sexuality, about how your bodies work and how they respond during sex, and we're going to separate facts from myths on these topics.
 - We'll spend some time with couples together in one group and some time with the women and men in different groups.
 - You'll end the session sitting together as a couple and talking about your relationship.

Tell the group that you want to establish some ground rules because sometimes people don't feel comfortable talking about sexuality in a group setting. Sometimes folks worry that they will sound stupid, that they might be judged, or that people will gossip about them later. Present the following rules for the group to consider:

- There are no dumb questions. (Ask anything. We don't expect you to know much because most of us have not had good sex education at home or at school. Even if we did, it might

have been a long time ago. Take advantage of this opportunity to ask anything you want to know.)

- No judgments or put downs. (Individuals are going to have different attitudes and values. It's fine to disagree but please don't put someone down because they see things differently than you do.)
- No assumptions. (People will have had very different backgrounds and experiences when it comes to sexual behavior. Let's be open to finding out what people think and what their experiences have been.)
- Take care of yourself. (When it comes to sexuality, some of us have had bad experiences in the past. Some people have grown up feeling that it's not OK to talk about sex; some people learned that their sexual organs are "nasty;" and some people have experienced sexual abuse or rape. It can be hard to talk openly about sex if you've had any of these experiences, so you can pass if we're talking about something that makes you feel uncomfortable or you can mentally focus on something else if our discussions take you back to any bad memories. However, keep in mind that our group could be a safe space for you to begin to think and talk about things that have happened to you in the past and to begin to take better charge of your own sexuality.)
- Maintain confidentiality. (What gets said in this room needs to stay in this room.)

Ask participants to react to the ground rules and to add any other guidelines that would help them feel comfortable talking openly about sexuality issues.

2. **Game - Separate Groups (10 minutes):** Introduce the first activity which is *The Newlywed Game*. Ask if anyone ever saw the old TV show where newly married couples competed to find out how much they knew about each other. Announce the prize that will go to the couple with the highest score. There are 60 possible points.

Begin the game using the following process:

- Divide the group by gender. The men will go with the male facilitator and the women will go with the female facilitator. Make sure that the two groups are not within earshot of each other.
 - Read the first question your group has to answer about their partners. Go around the room and ask each person for his/her response. Give them an opportunity to say why they chose this response and give them the card that contains their particular response to the question. Have them place the card face down on their laps. Make sure the cards are placed on their laps in the correct order. The answer to the first question is face down at the top of the stack; the answer to the second question is next; and the answer to the third is last.
 - Continue in this same manner for the next question. Note that the men have three rather than two questions to answer, so they will need a little more time in their group. To keep things balanced the female facilitator should engage the women in more discussion of their responses while the male facilitator will need to keep things moving at a brisk pace.
 - Bring the two groups back together.
3. **Game - Groups Come Back Together (10 minutes):** Once the couples are reunited, ask each person to keep their cards face down so their partners cannot see their answers. Continue the game:

- Announce that it is time to find out how much the women know about their partners. Say, “Each woman had to answer two questions about her partner. I am now going to ask the men the questions that we asked their partner. You will get 10 points for each correct answer.”
- Going around the room, ask each of the men the first question, “How would you describe your sexual style?” Read each of the options. After the man gives his answer, ask him to explain briefly and then have his partner turn the card over and reveal her answer. Award the 10 points if the answer is correct.
- Ask the second question, “What do you like best about your body?” Use the same process.
- Explain that it’s time to see how well the men know their partner’s attitudes and feelings about some sexual issues. You will use the same process except this time there is a bonus question worth 20 points!
- Going around the room, ask each of the women the first question, “What did your parents/ caregivers tell you about sex?” After each woman gives her answer and explanation, have her partner turn the card over and reveal his answer. Award the 10 points if the answer is correct.
- Ask the second question, “What do you like best about your body?” Use the same process.
- Ask the bonus question worth 20 points, “What do you appreciate most in a sexual partner?” Award the points.

Look at the scores and announce the winning couple. In case of a tie, ask the tied couples to write down a number from 1-50. Collect the numbers. The couple with the number closest to 50 wins the prize. Once the prize has been awarded, end with the questions below.

Discussion Questions

1. Why do you think we did that activity?
2. What was something you learned about your partner?
3. How well do you think you know each other when it comes to sexuality?

FACILITATOR RESOURCE NEWLYWED GAME QUESTIONS

QUESTIONS FOR FEMALE PARTNERS

1. How would your partner describe his sexual style? *(For the men: How would you describe your sexual style?)*
 - a) Looking out for number one
 - b) Her pleasure is my pleasure
 - c) Freaky
2. What will your partner say he likes best about his body? *(For the men: What do you like best about your body?)*
 - a) Face
 - b) Physique/Overall build
 - c) Sexual equipment

QUESTIONS FOR MALE PARTNERS

1. What will your partner say her parents/caregivers told her about sex? *(For the women: What did your parents/caregivers tell you about sex?)*
 - a) Keep your legs closed
 - b) Don't bring any babies in this house
 - c) Wait 'til you get married
2. What will your partner say she likes best about her body? *(For the women: What do you like best about your body?)*
 - a) Face
 - b) Overall size and shape
 - c) Hips or butt
3. What will your partner say she appreciates most in a sexual partner? *(For the women: What do you appreciate most in a sexual partner?)*
 - a) Romance and seduction
 - b) Paying attention to what pleases her
 - c) Honesty and faithfulness

FACILITATOR RESOURCE
NEWLYWED GAME ANSWERS READY TO COPY

QUESTIONS FOR FEMALE PARTNERS

1. How would your partner describe his sexual style? *(For the men: How would you describe your sexual style?)*

Looking out for
number one

Her pleasure
is my pleasure

Freaky

2. What will your partner say he likes best about his body? *(For the men: What do you like best about your body?)*

Face

Physique/
Overall Build

Sexual Equipment

QUESTIONS FOR MALE PARTNERS

1. What will your partner say her parents/caregivers told her about sex? *(For the women: What did your parents/caregivers tell you about sex?)*

Keep your
legs closed

Don't bring any
babies in this house

Wait 'til you
get married

2. What will your partner say she likes best about her body? *(For the women: What do you like best about your body?)*

Face

Overall size
and shape

Hips or butt

3. What will your partner say she appreciates most in a sexual partner? *(For the women: What do you appreciate most in a sexual partner?)*

Romance
and seduction

Paying attention to
what pleases her

Honesty
and faithfulness

MAN/WOMAN TALK ABOUT SEX

Purpose: To increase participants' knowledge of and comfort with female and male sexual anatomy, physiology, and sexual response.

Materials: Facilitator Resources: *Woman to Woman* and *Man to Man Outlines, Female & Male Sexual/Reproductive Systems*; Handouts: *Female External Genitals, Internal Male & Female Reproductive Organs*, and *Journey of the Sperm and Egg*

Time: 35 minutes

Planning Notes:

1. We've included several facilitator resources to help you lead this activity. First, there are outlines to guide the discussion in each small group. Second, there is background information on the male and female sexual systems that you should read and digest. Finally, there are handouts to distribute to participants.
2. Print copies of the attached PDF versions of the internal male and female reproductive organs. Or you can download copies of the male and female internal reproductive systems free from <http://www.etr.org/recapp/documents/freebies/Reproductivechart200209.pdf>
3. If possible, get a copy of the book *Body Drama* by Nancy Amanda Redd (Gotham Books, 2008) which contains tasteful photography of vulvas on pp 118 & 119. You can show these pictures to the women's group when discussing attitudes about female genitalia. Pages 110-118 do a very nice job of encouraging positive attitudes which is important because many women have feelings of shame or disgust about their vulvas. You can purchase an inexpensive used copy of this book from *Amazon.com* or check out a free copy from your public library.
4. In this activity men and women meet in separate groups to discuss sexual anatomy and physiology, sexual response, and conception. You will need two rooms so that each group can have privacy. Ideally, you will have a male facilitator to work with the men's group and a female with the women's group.
5. When discussing facts about the male or female genitalia, try to encourage positive attitudes. Start where the group is. Accept whatever language they use for body parts but you should always use correct language. In a respectful and caring manner, confront negative attitudes, put downs, and shaming language. In the men's group, remind the guys that some of them are raising daughters who they want to grow up to become sexually healthy women. How are or will they help their daughters feel good about their own bodies?

Procedure:

1. **Introduction (2 minutes):** Introduce this activity by making the following points:
 - It is very important for men and women to be able to communicate with each other about sex, but it is also helpful to spend time in an all female or all male space to compare notes, share stories, and better understand our own bodies and sexual functioning.
 - You will get into separate groups and do some straight talk, woman to woman and man to man.

2. **Separate Groups (25 minutes):** Divide the group by gender. Each facilitator should lead an informal and lively discussion using the attached outlines.
3. **Brief Processing (3 minutes):** Reconvene the group and ask the men and women to give each other a little feedback about what they took away from their separate sessions.

FACILITATOR RESOURCE WOMAN TO WOMAN OUTLINE

1. **Getting Comfortable with Your Vulva (10 minutes):** If you have the book *Body Drama*, open it to page 118. Otherwise, distribute the handouts of the female external genitalia.
 - What names were you taught for your genitals (down there) when you were growing up?
 - What's your reaction to these pictures? (Explain the difference between the vulva and the vagina.)
 - How many of you have seen this view of yourselves? (You have to sit with a mirror between your legs to get this view.)
 - There are all kinds of negative messages about the vulva—"It's ugly. It smells like fish. It needs to be sprayed with feminine hygiene products." Have you heard these messages? How do you feel about them?

Give information about the natural cleansing ability of the vagina. Make the point that vulvas are unique, just like faces and that they have a musky genital odor that is not foul unless the person has poor hygiene or has an infection.

2. **Sexual Response (8-10 minutes):** Talk about what happens in the body. You might ask the women to share what happens for them during excitement and orgasm. They may be less familiar with the terms plateau and resolution. You can teach them about that.
 - Excitement: The vagina lubricates, breathing gets rapid, heart beats faster, nipples get erect, clitoris gets erect (just like the penis).
 - Plateau: Excitement increases but it may go up and down depending on the stimulation or what's going on in the woman's mind.
 - Orgasm: When the excitement reaches its highest level, orgasm or climax happens. It's different for different women but usually involves rhythmic contractions inside the vagina and a sense of release. If the woman is in the mood and the right stimulation continues, she has the capacity to have multiple orgasms.
 - Resolution: Everything goes back to its un-stimulated state.

Refer to the facilitator resource for more information about sexual response. Get the women to talk about orgasm. Not all women have orgasms. Ask: Have you had orgasms? What are your orgasms like?

3. **How Pregnancy Happens (12 minutes):** Distribute the handouts of the female and male internal reproductive organs and *Journey of the Egg and Sperm*. Say something like, "I know all of you have had at least one baby, but who can tell me in your own words about the journey that the egg and sperm make to meet each other and form a pregnancy."

Briefly review the handout, *Journey of the Egg and Sperm*. Ask participants to locate the various organs (ovaries, Fallopian tubes, uterus, testicles, etc., on their anatomy handouts as they review the process of conception).

FACILITATOR RESOURCE MAN TO MAN OUTLINE

1. Messages about Genitals (10 minutes):

- What names were you taught for your penis when you were a little boy?
- How many of you are circumcised?
- Did (would) you circumcise your sons—why or why not?
- How many of you ever looked at porn and compared yourselves to the men in the pictures or films?

If time allows, distribute the picture of the external female genitals. Ask:

- What's your reaction to the female genitals? (Explain the difference between the vulva and the vagina.)
- Who can tell me the function of the clitoris? (sexual pleasure!)

Give information about the natural cleansing ability of the vagina. Make the point that vulvas are unique, just like faces and that they have a musky genital odor that is not foul unless the woman has poor hygiene or has an infection.

2. Sexual Response (8-10 minutes): Talk about what happens in the body.

- Excitement: The penis gets erect, breathing gets rapid, heart beats faster, nipples get erect. In women the vagina lubricates and the clitoris gets erect.
- Plateau: Excitement increases. Erections may wax and wane—this is normal. As excitement increases the scrotum and testicles contract up closer to the body.
- Orgasm: When the excitement reaches its highest level, ejaculation and orgasm happen. Ejaculation happens in two phases:
 1. "I'm coming"—contractions happen that mix the sperm with fluids from the prostate gland and other organs
 2. Spurting fluid—fluids are propelled out of the urethra by strong rhythmic contractions.
- Resolution: The genitals and entire body return to an un-stimulated state. Men have a refractory period—an amount of time before they can get another erection and have another ejaculation; length of this period increases with age; young men can often get erect again very quickly. Men need to know that the refractory period will get longer as they get older.
- Fun Facts: Orgasm lasts an average of four seconds. Average number of ejaculatory spurts: 3-10; average speed of ejaculation: 25 miles per hour.

Refer to the Facilitator Resource for more information about sexual response. Get the men to talk about the refractory period. Have they experienced it? Have they seen any changes in the length of the refractory period since their teen years?

3. How Pregnancy Happens (10-15 minutes): Distribute the handouts of the female and male internal reproductive organs and *Journey of the Egg and Sperm*. Say something like, "I know all of you have had at least

one baby, but who can tell me in your own words about the journey that the egg and sperm make to meet each other and form a pregnancy.”

Briefly review the handout, *Journey of the Egg and Sperm*. Ask participants to locate the various organs (ovaries, Fallopian tubes, uterus, testicles, etc., on their anatomy handouts as they review the process of conception).

FACILITATOR RESOURCE

FEMALE AND MALE SEXUAL/REPRODUCTIVE SYSTEMS

This resource provides background information for facilitators. We recommend that you read and digest this information so you can feel comfortable with the content when you are working with participants in their small groups. You will not need to present this specific information in this format to participants.

FEMALE SYSTEM

External Parts and Functions

- **Vulva:** The whole of the female external genitalia is called the vulva. The vulva includes all of the following external parts except the anus.
- **Labia majora and labia minora:** Outer and inner folds of skin and fatty tissue on either side of the vagina; provide protection to the clitoris and the urethral and vaginal openings; referred to as vaginal lips.
- **Clitoris:** A highly sensitive structure located above the urethral opening at the point where the inner labia (lips) meet; the only function of the clitoris is for sexual pleasure; most women need clitoral stimulation to reach orgasm.
- **Urethral opening:** A small opening above the vagina where urine leaves the body.
- **Vaginal opening:** Located between the urethral opening and the anus; usually covered by a thin membrane (hymen) prior to first experience of intercourse; outlet for the menstrual flow.
- **Anus (not a part of the reproductive system):** The opening through which bowel movements or feces leave the body. It is also an erogenous zone. Bacteria from the anus can be very harmful for the vagina and lead to infection. Partners should take care not to transfer the penis, fingers, or an object from the anus to vagina.

Internal Parts and Functions

- **Bladder (not a part of the reproductive system):** A sac-like structure in the pelvic region; responsible for storing urine.
- **Urethra:** A tube through which urine passes from the bladder to the outside of the body.
- **Vagina:** Passageway extending from the uterus to the outside of the body; canal through which a baby passes during delivery; passageway for the menstrual flow to the outside; place where intercourse occurs. Capable of expanding during intercourse and childbirth. Lubricates during sexual arousal; the vagina lubricates or gets wet when a woman is sexually excited.
- **Cervix:** The opening into the uterus; protrudes into the uppermost part of the vagina. This opening is very small—only as wide as a piece of spaghetti. This is what has to dilate or open wider when a woman is about to deliver a baby.
- **Hymen:** A thin membrane that partially covers the opening to the vagina in most young girls—sometimes called a “cherry.” Some girls are born without a hymen and others may stretch or break their hymen during vigorous physical activity. Absence of a hymen does not mean a woman is not a virgin.

- **Uterus:** A pear shaped, muscular organ located in the pelvic region; beginning at puberty, the lining of the uterus sheds every month during menstruation; the fetus develops in the uterus during pregnancy.
- **Fallopian tubes:** Passageways for the egg from the ovary to the uterus; place where fertilization or conception occurs.
- **Ovaries:** Almond shaped structures located in the female pelvic region; each under the finger-like endings of the fallopian tubes; contain 300,000 to 500,000 immature egg cells at birth; produce female sex hormones, estrogen, and progesterone; begin release of ripe eggs at time of puberty.
- **Ovum or egg:** About the size of a pinhead; if not fertilized, it dissolves and is absorbed. Usually, one ovum is released monthly; if more than one egg is released, twins or multiple births may result.
- **Menstruation:** The monthly shedding of the lining of the uterus which forms to nurture a fertilized egg. If an egg is not fertilized, the lining is not needed so it leaves the body through the vagina. Menstruation generally begins between the ages of 9 and 17, and ends at menopause, usually when a woman is 45 to 55 years of age.

Reproductive Process

- **Ovulation:** Once a month, an ovary releases a mature egg, which then becomes available for fertilization. This occurs approximately 14 days before the next menstrual period begins which is about the middle of the cycle for women with an average 28-day cycle. The most fertile period for many women is at the halfway point between her two periods. However, it is possible for a woman to ovulate earlier or later due to illness or stress or if her cycle is particularly long or short.
- **Fertilization:** The union of an egg with a sperm in the Fallopian tube; sperm are capable of fertilizing an egg up to seven days after intercourse.

Female Sexual Response

A woman's body goes through certain predictable stages when she gets sexually excited. Many of these responses are the same in both men and women:

- **Excitement:** Nipples become erect; clitoris and labia get larger as they become engorged with blood; vagina lubricates; breathing and heart rate increase.
- **Plateau:** Excitement builds until it gets to its highest point, then it triggers a reflex called orgasm.
- **Orgasm:** The rhythmic contractions of the outer portion of the vagina. Not all women are aware of these contractions. Unlike men, women are capable of moving from one orgasm to another (multiple orgasms) if the sexual stimulation continues, but not all women have multiple orgasms. Some women report having ejaculations during orgasm when fluid (not containing sperm) spurts out of the urethral and/or vaginal openings; not all women experience ejaculation, either. Although there isn't agreement in the field about the reality of female ejaculation, the important thing is to validate a woman's experience with orgasm so she understands the wide range of normal. Female orgasm is very individual; each woman's experience is different and unique. And, not all women have orgasms every time they have sex. Generally, orgasm is pleasurable and includes a sense of release of sexual tension caused by excitement.
- **Resolution:** The genitals and entire body return to an unstimulated state: breathing and heart rate slow down, nipples and genitals decrease in size, and the body relaxes.

