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Sex positions

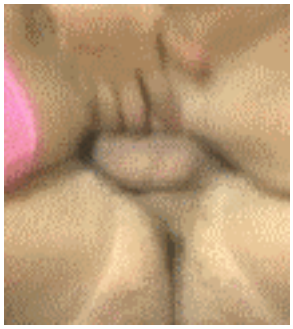
The missionary is the most commonly adopted lovemaking position, because it is so comfortable, but there are many different ways of enjoying each other's bodies, and each of the positions illustrated on the next pages may suggest another into which you can move.

Greater intimacy is offered by some positions' with all-over body contact and the opportunity to embrace and kiss, others offer deeper penetration, some are quite difficult to maintain, which creates a certain sense of urgency and excitement.

Adventurous lovers will find variations of their own, either by design or by chance: you may get overtaken by lust half way up the stairs or while talking in the kitchen. The important thing is to engage all your instincts and feelings, while remaining acutely aware of your partner's responses.

SEX POSITIONS

WITH PICTURES AND DESCRIPTIONS



ASTRIDE

CRAWL

CROSS

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CUNNILINGUS

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SIDE BY SIDE

SPLIT LEVEL

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Astride

With the man lying on his back on the bed, the woman can sit astride him and control the pace of their lovemaking. Facing him, she may squat on her haunches for a more powerful bouncing movement, or, as here, kneel, supporting herself with her hands. This way, she is free to lean forward and kiss his mouth. From this position it is easy for her to increase the intimacy by lying with her whole body along his. A variation is for her to face away from him, increasing the depth of penetration.

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SEX CHAT

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SEX AIDS and APHRODISIACS

SEX POSITIONS

SEX IN PREGNANCY

SEXUALLY TRANSMITTED DISEASES (STD)

---

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Crawl

Deep penetration can be achieved with the woman on all fours and her partner kneeling behind her. This position gives both lovers the opportunity to thrust against one another, and the man may also caress his partner's breasts, buttocks and clitoris. Rear entry positions like this one are ideal when both partners are in the mood for vigorous rather than tender lovemaking. A variation is for both partners to stand with the woman bending forward and supporting herself against furniture.

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Cross

Here the woman lies on her back on the bed and the man lies diagonally across her. She opens her legs to allow him to enter and he rocks gently from side to side. She can guide his movements with the pressure of her hands. This position is somewhat easier to maintain if the man lies beneath on his back and the woman is in control.

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Cuissade

This position is known as 'cuissade', from the French cuisse,meaning thigh. The woman lies on her back, with the man at her side. She raises the leg nearest to him and rests it on his body, and he enters from under her thigh, with his nearest leg crossing her body. They can hold one another and kiss, and the position is a very intimate one, possibly because of the 'secretive' form of entry. The woman can exert a certain amount of restraint with her thigh, which can make it more exciting.

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Cunnilingus

In cunnilingus, the man stimulates his partner's vulva and clitoris with his lips and tongue. For most women, cunnilingus gives the most delicious sensual pleasure and is the best way of climaxing. It is also extremely arousing for her partner.

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Cunnilingus - Oral sex upon a vulva

What is cunnilingus?

Cunnilingus is the fine art of making love to a vagina with your mouth and tongue. It is a delicate skill, requiring patience, practice, and dedication to get it right, but any woman you learn to do it right for will appreciate you all the more for it.

What applies to the penis applies to the vulva-- every one is different, requiring a different touch to make its owner happy. But few tools can equal the tongue for the amount of pleasure it can deliver to a happy vagina.

This article assumes that you know what a vulva looks like and can identify with some precision the mons veneris, labia majora, clitoral hood, clitoris, labia minora, urethra, vagina, and perineum, to name them (approximately) from top to bottom.

How fast should I go?

This isn't an attack. Don't go after the clitoris like a fireman attacking a fire. Quite often at first, the clitoris is far too sensitive for direct stimulation. Lick around it, stimulating the hood, teasing her inner labia, tasting her. Take your time and *listen* to her. Some women make noise, and some do not. It will be a while before you learn exactly what your lover prefers as far as oral sex is concerned.

Some women may like additional stimulation-- a finger or two into the vagina, or perhaps even the anus. She may want your hands to reach up and play with her breasts, or she may want your fingers to hold her labia apart so that your tongue can get at her vulva more directly.

I've heard cunnilingus doesn't taste good.

If the taste or smell bothers you or is a concern, ask her to wash first. Most people who enjoy cunnilingus agree that a clean vagina is a good, if acquired, taste.

As a woman nears her climax, she may want more direct stimulation. In general, fast, rhythmic stimulation is most effective at causing climax-- but there shouldn't be a rush to get there. Take your time and learn to appreciate what you can do for her.

What about cunnilingus during menstruation?

Some people are particularly turned off at the suggestion of cunnilingus during menstruation. If it is a concern to you, then wait. A tampon may well hold the blood back, as will a diaphragm, but some men can't stand the taste anyway. If your partner is healthy, however, there is no particular danger in menstrual blood, and some women find that orgasms during their periods allievate cramps.

MORE ON "HOW TO EAT PUSSY"

MORE ON ORAL SEX

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YAHOO! Submit options

another sex tutorial

Fellatio

In fellatio, the woman sucks, licks, kisses and strokes her partner's penis. Exquisitely satisfying for the man, fellatio can also give enormous erotic pleasure to the woman as she senses his responses and his total abandonment to her.

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MORE ON FELLATIO

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Fellatio - Oral sex upon a penis

What is Fellatio?

Fellatio, giving head, giving a blow-job. Many men love this kind of stimulation, and many people, both women and men, like giving it. Fellatio is the act of applying your lips to a man's penis with the purpose of giving him pleasure.

There are few tips to fellatio that can be given other than practice. The lips and the tongue are the major sources of stimulation, and it is with the lips and tongue that you should apply the attention to make him feel good. Both men and women respond well to pressure and rhythm. A steady, strong stroke will be enough to get the reaction you're looking for.

What if it doesn't smell or taste good?

If the smell isn't something you enjoy, then tell him to go take a shower! While this is something you're doing primarily for his pleasure, that doesn't mean you have to suffer if he's lacking in hygiene! And if you're worried about germs, your mouth has millions more germs than a clean penis.

What is "deep throating?"

Deep throating is the act of taking the penis down past your gag reflex. In reality, this particular sexual adventure is very overrated. The best way to give fellatio is still with the lips and tongue, taking only as much as you can without gagging. However, for those that want to know, the basic lesson is still practice. Take the penis as far as you can without choking, and then close your eyes and concentrate, taking each quarter inch, telling yourself that you won't choke, that you can take it out at any time, and slowly swallow it down. Then rise off of it just as slowly.

Are there any special spots on the penis?

Every penis is different, and each has its sensitive spots and its preferred ways of being handled. Listen to your lover. The sounds he makes and the feel of his body tensing are your best clues that you're going this right.

Should I use my hands?

Feel free to grasp with your hands whatever of the penis you can't fit into your mouth. Many men like as much stimulation as possible, and the feel of a wet mouth and a saliva-slicked hand are enough to send them to the brink of orgasm very quickly.

What is 69?

Some people feel that the best position to perform oral sex is the 69 position, where each partner lies with their head by the other's genitals. For fellatio, this even makes sense-- most penises curve upwards, towards the head, and in this position that curve matches the curve of the throat. However, it is difficult to both perform and appreciate oral sex at the same time. Try the position, or kneel by his body, but at least in the beginning do one thing at a time.

My boyfriend wants me to swallow. What do I do?

Which brings us to a sensitive issue: swallowing ejaculate. For many men, this is important to them-- they like to feel that by swallowing their semen, you complete this act of lovemaking and accept a part of themselves into your body. But many people don't like the taste of semen and can't bring themselves. Talk about this beforehand-- let him know if you can't handle it, and that it's not personal.

Can I make my seminal fluids taste better?

Macrobiotic nutritionists have actually done research on this question, and the answer is in: you are what you eat. Common sense dictates that if you taste good, your lover will want to eat you more often, so improving your body's taste and smell should be important to you.

In general, nutritionsists say that alkaline-based foods such as meets and fish produce a butter, fish taste. Dairy products, which contain a high bacterial putrefaction level create the foulest tasting fluids by far. (Dissent: almost everyone I know says that there is one worse than a high-dairy content-- asparagus. You can't miss the taste of asparagus-laced semen.) Acidic fruits, such as sweets, fruits, and alcohol give bodily fluids a pleasant, sugary flavor. Chemically processed liquors will cause an extremely acidic taste, however, so if you're going to drink alcohol,

drink high-quality, naturally fermented beers (Rolling Rock or Kirin) or sake.

What are the contents of semen?

The question of semen content arises especially among persons who regularly swallow semen, as in fellatio, and who are concerned about calorie intake and nutritional substances. The average ejaculate contains aboutonia, ascorbic acid, blood-group antigens, calcium, chlorine, cholesterol, choline, citric acid, creatine, deoxyribonucleic acid (DNA), fructose, glutathione, hyaluronidase, inositol, lactic acid, magnesium, nitrogen, phosphorus, potassium, purine, pyrimidine, pyruvic acid, sodium, sorbitol, spermidine, spermine, urea, uric acid, vitamin b12, and zinc.

The caloric content of an average ejaculate is estimated to be approximately 15 calories.

A last word.

There is only one true way to do fellatio, and that's with enthusiasm. You have to love what you're doing to him, either because you love him or you love sucking cock. Loving both is best! Faked orgasms have nothing on lackluster fellatio.

HOW TO SUCK COCK

MORE ON ORAL SEX

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Fireside

In this cozy position, which can follow cunnilingus, the woman sits comfortably in an armchair with her hands and legs around the man, who enters kneeling in front of her. If she leans back, he can support himself with his hands on the back of the chair, which will allow him more thrust.

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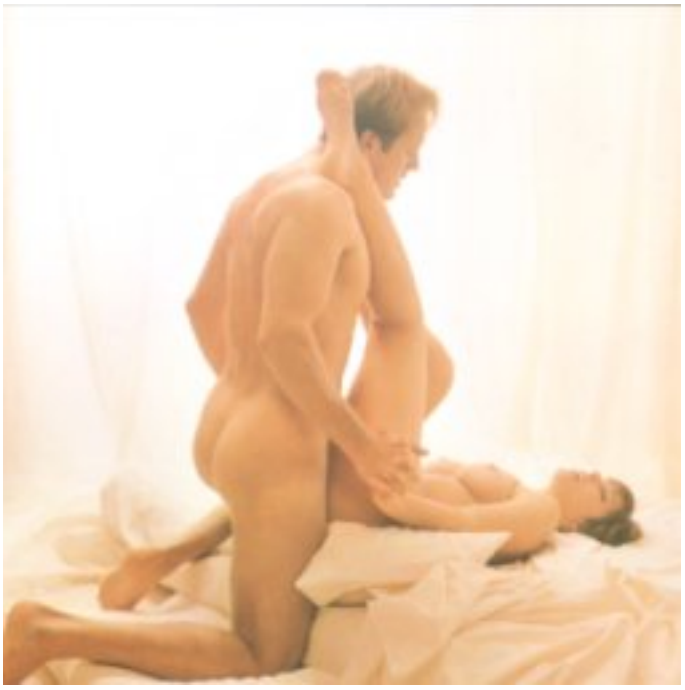
Futon



For this position you need to try out all your furniture to find a piece of the correct height. The woman lies on the edge of a table, futon or bed covered with quilts and pillows, and spreads her legs wide. The man can begin by kneeling to give her cunnilingus, then he enters her, supporting himself on his knees and holding her legs. This affords him a great deal of control, and the angle of penetration is steep.

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Head to toe

The man lies on his back with his legs spread and his penis inside the woman, who also lies down on her back, with her legs spread across his, her toes pointing to his head, and her head away from him. The woman is in control. The partners cannot see each other and sensation is concentrated on the genitals. This position can be adopted from one in which the lovers sit on the bed facing one another, their legs interlaced.

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Lap

This is a position that may suggest itself while cuddling on the sofa. The man sits with the woman straddling his lap, facing him. She controls the pace, they can kiss and he can caress her breasts. She moves up and down on him, supporting herself with her knees on the sofa, and her arms around his neck. If they use a dining chair, she can keep her feet on the floor and hold on to the chair back for support if necessary. If she faces away from him, they will be able to achieve deeper penetration, and she could support herself against furniture in front of her.

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Missionary

The missionary position is the most popular lovemaking position of all because it is comfortable, affords a great deal of body contact and good depth of penetration. The lovers can kiss and hold each other at the same time. The woman lies on her back with her legs spread and her knees raised, and her partner lies on top between her legs. From this position the woman can move to clasp her legs behind her partner's back or to close them tightly underneath him, while he spreads his.

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Sex in pregnancy

Unless your doctor tells you otherwise, it is perfectly safe for you to have **sex** throughout your pregnancy.

However, towards the expected birth date, your size may make many positions uncomfortable for you. Penetration may be easiest if you lie on your side and your partner enters from behind. **Oral sex** and mutual **masturbation** should cause no problems. Some women fear that sexual activity or orgasm may trigger off labor but sex cannot induce labor unless the baby is due anyway, when the prostaglandin present in the man's semen may cause it to start.

The sex drive of some women decreases during the first

trimester of pregnancy. This may be due to tiredness and nausea, or to a hidden belief that it is 'not right' for a mother to enjoy sex. The problem will usually disappear of its own accord. In some women, the sex drive actually increases during the middle three months (the second trimester) of pregnancy, and some claim that their lovemaking is more satisfying than ever before. This may be because the high level of circulating hormones means that a woman can be stimulated more easily and reach a pitch of sexual excitement more quickly than when not pregnant. A pregnant woman's sexual organs breasts, nipples and genitals - are especially highly developed, which probably increases sexual awareness. Finally, there is of course complete freedom from the worry of getting

pregnant, which allows a deeper level of 'letting go'.

