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ABSTRACT

This book contains six papers on condom availability programs in the public schools. "Executive Summary" (Stryker, Samuels, and Smith) looks at the consequences of unprotected sex, adolescent condom use, condom promotion and availability, the role of schools, sex education in schools, how school condom programs work, distribution mechanisms, staffing and counseling, parental involvement, funding sources, legal issues, and program evaluation. "A Survey of Condom Programs" (Leitman, Kramer, and Taylor) discusses the findings from a study of superintendents in 299 high-school and middle-school districts on condom availability programs. "The View from Schools: Four Focus Groups" (Greene) discusses the perspectives of four focus groups of urban and nonurban school superintendents and school board members. "Funding and Policy Options" (Brindis) looks at rules affecting public funding and describes several model programs and their funding streams. "Legal Issues" (Solomon) discusses the legal issues regarding condom availability programs in public schools. "Research and Evaluation" (Kirby) looks at findings from previous research and emphasizes the need for both research and evaluation into the effectiveness of condom availability programs in the schools. (NB)

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CONDOMS IN THE SCHOOLS

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A Publication from The Kaiser Forums
Sponsored by The Henry J. Kaiser Family Foundation

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CONDOMS
IN THE SCHOOLS

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Edited by
Sarah E. Samuels, Dr.P.H.
Mark D. Smith, M.D., M.B.A.

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Sponsored by The Henry J. Kaiser Family Foundation

The Henry J. Kaiser Family Foundation, based in Menlo Park, Calif., is one of the nation's largest private foundations devoted exclusively to health. Established in 1948 by industrialist Henry J. Kaiser and his wife Bess, the Foundation now has assets of approximately \$400 million. It is not associated with Kaiser hospitals or Kaiser Permanente.

The Foundation makes more than \$23 million in philanthropic expenditures each year, focusing its grantmaking on government's role in health, on the health of low-income and minority groups, and on developing a more equitable and effective health care system in South Africa. The Foundation also has an interest in promoting innovation and policy change in its home state of California.

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INTRODUCTION

When school principals were surveyed twenty years ago about the biggest challenges facing their schools, the top-ranked answers included running in the halls, talking in class, tardiness, and chewing gum. These same principals will tell you today that they worry about violence, gangs, guns, drugs, and teen pregnancy.

Faced with shrinking budgets and declining SAT scores, schools are increasingly asked to fulfill functions beyond their educational mission. In the process, schools have become ideological battlegrounds. Perhaps the most heated battle today involves how best to deal with teen pregnancy and the spread of HIV and other sexually transmitted diseases.

To address these concerns, schools across the nation are considering whether to make condoms available to their students. The condom debate involves a clash of cultures: public health experts, AIDS activists, educators, parents, and teens all have differing perspectives on the best approach.

Although the thought of adolescent sexuality may cause adults (and parents) to squirm, the facts are incontrovertible. Each year between 2.5 million and 3 million teenagers become infected with a sexually transmitted disease. One million teenagers become pregnant. Cases of AIDS among people in their twenties (who were likely infected during their teens) continue to skyrocket.

Many of the questions involved in this debate are value questions. Should abstinence be the exclusive message of school curricula? What role should parents, the school, and the state play in matters of teen sexuality? Other questions are more susceptible to answers from social science research, such as: Does providing

condoms promote sexual activity among younger students? Are the schools a necessary vehicle for condom promotion when condoms are available through other venues?

To help clarify this debate, the Kaiser Family Foundation convened a two-day meeting with school administrators, public health officials, social scientists, parents and teen-agers as part of its Kaiser Forum series. The group examined the history of condom programs in public schools, as well as the attitudes of school administrators. Participants analyzed legal hurdles and financial hurdles. Lastly, they looked at the difficulties in evaluating such programs to accurately gauge impacts.

The six papers collected here address those issues in depth. We hope their publication fosters greater understanding of this question, one of the most sensitive facing school leaders today. And we will continue, through our grant-making, to analyze whether, and how, the U.S. should encourage condom use among its young.

The Foundation has awarded two grants based, in part, on this forum:

Population Services International is using a technique called "social marketing" to encourage condom use among Portland, Oreg., teens at high risk of contracting HIV. The project has placed condom machines in locations where teens congregate, and has launched a radio and television campaign encouraging safe sex.

ETR Associates will study all school districts with condom availability programs. This project will examine why the districts adopted the programs; the legal, political and financial problems in setting up the programs; their costs and methods of financing; and perceptions about how the programs are working.

We hope the original forum, this book, and our resulting grants encourage more open, informed debate. If we accomplish that alone, we will have met our goal.

Drew E. Altman
President
Kaiser Family Foundation

EXECUTIVE SUMMARY

Efforts to avoid unintended pregnancies and prevent sexually transmitted diseases (STDs) among teen-agers are now focusing on access to condoms as a primary approach to prevention. Scores of local school districts are considering or implementing programs to make condoms available (Appendix IV). When the schoolyard becomes the crucible for the condom debate, some highly charged questions emerge concerning the role of parents, the church, and the state in influencing the sexual behavior of adolescents.¹⁻³

Should schools be in the business of handing out condoms? An August 1992 Gallup Poll of a sample of 1,316 adults revealed that 68% believed that public schools should distribute condoms. Of those favoring distribution, 43% said condoms should be available to all students who want them and 25% favored requiring parental permission. Twenty-five percent of respondents opposed condom distribution in schools.⁴ Opponents of school condom distribution include some who favor school involvement in sex education. A Washington, D.C., minister put it this way: "When they teach you drivers ed, they teach you how to drive. They don't give you a car."⁵

The condom availability debate has taken place on a moral and ideological plane. It has been largely uninformed by empirical considerations about whether increasing condom availability will actually have an impact on the rate of teen-age pregnancies or STDs. Proponents of condom availability programs in the schools note that youthful sexual activity is a fact of life no matter

By the time they are twenty years old, 68% of females and 86% of males have had intercourse.

how vigorously young people are exhorted to abstain. Proponents rely on short-term, public-health considerations and concern about the consequences of unintended pregnancies and

the dire threat of the human immunodeficiency virus (HIV).

Those who oppose making condoms available through schools say parents and the church should prevail in matters of sexual morality. They emphasize traditional family and religious values that encourage sexual abstinence outside of marriage. Opponents argue that providing condoms in schools threatens family privacy and integrity and undermines parental authority, promoting early sexual activity among young people who may not be sufficiently mature to deal with the intimacy and responsibility that sexual relationships entail.

Attempts to introduce condoms into the schools have produced much *Sturm und Drang*. The degree of consternation such proposals provoke is testimony to the deep-seated questions of values. Those whose mission is rearing or educating youngsters may have sharply divergent outlooks from those whose primary goal is preventing the spread of HIV or reducing the number of unintended pregnancies.

To clarify the public policy debate and to distinguish questions about values from questions about social science, the Kaiser Family Foundation convened a meeting of educators and administrators, physicians and public health officials, specialists in HIV prevention and contraceptive behavior, researchers and evaluators, parents and teen-agers (Appendix I). The two-day session took place in Menlo Park, Calif., on June 18-19, 1992.

To set the stage for discussion at the forum, the Kaiser Foundation commissioned a Harris poll of educational administrators to find out how often, in what context, and with what result condom availability programs are being proposed in public high

schools. The foundation also hosted a series of focus groups conducted by the National School Boards Association and consisting of school board members and school superintendents from urban and nonurban districts.

In preparing for the forum, the Kaiser Foundation also commissioned a series of papers that constitute this volume. Barbara Solomon describes some of the legal hurdles to establishing and operating school-based programs. Claire D. Brindis examines potential funding from public and private sources. Finally, Douglas Kirby explores the prospects for evaluating the impact of condom availability programs, drawing lessons from evaluation of school-based clinics and sex education programs.

The Consequences of Unprotected Sex

Adolescence is a time of sexual experimentation and coming of age. Sexual activity among U.S. teen-agers is increasing, with serious consequences. By the time they are twenty years old, 68% of females and 86% of males have had intercourse.¹ A significant fraction of the adolescent population has begun to have sexual intercourse before entering high school. One million teen-age girls—one in ten—become pregnant every year.² Eight in ten teen-age pregnancies are unintended—nine in ten among single teen-agers and about half among married teen-agers. For teen-age mothers, the younger the mother, the greater the likelihood she and her baby will experience health complications. Such problems are associated with delayed or minimal prenatal care, poor nutrition and other lifestyle factors. Teen-age mothers are at greater risk of socioeconomic disadvantage throughout their life and are more likely to need to resort to public assistance for economic support than women who delay childbearing until later years.

Teen-agers make up a sizable portion of the nation's cases of STDs.³ Each year, 2.5 million to 3 million adolescents are infected with STDs.⁴ The number of cases of acquired immune deficiency syndrome (AIDS) among teen-agers is growing. From November

1990 to November 1991, AIDS cases among teen-agers between the ages of thirteen and nineteen increased 25%; there was a 23% increase among those between twenty and twenty-four years old. Adolescents account for less than 1% of AIDS cases nationally, but 21% of all individuals diagnosed with HIV disease are in the twenty- to twenty-nine-year age range.¹⁰ The lengthy incubation period of the virus suggests that a substantial portion of these individuals were infected while they were teen-agers.

Adolescent Condom Use

Awareness that condoms can effectively prevent unintended pregnancies and STDs has grown considerably in the age of AIDS.¹¹ Still, fewer than half of sexually active high school students reported having used a condom the last time they had intercourse.¹² Studies show widespread awareness of the risk of HIV disease and the role of condoms in disease prophylaxis. However, awareness of risk and appreciation of condoms' protective value are not necessarily related to use or intention to use condoms. There are a number of obstacles preventing consistent condom use among sexually active teen-agers. Matters of convenience often overshadow longer range concerns about health outcomes as determinants of condom use.^{13,14}

Teen-agers who fail to use condoms consistently believe that condoms are awkward to use and reduce the spontaneity of sexual encounters. They also cite practical factors, such as confidentiality, cost, and availability of transportation to places where condoms can be purchased.¹⁵ Because condom use depends on the cooperation of the male partner, adolescent women need support in developing the communication skills necessary to persuade a partner to use a condom or to refuse intercourse if a partner resists condom use.¹⁶

Condoms have not been particularly popular among adolescents. They remain useful in preventing STDs among adolescents who are relying on other forms of birth control, although it may be

considerably more difficult to achieve consistent use of two or more methods.¹⁷ While proper condom use can effectively prevent pregnancy, the risk of pregnancy is higher compared with hormonal contraceptives.