MALE SYSTEM

External Parts and Functions

- **Penis:** The male organ for sexual intercourse and for urination. The average length of a flaccid penis is 3.9 inches, with a girth of 3.7 inches. The average length of an erect penis is 5.9 inches with a girth of 4.9 inches. Typically, the smaller the penis when flaccid, the more it grows when erect. Larger penises don't usually get all that much bigger when erect.
- **Circumcision:** The removal of the foreskin, which covers the head (glands) of the penis; a procedure usually performed during the first 10 days of life for religious and/or personal reasons; aids in the removal of smegma, a normal, cheesy secretion from the penis that can accumulate under the foreskin; does not affect sexual functioning.
- **Erection:** The process by which the penis fills with blood and becomes hard in response to thoughts, fantasies, temperature, touch, or sexual stimulation.
- **Scrotum:** The wrinkly skin pouch located behind the penis; holds and provides protection to the testicles; maintains temperature necessary for the production and survival of sperm.
- **Testes:** Two round glands that descend into the scrotum following birth; produce and store sperm from puberty throughout life; they produce testosterone, the male sex hormone.
- **Anus (not a part of the reproductive system):** The opening for the expulsion of feces from the body; also an erogenous zone.

Internal Parts and Functions

- **Vas deferens (sperm tube):** Passageway for sperm; one leads from each testicle to join with the urethra.
- **Seminal vesicles:** Two sac-like structures lying behind the bladder; they secrete a thick fluid that forms part of the semen.
- **Prostate gland:** A gland located in the male pelvis; secretes a thick, milky fluid that forms part of the semen.
- **Cowper's gland:** Two pea-sized glands that secrete a clear, sticky fluid that is released from the penis soon after erection; this fluid may contain sperm; it neutralizes the acid in the urethra, making the passage safe for sperm.
- **Urethra:** The tube through which urine passes from the bladder to the outside of the body; closed to urine during ejaculation.
- **Sperm:** The male tadpole shaped sex cells; too small to be seen without a microscope; movement aided by lashing their tails; production begins usually between the ages of 12 and 14; 200 to 500 million cells released per ejaculation; may survive five days in the Fallopian tubes, but rarely cause fertilization after 72 hours.
- **Ejaculation:** The release of semen from the penis; usually accompanied by orgasm. Fun Facts: Orgasm lasts an average of 4 seconds. Average number of ejaculatory spurts: 3-10; average speed of ejaculation: 25 miles per hour.
- **Semen:** The sperm-containing fluid that spurts out of the penis at the time of ejaculation; the fluids that later mix with sperm are produced and stored in the seminal vesicles and prostate gland. Fun

Facts: Semen contains 5 calories per teaspoon and is high in protein.

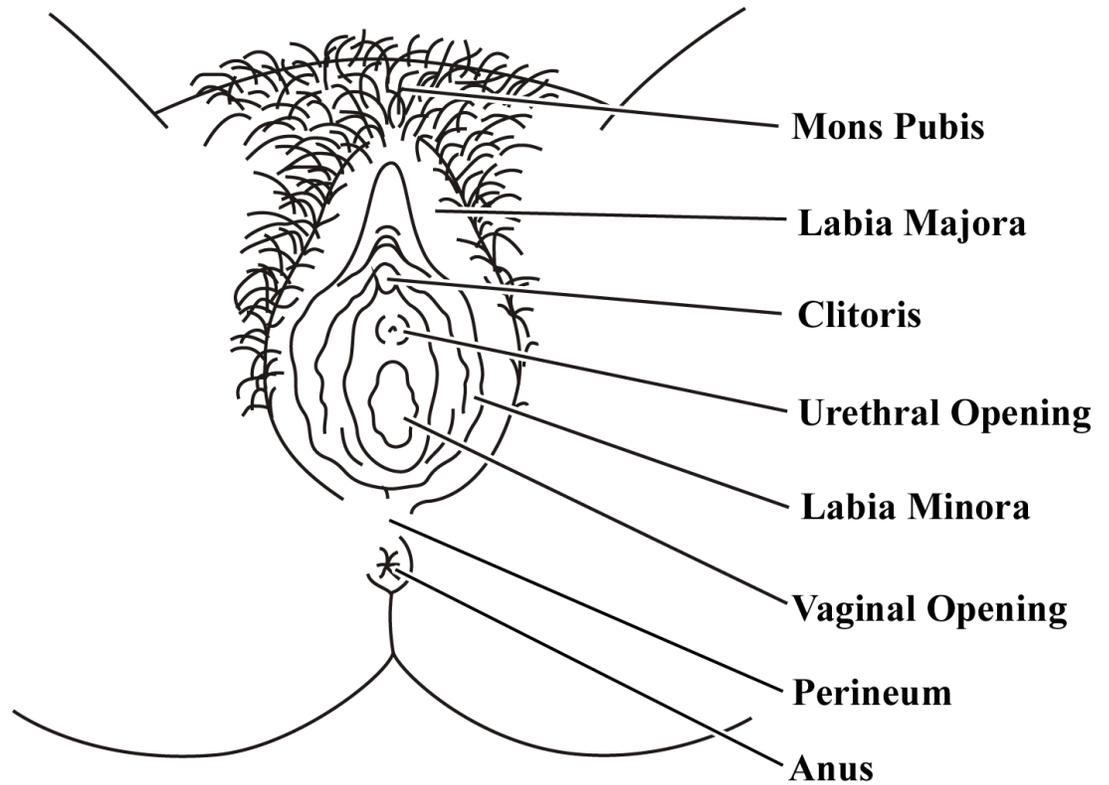
- **Nocturnal emissions (wet dreams):** Erection of the penis and subsequent ejaculation during sleep; nature's way of releasing excess sperm from the testicles; sometimes triggered by sexual dreams and fantasies; occurs most frequently in young males who do not engage in masturbation or sexual intercourse.

Male Sexual Response

A man's body also goes through predictable stages when he gets sexually excited:

- **Excitement:** Nipples become erect; penis, testicles, and other body parts swell as they become engorged with blood; penis becomes erect; scrotum and testicles contract and move up closer to the body; muscle tension increases; breathing and heart rate increase.
- **Plateau:** Excitement builds until it gets to its highest point, then it triggers a reflex called orgasm.
- **Orgasm:** Ejaculation happens in two phases; first, glands containing fluids contract and deposit their fluids into the urethra; men feel these contractions which are like a signal saying, "I'm about to come." The second phase occurs when the fluids are propelled out of the urethra by strong rhythmic contractions; involuntary muscle contractions and spasms may occur in various parts of the body. The pleasurable sensations of orgasm usually accompany ejaculation but sometimes men can experience the peak pleasure of orgasm without ejaculation and vice versa.
- **Resolution:** The genitals and entire body return to an unstimulated state: breathing and heart rate slow down, nipples and genitals decrease in size, and the body relaxes; for most men, a period of rest, called the refractory period, is necessary for them to be able to get another erection and go on and have another ejaculation. The length of this period varies according the man's age, how exciting the situation is, and the amount of time since his last ejaculation. Young men have short refractory periods and can often get erect again very quickly. As men age, the refractory period gets longer. It's important for men to understand that they will experience changes like this as they get older.

HANDOUT EXTERNAL FEMALE GENITALIA



HANDOUT

JOURNEY OF THE SPERM AND THE EGG

Here's the story of how pregnancy happens... the journey of the sperm and the egg. Women are born with all of their eggs. Once a month, an egg is released from the ovary. Usually, only one ovary releases an egg. This process is called ovulation. Women ovulate (release an egg) approximately 14 days before the next period. In general, a woman is most fertile (most likely to get pregnant if she has sex without using birth control) at about the halfway point between two periods. Once an egg is released, it travels into the Fallopian tube. The uterus prepares for the possibility of a pregnancy by building up a thick, nutrient-rich lining which can nurture the fertilized egg.

Unlike women, men's testicles are constantly producing sperm. It takes a few months for sperm cells to develop and mature and be ready to fertilize an egg. Since the testicles produce sperm all the time, there is always mature sperm around (in the testicles, epididymis, and vas deferens).

Every time a man and woman have sexual intercourse, unless he is using a condom or withdraws his penis in time, millions of sperm are ejaculated into the vagina...anywhere between 200 to 600 million sperm! Those millions of sperm then begin their journey to find an egg. Sperm are tiny, microscopic cells but they are great swimmers. They also mix with fluids from the prostate gland and seminal vesicles, which helps keep them strong and makes it easier for them to swim. The mixture of sperm and fluids is called semen. Once they are deposited in the vagina, they swim up to the mouth of the uterus which is called the cervix. The sperm then move on into the uterus where they must continue swimming to reach the fallopian tubes.

If the woman has released an egg, the sperm that have made it to the correct fallopian tube will work hard to fertilize the egg. The sperm swim through the cervix all the way to the other end of the womb to finally reach the fallopian tube. If the sperm is lucky, the woman has just ovulated and the egg is on the way. If not, the sperm will wait around for ovulation, or for the egg to drop. Sperm can survive in the womb for 3-5 days.

Note: This does not mean that fertilization will always happen, even if a man and woman have unprotected intercourse during her most fertile time (which is during ovulation—around the halfway point between her periods). Some women think they are infertile if they don't get pregnant even though they aren't using birth control for a period of time. This is not the case. It's just the luck of the draw... a pregnancy could happen the next time she has sex without birth control, or the time after.

Think of it this way: If 100 couples have intercourse on a regular basis for a year without using contraception, 90 of those couples will experience a pregnancy!

It takes just one single sperm to fertilize an egg. Once the egg is fertilized, the cells multiply and develop quickly. The fertilized egg (now called a blastocyst) moves toward and hovers in the uterus or womb, until it is ready to "implant" into that thick, nutrient-rich lining of the womb. When the fertilized egg implants, the woman is pregnant.

If the egg does not get fertilized, the lining of the uterus is not needed and it is discharged from the woman's vagina in the form of her monthly period.

MYTH-INFORMATION GAME—SEXUALITY

Purpose: To increase participants' knowledge of male and female sexuality; to dispel commonly-held myths about male and female sexuality and conception.

Materials: Facilitator Resource: *Sexuality—Myth or Fact?*

Time: 30 minutes

Planning Notes:

1. Read the facilitator resource material thoroughly so you can get comfortable with the information. Get familiar with the material so you can give the explanations for each statement without reading. However, it would be better to read the explanation than to give an inaccurate or unclear message about the statement you're discussing.
2. This activity is intended as an interesting way to clarify information about male and female sexuality and male/female relationships. Your goal is to find out what participants believe and to confront myths. You want to help participants: a) understand and respect differences between male and female sexuality and b) gain factual information about sexuality and conception.
3. Let this discussion be informal, playful, and fun. However, it's very important for you as facilitator to be a role model regarding appropriate attitudes toward sexuality. Facilitators have a great opportunity to model a healthy respect for each other and a comfort with sexuality. It's especially helpful for facilitators to acknowledge a few of their own mistaken notions or uncertainties about sexuality, and to acknowledge the harm that comes from buying into sex-role stereotypes.

Procedure:

1. Explain that you're going to read some statements that people believe about sexuality and get the group's reactions. The group will have an informal rap session about sex.
2. Read each of the statements you've chosen. For each statement, have the group discuss whether they think it is a fact or a myth and why. Be prepared to provide explanations for why each of the statements is either a fact or a myth.
3. Once you've given the correct explanation for each statement, get reactions from the group. Encourage discussion about the statements and the answers.
4. After all the myths have been discussed, ask the questions below.

Discussion Questions:

1. What's one thing that surprised you?
2. What did you hear or learn today that might be useful to you?

FACILITATOR RESOURCE SEXUALITY—MYTH OR FACT?

1. **If a woman doesn't reach orgasm (come), it's her man's fault.** (Myth.)
 - Men are often taught that they should know everything about sex, but it's impossible for a man to know how to please every partner. Each person is different and different things turn each of us on.
 - Women must take responsibility for their pleasure and tell their man what they like.
 - Moves that a former partner liked may leave your current lover cold. Men should pay attention to their partner's responses but they are not magicians or mind readers.
2. **It's a man's role to initiate and take charge of sex.** (Myth.) Some men are turned on by a partner who initiates and others are threatened by an aggressive person. Some women are very comfortable initiating sex.
3. **A man always wants and is always ready to have sex.** (Myth.) This belief has caused many men to have sex when he didn't really feel like it or want to. Real men aren't sex machines who can push a button and perform on command. The truth is men aren't always in the mood and they aren't turned on to every person who is ready to "get it on." Ask the guys, "How many of you have had sex with someone when you didn't want to? Why did you do it? What was it like?"
4. **Women usually take considerably longer to get aroused and reach orgasm than men.** (Fact.)
 - Men tend to respond to direct stimulation of the penis and can move on to orgasm very quickly. Often a man can come pretty easily after 3 or 4 minutes of direct stimulation of his penis, while it takes many times longer for many women to reach orgasm.
 - Many women tend to respond well to indirect stimulation—kissing, teasing and foreplay, focusing on all of her body and not just her nipples, clitoris, and vagina. Pleasure increases when they have a gradual building of sexual tension and a certain level of arousal before the touching becomes more direct.
 - Once aroused, most women need stimulation of their clitoris in order to reach orgasm.
5. **The bigger a man's penis, the better a lover he is.** (Myth.)
 - Constant joking and media messages promote the attitude that "bigger is better" when it comes to penises.
 - Penises do vary in size, both in the flaccid (soft) state and when erect. However, erect penises vary less than soft penises do. Therefore, we say that erection is the great equalizer. Penis size is not related to a man's weight, height, or size of his feet or hands.
6. **A woman cannot get pregnant if she has sex during her period.** (Myth.) A woman can get pregnant anytime she has sexual intercourse with a man and is not using a reliable method of birth control.
 - While it is true that it is a lot less likely that a woman with regular periods will get pregnant during her period, it's still possible. Usually ovulation happens in the middle of a woman's cycle (the halfway point between two periods), not during her period.
 - However, many women do not have regular cycles so they might ovulate or release an egg earlier than

normal. And all kinds of things like illness and stress can throw off your cycle. Also, sperm can live in the body for 3-5 days after intercourse.

- The most likely time for a woman to get pregnant is mid-cycle. This is when women are most fertile and when unprotected sexual intercourse is most risky. But without birth control, the risk is always present any time of the month.
- By the way, a woman can get pregnant whether or not she has an orgasm!

7. It's more important to use a condom with an "on-the-side" partner or one-night stand than a steady partner. (Myth.)

- Partners having sex "on-the-side" sometimes try to protect themselves in the outside relationship, but often they don't use a condom every time they have sex. Therefore, they are taking risks and can bring home a disease to their partner.
- Couples who make the commitment to be completely monogamous (one-on-one), should get tested to make sure they don't have HIV—the virus that causes AIDS—or any other STIs. If they test negative, they are safe as long as neither of them engages in unprotected sexual behavior with another partner. The only way to be really safe is to ALWAYS use protection with every partner.

8. A man who does more work around the house often gets more sex from his woman. (Fact.) A 2008 report from the Council of Contemporary Families (CCF) found that American men today are doing double the housework and spending three times more time with their children compared with 50 years ago. "When men do more of the housework, women's perceptions of fairness and marital satisfaction rise and the couple experience less marital conflict," states the report. It goes on to say that "therapists report that there is a direct correlation between men doing more in the home and the frequency of sex."

PARTNER CONVERSATIONS: OUR RELATIONSHIP

Purpose: To have participants talk about what they would each like more and less of in their sexual relationship.

Materials: Handout: *Our Relationship*

Time: 30 minutes

Procedure:

1. **Talking about Sexuality (7 minutes):** Explain that in the final activity of the session couples are going to have some one-on-one conversations about their sexual relationship. Say something like:
 - I've heard couples say that they sometimes have trouble talking about when one of them wants sex more often than the other. Do you think that is a common issue for couples? What are some other sexual issues that couples might be dealing with?

Offer the following tips for making these kinds of conversations a little easier:

- Pick a convenient and comfortable time to talk. Try to make sure both of you are relaxed and open and not feeling stressed.
 - Bring up the issue in a soft style. Use "I" statements. If possible, begin by talking about something positive or something that is going well. Avoid words like always and never and avoid making accusations or putting your partner down. For example, if a woman has been trying a sexual activity that her partner likes but she doesn't, she might say:
 - I want to talk to you about something that's been bothering me and I'm nervous because I don't want you to be upset or disappointed. I don't really want to do _____ anymore. I know you like it, so I've tried it, but I'm just not into it and it doesn't make me feel good.
 - Let your partner know that you're feeling a little awkward or uncomfortable, if you are. It's OK and normal to feel that way. Hold onto your sense of humor.
 - Tell your partner how you feel and what you want. Find out how your partner feels and what he or she wants. Listen, negotiate, and be open to compromise.
2. **Instructions and Individual Activity (5 minutes):** Introduce the partner activity by saying:
 - This activity will give you a chance to practice some of these techniques and focus on your couple communication about sexuality.
 - You'll complete the handout individually and then you'll sit together and share your answers.

Distribute the handout and review it briefly. Read the questions aloud if you have any concerns about literacy for participants. Allow a couple of minutes for participants to complete the handouts individually. Then give these directions:

- Sit together as a couple facing each other, knee to knee.
- Take turns sharing your responses to each question on the handout.
- When your partner is talking, use your listening skills to make sure you are really hearing what they are saying.

- We're going to be checking in with each couple to see how the conversation is going and provide any support that you might want.
3. **Partner Activity (15-20 minutes):** Have the couples begin their conversations. Float around observing the couples. After about 7-8 minutes, start checking in with each of the couples to answer any questions or provide support.
 4. **Processing (5 minutes):** Reconvene the group and get some general responses:
 - What was that conversation like?
 - How did that compare with the way you typically talk about sex?
 - How do you think it would affect a couple's sex life if one or both of them are worried about getting pregnant every time they "do it?" (Make the point that it's easier to have hot sex if you aren't worried about anything. After all, the brain is the biggest sex organ! In fact, many women reach their sexual peak in their mid 30's and 40's after most women have stopped having babies.)
 - Overall, what's your reaction to today's session on sexuality? How will you actually use anything that we discussed today?

HANDOUT FOR PARTNER CONVERSATIONS: OUR RELATIONSHIP

Directions: Complete the handout individually and then sit with your partner and share your answers.

1. On a scale from 1-5 how comfortable and open are you when talking with your partner about sex.

Not Comfortable		So-So		Very Comfortable
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

2. What is one thing you really appreciate about your partner when it comes to your sexual relationship?

3. What would you like more of in your sexual relationship?

4. What would you like less of?

PLANNING FOR CHILDREN I

GOAL FOR THIS SESSION

To promote the importance of timing pregnancies in order to reach family goals and achieve family stability.