Some women and their partners worry that sex may harm

the unborn child, but such fears are groundless. The fetus is protected from infection by the plug of mucus at the neck of the womb. In rare cases, infection can occur, but this is usually due to lack of normal hygiene precautions or having sex with several different partners. The baby is also protected against being squashed by the amniotic fluid in which it floats in the womb. Avoid over-athletic sex because it will be uncomfortable for you, but don't worry about hurting the baby. Sex should not cause a miscarriage in a normal, healthy pregnancy.

You can resume sex after

childbirth as soon as it is comfortable to do so. Women who have had an episiotomy (in which the perineurn is cut to facilitate birth), will probably feel sore for at least three weeks. When you feel confident that your wound has healed, begin to re-establish your sex life, taking it slowly and gently and using a lubricating jelly if necessary to prevent scar tissue causing discomfort or pain. It is important to establish sexual contact with your partner as soon as you can, as you will both need to get close again. If you still feel sore, remember there are other ways of giving and receiving affection. Don't let your partner feel that you are lavishing all your care and attention on your baby and excluding him from your love.

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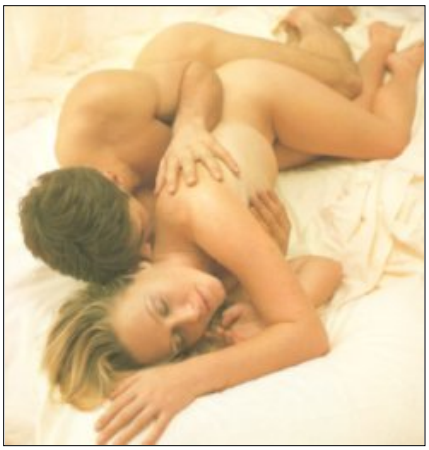
Positions for pregnancy

Spoons



The woman lies comfortably on her side and the man enters her from behind, fitting his body closely to hers. This position puts no pressure on the woman's abdomen and is suitable for the most advanced stages of pregnancy. The man can cuddle up close and caress her breasts, while kissing her shoulders and the nape of her neck.

Leapfrog

The woman kneels on the bed with legs spread wide, and falls comfortably forwards as the man enters her from behind. He can then caress her back and control the depth of thrust. This position is ideal when the woman starts to feel uncomfortable with the man's weight pressing down on her and she wants to protect her belly from over-enthusiastic thrusting.

Astride

This is a good position for the middle months of pregnancy, when the missionary position has become uncomfortable, but the woman has quite a bit of energy for sex. She sits astride the man's lap and supports herself with her arms. He can help her as she moves up and down on top of him, taking control when she gets tired.

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Oral sex

Oral sex begins with the first deep kiss, and continues with kisses all over the body, concentrating finally on the genitals. On the part of the giver it requires a degree of emotional involvement, because it must be done with patience, tenderness, sensitivity and mounting but controlled excitement if it is to be really good. Lovers who give oral sex reluctantly and without generosity or enjoyment make their partners feel guilty and selfish, and too tense and worried to relax and take pleasure themselves.

From the receiver, oral sex requires trust, and the confidence that comes with being made to feel desirable. In sex, as in other areas of life, it is often more difficult to receive generosity than to give it, but the person who succumbs completely to pleasure delivers himself or herself over to the lover, and this also gives a sense of wonderment. It goes without saying that sexual hygiene is of prime importance for anyone who engages in oral sex.

Oral sex for women is called **cunnilingus**. For many women, cunnilingus is the most exciting of all the variations of sex, and a gentle and skilful lover should be able to make his partner come with his tongue more easily than in any other way. A strong slippery tongue can be used with precision on the clitoris without danger of causing any pain, unlike a finger.

Begin by kissing your partner's face and mouth, and then gradually work your way down her body, kissing and stroking her breasts, belly and inner thighs. Flick your tongue in light feathery kisses along the fleshy folds of the outer labia, smoothing away the pubic hair and then parting the labia gently with your fingers. Move very gradually inwards with your tongue. Vary your movements according to your partner's response. Try nuzzling, burrowing, thrusting with

your tongue into her vagina, sucking, long delicate licks, short rapid flicking licks. She may not like her clitoris to be stimulated directly at first, so proceed tentatively until she is fully aroused.

Once she can trust YOU and feel confident that you like what you are doing, she will be able fully to let go in orgasm. Being 'on the spot', a man can get a special thrill from experiencing so directly the blissful effect he has on his partner, as well as from her vulnerability and trust.

Oral sex for men is called **fellatio**. The experience of having their penis sucked, licked and kissed is one that most men find intensely exciting. In some cases, there may be psychological barriers to overcome. Some men fear being bitten during oral sex. The woman should open her mouth as wide as possible, and close her lips, but not her teeth, over the penis. Using all the muscles in the lips and tongue will mean that the teeth should not come into contact with the penis at all.

Some women are worried that they may be choked during fellatio. The way to allay this fear is to remain in control: you are the one who should move while your partner lies still, so there is no possibility of his thrusting deep into your throat and making you gag. Some women find the idea of swallowing semen repugnant. Of course there is no need for you to do this if you do not wish to, but many women do enjoy having their partner ejaculate into their mouth.

Work your way down your partner's body, beginning with kissing his face and mouth and progressing to his genitals. Be very gentle, as they are highly sensitive to pain. There are many ways of stimulating the penis with your lips and tongue. You can lick all along the shaft with a delicate tongue, then use more pressure and press your open lips as well as your tongue against it as you rub them up and down towards the head. You can lick and kiss the frenulum - the sensitive place where the glans joins the shaft on the underside, which will be facing towards you if the man is lying on his back with an erection. You can take the head of the penis in your mouth and suck it, tickling it at the same time with your tongue, and you can move your lips as far down the shaft as is comfortable. Then move up and down, sucking and pressing with your lips and

tongue.

The '69' position is so called because the figures resemble a couple giving each other oral sex. While many couples find this a good way of arousing each other, others find it difficult to concentrate on giving and receiving such intense pleasure at the same time. If you are about to come in this position, it is best to break off from pleasuring your partner to avoid inadvertently biting him or her. Use your fingers to indicate to your partner what is happening and let yourself go in orgasm.

MORE ON FELLATIO

MORE ON CUNNILINGUS

MORE ON SEX POSITIONS

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Masturbation

Masturbation is a natural and healthy method of sexual release engaged in by most people of both sexes. It is also a good way of learning one's own sexual response. Women who can bring themselves to orgasm by masturbating are more likely to have orgasms with their partners, and men who can masturbate for 15-20 minutes without ejaculating are less likely to suffer from problems of premature ejaculation during intercourse. Stimulating your partner's genitals is also called masturbation, and is an important part of lovemaking.

The external female genitals are called the vulva. Pubic hair grows on the labia major, and inside these outer vaginal lips are the labia minor, which are pinker and moister. If the sight of your own genitals is not familiar to you, examine them in a hand mirror while you relax after a bath or shower. The clitoris is situated where the labia minor join at the top. It is a pink knob about the size of a dried pea, and is highly sensitive. The clitoris is protected by a hood, which retracts during sexual arousal. Below the clitoris is the tiny opening of the urethra, through which urine passes, and below that is the opening to the vagina.

When you start to masturbate, make sure you have plenty of time during which you won't be interrupted. Go somewhere where it is quiet, completely private, and warm. Some women like to lie on their back, some on their front; some like their legs pressed tightly together, others like them spread wide apart, or propped up above the body. Use a lubricant and stroke yourself gently, with your fingers or an object such as a vibrator, varying your movements from time to time to find out where and how you like to be stimulated.

Many women find the clitoris too sensitive for direct stimulation, so you could begin by rubbing the whole vulva, then gradually move inside with delicate fingers. Allow yourself to fantasize to increase arousal. Be patient, but if the pleasure wears off without you having had an orgasm then you should stop. Don't be disappointed with yourself, as it may take several sessions before you can relax enough to really let go.

When you feel a gathering tension in the vaginal area and a build-up of warmth, orgasm is on the way. Continue to stimulate yourself, as if you stop, these sensations will fade and it may be difficult to get them back again. The clitoris becomes increasingly sensitive as you proceed, whether you are stimulating it directly or not, and then orgasm breaks out with waves of vaginal contractions. Most women like some form of genital contact during orgasm: either continued stimulation or pressing or holding the vaginal area. Some like to insert a finger into the vagina as they come.

Most men are

expert at giving themselves pleasure, but there's no harm in extra practice. A good way of finding out exactly how your genitals respond to stimulation is by soaping and gentle massage in the bath, allowing yourself to fantasize as you do so. Some men enjoy fondling their testicles, and some enjoy penetrating the anus with a finger. There are many different strokes you can use on the penis. If you are uncircumcised, you can draw the foreskin over the head of the penis and then pull it back down the shaft to get an erection; if you are circumcised, repeated squeezing round the shaft and letting go is usually effective. Then you can let your hand glide up and down the shaft in long slow movements, gradually building up speed and pressure. You may enjoy rubbing or tickling the glans of the penis, though for some men this is too sensitive. You may like gentle or firm pulling, stroking, squeezing and stretching. Try holding off ejaculation by varying the stroke when you become too excited, before finally letting go in orgasm.

Masturbation need not be something that you do only when you are alone. Many people find the sight of their partner masturbating highly erotic. It can also be very instructive to discover how your partner reaches orgasm alone, as this will be the best method for you to adopt when you are masturbating him or her. Masturbating with your partner will break down inhibitions and allow you to get even closer.

Masturbating your partner

in the way he or she enjoys is an important part of lovemaking, and many women like being masturbated to orgasm before penetration. Both men and women need to learn how to handle each other's genitals with tenderness and sensitivity.

HOW TO GIVE THE PERFECT HAND JOB

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Side by side

This position, with the lovers lying side by side and facing one another, is easy to slip into after mutual masturbation, and can be a prelude to rolling over with either partner on top. Here, the woman has her leg wrapped round her partner's body to facilitate deeper penetration: she pulls him towards her with her leg as he thrusts. The partners can kiss and touch each other's genitals while making love in this position.

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Split level

This is one of a number of 'split-level' positions that gives the partners a different view of each other and a different angle of penetration. Here, the woman lies on her back, her legs round her partner's waist, while he kneels. He is in total control, and can also stimulate her clitoris with his fingers. From this position he can let her legs drop and lie on top of her in the missionary position, or he can raise her legs, resting them around his shoulders, then bend forward to kiss her mouth at the same time gaining depth of penetration.

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Spoons

The 'spoons' position is so named because of the close fit of the two bodies. The partners lie on their sides and the man enters from behind. This position is cozy and relaxing, good for slow drowsy lovemaking prior to failing asleep, or on waking during the night. It is also a comfortable position to adopt later in pregnancy when most others put too much pressure on the woman's belly.

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Spread-eagle

In this rear entry position, the woman lies face down with the man on top of her. She spreads her legs and he supports his weight on his arms. If she raises her bottom off the bed slightly, perhaps with the aid of a pillow under her hips, then it will be possible to achieve deeper penetration. The man can also lie with his full weight on his partner, from which position it is easy to roll into 'spoons'.

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Standing

Both parties stand, using the wall as support. This position is often used when the desire to make love strikes unexpectedly. Part of the excitement lies in the fact that it is not easy to move in this position.

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Standing carry

The man stands, holding his partner in his arms. She wraps he legs round his waist and her arms round his shoulders. She can move against him by pulling herself up and down, and he can help her with his arms. This position can be assumed from sitting. It can, of course, be adopted in a very confined space, but it is quite strenuous. From this position you can return to sitting, or the man can gently lower his partner on to a bed or preferably a table, where thrusting can continue without so much exertion.

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Swimming

The man lies on his back, spreading his legs, and his partner lies on top of him, her legs along his, her feet on his. There is a good opportunity for kissing and total body contact. She controls the pace of lovemaking by dragging herself up and down against him. Many women find this position very exciting and are more likely to reach orgasm without direct clitoral stimulation this way than any other.

She can vary the position by closing her legs tight while his remain spread, or by getting him to close his, or both. She can also move easily from this position to sit up facing him.

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Urgent

This position is ideal for when you are unexpectedly overtaken by the urge to make love. It does not require more than a loosening of the clothes if you want. The woman leans over the nearest available piece of furniture and the man enters from behind. It is good for fast exciting sex and gives both partners the opportunity to thrust against one another.

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Webmasters

Webmasters

Glossary of HIV/AIDS Terms

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

___ This glossary is provided for a better understanding of HIV/AIDS terminology in current usage. Medical and scientific terminology are based on the Surgeon General's Report of AIDS, publications of the Centers for Disease Control and Prevention, the former Global AIDS Programme of the World Health Organization (now part of U.N.AIDS), AIDS Treatment Data Network, and Harvard's Global Policy on AIDS Coalition. The research literature was also consulted through the internet. This glossary is up to date; some terms in this field have changed (e.g. ARC; GRID) and are no longer used. For purposes of discussion in this report, the term AIDS is commonly used to include HIV infection and disease and AIDS-related opportunistic infections and related-diseases. HIV/AIDS is also used.

A

Abstinence-only: A strict morality-based philosophy that preaches "no" to any sexual activity before marriage. Not having sexual intercourse is the safest way to avoid the sexual transmission of HIV/AIDS, although a majority of young adults and teens do not believe abstinence-only is a realistic option. However, the reality of HIV/AIDS is simple: avoid the exchange of bodily fluids and blood especially.

Abstinence-based: A slightly more open curriculum that stresses abstinence as the safest way to avoid HIV but allows for some discussion of sex and the ethics of sexual activity.

