



# prACTice MATTERS

A collaboration of Cornell University, the University of Rochester, and the Center for School Safety

## The Case for Condom Education

by Karen Schantz

Many effective sex education programs incorporate lessons on using condoms into their efforts to reduce young people's risk of unplanned pregnancy and sexually transmitted disease (STD). Along with communication and relationship skills, condom skills are taught to ensure that youth will be able to protect themselves when they become sexually active. Condom education typically includes lessons that build motivation to use condoms, practice negotiating condom use, a demonstration by the teacher using a plastic penis model, and, in some cases, time for participants to practice putting a condom on a penis model.



In the US, despite widespread parental support for sex education, condom education is often treated as controversial. School administrators, teachers, and parents sometimes object to or even prohibit the demonstration and practice components of an evidence-based program, weakening the program's positive effects and leaving youth without the protective skills they will need. In this article, we make the case for condom education.

### Why teach adolescents to use condoms?

Many middle and high school aged teens are not having sex yet. However, given the compelling evidence that sex education does not make youth more likely to start having sex (AAP, 2013), it makes sense to equip them with the knowledge and skills they will need as soon as they start having sex – on average around age 17 (Guttmacher, 2014). We know that youth need these skills because rates of STDs and unplanned pregnancy are unacceptably high in this age group, condom use among teens is

**Karen Schantz** is an extension support specialist in Cornell University's Bronfenbrenner Center for Translational Research, and communications coordinator for the ACT for Youth Center of Excellence.



inconsistent, adolescents are more likely to experience condom failures, and these failures discourage condom use. Condom education is an effective way to help youth use condoms correctly and consistently when they begin to have sex.

**Rates of STDs and unplanned pregnancy are unacceptably high.**

Half of new STD infections are found among teens and young adults, even though this group comprises only one-quarter of the sexually experienced population (Guttmacher, 2014). The need to help youth protect themselves from HIV/AIDS has not gone away; teen males who have sex with other males are especially vulnerable to HIV and are disproportionately affected (CDC, n.d.). Although they have declined for many years, US rates of teen pregnancy and birth – the majority unplanned – continue to be high in comparison to similar countries (Ventura, Hamilton, & Matthews, 2014).

**Used consistently and correctly, condoms work.** Latex condoms are a highly effective method for reducing the risk of pregnancy, HIV, and many other STDs when they are used consistently and correctly. Condoms are the best available protection against STDs for people who are sexually active. Some STDs (like genital warts and genital herpes) are transmitted through skin-to-skin contact; if the condom does not cover the affected area there will still be risk of transmission (New York State Department of Health, 2014).

**Condom use is inconsistent.** While the rate of condom use at last sex is relatively high among sexually active high school students (60% in 2013), this still leaves 40% unprotected. Nearly all sexually active teen women use condoms as birth control at least once, but the method is not used consistently; withdrawal, used at some point by 60%, is the second most popular way for teen women to prevent pregnancy (Martinez & Abma, 2015). Inconsistent use leaves youth vulnerable to unintended pregnancy and STDs/HIV.

**Adolescents are more likely to experience condom failures.** Though adolescents are more likely than adults to use condoms, they do not necessarily use them correctly: adolescents experience more condom failures (Graham et al., 2005). Condom use seems simple – but is it? There are at least 10 discrete steps involved in using a condom correctly. Condoms are rarely defective; when they fail, it is most often due to human error. Frequent errors include (Sanders et al., 2012):

- Storing the condom incorrectly (condoms should be kept in a cool place; they should not be kept in a pocket)
- Opening the condom packet with something sharp
- Unrolling the condom before putting it on
- Failing to leave room at and squeeze air out of the tip of the condom
- Putting the wrong side of the condom on the penis, then turning that condom over and using it again
- Failing to use enough lubrication, or using an oil-based lubricant

## Pregnancy Prevention: Dual Use

Paired with a hormonal birth control method or IUD, condoms offer increased protection against unplanned pregnancy. Dual use is recommended for teens who want to avoid pregnancy and STDs but is not yet common among US adolescents (AAP, 2013).



- Putting the condom on after intercourse has begun
- Removing the condom before completing intercourse

Well-designed programs can help young people prevent these errors.

**Condom failures launch a vicious cycle, discouraging use.** Youth who have never had the opportunity to learn how to use a condom correctly may give up on safer sex: incorrect use leads to condom failures, and condom failures may lead to condom avoidance (Graham et al., 2005; Lindemann et al., 2005).

**Condom education works.** In a national study of 1,156 sexually active adult men, participants were asked about STD testing, STD diagnoses, and condom education in high school. Those who were taught how to use a condom in school were more likely to have been tested for STDs, and less likely to have been diagnosed with an STD (Dodge, Reece, & Herbenick, 2009). Another study found that condom failures were associated with lack of education regarding proper use (Graham et al., 2005). Youth who have had sex education are more likely to use condoms the first time they have sexual intercourse, and more likely to use them consistently, than are youth who have not had formal sex education (Manlove, Ikramullah, & Terry-Humen, 2008).

