Promoting Access to Condoms for Youth in Mississippi through Community Interventions

Harvard Law School Mississippi Delta Project

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I. Introduction[1]

This report is written in collaboration with Mississippi First to assist them in their efforts to increase access to condoms for adolescents and young adults in Mississippi, with a particular focus on the Delta Region.[2] Spurred by high rates of teen pregnancy and sexually transmitted infections in the state, Mississippi First has long been working to empower Mississippi youth by giving them the knowledge and means to make informed decisions. In 2014, Mississippi First created the Mississippi Youth Council ("MYCouncil") to "ensure that young people in Mississippi have a voice in the debate around their sexual and reproductive health, education, and rights."[3] The youth activists in MYCouncil work through a grassroots approach to support comprehensive sexuality education and access to sexual and reproductive health services for all young people.[4] This report is part of their ongoing efforts to explore solutions around increasing youth access to reproductive health resources generally, focusing specifically on strategies to increase condom access for teens.

Condom access is an important step to improving the sexual health of Mississippi youth. Studies have shown that increased condom access results in increased condom use, which in turn leads to lower rates of sexually transmitted infections and teen pregnancies. Better health for teenagers ensures their education remains undisrupted, promoting economic growth and overall community improvement. This report will focus exclusively on condoms, rather than other forms of birth control, because it offers advantages to teenagers that other contraceptives do not. First, unlike the pill or any other form of birth control, condoms are effective in protecting against sexually transmitted infections, including HIV.[5] Second, condoms are inexpensive and sometimes free. Third, they are convenient—you do not need a prescription or ID to buy them, and they are small, discreet, and portable. Finally, unlike hormonal birth control options, condoms generally have no side effects.[6]

While condoms are currently available for free or reduced cost to Mississippi teens at many local health clinics, this is a limited form of access, as it is simply not realistic to expect that all teens would be willing or able to locate their nearest clinic and drive there only to obtain condoms. With this problem in mind, this report considers alternative strategies to increase

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[1] This report was prepared by Trisha Jhunjhnuwala, Susana Cervantes, Sarah Bacot, Susanna Barron, Tristan Bird, Lisa Fitzgerald, Josh Komarovsky, Linda Liu, and Gene Park, members of the Harvard Law School Mississippi Delta Project, under the supervision of Desta Reff, Harvard Delta Clinical Fellow.

[2] Mississippi First, a non-profit, non-partisan organization specializing in education policy research and advocacy and dedicated to providing resources to raise awareness about key education reform issues in the state. Mississippi First supports comprehensive "abstinence-plus" education, based on the tremendous need to reduce teen pregnancy and STI infection rates in the state and the demonstrated ineffectiveness of abstinence only programs in accomplishing these important public health goals. Their policy position specifically emphasizes age appropriate and medically accurate information and a strong parental involvement component. *Mississippi First Sex Education Policy Position*, MISS. FIRST (2014), http://1iq0332x28t34od07uajkv11.wpengine.netdna-cdn.com/wp-content/uploads/2014/02/Mississippi-First-Sex-Education-Policy-Position.pdf (last visited Dec. 30, 2015).

[3] *Mississippi First Launches Mississippi Youth Council, Calls For Applicants*, MISS. FIRST (Apr. 7, 2014), http://teenhealthms.org/blog/mississippi-first-launches-mississippi-youth-council-calls-for-applicants/.

[4] *Id.*

[5] *What are the benefits of condoms?*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/learn/birth-control/condom/what-are-the-benefits-of-condoms (last visited May 11, 2016).

[6] Assuming the parties do not have latex allergies—and even if they do, non-latex condoms are available. *Id.*

access to condoms through community institutions that are part of young people's everyday lives. Specifically, the report examines three spheres of the community—retail businesses, religious institutions, and schools—and outlines their programs and policies regarding access to condoms. For each of these categories, this report provides information on the current status of condom availability, attitudes toward sexual health issues generally, examples of attempts to improve availability at each of these sites, and recommendations for improving condom access for youth in the region.

These recommendations are based in part on initiatives developed in other regions, but they are tailored to the conservative and religious culture in Mississippi. Mississippi adults are generally more religious and conservative than the country as a whole.[7] 63% of people identify as very religious, compared to 40% nationwide.[8] The intersection of social conservatism and religion plays an integral part in shaping policies about sexual health, education and contraception. This report and its suggested strategies are sensitive to this cultural environment, and thus focus on dispelling certain myths about contraceptive use, fitting sexual education within a religious framework, and highlighting the benefits of information transparency.

II. The Current State of Sexual Education and Contraception Access in Mississippi

This section will give an overview of the demographics and statistics relevant to sexual and reproductive health, contraceptive use and access, and the state of sexual education in Mississippi. This background information contextualizes the issue of condom access and helps inform the suggested strategies found later in the report.

A. The Consequences of Teen Pregnancy

Teens in Mississippi engage in sexual activity at higher rates and earlier ages than the national average and are less likely to use contraception when they do so. In 2013, 54.2% of Mississippi high school students reported ever having had sexual intercourse, compared to 46.8% of high school students nationwide.[9] Additionally, 19.7% of Mississippi teens reported having had four or more sexual partners, compared to 15% nationally.[10] This suggests that lack of access to condoms does not significantly deter teens from engaging in sexual intercourse, but only from doing so with adequate protection. Mississippi students are also twice as likely to have engaged in sexual intercourse before the age of 13.[11] This is especially troubling because contraceptive use is particularly low among teens that initiate sex at young ages.[12] In general,

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[7] *Religious Landscape Study*, PEW RES. CENTER, http://www.pewforum.org/religious-landscape-study/ (last visited May 18, 2016); *Religious Landscape Study: Adults in Mississippi*, PEW RES. CENTER, http://www.pewforum.org/religious-landscape-study/state/mississippi/ (last visited May 18, 2016).

[8] Frank Newport, *New Hampshire Now Least Religious State in U.S.*, GALLUP (Feb. 4, 2016), http://www.gallup.com/poll/189038/new-hampshire-least-religious-state.aspx.

[9] Laura Kann et al., *Youth Risk Behavior Surveillance—United States,* CENTERS FOR DISEASE CONTROL & PREVENTION MORBIDITY & MORTALITY WKLY. REP. SURVEILLANCE SUMMARIES, June 13, 2014, at 24, 113, http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf.

[10] *Id.* at 114-15.

[11] *Id.*

[12] Lawrence B. Finer and Jesse M. Philbin, *Sexual Initiation, Contraceptive Use, and Pregnancy Among Young Adolescents,* 132 PEDIATRICS 886, 889 (2013) (Showing that only 52% of teens who became sexually active at age 12 or younger used contraception during the month when they first had sexual intercourse).

contraceptive use among Mississippi teens is low. For example, a survey in 2013 found that 78% of Mississippi high school students that reported being sexually active did not use any form of hormonal birth control, and 39% of students did not use a condom.[13]

High rates of sexual activity and low rates of contraceptive use have widespread impacts in Mississippi. The state's teen pregnancy rates are much higher than the national average. In 2014, the birth rate among teen girls aged 15-19 was 38 per 1,000 in Mississippi, compared to 24.2 nationwide.[14] Further many of these pregnancies could have been prevented by more widespread contraceptive use. Indeed, a study found that in 2011, 84% of births in Mississippi to women 19 and younger were unintended.[15] These unintended teen pregnancies have a significant impact on these women and their families, and engender a number of important social and economic consequences. For example, only 33% of teen mothers graduate high school, compared to the state average of 75.5%.[16] Over the course of a lifetime, a high school graduate will earn on average $331,000 more than a high school dropout.[17] Children of teen mothers are more likely to experience health problems, do poorly in school, and be at risk of abuse or neglect.[18] Sons of teen mothers are 13% more likely to be incarcerated, and daughters are 22% more likely be teen mothers themselves.[19]

Teen pregnancy is both a cause and a consequence of poverty in Mississippi. For young parents, pregnancy can disrupt or completely derail their education, making it more difficult for both them and their children to achieve higher education and establish a career. Since these trends often continue over multiple generations, the cycle of limited educational opportunities and poverty is perpetuated. The costs of unintended teen pregnancy also affect the region as a whole. In 2009, births to teen mothers in Mississippi cost taxpayers $155 million, including lost tax revenue based on lower wages, costs for foster care placement for children, and public assistance costs.[20] These statistics show that this issue reaches more actors than just those immediately involved; it costs taxpayers money, damages communities, and perpetuates the cycle of disrupted education and poverty. The state needs to take into consideration these sweeping, long-term consequences.

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[13] *Minor Consent & Confidentiality in Mississippi*, TEEN HEALTH MISS. 1, http://2k5xr1llq6o3qzctc2410evk.wpengine.netdna-cdn.com/wp-content/uploads/2016/02/clinicstaffbooklet.pdf (last visited Apr. 6, 2016).

[14] *Trends in Teen Pregnancy and Childbearing*, U.S. DEP'T OF HEALTH & HUMAN SERVS. (June 2, 2016), http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/teen-pregnancy/trends.html (follow "See the data" hyperlink under Figure 2).

[15] *Reducing Teen Births In Mississippi*, MISS. FIRST 1, http://www.mississippifirst.org/wp-content/uploads/2014/02/Mississippi_FactSheet_9.8.pdf (last visited Oct. 31, 2015).

[16] *Do You Know What You're Spending on Teen Pregnancy in Mississippi?: A Report on the Economic Costs and Common-Sense Solutions to Reduce the Teen Birth Rate,* WOMEN'S FUND OF MISS. 2, http://www.womensfoundationms.org/documents/WomensFund_Issue_Brief_Embargoed_BW.pdf (last visited Oct. 31, 2015) [hereinafter *Economic Costs*]; *Mississippi Increases Graduation Rate, Test Scores Continue Improvement*, MISS. DEP'T EDUC. (Aug. 21, 2013), http://www.mde.k12.ms.us/TD/news/2013/08/21/mississippi-increases-graduation-rate-test-scores-continue-improvement (last visited June 12, 2016).

[17] Anthony P. Carnevale et al., *The College Payoff: Education, Occupation, Lifetime Earnings*, CENTER ON EDUC. & WORKFORCE 3 (2011), https://cew.georgetown.edu/wp-content/uploads/2014/11/collegepayoff-complete.pdf.

[18] *Economic Costs, supra* note 16, at 2.

[19] *Id.*

[20] *Id.* at 3.

B. The Rise of Sexually Transmitted Infections

Mississippi also has troublingly high rates of sexually transmitted infections ("STIs") among teenagers, and these rates have actually increased in recent years. Chlamydia is the most frequently reported bacterial sexually transmitted disease ("STD") in Mississippi, and the case rate of chlamydia in Mississippi is the second highest in the nation.[21] In 2010, females in Mississippi aged 15-24 had the highest rates of chlamydia of any other age group.[22] These age groups also account for the highest rates of chlamydia in males.[23] Mississippi also had the highest gonorrhea case rate in 2010, and ranked third in the nation for primary and secondary syphilis.[24] Between 2006 and 2010, rates of primary and secondary syphilis increased 163%, and 61.1% of persons reporting infection in 2010 were teens and young adults aged 15-29.[25] Similar issues are present with HIV. Mississippi has a much higher rate of HIV diagnosis than the majority of states[26], with teen rates specifically on the rise. Indeed, HIV rates among 15-29 year olds in the state increased 24% from 2006-2010, while rates among other age groups remained largely unchanged.[27] The fact that these teenagers and young adults are disproportionately affected by sexually transmitted infection indicates that it is especially important to provide information and condom access at a young age.

In addition to the physical consequences of STIs and the economic burden associated with treating them, these conditions can have a negative impact on an individual's social, emotional, and mental well-being. The social stigma associated with STIs is particularly pronounced in the South, due to the prevalence of strong conservative values.[28] For example, in a study surveying health workers, patients, and students in Alabama, results showed that fear of being "outed" tended to discourage people from seeking treatment for an STI, particularly in small towns where patients worried they would be recognized by their neighbors while entering an STI clinic.[29] Additionally, religious attitudes affected how health workers perceived patients—particularly young women—characterizing them as more promiscuous.[30] A diagnosis of an STI can lead to psychosocial effects including "guilt, embarrassment, isolation, fear, and denial."[31] The stigma attached to an STI diagnosis can also lead to delayed treatment and negative health outcomes.[32] Emotional factors may prevent those who fear they have contracted

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[21] *State of Mississippi 2010 STD/HIV Epidemiological Profile*, MISS. STATE DEP'T OF HEALTH 11 (2010), http://msdh.ms.gov/msdhsite/_static/resources/3591.pdf.
[22] *Id.* at 14.
[23] *Id.*
[24] *Id.* at 17, 24.
[25] *Id.* at 24–25.
[26] *Id.* at 37–39; An area's confidential name-based HIV infection reporting is considered mature after 4 years, when reporting delay estimates have been calculated and reliable trends over time can be determined. *Diagnoses of HIV Infection in the United States and Dependent Areas*, 24 HIV SURVEILLANCE REP. 1, 12 (2012), http://www.cdc.gov/hiv/pdf/statistics_2012_HIV_Surveillance_Report_vol_24.pdf.
[27] *State of Mississippi 2010 STD/HIV Epidemiological Profile*, *supra* note 21, at 47-48.
[28] *See* Bronwen Lichtenstein, *Stigma as a Barrier to Treatment of Sexually Transmitted Infection in the American Deep South: Issues of Race, Gender and Poverty*, 57 SOC. SCI. AND MED. 2435, 2436 (2003).
[29] *Id. at* 2439-40.
[30] *Id. at* 2438-39, 2442.
[31] *Id.* at 2435.
[32] Lichtenstein, *supra* note 28, at 2436.

an STI from seeking testing.[33] This lack of awareness about one's own STI status only perpetuates the spread of infection. Increasing the availability of condoms, in conjunction with information about the importance of contraceptive use for STD prevention and birth control, could have a significant positive impact on not only the physical health of adolescents in the state, but also their lifelong mental, emotional and economic well-being.