Acquired Immunodeficiency Syndrome (AIDS): A progressive weakening of the immune system accompanied by one or more indicator diseases (opportunistic infections) -- including Kaposi's sarcoma, invasive cervical cancer, pneumocystis carinii pneumonia, and wasting syndrome. In AIDS, common immune system deterioration is marked by a depletion of T-helper (T 4/CD4) cells, which help stimulate antibody production. AIDS is commonly thought to be caused by a retrovirus, HIV.

AIDS: is now a commonly-used term for Acquired Immunodeficiency Syndrome and also for HIV/AIDS; WHO uses the term to "denote the entire health problem associate with HIV infection."

American Foundation for AIDS Research (AmFAR): was co-founded in 1985 by Dr. Mathilde Krim and by Dr. Michael Gottlieb. It remains an influential advocate for HIV/AIDS research and programs.

Anal sex: Sexual intercourse when the penis is inserted in the anus. Often used as a birth control measure by young adults.

Antibiotic: A substance that kills or inhibits the growth of organisms. Once considered a magic bullet, antibiotics are now commonly used to combat disease and infection. Indications are growing that many human viruses and bacteria are becoming resistant to current antibiotics.

Antibody: Members of a class of proteins known as immunoglobins. Antibodies may tag, destroy and neutralize bacteria, viruses or other harmful toxins. Antibodies attack infected cells, making them vulnerable to attack by other elements of the immune system.

Antigen: A foreign protein that causes an immune response (the production of antibodies to fight antigens). Common examples of antigens are the bacteria and viruses that cause human disease. The antibody is formed in response to a particular antigen unique to that antigen, reacting with no other.

Antiretroviral: A substance that stops or suppresses the activity

of a retrovirus such as HIV. AZT was the first widely used antiretroviral drug and now more combinations are reaching the market. Antiretrovirals are not a cure but do help manage AIDS as a chronic disease and perhaps helps strengthen a PWA's health.

Asymptomatic: When there is no visible or noticeable changes in the body; i.e., an HIV-positive person does not show any signs of "AIDS symptoms." Thus, asymptomatic carriers are a threat to their unsuspecting sexual partners.

At risk: Individual behavior that identifies a person who is engaging in behaviors that are likely to transmit HIV, the AIDS virus. "Groups" per se are not at risk -- rather the commonly-practiced behaviors of their individual members make them more susceptible to be infected.

Autoimmune disease: A disease which arises from and is directed against an individual's own tissue (a problem with transplants).

AZT: AZT, Retrovir and Zidovudine are the common names for the chemical 3'-azidothymidine. It was the first drug on the market for AIDS. It was thought that AZT might be the cure for AIDS-related diseases but the hopes were dashed at the 1993 International AIDS Conference in Berlin. AZT is neither as good as its manufacturer claims, nor is it as bad as AIDS activists have alleged. In combination with other drugs (see "cocktail"), it can be helpful in slowing the progress of HIV/AIDS. It definitely helps to cut down on the transmission of perinatal AIDS.

B

B cells (B lymphocytes): One of the immune system's cell types; B cells fight infection primarily by making antibodies. During the time of infection, these cells are transformed into factories that make thousands of antibodies against the foreign antigen.

Behavior intervention/modification programs: Education programs designed to change a specific behavior. Behavior modification generally does this by targeting a very specific, observable behavior and then reinforce a series of small

changes in behavior until the desired behavior is established.

Bisexual: Having sex with both men and women. Many teens experiment with members of the same sex out of curiosity.

C

CD4 (T4): The protein imbedded on the surface of T-helper cells to which HIV attaches itself and through which it first enters the cells.

CD8 (T8): A protein embedded in the cell surface of T-suppresser cells.

Centers for Disease Control and Prevention (CDC): Best known as the CDC, this preeminent federal public health agency is a branch of the Public Health Service that is directly involved with the HIV/AIDS epidemic. It is based in Atlanta, Georgia.

Celibate: Choosing to abstain from any sexual activity. It is often presented as holy scripture for many religious orders, and less often for unmarried people; a prevention techniques for HIV/AIDS.

Chronic: Continuous or ongoing -- As PWAs live longer, HIV/AIDS is becoming a chronic disease.

Clades: "Families of a viral strain." Presently there are seven known clades of HIV but more are expected to be found.

Clinical trial: A test to see how well a new drug works on people (under tight government and clinical supervision.)

Combination therapy: The use of two or more drugs as treatment. Also, the use of two or more types of treatment in combination, alternatively or together.

Commercial sex workers (CSWs): Common medical/epidemiological term for people (usually females, but also males) who engage in prostitution (sex for money) as employment.

Comprehensive sex ed health: Offers full and complete

information on the sexual transmission of HIV/AIDS; nothing is deleted.

Condom: A prophylactic barrier a man wears on his penis for sexual intercourse. While not 100 percent effective, its use is recommended by most AIDS prevention professionals as an aid to prevent HIV transmission.

Cytokines: Proteins produced by white blood cells that act as chemical messengers between cells to mediate immune response. CD8 (T-suppresser) cells release a cytokine that appears to block HIV replication in infected cells, at least until the advanced stage of HIV disease.

Cytotoxic: Term used to describe something which damages or kills cells. Also used as the name of a type of T cell.

D

DNA (Deoxyribonucleic acid): A double strand of nucleotides (chemical building blocks) that contain genetic information.

E

Elisa (also ELISA): One of the first blood assay tests developed (by Abbott Labs in 1984) to test for HIV antibodies in the blood.

Epidemic: A contagious disease that spreads rapidly among many individuals in an area such as a province or country (see pandemic).

Experimental drug: A drug that has not been approved for use as a treatment but is being tested.

F

Female condom: A new prophylactic (latex and plastic) barrier that women put inside the vagina before sexual intercourse.

G

Gamma globulin (IgG): The portion of the plasma that contains antibodies.

Gay: Term commonly used to describe men who have sex with men exclusively (see homosexual, also lesbian).

Gp120: A piece of HIV that can cause damage to the immune system and other parts of the body. Gp120 is the foundation for several new vaccines.

H

Helper-suppresser ratio: The ratio of T-helper cells to T-suppresser cells. In people with HIV this ratio becomes increasingly inverted over time as T-helper cells become less.

Helper cells (T4, CD4): See T-helper cells.

Hemophilia: An inherited disease that prevents the normal clotting of blood. Many of the first wave of HIV/AIDS infected people were hemophiliacs who received contaminated blood supplies.

Hepatitis B (HBV): A viral liver disease that can be acute, chronic, and even life-threatening, particularly in people with poor immune resistance.

Heterosexual: Men who have sex with women; women who have sex with men (also referred to as "straight").

High risk behavior: Behaviors that are the most likely to lead to infection: unprotected sex (anal, vaginal, sometimes oral); using contaminated needles/sharing syringes; coming in ultimate contact with bodily fluids (blood, semen, vaginal fluids, and perhaps, although not usually, saliva).

HIV disease: A term used to describe a variety of symptoms and signs found in people who are HIV positive. These may include recurrent fevers, unexplained weight loss, swollen lymph

nodes, or fungus infection of the mouth and throat. Also described as symptomatic HIV infection (previously known as ARC). Most commonly used to describe AIDS.

HIV-negative: When test results show there are no HIV antibodies in the blood (i.e., no HIV infection).

HIV-positive: When test results show there are HIV antibodies in the blood (i.e., HIV infected); the stage before AIDS-related diseases. Also referred to as being sero-positive.

Homosexual: Men who have sex with men (gay); women who have sex with women (lesbian).

Human Immunodeficiency Virus (HIV): The retrovirus thought to cause AIDS. Many different strains of HIV have been isolated. Name and acronym selected by respected group of international scientists in 1986 to describe HTLV-III; LAV; and ARV.

Immunity: A natural or acquired resistance to a specific disease. Immunity may be partial or complete, long lasting or temporary.

Incidence: The extent or frequency with which new HIV infections and AIDS cases occur, in a defined population, within a specified period of time.

Incubation period: Term used similar to "latency period;" when an organism is in the body but not symptomatic.

Inhibitor: A drug, chemical or substance that inhibits or blocks something from happening. Protease Inhibitors are a new drug that is expected to help inhibit the progression of HIV.

Injecting Drug Users (IDUs): Current term now favored as substitute for "intravenous" drug users (IV drug); includes individuals who inject into the muscle or just below the skin, as well as injecting into the veins and arteries.

Intercourse: Sexual activity that includes penetration by the penis of the vagina and anus (also "coitus" and "fuck").

Interferon: A substance that is produced when the body detects infection with a virus. Interferon is released to coat uninfected cells to protect them.

Interleukin: A group of cytokines that help immune system cells communicate and modulates immune response.

Intravenous (IV): Intravenous drugs are injected directly into the veins and arteries ("injecting" drug user is now favored in place of "i.v.").

K

Kaposi's sarcoma (KS): Blood vessels which grow rapidly and cause pink to purple painless spots on the skin. KS can also grow in other places such as the lungs. It can be accompanied by fever, enlarged lymph nodes and stomach problems.

Knowledge, Attitude, Belief and Practice Survey (KABP): Standard for questionnaire surveys; used extensively as a prime HIV/AIDS educational research methodology.

L

Latency: The period when an organism in the body is inactive and/or not producing any ill effects. HIV is never really latent, although an infected person may not have symptoms or feel bad.

Latex condom: Most condoms are made out of latex material (safer than natural lambskin prophylactics), although rubber quality varies greatly. Some are very good atinhibiting HIV transmission (nearly 100 percent effective) while others, usually ultra-thin or novelty brands are only 50 to 75 percent effective.

Lesbian: Term commonly used to describe women who have sex with women.

Lymph Glands: Small immune system centers that are located all over the body. Lymph glands protect the bloodstream from infection by filtering out infection particles.

M

Macrophage: A large immune system cell that roams through the blood looking for foreign matter. These cells also alert the rest of the immune system that help is needed.

Maintenance therapy: Use of a treatment after the disease(s) has been brought under control. For example, unless maintenance therapy is used against PCP, the disease will probably occur again.

Men having Sex with Men (MSM): A term used originally by the CDC for describing gay and bisexual men.

Monogamous: Choosing to have one sexual partner for a period of time, as in marriage or a steady relationship (promoted as a sexually safer way of living in the 1990s).

Morality-Based: Term commonly used to describe religious-based tenets. (There is disagreement with the term "morality" as people who favor safer sex techniques believe that their point of view is also morality-based. i.e., saving lives.)

N

Nonoxynol 9: An effective spermicide coating with condoms that can kill many STDs and HIV.

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O

Opportunistic Infection (OI): Infections that are caused by agents that are frequently present in the body or environment, and can cause an infection in an immune-compromised person by an organism that does not usually cause disease in healthy people. When an individual's immune system becomes weak,

these organisms may cause serious or even life-threatening illnesses.

Oral sex: Refers to sex using the mouth and genitalia (also "fellatio," "blow job," "sucking," also "cunnilingus.")

Outercourse: New "safer sex" term refers to foreplay ("petting") and mutual masturbation between partners, as contrasted with sexual intercourse.

P

Pandemic: Contagious disease prevalent over a wide geographical area (the global AIDS incidence is a pandemic).

Pathogen: A substance or organism capable of causing disease.

Pathogenesis: The origin and development of a disease.

PeerCorps®: Dr. Chittick's favored prevention technique utilizing trained AIDS educators doing outreach with peers.

Perinatal Transmission: Refers to HIV transmission from the mother to the baby during birth (estimated to occur in one-third of cases, unless AZT is used).

Person with AIDS (PWA) or people living with HIV/AIDS (PLWHA): PWA is the term commonly used to anyone living with HIV/AIDS.

Pneumocystis carinii pneumonia (PCP): A lung infection that causes the greatest number of deaths in people who are HIV positive. It is both treatable and preventable.

Polymerase chain reaction (PCR): A very sensitive test for the presence of HIV.

Prevalence: Commonly occurring infection of HIV or cases of AIDS in a population; generally refers to all cases existing with an infection/disease (i.e., HIV/AIDS) at a specified period of time.

Promiscuous: Engaging in sexual intercourse with more than one partner (this dictionary definition, including the use of

"indiscriminately," is not pejorative here, but refers to multiple-sex partners over a relatively short period of time).

Prophylactic: A preventive medicine, device or measure; often referring to condoms or a dental dam.

Protease/ Protease Inhibitors: A substance in the blood that breaks down proteins. Drugs that inhibit protease may stop HIV from breaking down the proteins it needs to grow. Protease inhibitor trials involving PWAs are showing promise and the first drugs are being introduced.

p24 antigen: A protein fragment of HIV. The p24 antigen test measures this fragment. A positive result from p24 antigen suggests that HIV is multiplying, although there is debate about this.

R

Reality-Based: Term commonly used to describe explicit and detailed "sex ed" curriculum with safer sex HIV/AIDS components (often used as the opposite of abstinence-only).

Resistance: The ability of a disease to overcome a drug. For example, after long-term use of AZT, HIV can develop strains of virus in the body that are no longer suppressed by this particular drug, and therefore are said to be resistant to AZT.

Retrovirus: A strand of RNA (ribonucleic acid) surrounded by a protein shell. Retroviruses capable of infecting and causing disease in humans are relatively rare (and were only discovered in 1978). HIV is a retrovirus.

Reverse transcriptase: An enzyme that is crucial for HIV to grow and multiply.

RNA (Ribonucleic acid): A strand of nucleotides (chemical building blocks) that transmit genetic information. RNA performs the same functioning in retroviruses that DNA does in viruses.

S

Secondary Virgins: Young people who have had sex once or twice but then choose to be sexually abstinent, often after learning about HIV/AIDS in sex ed classes.

Sero Dia Agglumination Tests: One of the early HIV tests to measure HIV antibodies in the blood.

Seroconversion: After the initial introduction of HIV infection, when HIV antibodies can be detected in the blood.

Seropositive: Refers to blood that shows traces of HIV antibodies (i.e., HIV-infected persons, but without symptoms.