## What makes condom demonstrations and practice effective?

Condom education components within evidence-based programs (Be Proud! Be Responsible!, Making Proud Choices!, and Reducing the Risk, for example) are grounded in theory and follow instructional design principles that are based in research. Theory and research remind us that youth don't change their behavior based on knowledge alone – telling students about the dangers of STDs and the protective nature of condoms is important but insufficient. Skill building, condom use self-efficacy (the belief that one will be able to use condoms successfully), and motivation must be addressed as well.

### ***Building skills: When I need to use condoms, I will know how.***

It is well-established that skill-building interventions, including condom programs, are more effective than those that simply attempt to increase knowledge (Lindemann et al., 2005). Condom demonstrations and practice embody several principles of effective instructional design (Kirby et al., 2011):

- Demonstrate rather than describe
- Break down complex skills into smaller steps
- Engage students in actively solving problems
- Use a variety of teaching methods (for example, teach correct condom use with a condom demonstration *and* a “condom line-up” activity in

## Parents approve of condom education

Condom skill building in schools is less controversial than many believe. One large study found that a majority of Minnesota parents believed that adolescents should learn about condoms in school and that instruction should include handling actual condoms. The finding held across most demographics, with the exception of religiously or politically conservative parents and those whose children were in private school (Eisenberg et al., 2009).

which youth put the steps into the correct order)

***Building self-efficacy: When I need to use condoms, I believe I will succeed.***

Condom use self-efficacy has been shown to be “one of the strongest and most consistent predictors of heterosexual condom use” (Black et al., 2011). Most successful STD/HIV prevention programs are based on Albert Bandura’s social cognitive theory, of which a key concept is self-efficacy (DiClemente et al., 2008). Bandura proposes four strategies for increasing self-efficacy (summarized in Kirby et al., 2011):

- Mastery experiences: the participant’s personal experiences of success
- Vicarious experiences: observing others’ success
- Verbal and social persuasion: a credible person persuades the participant that she or he will succeed
- Reducing negative/generating positive physical and emotional reactions: anxiety over performing the task is reduced.

**Resources**

Visit the Condoms and Dental Dams page on the ACT for Youth Center of Excellence website for more information and resources.

[http://www.actforyouth.net/sexual\\_health/behaviors/condom.cfm](http://www.actforyouth.net/sexual_health/behaviors/condom.cfm)

Each of these strategies can be accomplished in a well-designed and well-executed condom education session that includes both demonstration and practice. Properly structured and facilitated, condom demonstrations and practice build self-efficacy by allowing participants to observe others’ success, hear from the instructor and/ or peers that they can do this task, experience success in the practice session, and decrease their fears about using condoms. Anxiety is reduced and confidence increased when youth are simply given an opportunity to see and handle condoms in a safe and comfortable setting, rather than handling them for the first time in a sexual encounter with a partner (Williams & Fortenberry, 2011).

***Motivating condom use: When I start having sex, I want to use condoms.***

Information about the dangers of unprotected sex must be relevant to the program participant if it is to be motivating: youth must fully grasp the fact that they are personally at risk if they do not use condoms. Programs can also motivate youth by giving them reasons to feel positive about using condoms.

**Personalizing risk.** Health behavior theorists stress that people are more likely to change an unsafe behavior when they perceive themselves to be vulnerable (Kirby et al., 2011). Evidence-based programs often include activities that open participants’ eyes to their own vulnerability once they become sexually active. When they believe that they are at risk of an unwanted pregnancy and STDs/HIV, youth are more motivated to use condoms.

Of course, the programming must be relevant to the individual participants in the room. A program that focuses on the risks of unprotected penile-vaginal sex is likely to be ignored by youth who engage primarily in same-sex sexual activity, and HIV

---

positive youth will need to grasp the danger of being infected by a different strain of the virus (New York State Department of Health, 2014).

**Sexual pleasure and positive attitudes.** We teach young people about condoms because we want them to be safe when they become sexually active. But for the youth we are trying to persuade, the desire to be safe is in competition with other desires. Though adults may be uneasy with including sexual pleasure in the discussion, comfort and pleasure are important aspects of condom use. Adolescents who believe that condoms reduce pleasure are, in fact, less likely to use them (Brown et al., 2008, Williams & Fortenberry, 2011), while the belief that condoms will not interfere with enjoyment of sex is a protective factor (Kirby, 2007).

Adolescent males who have positive opinions about condoms are more likely to use them: in one national study, a positive opinion was the greatest predictor of adolescent males' condom use (Manlove et al., 2008). Studies have also found that promotions linking condoms to positive sexual experiences do lead to greater condom use (AAP, 2013).