C. Current State Policies on Condom Access & Sexual Education

In 2011, the Mississippi Legislature passed House Bill 999, which required school districts to adopt a sex education policy by June 30, 2012.[34] Per the law's mandate, school districts must adopt either an "abstinence-only" policy or an "abstinence-plus" policy.[35] Abstinence-plus programs may discuss contraceptives as long as they discuss the risks and failure rates of those contraceptives. They may also discuss the nature, causes, and effects of sexually transmitted diseases. However, "in no case shall the instruction or program include any demonstration of how condoms or other contraceptives are applied."[36] The law also sets forth other restrictions on teaching sex education in public schools, such as separating boys and girls during sex education and requiring parents to opt-in for their children to participate.[37] However, in a 2011 survey of 3,600 Mississippi public school parents, most parents stated that they wanted a comprehensive sex education curriculum (92%).[38] Although 90% of parents said schools should talk about the benefits of abstaining from sex, 78% said they wanted instruction on birth control methods, two-thirds said health instructors should tell teenagers where to obtain contraceptives, and more than half said they would prefer condom demonstrations in class.[39] While the passage of a law requiring schools to teach sex education was a major step forward for Mississippi, these survey results demonstrate that the majority of Mississippi parents would support even more comprehensive education policies than the current law allows for.

Under federal law Mississippi youth must be allowed to access reproductive health services confidentially and based on their own consent at sites funded by federal dollars under Title X.[40] The Mississippi State Department of Health supports 97 Title X public health clinics. Many of these clinics make condoms available for free or at a reduced cost. Therefore, adolescents who are thinking about having sex or are already having sex do have some options when seeking both information about how to engage in safe sex and the contraceptives necessary to do so. However there are many barriers such as transportation difficulties, misinformation and embarrassment or fear which prevent many teens from actually acquiring and using them.

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[33] *Id.*
[34] House Bill 999 originally provided that the sex education requirements would be repealed on July 1, 2016. However, the Governor signed a bill in April 2016 extending the requirements for another five years. They are now set to expire on July 1, 2021. H.B. 494, 2016 Leg., Reg. Sess. (Miss. 2016).
[35] H.B. 999, 2011 Leg., Reg. Sess. (Miss. 2011).
[36] *Id.*
[37] *Id.*
[38] *Poll Results Show Mississippi Parents Overwhelmingly Support Teaching Sex Education in Schools*, SEXUALITY INFO. & EDUC. COUNS. U.S. http://www.siecus.org/index.cfm?fuseaction=Feature.showFeature&featureID=2129 (last visited July 12, 2016).
[39] Sarah Carr, *Sex Education in Mississippi: Will a New Law Lower Teen Pregnancy Rates?,* TIME, (Sept. 29, 2012), http://nation.time.com/2012/09/21/sex-education-in-mississippi-will-a-new-law-lower-teen-pregnancy-rates/.
[40] *Minor Consent & Confidentiality in Mississippi*, TEEN HEALTH MISS. 6 (Feb. 2016), http://2k5xr1llq6o3qzctc2410evk.wpengine.netdna-cdn.com/wp-content/uploads/2016/02/clinicstaffbooklet.pdf.

These barriers highlight the importance of increasing access to condoms through multiple community resources—not just health centers, specifically access points that are more youth-friendly, youth-trusted, and youth-frequented.

D. The Beneficial Effects of Increased Condom Access

Public health research shows that easier access to condoms correlates with lower rates of teen pregnancy and STIs. A systematic review of condom distribution in the U.S. found that increasing the availability of or accessibility to condoms was effective in increasing actual condom use across various populations (including youth).[41] Greater condom availability also resulted in delayed sexual initiation among youth and reduced incidence of STIs.[42] Between 1991 and 2003, teen birth rates in the United States declined by 33%, which was largely attributable to an increase in contraceptive use.[43] During this period, condom use increased among 15-19 year olds by nearly 20%--the greatest increase of any contraceptive method.[44] This increase was the result of a number of different factors including more comprehensive sex education, the introduction of more effective contraceptives, and wider health insurance coverage of hormonal birth control.

However, even just increasing condom access and related education has been found to have positive effects on teen sexual behavior. A 2003 study assessed sexual practice and condom use differences in adolescents enrolled in Massachusetts high schools with and without condom availability programs.[45] The results showed that interventions designed to enhance positive beliefs and perceptions related to condom use (for example, emphasizing that condom use does not reduce sexual pleasure) showed a reduction in the number of unprotected sexual encounters among sexually active adolescents.[46] **Additionally, in those schools where condoms were available and the sexual education program included condom use instructions, students reported fewer sexual encounters.**[47] This finding refutes the misconception commonly espoused by abstinence-only sex education advocates that contraceptive information and distribution leads to increased sexual activity.

In addition to condom distribution in schools, the availability of condoms elsewhere, such as through healthcare providers or retail stores, may also have a significant impact on condom use among adolescents. For example, a 2013 policy statement by the American Academy of Pediatrics indicated that clinic-based methods (such as conversations with a health provider or community health center) have also been effective to increase condom use and decrease STI

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[41] MR Charania et al., *Efficacy of Structural-Level Condom Distribution Interventions: A Meta-Analysis of U.S. and International Studies, 1998–2007*, 15 AIDS BEHAV. 1283, 1293–94 (2011).
[42] *Id.* at 1290.
[43] John S. Santelli, *et al.*, *Explaining Recent Declines in Adolescent Pregnancy in the United States: The Contribution of Abstinence and Improved Contraceptive Use*, 97 AM. J. PUB. HEALTH 150, 150, 154 (2007).
[44] *Id.* at 152.
[45] Susan M. Blake et al., *Condom Availability Programs in Massachusetts High Schools: Relationships With Condom Use and Sexual Behavior*, 93 AM. J. PUB. HEALTH 955, 955 (2003), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447877/.
[46] *Id.*
[47] *Id.*

rates among adolescents.[48] As a result of these findings, the group recommended that pediatricians and other clinicians actively support and encourage the consistent and correct use of condoms as well as other reliable contraception as part of anticipatory guidance with both male and female adolescents.[49] Finally, a 2001 study of adolescents in Monroe County, New York, showed that most adolescents reported obtaining, or planning to obtain, condoms in stores rather than from free health care settings, and suggested that increasing condom visibility in private grocery stores may increase the accessibility of condoms to adolescents in areas with the highest STD rates.[50]

It is evident that a lack of condom access has led to a number of problems in Mississippi. Statistics of high teen pregnancy rates and increasing STI rates show that information and accessibility to safer sex practices is paramount. Broader social and economic implications demonstrate the issue is important for everyone in Mississippi, not just its youth. Increasing the availability of condoms is a low-cost and highly effective means to address these issues.

III. Target Sites for Increasing Access to Condoms

This section of the report provides in-depth discussion, highlights specific issues, and recommends strategies for improvement relating to access to condoms within three facets of the community: private retailers, churches, and schools. These three parts of society play different roles in condom access among youth. Teenagers spend a majority of their time in school, and may be first introduced to safe sexual practices there. Private retailers and businesses sell condoms, and it is often the first stop to obtain contraception. Religious organizations play a large role in the community in Mississippi and are often part of a teenager's early life. While there are alternative avenues through which this problem could be addressed, these three prongs of society provide a strong starting point for developing a comprehensive solution to a complicated problem.

A. Businesses & Private Retailers

Private businesses and retailers selling condoms is a vital component of condom access. Most adolescents obtain or intend to obtain condoms through stores rather than free health care settings.[51] Condoms are often inexpensive, and there is a higher level of anonymity in buying condoms in a store rather than obtaining them from physicians, schools, or community leaders, both of which are appealing to teens. Condoms are also widely available through retailers: almost all drug stores carry condoms, and a majority of supermarkets, small grocery stores, and gas stations carry condoms as well.[52]

This wide availability of condoms in stores would lead one to assume that it is quite easy for youth to obtain condoms. However, in the Mississippi Delta, the opposite is, in fact, often true:

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[48] Rebecca F. O'Brien et al., *Condom Use by Adolescents,* 132 AM. ACAD. PEDIATRICS 973, 977-78 (2013), http://pediatrics.aappublications.org/content/132/5/973.
[49] *Id.*
[50] Jonathan Klein et al., *Where Do Adolescents Get Their Condoms?*, 29 J. ADOLESCENT HEALTH, 186, 189, 191 (2001), http://www.jahonline.org/article/S1054-139X%2801%2900257-9/abstract.
[51] *Id.* at 189.
[52] *Id.* at 189–90.

many stores keep condoms behind the counter or in locked glass display cases, creating a barrier for teenagers seeking to purchase the contraceptives.[53] Often, teenagers have to ask a store keeper to give them condoms or to open the glass display, taking away the advantage of anonymity. Locking away condoms gives the impression that it is somehow wrong or illegal for youth to purchase condoms, akin to buying cigarettes or alcohol. In many areas of Mississippi, teenagers that ask for condoms are met with questioning, judgment, and disapproval, thereby discouraging condom use altogether. Changing the way condoms are displayed and accessed through private retailers is vital for increasing condom use in the state.

This section will first detail the current state of retail condom distribution in Mississippi. Then, it provides examples from other regions and industries that show possible models for change. Finally, this section provides offers recommendations in increasing access to condoms within private retailers and businesses.

1. Current Research & Practices Regarding Retail Condom Distribution

a. Previous Research on Barriers to Access

In a study conducted as part of the Creating Healthy and Responsible Teens (CHART) Initiative, businesses selling condoms in Mississippi were evaluated for their youth-friendliness based on criteria such as the type of signage provided, friendliness of employees, affordability, whether or not condoms were unlocked, and whether information about sex, pregnancy, and STIs was readily available.[54] The study then classified businesses as youth-friendly or not based on the results of the surveys conducted.[55] The vast majority of businesses selling condoms in the Delta were found not to be youth-friendly.[56] In fact, entire counties, such as Leflore, Yazoo, and Sunflower Counties, had no youth-friendly distributors.[57]

Additionally, research led by Advocates for Youth, an organization focused on increasing sexual health education and resources for young adults, provides further insight on statewide availability of condoms in stores and pharmacies.[58] Advocates for Youth sent young adult members into Mississippi businesses to ask where the condoms were located.[59] While some participants found employees helpful, others reported being questioned by employees or other

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[53] This is not a procedure unique to the Delta. Many other cities and states have reported pharmacies and businesses locking up condoms or keeping them behind the counter. For reports from other cities, *see* Bob Purvis, *Some Pharmacies Locking Up Their Condoms*, MILWAUKEE WIS. J. SENTINEL (Jan. 2, 2007), http://www.jsonline.com/news/milwaukee/29252064.html; Wendy Norris, *Crowdsourcing Condoms: Where they Are and Are Not*, REWIRE (Dec. 11, 2009), http://rhrealitycheck.org/article/2009/12/11/crowdsourcing-condoms-where-they-are-and-are-not/.

[54] *Find Healthcare and Condoms*, MISS. FIRST, http://teenhealthms.org/find-healthcare/ (last visited Jan. 31, 2016).

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] *Personal Stories with Condom Surveys in Mississippi*, AMPLIFY: A PROJECT OF ADVOC. FOR YOUTH, http://amplifyyourvoice.org/u/jamspro3966/2015/02/03/personal-stories-with-condom-surveys-in-mississippi/ (last visited Jan. 31, 2016).