Seroprevalence: The number of a population or group (identified by their behaviors) who are infected with HIV.

Sex Ed (Sexual Education): Education that deals with detailed sexual education for teenagers (also referred to as comprehensive health education).

Sexually transmitted disease (STDs): These diseases include herpes, syphilis, gonorrhea, chlamydia, HIV/AIDS, and others. STDs make HIV easier to spread from one person to another. Currently, the term sexually transmitted infections (STIs) is also being used to refer to STDs.

Sexually transmitted infections (STIs): A term now becoming more used among medical professionals.

SIDA: French (and Spanish) acronym for Syndrome Immuno-Déficitaire Acquis.

Spermicide: Used with some condoms (Nonoxynol 9 is a common spermicide) and birth control creams to kill STDs, HIV and sperm.

Surrogate markers: T4 cells are used as a surrogate marker in people who are HIV-positive. The T4 cell count itself is not really a direct measure of HIV, but a declining count is a sign that disease is progressing. The T4 cell count is then said to be a surrogate marker for HIV. Different surrogate markers are being studied to see how well they measure the progress of HIV.

Symptom: A change in the body's appearance or functioning (including mental and psychological changes) that indicates the presence of a disease or illness.

Symptomatic: A change in normal bodily function; i.e., HIV-positive person shows symptomatic signs of AIDS.

Systemic: Affecting the whole body.

T

T4 cells: See T-helper cell.

T-helper cell (T4/CD4 cell): A type of white blood cell that activates T-killer cells and helps stimulate antibody production. Physicians regularly measure T-helper cell counts (CD4 counts) in HIV-positive people to monitor immune system function. The normal range for T-helper cells is 480-1800, but may vary in individuals. HIV first enters cells by attaching itself to the CD4 receptor on the surface of T-helper cells.

T-killer cell (cytoxic T cells): A type of white blood cell that kills foreign organisms when activated by T-helper cells.

T-suppresser cell: A type of white blood cell that helps control the body's response to an infection.

Thymus: The organ of the body that trains T cells to be part of the immune system.

Toxic reaction: A poisonous or unwanted reaction to a vitamin, drug or other substance. A toxic reaction occurs when a helpful medicine also causes damage to the blood or body. Toxicity is a measurement of how much damage may be caused.

Transfusion: The process of giving blood, or parts of blood from one person to another. Some people choose to have their own blood drawn and stored, to be transfused back into them at a later time.

Transmission: The passing of HIV through blood, semen, vaginal secretions or breast milk from an infected individual to another person. These four are the only body fluids known to transmit HIV (although a small amount of HIV might be in saliva, it is not thought to transmit HIV).

Tuberculosis (TB): An infection caused by "Mycobacterium" tuberculosis. It is reported to be rising in urban areas and TB is increasingly common among PWAs.

U

United Nations AIDS (U.N.AIDS): Created in 1995 to coordinate all of the different UN providers of AIDS services, U.N.AIDS began operations in 1996 under its first director, Peter Piot.

Universal Precautions: Refers to safety measures (i.e., sterilization, latex gloves) used by personnel in hospitals and clinics to ensure that infectious agents are not passed by unclean or contaminated equipment or accidents.

V

Vaccine: A suspension of an infectious agent (e.g., virus) or part of that agent. The suspension is administered (usually by injection) in order to confer resistance or immunity to that infectious agent. Other kinds of vaccines, therapeutic vaccines, are in development and being studied. Therapeutic vaccines may help fight HIV even after infection.

Viral Load: The amount of HIV in the blood; branch DNA is a new testing measure that determines the progression of AIDS (compared to the CD-4 count that measures the number of T -helper cells in the blood).

Viremia: The presence of a virus in the blood stream.

Virucides: A physical or chemical agent that destroys or inactivates viruses (researchers are looking for one especially for women to avoid STDs/HIV.)

Virus: A strand of DNA surrounded by a protein shell. Viruses are the smallest known infectious organisms and are unable to live or multiply outside of a host cell. Viruses can cause infectious disease (e.g., small pox, polio, influenza, herpes).

Infection with some viruses, such as CMV, may not produce symptoms in people with an intact immune system, but may prove dangerous or life-threatening for people with HIV/AIDS.

W

Wasting syndrome: A condition characterized by involuntary weight loss of more than 10% of baseline body weight plus either chronic diarrhea or chronic weakness and fever for more than 30 days, when these conditions cannot be explained by any illness other than HIV infection.

Wave: A metaphor used by researchers to explain the different stages of HIV infection and cases of AIDS in the population.

Western blot: One of the major confirmatory tests for HIV antibodies in the blood (see Elisa).

White blood cells (WBCs): White cells protect the body against foreign substances such as disease-producing micro-organisms. They are the heart of the immune system.

Window period: Refers to the time between infection with HIV and when its antibodies can be detected in the blood (as short as six weeks but usually longer, up to six months for test purposes).

Z

Zidovudine (ZDV): A drug shown to be effective in reducing the number of babies born with perinatal HIV.

HOME

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ANAL SEX

The Art of Anal Intercourse dates back to ancient times suggests that the practice of anal sex stimulation of the anorectal area, including penile penetration has been around for many centuries. In fact, some might find it surprising how common a practice it is among heterosexual couples today. In one survey of 100,000 female readers of *Redbook* magazine, 43 percent of the women said they'd tried it with their partners at least once. Of that number, 40 percent said they found it somewhat or very enjoyable. (That is, about a quarter of the total number of women surveyed said this.) Forty-nine percent said they didn't care for it, and 10 percent said they had no strong feelings one way or the other. While not a controlled scientific study, this survey roughly parallels the findings of many other sexual surveys.

Something else that may come as a surprise to many: While a fair number of heterosexuals engage in the practice, not all homosexuals do. In a review of the existing data on the subject, the *Kinsey Institute* concluded that between 59 and 95 percent of male homosexuals had engaged in anal sex at least once.

In the age of AIDS, anal sex has received a lot of bad press and for good reason. Unprotected anal intercourse is the single most risky behavior in terms of exposure to the dreaded disease. It bears mentioning, however, that if neither you nor your partner is already infected with HIV (human immunodeficiency virus), you cannot get AIDS from anal sex. This may seem self-evident, but in a nationwide sex survey conducted by the Kinsey Institute, half of the American adults questioned said they thought you could get AIDS through anal intercourse, whether or not one partner was infected. This is simply not true.

What is true is that having anal intercourse with an infected partner, without using a condom, is

the kind of sex behavior most likely to transmit AIDS. That's probably because the sensitive lining of the rectum is likely to tear during intercourse, allowing AIDS-infected blood or semen to pass directly into a sex partner's bloodstream. In fact, the evidence for this mode of AIDS transmission is so clear-and AIDS itself is so scary-that doctors now recommend against having anal sex with anybody, under any circumstances.

If you insist on trying it anyway, take two precautions: The vagina is naturally elastic and moistened by its own natural lubricants, but the rectum is not. Therefore, before attempting anal penetration, it's important to use a waterbased lubricant like K-Y Jelly. Also, before entering the vagina after anal intercourse, be sure to thoroughly wash the penis. Otherwise, it's likely to transfer bacteria from the rectum, which may cause vaginal infections.

AIDS HIV

HOW TO USE A CONDOM

HOMOSEXUALITY

SEX AIDS AND TOYS

HOME

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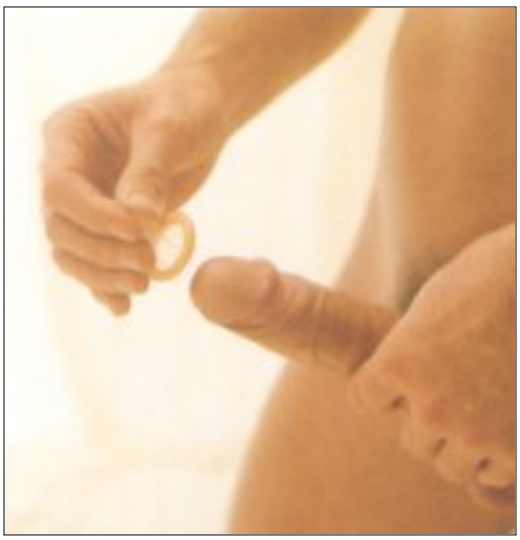
another sex tutorial - ANAL SEX

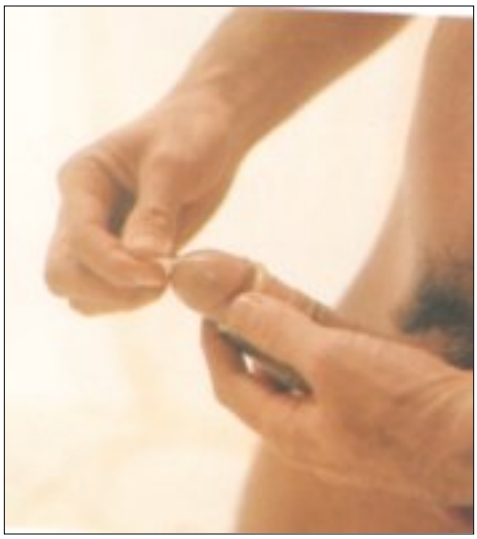
another sex tutorial

How to use a condom

Condoms come ready-rolled and most end in a teat, which catches the semen.



1- Expel the air from the teat at the tip of the condom by squeezing it.



2 - Place the opening of the condom on the head of the penis.

3 - Roll it down the shaft to fit comfortably.

4- When fully unrolled, the condom should extend almost to the base of the penis and fit like a second skin, feeling silky and smooth.

After ejaculation, the **condom** should be removed carefully to prevent spillage. First, the man withdraws his penis from the woman's vagina, holding the condom securely to his penis so as not to leave it behind. Then he removes it and disposes of it. Of course, care must always be taken that any semen left on the penis does not get transferred - on the fingers, for example - to the woman's vagina.

Putting on a condom can be fun. Some women enjoy doing this for their partners. You can use your lips and tongue to help your fingers unroll the condom down the shaft of the penis - but be careful not to snag the delicate material with your nails or jewelry.

HOME

another sex tutorial

Contraception

The ovulation testing pack

is a completely new method of natural family planning that allows you to enjoy making love without using any contraceptives on most days of your cycle. The pack includes a personal monitor that checks your urine samples and analyses them to indicate the days of the month on which you are likely to get pregnant. You should use contraceptives if you wish to make love on those days**.** The pack is 93-95 per cent reliable and very easy to use.

Natural family planning,

by contrast, requires meticulous record keeping and iron self-discipline. It involves charting your temperature day by day throughout the menstrual cycle to discover the period of ovulation, during which you must abstain from sex. Any unpredictable irregularity in the cycle can carry the risk of pregnancy.

The Pill is up to 99 per cent reliable. It allows for

completely spontaneous lovemaking. The freedom it gives is of enormous psychological benefit in any relationship. The Pill also regulates the menstrual cycle and reduces period pain and heavy bleeding in many women. Mild side effects occur in some women who take the Pill, but they usually disappear after a few months. They may include nausea, headaches, and depression, weight gain and some bleeding between periods. If side effects persist, the doctor or clinic will usually recommend a change of contraception. Before your doctor prescribes the Pill, he or she will ask for your medical history, including

incidence of thrombosis in your family. The health risks involved in taking the Pill are slight when compared to the risks of pregnancy and childbirth.

The combined Pill contains

synthetic forms of the sex hormones estrogen and progesterone, which interfere with the woman's regular 28day menstrual cycle. In a woman who is not taking the Pill, production of the sex hormones fluctuates during the cycle, and it is this fluctuation that triggers ovulation. When the Pill keeps the hormone level artificially constant, the signal to ovulate is cancelled out. The same happens during pregnancy, which is why overlapping pregnancies do not occur. Anyone who smokes heavily may be at risk of thrombosis, smokers and those who are over 35 are often advised not to take the combined Pill.

The progestogen - only Pill is not, as sometimes assumed, a low

dose Pill, but one containing a single hormone, progestogen. It has the effect of thickening the secretions in the cervix, which makes it difficult for sperm to pass. It can be taken by breast feeding mothers, unlike the combined Pill, which suppresses lactation.

The condom is 85-98 per cent

effective as a method of contraception. Condoms work by preventing the sperm from getting to its destination, and they do not interfere with the body's chemistry. The condom is also the key to safe sex as it protects against all sexually transmitted diseases. For more details about condoms and how to use them, see page 128.

Caps and diaphragms act

as a contraceptive by forming a barrier across the neck of the womb (cervix), which prevents the sperm from reaching and fertilizing the egg. A good fit is crucial. You need to be examined by your doctor or family planning clinic so that the right-sized cap or diaphragm can be chosen, and you can be shown how to insert it. A cap or diaphragm should always be used with a spermicide. This combination has been found to be a 95 per cent safe contraceptive. Smear a

little spermicide on to the diaphragm and around the rim, to facilitate insertion. Squeeze the diaphragm into a boat shape and insert it as you would a sanitary tampon, opening the lips of the vagina with one hand. When the rim rests behind the pubic bone at the front and the dome covers the cervix at the back, it is in place. Doctors recommend that you should not leave the diaphragm or cap in place for longer than 24 hours, but you should wait for at least six hours after intercourse before removing it. Remember that spermicide will be effective only for about three hours, so you will need to put more into the vagina if you have intercourse after the diaphragm or cap has been in place for that length of time. When you remove the diaphragm or cap, wash it carefully in warm soapy water and allow it to dry in a warm place, or pat gently with a towel.