Condom Promotion or Condom Availability?

As nonprescription items, condoms are widely available, even to minors. Their widespread availability has prompted criticisms that school-based efforts at promoting condom availability are akin to "carrying coals to Newcastle."¹⁸ Indeed, in some schools condoms have become a "trendy fashion statement," with boys wearing them on their belt loops and girls dangling them from key chains.

However, availability of condoms may not translate into ready access. In a 1988 survey of drugstores and convenience stores in Washington, D.C., conducted by the Teen Council of the Center for Population Options, only 13% of the stores had clear markings indicating where the condoms were shelved. In a third of the stores, the condoms were kept behind a shelf, necessitating assistance from a store clerk. Adolescent females asking for help in finding or purchasing condoms reported "resistance or condemnation" 40% of the time.¹⁹

One way to encourage more widespread use of condoms is "social marketing"—that is, "the application of Madison Avenue techniques to promote social goals such as contraception."²⁰ Social marketing concepts have been used with great success in developing countries to market condoms and other contraceptives for purposes of family planning; these techniques are now being applied to HIV prevention as well. The social marketing approach integrates marketing research, product conception, promotion, pricing, and physical distribution of products.

The success of social marketing of condoms is epitomized in the work of Population Services International in Zaire. PSI's research showed that it would be easier to develop a network to sell

condoms than to give them away for free. The brand name Prudence was adopted and condoms were sold in packages festooned with a black panther. The number of condoms sold or given away shot up within a few years to 18 million annually from 500,000, according to the World Health Organization. Zairians began to use Prudence as a generic term for condoms, just as they call any pen a Bic.

As the U.S. National Commission on AIDS has noted, "The United States has yet to embark on campaigns such as have been undertaken in other countries to foster fundamental changes in social attitudes about condoms." Such efforts are embarrassingly modest, given U.S. marketing savvy and the importance of the issue. According to DeJong, "Historically United States condom marketers have struggled against the notoriety of their product and its association in the public mind with extramarital sex, promiscuity, and prostitution."²⁰ Because of these associations, condom manufacturers have almost exclusively targeted middle-class white consumers. Condom advertising seldom features blacks or Hispanics. Nor are gay men or teen-agers targeted specifically.

Condom advertisements remain a rarity in the most obvious medium for their promotion—television. Of the four major television networks, only Fox has cleared the way for national television advertising of condoms. Public service announcements in the television campaign by the Centers for Disease Control called "America Responds to AIDS" make only passing or oblique references to condoms. Government and television network concerns about offending a minority of viewers have kept explicit condom ads off of the U.S. television airwaves, despite polls that show more people object to advertising for beer and wine, cigarettes, or feminine hygiene spray than advertising for condoms.²¹

Advertising is not the only vehicle for promoting condoms and sexual responsibility in the media. Consider the impact of what appears on television between the commercials. By the time teenagers graduate from high school, they have clocked 15,000 hours in front of the television, compared to 11,000 hours in the

classroom. Of the 14,000 sexual references or innuendos each year, only one in eighty-five involves mention of such topics as STDs, birth control, or abortion.²²

Some promising innovations in promoting condoms in the United States are on the horizon. Local ordinances have been proposed to require that condoms be sold at outdoor concerts, in hotels, in bars, and at other liquor outlets. Groups such as the Los Angeles office of the Center for Population Options are working with television producers and writers to incorporate safe-sex messages into dramatic story lines, echoing efforts of public health activists to integrate seat-belt use, responsible drinking, and designated drivers into television dramas. Population Services International is applying the social marketing techniques used in developing countries in a pilot program in Portland, Oreg., that involves a wide array of local businesses, social institutions, and media.

The United States has yet to embark on campaigns such as have been undertaken in other countries to foster fundamental changes in social attitudes about condoms.

Schools May Be the Appropriate Place to Promote Condoms

The failure to prompt a sea change in the willingness of young people to use condoms has prompted loose coalitions of parents, teachers, school board members, students, and public health officials to turn to the schools. The role of AIDS activists in sparking the condom availability debate has received much media attention, but a survey shows they are less frequently cited as initiators of the discussion.²³

Schools are increasingly called upon to fulfill many of the functions that were once the province of the family, the church, or the family doctor. About 325 schools nationwide operate clinics that offer primary health care and, in some cases, dispense various

contraceptives.²⁵ Many schools bolster their educational offerings with programs aimed at combating hunger, violence, and illicit drug use, despite some misgivings from critics who think schools have enough to handle without becoming “caretakers for all society’s problems.”²⁶

Sex Education in Schools is Widespread

Most schools already provide education about sexuality and sexual risk taking, whether under the heading of health, family life, or reproductive biology courses.²⁷ All but a few states mandate or recommend sex education. By means of statute or regulation, thirty-three states specifically mandate HIV/AIDS education; fifteen others encourage it. Of states with an HIV/AIDS curriculum, more than 90% have guidelines regarding discussion of abstinence.²⁸

In a survey of 4,241 seventh- through twelfth-grade teachers who were in the specialties most likely to be involved in sex education, Forrest and Silverman²⁹ found that most believed that education regarding pregnancy, AIDS, and other STDs should be covered by grades seven and eight at the latest; such education is much more likely to begin in the ninth or tenth grade. Many respondents said they developed original teaching materials because of inadequate curricula. The survey showed that the largest gap between what teachers think should be taught and what is actually taught relates to the specifics of birth control methods—which ones to use and where to obtain them. DeMauro echoed these findings by revealing that although 74% of state HIV/AIDS curricula mention condoms, only 9% include information about how to use them.³⁰

How School Condom Programs Work

While virtually all schools have some form of sex and AIDS prevention education and many offer clinic services, a 1992 survey of school districts showed that relatively few schools have instituted

condom availability programs. A larger number of school districts have extensively debated the issue.²³

In many districts, the debates have been vigorous and protracted, involving public hearings over many months. In New York City, for example, where a only a handful of citizens turned out for hearings on the public schools' \$6.5 billion budget, more than 500 people signed up to testify at a series of public hearings on condom availability.³⁰ Emotions run high on this issue. AIDS activists from local ACT-UP (AIDS Coalition to Unleash Power) groups have risked arrest for trespassing to distribute condoms on school grounds.³¹ In the summer of 1992, a California assemblyman introduced a bill, which died in committee, to ban the "nonsale" distribution of condoms within 1,000 feet of a school building.

Participants in public hearings have pointed to the value of the debates in bringing to the fore issues of teen-age sexuality, pregnancy, disease prevention, and AIDS. Local politics have been reflected in program design. The variations in condom availability programs tend to result from concerns about overcoming parental and community objections and avoiding liability. Considerations of program effectiveness, about which there are few reliable data, have had less of an impact on program design.

Program variations include differences in where condoms are available, who is eligible to receive them (especially by grade or age), mandatory vs. voluntary counseling, and the extent of parental involvement. There is also an array of funding and staffing arrangements involving both paid staff and volunteers.

Distribution Mechanisms

Condoms may be made available in specially designated resource rooms, in health education classes, or through school nurses. School systems with clinics may make condoms available as part of a wider array of health services related to contraception and reproductive health. In some schools, there is a limit on the number of condoms students may receive at each visit (for ex-

ample, two in the Los Angeles program vs. five per visit in Commerce City, Colo.).³²

Those who urge handing condoms out with few restrictions and minimal or no counseling point to studies showing that a frequent impediment to teen-agers' use of condoms is embarrassment in buying them and admitting to adult strangers that they are having intercourse.¹⁹ A gay teacher at Cambridge Rindge and Latin School in Cambridge, Mass., the first school in the nation to make condoms available without parental permission, urged putting condoms in fishbowls or in dispensers rather than making them available only through school personnel. "For kids who are uncomfortable with talking about their sexual orientation, [requiring counseling] is just one more obstacle," this teacher says.²

The Massachusetts Department of Education guidelines on condom availability suggest placing vending machines on high school grounds. Falmouth, Mass., has placed vending machines in high school lavatories for boys and girls and enabled junior high school students to obtain condoms from school nurses.

Staffing and Counseling

Individuals who distribute condoms and who may be involved in associated counseling include teachers, adult volunteers from the community, or specially trained peer counselors. Some programs are managed by the local health department while others are administered by the school district. Some schools have special education sessions that students must attend before they become eligible to receive condoms. These sessions may involve group counseling, health education videos on how to use condoms, or individual counseling. The staff members involved in initial education and counseling efforts may not be those to whom students subsequently return to replenish their supply.

In some cases, schools have followed a medical model, requiring that school nurses or other health aides be involved in condom distribution. In one case, the contracts of school nurses

were rewritten so the health department rather than the school district could pay them before they distributed condoms (Brenda Z. Greene, personal communication). Involving a health professional may be a way of avoiding perceived liability problems, a way of using staff already on the payroll, or a means of opening the door for a discussion of a variety of health concerns.* Staffing requirements have a significant impact on funding needs. The extent to which condom programs rely on teachers and staff already involved in family-life or sex education programs is a key factor.

Parental Involvement

The extent of parental involvement has been the most significant bone of contention in the debate about condom availability in schools.³ Michael Petrides, a member of the New York City School Board who is from Staten Island, summed up the feelings of a vocal minority of parents: "There is no way in this city and in these United States that someone is going to tell my son he can have a condom when I say he can't."²

The options for parental involvement vary. Some school programs do not require notice to parents or permission from parents as a prerequisite to student participation; others require signatures only from those parents who would like to excuse their children. Some school districts require parental permission, occasionally in the form of notarized signatures, before teen-agers may receive condoms. Requiring such affirmative action on the part of parents is likely to result in large numbers of youngsters being excluded from the programs, intentionally or not.

* One study⁴ of sexually active adolescents outside the school setting suggests that providing the opportunity to redeem prescriptions for condoms may encourage condom acquisition, especially for middle-class youngsters who receive "anticipatory guidance" on HIV prevention. "Perhaps the experience of acquiring condoms in a medical setting first may make adolescents more comfortable in buying condoms later on in the 'real world,'" the authors wrote.

Most school programs provide parents some opportunity to excuse their children from the programs. However, at least two school boards have totally eschewed parental involvement in order to reach the largest possible number of adolescents. In New York City and Santa Monica, Calif., parental veto is not permitted. Interestingly, both school districts permit parents to exclude their children from the AIDS education portion of these programs.