[59] *Id.*

patrons in the store regarding their age or why they wanted to purchase condoms.[60] For a teen, this would be a particularly difficult, discouraging, and possibly detrimental experience. Asking an employee to unlock a cabinet or provide condoms from behind the counter may be embarrassing, or even shameful, and could deter a teenager from purchasing condoms at all. A participant in this study wrote:

> While most vendors have condoms of some form, they are frequently hidden from view behind checkout counters and locked cases...I became distinctly aware of how embarrassing it would be to be in need of condoms and have to go through the embarrassment of asking for them.[61]

Another participant stated:

> While going to all of these different stores...I felt one word: shame. Let me make this clear, the project itself was not shameful, I felt empowered actually, but the looks and stares and the 'you're way too young for this, I hope you're not looking at what I think you're looking at' comments reduced that empowering feeling and lowered it to much, much shame.[62]

It is important to note that, while these young adults were questioned about their age in relation to their purchase of condoms, it is not illegal to sell condoms to minors.[63] Any store policy on refusing to sell condoms, questioning the purchase of condoms, or locking condoms in a box, is not based on any legal obligation but purely an affirmative, often detrimental, choice by stores.

b. Store Policies Around Condoms Distribution and Their Rationale

A series of informal telephone surveys to retail businesses in the Delta revealed different facets of this issue. First, that there is no uniform policy or rationale for displaying and selling condoms in the Delta (even within similar types of stores, such as gas stations and pharmacies),[64] but in stores that do lock up condoms, a common rationale for this practice is to prevent theft. Second, it became clear from these surveys that even when there is an explicit corporate policy

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[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *See Eisenstadt v. Baird*, 405 U.S. 438, 443 (1972) (holding that refusing to sell contraceptives to unmarried individuals violated the Equal Protection Clause); *Carey v. Population Servs., Int'l*, 431 U.S. 678, 687 (1977) (holding that certain policies prohibiting sale of contraceptives to minors violated the Due Process Clause). For an article that explores the issue in more depth, *see* Heather Corinna, *Get Real! Is it Really Illegal to Sell Me Condoms?*, REWIRE (July 17, 2009), http://rhrealitycheck.org/article/2009/07/17/get-real-is-it-really-illegal-sell-me-condoms/.
[64] We contacted a range of stores including major chain stores, pharmacies, gas stations, and local establishments. Once we had an employee or manager on the line, we asked both specific and open-ended questions about their policies—and the rationale for such policies—surrounding condom displays. When the stores had some type of condom lockup policy, we inquired as to whether the store encounters a high number of teenagers going to the counter to ask for condoms.

regarding condom displays, not all store branches follow it or even know that it exists.[65] Third, policies and practices around condom storage and sales did not appear to reflect any research or substantial evidence about profit maximization, appeal to consumers, or best benefit to the community; rather, they were simply based on custom and intuition. Finally, unwillingness to respond to questions concerning condoms illustrated the taboo nature of this topic.

First, theft concerns are the most commonly stated reason for locked condom displays.[66] For instance, at the Get Well Drug and Dollar in Leland, corporate policy dictates that condoms be placed behind the counter due to theft concerns.[67] At Fred's in Clarksdale, condoms are displayed in locked boxes in the aisles of the store, also because of theft issues.[68] McGuffee's Drugs in Mendenhall used to place condoms on the shelves but recently moved them to behind the counter, also citing theft as the reason.[69] Theft is an understandable concern--condoms are anecdotally reported as a commonly stolen product, and some national corporate policies allow condoms to be locked up if theft reaches a certain percentage level.[70] However, there is little to no concrete data to demonstrate that condom theft poses a significant threat to retailers' bottom line. For example, at McGuffee's Drugs, which recently began locking condom displays due to concerns about theft, employees could not identify any specific instances of theft of condoms.[71]

Similarly, a pilot study in Iowa which measured the impact of unlocking condoms in stores where they had previously been locked up found that although participating pharmacies named theft as a reason for locking up their condoms, they had not actually been keeping track of theft.[72] Therefore it was unclear whether the policy of locking up condoms had ever been necessary or effective. That study also showed that unlocking condoms resulted in a net increase in revenue from condom sales, even when taking into consideration increased loss from theft.[73] This suggests that unlocking condoms is not just good for customers and public health, but also good for businesses. Even if retailers are concerned about theft, there are ways to combat theft other than locking up condoms, such as putting condoms in a more visible part of the store (near cash registers or in highly trafficked aisles). Some stores have also implemented special anti-theft racks that make a clicking sound when items are lifted from the rack, and that allow customers to retrieve only a limited number of condom packages at one time.[74]

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[65] *See infra* notes 75-78 and accompanying text.
[66] Telephone Interview with Anonymous Employee, Get Well Drug and Dollar in Leland, MS (Oct. 27, 2015) (notes on file with the Mississippi Delta Project); Telephone Interview with Anonymous Employee, Fred's in Clarksdale, MS (Oct. 27, 2015) (notes on file with the Mississippi Delta Project); Telephone Interview with Anonymous Employee, McGuffee's Drugs in Mendenhall, MS (Oct. 27, 2015) (notes on file with the Mississippi Delta Project).
[67] *Id.*
[68] *Id.*
[69] *Id.* The manager specified that there is nothing corporate about this new policy; it is simply what the store instituted in response to thefts.
[70] Bill Browning, *CVS: Condoms vs. Shoplifters*, HUFFINGTON POST (Nov. 17, 2011, 9:02AM), http://www.huffingtonpost.com/bil-browning/cvs-condoms-vs-shoplifter_b_221636.html.
[71] Telephone Interview with Anonymous Employee, McGuffee's Drugs in Mendenhall, MS (Oct. 27, 2015) (notes on file with the Mississippi Delta Project).
[72] Mary L. Aquilino et al, *Unlocking the Condoms: The Effect on Sales and Theft,* 9 PHARMACY PRACTICE 44, 48 (Mar. 11, 2011), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4132972/pdf/pharmpract-09-044.pdf.
[73] *Id* at 45-46.
[74] Purvis, *supra* note 53.

Second, the existence of corporate policies does not always guarantee that they are followed. Several of the national chain stores, such as Walgreens and Rite-Aid have corporate policies not to lock up condoms in the stores.[75] However, a Cleveland Walgreens began to place large boxes of condoms under lock in the fall of 2015 in response to theft, although they still leave smaller packets of three condoms unlocked.[76] Given that Walgreens has a policy against locking up condoms, it is unclear if stores are intentionally not complying with corporate policy.[77] It is also possible that even when corporate policies exist, the Delta stores might not know about them. For example, a manager at a Rite Aid in Yazoo City had never heard of any corporate policies regarding condom displays, even though they exist.[78]

Third, the choice to keep condoms behind counters or in locked cases is one that is rarely questioned, and, even when it is, the reason often cited is simply just custom. For example, the Greenwood Exxon-Mobile keeps condoms behind the counter. When asked for the rationale of this, most answered that it is common procedure at all gas stations. The Cleveland Shell and the Greenville Double Quick gave similar answers to such questions.[79] This indicates that retailers may not be making a conscious, well-informed decision when they lock up their condoms. These businesses may be more susceptible to campaigns encouraging condom accessibility, because these campaigns will provide information about the detrimental effects barriers to condoms have on teenagers, communities, and the economy.

Finally, while some employees and store managers were willing to discuss their policy, others directed the interviewers to corporate offices or flatly refused to discuss the issue. One Dollar General Manager became very aggressive after hearing that the survey was for an informational report about condoms and promptly hung up the phone.[80] A manager at a Kroger refused to disclose whether or not the store sold condoms (although another employee confirmed that they did) and when asked if there might be a better time to call back and discuss the issue, stated, "No ma'am, I don't think there is."[81] Another manager from Family Dollar became unwilling to answer questions after learning about the purpose of the interview.[82] She stated that

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[75] Trenton Straube, *Condom Lockup*, POZ, (Oct. 1, 2009) http://www.poz.com/articles/cvs_condoms_hiv_2376_17267.shtml.

[76] Telephone Interview with Anonymous Employee, Walgreens in Cleveland, MS (Oct 27, 2015) (notes on file with Mississippi Delta Project).

[77] Straube, *supra* note 75.

[78] Telephone Interview with Anonymous Employee, Rite Aid in Yazoo City, MS (Oct. 27, 2015) (notes on files with Mississippi Delta Project). In several instances, the employees seemed unwilling to discuss their condom display policies and instead directed us to call their corporate headquarters. Telephone Interview with Anonymous Employee, Family Dollar in Clarksdale, MS (Oct. 27, 2015) (notes on files with the Mississippi Delta Project). It is unclear if they did so because they were not aware of any policies or because they felt uncomfortable discussing this topic.

[79] Telephone Interview with Anonymous Employee, Exxon-Mobile in Greenwood, MS (Oct. 27, 2015) (notes on files with the Mississippi Delta Project); Telephone Interview with Anonymous Employee, Shell in Cleveland, MS (Oct. 27, 2015) (notes on files with the Mississippi Delta Project); Telephone Interview with Anonymous Employee, Double Quick in Greenville, MS (Oct. 27, 2015) (notes on files with the Mississippi Delta Project).

[80] Telephone Interview with Anonymous Employee Dollar General in Greenville, MS (Oct. 26, 2015) (notes on files with the Mississippi Delta Project).

[81] Telephone Interview with Anonymous, Employee Kroger in Cleveland, MS (Oct. 26, 2015) (notes on files with the Mississippi Delta Project).

[82] Telephone Interview with Anonymous, Employee Family Dollar in Greenville, MS (Oct. 26, 2015) (notes on files with the Mississippi Delta Project).

the corporate office does not allow her to speak to anyone about products and hung up without another word.

Overall, these responses are illustrative of the uncomfortable business culture that exists around condom access and sales and demonstrate that there was no uniform rationale in stores' practices of locking up condoms. Theft is a commonly cited rationale, yet it may be based upon incorrect assumptions and unclear data. Many times, custom and tradition were reported as rationales for behind-the-counter condom displays, showing that businesses may not be thinking about the effects of their condom displays. Finally, even when there was an official policy or rational, many of the retail stores failed to follow it. In order to increase access to condoms through private retailers, businesses should be better informed of their corporate policies (where there is one) and the effects locked condom displays may have on sales and public health.

2. Models for Success

a. Community Advocacy

To encourage stores to open up access to condoms, one can look to the strategies used by advocates in other cities and states that have dealt with this problem. For instance, when CVS initially made the decision to lock up condoms in certain urban locations on a "store-by-store" basis, Change to Win, a group of labor unions, started the "Cure CVS" campaign in Philadelphia.[83] In addition to protesting in front of CVS stores to draw attention to what they believed was a discriminatory practice, Change to Win also promulgated a petition asking CVS to rethink its condom policy.[84] It also reached out to a diverse group of 200 allies, including black churches, AIDS service organizations, and health advocates to sign the petition and raise awareness for the negative impacts of such a corporate policy. The campaign was successful, and CVS subsequently reversed their policy.[85]

Another example of a successful movement in reversing a condom lock-up policy is the "Save Lives, Free the Condoms" ("SLFC") movement in Washington D.C., again involving CVS.[86] In 2006, students at the George Washington University School of Public Health and Health Services noticed that the inaccessibility of condoms at local pharmacies was a significant barrier to safe sex practices—roughly 40% of CVS stores in D.C. placed condoms in locked glass cases.[87] From the start, SLFC instituted regular meetings, community organizing, protests, petitions, social networking, and media outreach to advocate for accessibility of contraceptives.[88] One year after the campaign, approximately 91% of the 53 CVS stores they interviewed stocked condoms on open shelves.[89] After CVS agreed to unlock the condoms, SLFC started a blog in

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[83] Matthew Ray, *CVS Stores Reverse Controversial Condom Lockup Policy*, EDGE MEDIA NETWORK (Mar. 24, 2009), http://boston.edgemedianetwork.com/news////88774/cvs_stores_reverse_controversial_condom_lock-up_policy.
[84] Straube, *supra* note 75.
[85] *Id.*
[86] *Advocacy Success: Save Lives, Free the Condoms*, METRO HEALTH 4 (May 2010), http://mwpha.org/Metro%20Health%20May%202010.pdf.
[87] *Id.*
[88] *Id.*
[89] *Id.*

which they posted pictures of the condom aisles at CVS stores showing whether the condoms were unlocked or not, as a way to ensure that CVS kept their promise.[90] The success of this campaign shows the strength of community pressure and social advocacy.