OBJECTIVES

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

1. Identify the impact of a new baby on the couple’s finances, relationship, and family stability.
2. List longer-acting methods of contraception that are especially effective and convenient for busy couples who already have children. Describe ways that men can support the use of effective contraception.
3. Describe their beliefs about childbearing and pregnancy planning.
4. Clarify whether they are actively trying to prevent another pregnancy at this time. (Note: If there is any confusion or ambivalence, pregnancy is highly likely!)

SESSION-AT-A-GLANCE

Activities & Sequence	Objectives <i>Couples taking part in the activity should be able to...</i>	Time	Materials <i>FR = Facilitator Resource H = Handout</i>
In Their Shoes	Identify the impact of common obstacles encountered by low-income couples with children when they have unplanned pregnancies	50 min	<ul style="list-style-type: none"> • Planning for Children Questionnaire (H) • Couple Scenarios & Directions (FR) • Couple Station Cards (FR)
Same Gender Conversations	Explore gender-based attitudes about childbearing, dispel myths, and increase knowledge of male birth control methods and longer-acting female methods; describe ways that men can support the use of effective birth control	40 min	<ul style="list-style-type: none"> • 2 LCD projectors & 2 Laptop computers (optional) • Man Talk about Sex & Birth Control (PPT) • Woman Talk about Sex & Birth Control (PPT)
Partner Conversations: Are We or Aren't We?	Identify whether they are or aren't actively trying to prevent pregnancy at this time	30 min	<ul style="list-style-type: none"> • Sexuality—Myth or Fact (FR)

IN THEIR SHOES

Purpose: To identify the impact of obstacles faced by low-income couples with children when they have unplanned pregnancies.

Materials: Handout: *Planning for Children Questionnaire* and Facilitator Resources: *Couple Scenarios* and *Couple Station Cards*

Time: 50 minutes

Facilitator Notes:

1. This session is a component of the *Planning for Children Module*. The entire module is designed to be incorporated into a more comprehensive program on relationships. If you opted to conduct the session on sexuality (*Let's Talk about Sex*), then you've already done a good job of creating a comfortable environment for discussing these issues. If you did not opt to conduct that session, then you will need to create some ground rules. Your tone right from the outset will be invaluable in creating a warm and open learning environment.
2. The individuals and couples in your program are going to be in many different places when it comes to their beliefs about childbearing, the number of children they would ideally like to have, and their current desire to prevent or to seek pregnancy at this time. Some group members might be actively trying to get pregnant, some might be ambivalent, some might believe that this is not a good time to have another baby but they aren't doing anything consistent to prevent pregnancy, and still others might not want any more children. You have to create space in your group for people with any of these perspectives to feel safe and comfortable discussing the issues and for people to share their feelings when they may be the only one in the room who feels that way.
3. This activity is complex. Read it several times to fully digest the process. Decide in advance which two (of the four) scenarios you think are most relevant for your group. You will not have time for more than two scenarios.
4. Make large labels or posters with the following headings:
 - Housing
 - Health
 - Education & Finances
 - Employment & Finances
 - Child Support
 - Children's Well Being
 - Transportation
 - Partner/Extended Family Relationships
5. Set up three different stations in the room which will represent areas or components of the couples' lives that might be impacted by bringing another child into the family. You might use three small tables or desks for the stations. Or you could designate wall space to hang your posters or labels.
6. As participants walk into the session, ask them to complete the questionnaires individually. Provide clarification or assistance as necessary:

- Explain the questionnaires carefully and let people know in advance that they will be sharing their responses with their partners later in the session.
- Encourage participants to be as honest as possible, particularly about things like their current level of knowledge, because this information will help you evaluate the effectiveness of these sessions.
- Pay attention to any cues that might indicate that a woman (or man) is uncomfortable with her/his partner knowing about their current or past use of contraception.
- Collect the questionnaires and hold them until later in the session.

Procedure:

1. **Introduction and Group Contract (5 minutes):** Welcome participants and let them know that the next two sessions will focus on the issue of planning for pregnancy and children. Make the following points:
 - All of you are in this program because you want to become stronger as a couple. You're taking steps to get on your feet financially so you can provide a stable upbringing for your children.
 - Today we're going to talk about the ways that having another baby at this particular time can possibly impact your current efforts to become a more stable family.
 - When thinking about the possibility of having more children, many people have mixed feelings. Most people really value having children and being a mother or father can give a person's life a sense of meaning and purpose.
 - At the same time, children who come into the world have needs and it takes money, time, energy, and lots of love to raise them.
 - These two sessions are going to help you think about your attitudes and beliefs about children, your current situation as a couple, your thoughts about having more children in the future, and if you want more children, how you would ideally time and space future pregnancies.
 - We're going to do some interesting activities in the large group; you'll spend some time in a separate men's and women's group; and you'll sit together as a couple to talk, plan, and get on the same page about planning for more children.
2. Tell the group that you want to spend some time creating the right mood for talking about these issues. Go over the following information:
 - We believe that each individual has the right to determine how many children they want to have, when they want to have them, and with whom they want to have them.
 - Often couples wait until they find themselves pregnant to begin making plans to manage the financial and day-to-day arrangements of bringing a new child into the family.
 - Our goal is to help you decide *what you want*; to consider what your current and any future children need from you; and to get on the same page as a couple so you can have a shared vision and a plan for your family in advance of any surprises.
 - We're going to start where you are... so don't worry. If you want to have another child right away; if you're pregnant now; if you don't want another child right away but aren't doing much to prevent pregnancy; if you're ready for a permanent method of birth control... wherever you are, that's where we're going to meet you.

- Since we're going to talk about pregnancy planning, we'll end up discussing topics such as having sex and using birth control to prevent pregnancy. I want to make sure that everyone feels comfortable discussing these topics in this group.
 - Let's adopt the following rules to help create a space that feels comfortable for these kinds of topics.
 - No judging or putting down someone for their beliefs or values.
 - There are no dumb questions—there are a lot of myths about sex and birth control—so ask anything you're curious about.
 - If something is too personal or too private, you can pass.
 - What gets said here, stays here.
3. **Brainstorming (15 minutes):** Ask how many people in the room are pregnant or planning to have more children in the future. Ask participants to do a quick brainstorm about both the good and the hard stuff that can come along with having another child. Write “The Good Stuff” at the top of a chart and ask the group to tell you all of the positive things that might come along with a new child in the family. Do this for five minutes and write their responses on the chart. Now write “The Hard Stuff” on a different chart and ask how a new child might make life harder for them or the children they already have. List their responses on the chart. (Encourage them to think about things like specific financial expenses, demands on parents' time and energy, childcare needs, need for additional living space, changes in routines, effects on the couples relationship, and impact on any existing children in the family. Don't spend more than 5 minutes on this.)
 4. **Reality TV Show Activity (30 minutes):** Tell the group that they are going to participate in an activity called “In Their Shoes,” which is kind of like a reality TV show. Two couples in the room will volunteer to be participants on the show and walk in the shoes of a couple that has just found out they're about to have another baby. Recruit the first couple volunteers. Explain that there will be some role-playing involved so you need folks who don't mind doing a little acting. Once you have your volunteers, give these instructions:
 - I'm going to read a scenario that gives some background information on who you are and what's going on in your life.
 - You'll spend 1-2 minutes role-playing a conversation that you might have with your partner about your situation.
 - Finally, you'll go visit some stations to find out what happens to you in three areas of your life.
 - The rest of the group will be members of the studio audience and from time to time we'll ask you a few questions and give you a chance to make comments.
 5. (Note: Put your first set of posters up for the three stations: Health, Employment and Finances, and Child Support.) In an engaging style, tell the volunteers about their characters: Jasmine and Marcus. Ham it up a bit...don't just read. Once they've heard about their characters, ask them to role-play for a couple of minutes about how they are feeling. After a couple of minutes, say “freeze” and stop their conversation. Ask a few questions:
 - To the studio audience, how would you feel if you were in this couple's shoes?
 - To Jasmine and Marcus, what are some of the things that might happen in your life now that you're having another child?

6. Tell Jasmine and Marcus that they're going to find out what actually happens to them in three areas of their life. Have them get up and walk over to the first station (Health). Ask the studio audience, "What are some health issues that might come up with Jasmine's pregnancy?" Direct the couple to the Health Station and read the information from the facilitator resource. Have the couple (in their roles) tell the studio audience how they are feeling. After a minute or so, say, "freeze." Get reactions from the audience.
7. Move onto the second station (Employment and Finances) and read the information for that station. Get the couple to talk about how they are feeling and get reactions from the studio audience. Continue in this manner for the third station, Child Support. At the end of the discussion, thank Jasmine and Marcus, get them out of their roles, and send them back to their seats.
8. (Note: Change the posters on the stations to correspond with the stations to be visited by the next couple you've chosen for the activity.) Recruit your next set of volunteers and use the same process that you used earlier. When you're done, thank all of the actors and the studio audience and get people out of their roles. The reality show is over and now the group will discuss what happened and what they can learn from the activity.
9. Stress that the activity has highlighted the following message: For a couple that is struggling to get on their feet, unexpectedly bringing a new baby into the family can bring health issues, stress to the couple's relationship, financial pressures, and less time and attention for existing children.
10. Use the questions below to debrief the activity.

Discussion Questions:

1. How realistic were these scenarios?
2. What do you think it would really be like for you and the children you already have if you had another baby now? (Encourage participants to think about all the ways portrayed in this activity—health, finances, housing, partner relationship, children's well-being.)

HANDOUT PLANNING FOR CHILDREN QUESTIONNAIRE

Directions: Please answer each question to the best of your ability.

Name: _____

Date: _____

Age: _____

of children you're raising: _____

Currently pregnant: _____

1. How informed are you about birth control methods?

Not Well Informed		Very Well Informed		
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

2. Check all the methods of birth control (contraception) that you've ever used.

- Condom
- Withdrawal
- Depo-Provera (the shot)
- IUD
- Implant
- Pills
- EC/Plan B
- Diaphragm
- Vaginal Ring
- Patch
- Rhythm

3. What method are you using now? _____

4. Do you use the method every single time you have sex? Yes No

5. Do you plan to have another child in the next year? Yes No

6. How would you feel if you or your partner got pregnant in the next year?

- Very happy
 A little happy
 A little unhappy
 Very unhappy

7. How much do you and your partner agree on whether and when to have more children?

Disagree/Never talk about it			Agree/On the same page	
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

8. Do you and your partner have a clear plan for spacing and timing any future pregnancies?

Yes No

Thank you for completing this questionnaire!

FACILITATOR RESOURCE

COUPLE SCENARIOS

COUPLE #1: JASMINE AND MARCUS

You've been together for four years and have a 2-year-old daughter. Marcus, you work full time in a minimum wage job. You have a 6-year-old son, Aaron, from a different mother. You give Aaron's mother money off and on when you have it. Jasmine, you do temp work off and on. You are living together in a small one bedroom apartment in a tough neighborhood and are trying to move to a larger apartment in a safer area. You found out today that you're having a baby! Standing in this couple's shoes, how do you feel?

Visit the stations in this order:

1. Health
2. Employment and Finances
3. Child Support

COUPLE #2: LONDELL AND SHANICE

You've been together for two years. Shanice, you were a mother with a 3-year-old daughter (Imani) when you met Londell. The two of you had only been together for three months, when you got pregnant. Londell, you were really stressed when Shanice told you she was pregnant and you stayed away from her until your son, Dante, was born. Shanice, you forgave Londell when he showed up at the hospital and promised to become a real family. Londell, you do construction work that pays well but isn't regular. Shanice, you receive public assistance and live in a one-bedroom apartment subsidized by Section 8. Londell moved into your apartment after Dante's birth and he pays most of the bills except rent. Londell is great with your daughter Imani who has a lot of behavior problems. Dante is now one year old. You found out today that you're having a baby! Standing in this couple's shoes, how do you feel?

Visit the stations in this order:

1. Employment and Finances
2. Transportation
3. Children's Well Being

COUPLE #3: CACHE AND BRANDON

The two of you have been together for two years. You have a 1-year-old son, Antonio. Both of you would like to have another child in a few years, hopefully a girl. Cache, you attend community college and are studying to become a licensed practical nurse (LPN). Six months ago, you and Antonio moved into Brandon's tiny efficiency apartment. It's really hard to be in such a small space so you've been complaining a lot. Brandon, you work full time in a minimum wage job. You're expecting a \$900 tax refund and you're planning to use that as a security deposit on a one-bedroom apartment. You found out today that you're having a baby! Standing in this couple's shoes, how do you feel?

Visit the stations in this order:

1. Health
2. Education and Finances
3. Your Relationship

COUPLE #4: ADRIAN AND LAKEISHA

You've been together off and on for the last 8 years and have two children: 7-year-old Adrian Jr. and 1-year-old Kyra. Adrian, you're an ex-offender and you've had a tough time finding employment since your release from prison two years ago. You're a hard worker who does a lot of off-the-books jobs, painting or helping a friend who does home improvement work. Unfortunately, the work is not dependable so you're unemployed a lot. Lakeisha, you're an upbeat, fun-loving woman who is Adrian's biggest supporter. Right now you're living with Adrian's father, James, and stepmother, Alicia, but Alicia wants you and the two kids out as soon as possible. You found out today that you're having a baby! Standing in this couple's shoes, how do you feel?

Visit the stations in this order:

1. Housing
2. Employment and Finances
3. Partner/Extended Family Relationships

FACILITATOR RESOURCE COUPLE STATION CARDS

COUPLE #1: JASMINE AND MARCUS

Health

Jasmine, you gained 60 lbs during pregnancy and were diagnosed with diabetes in your eighth month. You gave birth to a healthy baby boy, Marcus Jr. When you got home with the baby, you were really depressed and didn't seem to have the energy to take care of your son. The doctor told you that diabetes and postpartum depression often go together. Marcus, you've been working hard to understand Jasmine's depression but you're worn out after working all day and coming home to crying children. You want Jasmine to get herself together. **What are you thinking? What are you feeling?**

Employment and Finances

Jasmine, you haven't done any temp work since you were diagnosed with diabetes. So, Marcus, you've had to pay all of the family's bills and with a new baby, it's a lot. Also, Aaron's mother filed a child support case and now \$200 is coming right out of your check every month. There's no way you can move to a larger apartment now. **What are you thinking? What are you feeling?**

Child Support

With the child support coming directly out of your check, you can no longer pay all of your bills, so you go to the Child Support Office to get your child support order modified. When you get there, they give you some "Review and Adjustment" forms to complete and tell you that it will take up to six months for them to schedule a hearing. **What are you thinking? What are you feeling?**

COUPLE #2: LONDELL AND SHANICE:

Employment and Finances

Shanice, you gave birth to a healthy baby girl, Mina. Londell, since Mina's birth, there's been a downturn in the economy and you're working a lot less than usual. You can't pay your old bills and now there are even more things to buy like diapers and formula. **What are you thinking? What are you feeling?**

Housing/Transportation

Shanice, today you have a 9:00 appointment to get recertified for Section 8. You wake up at 6:30 and get all three kids bathed, fed, and dressed. Imani is in a terrible mood and throws several tantrums. By the time you get yourself dressed and pack a bag with diapers, bottles, snacks, and toys, it's 8:30. You put Mina in a stroller and head to the bus stop with 2-year-old Dante and 4-year-old Imani in tow. You finally get to the housing authority at 9:30 and sit there for two hours before you're seen. **What are you thinking? What are you feeling?**

Child Well-Being

Shanice, when you get home from the housing authority, you're completely worn out. Imani is still cranky and irritable. Londell, you use all of your tricks to calm Imani down but she just keeps screaming. Finally you lose your temper and spank her behind but all she does is scream more. **What are you thinking? What are you feeling?**

COUPLE #3: CACHE AND BRANDON

Health

You find out that the pregnancy is going well. Brandon, you go with Cache to most of her appointments and today you she gets a sonogram and the two of you see a picture of your baby for the first time. You find out that you're having a girl! **What are you thinking? What are you feeling?**

Education and Finances

Cache, you finished your current semester, but then decide to quit community college until the baby is about a year old. So your dream to become a nurse will have to be postponed. Brandon, when you didn't receive your \$900 tax refund, the IRS explained that the funds had been garnished by a company because of a bill that you never paid. So without the money for a security deposit, you can't move. **What are you thinking? What are you feeling?**

Your Relationship

Cache, you decide that you cannot go back to the efficiency with a newborn and a toddler. Brandon, you want the family to stay together but don't see how you can make it work. Together you decide that Cache will ask her mother if she can move back home. Cache's mother agrees. Brandon, you get a second job to try to earn enough money for a larger apartment. You're providing some child support and saving some money but because you're working all the time, you hardly ever see Cache or the kids. **What are you thinking? What are you feeling?**

COUPLE #4: ADRIAN AND LAKEISHA

Housing

Adrian, when your stepmother, Alicia, finds out that Lakeisha is pregnant, she goes off and curses Alicia out. Lakeisha, you pack up your stuff and move the kids in with a friend on a temporary basis. **What are you thinking? What are you feeling?**

Employment and Finances

Adrian, you decide to get back into the game one last time to earn some fast money so you can finally get an apartment and move out of your father's house. Things go well so you keep hustling for a few extra months. You get arrested and, because it's your third strike, you face a long mandatory sentence. **What are you thinking? What are you feeling?**

Partner/Extended Family Relationships

Lakeisha, after Adrian's arrest, his dad calls and asks you to move back in with him and Alicia. Now that Adrian is back in jail, his dad and Alicia seem more willing to help you and the grandkids. You give birth to a beautiful baby boy, Antwon. Surprisingly, Alicia just adores Antwon and is acting pretty decent. Lakeisha, you take the children to see their father every other month but the whole situation is really hard. Adrian, you barely know your baby son, Antwon, and you can see that Adrian Jr. is heading down the wrong path now that you're away again. **What are you thinking? What are you feeling?**

SAME GENDER CONVERSATIONS

Purpose: To have participants identify and explore a range of issues related to childbearing, communication, and birth control in a single-gender setting.

Materials: Samples of birth control methods, 2 LCD Projectors and 2 laptop computers (optional), PowerPoint Handouts: *Man Talk about Sex and Birth Control* and *Woman Talk about Sex and Birth Control*

Time: 35 minutes

Planning Notes:

1. In this activity men and women meet in separate groups to discuss issues related to pregnancy planning. You'll need two rooms so each group can have privacy. Ideally, you'll have a male facilitator to work with the men's group and a female to be with the women's group.
2. There are notes within the PowerPoint presentation to guide the discussion in your small groups. The idea is to have an informal, lively, and free-flowing discussion. The PowerPoint is included only to provide visual aids and to be a guide for the discussion. **If you don't have access to two LCD projectors or don't want to use PowerPoint, then you will need to print out the PowerPoint handouts so participants can have access to the visuals.** We recognize that some nonprofit organizations will not have this equipment.
3. Review the PowerPoint presentations. Be sure to study the notes that accompany the slides, so you can see the open-ended questions and additional comments that will help you facilitate the activity. Plan how you will present the information being sure to tailor your comments for your population.