The female condom is as

effective as other barrier methods. It lines the vagina and has an inner ring that sits over the cervix and an outer ring that lies flat against the labia. The female condom is made of colorless odorless polyurethane. The woman pushes the condom up inside her vagina before intercourse, and afterwards removes it and disposes of it. Like the male condom, the female condom is not reusable. It comes ready lubricated for easy insertion and no spermicide is necessary. Female condoms are made in one size only and will fit all women. During intercourse, it is a good idea for the woman to guide the man's penis into the condom to make sure it does not enter the vagina outside the condom. As the female condom is loose fitting, it will move during sex, but you will still be protected, because the penis stays inside the condom. To remove the condom after sex, simply twist the outer ring to keep the semen inside, and pull the condom out gently.

The I U D (intra-uterine device) or coil is a

small plastic and copper device that is inserted into the womb to prevent conception. Only a doctor trained in family planning can do this. The IUD comes compressed in a thin tube, which is slid through the cervical canal into the uterus and then withdrawn, leaving the IUD to spring into shape. Thin threads hang from the IUD about 3cm/ 1 inch into the vagina, and these can be felt with the fingers to make sure that the device is still in place. To remove an IUD, the doctor pulls the strings with a specially designed instrument.

Depending on type, IUDs are usually replaced about every five years. The IUD is reckoned to be 96-99 per cent effective as a contraceptive, although it is not clear exactly how it works. Many women like it because it allows both partners to be spontaneous in their lovemaking. However, it does not suit everyone. Some women experience discomfort and bleeding for a few hours or days after the IUD is inserted, and one in four women have to have it removed because of acute pain and heavy bleeding. Sometimes an IUD may fall out; this is more likely to happen during a period than at any other time, and this is why it is important to check regularly that the thin strings are still inside the vagina.

Contraceptive injections may be given with a drug that contains hormones of the progestogen type. An injection is needed every 8-12 weeks and is a virtually 100 per cent reliable contraceptive. However, it often has a disruptive effect on a woman's menstrual cycle, making periods more frequent or even disappear altogether. Return of regular periods may be delayed for up to a year after the last injection.

Contraceptive implants release a hormone into the bloodstream. The implants are small, stick-like and pliable, and are inserted under the skin of the inner upper arm by your doctor or clinic in a simple, almost pain free procedure. They cannot be seen. The effects will last for up to five years, and although the implants can be removed at any time, the body will not be free of the hormone for a short time afterwards. Implants are more than 99 per cent reliable, although they may make periods less regular or disappear altogether. These side effects may settle down after several months.

Emergency contraception is also called the 'morning-after Pill'. This last-resort method can be used if intercourse has taken place without contraception or if the usual method has failed, say in the event of a burst condom. It may also be prescribed to a woman after a sexual assault. It can be given up to 72 hours after intercourse and is 96-99 per cent effective.I

The danger of AIDS, young people often had sex with a new partner without a condom, particularly if they had been drinking. It is important to remember that AIDS is much more

dangerous to your health than pregnancy, and unlike pregnancy, there is no way that the disease can be terminated.

The message is clear: anyone who engages in casual sex or is having sex with a new partner should use a condom even if contraceptive protection is provided by the Pill. Women as well as men are recommended to carry condoms with them.

Clean bodies are generally more appealing than dirty ones, though the smell of a lover's sweat can have aphrodisiac qualities. Bathing is not always practicable or desirable, but you should always wash the genitals and anus before sex, to protect against infection, to increase the enjoyment of your partner and to give self confidence. Soap and water are all that is needed. Deodorants and perfumes kill the body's delightful natural scents, and they also taste unpleasant. Vaginal deodorants can be positively harmful, destroying the micro-organisms in the vagina that protect against disease. Always wash anything that is inserted in the anus, as anal sex carries the highest risk of infection.

MORE INFORMATION ON AIDS

HOW TO USE A CONDOM

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Female orgasm

Since the 1960's, when Kinsey began to bring sex out of the closet, there has been such a great deal of open discussion centred around the female orgasm that many women feel under intense pressure to 'perform'. If you feel your partner is comparing you to previous lovers, or to an orgasmic ideal in his head, it detracts from the intimate pleasure of sex and turns it into a competition.

Many women are bothered by the idea that there may be two types of orgasm - vaginal and clitoral. They wonder whether the orgasms they are experiencing are 'the real thing'. But are there really two types of orgasm? It was Freud who first suggested that there were. He said that the orgasm experienced through clitoral stimulation was the precursor of a deeper, more satisfying orgasm experienced in the vagina during penetration by the penis. According to him, the vaginal orgasm was a 'true, mature' sexual response, while the clitoral orgasm was its immature inferior. The value judgements Freud and his followers placed on the two types of orgasm have caused a lot of unhappiness among some women who never experience orgasm during penetration. They feel that they are missing out, and are therefore inadequate: less than 'real women'.

Researchers into sexual response have been much concerned with the categorization of the female orgasm since Freud's time. Kinsey's view was that there was only one type of orgasm, that it was triggered by clitoral stimulation and involved contractions of all parts of the female body,

including the vagina. He could not distinguish a second type of orgasm that centered solely on the vagina, and he utterly refuted Freud's distinction between 'mature' and 'immature' orgasms.

Subsequent clinical evidence has proved conclusively that Kinsey was right, and now sexologists are generally agreed that an orgasm is an orgasm. Researcher Helen Kaplan has come to this conclusion: 'Regardless of how friction is applied to the clitoris, i.e. by the tongue, by the woman's finger or her partner's, by a vibrator, or by coitus, female orgasm is probably always evoked by clitoral stimulation. However, it is always expressed by circurnvaginal muscle discharge.'

Although all orgasms are equal, women do report different sensations according to whether they are being penetrated or masturbated. And the surprise is that masturbatory orgasms, which are experienced by all women who can teach themselves to come through masturbation, alone or with a partner, are the more pleasurably acute. All women who orgasm in this way know the acute tension of the clitoris. The voluptuous rushing sensation that breaks into multiple contractions of the surrounding tissue. A small minority of women (around 20 per cent, according to sex researcher Shere Hite), who also orgasm with a penis inside the vagina, describe that as a quite different experience. Although Freud claimed that orgasms during intercourse were superior, the majority of women in a survey carried out by Shere Hite said they were less intense. Whereas masturbatory orgasm is experienced as a high, sweet, rippling sensation, the peak of sensitivity, orgasm with penetration is like the boom of a distant explosion, powerful, but somewhat muffled.

Orgasms triggered by the partner's fingers or tongue, and by masturbation, are probably more intense because stimulation is more localized and more sensitively guided. Masters and Johnson reported stronger contraction spasms and higher rates of heartbeat during orgasm without intercourse, and especially

during masturbation, and many women confirmed that they had their best orgasms when alone. Orgasm during penetration is undoubtedly quite rare for many women because a thrusting penis can stimulate the clitoris only 'in passing', if at all, depending on the position of the couple. The orgasm experienced may be more diffuse because the penis alters the focus of attention from the clitoris to the whole of the lower part of the woman's body, and because the vagina is full ‘muffling' the sensation.

A simultaneous orgasm,

when both partners come together during penetration, may feel like a surprisingly big underground explosion, but it probably offers the least in terms of sensual awareness. The reason for this is that if both parties are focused on their own experience or 'black-out' and become oblivious of each other, the sensation of the partner's orgasm is largely lost. For a woman, simultaneous orgasm is often followed by a feeling of disorientation, and a disappointment that lovemaking has come to an end.

Orgasm during intercourse is often less acute.

However, many of the women who are able to experience it prefer it for emotional reasons, because it involves complete body-to-body contact, holding the partner and giving oneself to him at the same time. Feeling whole and loved and emotionally satisfied are important aspects of a good sexual relationship, but these feelings can be experienced whether orgasm takes place during intercourse or not. What is important is that women should experience regular masturbatory orgasms. Orgasm relieves tension, recharges the body and revitalizes the mind. It leaves the woman feeling sparkling and whole. When shared with a partner, it represents the peak of sexual fulfillment and can be a powerful expression of love, helping to unite the couple.

Multiple and sequential orgasms, like vaginal and clitoral

orgasms, are concepts which have caused a lot of confusion and left many women worried that their sexual response might be somewhat inadequate. Because orgasms come in waves,

some women are not even sure whether their orgasms are multiple or single. Multiple orgasms are those that are experienced in a chain, one directly after another; sequential orgasms are those with a gap of a few minutes between each one. It seems that true multiple orgasm is extremely rare, although many women are capable of sequential orgasm.

On the topic of multiple orgasm, Masters and Johnson wrote: "If a female who is capable of having regular orgasms is properly stimulated within a short period after her first climax, she will in most instances be capable of having a second, third, fourth, and even a fifth and sixth orgasm before she is fully satiated. As contrasted with the male's usual inability to have more than one orgasm in a short period, many females, especially when clitorally stimulated, can regularly have five or six full orgasms within a matter of minutes."

Being capable of six orgasms in a row is not the same as needing or even wanting that many. According to Shere Hite, about 90 per cent of women who orgasm feel completely satisfied with a single climax. And in many women the clitoris remains hypersensitive, and further stimulation is uncomfortable and can even prove painful.

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Does the G-spot really exist?

The G-spot is named after its discoverer, Ernst Grafenberg. While many women still doubt its existence, others claim that stimulating a place about 5cm/2 inches inside the vagina towards the front of the body gives them intense pleasure.

The G-spot is said to be the female equivalent of the male prostate gland, which is situated about 5cm/2 inches up the rectum towards the front of the body. Stimulation of both these places can lead to orgasm in some cases. Some women have even found that they ejaculate a fluid if they have an orgasm by stimulation of the G-spot, and researchers in Canada and the United States claim that the composition of the fluid is remarkably similar to the secretion of the prostate gland.

How do you find the G-spot?

If you doubt the existence of the G-spot, you can try to find it yourself. The easiest way to reach it is with your own or your partner's finger, but there are also positions for intercourse in which the penis stimulates the sensitive area. Rear-entry is best, particularly with the man on top and a pillow beneath your hips, so that the penis presses against the front wall of the vagina.

MORE INFORMATION ON THE G-SPOT

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Homosexuality

Human sexuality is a complex phenomenon, and not so neatly categorized by the labels 'heterosexual' and 'homosexual' as society could wish. Between the strong and exclusive attraction of man to woman, and that of man to man, or woman to woman, lies a whole spectrum of sexual and emotional affinities: the ardor, or warmth, or coolness of any human relationship depends on the individuals within it, and not on any of the arbitrary specifications which might be imposed by society.

Some men want sex with other men as a permanent part of their lives; some are curious about male bodies, and may experiment at some time in their lives; some feel equally attracted to men and to women; some men enjoy looking at other men's bodies without desiring sexual contact; some prefer the company of other men for leisure; some work in an all male environment. Women also feel and do all these things with other women. These infinite permutations and the confusion that results from them cannot be accommodated by society, which needs order in which to function. Order means ignoring varying shades of grey and distinguishing only between black and white; it means putting labels on things. And since society is never stronger than when it is united against a common evil, labeling things also means defining society's outcasts.

Various attempts have been made this century to 'explain' homosexuality, and even to 'cure' it. But the question is not really why some people are homosexual, but why our society is heterosexual. People born into a homosexual society generally conform to the norm, just as do people born into a heterosexual society. Most of us have a broad enough sexual

response to allow us to be conditioned comfortably to either mode of behavior. The people who feel less comfortable with the status quo, and those who feel positive discomfort with it are in no way unnatural; rather, it is the restrictions that society places on them that should be considered against nature.

One man in three has had some form of homosexual experience resulting in orgasm, according to the Kinsey Report, published in 1948. Kinsey was not saying that one man in three was homosexual; but he was tearing off the label that branded sexuality between men as 'abnormal'. Kinsey pointed out that humans were not alone among animals in engaging in same-sex activity: the assumption that animals had sex only when reproduction could be guaranteed was a man-made one, designed to bolster the view that homosexuality was 'against nature'. Of course, half a century has elapsed since the publication of the Kinsey Report and sexual mores have changed. However, Kinsey's findings still represent extremely valuable research into this area of sexual behavior and the underlying trends are still relevant today.

Homosexual encounters between men usually begin in foreplay and end in orgasm, but the pattern of lovemaking is much less rigid than the pattern of lovemaking between men and women tends to be, and both partners almost always reach orgasm. Many homosexual men consider sex with other men to be liberating because there are no rules: it does not involve pressure to perform or pressure to satisfy the other person, and mutual satisfaction is effortless because men understand each other's bodies so well.

Men report that another advantage of sex without obligations is that they feel they can come straight to the point; a sexual relationship often precedes a social friendship, and not the other way around. Many men describe their sexual relations with male partners as generally more honest and straightforward, both physically and emotionally, than their relationships with women.

Most homosexual men derive a great deal of physical and emotional satisfaction from

being penetrated. Hygiene should always be the first priority in any act of anal penetration, as disease is especially. easily transmitted in this way. Always wear a condom. A condom on a finger inserted into the anus can aid lubrication as well as protect against scratches - from fingernails and rough skin -that could lead to infection. You should always wash thoroughly before and after anal sex, and if you use a vibrator for penetration, make sure that this is washed thoroughly too, in hot soapy water with a splash of antiseptic added.

Some women rebel against the narrowness of the status quo and become lesbians for political reasons, feeling dissatisfied with a male dominated society, others do so because they find men unsatisfactory as lovers or as partners on an emotional level, and others because they are intensely emotionally involved with a member of their own sex and wish to express their feelings through their sexuality.

ANAL SEX

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Kissing

There is an infinite variety of kisses that lovers can exchange, from playful or tender lip kissing to deeply arousing open-mouth kissing with tongue play. Kissing someone you are mad about is one of life's great pleasures - or should be. Surprisingly large numbers of people have no idea how to kiss, and a poor kisser can be a terrible disappointment, just as someone who is a skilled practitioner of the art of kissing can have you tearing off your clothes.