These large movements highlight the importance of gaining key allies in the community, using concrete information and statistics to gain legitimacy, and employing media outlets to gain attention.

b. Business Education

Strategies used to train and influence businesses around other issues of public health concern may also be helpful models for increasing access to condoms in retail settings. For example, there are many training programs and initiatives designed to promote best practices around the sale of tobacco products. At the national level, the Federal Drug Administration provides several resources to help retailers better understand their responsibilities under federal laws that regulate the marketing and distribution of tobacco products "to protect the public health generally and to reduce tobacco use by minors."[91] First, they have promulgated guidance on how to create and run a successful retailer training program within individual stores.[92] Second, they host a webinar series and have created training videos to educate retailers on how to comply with the law.[93] Finally, the FDA supports the "Break the Chain of Tobacco Addition" campaign, which offers retailers free materials such as posters, stickers, flyers, and window hangings in both Spanish and English summarizing the applicable laws.[94] These materials help raise awareness of the federal regulations and the effects of tobacco use among both employees and customers. The "Break the Chain" campaign also involves a pledge to support responsible retailing, which can be shared via social media.[95]

FDA guidelines suggest that all retailers selling tobacco products have written policies on the sale and distribution of such products, and develop training programs to enforce those policies.[96] Recommended content for the training, includes: (1) a summary of the applicable

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[90] *Save Lives: Free the Condoms*, http://savelivesfreethecondoms.blogspot.com (last visited July 11, 2016).
[91] GUIDANCE FOR INDUSTRY: TOBACCO RETAILER TRAINING PROGRAMS (REVISED)*, U.S. FOOD & DRUG ADMIN. 2 (2014), http://www.fda.gov/downloads/TobaccoProducts/Labeling/RulesRegulationsGuidance/UCM218906.pdf [hereinafter GUIDANCE FOR INDUSTRY].
[92] *Retailer Training and Enforcement*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/Retail/ucm249332.htm (last updated Nov. 3, 2015).
[93] *FDA Tobacco Compliance Webinars*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/ucm220111.htm (last updated May 17, 2016); *Retailer Training Videos*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/Retail/ucm369539.htm (last updated Oct 22, 2015).
[94] *FDA Center for Tobacco Products Clearinghouse*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/ucm284328.htm (last updated May 19, 2015).
[95] *Pledge to Protect Kids from Tobacco*, U.S. FOOD & DRUG ADMIN., http://www.fda.gov/TobaccoProducts/GuidanceComplianceRegulatoryInformation/ucm257064.htm (last updated Jul. 8, 2015).
[96] GUIDANCE FOR INDUSTRY, *supra* note 91, at 7, 9.

laws and penalties; (2) the health effects of youth tobacco use (explaining why the issue is important through statistics); (3) any written company policies concerning tobacco sales; (4) a comprehensive description of the tobacco products covered by the laws; (5) several age verification techniques; (6) guidance for refusing sales; and (7) testing to ensure that employees have the knowledge to comply with the law.[97] The FDA also recommends training frequency, methods, and review, as well as hiring and management practices.[98] For example, employees should be trained as soon as possible, and new employees should be trained prior to selling tobacco products.[99] Training can be conducted in the store or by a trainer in a classroom setting. The training program guide recommends that refresher trainings to be provided at least yearly.[100] Additionally, the FDA suggests that those selling tobacco products be at least 18-years-old, and that retailers should implement an internal compliance check program in which "mystery shoppers" will buy tobacco products to ensure compliance.[101]

At the state and local level, many public health agencies, non-profits, and business associations supplement these federal resources, promoting best practices and compliance with state and federal law by providing online trainings and in-person workshops for retailers and their employees.[102] Multiple studies have shown that these targeted education effects have been successful in reducing illegal sales of tobacco to minors.[103] For example, one study in San Diego County, CA found that only 32% of stores that had participated in a tobacco sales training program sold cigarettes to minors following the intervention, compared to 59% of stores in the control group, which did not receive any education.[104]

One very likely reason that tobacco training programs are so popular and successful is that there are federal and often state or local laws mandating compliance. The incentive to create training programs is higher where it could mean reduced penalties and compliance with the law. But while the threat of punishment under the law is a strong motivator, studies have shown that positive, non-legal incentives can also influence merchant behavior as well. For example, one program in Oregon that combined merchant training with positive incentives, such as gift certificates and public recognition of clerks that refused to sell tobacco to minors (in newspaper articles, paid ads, etc.), showed a drop in illegal youth sales from 62% of outlets committing violations to 24% during the intervention.[105] Positive recognition and incentive programs for

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[97] *Id*. at 7–12.
[98] *Id*. at 13-14.
[99] *Id.* at 13.
[100] *Id*.
[101] *Id.* at 13–14.
[102] *See, e.g.*, *Tobacco Sales: Do the Right Thing*, ST. CONN. DEP'T MENTAL HEALTH & ADDICTION SERVICES, http://www.cttobaccotraining.com/ (last visited May 19, 2016); Jeff Meyers, *County Offering Businesses Tobacco-Sales Training*, PRESS REPUBLICAN (Jan. 29, 2013), http://www.pressrepublican.com/news/local_news/county-offering-businesses-tobacco-sales-training/article_4fc059ba-2160-5b38-add7-5a5d87ce5ec9.html; *Online Tobacco Training*, N.Y. ASS'N OF CONVENIENCE STORES, http://www.nyacs.org/index.php/responsible-retailers-of-new-york (last visited May 19, 2016).
[103] *Smoking and Tobacco Use Highlights: Minors' Access to Tobacco*, U.S. FOOD & DRUG ADMIN., http://www.cdc.gov/tobacco/data_statistics/sgr/2000/highlights/minor/ (last reviewed Jul. 21, 2015).
[104] *See* Marianne B. Wildey et al., *Sustained Effects of Educating Retailers to Reduce Cigarette Sales to Minors*, 110 PUB. HEALTH REP. 625, 625 (1995).
[105] Anthony Biglan et al., *Mobilising Positive Reinforcement to Reduce Youth Access to Tobacco*, 4 TOBACCO CONTROL 42, 44–45, 47 (1995).

businesses have also been used to promote legal compliance and best practices surrounding the rights of breastfeeding mothers. For example, the Maternity Care Coalition of Philadelphia has a program in which businesses that meet certain qualifications can get certified as "in compliance with city and state laws," and labeled a "Breastfeeding Friendly Business."[106] This means they are recognized on an "Employer Spotlight Page" and put on a list of breastfeeding friendly businesses.[107] The Coalition also distributes decals and stickers that the employer can put in their windows indicating that breastfeeding is welcome.[108] Such public, positive recognition not is designed to incentivize participation by businesses and normalize breastfeeding.

Similar strategies combining training with positive incentives could be used to influence business policies and practices around condom sales. The next section will detail how these models for change are applicable to access to condoms.

3. Recommendations and Conclusions

Teens seeking to purchase condoms from local businesses encounter barriers in the form of locked displays, unfriendly staff, and behind-the-counter inaccessibility. Finding ways to unlock condoms in stores or put them in the aisles instead of behind the counter is one step toward increasing access to contraceptives.

Like the tobacco training programs described above, a similar business curriculum could be instituted to educate retailers about the detrimental effects of a condom lock-up policy. Non-profits such as Mississippi First or the Mississippi Youth Council could be instrumental in developing these training curricula and materials, and should consider partnering with local health departments or business associations to provide training directly to retailers. An "Access to Condoms" retailer-training curricula should include three prongs: (1) examples of model written policies regarding condom display and sales; (2) recommendations regarding the contents of an employee training program, as well as training frequency, review, and methods; and (3) hiring and management practices.

Model written policies should require that condoms be displayed unlocked on the shelves, available to purchase without having to ask for assistance. The policy can also offer alternatives to locking up condoms should theft become an issue. For example, the policy might allow managers to move condoms to more visible parts of the store, display condoms on special racks that only allow a certain number of condom boxes removed at a time, or allow smaller packs of condoms unlocked in the aisle while larger packs are kept behind the counter or locked up.

Content of an "Access to Condoms" employee training program should include, but is not limited to:

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[106] *Breastfeeding: Businesses and Employers*, MATERNITY CARE COALITION, http://maternitycarecoalition.org/breastfeeding/#Businesses (last visited July 11, 2016).
[107] *Id.*
[108] *Id.*

1. Overview of the problem in Mississippi (teenage pregnancy and STI rates), including long-term consequences of inaccessibility to condoms, such as the economic and social costs for teenagers, taxpayers, the community, and the state;
2. Background information about the benefits of condoms as a method of contraception, the efficacy of condoms in preventing pregnancy and STIs, and a section dedicated to dispelling myths surrounding condom use (for example, that condom use does not encourage promiscuity);
3. How condom lock-up policies affect condom sales and condom use by teenagers;
4. A detailed account of any written corporate policies about condom displays;
5. A comprehensive description of what products should not be locked up (i.e., various types of condoms, including female condoms);
6. Guidance on how to answer questions regarding condoms (i.e., without judgment or without injecting personal views); and
7. Testing to ensure understanding of the issue.

Each retailer can decide how it would like to conduct its trainings. For example, trainings could be conducted within the store, by a trainer in a classroom setting, or via written materials or the internet. Training should occur at least yearly for existing employees, and before a new employee starts work. Finally, these practices can be supported by hiring and management practices, such as hiring younger employees to make teenagers more comfortable asking questions, creating "mystery shopper" programs to check for store and employee compliance with corporate policies, and establishing appropriate consequences for non-compliance.

Designing a training program is a good step towards complete condom accessibility, but it is meaningless if employers have no incentive to participate in such programs. In creating incentives, there are a few possible avenues. First, like the Tobacco Control Act or breastfeeding laws, a legislative approach could be helpful. A legal mandate to keep condoms unlocked, with civil penalties for businesses that do not comply, will most certainly provide the incentive needed to create more condom-friendly businesses. However, no other states have similar laws, and there is no reason to expect that Mississippi would be the first to pass such a law. While this could be a potential long-term solution, it is unlikely to happen in the near future.

Second, social advocacy could help to instigate change, such as the Cure CVS and Save Lives, Free the Condoms movements outlined above. This involves specific appeals to store owners as community members, pointing to the issue of sexual and reproductive health as one of community health and safety in the Delta. Both Cure CVS and Save Lives, Free the Condoms relied in part on statistics demonstrating the disparate impact of certain issues on marginalized communities, including low-income communities and people of color.[109] Statistics regarding teen pregnancy combined with the stories highlighting the shame and embarrassment members of Advocates for Youth experienced as they attempted to locate condoms could be used to convince business owners of the importance of condom access for teenagers. Given the effectiveness of condoms in preventing pregnancy and STIs, increasing access to condoms by

[109] *See* Ray, *supra* note 83; Steve Mikulan, *Rubber Soul: CVS Accused of Locking Up Condoms in its Eastside Stores*, LA WKLY. (Apr. 7, 2009), http://www.laweekly.com/news/rubber-soul-cvs-accused-of-locking-up-condoms-in-its-eastside-stores-2385205.

unlocking them or putting them on the aisles could be sold to business owners as a policy shift benefitting public health. Larger campaigns for sexual health within churches, health departments, or schools may be effective in creating a comprehensive picture of the importance of access to condoms from a community perspective.

Third, showing store owners that it is actually more lucrative to display condoms unlocked than locked will help incentivize accessibility to condoms. Part of this will be to challenge assumptions about condom theft. Of those Delta store managers and owners willing to discuss the rationale behind their policy of locking up condoms, some said the policy was aimed at preventing theft. Convincing business owners that they might actually increase profits by increasing access to condoms could be an effective way of prompting discussion without immediately implicating cultural and religious issues. Studies have shown that more access to condoms increases their use, which would result in increased sales.[110]

While more data from long-term and widespread studies is necessary to make definite conclusions about the business impact of unlocking condoms in retail stores, working with local businesses to implement a pilot study over a few months might be one way to more accurately understand the "problem" of theft and to possibly challenge the assumptions of business owners on the issue. This study can be structured like a study conducted in Iowa, in which researchers found that removing condoms from glass cases resulted in a net increase of condom sales, outweighing the amount stolen.[111] This study would select a number of pharmacies, grocery stores, drug stores, and gas stations that keep their condoms behind locked displays. Then, these stores would agree to unlock condoms or remove them from behind the counter for an agreed amount of time, at least a few months. The stores would provide baseline inventory numbers, and monitor sales by their electronic systems. The stores would then report the number of monthly sales/thefts following implementation of the new policies. Finally, the number of sales/thefts should be analyzed by comparison to the same sales period one-year earlier. A pilot study designed in this way could create conversation around the issue and help businesses become more open to the idea of unlocking condoms.

Finally, creating a recognition program for those stores that encourage access to condoms could provide important incentives for businesses to unlock condoms and institute training programs. This could be modeled after the "Breastfeeding Friendly Business" recognition program, in which those businesses that comply with laws and provide education for its staff members are recognized as breastfeeding friendly by being put on a list of exemplary businesses. Similarly, Mississippi First or the Mississippi Youth Council, in partnership with local health clinics or the State health department, could institute a "Youth Friendly Retailer" program in which retailers that institute training programs for their staff and remove glass-case and behind-the-counter barriers to condoms will be recognized. Stickers on the store-front windows will let teenagers know that they can walk into that store and buy condoms without judgment or difficulty. The requirements to become a "Youth Friendly Retailer" could be: (1) complete accessibility to condoms by having them available on store shelves without barrier; and (2)

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[110] NATIONAL CENTER FOR HIV/AIDS, HEPATITIS, STD, AND TB PREVENTION, *Condom Distribution as a Structural Level Intervention*, CENTERS FOR DISEASE CONTROL & PREVENTION 1 (Oct. 2010), http://www.cdc.gov/hiv/pdf/prevention_programs_condom_distribution.pdf.

[111] Aquilino et al., *supra* note 72 at 46.

participation in an "Access to Condoms" staff training program. The organizing non-profits could create a webpage dedicated solely to Youth Friendly Retailers, where various businesses that qualify as youth-friendly are spotlighted. On this website, businesses could also apply for certification and a free window decal. This recognition program works as a kind of marketing – it lets consumers know that they are supportive of the community's youth and in combatting teen pregnancy and STIs. This kind of marketing could drive up sales, acting as an incentive to become more youth-friendly.

Ultimately, the best approach may be a mix of these suggestions. Creating a training program for private retailers across the state is a concrete first step in alleviating this issue. A business curriculum would include the negative effects their current policies of locking up condoms have on teenagers, the community, and the economy. It would also underscore the important role that retailers have in addressing this issue. Tackling theft concerns by instituting a study showing that they are unfounded will help retailers change practices by appealing to profits and sales. Additionally, instituting a recognition program may help motivate retailers to become more youth-friendly purely for marketing purposes. Larger campaigns, such as those involving community and grass-roots advocacy lobbying for legislative and social change, can work in the background of these more short-term solutions. In sum, private retailers and businesses are an extremely important player in increasing access to condoms for teenagers. Because of their integral role in condom availability, it is vital to change store policies keeping condoms locked up or behind the counter.