## The Takeaway

Increased condom use among sexually active teens is one of the key target outcomes of evidence-based sex education. But it's important to keep in mind that increased use is beneficial only if it is consistent, correct use. If youth are to use condoms correctly, they need to be familiar with and skilled in each of the steps involved. We know that providing information alone is not sufficient to change behavior; well-designed activities that build skills, self-efficacy, and motivation – including condom demonstrations and practice – are essential to help youth maintain good health. ★

## References

- American Academy of Pediatrics (AAP) Committee on Adolescence. (2013). Policy statement: Condom use by adolescents. *Pediatrics*, 132(5), 973–981.
- Black, D. S., Sun, P., Rohrbach, L. A., & Sussman, S. (2011). Decision-making style and gender moderation of the self-efficacy–condom use link among adolescents and young adults. *Archives of Pediatrics & Adolescent Medicine*, 165(4), 320-325. doi:10.1001/archpediatrics.2011.17
- Centers for Disease Control and Prevention. (n.d.). *HIV surveillance in adolescents and young adults* [Slide set]. Retrieved from [www.cdc.gov/hiv/library/slideSets/](http://www.cdc.gov/hiv/library/slideSets/)
- DiClemente, R. J., Crittenden, C. P., Rose, E., Sales, J. M., Wingood, G. M., Crosby, R. A., & Salazar, L. F. (2008). Psychosocial predictors of HIV-associated sexual behaviors and the efficacy of prevention interventions in adolescents at-risk for HIV infection: What works and what doesn't work? *Psychosomatic Medicine*, 70, 598-605. doi:10.1097/PSY.0b013e3181775edb
- Dodge, B., Reece, M., & Herbenick, D. (2009). School-based condom education and its relations with diagnoses of and testing for sexually transmitted infections among men in the United States. *American Journal of Public Health*, 99(12), 2180-2182. doi:10.2105/AJPH.2008.159038
- Eisenberg, M. E., Bernat, D. H., Bearinger, L. H., & Resnick, M. D. (2009). Condom provision and education in Minnesota public schools: A telephone survey of parents. *Journal of School Health*, 79(9), 416-424.

- Graham, C. A., Crosby, R. A., Sanders, S. A., & Yarber, W. L. (2005). Assessment of condom use in men and women. *Annual Review of Sex Research, 16*, 20-52.
- Guttmacher Institute. (2014, May). *Fact sheet: American teens' sexual and reproductive health*. Retrieved from [www.guttmacher.org/pubs/FB-ATSRH.html](http://www.guttmacher.org/pubs/FB-ATSRH.html)
- Kirby, D. (2007). *Emerging answers 2007: Research findings on programs to reduce teen pregnancy and sexually transmitted diseases*. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy.
- Kirby, D., Coyle, K., Alton, F., Roller, L., & Robin, L. (2011). *Reducing adolescent sexual risk: A theoretical guide for developing and adapting curriculum-based programs*. Retrieved from ETR Associates website: [http://pub.etr.org/upfiles/reducing\\_adolescent\\_sexual\\_risk.pdf](http://pub.etr.org/upfiles/reducing_adolescent_sexual_risk.pdf)
- Lindemann, D. F., Brigham, T. A., Harbke, C. R., & Alexander, T. (2005). Toward errorless condom use: A comparison of two courses to improve condom use skills. *AIDS and Behavior, 9*(4), 451-457. doi:10.1007/s10461-005-9017-y
- Manlove, J., Ikramullah, E., & Terry-Humen, E. (2008). Condom use and consistency among male adolescents in the United States. *Journal of Adolescent Health, 43*(4), 325-333.
- Martinez, G., & Abma, J. C. (2015, July). *Sexual activity, contraceptive use, and childbearing of teenagers aged 15-19 in the United States* (NCHS Data Brief No. 209). Retrieved from the Centers for Disease Control and Prevention website: [www.cdc.gov/nchs/data/databriefs/db209.pdf](http://www.cdc.gov/nchs/data/databriefs/db209.pdf)
- New York State Department of Health. (2014, January). *Frequently asked questions (FAQs) about condoms*. Retrieved from [www.health.ny.gov/diseases/aids/consumers/condoms/faqs.htm](http://www.health.ny.gov/diseases/aids/consumers/condoms/faqs.htm)
- Sanders, S. A., Yarber, W. L., Kaufman, E. L., Crosby, R. A., Graham, C. A., & Milhausen, R. R. (2012). Condom use errors and problems: A global view. *Sexual Health, 9*(1), 81-95.
- Ventura, S. J., Hamilton, B. E., & Mathews, T. J. (2014, August 20). National and state patterns of teen births in the United States, 1940-2013. *National Vital Statistics Reports 63*(4). Retrieved from the Centers for Disease Control and Prevention website: [www.cdc.gov/nchs/data/nvsr/nvsr63/NVSR63\\_04.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr63/NVSR63_04.pdf)
- Williams, R. L., & Fortenberry, J. D. (2011). Update on adolescent condom use. *Current Opinion in Obstetrics & Gynecology, 23*(5), 350-354. doi:10.1097/GCO.0b013e32834a93bf



**ACT for Youth Center of Excellence**

Bronfenbrenner Center for Translational Research  
 Beebe Hall • Cornell University • Ithaca, New York 14853  
 607.255.7736 • [act4youth@cornell.edu](mailto:act4youth@cornell.edu)  
<http://www.actforyouth.net>  
<http://www.nysyouth.net>

*The ACT for Youth Center of Excellence is a partnership among Cornell University Bronfenbrenner Center for Translational Research, Cornell University Cooperative Extension of New York City, the Center for School Safety at Ulster BOCES, and the University of Rochester Medical Center.*