The lovers' kiss or French kiss, involving the whole mouth and tongue, is said to have its origins the way mothers used to feed their babies in prehistoric cultures. This practice can be observed in peasant communities in some parts of Europe even today. The mother chews the food for her baby before transferring it directly from mouth to mouth She pushes her tongue, and the food, inside the infant's mouth, and it reacts with searching movements of its tongue inside her mouth. Considerations of hygiene and today's associations of mouth-to-mouth contact with sexual arousal make this type of feeding unacceptable in our society, but the action lives on in adult erotic behavior.

A deep kiss is very often the first mutual acknowledgement that sexual attraction exists between a couple, and it is the first element of sexuality to disappear from a relationship that is on the wane. According to Relate (the British Marriage Guidance Bureau), couples whose marriages are in trouble are more likely to have intercourse than to kiss. That mouth and tongue contact retains a special intimacy while intercourse can seem businesslike and remote is also illustrated by the fact that

prostitutes never kiss their clients.

The first thing to do when kissing a new lover is to find out with your lips and tongue where his or her teeth are, so you can avoid banging into them with your own teeth. Clashing teeth is as impersonal as clashing spectacle frames. The next thing to remember is that kissing should be wildly exciting: don't get stuck in a rut endlessly repeating the same movement, or your partner will lose concentration and grow bored. Vary the pace, and vary the initiative, sometimes taking it, sometimes being receptive to your partner.

Here are a few tips for more enjoyable kissing:

* If your new partner does not smoke and you do, now would be a very good time to give up the habit. Non-smokers do not like the taste or smell of tobacco.

* Until you have got to know someone well and they have assured you they don't mind it, don't eat strong tasting food, such as garlic or curry, unless your lover is eating it too.

* Oral hygiene is important. Make sure your mouth looks and tastes good. Get your dentist to de-scale your teeth regularly and eat a healthy diet so that your breath is fresh.

* Don't kiss or have oral sex if you have a mouth or throat infection. Kissing can transfer an estimated 250 different bacteria and viruses carried in saliva, though as yet there is no evidence to suggest that AIDS can be caught in this way.

* Being kissed passionately by a man with a stubble chin is not anywhere near as erotic as

being kissed passionately by a man who has recently shaved.

* If you have a beard,

consider the fact that it makes a barrier between your skin and your lover's. There is no doubt that **more** erotic contact is possible between a clean-shaven man and his partner**.**

* Women who wear make-up should be prepared to have it licked off or, at the very least, smudged. Consider how you feel about this before applying your make-up, but whatever you do, don't let yourself be inhibited by a perfectly painted face. Many men would prefer to kiss a face bare of make-up anyway.

* To maximize sensation

when kissing, make full use of all the muscles in your mouth and tongue. it is much better kissing someone whose mouth responds to yours and who knows how to use pressure, than someone whose mouth is flabby and slack.

* Remember that nothing, but nothing, is worse than a slobbery kiss.

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Premature Ejaculation

Anxiety is often the cause of premature ejaculation.

In an extramarital relationship a man may ejaculate as soon as he penetrates his partner's vagina, despite the fact that he does not have this problem with his wife. This is a sign of guilt. A man may also ejaculate before he wishes to if he feels frightened that his technique is not good enough, and ejaculating quickly will prevent him from having to reveal his lack of experience.

Believing that sex is bad

because of what you were told as a child is another possible cause of premature ejaculation. If as a boy, you were punished for masturbating, you may have taught yourself to come quickly to lessen the chance of being found out and to minimize the guilt you felt at your own pleasure.

Fear of getting too close

to another person may also be a contributing factor. Intimacy always brings with it the risk of loss, and the unbearable pain attendant on that loss. Subconsciously, a man who gets sex over with quickly may be trying to protect himself from close emotional involvement.

Several techniques can help men last longer, and these should be used in conjunction with examining the cause of the problem. Understanding what is wrong often brings its own release.

The stop-start technique for delaying ejaculation

The aim of these exercises is to learn to keep yourself below the point at which ejaculation seems inevitable for as long as possible. Men who do not have a partner can practice the first three steps. In them selves, they will help you gain a greater measure of control. For the final four steps you will need the co-operation of a partner.

* Step one Masturbate with a dry hand. Avoid fantasizing, and concentrate instead on the sensation in your penis. Allow the pleasure to build up but stop immediately you feel you are about to lose control. Relax for a while, still keeping your mind free of fantasies, until the danger of ejaculation has passed, then begin again. Following the same pattern, aim to continue stopping and starting for 15 minutes without orgasm. You may not be able to manage it at first, but keep trying. As you get more practiced, you will probably find you have to stop less often. When you have completed three 15-minute sessions on three consecutive occasions (not necessarily one immediately after the other!), proceed to step two.

*** Step two** involves masturbating with a lubricating jelly to heighten sensation, and make delay more difficult. Follow the technique in step one until you have completed three separate consecutive sessions as above.

* **Step three** You will now have gained a good measure of control. The next step involves masturbating with a dry hand for 15 minutes before ejaculation. Keep focusing on your penis rather than fantasizing. When you feel yourself getting dangerously excited, don't stop, but instead, change rhythm or alter your strokes in such a way that the pressure to ejaculate fades. Experiment to see which strokes excite you most, and which allow you most control. Work on this step until you have completed three consecutive sessions as before.

* **Step four Now** involve your partner. Lie on your back and get her to masturbate you with a dry hand, as in step one. Concentrate on the sensations in your penis and ask her to stop every time you get too aroused before the 15 minutes is up. The aim is to last for three consecutive 15-minute sessions.

* **Step five** Repeat step four, but ask your partner to use a lubricant while she masturbates you. You will find ejaculation much more difficult to control, and you may have to ask her to stop more often. Once you have mastered three consecutive 15-minute sessions, you are ready to try the stop-start technique with intercourse.

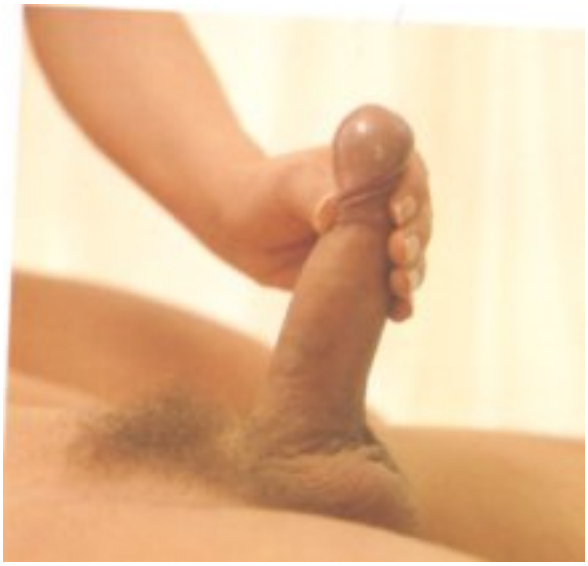
* **Step Six** The best position for delaying ejaculation is with the woman on top. Once you are inside her, ask her to move gently. Put your hands on her hips so that you can let her know with your hands when you want her to stop, and when you are ready for her to start again. Again, aim to last for 15 minutes, but if you can't, don't worry; you can start again once you recover your erection, and the second time you will probably have more control. During intercourse, concentrate entirely on yourself. Give your partner your full concentration and bring her to orgasm either before or afterwards, with oral or manual stimulation.

* **Step seven** Move on to other positions. It is more difficult to delay -ejaculation with the man on top, so save this until last.

The squeeze technique for delaying ejaculation

The 'squeeze' action is designed to cause your erection to subside, and it can be applied every time you get too close to ejaculation. Your partner performs the squeeze by gripping your penis firmly, and pressing with her thumb on the frenulum. This is the place on the underside of the penis where the head joins the shaft. At the same time, she presses on the opposite side of the penis with her forefinger, and with her other fingers **curled round the** shaft. It is important that she presses fairly hard on the penis and doesn't move her hand while doing so.

Too light a touch could cause you to ejaculate straight away.



* **Step one Get your partner to** masturbate you with a dry hand. Any time you get too close to ejaculation, signal to her to stop and squeeze your penis. As with the stop-start technique, aim to last for three consecutive 15minute sessions before moving on to step two.

* **Step two** get your partner to masturbate you slowly and gently as before, but this time ask her to use a lubricant. Follow the procedure for step one.

* **Step three** now you are ready for intercourse, but not for thrusting. Instead, lie on your back and ask your partner to sit on top of you, with your penis inside her. Neither of you should move. As soon as you feel the urge to come, your partner should rise off you (this movement is dangerous as it applies stimulation), and immediately hold your penis in the squeeze grip. Repeat the exercise a couple of times before you allow yourself to ejaculate.

* **Step four When** you feel more confident about your self-control, ask your partner to move gently while she sits on top of you in the same position. When you feel the urge to ejaculate, she should move off you and squeeze as before, until you can last 15 minutes without ejaculating.

* **Step five you** are now ready to try other positions, but remember that with the man on top, you will have least control. As with the stop-start technique, during intercourse you should focus all attention on yourself. Your partner will not feel neglected if you bring her to orgasm orally or

manually either before or after intercourse.

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THINKING ABOUT BIRTH CONTROL

Thinking about birth control is part of thinking about having intercourse. Some people choose to engage only in sexual behaviors other than intercourse -- some because they prefer other forms of intimacy; some because they're not ready for intercourse; and some because they don't want to risk pregnancy.

Choosing a method of birth control isn't always easy. In addition to thinking about the effectiveness, benefits, and possible side-effects of the methods you're considering, you need to think about what you feel comfortable using. It's important to ask yourself what methods realistically fit with your personality and lifestyle.

Talking about birth control with a partner can be hard. It may help to try to sort out your own feelings before you bring up the subject with your partner. Try to find a time and a way to talk about it that feels comfortable to you.

What Do Effectiveness Rates Mean?

A range of effectiveness is listed for each method of birth control in this handout. The lower rating listed is the "typical effectiveness," which takes into account incorrect or inconsistent use. The higher number is the "theoretical effectiveness" rate, which describes the method's effectiveness when used correctly every time a couple has intercourse. Effectiveness statistics are difficult to evaluate because they vary widely

depending on the design of the research study. The method with the highest effectiveness rating may or may not be the "best" method for you. The best method is the one which you are informed about, comfortable with, and will use consistently.

Birth Control and Sexually Transmitted Diseases (STDs)

You may be primarily concerned with preventing pregnancy when you choose a method of birth control, but if you or your partner has ever had sexual contact with anyone else, you may be at risk for contracting an STD. Using condoms and spermicide provides the greatest protection against STDs. Other methods of birth control (noted in this handout) may also provide some protection. Many women and men use condoms and spermicide along with other methods of birth control to protect themselves and their partners from STDs.

What If Your Method Fails?

Correct and consistent use of your birth control method makes it less likely to fail; however, no method is perfect. If your method fails, or you have unprotected intercourse, the risk of pregnancy may be reduced by immediately inserting two applications of spermicide into the vagina. Also, call the Gynecology Clinic or Dial-A-Nurse about the availability of the morning-after pill.

METHOD Birth Control Pill EFFECTIVENESS 97-99.9% HOW TO OBTAIN Requires recent gynecological exam and attendance at Birth Control Education Class. Call Gynecology for appointment and class schedule. STD PROTECTION No OTHER CONSIDERATIONS Provides continuous

protection. Must be taken at the same time every day. Regulates menstrual cycle, decreases cramps and flow. May cause breakthrough bleeding, breast tenderness, nausea, weight gain/loss during the first few months. Some women are not good candidates because of medical history.

METHOD Norplant (Hormonal Implants) EFFECTIVENESS 99.9% HOW TO OBTAIN Not available at McKinley -- call Gynecology for information. Newly available in 1991. Initial cost $400-$600. STD PROTECTION No OTHER CONSIDERATIONS Requires minor outpatient surgical procedure for insertion and removal. Provides continuous protection for five years (may be removed sooner, if desired). May cause weight gain. Frequently causes irregular bleeding during the first year of use.

METHOD Depo-Provera (DMPA (Hormonal Injections EFFECTIVENESS 99.9% HOW TO OBTAIN Not available at McKinley, call Gynecology for information. Approved for contraception use in 1992. Cost is $25 - $45 per injection. STD PROTECTION No OTHER CONSIDERATIONS A shot every 12 weeks provides continuous protection. Does not contain estrogen. May cause irregular bleeding and spotting, heavier or lighter periods. May cause breast tenderness, nausea, during first few months. May cause weight gain.

METHOD IUD (Intrauterine Device) EFFECTIVENESS 97-99.2% HOW TO OBTAIN Requires 2 appointments for gynecological exam and insertion. STD PROTECTION No OTHER CONSIDERATIONS Provides continuous protection. May cause heavier menstrual bleeding and more severe cramps. Some women are not suitable candidates.

METHOD Diaphragm & Cervical Cap EFFECTIVENESS 82-94% HOW TO OBTAIN Requires recent gynecological exam and may require multiple appointments for fitting STD PROTECTION Some OTHER CONSIDERATIONS Most effective if inserted before any genital contact. Does not affect menstrual cycle. Some women cannot be fitted. Minimal side effects. Some consider it messy or difficult to use.

METHOD Condom EFFECTIVENESS 88-98% HOW TO OBTAIN Can be obtained at Health Resource Centers (locations on back of handout) and at drug stores STD PROTECTION Yes, most effective OTHER CONSIDERATIONS Most effective if put on before any genital contact. Recommended to be used with additional spermicide. May reduce sensation.

METHOD Spermicides (Jelly, foam, cream) EFFECTIVENESS 79-97%

HOW TO OBTAIN Spermicidal jelly is available at Health Resource Centers (locations on back of handout). Other spermicides can be obtained at drug stores. STD PROTECTION Some OTHER CONSIDERATIONS Most effective if inserted before any genital contact. Some consider messy to use. Recommended to be used with a condom. Provides additional lubrication. May cause irritation (switching brands may help)

METHOD Sponge EFFECTIVENESS 82-94% HOW TO OBTAIN Not available at McKinley -- can be obtained at drug stores. Cost is $1 - $2 each. STD PROTECTION Some OTHER CONSIDERATIONS Most effective if inserted before any genital contact. Effective 24 hours. Recommended to be used with a condom. Some consider it

messy or difficult to use. May cause itching, irritation. May not fit all women well.