B. Churches

The cultural and political influence of churches is so significant in Mississippi that any serious attempt at reform should seek to engage and work with religious leaders on some level. Mississippi is the most religious state in the Union, with 63% of adults classified as "very religious," compared to 40% nationwide.[112] The state's religious population is overwhelmingly Christian,[113] with Baptists being the largest single denomination.[114] Moreover, churches are often the centers of community life: 49% of adults in Mississippi say they attend church at least once a week and 50% consider religion to be the first thing they look to when determining whether something is right or wrong.[115] This gives religious leaders a powerful role in shaping attitudes about sex and sexuality. This section of the report describes how religious concerns about contraception have historically created barriers to access, highlights churches in Mississippi and elsewhere that are taking positive steps towards educating youth about reproductive health, and provides suggestions as to how advocates can partner with churches and other faith-based organizations to lead reforms on these issues in a way that remains respectful of deeply held religious values.

1. Religious Opposition to Contraception and Comprehensive Sex Education

[112] Newport, *supra* note 8. ("Very religious Americans are those who say religion is important to them and who attend services every week or almost every week.").
[113] *See Religious Landscape Study*, *supra* note 7.
[114] *Id.*
[115] *Id.*

While a number of churches do offer sexual education programs as a way of addressing high rates of teen pregnancy, church programs tend to follow the "abstinence-only" model and rarely provide information about the use of contraceptives. Much of this can be explained by culturally conservative attitudes towards pre-marital sex and contraception. While most protestant Christian denominations condone the use of contraception between married couples,[116] many believe that the biblical scriptures condemn premarital sex.[117] Thus any attempt to teach young people about contraception is seen as promoting sin.[118] These attitudes have been reinforced by federal policy. Beginning in 1981, the federal government provided significant funding to faith-based organizations that taught abstinence-based sexual education.[119] Federal support for abstinence reached 215 million dollars per year by 2008, and roughly a third of that funding was directed to private faith-based organizations.[120] Federal support for religious abstinence education has drastically declined since the end of the Bush administration, but it is still significant, adding up to about 10 million dollars per year.[121] This is despite the fact that multiple studies have proven abstinence-only programs to be completely ineffective in reducing sexual activity among teens.[122] One study has even shown that young people who take "abstinence pledges," or vows to refrain from sex, are at increased risk for STDs and unintended pregnancies compared to their non-pledging peers--probably because they are less likely to use contraception when they do have sex.[123] Nevertheless, over thirty years of pro-abstinence policy has left a strong cultural legacy, reinforcing how churches have decided to deal with sexual education; abstinence programs are usually the first (and often only) option they consider.

In addition to affecting education, conservative attitudes likely play a role in limiting access to condoms for youth. The Mississippi state legislature has previously considered a bill that would forbid the sale of condoms to minors without a prescription, and another that would forbid school-based health clinics from dispensing contraception.[124] While neither bill ultimately

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[116] *See* Flann Campbell, *Birth Control and the Christian Churches*, 14 POPULATION STUD. 131, 132 (1960), http://www.jstor.org/stable/2172010.

[117] *See, e.g.*, *On Biblical Sexuality and Public Policy*, S. BAPTIST CONVENTION (2009), http://www.sbc.net/resolutions/1196/on-biblical-sexuality-and-public-policy (last visited July 11, 2016) ("Any sexual behavior outside this husband/wife marriage relationship is sinful, including premarital sex").

[118] *See*, *e.g.*, Fr. Mark Hodges, *San Francisco School District: Let's Hand Out Condoms to 6th-Graders*, LIFE SITE (Feb. 5, 2016, 10:31 AM), https://www.lifesitenews.com/news/san-francisco-school-district-lets-hand-out-condoms-to-6th-graders.

[119] Heather Boonstra, *Matter of Faith: Support for Comprehensive Sex Education Among Faith-Based Organizations*, 11 GUTTMACHER POL'Y REV. 17, 17 (2008), https://www.guttmacher.org/pubs/gpr/11/1/gpr110117.html.

[120] *Id.*

[121] President Obama's proposed 2017 budget would cut all funding for abstinence-only education, but the final budget is yet to be approved by Congress. *See President Obama Cuts Funding for All Abstinence-Only Education*, WOMEN IN THE WORLD (Feb. 18, 2016), http://nytlive.nytimes.com/womenintheworld/2016/02/18/president-obama-cuts-funding-for-all-abstinence-only-sex-education/. *See generally A History of Federal Funding for Abstinence-Only-Until-Marriage Programs*, SEXUALITY INFO. & EDUC. COUNS. U.S., http://www.siecus.org/document/docWindow.cfm?fuseaction=document.viewDocument&documentid=68&documentFormatId=68 (last visited July 11, 2016).

[122] *What the Research Says…Abstinence-Only-Until-Marriage Programs*, SEXUALITY INFO. & EDUC. COUNS. U.S., http://www.siecus.org/index.cfm?fuseaction=Page.ViewPage&PageID=1195 (last visited June 4, 2016).

[123] Olga Khazan, *The Unintended Consequences of Purity Pledges*, ATLANTIC (May 4, 2016), http://www.theatlantic.com/health/archive/2016/05/the-unintended-consequences-of-purity-pledges/481059/.

[124] DEBRAN ROWLAND, THE BOUNDARIES OF HER BODY: THE TROUBLING HISTORY OF WOMEN'S RIGHTS IN AMERICA 105 (2004); *See also* H.B. 153, 2001 Leg., Reg. Sess. (Miss. 2001).

passed,[125] their proposal indicates that some portion of Mississippians have very strong feelings against providing youth access to condoms. This underlying cultural tension may partially explain why, for example, many retailers keep condoms locked behind counters or question young people who ask about condoms,[126] and why very few Mississippi schools currently provide condoms to students.[127]

2. Positive Models for Change

There are a few examples of churches in Mississippi and elsewhere moving towards a more progressive view of the church's role in providing sexual education, and in some cases, access to condoms. The First United Methodist Church (FUMC) in Tupelo, Mississippi has been a pioneer in the Mississippi region for decades in offering sexual education to the young members of its ministry. FUMC implements a program called "Created by God," which is headed by the church's Director of Older Children's Ministry, Kristen Partin.[128] The program was developed in response to growing concerns about the negative effects of reproductive misinformation, as the community was seeing children as young as ten years old getting pregnant.[129]

"Created by God" is geared towards helping 6th graders as they transition through puberty, and it is built on the idea that "God had a plan when he made us, so our bodies should be treated with respect."[130] In order to enhance medical accuracy, OB/GYN nurses come in to facilitate discussions about sex, contraception, the body, and the changes that adolescents go through during puberty. Games supplement these lessons in biology.[131] For example, in the game "Martian," one child is chosen to be the Martian, and the rest of the class must try to explain to the Martian what a particular word means, without using certain other key words. Such games reinforce students' learning and help emphasize the importance of communication.[132] According to Kristen Partin, the biggest success of the program has been encouraging adolescents to ask questions. Members of the program are more comfortable talking to their parents and leaders in the church about sex.[133]

While the "Created by God" program provides some very limited information about contraception, the focus of the program is abstinence, and it does not include detailed information on how to access or use condoms.[134] Nonetheless the program models some helpful starting strategies that may be useful in developing an even more comprehensive curriculum. For one, it demystifies sex by providing students with important, medically accurate information about their changing bodies through lessons and expert guest speakers from the community.

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[125] *Id.*
[126] *See supra* notes 53, 54-62 and accompanying text.
[127] *See infra* note 157 and accompanying text.
[128] Telephone Interview with Kristin Partin, Director of Older Children's Ministry, First United Methodist Church of Tupelo, Miss. (Mar. 23, 2016) (notes on file with the Mississippi Delta Project).
[129] *Id.*
[130] *Id.*
[131] *Id.*
[132] *Id.*
[133] *Id.*
[134] *Id.*

Perhaps even more importantly, it encourages open communication about sex through games and frank discussions. These strategies help empower students to seek out information on their own.

For a faith-based model that does in fact provide comprehensive sex education including information about and access to contraception,[135] the Our Whole Lives ("OWL") curriculum developed by the Unitarian Universalist Association ("UUA") and the United Church of Christ ("UCC") is helpful.[136] This program takes a holistic approach to sex education, teaching youth about "relationships, gender identity, sexual orientation, sexual health, and cultural influences on sexuality," while emphasizing values such as self-worth, sexual health, responsibility, and justice and inclusivity.[137] While the basic OWL curriculum is secular and is used in both churches and schools across the country, the program can also be taught in a more explicitly religious mode with the addition of a companion book, *Sexuality and Our Faith*.[138] All the resources and materials needed to implement the program are available through the UUA website. Some materials are free, while others are available for purchase.

Like the "Created by God" program, a major goal of the OWL program is to empower youth through knowledge and communication. For example, in the OWL program at the UCC congregation of Robbinsdale, MN, games are used to open lines of communication. One of the games is an icebreaker where a ball is thrown around the room and the recipient shouts out slang words for sex. The goal is to get adolescents comfortable talking about topics that are usually taboo. According to the church's communications coordinator and future OWL facilitator, "the program has become a great success."[139] Not only do youth become comfortable talking about such issues within the program, but they also start to open up and ask the awkward but important questions at home.

The OWL curriculum differentiates lessons for different age groups, and the lessons for teens include information about how to access and use condoms and other contraception.[140] The program can provide such lessons because while the UCC does not officially condone premarital sex, it affirms the distribution and use of condoms as an act of love, moral responsibility, and affirmation of life.[141] As the United Church of Christ HIV & AIDS Network (UCAN) has officially stated:

> The bottom line is this: safer sexual behavior can be a matter of life and death, so, when people choose to engage in sex we must affirm safer sexual behavior. Thus,

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[135] *Why give out condoms*, UNITED CHURCH OF CHRIST, http://www.ucc.org/ucan_why-give-out-condoms (last visited Dec. 28, 2015).
[136] *Our Whole Lives: Lifespan Sexuality Education*, UNITARIAN UNIVERSALIST ASSOC., http://www.uua.org/re/owl (last accessed Apr. 2, 2015).
[137] *Id.*
[138] *Id.*
[139] Telephone Interview with anonymous, Communications Coordinator, Robbinsdale United Church of Christ (Mar. 18, 2016) (notes on file with the Mississippi Delta Project).
[140] *See Our Whole Lives: Lifespan Sexuality Education*, *supra* at note 136 (providing links to materials for different age groups); *Our Whole Lives, Grades 7-9, Second Edition*, IN SPIRIT UU BOOK & GIFT SHOP, http://www.uuabookstore.org/Our-Whole-Lives-Grades-7-9-Second-Edition-P17473.aspx (last visited Jun. 4, 2016) (Summarizing "Workshop 22: Contraception and Safer Sex" under the "Table of Contents" tab).
[141] *Why Give Out Condoms, supra* note 135.

> it is our moral responsibility to make condoms available because doing so not only sends the right message about loving responsibly, it saves lives.[142]

The Robbinsdale UCC did not indicate whether their congregation directly facilitates access to condoms (e.g., through a condom distribution program), but at a national level the UCC supports the distribution of condoms in places of worship.[143] In fact, the UCAN has distributed condoms at the UCC General Synod (a biennial national conference drawing thousands of participants) and other events since 1989.[144]

The dominant, conservative religious culture in Mississippi may hinder efforts to address contraception as openly as the UCC and UU have done, but Reverend Debra W. Haffner provides one model for opening up the discussion about sexual health in religious spaces in her book, *A Time to Embrace: Why the Sexual and Reproductive Justice Movement Needs Religion*. She suggests reproductive justice advocates locate religious leaders "who support reproductive health and rights and have a commitment to the most vulnerable."[145] These leaders would then be educated to frame the moral issues in a different light. Instead of focusing on the rhetoric condemning contraception, leaders would give voice to the understanding that being in control of one's body by engaging in safer sex and preventing unwanted pregnancies is integral to physical, social, and economic well-being.[146] Framing the issue in this way would allow church leaders to see that access to condoms could help achieve the shared goals of improving community conditions for the youth and for the community as a whole.

3. **Recommendations & Conclusions**

It is impossible to separate religion from the debate about contraception and sexual education because churches continue to be a significant part of the Mississippi culture. Current religious attitudes have limited youth access to condoms, contributing to high rates of teen pregnancy and STIs, which in turn have long-term psychological and economic consequences. However, churches have the power to play a positive role in uplifting their communities by supporting access to sexual health resources. Data supports the fact that promoting information and access does not encourage premarital sex.[147] Rather, in recognition of the time-tested fact that many youth engage in premarital sex despite the church's prohibitions,[148] providing sexual health resources to youth gives them the necessary means to protect their health if and when they choose to have sex. Extending this protection to youth in the community regardless of their choices reflects important Christian values of love and mercy. Contraception advocates should

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[142] Barb Powell, *UCC's Health Advocates Press for Increased Condom Distribution*, UNITED CHURCH OF CHRIST (Mar. 19, 2009), http://www.ucc.org/uccs-health-advocates-press; *See also About General Synod 2017*, UNITED CHURCH OF CHRIST GENERAL SYNOD 2017, http://synod.uccpages.org/ (last accessed June 4, 2017).
[143] *Id.*
[144] *Why Give Out Condoms, supra* note 135.
[145] Debra Haffner, *A Time To Embrace: Why the Sexual and Reproductive Justice Movement Needs Religion*, RELIGIOUS INST. 51 (2015), http://religiousinstitute.org/wp-content/uploads/2015/10/1-Time_to_Embrace_Color.pdf.
[146] *Id.*
[147] *See supra* notes 41-47 and accompanying text.
[148] Tyler Charles, *The Secret Sexual Revolution*, RELEVANT MAG. (Feb. 20, 2012), http://www.relevantmagazine.com/life/relationship/features/28337-the-secret-sexual-revolution (indicating that 80% of unmarried evangelical Christians aged 18-29 have had premarital sex).

work to educate church leaders about the ways in which reproductive justice intersects with their commitment to social justice and serving the needs of their congregations.