Procedure:

1. Introduce this activity by making the following points:
 - In our society, men and women sometimes have different opinions and perspectives about sex, birth control, and having children.
 - This activity will give you a chance to communicate with members of your own gender and explore your experiences and opinions.
 - You will get into separate groups and do some straight talk, woman to woman and man to man.
2. Divide the group by gender. Each facilitator should lead a discussion using the facilitator notes in the PowerPoint presentations. The goal is to create safe space with same gender groups so participants can talk frankly.
3. Time the small group discussion very carefully and be sure to coordinate with your co-facilitator so you end at the same time. Allow no more than 35 minutes. Check in with each other to make sure that you're on schedule before reconvening the large group.

PARTNER CONVERSATIONS: ARE WE OR AREN'T WE?

Purpose: To have participants identify whether they are or aren't actively trying to prevent pregnancy at this point in their relationship.

Materials: Handouts: *Are We or Aren't We?* and *Completed Questionnaires*

Time: 30 minutes

Planning Notes:

1. Have the completed questionnaires from the first activity on hand and ready to redistribute. Make sure you've reviewed them briefly so you have some indication of each person and each couple's profile.
2. Plan to collect the questionnaires again at the end of the activity so you can retain them as a pre-survey for evaluation purposes.
3. While you don't have time to go into the issue here, be prepared to refer any couples who are pregnant or planning a pregnancy to additional info/resources for healthy pregnancies, prenatal care, etc.

Procedure:

1. **Questionnaires (5 minutes):** Redistribute the questionnaires that participants completed at the beginning of the session. Make these points:
 - You completed these questionnaires when you first walked into the room today. Look back at your answers and think about them in light of all of our discussions.
 - There are a couple of things we're going to ask you to discuss with your partner now. Question #5 asks if you plan to have another child in the next year and question #6 asks how you would feel if you got pregnant in the next year.
 - Some people feel clear about their plans for more children and others feel ambivalent (have mixed feelings). Check your answers. If you said you weren't planning on having a baby in the next year and you'd be a lot or a little unhappy if you/your partner got pregnant, then your feelings are pretty clear. If you said you weren't planning on having a baby but you'd be a little or a lot happy about it, you're ambivalent. That means, although you aren't planning on having a baby, you're very open to the possibility. It's normal to have ambivalent feelings, but folks who are ambivalent tend to be a lot less motivated to use birth control to prevent pregnancy.
 - Also look at questions #3 and #4 which ask what method you're using now and whether you use it every time you have sex. If you said that you were not planning on having another baby in the next year and you/your partner are not using a method (or don't use it every time), then it's time to step back and really consider where you stand on this issue. If you're not actively and carefully trying to prevent a pregnancy, then you're actually trying to get pregnant.
2. **Handout and Instructions (3 minutes):** Take a few minutes to hear reactions to what you've just said. Distribute the *Are We or Aren't We?* handout. Review the handout which guides the couples in sharing their responses to the questionnaire. Give these instructions:
 - Sit together as a couple facing each other, knee to knee.

- Take turns sharing your responses to each question on the handout.
 - When your partner is talking, use your listening skills to make sure you are really hearing what they are saying.
 - We're going to be checking in with each couple to see how the conversation is going and provide any support that you might want.
 - Compare your answers to see if you agree or disagree on most things.
3. **Partner Conversations (17 minutes):** Have the couples begin their conversations. Float around observing the couples. After about 7-8 minutes, start checking in with each of the couples. Get a sense of how things are going and provide support to any couples that need assistance.
 4. **Processing (5 minutes):** Reconvene the group. Find out how things went for the couples. Ask:
 - For those who plan to get pregnant in the next year, think back to the “In Their Shoes” activity we did earlier. How would a new baby impact your family life—finances, housing, etc.? What's your plan for taking care of yourself so that you have a healthy pregnancy and baby?
 - How many of you had to admit that because you are not actively and carefully trying to prevent pregnancy, you're actually setting yourself up to get pregnant?
 - If you realize now that you've been behaving as if you're trying to get pregnant and you aren't happy about that, how open are you to trying to use a birth control method more effectively?
 5. **Collect the questionnaires again.** Tell participants that you will continue to focus on these issues for one more session. Encourage the couples to keep talking about how they want to space and time any future pregnancies.

HANDOUT FOR PARTNER CONVERSATIONS: ARE WE OR AREN'T WE?

Directions: Sit together and talk honestly about your answers to the questionnaires.

1. Share your answers and pay attention to what they say about how you really feel about having another baby within the year. For example:
 - Did you say you're not planning on having a baby but you'd be happy if you/your partner got pregnant?
 - Did you say that you're not planning on having a baby but you're not using a method consistently to prevent pregnancy?

2. Remember if you're NOT actively doing anything to prevent pregnancy, you're actually setting yourselves up to get pregnant. How do you feel about that? Are you OK or do you want to get more serious about pregnancy prevention?

3. How much do you and your partner agree or disagree?

PLANNING FOR CHILDREN II

GOAL FOR THIS SESSION

To enable couples to get on the same page (create a shared vision) about if or when to have another child and the use of contraception to achieve this goal.

OBJECTIVES

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

1. Differentiate between myths and facts about birth control methods.
2. Identify some strategies for communicating/negotiating with their partner about contraception in tough situations.
3. Create a plan for timing any future pregnancies in order to reach family goals and achieve family stability.

SESSION-AT-A-GLANCE

Activities & Sequence	Objectives <i>Couples taking part in the activity should be able to...</i>	Time	Materials <i>FR = Facilitator Resource H = Handout</i>
Myths & Facts About Birth Control	Differentiate between myths and facts about birth control	45 min	<ul style="list-style-type: none"> • Myth/Fact Statements (FR) • Contraceptive Methods (FR) • Birth Control Methods (PPT Handout) • Birth Control Facts (H)
Case Studies: What Would You Do?	Identify some strategies for communicating/negotiating with their partner about contraception in tough situations	35 min	<ul style="list-style-type: none"> • Case Studies (FR)
Partner Conversations: Making a Plan	Describe their plan for preventing pregnancy	40 min	<ul style="list-style-type: none"> • Planning for Children Post-Survey (H)

MYTH-INFORMATION GAME: BIRTH CONTROL

Purpose: To have participants differentiate between facts and myths about methods of birth control.

Materials: Small prizes; Kit of birth control methods; Optional LCD projector and laptop; PowerPoint Presentation: *Methods of Birth Control*; Facilitator Resources: *Myth/Fact Statements* and *Facilitator's Guide to Birth Control*; Handouts: *Birth Control Facts* and *Birth Control Methods PPT*

Time: 45 minutes

Facilitator Notes:

1. This session builds on the previous session, *Planning for Children I*. Ideally, there are no couples attending this session who did not attend the earlier session. However, stuff happens, so you may end up with a couple who missed the earlier session. If that happens, please briefly review the following points with those “new” couples.
 - Last week we started a brief program that we’re calling *Planning for Children*. The goal is to help you take charge of timing any future pregnancies so you can reach your goals and become stable as a family.
 - We are not pushing any point of view and recognize that you have the right to have as many children as you want, whenever you want.
 - Our goal is to help you decide **what you want**; to consider what your current and any future children need from you; and to get on the same page as a couple so you can have a shared vision and plan for your family in advance of any surprises.
 - We’re going to start where you are... so don’t worry... wherever you are, that’s where we’re going to meet you.
2. Do some research to identify the Title X family planning health centers in your community. You can find Planned Parenthood clinics by calling 1-800-230-PLAN or go to the National Family Planning and Reproductive Health Association website: http://nfprha.org/main/about_us.cfm?Category=Member_Clinic_Directory&Section=Main to get a listing of Title X family planning health centers. Call some of the clinics to inquire about their services for low-income women and men. Find out if Medicaid recipients have access to all the methods of birth control or if there are limitations. Also, find out if the health center has any pamphlets, charts, or birth control kits that you can borrow. It’s nice (but not mandatory) to have a birth control kit containing samples of the various methods for the session.
3. The *Birth Control Facts* handout was developed by ETR Associates. You can order copies of this low-cost pamphlet from their website: <http://pub.etr.org/ProductDetails.aspx?ProdID=137>.
4. Read the facilitator resource material thoroughly to get comfortable with the information. It’s great if you are knowledgeable enough to give the explanations for each myth/fact statement without reading. However, it’s better to read the explanation than to give an inaccurate or unclear message about the statement you’re discussing.
5. The *Myth-Information Game* is a fun way to dispel myths and give additional information about birth control. Your goal is to listen to participants, confront myths, and make sure that they have overall knowledge of birth control methods, especially those that are long-acting and most effective. At the end of the game, be sure to show the slide that compares the effectiveness of all of the methods.

6. Obtain some small prizes for the winners of the *Myth-Information Game*, for example, picture frames or small photo albums from the dollar store.
7. We have included a PowerPoint presentation that accompanies the *Myth-Information Game* to provide visuals of the various birth control methods you will be discussing. We strongly encourage you to use the PowerPoint if at all possible. If you are using the PowerPoint, set up the LCD projector and make sure everything is working properly. There are slides that correspond with some of the myth/fact statements and you will see those references noted on the facilitator resource: *Myth/Fact Statements*. Review the myth/fact statements and the slides carefully to see how they need to be tied together. If you don't have access to an LCD projector, you must make copies of the PowerPoint handouts. If you don't have either the PowerPoint presentation or handouts, participants will not be able to actually see diagrams of the methods you're discussing and the activity will be less effective.
8. When conducting this entire session, keep in mind that some of the couples might already be using a method fairly consistently, some may be using a method inconsistently, some may be trying to get pregnant, and some may be very open to finding a method that could work for them.

Procedure:

1. **Check-in and Energizer (15 minutes):** Welcome participants to the second session, *Planning for Children II*. (Note: If you have any "new" couples who didn't attend the previous session, do some stage setting with them as outlined in Planning Note #1. Ask some of the couples who were present last session to describe what they did to the "new" couples.) Do a brief check in:
 - Ask if any couples talked about planning for children after they left the session or during the week. If so, what kinds of things did they discuss?

Give an overview of today's session:

 - We're going to play a myth/fact game. You say you're already very knowledgeable about birth control, so this will be a good test of your knowledge.
 - We're also going to discuss and possibly role-play some challenging situations (related to using and being consistent with birth control) that couples might find themselves in.
 - Finally, we'll have you sit down and put a plan together for how you'll plan and space any future pregnancies in order to accomplish family goals.
2. Conduct a brief energizer called "Values Voting" that will get group members up out of their seats and talking about their attitudes about birth control. Give these instructions:
 - I will read a statement. Decide whether you agree or disagree with it.
 - If you agree, you will come stand here (point to a position in the room); if you disagree, you will stand here (point to a different position a little distance away). There is no unsure position, so decide which way you're leaning.
 - When everyone has chosen a position, you take turns telling us why you chose this position.

Read the statement: "Postponing having children in order to accomplish your personal or financial goals is selfish." (Note: An alternative statement to read would be: "It's OK for a couple to actively plan to have another baby even though they are struggling to support the child(ren) they already have.")

Have participants get up and vote on whether they agree or disagree with the statement. Ask them to

go with their gut and not to worry about where anyone else is standing. Ask each individual to give a very short explanation of their position on the statement. Have participants return to their seats and discuss their reactions:

- How did your views compare with your partner's and how do you feel about that?
- How have your beliefs and opinions about this issue affected your behavior?

Note: As an alternative to the “Values Voting” process, you might just do a temperature check with the group by reading the statement and asking each person in the group to say if they agree or disagree and why.

3. **Myth-Information Game (30 minutes):** Explain how the *Myth-Information Game* will work:

- I'm going to put you in teams to see who knows the most about birth control. (Note: you can choose teams however you want: have each couple join another couple to make teams of four people; or just form two or three teams randomly.)
- Each team will choose a spokesperson.
- I will read some statements about birth control. Put your heads together and decide as a team if you think the statement is a fact or a myth and why.
- Teams will take turns giving answers. When you give your answer, you have to say why the statement is a fact or a myth.
- After about 30 seconds, I'll ask the spokesperson for your answer.
- If it's your turn and you're right, your team gets a point. The team with the most points wins a small prize.

Form the teams and begin reading statements. Be sure to fully discuss the explanations for each statement and the facts behind any myths. Also refer to PowerPoint slides either on the screen or on handouts as directed in the facilitator resource. If you have actual methods, show them as you discuss the various statements. Encourage participants' comments and feedback during the game.

4. At the end of the game, you will be showing PowerPoint slide #14 which compares the different methods of birth control in order of effectiveness and slide #15 which lists priorities for choosing a method. Ask: What would you be most concerned about (priorities) when deciding which of these methods to use? Expect responses such as: a) how hard is it to use? b) are there any health risks? c) will it really prevent pregnancy? Weave some of these points into the discussion as appropriate:
- If your biggest concern is not getting pregnant, you would want to use a highly effective method such as the implant, IUD, shot, pill, ring, or patch.
 - If you need something really easy without much to remember, then the longer-acting methods like the implant, IUD, or shot are good options.
 - If you're concerned about birth control methods making you fat, weigh that against the kind of weight gain that can come along with pregnancy.
 - If you have concerns about hormones, the ParaGard Copper T IUD doesn't have hormones and is effective for up to 10 years. The long-acting methods are really great for busy parents and they are easily reversed!

- If you don't have Medicaid or other insurance, then birth control can be expensive. Some clinics provide contraception on a sliding scale. Compare the cost of using contraception with the cost of having and raising a child.
 - If you're a man who wants to take on more responsibility for preventing pregnancy, you could make sure you use a condom every time you have sex, or be very precise about using withdrawal, or, if you're ready for something permanent, get a vasectomy.
 - If you're concerned about preventing STIs/HIV, remember condoms protect against disease. The other methods only work to prevent pregnancy. So use condoms and another method of contraception.
 - If none of the methods seem like good options and it's not important to be able to have children in the future, then permanent methods might be the best choice.
5. After all the statements have been discussed, determine which team won the game and give the prizes. Ask the questions below.

Discussion Questions:

1. What methods would you consider using at this point? (Note: If anyone is already using a method successfully, ask them to talk about their experience.)
2. What do you want to talk with your partner about when it comes to birth control?

FACILITATOR RESOURCE BIRTH CONTROL—MYTH OR FACT?

Directions: These myth/fact statements are to be used in conjunction with the PowerPoint presentation, *Birth Control Methods*. The goal is to read statements related to a group of birth control methods, then show the slide about those methods, and finally give some information—important things to know—about those methods. So you will intersperse a little teaching into the game. If you're not showing the presentation, simply have participants refer to the slides on the PowerPoint handout.

1. **There are certain positions of intercourse that will help prevent pregnancy (for example, standing up or woman on top).** (Myth.) Some people believe that having sex in certain positions, such as standing up, will force the sperm out of the woman's vagina. In truth, positions during sex have nothing to do with whether or not fertilization occurs. When a man ejaculates, the sperm are deposited well into the vagina. Remember sperm can swim and they will begin to move up through the vagina into the cervix and on into the Fallopian tubes where they can possibly meet up with an egg. It is also a myth that a woman must have an orgasm to get pregnant.
2. **A woman's most fertile time of the monthly cycle is right after her period.** (Myth.) Actually the risky time is rather long. Menstrual cycles vary in length. Let's talk about a perfect 28-day cycle which is four weeks. If you think of the first day of your period as day one, then the risky days are anywhere from day 7 to day 19. That's a long time to be concerned about and also many women don't have 28-day cycles. So bottom line – avoid taking chances any time during the month.
3. **A woman who's had a lot of female (gynecological) problems and hasn't gotten pregnant for a while (although not using birth control) is probably sterile.** (Myth.) A lot of babies have come into the world because women decided that they couldn't get pregnant again. I'm sure some of you know situations like this. Unless your doctor has told you that you definitely cannot get pregnant, you should use birth control if you don't want to have another baby right now.
4. **Implants (Implanon) cause changes in a woman's menstrual flow that can be harmful to her health.** (Myth.) The implant is a rod that contains hormones that is placed under the skin in a woman's arm. Many, but not all, women experience changes in their menstrual bleeding when they use implants. These changes can be annoying but they aren't harmful to a woman's health. It is also not harmful to actually stop menstruating after one or two years of implant use. Blood will not build up inside of the body. Implants are very effective for up to three years but they can be removed sooner if the woman chooses. *{Note: refer to PowerPoint slide #2}*
5. **It is common for an IUD to leave the uterus and travel to a woman's heart or brain or get stuck in her fat if she is overweight.** (Myth.) Because of the way a woman's body is made, that won't happen. Remember the IUD is a small object that is inserted by a health practitioner into the uterus. Think of your body as a home. The uterus is a room in the home and there is only one way in and one way out of the room—through the cervix and out through the vagina. If the IUD gets expelled from the uterus, it would typically come out through the vagina. Note to Facilitators in case participants ask about this: In rare cases IUDs have come through the perforated wall of the uterus into the abdomen (which could require surgery for removal), but can't get to any other parts of the body. *{Note: refer to PowerPoint slide #2}*
 - *Show PowerPoint Slide #2:* These are pictures of the IUD and the implant—two long-acting methods that are very effective at preventing pregnancy. Review the notes that accompany this slide.
 - *Show PowerPoint Slide #3:* These are some important things to know about the IUD and the implant.