METHOD Fertility Awareness EFFECTIVENESS 80-98% HOW TO OBTAIN Individual instruction about this method is available at Planned Parenthood -- call 359-8022 to schedule an appointment. STD PROTECTION No OTHER CONSIDERATIONS Requires some instruction, high motivation, and diligent record-keeping of fertility indicators. Increases awareness of changes in menstrual cycle. Requires use of back-up method or abstinence from intercourse during fertile part of cycle. Can be an all natural method. Stress, illness, or vaginal infection can affect fertility indicators

A NOTE ABOUT WITHDRAWAL, RHYTHM, AND DOUCHING Withdrawal is a method couples sometimes use. It can fail due to the presence of sperm in pre-ejaculatory fluid, or the couple misjudging when the man should withdraw. This method requires a high level of trust and cooperation, and couples may find it unsatisfying to use. Withdrawing before ejaculation is better than using no method at all. Couples who use the rhythm ("safe time") method abstain from intercourse (or use another form of birth control) during the fertile time in the woman's menstrual cycle. This method can fail because it is possible for a woman to ovulate at any time during her cycle, including while she is menstruating. The Fertility Awareness Method (described briefly in this handout) combines charting of a woman's menstrual cycle with other fertility indicators to provide more complete information about when ovulation occurs.

Douching after intercourse is not an

effective form of birth control, because some sperm may reach a woman's uterus almost immediately after ejaculation. In addition, douching may push sperm toward the uterus and increase the likelihood of pregnancy.

Reference: Hatcher, et. al. (1990). Contraceptive Technology, 1990-1992, 15th Revised Edition, New York: Irvington Publishers, Inc.

THE DIAPHRAGM

What Is a Diaphragm? ---------- The diaphragm is a soft, thin rubber cup that is placed in the vagina before intercourse. It is a "barrier" method of contraception, and one of its advantages is minimal side effects. The diaphragm covers the cervix and prevents sperm from entering the uterus. When properly used with spermicidal jelly or cream each time you have intercourse, the diaphragm can be 97% effective. Since women differ in the size and shape of the vagina, diaphragms are made in several sizes and types. The correct size and type can only be determined by a doctor or nurse during a pelvic exam.

When Do I Insert the Diaphragm? ---------- The diaphragm must be inserted before intercourse. If intercourse does not occur within 2 hours, a second application of the spermicide is necessary. The diaphragm should not be removed to do this. Insert the additional jelly or cream with an applicator. An application of spermicide is required each time you have intercourse. Be careful not to dislodge the diaphragm with the applicator. You need:

Diaphragm -- available by prescription at

McKinley Health Center pharmacy; comes in its own plastic case.

Spermicidal Jelly or Cream -- available by prescription at McKinley pharmacy; available from both Health Resource Centers; available at other pharmacies for purchase over-the-counter.

Plastic Applicator -- for inserting additional spermicide. Available at McKinley and generally comes inside the spermicide package.

How Do I Insert It? ---------- Wash your hands before handling the diaphragm. Before insertion, put about 1 tablespoon of spermicidal jelly or cream into the dome of the diaphragm and spread some around the rim. If desired, apply a small amount to the outside of the diaphragm to aid insertion. The diaphragm may be inserted while you are standing, squatting or reclining. (It can also be inserted by your partner.)

First, using the thumb and first 2 fingers, press the rim together so that the diaphragm folds in the middle. With the other hand, spread the vaginal lips. Now, insert the diaphragm into the vaginal canal and gently push the diaphragm along the vaginal floor as far as it will go, to make sure it passes the cervix. The diaphragm will open up once inside; now, tuck the front rim up behind your pubic bone. Check to make sure the cervix is covered! Run your finger over the surface of the diaphragm -- you should feel the cervix behind the diaphragm. If the diaphragm is uncomfortable, remove it and reinsert. Be sure and check the cervix again.

When and How Do I Remove It? ---------- The diaphragm must be left in place 6 - 8 hours after intercourse. To remove the diaphragm,

hook your finger under the front rim and gently pull down and out. If you have difficulty with removal, bear down, while squatting, and pull on the diaphragm.

Care of Your Diaphragm:
---------- After removing the diaphragm, wash it with a mild soap and water. Rinse it with clean water. Dry carefully. Do not use perfumed soaps containing cold cream or detergents to wash the diaphragm. The elements in these soaps may have a harmful effect on the latex rubber diaphragm.

Dust the diaphragm lightly with cornstarch and replace it in the container. Do not allow the diaphragm to air dry. Do not use any type of body powder, baby powder, flour or face powder, as they may contain elements that could affect the latex rubber diaphragm. Do not use cold cream, Vaseline or other oily substances as a diaphragm lubricant, as these may also be harmful to the diaphragm.

Additional Information: ----------

1. If you gain or lose 10 lbs. or more, or become pregnant, the diaphragm should be refitted.

2. If you think you may have sex, you can insert your diaphragm before you go out. Be sure you insert additional jelly with the applicator before intercourse (if more than 2 hours).

3. In the past, women were counseled to only use certain positions during intercourse. There is no evidence to support this. There should be no fear of dislodging the diaphragm if it is fitted and inserted correctly.

THE PILL

Over 10 million women in the United States currently use an oral contraceptive,

the pill, to prevent pregnancy. There are a number of different brands available, manufactured by several different companies.

The questions and answers outlined below provide important information to assist you in using the pill in the safest, most effective manner. Be sure to read these directions before you start taking your pills, and any time you are not sure what to do. Please address any questions you have to your medical provider.

How does the pill work? ---------- * It prevents ovulation * It alters the cervical mucus, making it less penetrable to sperm It alters the endometrial lining, inhibiting implantation of a fertilized egg, if ovulation has occurred.

How effective is the pill? ---------- The pill is 99% effective when taken correctly. If you stop taking the pill, you may become pregnant very soon. Many pregnancies occur when women stop taking their pills and have intercourse without using another method of contraception.

Who should or should not take the pill? ---------- Each person is evaluated on an individual basis. Determining factors include: past medical history, family history, and findings of a physical exam.

What are the benefits? ---------- * decreases blood loss and incidence of iron-deficiency anemia * decreases severity of menstrual cramps * regulates menstrual periods * decreases risk of fibrocystic breasts and ovarian cysts * often improves acne

What are the risks? ---------- The risks of using the pill are low compared to the risks of pregnancy and childbirth.

Nearly all risks are associated with the cardiovascular system. Smoking significantly increases these risks. If you experience any of the following symptoms, you should seek medical care right away and tell the physician you are on the pill:

A - Abdominal pain (severe) C - Chest pain, shortness of breath, coughing up blood H - Headache (severe), numbness or weakness in arms and legs E - Eye problems (vision loss, blurring, or flashing lights) S - Severe leg pain in calf or thigh

What about cancer and the pill? ---------- Since 1960, when birth control pills first became available, important information about pills and cancer has been learned: pills reduce the risk for ovarian cancer; pills reduce the risk for endometrial cancer; most studies suggest that pills neither reduce nor increase risk for breast cancer.

Further research is needed, as there may be a small number of women who are at increased risk for breast cancer. Women are recommended to do breast self-examination every month, and report any changes or problems to their health care provider.

How do I get a pill prescription? ---------- First-time pill users must attend a birth control education session at McKinley. All pill users must have a pap test done within the year by a McKinley clinician or by a health care provider or clinician. First-time pill users are dispensed three (3) pill packets. Before you finish taking the third packet, return to Pharmacy for refills. If you have any problems, call Gynecology Clinic.

How do I take the pill? ----------

Important facts to remember are:

1. (Before you start taking your pills), look at your pack to see if it has 21 or 28 pills. The 21-pill pack has 21 "active" pills to be taken one-a-day for 3 weeks, followed by 1 week without pills. The 28-pill pack has 21 "active" pills to be taken one-a-day for 3 weeks, followed by 1 week of "reminder" pills to be taken one-a-day for 7 days.

2. The right way to take the pill is to take one pill every day at the same time. Establish a regular routine. If you miss pills, you can get pregnant. This includes starting the pack late. The more pills you miss, the more likely you are to get pregnant. Take a pill every day, until you have completed the pill pack.

3. Some women have spotting or light bleeding, breast tenderness, and/or nausea during the first 1-3 packs of pills. If you experience any of these, do not stop taking the pill. For nausea, try taking your pill after meals. All of these symptoms will usually go away. If they don't, check with your health care provider before getting a refill from the pharmacy.

4. If you take a pill more than six hours late, it is considered a missed pill. Varying the time you take your pills may cause spotting or bleeding and increase the risk of pregnancy.

5. If you have vomiting or diarrhea, for any reason, or if you take other prescription medicines, including antibiotics, your pills may not work as well. Use a back-up method (such as condoms, foam, or sponge) if you have intercourse, and check with your health care provider. (See handout titled Oral Contraceptives and Drug Interactions).

6. Your period will probably be shorter and lighter. If you miss a period, and you've

taken your pills correctly, you are probably not pregnant. Stay on schedule with your pills and get a pregnancy test to be sure.

7. At the end of your pill pack: If you are on a 21-pill pack, you should wait 7 days to start your next pack. You will probably get your period during that week. Don't wait longer than 7 days to begin your next pack. If you are on a 28-pill pack, you will start a new pack the day after you finish your current pack. Do not wait any days.

WHEN TO START THE FIRST PACK OF PILLS

You have a choice of which day to start taking your first pack of pills. Decide with your health care provider which is the best day for you. Pick a time of day which will be easy to remember.

Day 1 start: ---------- 1. Take the first "active" pill of the first pack during the first 24 hours of your menstrual period.

2. You will not need to use a back-up method of birth control, since you are starting the pill at the beginning of your period.

Sunday start: ---------- 1. Take the first "active" pill of the first pack on the Sunday after your period starts, even if you are still bleeding, If your period begins on Sunday, start the pack that same day.

2. Use another method of birth control as a back-up method if you have intercourse any time from the Sunday you start your first pack until the next Sunday (7 days). Condoms (used with foam or the sponge) are good back-up methods of birth control.

WHAT TO DO IF YOU MISS PILLS

If you miss 1 "active" pill: 1. Take it as soon as you remember. Take the next pill at your regular time. (This may mean you

take 2 pills in 1 day.) 2. You do not need to use a back-up method if you have intercourse.

If you miss 2 "active" pills in a row in week 1 or week 2 of your pack: 1. Take 2 pills on the day you remember and 2 pills the next day. 2. Then take 1 pill a day until you finish the pack. Remember, bleeding may occur. 3. If you have intercourse, you must use another birth control method (such as condoms, used with foam or sponge) as a back-up for the next 7 days after you miss the pills.

If you miss 2 "active" pills in a row in week 3 of your pack: 1. If you are a Day 1 Starter -- Throw out the rest of the pill pack and start a new pack that same day. If you are a Sunday Starter -- Keep taking 1 pill every day until Sunday. On Sunday, throw out the rest of the pack and start a new pack of pills that same day. 2. You may not have your period this month, and spotting may occur. However, if you miss your period 2 months in a row, call your health care provider, because you might be pregnant. 3. If you have intercourse, you must use another birth control method (such as condoms, used with foam or sponge) as a back-up for the 7 days after you miss the pills.

If you miss 3 or more "active" pills any time during your pack: 1. If you are a Day 1 Starter -- Throw out the rest of the pill pack and start a new pack that same day. If you are a Sunday Starter -- Keep taking 1 pill every day until Sunday. On Sunday, throw out the rest of the pack and start a new pack of pills that same day. 2. You may not have your period this month, and spotting may occur. However, if you miss your period 2 months in a row, call your health care provider, because you might be pregnant. 3. If you have intercourse, you must use another birth control method

(such as condoms, used with foam or sponge) as a back-up for the 7 days after you miss the pills.

If you forget any of your 7 reminder pills in week 4 of your 28-day pill pack:

1. Throw away the pills you missed. Keep taking 1 pill each day until the pack is empty. you do not need to use a back- up method if you have intercourse.

If you are still not sure what to do about the pills you have missed:

Use a back-up method any time you have intercourse. Keep taking one "active" pill each day, and contact your health care provider.

Is there anything else I need to know? ---------- The birth control pill does not protect against sexually transmitted diseases. Condoms and spermicide do.

If you are concerned about any difference in your treatment plan and the information in this handout, you are advised to contact your health care provider.

Reference: ---------- Hatcher, R., Guest, F., Stewart, F., Stewart, G., Trussell, J., Bowen, S., & Cates, W. (1989). Contraceptive technology, 14th Revised Edition. New York: Irvington.

HOW TO USE A CONDOM

1. Put the condom on before any genital contact. If uncircumcised, pull back the foreskin.

2. Cover the head of the penis with the condom and gently press the air out of the tip. Unroll it, so that the entire erect penis is covered. A drop of lubricant may also be placed in the tip of the condom before unrolling it onto the penis.

3. If needed, you may generously apply a water-based lubricant to the outside of the condom before penetration. Do not use oil-based lubricants.

4. To prevent slippage, hold the condom at the base of the penis whenever withdrawing.

5. If ejaculation occurs, withdraw the penis before it gets soft. Hold onto the condom to prevent slippage. Throw the condom away.

HOW TO USE SPERMICIDAL JELLY

1. For vaginal intercourse: insert spermicide before any genital contact and repeat application if more than 15 minutes passes before intercourse.