Following Rev. Debra Haffner's model, advocates might start by identifying churches that have already demonstrated a strong dedication to aiding vulnerable populations, or who have recognized the problem of teen pregnancy in their community and implemented some form of sex education in response. Advocates could then work with leaders in those churches to develop faith-based abstinence-plus education programs for youth that still emphasize abstinence as the only church-approved option, but also provide pragmatic information about contraception. Notably, they wouldn't have to create these materials from scratch. Resources from faith-based programs like Our Whole Lives are already available online and in print, and these materials could be adapted to a particular congregation's needs. Taking a lesson from the Created by God program, churches might also think about ways that they can incorporate games into their programs to help get students comfortable talking about difficult topics, and also how they might partner with people in their community, like OB/GYNs, that can be an additional resource for youth. Ultimately, churches could even develop condom availability programs. Existing models of condom distribution are discussed in greater detail in the later "Schools" section of this report, and churches might further draw upon these models and modify them as appropriate.

Alternatively, or additionally, advocates could provide churches with faith-based handouts, posters, and other informative materials listing local resources (such as health clinics) and reliable online sources where teens can access condoms and accurate health information. That way, even churches that are uncomfortable directly distributing condoms or providing comprehensive sex education might at least be able to point teens in the right direction.

Advocates may encounter resistance in these attempts at outreach, and many churches will probably continue to advocate abstinence-only education and programs. However, by starting small, working with the few churches that seem open to change, and documenting the success of their programs, advocates may ultimately be able to leverage that momentum into a larger cultural movement based on the theological rationale that safer sexual behavior can contribute to a healthier spiritual community. Even if churches are unwilling to provide direct access to condoms, religious leaders can help destigmatize condoms by encouraging open discussions about safe sex and contraception use within the church. Because religion has such a strong influence on social attitudes in Mississippi, this opening up could have rippling effects throughout the community, making it easier for youth to access condoms from other sources such as retailers and schools, and thus producing healthier communities.

C. Schools

Studies by the Center for Disease Control have found that factors influencing increased condom use include both attending a school where condoms are made available and having access to formal, comprehensive sex education.[149] This is not surprising, considering most young people spend more time at school than they do at any location other than their home, with

[149] Rebecca F. O'Brien et al., Comm. On Adolescence, *Policy Statement: Condom Use by Adolescents*, 132 PEDIATRICS 973, 975 (2013).

the average student logging close to 1200 hours per year at school.[150] This means that schools play a huge role in shaping student mindsets about sexual health and can become an incredibly effective and important point of access to condoms by creating condom availability programs.[151]

School condom availability programs are interventions that make condoms available to sexually active youth in schools, at low or no cost, without judgment or shaming.[152] These are also sometimes referred to as "condom distribution" programs, but the term "availability" is generally preferred, as it emphasizes that the purpose of these programs is to make condoms available to sexually active teens who want them, and not to hand out condoms to all students whether or not they are interested.[153] Successful methods for making condoms available vary widely between different schools--some require students to ask an adult (commonly the school nurse), while others allow students to obtain condoms from a basket or vending machine.[154] Regardless of the specific method utilized, these programs have significant benefits. When condoms are available at schools, students do not need to make a special trip to the local health clinic or drug store to practice safe sex, removing some of the need for transportation and pre-planning, and making access extremely convenient. In addition to directly increasing access, school availability programs can help destigmatize condoms and their use; for example, providing access to condoms in the school setting has been shown to reduce the embarrassment associated with purchasing condoms at local stores in the community.[155]

This section will describe the current state of condom availability in Mississippi schools, dispel some of the myths and misconceptions that have made schools reluctant to provide greater access to reproductive health resources, and focus on the potential that schools have to improve rates of condom use through condom availability programs and more comprehensive sex education.

1. The Current State of Condom Availability in Mississippi Schools

Currently, Mississippi law does not permit condom distribution in school sexual education classes.[156] This law does not extend to all methods of condom distribution in

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[150] *See Schools and Staffing Survey: Average Number of Hours in the School Day and Average Number of Days in the School Year for Public Schools, by State: 2007-2008*, NAT'L CENTER FOR EDUC. STAT. https://nces.ed.gov/surveys/sass/tables/sass0708_035_s1s.asp (last visited June 9, 2016). *See also America's Adolescents: A Day in the Life*, OFF. ADOLESCENT HEALTH, http://www.hhs.gov/ash/oah/adolescent-health-topics/americas-adolescents/day.html (last visited June 9, 2016) (indicating that teens spend more time on education than any other single activity besides sleep).

[151] *See* O'Brien, *supra* note 149, at 978 (calling schools "appropriate sites for the availability of condoms because they contain large adolescent populations and may potentially provide a comprehensive array of related educational and health care resources.").

[152] *Questions and Answers: Condom Availability Programs*, SEXUALITY INFO. & EDUC. COUNS. U.S, http://www.siecus.org/index.cfm?fuseaction=page.viewpage&pageid=1362 (last visited Jun. 4, 2016). Condom availability program" is a general term that can also be used to describe similar programs that operate in other locations and target other populations, but this report focuses on programs targeting youth in schools.

[153] *Id.*

[154] *School Condom Availability*, ADVOC. FOR YOUTH, http://www.advocatesforyouth.org/publications/449-school-condom-availability (last visited May 19, 2016).

[155] Renee Schmiedl, *School-Based Condom Availability Programs*, 20 J. SCHOOL NURSING 16, 20 (2004).

[156] H.B. 999 § 1, 2011 Leg., Reg. Sess. (Miss. 2011).

schools—there are no laws specifically prohibiting condom distribution in, for example, nurses' offices. Nonetheless, even though there is no law against it, many school districts in Mississippi have official or unofficial policies preventing school nurses or any other school staff from providing condoms to students.[157] This law and these practices may be rooted in common fears that making condoms easily available encourages pre-marital sex, and will result in more teens having sex, and at earlier ages.[158]

However, research shows that these fears are unfounded. Over 400 public schools in the US make condoms available to students,[159] and studies of these programs have consistently shown that access to condoms does not increase rates of sexual activity;[160] rather, it increases condom use, and therefore safety rates, among already sexually active students.[161] These studies also showed that condom availability programs had no significant effect on the average age of initiating sexual activity.[162] These facts weigh strongly in favor of making condoms available in schools.

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[157] Telephone Interview with Kakawonda Hibbler, District Nurse, Sunflower County, MS (Jan. 19, 2016) (notes on files with Mississippi Delta Project). While the school system in this county did not permit nurses to distribute condoms, policies regarding condom distribution likely vary from district to district. Additionally, there may be nurses distributing condoms but who do so without approval from school administration.

[158] *See, e.g.*, Malcolm Friedberg, *Sex, Condoms in Schools*, HUFFINGTON POST (Oct. 18, 2007 3:51 PM), http://www.huffingtonpost.com/malcolm-friedberg/sex-condoms-in-schools_b_69023.html ("Isn't handing out condoms encouraging 11-year-old kids to have sex?"); Franz N. Borghardt, *Condoms Have No Place in Schools*, LSU NOW (June 16, 2005), http://www.lsunow.com/condoms-have-no-place-in-schools/article_3b0768da-5e6f-5ef0-8eb7-07d9ed2f689a.html ("By distributing condoms, the state in effect condones sex"); *Teach Character Not Condoms: The Plain Truth*, FREDERICK DOUGLASS FOUND., http://fdfny.org/teach-charecter-not-condoms-the-plain-truth/ (last visited June 4, 2016) ("Do we promote fornication among our youth even though it is a God and scientific fact that the early onset of sexual activities have major consequences such as: depression, addiction, suicide, broken marriages, unhealthy relationships, un-wanted pregnacy [sic], STD's and more.").

[159] *School Condom Availability*, *supra* note 154.

[160] Douglas Kirby, *The Impact of Schools and School Programs Upon Adolescent Behavior*, 39 J. SEX RES. 27, 30 (2002) (reviewing four studies of school condom availability programs, all of which showed no significant increase in sexual activity). *See* also, Frank F. Furstenberg, Jr. et al., *Does Condom Availability Make a Difference? An Evaluation of Philadelphia's Health Resource Centers*, 29 FAM. PLANNING PERSP. 123, 125 (1997) ("[T]he proportion of students who had ever had sex actually dropped from 64% to 58% in the nine Philadelphia high schools with condom availability centers, while it increased from 56% to 59% in comparison schools lacking such centers."); Douglas Kirby et al., *The Impact of Condom Availability [Correction of Distribution] in Seattle Schools on Sexual Behavior and Condom Use*, 89 AM. J. PUB. HEALTH 182, 185 (1999) (percentage of students who had ever had sex decreased slightly, from 46 to 42%, after implementation of condom availability program); Mark A. Schuster et al., *Impact of a High School Condom Availability Program on Sexual Attitudes and Behaviors*, 30 FAM. PLAN. PERSP. 67, 71 (1998), http://www.jstor.org/stable/2991662 (no increase in the percentage of males or females who reported having vaginal intercourse following implementation of condom availability program in a Los Angeles high school); Susan M. Blake et al., *Condom Availability Programs in Massachusetts High Schools: Relationships with Condom Use and Sexual Behavior*, 93 AM. J. PUB. HEALTH 955, 957 (2003) (youth enrolled in schools with condom availability programs slightly less likely to report ever having had sex compared to youth at schools without programs).

[161] *See* Kirby (2002), *supra* note 160, at 31 (of four studies of school condom availability programs reviewed, two showed increases in condom use, one suggested trends in that direction, and fourth showed no increase); Blake, *supra* note 160, at 957 ("Sexually active adolescents enrolled in condom availability schools were twice as likely to report using condoms during their most recent sexual encounter.").

[162] *See* Kirby (1999), *supra* note 160, at 185; Blake, *supra* note 160, at 958.

2. The Current State of Sex Education in Mississippi Schools

In order to provide an effective condom access program, instruction on correct condom use is essential. As a part of any condom availability plan, Mississippi schools would need to consider modifying their sex education framework, as currently only 59.1% of sex-education programs in the state include an introduction to "condoms and contraceptives and a discussion of the risks and failure rates of contraceptives," and a mere 16.1% teach "how condoms or other contraceptives are applied."[163]

While Mississippi recently took a major step towards reproductive justice by mandating that all schools teach sex education, the law falls short of requiring the kind of comprehensive sex education that has been shown to be most effective at decreasing teen pregnancies and STDs. As described in the introduction, Mississippi House Bill 999 required each school district to choose one of two curriculums: abstinence-only or abstinence-plus.[164] A growing number of school districts are adopting abstinence-plus programs, which provide information about contraception, but the majority still use abstinence-only programs.[165] Furthermore, even abstinence-plus programs are not permitted to provide any actual demonstration of condom use. This means that many students are not getting instruction in how to safely use condoms. This knowledge gap would have to be addressed before introducing any kind of condom availability program in schools.

Another issue shaping the problem is a lack of staff capacity to support quality sex education and successful condom distribution. School nurses can play a valuable role by assisting with the development of accurate sex education curricula for classrooms, counseling individual students on issues of sexual health, and distributing condoms to students in a safe, private environment. However, according to one school nursing supervisor in the Delta, there is currently only one school nurse for every three schools.[166] This means that each school only has part-time access to a nurse, and a nurse's schedule at each school is quite full. This staffing shortage already limits the involvement that school nurses can have with sex-education programs, and would likely pose a challenge for condom access initiatives as well.

3. Models for Condom Availability Programs in Schools

Schools considering implementing a condom availability program will need to take into account a number of factors, including the method of distribution, whether and how to obtain parental consent, whether the condoms will be free or cost money, the kind of condoms that will be available, how to provide training for staff, and who will be responsible for oversight of the program. To provide some insight into this process, this section profiles two models of successful condom availability programs implemented in large urban school districts.

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[163] Jerome R. Kolbo et al., *Sex-Related Education Policy and Practices in Mississippi Public Schools*, CENTER FOR MISS. HEALTH POL'Y 29 (2015), http://www.mshealthpolicy.com/wp-content/uploads/2015/12/2015-SRE-Evaluation-Final-Report10-27-15.pdf.

[164] H.B. 999 § 1, 2011 Leg., Reg. Sess. (Miss. 2011).

[165] *MDE 2014-2015 Sex Education Data*, JACKSON FREE PRESS (Feb. 24, 2016), http://www.jacksonfreepress.com/documents/2016/feb/24/mde-2014-2015-sex-education-data/ (indicating 64 districts abstinence-plus, 79 districts abstinence-only, and 3 districts with both).