Funding Sources*

The cost of condom availability programs in schools varies considerably, depending upon the services associated with condom distribution. Expenses may involve faculty or administrative staff time, training of peer counselors or other volunteers, legal advice, developing associated educational materials, overhead for school space used for the program, and evaluation costs. Condoms tend to be the least expensive part of most programs, especially when they are purchased in bulk.

Though there are potential sources of federal dollars, restrictions on the use of federal monies make the U.S. government an unlikely funding option. Federal support for family planning programs aimed at adolescents comes from Title X, Medicaid, maternal and child health block grants, and social-services block grants. Competition for these funds is vigorous, and condom availability programs may not be eligible if they focus more on interrupting the spread of STDs than preventing unintended pregnancies. There has been little federal support for school-based family planning efforts, except for those stressing abstinence as a singular message. Forty-four states and the District of Columbia fund some type of family planning efforts. In some cases, school-based condom availability programs may be eligible for state funds. Faced with government budgets

* The material in this section is from the paper in this book entitled "Funding and Policy Options," by Claire D. Brindis.

stretched to the limits and political entanglements, many condom availability programs have been underwritten with funds from multiple sources. Money for staff may come from one source, funds for education and counseling from another, and money for supplies and materials from yet another source. Adolescent clients may be charged a small user fee to help defray the costs of condoms.

New York City's program is one of the nation's most ambitious. In 1991, the school board voted 4-3 to adopt a condom availability program that is slated to reach all of the city's 120 schools and seventeen school-linked clinics, encompassing 261,000 students. Condoms are donated by two manufacturers: Schmid Laboratories of Sarasota, Fla. (Trojans), and Carter-Wallace of New York, N.Y. (Ramses). Private sources, led by the Aaron Diamond Foundation, are funding the administrative support and the training of peer counselor health advocates. Many New York City schools are making in-kind donations of space. The New York City Department of Health provides written materials and technical assistance. In some cases, nearby medical schools and hospitals provide in-kind contributions by working to help develop programs and train counselors.³⁰

Legal Issues*

Concerns about legal liability and threats of lawsuits have played a significant role in shaping the design and implementation of condom availability programs. Such concerns have helped determine who is eligible to receive condoms, who hands them out, and whether parental involvement is allowed, solicited, or unwelcome.

There are few precedents circumscribing the authority of school boards to adopt condom availability programs. A few states

* The material in this section is from the paper in this book entitled "Legal Issues," by Barbara Solomon.

In most states, there aren't any specific statutes; rather, legal guidance comes from state laws and local ordinances regulating public schools and the content of educational programs.

address the question by statute. For example, Arkansas³⁴ allows local school boards to decide whether to distribute contraceptives in school clinics, requires parental consent, and prohibits use of state funds to do so. Louisiana³⁵ prohibits distribution of contraceptive devices in schools or the use of explicit materi-

als in sex education courses. Maryland³⁶ prohibits the distribution of contraceptives in school vending machines. Michigan³⁷ prohibits the distribution of family planning drugs or devices on school grounds. Other states address the nature of information about condoms to be imparted to students in sex education classes by requiring, for example, that the effectiveness of condoms be discussed.

In most states, there aren't any specific statutes; rather, legal guidance comes from state laws and local ordinances regulating public schools and the content of educational programs. Relevant federal law or policy is limited to constitutional rights, such as privacy or due process, and statutes and regulations governing the use of federal funds.

The uncharted legal territory that condom availability programs face has given some school officials pause. School board members, teachers, administrators, and program volunteers have raised concerns about liability if condoms break or fail and result in disease transmission or unintended pregnancies. Such concerns, which legal commentators consider a remote risk, have been allayed in some programs by distributing condoms with manufacturers' instructions clearly cited.

Another question is whether providing condoms entails the delivery of health care, which implies the need for the consent of parents or guardians. Such consent for medical care is required

when unemancipated minors—unmarried individuals under a certain age, usually eighteen years—receive health care.³⁸ In many states, exceptions to this requirement have been made for diagnosing or treating STDs or rendering advice and counsel on reproductive decision making.³⁹

Condom availability programs that allow voluntary distribution without explicit parental consent have been criticized for usurping parental authority in matters of sexual morality and religious belief.⁴⁰ In addressing matters of family integrity and adolescent autonomy, U.S. courts have tended to affirm parents' rights to rear children as they see fit, within certain limits to protect children's interest and the public welfare. Hence, the U.S. Supreme Court has held that parents have the right to choose a school for their children, although states can make education mandatory and decree certain minimum standards. Once the children are in school, individual parents generally are not permitted to dictate the content of curricula. Still, in matters of health and hygiene, some school districts have allowed parents to excuse their children from certain classes if lessons conflict with a family's religious beliefs.⁴¹

In 1989, New York's highest court upheld the right of a couple in Valley Stream, Long Island, to excuse their high school-age children from AIDS education classes. As members of the Plymouth Brethren, a small Irish Christian sect, the parents argued that instruction on matters of sexual morality were solely their

³⁸ The perception that parental consent is necessary may deter some adolescents from seeking care. In one study, 44% of teen-agers believed that public health clinics must inform parents of offspring treated for STDs; 40% thought parental permission must be obtained before teen-agers could be treated.

Abortion decision making is another matter. Thirty-five states have laws requiring parental consent or parental notification before a minor can have an abortion, although these laws are being enforced in only eighteen states; court orders or the directives of state attorneys general have blocked such laws in the remaining states. In many states, a judge can grant permission for an abortion for a minor absent parental permission or notification, but judicial practices in this regard vary widely from state to state.

province. They contended that their exemption should even extend to classes that treated the subject of AIDS in a purely academic fashion, such as an examination of the role of the media in shaping sexual attitudes. The court based its ruling in part on the unique and strongly held beliefs of a small religious sect.

The U.S. Supreme Court has ruled on minors' right of privacy as it relates to reproductive decision making and access to contraceptives, affirming minors' right to purchase nonprescription contraceptives. In an oft-cited passage in his concurrence in *Carey v. Population Services International*,⁴² Justice Stevens discussed how far the state should go in disapproving sexual activity by minors:

Although the State may properly perform a teaching function, it seems to me that an attempt to persuade by inflicting harm on the listener is an unacceptable means of conveying a message that is otherwise legitimate.... It is as though a State decided to dramatize its disapproval of motorcycles by forbidding the use of safety helmets. One need not posit a constitutional right to ride a motorcycle to characterize such a restriction as irrational and perverse.⁴³

Condom availability programs already have been the subject of a few court challenges. A trial judge ruled in favor of New York City's program, finding that a "crucial aspect of the school program is that it is entirely voluntary and imposes no mandatory requirements on students to participate."⁴⁴ The program, described as "neutral on its face and supported by a compelling state interest,"⁴⁵ was held not to violate First Amendment protection of the free exercise of religion. The trial court also found that although the distribution of condoms is "clearly health related," it does not constitute a "health service" under New York state law such that parental consent would be necessary.⁴⁶

New York City's program and the protracted struggles involved in implementing it also highlight some of the problems in relating condom availability to sexual education programs

mandated by the state. *New York Times* editorials have described the "fierce but foolish" battle between those who advocate abstinence as the only way to avoid AIDS and those who emphasize the use of condoms.

Implementing a state mandate that says oral and written instruction on AIDS must devote "substantially more time and attention to abstinence" than to means of avoiding infection, New York City required outside experts who teach AIDS prevention to sign an oath to that effect. A *New York Times* editorial labeled the school board's action as "AIDS obsession" and "absurd micromanagement," concluding that teaching abstinence and encouraging condom use are not inconsistent and "each method can contribute in a small way to preventing the spread of the HIV virus."⁴⁷

These are just a few of the legal concerns that have shaped the debate about condom availability in schools. There is little doubt that courts and legislatures will continue to enter the fray as more schools consider and implement such programs.

Program Evaluation*

There has been much conjecture about the impact of promoting condom availability in various settings. A 1987 report of the National Research Council recommended the "development, implementation, and evaluation of condom distribution programs." In reviewing the literature, the NRC noted that "although these findings suggest the potential usefulness of new efforts to implement and test condom distribution programs, they do not provide any conclusive evidence of the effectiveness of such an approach."⁴⁸

* The material in this section is from the paper in this book entitled "Research and Evaluation," by Douglas Kirby.

The ultimate hope for introducing condoms into the schools is that wider availability will help reduce the numbers of unintended pregnancies and STDs by reducing unprotected sex. As noted earlier, making condoms available to all teen-agers could spur pregnancy and STDs if sexual intercourse increased and condom use were incomplete or ineffective, or if use of other birth control measures diminished.

It may be quite difficult to measure the discrete impact that condom availability programs in schools have on the occurrence of STDs and birth rates, which fluctuate widely and are confounded by the numbers of young women who choose to terminate their pregnancies.¹⁹ However, there are intermediate measures of effectiveness. These include changes in attitudes about condom use, the number of condoms distributed, and self reports regarding consistency of condom use. The attention to sexual risk-taking issues prompted by controversies over condom programs could result in salutary behavioral changes, such as delaying first-time intercourse, reducing the number of sexual partners, or relying more on a repertoire of safer sexual behaviors, such as masturbation or massage.

It is too early to gauge the impact of the latest wave of condom availability programs that were sparked by concerns about the HIV epidemic. In May and June 1992, Louis Harris and Associates conducted a survey of a stratified probability sample of 300 school districts from U.S. public/middle high schools for the Kaiser Foundation. It revealed that 8% of U.S. public middle and high school students attend school in districts where condom availability programs have been approved. About a third (34%) attend school in districts where "a lot" or "some" discussion about implementing such programs has taken place.²⁰

We need to know more about the way schools consider these issues, which schools are adopting programs, and the sources of support for and opposition to these programs.

As more schools debate the issue and are buffeted by proponents and detractors of condom availability, they have little

definitive data to guide them. In the absence of immediately relevant data, information from studies on the impact that sex education and contraceptive availability have on adolescent sexual activity may provide some insight.⁵⁰⁻⁵²

One threshold indicator for how the programs are working—the number of condoms distributed—varies considerably. Anecdotal reports from school districts reveal that the number ranges from twenty per month to 600 per month regardless of district size. A number of factors may account for this disparity, which seems far too wide to be explained by differences in degree of sexual activity.³² It may reflect variations in the use of condoms, the availability of condoms from other sources, or other factors related to program design. Many programs are in early phases of implementation. Indeed, some much-ballyhooed programs may be more of a plan than a program.