6. **A man who has had a vasectomy will no longer be able to ejaculate.** (Myth.) A vasectomy has absolutely no impact on the way a man ejaculates. His ejaculation will have the same force and the same feeling. There just won't be any sperm in the fluid. Vasectomy is not reversible so you have to be sure you don't want any more children. Vasectomy is nearly 100% effective. It can be done with or without surgery. *{Note: refer to PowerPoint slide #4}*
 - *Show PowerPoint Slide #4:* These are pictures of permanent methods of birth control for men and women. Review the notes that accompany this slide.
 - *Show PowerPoint Slide #5:* These are some important things to know about the permanent methods.
7. **Birth control pills reduce a woman's risk of getting certain types of cancer (ovarian and endometrial—lining of the uterus).** (Fact.) Although people fear that the pill causes cancer, women on the pill actually have lower rates of two types of cancer—cancer of the ovaries and cancer of the lining of the uterus. The risk of endometrial cancer (cancer of the lining of the uterus) and cancer of the ovaries actually goes down the longer you are on the pill. After one year, endometrial-cancer risk goes down by 50 percent; after 10 years, the risks are 80 percent lower than normal. Evidence of a link between pill use and breast cancer is still inconclusive. However, the most recent medical literature suggests that the pill has little, if any, effect on the risk of developing breast cancer. *{Note: refer to PowerPoint slide #6}*
8. **Birth control pills cause women to gain weight.** (Myth.) A lot of people believe this and, in fact, older forms of birth control pills had higher hormone levels and did cause weight gain. Today's pills have much lower doses of estrogen and studies show that the pill and most other hormonal methods do not increase weight. However, studies have linked Depo-Provera (the shot) with weight gain. People who are very concerned about weight gain have to consider how much weight might be gained during a pregnancy. *{Note: refer to PowerPoint slide #6}*
9. **Having a baby is more risky to a woman's health than taking birth control pills for a year.** (Fact.) The risk of death from pregnancy and delivery is about 1 in 8,700. Among women taking the pill, the risk of death for nonsmokers aged 15-34 is 1 in 1,667,000 and the risk among nonsmokers aged 35-44 is 1 in 33,300. *{Note: refer to PowerPoint slide #6}*
 - *Show PowerPoint Slide #6:* These are pictures of other hormone methods including the pill. Review the notes that accompany this slide.
 - *Show PowerPoint Slide #7:* These are some important things to know about these hormone methods.
10. **Women should give their bodies a 'rest' from all birth control every 3-5 years.** (Myth.) There is no reason for a healthy woman to stop using birth control. Regardless of the type of birth control you use, your body does not require you to stop at any point. An IUD that does not contain hormones must be replaced every 10 years. IUDs containing hormones should be replaced every five years. The pill can be taken for as long as 15 or 20 years. Taking a break from a method like the pill often leads to an unplanned pregnancy. Many unplanned pregnancies occur when couples stop using an effective birth control method for one reason or another. So always go back to your health provider and talk it over if you're having problems or feeling uncomfortable with your method.
11. **Condoms have an expiration date.** (Fact.) Condoms are made of latex, and latex breaks down over time. A condom that is past its expiration date is weaker and more likely to break; it provides much less effective protection. Heat and friction can also weaken the condom, so it's not a good idea to store condoms in a place where they will be exposed to your body heat for more than a short period of time. *{Note: refer to PowerPoint slide #8}*
 - *Show PowerPoint Slide #8:* These are pictures of barrier methods including the condom. Review the notes that accompany this slide.

- *Show PowerPoint Slide #9:* These are some important things to know about barrier methods.
- *Show PowerPoint Slides #10-12:* Briefly review these slides and the notes that accompany them.

12. **Emergency Contraception or Plan B can be taken up to five days after having unprotected sex.**

(Fact.) A lot of people don't know this and are confused because this method is also called the morning after pill. So people think it must be taken the morning after or within 24 hours of having unprotected sex. The package says the pills must be taken within 72 hours...but, according to the World Health Organization (WHO), you can begin taking it up to five days or 120 hours after unprotected sex. Of course, the sooner you take it the better. {Note: refer to PowerPoint slide #13}

- *Show PowerPoint Slide #13:* These are pictures of Plan B or Emergency Contraception. Review the notes that accompany this slide.
- *Show PowerPoint Slide #14:* This slide compares the different methods of birth control. They are shown from left to right in order of effectiveness.
- *Show PowerPoint Slide #15:* This slide lists possible priorities for choosing one of these methods. Ask participants what they would be most concerned about when trying to decide which method would be right for them.

REFERENCES

National Campaign to Prevent Teen and Unplanned Pregnancy: www.thenationalcampaign.org/survey/facts.aspx

Guttmacher Institute: www.guttmacher.org

Planned Parenthood at 1(800) 230-PLAN: www.plannedparenthood.org

CASE STUDIES: WHAT WOULD YOU DO?

Purpose: To have participants identify some strategies for communicating/negotiating with their partner about contraception in tough situations.

Materials: Facilitator Resource: *Case Studies*

Time: 35 minutes

Planning Notes:

1. There are three case studies to choose from in this activity. Read them and choose one that would be most relevant for your group.
2. Each case study is followed by some notes that you can use to help guide the discussion. The notes offer suggestions for good birth control options for the various couples. However, it's important to find out what your participants think and to offer these suggestions only if they don't come up from the group.

Procedure:

1. **Introduction of Activity (1 minute):** Give the following directions:
 - We're going to discuss a case study that deals with some of the tough issues and situations that couples face when they are trying to get on their feet financially.
 - I'll read the case study and then read some options for what the couple might decide to do.
 - You'll decide which option you would choose and why.
2. **Case Study (12 minutes):** Read the first case study you've chosen. As you read the possible options for this couple, designate positions in the room to correspond with each option. Or if you'd like, create signs for each position. Ask participants to move to the position in the room that corresponds with the option they think is best. Make it clear that it is OK if couples disagree about the option that they think is best.

Once participants have placed themselves in the room, give them a minute or two to talk to the other people standing with them about why they chose this option. The folks who chose "other" should explain what they would do and why. After a couple of minutes, ask each of the groupings to explain why they chose their option. When each option has been discussed, ask people to take their seats. Ask the discussion questions for the case study you've chosen. Get participants' reactions and use the notes to make additional points only if they don't come up during the discussion.

3. **Role-play (10 minutes):** Tell the group that you'd like to have a role-play that shows a conversation between the couple in the case study. The goal is to have one partner begin a conversation about how to move forward and avoid any future problems or accidents. Have participants brainstorm points that each partner could make in the conversation and then ask two volunteers to perform the role-play. After the role-play, ask the actors how they thought things went. Ask the group to give them some feedback about what they did well and want they could have done differently.
4. **Wrap Up (2 minutes):** Wrap the activity up by making these final points:
 - Most mothers come home after giving birth on a method of birth control; that is a great oppor-

tunity to begin this planning process. Male partners can help by getting involved in pregnancy planning as early as possible.

- Link your financial and family goals to your daily motivation to prevent or postpone pregnancy: “We have to keep saving money. Let me put the condom on for you.”
- Drinking and getting high greatly reduces your ability to be consistent with methods like condoms, which require careful use.
- Emergency contraception is available if you slip up or have an accident. It should not be used as a regular method—it’s a last resort... but it is there as a back-up.

FACILITATOR RESOURCE CASE STUDIES

CASE STUDY 1: BREHANNA AND MIKE

Brehanna and Mike have two children, ages 2-years and 6-months. Mike also has a 6-year-old son and pays child support to his ex. After giving birth, Brehanna came home from the hospital on DepoProvera (the shot) which is effective for three months. She and Mike started having sex again after four weeks. Brehanna never went back to the clinic to follow up on birth control; she was having a hard time losing weight and it seemed like the hormones were blowing her up. Now six months after giving birth, Brehanna thinks she's pregnant. When she told Mike, he got frustrated and said they were never going to get their finances together. Hurt by Mike's reaction, Brehanna asked, "You mean you don't want to have another child with me?" Mike said, "Not right now. I'm planning ahead so that we can get ourselves up and stable before we think about having another child." When Brehanna went to the clinic for a pregnancy test, it turned out that she was not pregnant. So what do they do now?

- A. Nothing
- B. Mike gets a vasectomy
- C. Brehanna gets a non-hormonal IUD (Paraguard)
- D. Other

DISCUSSION QUESTIONS

1. What can you relate to personally in this case study?
2. If you were Mike, how would you start a conversation about this with Brehanna? What would you want to say?

NOTES ON CASE STUDY 1

Possible Next Steps: The couple needs to talk honestly about how they feel and what they want. Mike does not want another child now but Brehanna seems torn. Perhaps, she wants to get pregnant even though the timing is bad. She must figure it out and be honest with Mike. Mike should recognize that Brehanna's feelings are normal although different than his own. Hopefully, he can be caring but also clear about not being able to take on another child right now. Bottom line: If Mike doesn't want another child right away, the only way he can completely control this is to use a condom or practice withdrawal each and every time he has sex with Brehanna.

Good Birth Control Options: The shot does sometimes cause weight gain so Brehanna and Mike could consider a different long-acting method such as the IUD or the Implant. Mike could support Brehanna in choosing a method that feels comfortable and easy for her. It's always helpful to weigh any possible consequences of using a particular birth control method with the health consequences of pregnancy and delivery.

CASE STUDY 2: KYRA & JAMAL

Kyra and Jamal have three children—ages 4-years, 2-years, and 9-months. They are both working but they struggle financially. They get by with food stamps, Medicaid, and a little help from their families. Kyra wants to become an RN and she doesn't want any more children. She actually considered having an abortion when she was pregnant with Jay but Jamal talked her out of it. When they started having sex again, Kyra told Jamal to use condoms 'cause she wasn't having any more babies and she was tired of using birth control. Jamal is using con-

doms but not all the time. They smoke weed...him more than her. They both enjoy sex and when Jamal is high, he never wants to use a condom. Last night they got high and had sex several times without a condom. So what do they do now?

- A. Nothing
- B. Kyra gets her tubes tied
- C. They use Plan B and make an appointment at the clinic for birth control
- D. Other

DISCUSSION QUESTIONS

1. What can you relate to in this case study?
2. What role does getting high play in this kind of situation?
3. What is likely to happen if they keep going as they are?
4. If you were Kyra how would you start a conversation about this with Jamal? What would you want to say?

NOTES ON CASE STUDY 2

Possible Next Steps: The couple needs to think carefully about how getting high is affecting their family. They must ask themselves: Do we ever get high in front of our children? How does getting high affect our ability to follow through on decisions we've made? How much money do we spend on weed? What else could we be doing with that money? Kyra needs to tell Jamal how she feels about him not using condoms as he promised when she had Jay.

Good Birth Control Options: If Kyra is completely sure that she doesn't want any more children, she might consider getting tubal sterilization. Or Mike could consider getting a vasectomy since Kyra really wants him to take responsibility for birth control. Or a very long-acting method such as the IUD would be a good choice because it is effective for as long as 10 years.

CASE STUDY 3: BEVERLEY & RASHAD

Beverley and Rashad are both 20 with a daughter, age 15-months. Rashad didn't finish high school. He does some painting off and on whenever his uncle calls him to work. The couple lives with Beverley's mother and her two other children in a three bedroom apartment. Beverley gets public assistance, food stamps, and Medicaid. The couple needs to move because Beverley's mother is trying to help but she's struggling, too. Beverley is young and healthy but she has a terrible memory and hates taking pills. Both Rashad and Beverley want to have more children in the future but they want to wait until they have good jobs and their own apartment. Currently they are using condoms occasionally. What should they do now?

- A. Nothing
- B. Beverley gets on a long-acting method like the IUD or Implant
- C. Rashad begins using condoms every time they have sex
- D. Other

DISCUSSION QUESTIONS

1. What can you relate to in this case study?
2. What is likely to happen if they keep going as they are?
3. How could either Beverley or Rashad start a conversation about these issues? If you were either of them, what would you want to say?

NOTES ON CASE STUDY 3

Possible Next Steps: The couple needs to sit down and create a plan to become more financially stable before having another child. They both need some help and support to get job skills so they can get work. Beverley is probably getting job training as a requirement for receiving public assistance from the state. Rashad could also get his GED and some job training. The couple needs to figure out how they can get the skills to get a job that pays a living wage. Then, when they get jobs, they can figure out what they want to earn and save before they have another child.

Good Birth Control Options: This couple needs to use a very effective method of birth control because they don't want another child until they get more settled financially. Since Beverley is young and healthy but has a terrible memory, they might choose a long-acting method such as the IUD or the implant that is very effective and doesn't require you to do anything for years (yet they are reversible if the couple changes their mind). Rashad could go with Beverley to clinic appointments and share responsibility for making or keeping any follow-up appointments. In the short term, Rashad must use condoms correctly every time he and Beverley have sex. If Rashad and Beverley end up having intercourse without a condom, they could practice withdrawal (Rashad pulls out). Plan B is there if they have an accident.

PARTNER CONVERSATIONS: MAKING A PLAN

Purpose: To have couples create a plan for spacing any future pregnancies in order to reach family goals and achieve family stability.

Materials: Handouts: *Our Family Plan* and *Planning for Children Post-Survey*

Time: 40 minutes

Procedure:

1. **Introduction (2 minutes):** Tell participants that the *Planning for Children* module is nearing an end. Make these points:
 - We hope we've demonstrated to you that taking charge and spacing any future pregnancies can help you:
 - Reduce health problems related to reproduction.
 - Reduce financial pressures and give you time to create the kind of home that you want for your family.
 - Reduce the pressures on you as a couple.
 - Give you time to invest in the children you already have.
 - This is the last time in the program that you will sit together to map out your plan for timing any additional children you decide together that you want to have in a way that will help you reach family goals.
 - Hopefully, this will become a regular topic of conversation in your relationship.

Distribute the handout, *Our Family Plan* and review it by reading the questions aloud. Give these instructions:

- Sit together as a couple facing each other, knee to knee.
 - Take turns sharing your responses to each question on the handout.
 - When your partner is talking, use your listening skills to make sure you are really hearing what they are saying.
 - We're going to be checking in with each couple to see how the conversation is going and provide any support that you might want.
2. **Partner Conversations (20 minutes):** Float around observing the couples. After about 8 minutes, start checking in with each of the couples. Plan to sit down with each couple for a couple of minutes to hear what they are thinking and support them in their planning process.
 3. **Processing (10 minutes):** Reconvene the group. Find out how things went for the couples. Ask a few volunteers to share their plan. If time allows and couples are willing, have them all share their plans briefly. If the couples are working with case managers, encourage them to share their plans with their case manager. Discuss the activity with these questions:
 - How easy or challenging was it to make this plan together?

- What are some things that might come up that could throw a monkey wrench in your plans? (Encourage the couples to check in with each other every few months—or more often—to make sure they are on track.)
 - How can you bounce back when a plan gets off-track?
4. **Evaluation and Closure (8 minutes):** Distribute the post-surveys and review them. Tell participants that these are very similar to the forms they completed at the beginning of the last session. Explain that by comparing answers you will be able to get a sense of how the session affected them. Collect the surveys and thank participants for completing them.

Spend the final few minutes asking the group to reflect on the *Planning for Children* sessions. Ask:

- What was most helpful to you about the sessions?
- How will you actually use anything from the sessions?
- What was not so helpful? What suggestions or recommendations do you have for improving these sessions?

Write their responses on a chart and retain them for evaluation purposes. Note: After the program, you can compare the pre- and post-surveys to see if there are any differences in participants' responses at the end of the module.

HANDOUT OUR FAMILY PLAN

Directions: Please answer each question to the best of your ability.

Names: _____

Date: _____

1. In the next 1-2 years, I want to accomplish the following:

2. In the next 1-2 years, we want our family to accomplish the following:

3. We have decided as a couple that it would be best to have another child:

Never In 1-2 years In 2-3 years In 3-5 years Other

4. We are actively trying to prevent a pregnancy right now.

Yes. Our plan for preventing pregnancy is to:

No. We are actively trying to have another baby now. Our plan for having a healthy pregnancy and baby is to:

5. Each of us will play a role in carrying out this plan. Here are some details:

What he will do:

What she will do:

HANDOUT PLANNING FOR CHILDREN POST-SURVEY

Directions: Please answer each question to the best of your ability.

Name: _____

Date: _____

Age: _____

of children you're raising: _____

Currently pregnant: _____

1. What birth control method are you using now? _____

2. How consistently do you use the method?

- Always Usually Sometimes Almost Never

3. If you're not using a method, check any methods you would consider using

- Condom
- Withdrawal
- Depo Provera (the shot)
- IUD
- Implant
- Pills
- EC/Plan B
- Diaphragm
- Vaginal Ring
- Patch
- Other

4. How informed are you about birth control methods?

Not Well Informed				Very Well Informed
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

5. Do you plan to have another child in the next year? Yes No

6. How would you feel if you or your partner got pregnant in the next year?

- Very happy A little happy A little unhappy Very unhappy

7. How much do you and your partner agree on whether and when to have more children?

Disagree/Never talk about it			Agree/On the same page	
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

8. Do you and your partner have a clear plan for spacing and timing any future pregnancies?

Yes No

Thank you for completing this questionnaire!

POWERPOINT HANDOUT MAN TALK ABOUT SEX AND BIRTH CONTROL

Note: This presentation including notes pages for instructors may be downloaded at www.thenationalcampaign.org/planningforchildren.



Man Talk About Sex and Birth Control

What Messages Did You Hear?

- ▶ Birth control is a woman's responsibility.
- ▶ Condoms are to prevent diseases; not so much about pregnancy prevention.
- ▶ Getting a woman to have a baby for you is a badge of honor/a way of romancing her—
"When you gonna have my baby for me?"

How These Messages Affect Us

- ▶ We have a lot of sex without using protection.
- ▶ We use condoms to prevent STDs & usually not with a committed partner (“she’ll think I’m cheating”).
- ▶ We end up with unplanned pregnancies and STIs.
- ▶ Women get stuck w/most responsibility for birth control and they want us to do more.
- ▶ Pregnancy happens early in relationships without a real plan for raising the baby together.

Keeping It Real

- ▶ How often do you or your partner use any birth control? Condoms?
- ▶ Where do you stand on having another child with your partner? Does your partner agree?
- ▶ What would you need to have in place to feel comfortable having another child together?

- ▶ What role do you currently play in preventing another pregnancy?
- ▶ If you aren't actively trying to prevent pregnancy, you are behaving like you're trying to get pregnant.
- ▶ What more could you do to actively prevent pregnancy?

What's a Man's Role?

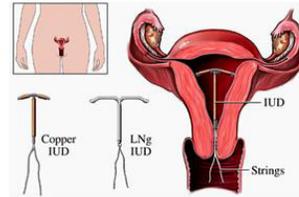
- ▶ Bring up the issue of spacing any future pregnancies... don't leave it up to chance.
- ▶ Focus on finances—current income, bills, costs of a new baby; what is your situation with child support and how would another child affect that?
- ▶ Support your woman in using a very effective birth control method; it's not fair... but the most effective methods are female methods.
- ▶ Use condoms correctly every time you have sex to prevent pregnancy and STIs.
- ▶ If you don't want more children, get a vasectomy.