[166] Telephone Interview with Kakawonda Hibbler, *supra* note 157.

a. New York City Department of Education: Health Resource Rooms

Since 1991, the city of New York has made condoms available for free to students in all its public high schools through the Condom Availability Program (CAP).[167] Initially created as part of a larger campaign to curb the spread of HIV/AIDS, the original program required each school to designate at least one resource room in the school where students could access condoms and information on AIDS prevention; provide a minimum of six HIV/AIDS lessons per grade; and establish a committee to oversee implementation of the program.[168] District policy also dictated that the resource room be open at least 10 periods per week throughout the school year, that its hours be publicly posted, that at least one male and one female staff member be identified as resource room volunteers, and that parents be provided with at least one HIV/AIDS information session.[169] Parents had the opportunity to refuse consent for their children to receive condoms through the program by signing an "opt-out" letter sent to the homes of all enrolled students.[170] The student identification numbers of students whose parents had opted out would then be compiled in a list maintained by resource room staff.[171] Students would obtain condoms by giving their ID numbers to the resource room staff, but students on the opt-out list would not be permitted to obtain condoms.[172]

A 1997 study comparing rates of condom use and sexual behavior in students of New York City high schools that had implemented the Condom Availability Program with those of students from comparable Chicago schools with no condom distribution programs indicated that CAP had a positive effect on condom use.[173] While the percentage of students who identified as sexually active was approximately the same in both school districts, the percentage of students who reported using a condom during last intercourse was five points higher in the New York schools (60.8% vs. 55.5%).[174] The effect of the program was especially pronounced among students who had more than three sexual partners in the past six months.[175] Among this group of

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[167] *Explanation of New York City Public Schools' Condom Availability Program*, N.Y.C. DEP'T EDUC., http://schools.nyc.gov/NR/rdonlyres/8083DD57-BAB5-43F4-854E-B0B87C367159/0/11ExplanationofNYCPublicSchoolsCondomAvailabilityProgram.pdf (last visited May 19, 2016).
[168] Sally Guttmacher, *Condom Availability in New York City Public High Schools: Relationships to Condom Use and Sexual Behavior*, 87 AM. J. PUB. HEALTH 1427, 1427 (1997).
[169] *Id.* at 1427–28.
[170] *Id.* at 1428. It is unclear whether the opt-out letter also allowed parents to opt-out of receiving sex education lessons. Today NYC schools send home an opt-out form that parents can easily sign and return to opt-out of the condom availability program. Parents also receive separate notice that they may write a letter to the school to excuse their children from participating in lessons about birth control and HIV/STD prevention. *See Sex Ed Notification Letter*, N.Y.C. DEP'T EDUC., http://schools.nyc.gov/NR/rdonlyres/52076565-B816-4C1D-9281-501B47A91656/0/LetterParentSexEdNotification2014_English.pdf (last visited Jun. 4, 2016); *Condom Availability Program Opt-Out Letter*, N.Y.C. DEP'T EDUC., http://schools.nyc.gov/NR/rdonlyres/6B8CDAC0-56AD-4320-AC23-FA9451DAAC3E/0/HIVAIDSOptOutletter_English.pdf (last visited Jun. 4, 2016).
[171] Guttmacher, *supra* note 168, at 1428.
[172] *Id.*
[173] *Id.* at 1427. Unfortunately it was impossible to measure the effects of the program directly (i.e., comparing pre-implementation New York data with post-implementation New York data) because no baseline measurement of condom use in New York schools was recorded prior to implementation of the program. *Id.* at 1432.
[174] *Id.* at 1430.
[175] *See Id.* at 1431.

higher-risk students, New York subjects were nearly twice as likely to use condoms than their Chicago counterparts.[176]

Since this study was conducted, the New York City Department of Education has expanded the scope of CAP even further. No longer focused primarily or solely on HIV/AIDS prevention, the "Health Resource Room" (HRR) in each school functions as a holistic source of support for students with questions about health and sexuality.[177] Not only do these sites provide condoms, they also provide general health information and referrals for students dealing with a range of issues--including depression, dating violence, and substance abuse—in addition to sexual health.[178] Each HRR is required to display a poster indicating that it is a "Safe and Supportive Zone" for LGBT students, and HRR staff must attend CAP trainings provided by the district.[179] In other ways, the requirements remain much the same as when the program was first initiated: the HRR must be open at least 10 periods a week, the location and schedule of the HRR must be posted in highly visible locations around the school, the HRR must be staffed by at least one male and one female, and parents must be given the opportunity to opt their children out of the program.[180] When students obtain condoms they can also choose to receive either written instructions or a visual demonstration of proper condom use, but they are not required to receive this counseling.[181] In order to ensure continued compliance with the program, principals must submit an annual School Health Survey, and schools are subject to site visits.[182]

The Health Resource Room is a promising model for Mississippi schools because it provides students with a safe and supportive space in which to access free condoms, optional counseling about condom use, and other valuable health information. Because the Resource Room model maintains parental power to opt-out of the program, it may be a particularly desirable method of distribution in more culturally conservative communities, where families may not be willing to support a program that allows completely anonymous access to condoms for all students (e.g., through a basket or vending machine).

b. District of Columbia Public Schools: Brand Name Condoms and the Wrap M.C. Program

The District of Columbia has provided free condoms in its public high schools since at least 2006, when the District launched a city-wide condom availability program targeting schools

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[176] *Id.* at 1431-32.
[177] *CAP*, N.Y.C. DEP'T EDUC., http://schools.nyc.gov/Academics/FitnessandHealth/CAP/default.htm (last visited May 19, 2016).
[178] *See NYC Teen Health*, NYC HEALTH, http://www1.nyc.gov/site/doh/health/health-topics/teen-home.page (last visited May 19, 2016).
[179] *CAP*, N.Y.C. DEP'T EDUC., http://schools.nyc.gov/Academics/FitnessandHealth/CAP/default.htm (last visited May 19, 2016).
[180] *Id.*
[181] *Explanation of New York City Public Schools' Condom Availability Program*, N.Y.C. DEP'T EDUC., http://schools.nyc.gov/NR/rdonlyres/8083DD57-BAB5-43F4-854E-B0B87C367159/0/11ExplanationofNYCPublicSchoolsCondomAvailabilityProgram.pdf (last visited May 19, 2016).
[182] *DOE Condom Availability Program*, N.Y. CITY DEP'T EDUC., http://schools.nyc.gov/NR/rdonlyres/0C0DB0A1-9784-4779-B8D9-FD15D9089F9B/0/CAPOnePageSummary.pdf (last visited May 19, 2016).

along with a variety of other locations.[183] Initially, students could only obtain free condoms from the school nurse, and only Durex brand condoms were available.[184] However, this changed in 2009, after the District commissioned a series of focus groups and surveys as part of the *Youth Sexual Health Project* to assess youth attitudes towards condom use and the existing condom availability program.[185] The surveyors were surprised to find that relatively few students were taking advantage of the free condoms available in schools for two primary reasons.[186] First of all, many students felt uncomfortable asking the school nurse for condoms, feeling that nurses were untrustworthy and judgmental, and that approaching a school nurse felt like "asking [your] grandma or auntie for condoms."[187] Many participants noted that they would prefer talking to a younger person, such as a "cool" teacher, and someone of the same gender.[188] Secondly, students had strong brand preferences with respect to condoms, viewing Trojan condoms as the highest quality and most reliable condoms, with a particular preference for Trojan Magnums.[189] Students tended to perceive Durex condoms as of lower quality and more likely to "pop or break" than Trojans.[190]

Based on these results, District of Columbia Public Schools made two major changes to its school condom availability program. First of all, the District began offering Trojan condoms, including the popular Magnum variety.[191] Even though this presented a slight increase in cost (Trojans cost 6-9 cents per condom, compared to 5.7 cents per Durex condom), and testing has shown that Durex condoms are as effective and reliable as Trojans, city officials decided the switch was worth the expense if youth were more likely to use the Trojan brand condoms.[192]

Secondly, the District introduced the "Wrap M.C." program to its public high schools.[193] This program allows anyone in the school—teachers, coaches, counselors, and even students—to become a Wrap M.C. or "Master of Condoms" after completing a thirty-minute online training course.[194] Upon passing a short test about proper condom usage and sexual health, Wrap M.C.s are certified to distribute condoms to students.[195] A Coordinator at each school is designated as the point-person with the District to help distribute materials to certified M.C.s.[196] In addition to distributing condoms, Wrap M.C.s are also encouraged to strike up discussions about sexual health with students, including instructions on proper condom use, and advice about negotiating

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[183] Tim Craig, *D.C. to Begin Using More-Expensive Trojan Condoms in HIV Prevention Program*, WASH. POST (May 21, 2010), http://www.washingtonpost.com/wp-dyn/content/article/2010/05/20/AR2010052003980.html.
[184] *Id.*
[185] *See generally* Kiana Bess et al., *Youth Sexual Health Project: A Framework for Change*, HEALTHY YOUTH DEV. TEAM (2009), https://docs.google.com/viewer?a=v&pid=sites&srcid=ZGVmYXVsdGRvbWFpbnxvc3NlaHlkdHxneDoxZjY2ZWIxOGM3OTQ2YjVh.
[186] *See id.* at 5–7.
[187] *Id.* at 5–6.
[188] *Id.* at 6.
[189] *Id.* at 7.
[190] *Id.*
[191] *See* Craig, *supra* note 183.
[192] *Id.*
[193] *Id.*
[194] *Id.*
[195] *About the Wrap M.C. Program*, WRAP M.C., https://wrapmc.wordpress.com/ (last visited May 19, 2016).
[196] *Id.*

condom use with partners.[197] However, students are not required to receive counseling before obtaining condoms.[198]

The Wrap M.C. program provides two unique advantages. Firstly, for schools struggling with space and resource constraints that might prevent them from implementing something like the Health Resource Model described earlier, the Wrap M.C. program provides significant flexibility. There's no need to hire special staff to serve as M.C.s, and they do not necessarily need a specially designated space or time to operate—students can simply approach them during free moments throughout the day. Secondly, the M.C. model increases the range of available condom sources, thus increasing the likelihood that students will obtain condoms. Students who may be embarrassed to approach the school nurse for condoms can instead obtain condoms and counseling from people they may be more comfortable with, including teachers, coaches, and peers.

The number of condoms distributed in D.C. schools increased dramatically after the implementation of these changes, from about 15,000 in 2009[199] to 200,000 in 2011.[200] Around the same time period (from 2007 to 2012), the percentage of D.C. youth who reported ever having sex actually decreased (29% to 19% for middle schoolers, and 57% to 54% for high schoolers).[201] This bolsters other research that has found that increasing access to condoms does not increase rates of sexual activity.[202] The success of the program highlights the importance of assessing student perceptions and actually taking those results into account when designing or redesigning condom availability programs.

Thus the D.C. model provides important lessons for schools interested in establishing a condom availability program. First of all, schools should acknowledge the very real effect that brand preferences play in influencing youth behavior, and should consider spending the extra money to purchase more recognized brands. Secondly, schools should allow students to obtain condoms from people that they know and trust, which may mean establishing something like the Wrap M.C. program where anyone can become certified as a condom distributor and educator. Finally, schools should plan how they will measure the success of their programs, creating and scheduling regular evaluations to collect data on student behavior and perceptions. This will allow schools to continually reassess and improve their programs to best meet the needs of students.

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[197] *Id.*

[198] Penny Starr, *D.C. Gave Away 200,000 Condoms at Public High Schools Last Year—16 Per Student*, CNS NEWS (Aug. 9, 2012), http://cnsnews.com/news/article/dc-gave-away-200000-condoms-public-high-schools-last-year-16-student.

[199] *See* Craig, *supra* note 183.

[200] *See* Starr, *supra* note 198 Tim George, *Washington D.C. 9-12 Graders Given 200,000 Free Condoms*, OFF THE GRID NEWS, http://www.offthegridnews.com/how-to-2/washington-d-c-9-12-graders-given-200000-free-condoms/ (last visited July 12, 2016). No formal surveys have been conducted since implementation of the Wrap M.C. program to determine if condom use has increased along with condom acquisition.

[201] *See* JULIE OST & LAURA MAURIZI, OFFICE OF THE STATE SUPERINTENDENT OF EDUC., 2012 DISTRICT OF COLUMBIA YOUTH RISK BEHAVIOR SURVEY SURVEILLANCE REPORT 22 (2012), http://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/2012%20DC%20YRBS_OSSE_0.pdf.

[202] *See supra* notes 41-47 and accompanying text.