Carefully designed studies can help shed some light on the condom availability debate. So far, very few condom availability programs have incorporated strategies for rigorous evaluation. Ambitious, well-designed studies are necessary to take into account the rapidly changing dynamics within schools and the barrage of influences from beyond school walls, including family, church, and the media. Research on formative issues related to the adoption and design of programs is necessary; so are studies on program effectiveness and its impact on sexual risk-taking behaviors.

Conclusion

For many in the public health community, the issue of condom availability in the schools is a public health issue—that is, preventing the spread of HIV. For better or worse, however, schools are run not by the public health system but by educators with different priorities and constraints. If, for instance, the advocacy of such a program in a particular community causes substantial public outcry and controversy, school officials might reasonably conclude that the issue is so peripheral to their central

mission that it is not worth jeopardizing crucial support from sectors of the community opposed to condom availability, such as certain churches or parental groups. To regard such a position as cowardice and invoke the supremacy of saving lives may threaten the working relationships between the public health and educational communities.

The condom availability debate probably will be played out in hundreds of towns and cities across the country. These debates involve fundamental values and beliefs about sexual decision making and privacy, family integrity and parental autonomy, and public health. A clearer understanding of the impact of condom availability programs will help frame these debates and more clearly distinguish questions of values from empirical questions that can be answered by careful research.

Jeff Stryker

Center for AIDS Prevention Studies,
University of California-San Francisco

Sarah E. Samuels, Dr. P.H., Program Officer

Mark D. Smith, M.D., M.B.A., Vice President

Henry J. Kaiser Family Foundation, Menlo Park, Calif.

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A SURVEY OF CONDOM PROGRAMS

Robert Leitman
Senior Vice President

Erich Kramer
Senior Vice President

Humphrey Taylor
President and Chief Executive Officer
Louis Harris and Associates Inc.
New York, N.Y.

Introduction

In 1992, the Henry J. Kaiser Family Foundation commissioned a study by Louis Harris and Associates Inc. of condom availability programs in the nation's public schools, focusing on the debate surrounding such initiatives and the approval process. Interviews were conducted nationally with the superintendents (or designees who could speak for districtwide policy) in 299 high-school and middle-school districts. The sample, drawn from a listing of all such districts in the United States, was proportionate to the number of students at the middle- and high-school levels in each district. Consequently, the percentage results represent the circumstances, vis-a-vis condom availability programs, of all high-school and middle-school students in the continental United States.

Data were collected from May 13 through June 5, 1992. All interviews were conducted from the Harris firm's telephone facilities in New York City. Appendix III offers further details on methodology.

Problems Bessetting Schools

The spread of the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) among students, concern about which has prompted approval of school-based condom availability programs in a handful of districts and discussion of such in many others, is viewed by superintendents as the *least* serious of seven health- and safety-related problems facing their districts.

Superintendents representing only 6% of the nation's middle- and high-school students consider HIV/AIDS a "very serious" problem and only 20% consider it at least "somewhat serious" in their district. The problem ranks in seriousness behind student drug use (6% "very serious," 66% at least "somewhat serious"), the spread of sexually transmitted diseases (STDs) other than AIDS (7% "very serious," 31% at least "somewhat serious"), violence in the schools (11% "very serious," 38% at least "somewhat serious"), poor nutrition among students (13% "very serious," 52% at least "somewhat serious"), alcohol use by students (14% "very serious," 81% at least "somewhat serious"), and student pregnancies (23% "very serious," 68% at least "somewhat serious").

To one degree or another, the spread of HIV/AIDS, the spread of other STDs, and student pregnancies all are most likely to be viewed as serious problems in large districts and in those with the largest proportions of low-income and minority students. Violence in the schools is in this category, as well. Concern about poor nutrition—while present in districts of all sizes—is concentrated in those with the largest proportion of low-income and minority students. In contrast, alcohol and drug use are generally viewed as more pervasive problems among districts of varying sizes and socio-demographic composition (Table 1).

Table 1. Seriousness of Problems

Question: How serious is each of the following problems in your district today? Would you say that's very serious, somewhat serious, not too serious, or not at all serious?

	Very serious %	Somewhat serious %	Not too serious %	Not at all serious %	Not sure %
Base: 299					
Student pregnancies	23	45	23	3	5
Alcohol use by students	14	67	14	2	3
Poor nutrition among students	13	39	35	10	3
Violence in the schools	11	27	44	15	2
The spread of STDs other than AIDS among students	7	24	28	15	26
Drug use by students	6	60	27	3	4
The spread of HIV/ AIDS among students	6	14	27	28	25

Note: Percentages in this and subsequent tables may not add up to 100% because of computer rounding or the acceptance of multiple answers from respondents. The base for each question is the number of people who answered the question.

Approved Condom Programs

Thus far, little progress has been reported on initiating condom availability programs in the nation's middle and secondary schools. Only 8% of high-school and middle-school students are in districts in which a condom distribution program has been approved, according to district superintendents or their designees. Approved condom programs are almost entirely concentrated in the nation's largest districts, in the East and West, in districts in which all or many students are from low-income households, and in districts with a large proportion of minority students. Districts in which the spread of HIV/AIDS is of concern are more likely to have approved a program than those in which other STDs are a concern (27% vs. 17%), although both are well above average in their likelihood of having done so. Districts in which student pregnancy is a concern aren't any more likely than average (8%) to have approved a program.

Though all of the districts in which a program has been approved report that their schools already have begun making condoms available in and through the schools, most say the program is being phased in gradually in the district (96%) and that the program just began in the 1991-92 school year (78%). One in five superintendents in districts with an approved program aren't sure what percentage of their schools (where such a program is appropriate) will have one when the program is fully phased in, and nearly half aren't sure what percentage of students in those schools will have access to condoms. However, those who can answer say all appropriate schools and all students in those schools will be eligible. Most say students can receive condoms beginning in the ninth grade. Seventy percent report that the condom availability program is not administered under any existing program. School nurses or other school health personnel (37%), nondistrict health care providers (34%), teachers (30%), and guidance counselors (26%) are mentioned as the type of personnel who will distribute condoms to students (Table 2).

Observation

The fact that the spread of HIV/AIDS among students is not high on the list of school problems, as superintendents see them, may explain why districts aren't in a hurry to implement condom availability programs. As this study confirms, concern about other STDs or student pregnancies alone could not spur serious discussion of such a controversial policy.

The question is this: Are superintendents' perceptions of the AIDS risk accurate? The finding that student pregnancy is a much greater concern than the spread of AIDS seems to suggest that superintendents pay little heed to the possibility that AIDS is spread through unprotected heterosexual intercourse.

Not surprisingly, active condom programs are concentrated in large districts with large proportions of low-income and minority students—the kind of districts most likely to report concern about the spread of HIV/AIDS but also concern about other STDs and pregnancies.

All districts with programs require that students who obtain condoms be given information or counseling. This information nearly always is in the form of pamphlets or written handouts (91%), less often in the form of spoken advice or instructions (65%), and least often in the form of sessions with doctors, nurses, or other health care professionals (34%).

Program funding is most likely to come from the health department (64%), though sometimes it is provided externally—through a foundation grant (39%) or from other sources (35%). Funding often covers the cost of condoms (68%) and staff costs (68%) (Table 3).

Table 2. Program Implementation

Base: Program approved.

Question: Have the schools in your district already begun to make condoms available in and through the schools, or not?

Q: In what school year (will/did) this program begin?

Q: Is the program being phased in gradually in schools in the district, or introduced at one time in all schools for which participation is appropriate?

Q: When the program is fully in place in your district, about what percentage of schools for which a program is appropriate will have condom availability programs?

Q: And about what percentage of students in the district for whom the program is appropriate will have condoms available to them?

Q: What is the lowest grade level in your district that (will have/has) access to condoms in or through the schools?

Q: (Will the condom distribution program be/Is the condom distribution program) administered under an existing program, or not? (IF YES:) What kind of program is that?

Q: Who (will distribute/distributes) the condoms in your district?

	Total
Base	7
	%
<hr/>	
Condoms already available	100
Not available yet	—
School year program began:	
1990-1991	22
1991-1992	78
% of appropriate schools that will have a program when fully phased in:	
Not sure	21
Median among those answering	100
% of appropriate students that will have condoms available to them when program fully phased in:	
Not sure	47
Median among those answering	100

Continued

Table 2. (continued)

- Question: Have the schools in your district already begun to make condoms available in and through the schools, or not?
- Q: In what school year (will/did) this program begin?
- Q: Is the program being phased in gradually in schools in the district, or introduced at one time in all schools for which participation is appropriate?
- Q: When the program is fully in place in your district, about what percentage of schools for which a program is appropriate will have condom availability programs?
- Q: And about what percentage of students in the district for whom the program is appropriate will have condoms available to them?
- Q: What is the lowest grade level in your district that (will have/has) access to condoms in or through the schools?
- Q: (Will the condom distribution program be/Is the condom distribution program) administered under another existing program, or not? (IF YES:) What kind of program is that?
- Q: Who (will distribute/distributes) the condoms in your district?

	Total
Base	7
	%
<hr/>	
Lowest grade level with access to condoms:	
Grade 6	1
Grade 9	72
Grade 10	26
Administered under existing program:	
HIV/AIDS education	8
Sex education	8
Other	29
Not administered under existing program	70
Administered by:	
School nurses or other school health personnel	37
Nondistrict health care provider	34
Teachers	30
Guidance counselors	26
Other	36

Table 3. Program Financing

Base: Program approved.

Question: How (will the program be/is the program) financed in your district—from the school district budget, from the health department budget, through a local government tax levied for the purpose, or from an external funding source such as a foundation grant?

Q: (Will/Does) the financing cover the condom costs, staff costs, administrative costs, or what?

	Total
Base	7 %
<hr/>	
Financed from:	
Health department budget	64
External funding/foundation grant	39
Other	35
Financing covers:	
Condoms	68
Staff costs	68
Administrative costs	32
Other	6
Not sure	26

One in five students (21%) in districts with a condom availability program are in districts that require active parental consent (consent in writing) before they can be given condoms; two in five (41%) are in districts that require passive parental consent (parents are notified, and if they don't object, the district assumes they have given their consent); and one-third (35%) are in

Table 4. Parental Consent Policy

Base: Program approved.