Fill the applicator completely by attaching to the tube and squeezing. Insert the applicator deep into the vagina and push the plunger completely into the applicator. Use an additional application of jelly if intercourse is repeated. Do not douche for eight hours after intercourse.

2. For anal intercourse: if spermicidal lubricant is used, it should be applied to the outside of the condom prior to penetration.

Even if you use a lubricated condom, the use of additional lubrication can increase pleasurable sensations and help prevent tearing of the condom. Lubricants or spermicides containing nonoxynol-9 can provide extra protection because this chemical kills many STD (sexually transmitted disease) germs.

STDs can be passed during vaginal, oral and anal sex. If you are using a condom for oral sex, you may prefer to use a non-lubricated or flavored condom. A condom can be cut to form a latex square for use as a barrier during cunnilingus or

during oral-anal contact.

If a condom breaks, immediate withdrawal is recommended. A new condom can then be used. To reduce the risk of pregnancy, a woman can immediately insert two applications of spermicide into the vagina.

THINGS TO REMEMBER

Latex condoms are recommended for best STD protection.

Proper usage can increase a condom's protection. Avoid sharp objects, fingernails, and air bubbles. Be sure there is plenty of lubrication.

Store condoms in a cool place.

Plan ahead and be prepared.

Learn the facts about how HIV and other STDs are spread.

Learn about how to talk with your partner about safer sex.

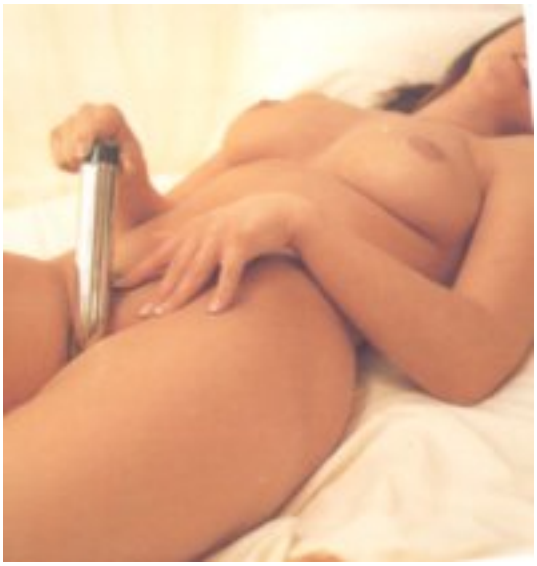
Alcohol and other drugs lower inhibitions, seriously affect judgment, and lead to unsafe sex.

HOME

another sex tutorial

Sex aids and aphrodisiacs

A variety of sex aids or toys are sold over-the-counter in sex shops or by mail order through magazines. These include Chinese balls (a woman can wear them in her vagina where they vibrate slightly as she moves about during the day) and condoms with various protrusions on them, which are designed to stimulate the clitoris during intercourse. Other condoms are brightly colored and flavored with fruit.



The vibrator is by far the most

popular sex toy. Shaped like a penis and battery-ope rated, it can be used in love play or for female masturbation. Some vibrators have an ejaculation mechanism. Many sex therapists advise the use of a vibrator for women learning to give themselves orgasms.

To help maintain erection, the simple ring designed to fit

at the base of the penis is probably the only useful device. A piece of ribbon will do equally well. Tied fairly tightly around the penis, it acts as a one-way valve. Blood enters the penis but is prevented from leaving it, and thus the erection is maintained for a little longer. A variety of creams and sprays that claim to prolong erections or to trigger orgasms are also available.

Named after Aphrodite,

the Greek goddess of love, aphrodisiacs are drugs claimed to excite lust. They may also be taken to stave off exhaustion or heighten pleasure during sex. The popularity of these drugs throughout history is a testimony to the fickleness of human sexual chemistry.

In some civilizations, highly

nutritious foods were regarded as the most reliable stimulants, and may indeed have had a beneficial effect on people whose diet was usually poor. The Greeks went for eggs, honey,

snails, and shellfish such as mussels and crabs. One Arab recipe from The Perfumed Garden recommends a glass of very thick honey, twenty almonds and a hundred pine nuts to be taken for three nights on retiring. Other recipes were to be applied externally. In order to increase the dimensions of small members and make them splendid', the author of *The Perfumed Garden* advised rubbing the penis with the melted down fat from the hump of a camel, bruised leeches, asses' members, and even hot pitch. These 'rubs' were probably less effective than the treatment of rubbing itself.

The Chinese

were more scientific in their approach. They measured and blended the powdered roots of plants, then gave them colorful names like 'the bald chicken drug'. This drug got its name when a septuagenarian civil servant who took it regularly, fathered three sons and paid so much attention to his wife that she could no longer either sit or lie down. He was forced to throw the remains of the drug out into the yard, where it was gobbled up by the cockerel. The cock jumped on a hen straight away, and continued mating with it for several days without interruption, all the while pecking at its head to keep its balance, until the chicken was completely bald, whereupon the cockerel fell off. The proud inventor of the drug claimed that if it were taken three times a day for sixty days, a man would be able to satisfy 40 women.

Horns

have long been thought to, have aphrodisiac properties because of their obvious phallic shape. Continuing belief in the potency of rhinoceros horn has brought the single-horned African rhinoceros to the brink of extinction. In fact horn consists of fibrous tissue, similar in construction to hair and nails. Like them, rhino horn contains the protein keratin, and the minerals sulfur, calcium and phosphorus. The addition of these elements to a poor diet might improve vigor, but a cheese sandwich would do just as well.

Another famous aphrodisiac

is Spanish fly, the common name of the beetle cantharides. The beetle is dried and the active principal, cantharidin, is extracted. If swallowed,

cantharidin causes an intense burning sensation in the throat, followed by diarrhea. Then the urinogenital tract becomes so inflamed that urination becomes impossible. The penis ends up engorged and throbbing, but this is due to excruciating pain rather than to sexual urgency. Taking Spanish fly can sometimes be fatal.

HOME

another sex tutorial

Sexually transmitted diseases

The SYMPTOMS of sexually transmitted diseases (STD) **are often impossible** to detect initially, but if your partner is infected, or you have a sexual relationship with someone who is promiscuous, then a check-up is essential. If symptoms do manifest themselves, they are likely to take the form of a discharge from the vagina, penis or anus, or itching or soreness around the genitals or anus, or a lump or rash on the genitals, anus or mouth.

- **Always use a condom.**

If you suspect you may have a sexually transmitted disease, you should see your doctor or clinic straight away. You can find the telephone number of your nearest clinic by looking up 'special clinic', 'venereal disease' or 'VD' in the telephone directory, or by phoning your local hospital. You will be tested as quickly as possible, and if the test is positive, you will be advised to contact your recent sexual partners, as they too may need treatment. Avoid sex until you are clear of the disease.

- **Always use a condom.**

AIDS stands for Acquired Immune Deficiency Syndrome, and the disease is caused

by the human immuno-deficiency virus, known as HIV Once it is inside the body, this virus invades the white blood cells, which normally fight off disease, then it multiplies and destroys them. It also breeds inside the brain. Three to four years normally elapse between infection with HIV and any subsequent development of the symptoms associated with AIDS.

- **Always use a condom.**

As AIDS develops the body's natural defences become depleted, and the AIDS patient is increasingly likely to contract diseases that a healthy body would normally ward off, and so rare forms of cancer and pneumonia develop. Sometimes AIDS patients are attacked by several infections at once, such as candida, herpes and TB. At the same time, the brain may succumb to increasingly severe dementia. Somewhere between one in ten and one in three of those infected with HIV are likely to develop **AIDS.** As yet there is no cure for AIDS. AIDS usually progresses through various infections and stages of increasing debility to the eventual death of the sufferer.

- **Always use a condom.**

How to avoid AIDS

- **Always use a condom.**
- **Avoid anal sex.**
- **Always use a condom.**
- **Don't share toothbrushes, razors or any other instrument that might transfer blood from cuts or abrasions.**

- **Always use a condom.**

The virus is present in body fluids, primarily semen and blood. It may also be present in saliva, though research indicates that saliva seems to present little risk. Having anal intercourse with an infected partner is the most likely way of catching AIDS, and 80 per cent of British cases so far have been male homosexuals.

The second most common way of contracting the disease is through infected blood. Almost a quarter of Britain's haemophiliac population now carry HIV because they have been injected with the clotting agent collected from infected blood. (Haemophiliacs are born without the blood-clotting factor, and can suffer severe bruising from a minor injury, and bleed to death from a cut unless they receive the clotting factor from donated blood.) HIV in the blood may also be transmitted on infected needles, and drug addicts are the third most highly at risk group of the population.

To become HIV positive you do not have to be homosexual or promiscuous, a drug addict or a haernophiliac. Heterosexuals are also at risk. Even a heterosexual in a steady relationship stands the risk of contracting the disease if their partner has been infected in a **previous relationship. Therefore** when embarking on any new relationship, it is safest to wear a condom.

Gonorrhoea is caused by the bacterium gonococcus, which cannot survive outside the body and is transmitted only by sexual intercourse, and never (as is sometimes imagined) on toilet seats or towels. In men the urethra, along which urine passes from the bladder, is infected, and there is sometimes pain on urinating and a thick discharge from the penis within a week after infection. In homosexual men the rectum may be infected, with the possibility of irritation and discharge from the anus. In women, gonorrhoea infects the cervix, urethra and

rectum, and, as with men, there may be discharge and pain on urinating. If infection spreads to the uterus there is a 10 per cent chance that the fallopian tubes may be blocked, causing sterility. Often, however, there are no symptoms in either men or women.

The treatment for gonorrhoea is usually a single dose of antibiotics such as penicillin, with a check-up afterwards to make sure the infection has cleared. If gonorrhoea is not diagnosed and treated, serious complications can develop. Men may suffer epicliclymitis - pain and swelling in the testicles; women may suffer peritonitis - inflammation of the membranes of the abdomen. Both sexes could develop gonococcal septicaernia, an infection of the bloodstream with skin rashes and arthritis. In serious cases, sterility can result in both sexes. Pregnant women with gonorrhoea may pass it on to their babies, who can be born with gonococcal opthalmia, an acute inflammation of the eyes. Complications are, however, relatively rare nowadays.

Non-specific urethritis or NSU can be identified by lumps, soreness or itching around the genitals, anus or mouth. There may also be a discharge from the vagina or penis. The treatment is usually a two-week course of antibiotics for anyone who has had contact with an infected person. During treatment, patients are asked to give up alcohol, as this can bring about a recurrence of the symptoms. Complications can occur, and these are similar to those for gonorrhoea, but fortunately early diagnosis and treatment can **prevent these.** It is possible for a man to be periodically reinfected with NSU without changing his sex partner, and no explanation has so far been put forward for this. However, both partners will need treatment each time NSU manifests itself.

Syphilis is quite rare in Britain today. It affects women less than men, and its main victims are male homosexuals. Symptoms appear between 10 days and 12 weeks after infection. In the primary stage of the disease a small hard sore or chancre appears on the penis, vagina or rectum. It is painless and usually disappears very quickly. A few weeks later, in the secondary stage, the patient is feverish, with swollen glands and itching skin. The disease is curable with antibiotics, but if for some reason it

should not be treated, serious complications will develop many years later. Until the advent of antibiotics, tertiary syphilis used to be quite common, with patients eventually suffering from dementia and dying a slow, agonizing death.

Chlamycliais one of the most common STDs and is caused by a bacterial parasite called chlamydia trachomatis. The disease is diagnosed by a swab test, and treatment is with antibiotics. Symptoms in men include a whitish yellow discharge from the penis, frequent 'burning' urination, and redness at the tip of the penis. Women may notice a discharge, a frequent need to **urinate, and mild discomfort** which they may mistake for vaginitis or menstrual cramps. However, many women experience no symptoms until they develop complications such as pelvic inflammatory disease, a serious condition which can result in infertility. Babies born to infected mothers may suffer from eye infection, which is sometimes serious, or pneumonia.

Genital herpes is a viral infection transmitted through sexual intercourse. It is very similar to the other sort of herpes, which causes cold sores, and can also be caught by having oral sex with someone who has active cold sores. The symptoms are itching, pain in the groin, discomfort on urinating and fever, followed by the appearance of painful red blisters on the vulva or penis, which burst to form ulcers. After about 10 days the symptoms disappear and the patient appears to be cured. But the infection is only lying dormant and may recur at any time, particularly when the patient is under stress. There is as yet no treatment for this disease. While the disease is dormant, it is safe to have sex without infecting one's partner, but it is impossible to predict the next attack, so the risk of infection remains. If the infection is active at **the end of** a pregnancy, a Caesarean section may be performed to prevent the baby becoming infected in the birth canal.

Genital warts are unpleasant but painless and can be treated quite easily. They are small lumps that appear on the penis, vulva, or anus and are mildly contagious. The treatment involves either painting the warts with a preparation called poclophyllin, or freezing them off with liquid nitrogen. An association has been identified between genital warts and cervical cancer, so it is important to get rid of them as

soon as possible, and to have regular cervical smears.

Thrush is a fungal infection that develops in certain conditions in the vagina. It is sometimes linked to taking the Pill, and if it recurs frequently, a different method of contraception may be advisable. A man may carry thrush, though he usually manifests no symptoms. Thrush causes vaginal soreness and itching, and a thick white discharge. The doctor will probably prescribe anti-fungal cream, to be used by both partners, and vaginal pessaries, though oral treatments are available too. Some women find that natural yoghurt in the vagina is effective. Avoid hot baths, and wearing tights, tight jeans and nylon knickers.

Trichomoniasis is one of the most common and least serious of all sexually transmitted diseases and may be passed on by bad hygiene practice in the use of towels as well as by sexual contact. It can exist in a symptomfree form and some people act as passive carriers for the disease. However, it can also cause discharge and pain in urinating in both sexes. Several drugs are available for treatment and their success rate is high.

- **Always use a condom.**

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