4. Recommendations and Conclusions

The models employed by New York and Washington D.C. schools share some common strengths, and analyzing both helps highlights elements that should inform the development of any school condom availability program:

a. Condoms Should Be Available for Free

Many students cite cost as a significant barrier to condom access.[203] When a distribution program that provided free condoms to small businesses in Louisiana switched to charging 25-cents per condom in order to meet budgetary constraints, the number of condoms distributed decreased dramatically, as did the percentage of customers at those businesses who reported using a condom during their most recent sexual encounter (77% to 64%).[204] Similarly, at a distribution program in Seattle schools where condoms were provided for free in baskets and in vending machines that charged 25 cents per condom, students obtained nearly 50 times more condoms from baskets than from vending machines.[205] These results suggest that even a small charge may create a barrier to access to condoms, and that schools should strive to make condoms available for free. School districts facing budgetary constraints might explore the possibility of partnering with existing distribution programs run through the state health department to help fund their program. Schools might also be able to obtain supporting grants through the CDC or other non-profit funding organizations.

b. Condoms Should Be Distributed in a Way that Balances Student Privacy Concerns with Appropriate Counseling

Possible methods of distribution vary from those that allow students complete anonymity—such as baskets or vending machines in private locations (e.g., restrooms)—to programs where students are required to ask an adult (commonly the school nurse) and receive counseling before they can acquire condoms. Counseling by school nurses usually consists of a warning that abstinence is the only 100% effective method of birth control and STD/STI prevention, and includes instructions for condom storage and usage.[206] In many schools, nurses are required to sign a form to record that counseling was provided.[207]

Existing research is currently unclear on whether it is more effective to allow students to obtain condoms anonymously or whether to require that students ask an adult who can deliver appropriate counseling at the time of distribution. At least one study has suggested that programs that allow students to obtain condoms anonymously may have a greater positive effect

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[203] *See* Bess, *supra* note 185, at 6 (noting that youth survey participants reported that "condoms are 'too expensive' and that their peers would be less likely to use condoms if they had to pay for them.").
[204] Deborah Cohen et al., *Cost as a Barrier to Condom Use: The Evidence for Condom Subsidies in the United States*, 89 AM. J. PUB. HEALTH 567, 568 (1999).
[205] Douglas Kirby, et al., *supra* note 158 at 184.
[206] Schmiedl, *supra* note 155, at 19.
[207] *Id.*

on condom use than those that require a student to approach an adult,[208] and other studies have shown hesitancy among students to approach an adult to acquire condoms.[209] However, distributing condoms through a trained intermediary provides unique advantages, including the opportunity to ensure that students have accurate information about correct condom use.[210]

Programs such as New York City's and Washington D.C.'s have tried to balance these concerns. While students in both of these programs do need to approach someone to obtain condoms, potential embarrassment is mitigated by 1) making condoms available in a private space; 2) identifying and training multiple distributors other than the school nurse, including distributors of different genders (and even peer distributors in Washington D.C.), so that students can approach whomever they trust most; and 3) making counseling available, but not mandatory. In the absence of definitive research to say whether privacy or counseling is ultimately more important in decreasing rates of fertility and STIs, Mississippi schools may do best to follow a similar middle path.

c. Students Should Be Able to Obtain Condoms Without Affirmative Parental Consent

Schools can take three approaches to parental consent: they can require that parents "opt-in," or sign a permission slip before their children can obtain condoms at school; they can allow parents to "opt-out," meaning that students are allowed to obtain condoms unless their parents have signed a letter saying their student cannot participate in the program; or they can operate entirely without regard to parental consent, allowing all students to obtain condoms. Weighing all concerns, an "opt-out" program is most advisable for Mississippi schools because it would be most likely to maximize participation while minimizing social and legal controversy. In fact, the majority of schools choose opt-out models, making up about 71% of schools with condom availability programs.[211]

Opt-out models are preferable to opt-in programs because opt-in programs exclude students whose parents would permit them to receive condoms but who fail to return the required paperwork.[212] Therefore opt-out models should tend to maximize the number of students allowed to participate. Indeed, published opt-out rates are generally quite low; for example, one recently instituted program in Gainesville, Florida reported an opt-out rate of about 3%.[213] This suggests that almost all students in schools with an opt-out program have access to condoms through their schools.

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[208] *See* Mark A. Schuster et al., *Impact of a High School Condom Availability Program on Sexual Attitudes and Behaviors*, 30 FAM. PLAN. PERSP. 67, 72 (1998), http://www.jstor.org/stable/2991662.
[209] *See* De Rosa CJ et al., *Improving the Implementation of a Condom Availability Program in Urban High Schools*, 51(6) J. ADOLESCENT HEALTH 572, 575 (2012).
[210] *Id.* at 578.
[211] *School Condom Availability, supra* at note 152.
[212] Schmiedl, *supra* note 155, at 20.
[213] Deborah Strange, *Alachua County Schools Condom Program Largely Accepted*, GAINESVILLE SUN (Apr. 10, 2016, 5:04 PM), http://www.gainesville.com/article/20160410/ARTICLES/160419991?tc=ar.

Clearly a program that does not require any consent at all would allow even more students to participate than an opt-out model. However, programs that require no form of consent are relatively rare (making up about 19% of school condom availability programs),[214] and are more likely to invoke public controversy and legal challenges.[215] Many believe that denying parents the option to refuse consent presents undue governmental interference with parental rights,[216] and parents in some districts have protested condom availability programs that did not allow parents to "opt-out." One state appellate court in New York even ruled that a school condom availability program without an opt-out provision was an unconstitutional violation of parental rights.[217]

Considering the strong influence of conservative Christian values in much of Mississippi, it seems especially unlikely that condom availability programs without an opt-out provision could muster enough community support to succeed. Therefore, in order to strike the strongest balance of high participation and low controversy, Mississippi schools should consider following an opt-out model like that employed by New York City. Schools can send home a notification and "opt-out" letter to all parents at the beginning of each school year, as well as to the parents of any students that enroll during the school year. Schools should then record the names or student ID numbers of all students that return a signed opt-out form, and compile a centralized list that is available to any staff involved in distributing condoms.

d. A Variety of Condoms Should Be Available, Including Recognized Name Brands

The results from Washington D.C.'s *Youth Sexual Health Project* survey illustrate that students are highly brand conscious with regard to condoms, and that the kind of condoms available may influence whether or not students choose to obtain condoms at school. Therefore schools should consider offering recognizable brands of condoms (namely Trojan and Trojan Magnum), or, if cost makes that impossible, at least making a concerted effort to inform students that less recognized brands have passed the same FDA testing as Trojans and proven equally effective in reducing the risk of pregnancy and STIs. Schools should also consider providing polyurethane condoms and female condoms for students who have latex allergies and students who may have difficulty negotiating condom use with a male partner.

e. Sex Education Should Include Accurate Information about Condom Use, including Demonstrations

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[214] *School Condom Availability*, *supra* note 154.
[215] *See, e.g.*, Cornell Barnard, *Parents Upset Over Proposal to Make Condoms Accessible to Middle Schoolers,* ABC13 (Feb. 26, 2016), http://abc13.com/education/parents-upset-over-proposal-to-make-condoms-accessible-to-middle-schoolers/1216346/; Elaine A. Lisko, *Condoms in Schools*, HEALTH LAW & POL'Y INST., https://www.law.uh.edu/healthlaw/perspectives/HealthPolicy/981021Condoms.html (last visited May 23, 2016).
[216] Miranda Perry, *Kids and Condoms: Parental Involvement in School Condom-Distribution Programs*, 63 U. CHIC. L. REV. 727, 760 (1996), https://www.jstor.org/stable/1600240?seq=1#page_scan_tab_contents.
[217] *Alfonso v. Fernandez*, 606 N.Y.S.2d 259 (N.Y. App. Div. 1993). *But see Curtis v. School Committee of Falmouth*, 652 N.E.2d 580 (Mass. 1995), *cert. denied*, 516 U.S. 1067 (1996) (holding that the lack of an opt-out provision did not render a school condom distribution program unconstitutional).

Increasing condom access is only one part of a successful condom availability program. Students must also know how to properly store and use condoms. While condoms have a "perfect use" failure rate of 2-3%,[218] the "typical use" failure rate is about 15%.[219] While some of this gap is attributable to inconsistent use (not using condoms during every sexual encounter), a growing body of research shows that condom use errors are also extremely common.[220] Such mistakes can contribute to slipping and breakage, and otherwise expose one's partner to bodily fluids, thus decreasing the effectiveness of condoms.[221] In order to ensure that students are equipped to use condoms properly, students should be given full instruction on condom use, including visual demonstrations.

Under current Mississippi law, school districts are not required to provide information on contraception use, and educators are forbidden from providing any kind of visual demonstration of condom use.[222] Advocates should continue to push for laws that would require districts to adopt evidence-based comprehensive sex education programs and that allow condom demonstrations. For further information on how to perform such demonstrations respectfully but effectively, schools can look to the *Condom Demonstration Guidance for Health Resource Room* promulgated by the New York City Department of Education, and available on their website.[223]

f. Condom Availability Programs Should Be Informed By Data and Regular Evaluation

In order to ensure that funds are being used effectively and that the program is having a positive impact on condom use and a negative effect on rates of unwanted pregnancy and STIs, schools developing condom availability programs should decide how and how often they will measure the success of the program. At minimum, direct quantitative measures to be tracked might include: the number of condoms distributed, the number of students engaging in sexual activity, the number of students who used a condom during their last sexual encounter, and rates

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[218] In other words, of women who rely on condoms for birth control and use condoms perfectly every time they have sex, 2-3% will become pregnant over the course of a year. *An Explanation of Condom Failure Rates*, GO ASK ALICE, http://goaskalice.columbia.edu/answered-questions/explanation-condom-failure-rates (last visited May 19, 2016).

[219] Stephanie A. Sanders et al., *Condom Use Errors and Problems: A Global View*, 9 SEXUAL HEALTH 81, 81 (2012).

[220] *Id.*

[221] *Id.* at 81–82.

[222] *See supra* notes 163-165 and accompanying text. Mississippi's sex education law is ambiguous about whether school nurses may be able to provide demonstrations outside the classroom, providing only that "in no case shall the instruction or program include any demonstration of how condoms or other contraceptives are applied." Miss. Code. Ann. § 37-13-171. It is unclear whether the "instruction or program" refers only to the classroom curriculum, or to any sex education that might take place in the school, including education by the school nurse. The law establishing school nurses' responsibilities and authority is similarly ambiguous, stating that nurses may provide abstinence education, but not explicitly forbidding them from providing information about contraceptives, including condom demonstrations. Miss. Code. Ann. § 41-79-5. This ambiguity may dissuade nurses from providing demonstrations, for fear that they may be violating the law.

[223] *Condom Demonstration Guidance for Health Resource Room,* N.Y.C. DEP'T OF EDUC., http://schools.nyc.gov/NR/rdonlyres/A5600E06-EB01-496F-94AB-FC736BE9775D/0/APPENDIXCCondomDemonstrationGuidanceforHealthResourceRoom.pdf (last visited May 19, 2016).

of pregnancy and STIs. Qualitative surveys and focus groups might further explore how students view the program, whether they have access to condoms elsewhere, and whether there are any barriers preventing them from taking advantage of the program. Just as Washington D.C.'s *Youth Sexual Health Project* survey helped reveal shortcomings in the district's policies, regularly re-assessing condom availability programs will help schools determine how they can best serve students.

School districts implementing district-wide policies should also develop ways to ensure that individual schools comply with the policies. As in the New York model, this might consist of a principal checklist and school health survey that must be submitted to the district annually, along with unexpected site visits and observations.

In conclusion, schools are an ideal location for condom availability programs because they provide students with a safe, comfortable, and extremely convenient point of access. In order to maximize the benefits of a school condom availability program, Mississippi schools should strive to 1) make condoms available for free; 2) allow students to obtain condoms in a private space from trusted, trained staff or peers; 3) establish an "opt-out" method of parental consent; 4) provide a variety of different kinds, sizes, and brands of condoms; 5) deliver accurate instruction on condom storage and use, including visual demonstrations; and 6) develop methods to oversee and measure continued implementation of the program over time.

IV. Conclusion

Mississippi has the second highest teen pregnancy rate in the country and among the highest rates of teen STI infection, which negatively impact overall health and economic outcomes for its residents. Limited access to condoms for adolescents living in the region contributes to these rates, and increasing the availability of condoms at a variety of sites would be an effective step forward in alleviating these negative outcomes. There are a number of strategies that could be used to achieve this goal, and the categories of community partners proposed in this report each require a unique approach. However, based on the research conducted for this report on obstacles to condom access in the region, as well as initiatives that have been successful in other regions, the most effective strategies involve highlighting the need for greater condom access, understanding the particular reasons for barriers to condom access (whether they be religious, political or financial in nature), and developing a program to increase condom availability that tailors best practices to fit each sphere of the community.

It is also important to note that while this report has primarily focused on the issue of access to condoms, interviews with Mississippi youth suggest a number of other issues that may contribute to condom use or non-use. These include a perception that condoms are ineffective (particularly free condoms provided at health centers), belief that condoms reduce pleasure for the wearer, and unequal bargaining power in sexual relationships between young men and women. Future studies should look into these issues more deeply and consider the kind of public education campaigns and cultural changes that may be necessary to overcome these barriers.

In the meantime, increasing access to condoms is nonetheless a critical step towards increasing condom use. Given the current status of condom availability and general attitudes

toward sex and sexuality in the region, attempts to make condoms more accessible for adolescents will undoubtedly meet with some resistance. However, approaching the issue with sensitivity to cultural norms, emphasizing the positive impact that greater condom access will have on individuals and communities, and developing partnerships with actors in a variety of areas in these communities will help ensure a successful campaign to increase condom availability in Mississippi.