Question: What kind of parental consent or notification (will/does) your district require before distributing condoms to a student? *Active consent*—by which I mean the parent has to give consent in writing; *passive consent*—by which I mean parents are notified and if they don't object, the assumption is that they've given their consent; *notification only*—by which I mean parents are told about the condom availability program but are not given the option to approve or object; or (will/does) your district not require that parents be notified at all?

	Total
Base	7 %
Active	21
Passive	41
Notification only	35
No notification at all	4

districts that require parental notification only (parents are told about the program but not given the option to approve or object to their children receiving condoms) (Table 4). Among districts in which the program has been implemented since the 1990-91 school year, all have received formal complaints about the program and virtually all (95%) have experienced lawsuits.

In most districts that have approved a program (62%), the success of the program will be formally evaluated.

Discussion About Condom Availability Programs

While nearly three in five middle- and secondary-school students across the United States are in districts in which the issue of a condom availability program has at least been broached, more than one-third are in districts in which there hasn't been any discussion (Table 5). Thirteen percent of students are in districts in which "a lot" of discussion has taken place, 21% are in districts in which there has been some discussion, 23% are in districts in which there hasn't been much discussion, and 36% are in districts in which there hasn't been any discussion. Superintendents of the largest districts, districts in the East and West, and districts with large proportions of low-income and minority students are most likely to report there has been "a lot of discussion" about a condom availability program.

Not surprisingly, approval of a condom program is never won without "a lot of discussion." And districts in which the spread of HIV/AIDS is considered at least "somewhat serious" are more likely to report "a lot of discussion" about a condom program than those in which the spread of other STDs elicits the same level of concern (32% vs. 22%). Those districts in which student pregnancy is considered a serious problem aren't any more likely than average to report "a lot of discussion" (13%).

In districts in which there has been any discussion (57%), teachers (29%), parents (29%), school board members (28%), the health department (27%), and students (24%) are about equally likely to have initiated the discussion, according to superintendents. AIDS activists are mentioned less frequently (11%). The likelihood of school board members having initiated the discussion diminishes as district size increases; the health department is more often mentioned as the initiator in medium and large districts than in small ones; superintendents in large districts are more likely than others to mention students as initiators; and superintendents in medium-size districts are more likely than those in large or small

Table 5. Condom Availability Program

Question: Whether or not such a program has been approved at this time, how much discussion has there been in your district about implementing such a program—has there been a lot of discussion, some discussion, not much discussion, or none at all?

Base	Total	District size			Region			
		Small	Medium	Large	East	South	Midwest	West
	299	64	103	132	64	98	74	63
	%	%	%	%	%	%	%	%
A lot	13	*	7	20	22	8	4	20
Some	21	10	17	27	30	19	8	27
Not much	23	19	24	24	17	21	28	28
None at all	36	38	51	27	29	34	57	26
Not sure	8	32	1	1	2	17	3	—

*Less than 0.5%

— = zero

districts to say they themselves initiated the discussion. Districts in which a program has been approved are more likely to cite teachers, students, AIDS activists, and pro-life activists, and are less likely to cite the school board and the health department, than districts in which there hasn't been approval (Table 6).

Again, in districts in which there has been any discussion, preventing the spread of HIV/AIDS has been the most important issue in the discussion (66% "very important"), followed distantly by preventing the spread of STDs other than AIDS (45%).

Table 6. Types of Individuals or Groups that Initiated Discussion

Base: There has been a lot/some/not much discussion.

Question: What types of individuals or groups initiated this discussion in your district?

	Total	District size			Condom program approved	
		Small	Medium	Large	Yes	No
Base	168	26	57	85	7	161
	%	%	%	%	%	%
Teachers	29	33	29	28	39	27
Parents	29	32	25	30	32	28
School board member(s)	28	58	38	20	9	32
Health department	27	5	30	30	15	29
Students	24	19	11	29	38	21
AIDS activists	11	—	2	16	34	7
The superintendent	11	4	21	8	4	12
Other residents	9	—	3	13	—	10
Doctors/nurses	8	1	5	10	—	9
Administration	8	14	7	7	—	9
Pregnancy prevention activist(s)	4	—	—	7	—	5
Pro-life activist(s)	4	—	—	6	26	1
Religious groups	4	3	4	4	—	5
Counselors	3	4	9	*	—	3
Board of education	2	3	1	2	6	1
Pro-choice activist(s)	*	—	—	1	—	1
Other	13	5	7	16	35	10
Not sure	8	3	7	9	21	6

*Less than 0.5%

— = zero

Preventing teen-age pregnancy is last on the list (36%) (Table 7). Preventing the spread of HIV/AIDS is seen as a "very important" issue in the debate in districts that have approved a condom program and in those that haven't. But preventing other STDs and teen-age pregnancy have not been "very important" discussion issues in districts in which programs have been approved. In addition, the findings suggest that the HIV/AIDS issue has been discussed most often in larger districts in the East and in districts in which all or many students are minority-group members. Preventing the spread of HIV/AIDS also seems to be more frequently reported as a discussion topic in districts in which the superintendent favors a condom program than in districts in which the superintendent opposes such a program.

In 15% of districts in which there has been any discussion about a condom availability program, the district superintendent favors such a program; in 42%, the superintendent opposes such a program; and in 34%, the superintendent does not have a stated opinion (Table 8). The likelihood of the superintendent favoring such a program increases as district size increases; is lower in the South than in the East, Midwest, or West; is highest in districts in which all or many of the students are from low-income or minority backgrounds; and, importantly, is far higher in districts in which there has been "a lot of discussion" than in districts in which there has been "some" or "not much" discussion. The likelihood also is higher in the few districts that have approved a condom program than in districts that don't have a program (Table 8).

Superintendents or their designees in districts in which any discussion has taken place guess that most high school teachers and principals in the district (15%), most community members other than high school students and their parents (13%), most school board members (12%), and most parents of high school students (11%) would favor a condom availability program. However, 44% of superintendents in districts in which discussion has taken place say their high school students would favor such a program (Table 9). Superintendents in larger districts, districts with the largest proportions of low-income and minority students, and especially districts in which there has been "a lot of discussion" about a

**Table 7. Importance of Issues
in the Discussion**

Base: There has been a lot/some/not much discussion about implementing such a program.

Question: The discussion of making condoms available to students through the schools could have been prompted by any number of issues. In your district, how important has (READ EACH ITEM) been as an issue in the discussion—very important, somewhat important, not too important, or not at all important?

	Very important %	Somewhat %	Not too %	Not at all %	Not sure %
Base: 168					
Preventing the spread of the HIV virus and AIDS	66	22	3	3	6
Preventing the spread of STDs other than AIDS	45	38	6	5	6
Preventing teen-age pregnancy	36	37	8	13	5

condom program and districts in which a condom program has been approved generally are more likely than others to say most members of the groups just enumerated favor such a program.

Reasons cited for not having had any discussion about a condom program include the lack of a need for one because there isn't a problem (26% of the 36% who say there hasn't been any discussion), the community is conservative (20%), condom availability is not a concern or an issue (18%), and community opposition (17%) (Table 10).

Table 8. Superintendent's Stated Opinion Regarding Condom Availability Program

Base: There has been a lot/some/not much discussion.

Question: What would you say your (general stated opinion/the general stated opinion of the superintendent of schools) with regard to the issue of making condoms available to students in and through the schools in your district? (Do you/Does he or she) favor, oppose, or have no stated opinion about making condoms available through the schools and in the schools?

	Total	District size			Region			
		Small	Medium	Large	East	South	Midwest	West
Base	168	26	57	85	34	54	37	43
	%	%	%	%	%	%	%	%
Favor	15	3	10	19	24	4	20	18
Oppose	42	67	61	31	27	52	53	39
Has no opinion	34	22	26	38	42	25	27	40
Not sure	9	8	3	11	7	19	—	3

	Lower income students			Minority students		
	All/Many	Some	Few/None	All/Many	Some	Few/None
Base	56	93	14	51	71	43
	%	%	%	%	%	%
Favor	20	12	7	23	9	8
Oppose	30	50	58	21	52	70
Has no opinion	32	36	35	40	33	22
Not sure	18	3	—	15	6	—

— = zero

Table 9. Other Groups' Opinions Regarding a Condom Availability Program

Base: There has been a lot/some/not much discussion.

Question: What would you say the general opinion of most members of each of the following groups is with regard to the issue of making condoms available to students in and through the schools in your district? Do most (READ EACH ITEM) favor, oppose, or have no stated opinion about making condoms available through the schools and in the schools?

	Most favor %	Most oppose %	Most have no stated opinion %	Not sure %
Base: 168				
High school students in your district	44	13	24	19
High school teachers and principals in your district	15	42	26	17
Community members in your district other than high school students and their parents	13	53	18	16
School board members	12	53	25	10
Parents of high school students in your district	11	61	17	10

Few districts that have not approved a condom program have held a public hearing on the issue (12%), and although for the overwhelming majority a formal vote of the school board would be

Table 10. Why Hasn't There Been Discussion?

Base: There has been no discussion.

Question: Why do you think there has been no discussion on this subject?

	Total
Base	127
	%
Don't have the problem/no evidence of need	26
Conservative community	20
Not raised as a concern/not an issue	18
Community/parents opposed to it/public sentiment	17
Religious community	9
We promote abstinence	6
Small/rural community	2
All others	8
Not sure	8

required to approve such a program (93%), even fewer districts (5%) report that a formal vote has occurred or is likely to occur in the next twelve months (only 14% of districts in which a vote has not occurred are even "somewhat likely" to take a vote). The largest districts are most likely to report having held a public hearing and having taken a formal vote. Districts that report "a lot of discussion" about a condom program seem more likely than others to have held a hearing and taken a formal vote, and districts in which "a lot" or even "some" discussion has occurred are more likely to take a formal vote in the next twelve months than districts in

Observation

Again, the findings confirm that concern about the spread of HIV/AIDS prompts discussion of a condom program. But even where discussion has begun, few superintendents favor making condoms available to students or believe that a majority in any major group of stakeholders in the schools, except students, would favor such a program. However, in the handful of districts in which a condom availability program has been approved, most superintendents say they favor the program, and superintendents in those districts are much more likely than average to say most school board members, high school teachers and principals, high school students, and parents favor the program, too. Though it is possible that consensus is reached (or imagined by superintendents) after board approval, these findings suggest that approval is not granted over the stated objections of the superintendent or of any major stakeholder group, and that strong factions in each group favor a condom program by the time the issue reaches intense discussion.

which there has been little or no discussion, according to superintendents.