Most Effective and Easy-to-Use Female Methods

- Implant



- Intrauterine Device (IUD)



Very Effective Methods

Work for 1–3 Months—More to Remember

Birth Control Pills



The Patch



The Shot



Vaginal ring

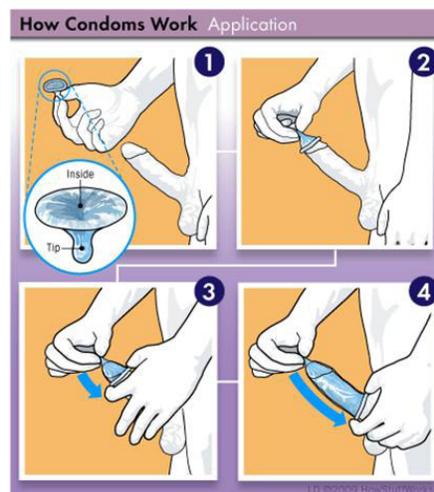


How Can Men Support Women?

- ▶ Start a conversation with her—“We can’t afford another child now; what do you think we should do about birth control?”
- ▶ Remind (not nag) her about appointments.
- ▶ Go with her to appointments.
- ▶ Help pay for the method.
- ▶ Check in with her. Ask how she’s doing. Remind her about using the method effectively.
- ▶ Keep a clear head—drinking and getting high affect your judgment and decision-making.

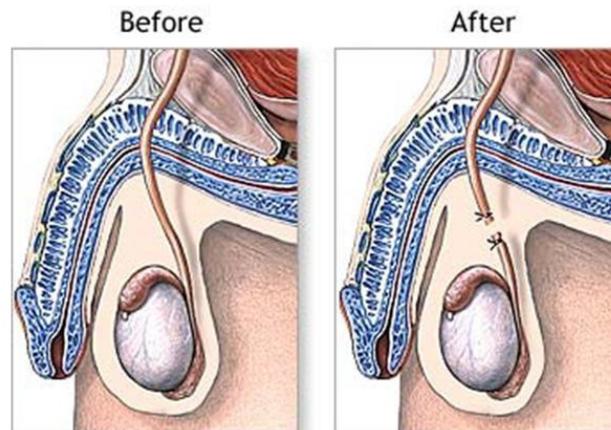
A Male Birth Control Method

Steps for Using a Condom Correctly

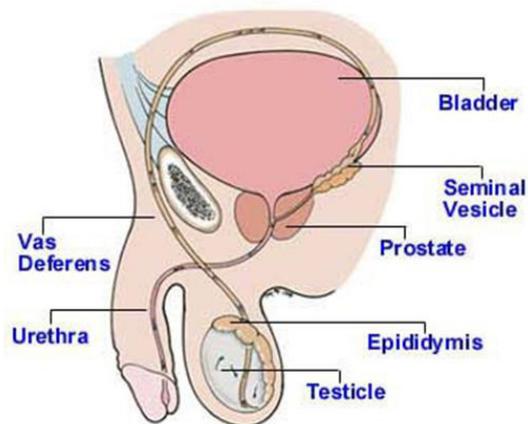


Male Sterilization—Vasectomy

If You Don't Want More Children



Male Anatomy



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- | | |
|----------------------|--|
| ▶ Affects manliness | ▶ Erections & ejaculations stay the same |
| ▶ Major surgery | ▶ Very minor procedure—no scalpel |
| ▶ Expensive | ▶ A lot cheaper than female procedures |
| ▶ Sex isn't the same | ▶ Sex is the same...just no sperm in the semen |

Myths

Facts

If You Don't Have Another Method, You Can Use...

- ▶ Outercourse: “If we don't have any birth control, let's do something other than intercourse to feel good this time.”
- ▶ Withdrawal: “If we don't have anything else available, I'll pull out.” (If you do this correctly, it's an effective method... way better than doing nothing.)

A Last Resort—Emergency Contraception

- ▶ If you had sex with no birth control.
- ▶ Can be used up to 120 hours after intercourse.
- ▶ 17 or older—can get it from a pharmacy with no prescription.
- ▶ Men can buy it.
- ▶ Prevents pregnancy.



So what are you going to do with this information?

Comments?

Questions?



POWERPOINT HANDOUT WOMAN TALK ABOUT SEX AND BIRTH CONTROL

Note: This presentation including notes pages for instructors may be downloaded at www.thenationalcampaign.org/planningforchildren.



What Messages Did You Hear?

- ▶ Women are responsible for birth control.
- ▶ Find a man; fall in love; get married; have children
-OR- Find a man; fall in love; have his baby; and hope the child keeps you connected.
- ▶ Women like us don't plan or space pregnancies—that's a "middle-class white" thing.
- ▶ Forget planning... whatever is going to happen, will happen.

How These Messages Affect Us

- ▶ We get stuck with most of the responsibility for birth control.
- ▶ Most of us don't have role models who really plan their pregnancies in this community.
- ▶ Pregnancy tends to happen early in relationships—seen as a way to keep a relationship together... but does it?
- ▶ We buy into the idea that it's impossible to plan for much in life...but are there some things you do plan?

Keeping It Real

- ▶ Where do you stand on having another child with your partner?
- ▶ Are you and your partner on the same page about this?
- ▶ What would you need to have in place to feel comfortable having another child together?

What's It Like Using Birth Control?

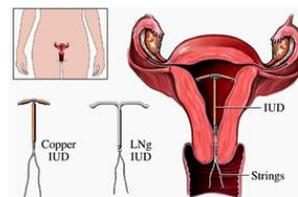
- ▶ What methods have you used?
- ▶ How have they worked for you?
- ▶ It's not fair but the most effective methods are female methods!

Most Effective and Easy-to-Use Female Methods

■ Implant



■ Intrauterine Device (IUD)



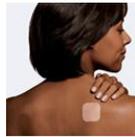
Very Effective Methods

Work for 1–3 Months—More to Remember

Birth Control Pills



The Patch



The Shot

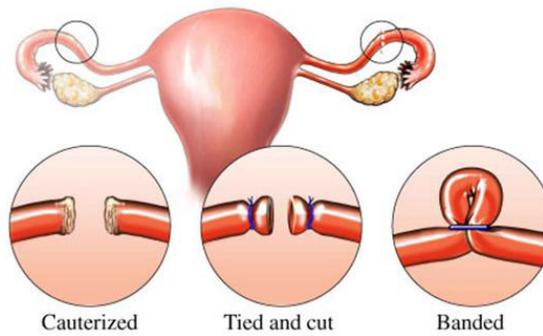


Vaginal ring



Female Sterilization—Tubes Tied

If You Don't Want More Children



What Can Men Do?

- ▶ What does your partner do to help prevent pregnancy now? What more do you want him to do?
- ▶ He can use condoms every time: “I want to keep saving to get that car. Let me get up and get that condom out of the drawer.”
- ▶ He can get a vasectomy: “We know we don’t want any more children. I’ll get a vasectomy.”

If You Don’t Have Another Method, You Can Use...

- ▶ Outercourse: “If we don’t have any birth control, let’s do something other than intercourse to feel good this time.”
- ▶ Withdrawal: He can pull out before he comes... as soon as he gets that feeling. If he does this correctly, it’s an effective method... way better than doing nothing.

A Last Resort—Emergency Contraception

- ▶ If you had sex with no birth control.
- ▶ Can be used up to 120 hours (5 days) after intercourse.
- ▶ 17 and older—can get it from a pharmacy with no prescription.
- ▶ Men or women can buy it.



Think About It:
If you aren't actively trying to prevent pregnancy, you're acting like you're actively trying to get pregnant.



FACILITATOR RESOURCE

FACILITATOR'S GUIDE TO BIRTH CONTROL

This document includes comprehensive information about methods of birth control. It comes from <http://www.managingcontraception.com/index.php?go=choices> by Dr. Robert Hatcher and the Contraceptive Technology team. As new methods of birth control are developed, you may check this website for updates. Some of the methods included here are not listed in the participant handout or on the PowerPoint slides. We've provided this for you in case you get asked tough questions by participants or you want more sophisticated information.

NO-COST METHODS THAT REQUIRE NO MEDICINE OR "EQUIPMENT"

Breastfeeding

- **What is the contraceptive effect of breastfeeding my baby?**

If you are feeding your baby only milk from your breasts, it is quite likely that your periods will not return for a number of months. If this is the case for you, then you probably won't get pregnant during the first six months of breastfeeding. After your baby is six months old, the contraceptive effect of breastfeeding decreases. The contraceptive effect of breastfeeding also decreases when your periods return or you start giving your baby formula or foods other than breast milk. At this point, you need to add additional methods to protect against pregnancy.
- **What are the advantages?**
 - Breastfeeding doesn't cost anything and can be convenient. It can be about 98% effective as a contraceptive for up to six months.
 - Breastfeeding helps the mother's womb return to normal and helps her return to her normal weight.
 - Breastfeeding is simply the best way to feed your baby. "BREAST IS BEST!" It encourages bonding between mother and baby and helps your baby have more immunity against infection.
 - Monthly periods are suppressed.
 - Breastfeeding generally does not interfere with sex, and breastfeeding may be pleasurable (physically and emotionally) for some women.
 - Breastfeeding has a slight protective effect against ovarian and pre-menopausal breast cancer. It also helps protect baby against diarrhea and ear infections because mother's antibodies are passed through breast milk.
- **What are the disadvantages?**
 - Breastfeeding does not keep all women from having their periods, and is not an effective contraceptive after your periods return. It's difficult to tell when breastfeeding stops working as birth control. The effectiveness of breastfeeding after six months is greatly reduced.
 - This method works best if you feed your baby only your breast milk. If feeding your baby more than breast milk, use a spoon rather than a bottle for the best contraception from breastfeeding. If you work, pumping milk from your breasts often helps improve the effectiveness of breastfeeding as a contraceptive.

- Some women are bothered by a dry vagina while breastfeeding. This is normal. Intercourse may be more comfortable if you use a lubricant for sex, such as Astroglide, Aqua Lube, or KY jelly.
 - Breastfeeding women must be willing and able to eat lots of healthy foods.
 - If the mother is HIV-positive, there is a 14%-29% chance that HIV will be passed to her baby through her milk. Breastfeeding is not recommended for HIV-positive mothers who have other safe and healthy food available for their babies. There are antibiotics an HIV-positive breast-feeding mother can take to reduce (but not eliminate) the risk of transmitting HIV to her baby.
 - Some women have an inadequate milk supply.
 - Breastfeeding can cause sore nipples and breasts, as well as a risk of mastitis (breast infection).
- **Where can I learn more?**
Call La Leche League at 1-800-LA LECHE for free information.
 - **What if I am depending on breastfeeding, my period returns, and I have unprotected sex?**
For 120 hours after sex, you can take emergency contraceptive pills to avoid becoming pregnant AND for 5-7 days after sex, you can have an IUD put in, so you won’t become pregnant. Emergency post-coital insertion of the Copper T 380 A IUD (ParaGard) is the most effective currently available post-coital contraceptive. Not all clinicians know about this. If you want more information or would like the phone numbers of clinicians near you that prescribe emergency birth control, call the toll-free hotline (1-888) NOT-2-LATE. Some of these sources of help are free. PLAN B is the emergency contraceptive pill that causes the least nausea and the least vomiting.

Fertility Awareness Method (Periodic Abstinence or Natural Family Planning)

- **What is the Fertility Awareness Method (FAM)?**
Fertility Awareness is a means of understanding your reproductive system by observing and writing down fertility signs. These signs determine whether or not you can become pregnant on a given day. You are actually fertile only about one-fourth of your menstrual cycle. It is a great way to learn more about your body. The three primary fertility signs are your temperature when you first wake up, your cervical fluid (the fluid from your cervix, the opening of the uterus), and the position of your cervix. FAM permits you to use this information so that you can abstain from intercourse when you are most fertile.

BEFORE OVULATION	AFTER OVULATION
<ul style="list-style-type: none"> • Waking temperatures remain low. • Cervical fluid is initially dry after menstruation, then becomes wet and similar to raw egg white. • The cervix rises and becomes softer and open. 	<ul style="list-style-type: none"> • Waking temperatures rise for 12-16 days. • Cervical fluid quickly dries up. • The cervix quickly drops and becomes firm and closed.

- **What are the advantages?**
 - Using FAM gives you with practical knowledge about your menstrual physiology.
 - If pregnancy is your goal, FAM helps you know when your most fertile days are so that you can have sex on those days.
 - This method is useful in conjunction with other contraceptive methods such as barrier contraceptives and withdrawal.
 - No side effects or complications from hormones.
 - Some religions and cultures approve of this method as the only acceptable form of contraception.
- **What are the disadvantages?**
 - Method requires thorough education (for both partners).
 - FAM requires daily charting of fertility signs.
 - This method requires discipline for a number of days in the cycle, in particular if you choose to avoid sex rather than use a barrier contraceptive during your fertile days. It takes at least six months of recording cycles to learn how to use natural family planning.
 - You can only use this if both you and your partner are monogamous and free from infection, since this method provides no protection against sexually transmitted infections.
 - As a contraceptive, FAM is unforgiving if used incorrectly. If you have sex when this method tells you to abstain, you are very likely to become pregnant.
 - This method is often unreliable during times of stress or illness because cycles may be irregular.
- **Where do I go to learn more about the Fertility Awareness Method?**

Go to www.irh.org. Some clinicians and family planning clinics can help you. You can also read *Taking Charge of Your Fertility: The Definitive Guide to Natural Birth Control and Pregnancy Achievement* by Toni Weschler or *Fertility Awareness Handbook* by Barbara Kass-Anese.

Withdrawal

- **What is withdrawal?**

When the man senses that he is about to come and he pulls his penis out of the vagina, this is called withdrawal. The man ejaculates (comes) outside of the vagina. Sperm is not deposited in the vagina, so pregnancy will not occur. This takes a lot of discipline! If the woman has not had an orgasm, the man can stimulate her in other ways after withdrawal. It works best if the couple has agreed to use this method in advance. Among typical couples who use withdrawal, about 27% will experience an accidental pregnancy in the first year. If withdrawal is used consistently and correctly, only about 4% will become pregnant in an entire year of having intercourse.
- **What are the advantages?**
 - Withdrawal is always an option. It is completely private.

- You may be surprised at how effective it is if used correctly every time.
 - No fluid, or much less fluid, is deposited into the woman's vagina (may be less messy).
 - Withdrawal causes no medical complications.
 - No supplies are required. Withdrawal is free (except for the cost of an unintended pregnancy should a failure occur).
 - With practice, withdrawal may increase a man's understanding and awareness of his sexual response cycle.
- **What are the disadvantages?**
 - Couples often want to keep thrusting. They don't want to stop when it is time to pull out.
 - The man may worry: "Will I withdraw in time?" And the woman may worry: "Will he withdraw in time?" This concern may decrease their enjoyment of intercourse.
 - Withdrawal provides poor or no protection against sexually transmitted infections, including HIV (the AIDS virus).
 - Sperm, in small numbers, may be present in the pre-ejaculatory fluid, or pre-cum, that comes out of the penis before ejaculation.
 - Males with sexual dysfunction such as premature ejaculation or unpredictable ejaculation may not be able to use withdrawal.
 - A man's cooperation and commitment to pulling out at the right time is needed for withdrawal to work.

METHODS FROM THE STORE, NO PRESCRIPTION NEEDED

Condom (male)

- **What types of condoms are there for men?**

Use of both a condom and another contraceptive leads to excellent protection against pregnancy and infection. Condoms are made of latex (often called "rubbers"), polyurethane (plastic), or natural membranes (often called "skins" and made from the intestine of sheep). Polyurethane condoms may be used by couples when either partner is allergic to latex. Condoms look like long thin balloons before they are blown up. Condoms act as a mechanical barrier; they prevent pregnancy by stopping sperm from going into the vagina. The condom is put onto the penis before the penis comes into contact with the vagina. Among typical couples who initiate use of latex condoms for men, about 15% will experience an accidental pregnancy in the first year. If condoms are used consistently and correctly, about 2% will become pregnant over the course of an entire year.
- **What are the advantages?**
 - Safe and effective at preventing both pregnancy and infection if used perfectly.
 - Sexual intercourse may be enjoyed more because there is less fear of STIs, HIV, and pregnancy.
 - Condoms may reduce the risk of cervical cancer because there's less risk of HPV infection.

- Men “last longer” when they use condoms. Prolonging sex may make sex more fun.
- Condoms come in many colors, sizes, and with or without ribbing. Variety is exciting!
- Condoms make sex less messy by catching the semen; less discharge, less odor.
- If the woman puts the condom on the man, it can be fun for both partners!
- Remember, penises and condoms come in different sizes. Find a condom that fits.
- Use a water based lubricant such as Astroglide or KY Jelly to decrease breakage.
- To decrease the chance of the condom slipping down the penis or falling off in the vagina, pull the penis out of the vagina right after ejaculation. Don't continue thrusting until the penis becomes soft.
- Practice putting a condom onto a banana. This will make it easier to use condoms during sex.
- With condoms, the risk of infertility for both partners is decreased.
- Condoms are fairly easy to get and usually do not cost a lot.
- A good contraceptive option during breastfeeding or with other methods as a backup.
- **What are the disadvantages?**
 - Unless a partner puts it on as a part of foreplay, the condom may interrupt sex.
 - Condoms require some practice to learn how to use.
 - When putting the condom on the penis you must avoid tearing the condom or putting a hole in it with fingernails, a ring, or anything sharp. This includes anything sharp in the mouth.
 - YOU CAN'T USE OIL BASED LUBRICANTS such as Vaseline, sun tan oil, or Crisco with latex condoms! These products can put a hole in a latex condom in a matter of seconds.
 - Some men cannot maintain an erection with a condom on.
 - The man must pull out soon after ejaculation. If he becomes soft, the condom can fall off and be left in the vagina without the couple knowing that this has happened.
 - Some people are sensitive (or allergic) to latex or find the smell very unpleasant. They should use polyurethane or nitrile condoms: Durex-Avanti, Trojan-Supra or either generation of the female condom (FC1 or FC2).
 - Buying, negotiating use, putting on, and getting rid of condoms may be embarrassing.
 - Condoms decrease enjoyment of sex for some couples by causing decreased sensation for either partner.
- **Where do I get condoms?**

Condoms can be purchased at any drugstore and many supermarkets and gas stations. Some health departments and family planning clinics give away condoms.

Condom (female)

- **What is the female condom?**

The first generation of female condoms, known as FC1 or by the brand name Reality Female Condoms, are made of a thin plastic called polyurethane. This is not latex or rubber. The second generation of female condoms (FC2) are made of a material called nitrile, which is a synthetic rubber and may be cheaper than the polyurethane kind. The condom is placed into the woman's vagina. It is open at one end and closed at the other. Both ends have a flexible ring used to keep the condom in the vagina. The female condom comes in only one size: 15 centimeters in length and 7 centimeters wide. The flexible and removable inner ring at the closed end is inserted into the vagina as far as possible; the inner ring may be removed or left in place in the vagina; the larger outer ring remains outside the vagina. Among typical couples who initiate use of female condoms, about 21% will experience an accidental pregnancy in the first year. If these condoms are used consistently and correctly, about 5% will become pregnant in the course of an entire year. Complete information about this contraceptive is available from your clinician or from the package insert.