In virtually all districts that have approved a condom availability program, the school board alone had the authority to give final approval (94%), and a formal vote of the board was required (94%) and taken (94%) as part of the approval process (Table 11).

Other Resources

While only 8% of the nation's middle-school and high-school students are in districts that have an approved condom availability program, as many as 48% are in districts that report

Table 11. How Programs Were Approved

Base: Program approved.

Question: Who had the authority to approve the program for your district—the superintendent, the school board, the health department, parents, or students?

Q: Was a formal vote of the school board required to approve such a program in your district, or not?

Q: Was a formal vote on this issue taken before the condom availability program was approved, or not?

	Total
Base	7
	%
Authority to approve	
School board	94
Superintendent	6
Formal vote required	94
Not required	6
Formal vote taken	94
Not taken	6

having a sex education program and 32% are in districts that report having an HIV/AIDS education program. HIV/AIDS education programs are far more likely to be reported in small districts than in medium-size or large districts, and are somewhat more likely to exist in districts with large proportions of low-income and minority students than in other districts. However, they aren't any more likely than average to be reported in districts whose superintendents view the spread of HIV/AIDS, the spread of other STDs, or student pregnancy as serious problems. Districts in which a condom program has been approved are less likely than others to

report an alternative AIDS education program. Similarly, sex education programs most often are reported in the smallest districts, are less likely than average to exist in districts in which the spread of AIDS and other STDs is considered a serious problem, aren't any more likely than average to exist in districts in which student pregnancies are viewed as a serious problem, and are reported by a far smaller proportion of districts with an approved condom program than by districts that don't have such a program (Table 12).

Few districts routinely refer students from the schools to community family planning agencies (12%), health departments (8%), and health clinics (7%) for condoms or other contraceptives; only 1% refer students to community HIV/AIDS programs, and 59% do not make any referrals to outside agencies for this purpose, according to superintendents. Districts in which the spread of AIDS/HIV is considered serious are about twice as likely as average to report referring students to a community family planning clinic, a health department, or health clinic, and are three times more likely than average to report referring students to a community AIDS program (Table 13).

About one-third of districts report that they have school-based clinics, but only 6% of those that do (or 2% of all districts) make contraceptives other than condoms available to students through the clinics.

Useful Information

Despite the low incidence of approved programs, about two-thirds of the nation's middle- and high-school students are in districts whose superintendents say it would be "very useful" to have data on health risks and disease rates (67%), information on how to assess parent and community attitudes (64%), and legal counsel and guidelines (64%) in developing a condom program. About three in five say the same thing about research data on the effectiveness of condom availability programs in schools (59%) and information on how to evaluate the impact of condom

Table 12. Alternative In-School Programs

Question: What other in-school programs or initiatives, if any, have been approved as an alternative to a condom availability program?

Base	Total 299 %
Sex education program	48
HIV/AIDS education program	32
Family life education program	20
Peer counseling program	15
Health education	7
Abstinence	6
Parent involvement	3
Teen pregnancy program	1
Human growth and development	1
Home economics	*
Other	14
None	24
Not sure	2

*Less than 0.5%

availability programs (58%). Fifty percent say information about how to implement the programs would be "very useful" and more than two in five say the same thing regarding information about the

Table 13. Referrals to Community Programs

Question: Are students in your district routinely referred from the schools to community programs for condoms or other contraceptives, or not?

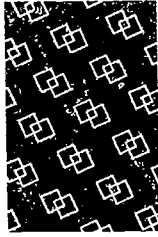
	Total	Very or somewhat serious		
		Spread of HIV/AIDS	Spread of other STDs	Student pregnancies
Base	299	40	73	189
	%	%	%	%
Referrals to:				
Family planning agency	12	22	17	15
Health department	8	19	14	10
Health clinic	7	15	12	8
HIV/AIDS community program	1	3	2	1
Other	8	6	9	7
No	59	32	44	55
Not sure	14	20	16	12

various types of condom availability programs (43%) (Table 14). Districts that have approved a condom program seem more likely than others to say that data on health risks and disease rates, data on the effectiveness of condom availability programs in schools, information on how to evaluate the impact of such programs, and information on how to implement them would be "very useful." Superintendents in districts with the largest proportions of minority students are most likely to find each type of information "very useful."

Table 14. Usefulness of Information

Question: In developing a condom availability program in a school district, do you think that each of the following would be very useful, somewhat useful, or not useful?

	Very useful %	Somewhat useful %	Not useful %	Not sure %
Base: 229				
Data on health risks and disease rates	67	24	7	2
Information on how to assess parent and community attitudes	64	24	10	1
Legal counsel and guidelines	64	22	14	1
Research data on the effectiveness of condom availability programs in schools	59	26	12	2
Information about how to evaluate the impact of condom availability programs	58	26	12	5
Information on how to implement programs	50	32	17	1
Information on various types of condom availability programs	43	34	21	2



THE VIEW FROM SCHOOLS: FOUR FOCUS GROUPS

Brenda Z. Greene
Manager, HIV and AIDS Education
National School Boards Association
Alexandria, Va.

Introduction

The National School Boards Association conducted four focus groups with school board members and school district superintendents to learn about their experiences regarding condom availability in schools. The groups met during the association's annual convention in Orlando, Fla., on April 26–27, 1992, which provided a convenient opportunity for school officials from diverse communities throughout the United States to gather.

The design plan called for the four groups to be constructed so they would meet the following criteria:

Group 1: Urban superintendents from districts with condom availability programs, and/or urban districts with a high incidence of the acquired immune deficiency syndrome (AIDS).

Group 2: Nonurban superintendents randomly selected from communities not including cities represented in Group 1.

Group 3: Urban school board members from districts with condom availability programs and/or urban districts with a high incidence of AIDS.

Group 4: Nonurban school board members randomly selected from communities not including cities represented in Group 3.

Two to three weeks before the convention, telephone invitations were extended to school officials who had preregistered. There was some difficulty recruiting urban superintendents because many of those who were eligible already had committed themselves to too many convention activities. To increase the pool of potential participants, invitations were extended to superintendents from districts in metropolitan areas of cities with a high incidence of AIDS.

Group Demographics

Group 1: Twelve of sixteen invited superintendents from urban areas were present. The group consisted of eleven men and one woman. Districts in Alabama, Illinois, Indiana, Minnesota, New York (two), Ohio, Oklahoma, Oregon, Texas (two), and Washington state were represented. Some were suburban districts adjacent to and part of the metropolitan statistical areas of cities with a high incidence of AIDS. District sizes ranged from 2,000 to 15,000 students.

Group 2: Six of thirteen invited superintendents from nonurban areas were present. This was an all-male group (only 5% of superintendents nationwide are female). Districts in Arizona, Florida, Indiana (two), Missouri, and New Mexico were represented. District sizes ranged from 706 to 12,000 students.

Group 3: Nine of thirteen invited school board members from urban areas were present. The group consisted of four men and five women. Districts in California, Massachusetts, New York (two), Oregon (two), Pennsylvania, Tennessee, and Texas were represented. Some were suburban districts adjacent to and part of the metropolitan statistical areas of cities with a high incidence of AIDS. District sizes ranged from 2,500 to 105,000 students.

Group 4: Ten of thirteen invited school board members from nonurban areas were present. The group consisted of five men and five women. Districts in Alabama, Arizona, Florida, Georgia, Kansas, New York, North Dakota, Ohio, Pennsylvania, and Virginia were represented. District sizes ranged from 800 to 71,000. This group was slightly flawed because board members from two districts—one a small city and one a bedroom community—should have participated in Group 3.

Two districts represented in the focus groups indicated they had a condom distribution program (one a combination vending machine/nurse program and the other a staff volunteer program). One district indicated it had a cooperative program with the district's school-based clinics.

Limitations

This report describes research based on a qualitative method. It does not represent the experiences, attitudes, and opinions of superintendents or school board members who didn't participate. The report cannot be used to demonstrate what percentage of superintendents or school board members in general hold the same opinions.

Themes

The four discussions had more commonalities than differences. For example, all groups discussed factors related to community opposition, the appropriate role and responsibility of schools, and what it would take to motivate a community to address the issue of condom availability. The major exception was the urban board members (Group 3), who generally were more supportive than the other groups of school involvement in making condoms available to students. The reason for this may have been the presence in Group 3 of representatives from three districts that have condom availability programs, and greater acknowledgement

by these participants that sexually active adolescents are at risk of a life-threatening disease.

Three themes emerged from the discussions:

1. Schools and school officials are unlikely to be the primary leaders of school involvement in condom availability programs.
2. Under certain conditions, schools would be willing to play at least a supportive or ancillary role in developing and operating condom availability programs.
3. Districts that have condom availability programs can share successful strategies for community support and program development.

Schools Are Unlikely to be Primary Leaders

Several discussion themes support the conclusion that schools and school officials are unlikely to be the primary leaders for school involvement in condom availability programs.

The Mission of Schools. Schools avoid involvement in condom availability primarily because it is not considered to be part of the traditional mission of schools. Nor is it on the nation's current education agenda. Some participants, particularly those from nonurban areas, expressed resentment that schools are being asked to take on responsibilities beyond education while being criticized for failing to educate students adequately. Two comments were: "We need to be devoting more time to education, not so much to other issues" and "Well, there are just so many resources available. The principal has so many things to do. A teacher has so many things to do. You can't really expect them to do everything and still expect them to have the energy left to deal with the educational problems."

Most participants said families are primarily responsible for instilling a moral foundation in youth and, when necessary, making sure that sexually active teens have access to protection. However, participants acknowledged that many families are unable

or unwilling to fulfill that responsibility. One commented that "We may be the best parents many kids know."

Instead, there is a continuing and perhaps increasing reliance on schools to take on the role of parent. Participants said this reliance interferes with schools' ability to achieve their educational goals. Several participants, particularly superintendents, suggested that a more appropriate role for schools is to help parents be better parents by teaching parenting skills and referring families to services outside the schools. "If the parents of today aren't doing good," said one official, "then the parents of tomorrow aren't going to have a good time of it either. That frightens me. We have to get back to what parenting is all about."

Regarding the prevention of teen pregnancy and infection by the human immunodeficiency virus (HIV), participants saw classroom education as the primary role of schools. They have accepted that responsibility. Participants said most schools have an extensive—even excellent—sex education or AIDS education program in place that deals with condom use. Abstinence is the primary goal—and sometimes the only goal—of the programs described. Some expressed the belief that there should not be a condom availability program without a strong educational program in place. One comment was, "I don't think it is the educational mission of the school to do anything other than...educate about abstinence." Another participant said, "I'm not...opposed to a teacher, a banana, a condom, and all of that. I just don't think we ought to be the vehicles that...distribute [condoms]."