- **What are the advantages?**

- Female condoms give women a new option in preventing both infection (especially against herpes and HIV, since it covers more of the external genitalia) and pregnancy.
- Female condoms give women more contraceptive control and a sense of freedom. The female condom is an option for a woman who cannot get a man to use a condom.
- Women don't need to see a clinician to get it. No prescription or fitting is needed.
- The female condom can be put in up to eight hours in advance.
- It is safe and fairly effective at preventing both pregnancy and infection.
- Your partner can insert it and make it part of lovemaking.
- The female condom is pre-lubricated inside and outside and any additional lubricant may be used.
- Polyurethane transmits heat well. This may make sex more fun.
- Either the polyurethane female condom (FC1) or the nitrile female condom (FC2) can be used if either partner is allergic to latex.
- The female condom is a good option during breastfeeding.
- Breakage is rare.

- **What are the disadvantages?**

- The female condom is large and some feel it is unattractive or odd-looking. Although it looks different and may appear unusual at first, its size and shape allow it to protect a greater area. Many of the couples who have used it like the way it feels.
- Some women do not like the idea of putting fingers or a foreign object into their vagina. It can be large, bulky, and can be difficult for some women to place into vagina.

- It will not work if the man's penis enters the vagina outside of the female condom. The penis must be directed into the condom.
 - Polyurethane condoms can make rustling noises prior to or during intercourse. A lubricant may decrease noises.
 - The female condom is not available in as many stores as the male condom. It may be hard to find, so call the store in advance.
 - Female condoms are more expensive than male condoms.
 - The inner ring may cause discomfort; if it does, it should be removed.
 - The female condom is less effective than latex male condoms in preventing both pregnancy and STIs.
 - Because of the cost, some couples have been tempted to wash and reuse female condoms. While studies showed that this does NOT damage the first generation female condom (FC1), there have not been similar studies about the new female condom (FC2). It is generally recommended that either type of female condom is discarded after being used once.
- **Where do I get condoms?**
Female condoms are sold at most drugstores and at some supermarkets. Call in advance to be sure. They are sold in packs of three or six. The package comes with a leaflet that explains how to use the condom. To learn more about the Reality female condom, call your clinician or call 1-800-274-6601. Also go to www.femalehealth.com.

Contraceptive Film (Spermicide)

- **What is film?**
Vaginal Contraceptive film (VCF) is a 2 inch by 2 inch paper-thin film with a chemical that kills sperm (nonoxynol -9). It is translucent (permitting light to go through it). It is placed on or near the cervix, the opening of the uterus. It dissolves in seconds. It should be inserted less than one hour, but at least 15 minutes before intercourse. The effectiveness of this method is not excellent. Complete information about this contraceptive is available from the package insert accompanying VCF film.
- **What are the advantages?**
 - Film is simple to use. It is not messy. There is no discharge. It is virtually undetectable. It is discreet! You can't tell it is there.
 - It can be bought at most drug stores. No prescription is needed.
 - Your partner does not need to help.
 - Film may be used alone or with a diaphragm or a condom.
 - Film can be used during breastfeeding.

- **What are the disadvantages?**
 - Film is not as effective as other contraceptives. The failure rate if 100 couples use it every time for one year is high: 15%. The typical user failure rate is even higher: 29%.
 - Insertion of film may interrupt sex. You need to use another one each time you have intercourse.
 - You should wash your hands with soap and water before putting your film in. Dry your hands carefully or the film will stick to your fingers.
 - Some people may be sensitive to film or find it causes irritation of the vaginal lining, which might increase the likelihood of STIs or urinary tract infections.
 - Contraceptive film definitely does not protect you from the AIDS (HIV) virus or other sexually transmitted infections. Use a condom if you or your partner may be at risk.

- **Where do I go to get film?**

Film may be purchased at many drug stores and discount department stores and supermarkets.

Contraceptive Foam (Spermicide)

- **What is spermicidal contraceptive foam?**

Foam is placed into the woman's vagina using an applicator (similar to tampon insertion). It has two effects. It kills or destroys sperm which is why it is called "spermicidal." It blocks the man's fluids from entering the cervical canal, thus stopping sperm from reaching the egg. Among typical couples who initiate use of vaginal spermicides, about 29% will experience an accidental pregnancy in the first year. If vaginal spermicides are used consistently and correctly, about 18% of users will become pregnant. Complete information about this contraceptive is available from your clinician or the package insert accompanying the foam you choose.

- **What are the advantages?**
 - Foam gives a women control over contraception.
 - It is available over-the-counter without a visit to a clinician.
 - It can be put into the vagina 20 minutes before sexual intimacy, but it is also effective immediately if you want to have sex right after putting foam into the vagina.
 - Foam is safe, no hormones are involved, and it is immediately reversible.
 - The man's penis can remain inside the vagina after ejaculation.
 - Foam adds lubrication and moisture.
 - Lubrication, in the case of foam, may heighten satisfaction in both partners.
 - Foam can be used during breastfeeding.
 - It can serve as immediate back-up if a condom should slip or break.

- **What are the disadvantages?**
 - Foam can be irritating to the vagina and some find it messy.
 - It is not protective against HIV (the virus that causes AIDS). If protection against infection is important, use condoms.
 - Practice putting foam into your vagina in advance. This will make it easier at the time of intercourse.
 - Some women do not like placing an applicator into the vagina.
 - Sometimes you can't be sure if there is enough foam in the can to provide protection for the next act of intercourse. Keep an extra can handy.
 - The taste of foam is unpleasant.
 - The container carrying the foam is large and may be embarrassing to carry around.
- **Where can I purchase foam?**

Foam may be purchased at drug stores and some supermarkets.

Emergency Contraceptive Pills

- **What is emergency contraception?**

Emergency contraception is pregnancy prevention after unprotected sex, suspected contraceptive failure, or rape. Emergency contraceptive pills (ECPs) are two large doses of ordinary birth control pills which may be taken within 120 hours (five days) after unprotected intercourse to avoid becoming pregnant. Making emergency contraception widely available could cut the number of unintended pregnancies in half and reduce the need for abortion. However, while emergency contraceptive pills prevent most of the pregnancies which follow a single act of intercourse, they are not as effective as ongoing contraceptives. Complete information about emergency contraceptive pills is available through your clinician or by calling 1-888-NOT-2-LATE.
- **What are the currently available emergency contraceptive options?**
 - Progestin-only pills (POPs)
 - PLAN B (or Next Choice): Take two pills as soon as possible within 120 hours of unprotected intercourse.
 - Combined oral contraceptive pills (COCs). Some regular birth control pills can be used as EC (like Ovral, Portia, Levlen, and others). This means taking extra pills. For specifics, ask your clinic, or go to the website www.ec.princeton.edu.
 - Copper T 380-A IUD insertion for up to 5-8 days after unprotected sex. This is the most effective emergency contraceptive. This is best for women who want to use an IUD for birth control anyway.

- **What are the advantages?**
 - ECPs prevent unwanted pregnancies after forced intercourse, a mistake, or condom breakage.
 - Women who can't take birth control pills on a regular basis can still use ECPs.
 - ECPs prevent abortions and cost less than an abortion.
 - They can be obtained in advance of having sex and left in your medicine cabinet in case of an emergency such as condom breakage or forced sex.
 - It is not dangerous to use emergency contraceptive pills more than once, but it is better to find an ongoing method of contraception that you will use consistently and correctly.
 - ECPs are available over the counter without a prescription for people 17 or older.

- **What are the disadvantages?**
 - Plan B pills can cause nausea (in about 25% of women) or vomiting (in about 10% of women). Nausea may be prevented by taking a Dramamine pill one hour before each dose of emergency contraceptive pills, but most clinicians provide Plan B with no anti-nausea meds.
 - ECPs are not as effective as other contraceptives. Also, ECPs are not as effective as inserting a Copper T IUD after unprotected sex.
 - ECPs should not be used as your regular contraceptive. However, if you do use ECPs several times, they are not dangerous.
 - ECPs provide no protection against sexually transmitted infections; you may need to be treated for infection.

- **Where can I get emergency contraception?**

If you are 17 or older, you can buy it from a pharmacy without a prescription. You can also contact your doctor, nurse or nurse practitioner, or a local family planning clinic.

METHODS THAT REQUIRE A PRESCRIPTION FROM HEALTH PRACTITIONER OR CLINIC

Birth Control Pill

- **What are combined birth control pills?**

Combined birth control pills contain two hormones, an estrogen and a progestin. They work by stopping ovulation (release of an egg) and by making the lining of the uterus thinner. Among typical couples who initiate use of combined pills, about 8% will experience an accidental pregnancy in the first year. This is because pills are sometimes used incorrectly. If pills are used consistently and correctly, just three in 1,000 women will become pregnant. Use a backup contraceptive for the first seven days of your first pack of pills. You do not need to use a backup method during the hormone-free days of your pill pack. Complete information about this contraceptive is available from your clinician or the package insert accompanying the specific pill brand you are taking. **READ YOUR PACKAGE INSERT CAREFULLY.**

- **What are the advantages?**

- Pills greatly decrease a woman's risk for cancer of the ovary and cancer of the lining of the uterus (endometrial cancer). They also lower your chances of having benign breast masses (breast masses which are NOT cancer), ovarian cysts, ectopic pregnancy, and pelvic inflammatory disease (PID).
- Pills decrease women's menstrual cramps and pain.
- Pills reduce menstrual blood loss and a woman's risk for anemia.
- Acne often improves, and hair growth on the face is reduced.
- Many women enjoy sex more when on pills.
- Some clinicians provide 3-6 months of pills without a pelvic exam.
- You can control the cycle so as not to have your period during certain times (honeymoon, exams, etc.)
- You can decrease the number of cycles over time by using a pill such as Seasonale (84 hormonal pills followed by 3-7 hormone-free days), or by using other monthly pill brands in a similar way.
- Pills can make periods very short and light. You may see no blood at all. Most women like this when they understand it is normal.
- Pills do not cause breast cancer.

- **What are the disadvantages?**

- Pills do not protect you from HIV or other STIs. Use a condom if you may be at risk.
- You have to remember to take the pill every day.
- You may have nausea and/or spotting (mostly during the first few cycles on pills).
- Taking the pill may cause headaches, depression, anxiety, fatigue, mood changes, or decreased enjoyment of sex in some women.
- A backup contraceptive is required for seven days if you miss (or think you missed) more than one pill
- Serious complications like blood clots may occur but are rare.
- Pills can be quite expensive and require a prescription.
- Pills may lead to higher rates of one rare type of cervical cancer (adenocarcinoma of the cervix).
- After stopping pills, you may not get your period for 1-3 months, but for most women it comes back the first month.

- **Where can I get pills?**

In the United States you need a prescription. You can get pills from your doctor, nurse practitioner, nurse midwife, health department, or family planning clinic.

Contraceptive Patch

- **What are contraceptive patches?**

One Ortho Evra patch is worn each week for three consecutive weeks, usually on the lower abdomen or buttocks. The fourth week is patch-free to permit withdrawal bleeding. The 4.5 cm square patch delivers both estrogen and a progestin and this stops ovulation. Used correctly and consistently the patch leads to only three pregnancies among 1,000 women using patches for a year! You do not need a back-up method during the seven patch-free days. Just make sure you put on the next patch on time. Complete information about this method is available through your clinician and through the patch package insert. Ortho Evra patches lead to higher estrogen being administered to women than pills or vaginal contraceptive rings. Whether this leads to slightly higher risks for women using patches is not clear.

- **What are the advantages?**

- You don't have to take a pill daily or interrupt sex to use a barrier contraceptive.
- Patches decrease a woman's menstrual cramps and pain.
- Patches decrease the amount of menstrual bleeding and a woman's risk for anemia.
- Acne may improve and facial hair is diminished.
- Many women enjoy sex more when using Ortho Evra patches.

- **What are the disadvantages?**

- The patch may be less effective for women weighing more than 198 pounds and overweight women should use a backup method (or consider other options)
- Patches do not protect you from HIV or other STIs. Use condoms if you may be at risk.
- You may have spotting (mostly during the first few cycles).
- Using patches may cause headaches, depression, mood changes, or decreased enjoyment of sex (infrequent).
- Serious complications such as blood clots may occur but are rare.
- Patches tend to be slightly more expensive than birth control pills. The patch costs approximately \$15-\$50 per month, depending on where you get it, whether you have insurance, and what your insurance policy says about it.
- Partial detachment of patches (2.8%), complete detachment (1.8%), and skin irritation may occur. Even less common (under 1%) is increased pigmentation of the skin under the patch. This hyper-pigmentation may last for a number of months.
- A back-up contraceptive for seven days is recommended if there is any question about starting use of a new patch late or if there is a question about the attachment of the patch.

- **Where can I get Ortho Evra patches?**

You will need a prescription from your nurse practitioner, physician, nurse midwife, or physician's assistant.

Vaginal Ring (NuvaRing)

- **How are NuvaRings used for contraception?**

One NuvaRing is placed in the vagina and is worn for three weeks. It is then removed. The fourth week is ring-free to permit withdrawal bleeding. The delicate two-inch in diameter ring delivers both estrogen and progestin and this stops ovulation. Used correctly and consistently the ring leads to only three pregnancies among 1,000 women using the ring for one year. You do not need a back-up method during the seven ring-free days. Complete information about this method is available through your clinician and through the NuvaRing package insert. It may help to have your clinician show you how to insert and remove a ring.
- **What are the advantages?**
 - You don't have to take a pill daily or interrupt sex to use a barrier contraceptive.
 - Rings decrease a woman's menstrual cramps and pain.
 - Rings decrease the amount of menstrual bleeding and a woman's risk for anemia.
 - Acne may improve and facial hair is diminished.
 - Many women enjoy sex more when using NuvaRings.
 - You can use rings for an extended period of time or continuously (with no hormone-free intervals).
 - The dose of estrogen is lower in the case of the NuvaRing than it is for the two other combined hormonal contraceptives, the pill and the patch.
- **What are the disadvantages?**
 - Rings do not protect you from HIV or other STIs. Use condoms if you may be at risk.
 - You may have spotting (mostly during the first few cycles using rings).
 - Using NuvaRings may cause headaches, depression, mood changes, or decreased enjoyment of sex (infrequent).
 - Serious complications such as blood clots may occur but are rare.
 - Without insurance, rings cost about \$40 per month or \$480 per year. It can be much less expensive at public clinics.
 - A back-up contraceptive for seven days is recommended if you put the next ring in late.
- **Where can I get NuvaRings?**

You will need a prescription from your nurse practitioner, physician, nurse midwife, or physician's assistant.

Diaphragm

- **What is a diaphragm?**

A diaphragm is a rubber, dome-shaped device which the woman places into her vagina so that it cov-

ers the cervix, the opening to the uterus. The diaphragm blocks the man's semen from entering the cervix. A spermicide placed onto the diaphragm kills sperm and physically blocks the cervix. Among typical couples who initiate use of the diaphragm, about 16% will experience an accidental pregnancy in the first year. If the diaphragm is used consistently and correctly, about 6% will become pregnant. Complete information about this contraceptive is available from your clinician or from the package insert accompanying your diaphragm.

(Note: The diaphragm is a barrier method, so it works differently than the ring which works through hormones, like the pill. Sometimes people get confused because both methods are circles that go in the vagina.)

- **What are the advantages?**

- When used perfectly, only six couples in 100 become pregnant the first year using a diaphragm.
- The diaphragm gives the woman control.
- The diaphragm can be put in within six hours of initiation of sexual intimacy.
- Your partner can put it in as part of lovemaking.
- There are no hormones involved and thus, there are no hormonal side effects.
- The penis can remain inside the vagina after ejaculation.
- Intercourse during a woman's period is less messy. The diaphragm holds back menstrual blood.
- The diaphragm may slightly reduce the risk for cervical infections including gonorrhea, chlamydia, human papilloma virus (HPV), and pelvic inflammatory disease (PID).
- It may be used during breastfeeding after vagina and cervix have returned to non-pregnant shape.

- **What are the disadvantages?**

- In typical use (as opposed to perfect use), this method has relatively high failure rates.
- You must be fitted for a diaphragm by a clinician.
- You should wash your hands with soap and water before putting in your diaphragm.
- Insertion of the diaphragm may interrupt sex.
- Using the diaphragm increases your risk for urinary tract infections.
- Some women find the diaphragm unattractive.
- If you do not like touching your vagina, the diaphragm may not be a good method for you.
- It is difficult for some women to insert a diaphragm correctly.
- If left in too long, the diaphragm slightly increases your risk for a serious infection called toxic shock syndrome. Don't leave your diaphragm in for more than 48 hours.
- The diaphragm may slip out of place during sex. If you change positions, you may want to check to see that the diaphragm is still covering the cervix.

- A new fitting may be necessary after having a baby, an abortion, a miscarriage, or gaining 15 or more pounds.
 - The diaphragm must be left in place six hours after the last act of intercourse.
- **Where can I go to get a diaphragm?**
You must be fitted for a diaphragm in a clinician's office. Be sure you are shown how to insert and remove the diaphragm. You should also walk around your clinician's office to test its long-term comfort. You will be given a prescription for the specific type of diaphragm you will use. You must go to a drugstore to get the actual diaphragm and the spermicide to use with the diaphragm.

Cervical Cap

- **What is a cervical cap?**
The cervical cap is a thimble-shaped latex device. The woman puts a spermicide (which kills sperm) in the cap and then places it up into her vagina and onto her cervix (the opening of the womb). Suction keeps the cap in place so sperm cannot enter the uterus or womb. Caps come in four sizes. Among typical couples who use a cervical cap before having a child, about 16% will experience an accidental pregnancy in the first year. If the cervical cap is used consistently and correctly, about 9% will become pregnant. More pregnancies occur if the cervical cap is started after a woman has had a child. Complete information about this contraceptive is available from some clinicians or from the package insert accompanying your cervical cap.
- **What are the advantages?**
 - The cervical cap is small and easy to carry. It can be placed in the vagina up to six hours before intercourse and should remain at least six hours after the last ejaculation and no longer than 48 hours.
 - It can remain in place for multiple acts of intercourse for up to 48 hours.
 - It does not matter how many times you have sex as long as you leave it in at least 6-8 hours after the last time you have sex.
 - Your partner doesn't have to know you are using it.
 - The cervical cap permits less messy sex during menstruation.
 - In the process of learning how to use the cervical cap, a woman learns a lot about her own anatomy!
 - It holds back menstrual blood during intercourse. This is not generally recommended because of the risk of toxic shock syndrome.
- **What are the disadvantages?**
 - Relatively high failure rate.
 - You must be fitted for a cervical cap by a clinician.
 - You should wash your hands with soap and water before putting your cap in.
 - Inserting the cap may interrupt sex.