Self-Interest. The actions of school officials regarding condom availability reflect their perception of the community's values and desires. Moreover, school officials may be unwilling to test the validity of their perceptions because of self-interest—namely, job

Schools avoid involvement in condom availability primarily because it is not considered to be part of the traditional mission of schools.

One of the participants' major objections to condom availability programs was that they would directly conflict with the objectives of approved curricula and community morals.

security. Most superintendents and board members see the issue of condom availability as political suicide. To get the issue on the agenda, it must be perceived as "politically safe." Until communities demand or the government mandates condom availability programs,

school officials will be hard-pressed to support them. One participant predicted that the community "would rise up. We would have six new board members almost immediately if the board members voted to provide condoms within the high school." Said another, "Not that we don't have the guts. We just don't like to see our guts out there being exposed because we took the step, and then all of a sudden we're the fall guy...." A third participant said, "The reason we don't talk about [a condom availability program] is that most of us want to continue to live [in the community]."

Most participants had "war stories" to share about community opposition to sex education and AIDS education. They agreed that the controversy surrounding condom availability would be as disruptive as those experiences, if not more so.

In general, groups opposed to condom availability programs represent various churches, cultures, and organizations. School officials from the Bible Belt region mentioned this anticipated community opposition more often than those from the East and West coasts. While some recognize that opposing voices often represent much less than a majority of the community, nevertheless the voices are considered vocal and extremely influential.

Mixed Message. One of the participants' major objections to condom availability programs was that the programs would directly conflict with the objectives of approved curricula and community morals. For example, making condoms available would conflict with the abstinence-based or abstinence-only

educational programs that are in place. Also, distributing condoms might encourage youngsters to have sex, thus putting them at risk for disease or pregnancy, which would be immoral. Some participants expressed these concerns as a personal belief and as an expectation of what they would hear from their communities. Most were not confident they could overcome such attitudes. "The whole purpose of their [the school board's] program is to discourage sexual activity, and they feel like [a condom availability program] would be encouragement," commented one official. Said another, "Parents are saying condoms promote sexual activity."

On the other hand, several participants said it is important to deal with reality—that adolescents are sexually active. These participants described condom availability as a health promotion issue. Mostly urban school officials and women held this view. Two comments were, "...we keep telling our kids to abstain, and kids just laugh in our face and go on doing it"; "I'm not sure you can get a sexually active ninth-, tenth-, eleventh-, [or] twelfth-grader to stop. You can try to instruct on the use of safe sex."

Legal Issues. Several participants raised concerns about the legal ramifications of schools making condoms available to students. School officials were aware that they probably would be sued if they implemented a condom availability program. The potential outcome of the suit was less important in some cases than the expenditure of time and money in response to litigation.

Discussion of legal issues centered on liability for product failure. (Interestingly, in early June one of the represented districts was sued by a group of parents and students who argued that the district's condom availability program aided and abetted a crime—sex involving minors—and deprived parents of the right to raise their children as they see fit.) "I see it as a liability issue," said a participant. "We are constantly being sued for anything and everything. About the time we start passing out condoms, a kid [will get] infected or a child [will get] pregnant...It's going to be our fault because we promoted it." Another comment was, "Let me point out the risk factors of condoms from a legal liability stand-

point. Are you going to stand and be the deep pocket? The manufacturer is going to be the first and the issuer is going to be the second deepest pocket." One participant expanded the legal issue by noting, "If it [condom availability] was mandated by the state, my school board would sue the state."

Condom Effectiveness. Participants didn't agree on whether condoms are even a viable option for preventing HIV infection, other sexually transmitted diseases (STDs), and pregnancy. Their comments revealed knowledge as well as misinformation about the effectiveness of condoms, both as a reliable disease- or pregnancy-prevention device and as a device that sexually active teens would use consistently and correctly. The concern about efficacy of condoms relates to the legal liability issue. Here are some comments: "In most cases, they [condoms] don't prevent AIDS"; "I guess that I couldn't be honest and tell you that I am real familiar with their success rate"; "Maybe we really need to talk to some of the kids in the inner cities...where condom distribution is taking place [to find out] whether or not they are really even using [condoms]."

Existing Availability of Condoms. There was disagreement regarding the availability of condoms. Several participants suggested that condoms are available to adolescents at drugstores, supermarkets, gas stations, and elsewhere, and, therefore, there isn't any need to make them available at school. One comment was, "You don't have to ask for them. They're on the counter everywhere."

Others acknowledged that obtaining condoms is challenging—that even adults are embarrassed to purchase them.

Schools May Be Willing to Be Involved

School officials see condom availability programs as a long-term possibility. Particularly in nonurban areas, they don't expect HIV infection to become such a critical concern in the near future that it would require their involvement. Board members anticipate

that superintendents will bring the issue to them when appropriate. Superintendents seem to believe that board members will take the lead role when necessary. Regardless of who takes the first step, school officials don't see themselves as the primary leaders in any movement toward condom availability programs. However, they can identify factors that would cause them to be involved in a supportive or ancillary manner.

Regardless of whether their schools have condom availability programs, school officials agree that health officials must take the lead in building support for and operating programs.

Leadership by Health Officials. Regardless of whether their schools have condom availability programs, school officials agree that health officials must take the lead in building support for and operating programs. Schools would cooperate with health agencies if there were community support: many said this already is happening to some extent. "The question is not really if it is the schools' responsibility," said one participant. "We are caught up in a lot of things that I don't feel are our jobs or responsibilities because nobody else is doing it. But there is another agency that can handle [condom programs]." Commented another, "Why is it a school problem? Are kids having sex in school? Are they having sex in the study halls, the library, corridors? If this is a home problem, a problem when they are not in school, why isn't it addressed through the clinics?" One official pointed out that, "Although many of us have had nurses and health care within the schools, when you come right down to it, we don't know a great deal about supervising health care. That's not our training, our background."

Officials said health agencies are the primary source of funds for condom availability programs. There was acknowledgement that funding challenges might be used as an excuse not to move forward.

Evidence of Need for Program. Before school officials and community members will get involved in a condom availability program, they must be convinced that there is a critical need for such a program.

There was general agreement that direct evidence of HIV infection—or, more specifically, an AIDS-related death—in the high school would motivate them to take action. The attitude expressed was that such an occurrence would engender community support for a program and thereby enable schools to be involved in making condoms available. Said one participant, “I think when we start seeing kids [in] the upper middle school and high school dying of HIV, then there is going to be a national call or a call within a geographical region of that state. But until that occurs, there is no reason why any of us should go out and say, ‘Let’s start distributing condoms today.’”

Several participants acknowledged that they probably won’t witness many school-age youngsters dying of HIV-related causes because of the length of time before symptoms appear. They indicated they support current efforts by health officials to report data on STDs and pregnancies that demonstrate the risks adolescents are taking and that prompt appropriate action by communities. “Some of us will put our foot into the water a lot sooner than others,” one official said, “but it has got to be an issue...the public really feels a need [to resolve]. It will take some time.”

Successful Strategies

During the discussion, participants, such as board members from a district that provides condoms through its school-based health clinics, had an opportunity to share information about successful strategies and ideas for building community support and developing programs.

First, they advised, relevant information needs to be provided continuously to key leaders. “The most powerful thing told me by one of the health nurses,” a school board member recalled, “was that she had treated six young women for chlamydia, a

sexually transmitted disease, in two weeks. They then went with [the women's] sexual contacts and did a history of sexual contacts the young men had had. Eighty-two sexual contacts had been made—a ripple effect—from six girls. Assuming that at least one of those might be HIV positive, that finally hit me.”

Second, survey the community to assess the levels of support and opposition. Avoid relying only on public hearings, during which a minority viewpoint can gain visibility beyond its merits. One participant reported that, “In [our community], rather than using public hearings for citizen input, we did polling very carefully schemed to diffuse what we had when we opened our teen clinics—a mass of nuts coming in and making a big noise.”

Third, plan to build momentum over time by using a variety of tools, such as community polls, news media, and a citizen hot line. “You just got to get the community to buy into it, let them think it was their idea, and let them bring it to you and work jointly to handle it,” advised one participant.

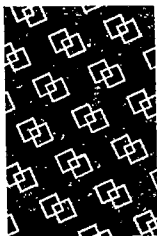
Other suggestions were to:

- Involve other entities, such as drugstores, supermarkets, and, without question, the health department, in making condoms more available.
- Build on the self-interest of health care providers and health insurance companies by involving them in developing programs.
- Avoid using the word “clinic,” a red flag in that it connotes contraceptive services.
- Sell health care, not condoms.

Summary

The way school officials approach the issue of condom availability undoubtedly varies among communities. Many factors influence a community's interest, readiness, and ability to make condom availability a priority. These include:

- Evidence that adolescents are engaging in behaviors that put them at risk of HIV infection, other STDs, or pregnancy, and the belief that a condom availability program will help adolescents reduce these risks.
- Evidence that most of the community will support a condom availability program as a health promotion/disease prevention tool despite conflicting personal or community values.
- Visible leadership from public health officials, health care providers, and others, including the religious, business, and parent communities.
- Belief that latex condoms are effective as disease- and/or pregnancy-prevention devices.
- Knowledge of the successes and failures of programs elsewhere, particularly in similar communities.



FUNDING AND POLICY OPTIONS

Claire D. Brindis, Dr. P.H.

Co-director,

Center for Reproductive Health Policy Research

Institute for Health Policy Studies

Associate Adjunct Professor,

Division of Adolescent Medicine

University of California, San Francisco

Introduction

The relatively new but increasing focus on the worrisome risk of the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) that American adolescents face, as well as older concerns regarding adolescent pregnancy and sexually transmitted diseases (STDs), have prompted an increasing number of communities to consider implementing innovative condom availability programs. This raises several important public policy questions, including how to financially sustain such efforts consistently over time. Although there are a number of potential funding sources for these programs, financial support for school-based condom availability programs clearly will require a reallocation of existing resources; it is difficult to generate funds for new programs—especially somewhat controversial ones, like condom availability. This shift will challenge existing policy priorities, and program sponsors and their supporters will need public support before the programs can be established.