- Using the cap increases your risk for inflammation of the surface of the cervix.
 - Some women do not like placing fingers or a foreign object into the vagina.
 - It is difficult for some women to insert a cervical cap properly.
 - If left in too long, the cap slightly increases your risk for a very serious infection called toxic shock syndrome. Don't leave your cervical cap in for more than 48 hours.
 - The cap might not be placed onto the cervix properly or it may slip out of place during sex.
 - A new fitting may be necessary after having a baby, an abortion, a miscarriage, or gaining 15 or more pounds.
 - Latex (rubber) may cause irritation or a woman may be allergic to it.
 - Odor may develop if the cervical cap is left in place too long, if not appropriately cleaned, or if used during bacterial vaginosis infection.
 - Severe obesity may make it difficult for the patient to place the cap correctly.
- **Where do I get cervical cap?**
Some clinicians, health departments, and family planning clinics can fit a cervical cap.

LONG TERM METHODS

Injection (Shot)

- **What are birth control shots?**
Depo-Provera is administered once every three months. It contains a type of hormone called progestin. It stops the woman from releasing an egg and provides other contraceptive effects. Many clinics recommend that you use a backup contraceptive for a week after your first shot. Among typical couples who initiate use of Depo-Provera, about three in 100 will experience an accidental pregnancy in the first year. Complete information about this contraceptive is available from your clinician or from the package insert that is provided when you are given Depo-Provera injections.
- **What are the advantages?**
 - Nothing must be taken daily or used at the time of sexual intercourse.
 - Sex may be enjoyed more because of less fear of pregnancy.
 - Depo-Provera is extremely effective. If women receive their injections right on time (about every three months), only three women in 100 will become pregnant in the course of one year.
 - Women, including women with fibroids, lose less blood using Depo-Provera and have less menstrual cramping. Often after a few injections women stop having periods. This is safe! Decreased risk of anemia.
 - Privacy is a major advantage. No one has to know you are using this method.
 - Nursing mothers can receive Depo-Provera injections. According to the World Health Organization, it's best to begin use after the baby is six weeks old, but most U.S. programs will provide Depo-Provera when a nursing mother leaves the hospital after delivery.

- You can start a new method if less than 13 weeks have passed since the last shot.
 - Depo-Provera may improve PMS, depression, and symptoms from endometriosis.
 - Can prevent ectopic pregnancies, sickle cell crises, and grand mal seizures.
 - Unlike combined pills, Depo-Provera is not less effective if you take medicines that affect the liver.
 - Decreased risk for cancer of the lining of the uterus (endometrial cancer).
- **What are the disadvantages?**
 - Do NOT start this method of birth control unless you will find it acceptable to have your periods change. They will change a lot.
 - Depo-Provera injections can lead to very irregular periods or no periods at all. If your bleeding pattern is bothersome to you, you can take medications which may give you a more acceptable pattern of bleeding.
 - Some women gain weight. To avoid weight gain, watch your calories and get lots of exercise.
 - Depo-Provera does not protect you from HIV or other infections. Use condoms if you are at risk.
 - You must return to the clinic about every three months for your injection.
 - Depression may become worse in some women.
 - It may be a number of months before your periods return to normal after your last shot. It takes an average of 10 months for fertility to return after the last shot, making it hard to plan pregnancy exactly.
 - Depo-Provera may lower your estrogen level and cause bone loss, but it is not a lot, and it seems to be reversible. Get regular exercise and take extra calcium to protect your bones from osteoporosis.
 - A few women are allergic to Depo-Provera. Fortunately, allergic reactions are very rare, but they occur, and the effects of the shot cannot be stopped once it is given. Such a woman may need anti-allergy medicine for several days to months.
 - Depo-Provera is expensive in some healthcare settings.
 - Increase in LDL (bad cholesterol) and decrease in HDL (good cholesterol) in some studies.
 - **Where can I go to get started using Depo-Provera shots?**
To your doctor, nurse practitioner, physician's assistant, health department, or family planning clinic.

Intrauterine Device (IUD)

- There are two kinds of IUDs available in the U.S.: Mirena (levonorgestrel, or hormonal), and Para-Gard (copper, or non-hormonal). World wide more women use IUDs than birth control pills. An IUD is a small device which is placed inside the uterus.

- **Levonorgestrel IUD (Mirena)**
 - **What is the Levonorgestrel IUD (Mirena)?**

An IUD is a small device which is placed inside the uterus. The Mirena contains the hormone levonorgestrel. The levonorgestrel causes the cervical mucus to become thicker so sperm cannot reach the egg. Among typical couples who use this IUD, one in 1,000 will experience an accidental pregnancy in the first year.

Mirena is as effective in preventing pregnancy as tubal sterilization and lasts at least for five years. This method has been available for 10 years in Europe and has been used by approximately 2 million women worldwide. In Europe 10-25% of women use an IUD compared to 2% in the United States. Mirena is part of the reason for the popularity of the IUD in Europe.
- **Copper T 380A IUD (ParaGard)**
 - **What is the Copper T IUD (ParaGard)?**

The vertical and horizontal arms of the Copper T 380A IUD contain copper, which is slowly released into the uterine cavity. Copper stops sperm from making their way up through the uterus into the tubes, and it reduces the ability of sperm to fertilize the egg. It also prevents a fertilized egg from successfully implanting in the lining of the uterus if fertilization has occurred. Among typical couples who initiate use of this IUD, less than 1.0% will experience an accidental pregnancy in the first year. Complete information about this contraceptive is available from your clinician or the package insert accompanying the Copper T 380 A (ParaGard).
- **What are the advantages?**
 - IUDs are the most effective reversible method ever developed.
 - IUDs prevent ectopic pregnancies.
 - IUDs are safe, inexpensive over time, and provide extremely effective long-term contraception from a single decision.
 - Use of an IUD is convenient, safe, and private.
 - The IUD may be inserted immediately following the delivery of a baby or immediately after an abortion. One of the costs of any contraceptive is the cost to you should your contraceptive fail. Given the extremely low failure rate of IUDs, a person using this method is far less likely to have the emotional and financial expenses associated with an unintended pregnancy.
 - Once an IUD is removed, fertility returns immediately. Approximately eight out of every 10 women who want to become pregnant will become pregnant in the first year after the IUD is removed (that's about the same as anyone else).
 - Mirena decreases menstrual cramping and dramatically decreases menstrual blood loss (about a 90% reduction in blood loss on average). Some women experience an absence of menstrual bleeding after one year (about 20%).
 - Mirena may be left in place for five years.
 - ParaGard is effective for at least 10 years.
 - The ParaGard IUD may be used by women who cannot use hormones.

- **What are the disadvantages?**
 - With Mirena: Your periods may change a lot, so be prepared. There may be more bleeding days than normal for the first few months and less than normal after 6-8 months. If your bleeding pattern is bothersome, contact your clinician. There are medications which can help you have a better pattern of bleeding.
 - With ParaGard: The number of bleeding days is slightly higher than normal and you may have somewhat increased menstrual cramping. If your bleeding pattern is bothersome to you, contact your clinician. There are medications which may give you a more acceptable pattern of bleeding and cramping. This may also get better after a few months. A very small percentage of women are allergic to copper.
 - For both:
 - There may be cramping, pain, or spotting after insertion.
 - The IUD does not provide protection against sexually transmitted infections. Use condoms if there is any risk.
 - There may be a high initial cost of insertion.
 - The IUD must be inserted by someone with training: a doctor, nurse practitioner, nurse midwife, or physician's assistant.
 - There is a small risk of uterine perforation at the time of insertion, but this is very low—about one in 1000 women.
 - Some men can feel the IUD strings during intercourse. Usually all you need is to have your provider trim the strings a little bit.
- **Where and when do I get an IUD?**
 - You can get an IUD from your doctor, nurse practitioner, nurse midwife, health department, or family planning clinic.
 - Not all clinicians insert IUDs. Check in advance.
 - Most clinics insert IUDs when a woman has her period or is within seven days after her period starts. If the risk of pregnancy can be excluded it may be possible to insert an IUD at other times.

Implant (Implanon)

- **What is the Implanon implant?**

Implanon is a 4 centimeter long rod with a core of a progestin called etonogestrel which is inserted under the skin of the upper arm. The progestin is released slowly and Implanon remains effective for three years. It provides a hormone much like the progesterone a woman produces during the last two weeks of each monthly cycle. It stops the woman from releasing an egg and provides other contraceptive effects. Many clinics recommend that you use a backup contraceptive for a week after your Implanon is inserted. There were no pregnancies at all in the women participating in the clinical trials leading to approval of Implanon. Complete information about this contraceptive is available from your clinician or from the package insert that is provided when your implant is inserted.

- **What are the advantages of Implanon?**
 - Three years of highly effective contraception from one decision.
 - Nothing needs to be taken daily or used at the time of sexual intercourse.
 - Sex may be enjoyed more because of less fear of pregnancy.
 - Implanon is extremely effective.
 - Women lose less blood using Implanon and have less menstrual cramping.
 - With Implanon, uterine pain and cramping was reduced or eliminated in 88% of women previously experiencing painful periods.
 - Nursing mothers can receive Implanon. According to the World Health Organization, it's best to begin use after the baby is six weeks old, but some providers will insert Implanon when a nursing mother leaves the hospital after delivery.
 - Implanon may improve PMS, depression, and symptoms from endometriosis.
 - Implanon can prevent ectopic pregnancies.

- **What are the disadvantages of Implanon?**
 - Do NOT start this method of birth control unless you will find it acceptable to have your periods change. They WILL change a lot.
 - Implanon usually leads to irregular periods. If your bleeding pattern is bothersome to you, you can take medications which may give you a more acceptable pattern of bleeding.
 - Implanon does not protect you from HIV or other STIs. Use condoms if you are at risk.
 - Fortunately, allergic reactions are very rare.
 - Implanon is expensive in some healthcare settings.

- **Where can I go to get started using Implanon?**
To your doctor, nurse practitioner, physician's assistant, health department, or family planning clinic.

Sterilization (Permanent)

Female Tubal Sterilization

- **What is a tubal sterilization?**
Tubal sterilization is an operation which blocks the tubes carrying a woman's egg to her uterus. This is the most commonly used method of birth control worldwide. Often the operation is accomplished through using a laparoscope (camera on a thin tube). This instrument is inserted through a small incision in the abdomen. The tubes are visualized so the surgeon can place rings, apply clips, or cauterize (burn) the tubes. After this operation your eggs will have no way to get to your uterus, and the man's sperm will have no way to get to your egg. The effectiveness of tubal sterilization differs slightly by the method of sterilization and by the woman's age. This operation should be considered permanent. You must be certain you do not want to deliver more children and will not change your mind. Complete information about this surgical proce-

cedure is available from your clinician.

Another non-surgical method of tubal sterilization is to implant Essure, a small device that is inserted into the fallopian tubes through a hysteroscope, and that blocks the egg from moving through it. No incisions are needed for this procedure, and recovery is very quick.

- **What are the advantages?**
 - Tubal sterilization is an extremely effective contraceptive.
 - It is a fairly simple operation which is safe and permanent.
 - Nothing needs to be done at the time of intercourse.
 - There is nothing to remember on a daily basis.
 - There are no hormones and no creams or foams involved.
 - Tubal sterilization will not affect your sex drive or ability to enjoy sex.
 - It is cost-effective in the long run.
 - This procedure protects against ovarian cancer (40% reduction in risk).

- **What are the disadvantages?**
 - Tubal sterilization may require surgery (an operation).
 - There is some pain or discomfort for several days although not with the Essure non-surgical method.
 - It is best to have someone accompany you on the day of surgery.
 - There is no easy way to check after tubal sterilization to see if it is “still working.”
 - Tubal sterilization is very effective but definitely not 100% effective. The failure rate is as high as 1-5% in the 10 years after the operation. If you think that you are pregnant at any time after your tubal sterilization, return to the clinic immediately. Should a pregnancy occur, there is an increased chance that it will be outside of your uterus (called an ectopic pregnancy).
 - It is difficult to reverse this operation if you later want to become pregnant. The operation to reverse tubal sterilization is highly technical, expensive, and its results cannot be guaranteed.
 - Regret after tubal sterilization is greater if a woman is under 25 when her operation is done, if she divorces or remarries, if a child dies, or if a woman has just had a baby or abortion.
 - Sterilization will not protect you from HIV or other sexually transmitted infections. Use a condom if you or your partner may be at risk.
 - A consent form and a 30-day waiting period maybe required before the procedure can be scheduled.

- **Where do I go to get this operation?**
Some clinicians perform this operation; others do not. You can get a referral to a clinician who does the tubal sterilization operation from your primary care clinician, health department, family planning clinic, or local medical society. Or call the national organization involved in sterilization training and service (Engender Health) at 212-561-8000.

Vasectomy (Male Sterilization)

- **What is a vasectomy?**
Vasectomy, or male sterilization, is the operation which blocks the tubes (called the vas deferens) that carry a man's sperm to the outside. It is performed in an office or clinic and involves cutting and tying off or cauterizing (burning) the vas deferens—the tubes that transport sperm out of the scrotum (sac) from the testicles. Some doctors offer the “No-Scalpel” method of vasectomy. Rather than making an incision, the doctor makes only one tiny puncture into the skin with a special instrument. This instrument is used to gently stretch the skin opening so that the tubes can be reached easily. The tubes are then blocked using the same method as a conventional vasectomy, but because no incision was made, there is very little bleeding and no stitches are needed to close the tiny opening. The opening will heal quickly with little or no scarring. This operation should be considered permanent. You should be certain you want no more children and will not change your mind. Complete information about this surgical procedure is available through your clinician or by going to the web site.
- **What are the advantages?**
 - A vasectomy is a minor operation. It is safe, extremely effective, and permanent.
 - It is excellent for men who have had all the children they want.
 - A vasectomy is less expensive and causes fewer complications than tubal sterilization.
 - Any time, even years later, you can have your semen checked to see if your operation is still working. If your semen has no sperm, your operation is working. Used in this manner, vasectomy can be close to 100% effective. Semen analysis can be done several times in the 1-3 years after a vasectomy just to be sure your Vas deferens has not recanalized.
 - A vasectomy gives the man the opportunity to play a responsible role in the contraceptive process.
 - It does not affect a man's ability to enjoy sexual intercourse.
- **What are the disadvantages?**
 - A vasectomy requires surgery, although some doctors do a no-scalpel vasectomy.
 - Some men fear the operation will affect their ability to have intercourse or will interfere with erection.
 - There is some pain or discomfort and scrotal discoloring (usually not severe) for several days after the operation. Pain can usually be relieved with mild pain medications. Keep an ice pack on the scrotum for at least four hours to reduce the chances of swelling, bleeding, and discomfort. Wear a scrotal support for two days (jockey shorts will be adequate).

- The operation is not effective immediately. You will need to use condoms until the sperm clears from the tubes. To find out if you are sterile, have your semen examined under a microscope after about 20-30 ejaculations. It is important to know that you have no mobile (moving) sperm. Then and only then can you be sure you are protected. Until one (or even two) semen test have shown no mobile sperm, you should use another contraceptive.
 - A very small percentage of men have chronic pain after a vasectomy.
 - Regret after vasectomy tends to be greater if the man's partner is under 25, if he divorces or remarries, if a child dies, or when the vasectomy is done immediately after a new baby.
 - The operation to reverse a vasectomy does not always work. It is highly technical, expensive, and its results cannot be guaranteed.
 - Vasectomy provides no protection against sexually transmitted infections including HIV (the AIDS virus).
- **Where do I go to get this operation?**
Most urologists, many family practitioners, and some nurse practitioners perform vasectomies. You can get a referral to a clinician who does vasectomies from your primary care clinician, health department, family planning clinic, or local medical society. Or call the national organization involved in sterilization training and service (Engender Health) at 212-561-8000.

LET'S TALK ABOUT SEX FEEDBACK SURVEY

Activity	Poor	Fair	Good	Very Good	Excellent
Newlywed Game	<input type="checkbox"/>				
Woman Talk about Sex	<input type="checkbox"/>				
Man Talk about Sex	<input type="checkbox"/>				
Myth-Information Game	<input type="checkbox"/>				
Partner Conversations	<input type="checkbox"/>				

1. What is your overall rating of this session? Please put an "x" under your answer.

Poor	Fair	Good	Very Good	Excellent
<input type="checkbox"/>				

2. How did the timing work for this session?

- Worked just fine
- These activities took more time than allotted _____
- These activities took less time than allotted _____

3. If you were running out of time and had to skip or shorten an activity in this session, which would it be?

4. Which activities did/would you adapt? Describe briefly.

5. What did/would you add to this session?

6. What else would improve this session?

PLANNING FOR CHILDREN I FEEDBACK SURVEY

Activity	Poor	Fair	Good	Very Good	Excellent
In Their Shoes	<input type="checkbox"/>				
Same Gender Conversations	<input type="checkbox"/>				
Partner Conversations	<input type="checkbox"/>				

1. What is your overall rating of this session? Please put an “x” under your answer.

Poor	Fair	Good	Very Good	Excellent
<input type="checkbox"/>				

How did the timing work for this session?

- Worked just fine
- These activities took more time than allotted _____
- These activities took less time than allotted _____

2. If you were running out of time and had to skip or shorten an activity in this session, which would it be?

3. Which activities did/would you adapt? Describe briefly.

4. What did/would you add to this session?

5. What else would improve this session?

PLANNING FOR CHILDREN II FEEDBACK SURVEY

Activity	Poor	Fair	Good	Very Good	Excellent
Myths & Facts about BC	<input type="checkbox"/>				
Case Studies	<input type="checkbox"/>				
Partner Conversations	<input type="checkbox"/>				

1. What is your overall rating of this session? Please put an “x” under your answer.

Poor	Fair	Good	Very Good	Excellent
<input type="checkbox"/>				

How did the timing work for this session?

- Worked just fine
- These activities took more time than allotted _____
- These activities took less time than allotted _____

2. If you were running out of time and had to skip or shorten an activity in this session, which would it be?

3. Which activities did/would you adapt? Describe briefly.

4. What did/would you add to this session?

5. What else would improve this session?



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