Major cost factors come into play when considering what level of service to provide. What staff and support resources are necessary to ensure that a condom distribution program is developmentally appropriate? Will the program include educational and individual counseling? Will referrals to outside agencies be provided along with condoms? The level of training for individuals who provide on-site condom-distribution services also will affect costs and the appropriate choice of funding channels. Depending on the type of program, the make-up of staffs will range from medical providers to trained volunteers. Whether the same staff members will be involved each time a student returns for a supply of condoms can affect costs as well.

Underlying these and other decisions is the question of school and community commitment to using readily available channels for reaching at-risk populations to provide comprehensive and reinforcing education. An important factor in developing and paying for school-based condom availability programs is a strong educational component that provides the rationale for condom use, strengthens good decision-making skills, and ensures the most effective possible use of the contraceptive. The component should include education about abstinence, particularly for students who may have entered sexual relations because of peer pressure and who may need support in examining or re-examining their sexual decision-making. It also should include support and skills related to improving interpersonal relationships and strengthening communication with partners. Finally, education and counseling can connect young people with other community resources.

Current programs range from the purely informal, wherein teachers keep supplies of condoms in a desk drawer, to programs that are formally sponsored and delivered by school district staff. Some reflect strong collaboration among schools and a number of community agencies, with a special role for local health departments and other health agencies. About 300 schools in the United States have on-site health centers, 11% of which incorporate some

kind of condom program.¹ The types of services and the degree of emphasis on each service varies as much as the type of sponsorship. Although prescriptions or clinical treatment are not required before condoms can be dispensed, education and counseling support for the continued and consistent use of condoms are essential. Many

support services do not qualify for reimbursement from federal and state health care programs and other funding sources.²

Although these components can add substantial costs to condom availability programs, compared with programs that merely make condoms available through vending machines or other school sources, most health professionals and educators recognize that the programs should not stand alone. Rather, they are an opportunity to provide valuable information and support to youth, and to connect them to other resources they may need. The hypothesis is that such services substantially enhance compliance. Evaluation of different delivery models is necessary to ascertain which approach is most effective for which adolescent groups.

Communities may identify a number of ways to minimize anticipated costs, depending on the number of existing school-based or school-linked programs and activities already available in the community, and on the range of services to be provided. The least expense would be incurred by giving responsibility for the program to an existing staff member—for example, a family-life education teacher or a school nurse—and devoting most other funds primarily to training staff and purchasing condoms. Grafting a program onto an existing structure can help increase its acceptability and the likelihood that this hybrid model can be maintained. Furthermore, collaboration with various community agencies and their funding

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resources helps ensure a reasonable sharing of costs. The greatest expenses are incurred when the program is an entirely new venture that, in addition to basic start-up costs, entails developing an administrative structure and hiring and training new staff members.

Communities must look beyond such costs and consider the value implied by social endorsement of these school-centered efforts. By making condoms more readily accessible in a psychologically comfortable context, such programs reflect society's commitment to protecting future generations. Encouraging young people to use condoms responsibly is a valuable and effective investment of resources. However, school-linked programs should be only one part of a multipronged, community-wide effort to change social norms regarding responsible sexual behavior.

Rules that May Affect Public Funding

Making condoms available on high school campuses may complement existing educational programs focusing on health, STDs, HIV/AIDS, and pregnancy prevention. Given the relatively minor cost of bulk purchases of condoms (as little as five cents to seven cents apiece), the most expedient way to make condoms available is to put them in fishbowls or other readily accessible places, such as a desk drawer, that don't require documentation by or identification of students. However, health providers, educators, and researchers hypothesize that the most effective approach is to dovetail distribution efforts with education programs focusing on HIV/AIDS and family life, and with existing, school-based health centers. Adding a condom availability component to these programs depends on two factors: the willingness of policy makers to expand the range of services they support, and a reconfigured staff to educate and counsel young clients individually or as a group. Health education videos showing the

proper use of condoms might enable staff to focus more on individual counseling. But to ensure the long-term survival of condom distribution programs, the following changes must be considered.

Clarifying and Establishing Policies on Use of Available Funds

Federal Regulations and Policies. There are a number of potential funding sources, such as the federal Public Health Title X and the federal Centers for Disease Control (CDC), that allocate HIV/AIDS monies. Changes in policy interpretations by these sources would be required, however, and additional funds will be needed to respond to requests for program expansion. Though using Title X dollars to fund condom availability programs isn't expressly prohibited (health providers have some discretion in how they spend these funds at the local level), in practice there is very little support from managers of funding streams for expending such funds on school-based family planning, unless the planning focuses exclusively on abstinence. Given that school-based health clinics have been allowed to use these funds only in a very limited way, either formally or informally, for the comprehensive family planning services they provide, the previous White House administration did not favor any attempt to allocate such funds for condoms. Although the Clinton Administration is in its infancy, its overall support of family planning services, AIDS prevention, and greater access to adolescents of preventive services means significant changes in policy may well be anticipated in this area. However, funding considerations and constraints may require a careful re-examination of existing funding sources to support condom distribution programs. The effort in this regard certainly is far more promising in the current climate than in the two previous administrations.

Any attempt to use Title X funds to finance condom availability programs raises several issues that can be resolved only through special waivers to the original legislation. First, clients

must have access to a comprehensive array of family planning services and contraceptive methods, with sufficient education and counseling to support their choice of methods. The narrow focus of condom availability programs immediately places them at odds with the original intent of Title X. Second, if condom availability is approached primarily as a public health measure to prevent the spread of STDs (including HIV) rather than as a direct family planning strategy, then use of Title X dollars is not appropriate under existing regulations. Third, using limited Title X family planning dollars for condom availability programs may be difficult to justify because family planning clinics already are pressed just to maintain their existing programs. Between 1980 and 1990, total public expenditures for family planning (adjusted for inflation) declined by one-third. Therefore, unless more Title X funds are allocated, it will be important for the federal government to establish policies that justify spending this money on condom availability, beyond community-based programs that serve women at risk of pregnancy (the current level of funding is sufficient to serve only about one-third of all women and men who qualify for subsidized family planning). One potential way to circumvent these obstacles is to consider using Title X funds to sustain only specific components of the condom availability program while paying for supplies by other means. Legitimate uses of Title X money include outreach, prevention education, counseling, and referral efforts. Other funds can be used to purchase condoms.

Three other federal programs provide funding for family planning services: Medicaid, the Maternal and Child Health Block Grant, and the Social Services Block Grant. As with Title X, written policies do not proscribe using these funds to support school-based condom availability programs, but again, because aid is limited, there must be a sound and persuasive rationale to justify the priority that school-based condom availability programs will require amid other prevention education, outreach, and service priorities.

Another source for school-based condom availability programs is federal funds that support HIV/AIDS and STD prevention. Again, clear policy statements and direction are necessary to ensure that school-based programs can be established. Even within one funding agency, there may be conflicting policies that govern use of funds. For example, the Division of Adolescent and School Health at the CDC provides national funding for school-based AIDS education. This program does not formally allow funds to be spent on condoms, although funds conceivably could be used to support staff members who provide education that reinforces messages generated by a school-based condom availability program. However, state offices of AIDS and state and local health departments might use other STD and AIDS-related funds from the CDC to support condom availability programs. States have a substantial and often flexible role in deciding how these funds are to be allocated at the local level.

Establishing Policies for Staff and Funding Reallocation and Redistribution

To maximize available funds, significant policy changes are necessary to recruit personnel and marshal existing staff for condom availability programs. Such issues as allocating staff time, assigning specific roles and responsibilities, and setting training requirements must be considered. School health programs typically cannot pay the salaries that attract physicians, so they rely heavily on midlevel practitioners and registered nurses to provide care, with back-up support from physicians employed by health departments, hospitals, and community health centers. Such an arrangement creates two kinds of problems. First, in some states, school nurses historically have been constrained by school-board directives and nurse-practice statutes from providing important health services. Changes in these policies may be appropriate. Second, restrictive Medicaid policies for payment to practitioners who aren't physicians have made it difficult for school health programs to bill for services. Although provisions of the Omnibus

Health departments may need to take the initiative by providing training and technical assistance in developing programs, and by supplying condoms.

Budget Reconciliation Act of 1989 authorized Medicaid payments to family and pediatric nurse practitioners, the new policy has not been formally evaluated; whether changes in reimbursement have contributed to an expanded role for midlevel providers and nurses is unclear.³

Collaborative programs between schools and other community providers require that explicit management priorities be established. Health departments may need to take the initiative by providing training and technical assistance in developing programs, and by supplying condoms. In many districts, school nurses may be available to staff condom distribution programs. Redeploying these nurses would be timely and appropriate, as many of them perform traditional, often state-mandated functions—immunization record-checking, mass screenings, and administrative work, for example—that in some cases non-nursing staff could handle. Many school districts have significantly pared nursing positions because of budget cuts, and have hired health aides to complete monitoring and other tasks that nurses formerly performed. Any reallocation plan must also consider whether the school nurse is interested in and committed to playing this new role, and take into account the training that would be necessary to enhance the nurse's comfort in discussing and dispensing condoms to young clients. If the nurse is to do more than organize health screenings and health promotion and disease prevention activities—that is, provide individual health education and counseling (including education and counseling regarding condom use), provide emergency first aid, and refer children with health problems to community health care providers for further diagnosis and treatment—a change in mandate will be necessary. So will additional budgetary support to sustain this expanded role. Perhaps even more importantly, nurses

and health educators must garner sufficient recognition for their "stand alone" educational and counseling services so these services qualify for reimbursement separate from reimbursement for clinical skills. Finally, nurses who accept this expanded role must be able to advocate the importance and value of providing outreach, prevention education, and counseling along with their other responsibilities.

Reallocation of school and health care staff is one way to integrate condom programs into existing health care or health education programs. Marginal expenses—the purchase of condoms plus the cost of the condoms themselves—can be relatively low if the condom program is integrated with existing programs. With appropriate training, teachers and school counselors also can be tapped to run condom availability programs. In such cases, teachers not only educate youth about condoms but also provide individual counseling and make condoms available. Schools that choose not to provide these services directly have another option: They can help station health educators, counselors from STD and family planning clinics, and other health staff at school-based sites.

Coordinating and Combining Professional Resources and Funding Streams

Although there is increasing interest at the federal, state, and local levels in improving collaboration and coordination among departments and programs, many professionals are to some extent unaware of activities at parallel agencies or at other levels. Given limited resources, this situation creates great potential for duplication of and gaps in services. Barriers to collaboration are diverse, ranging from categorical funding constraints in congressional legislation and the lack of a consistent definition of adolescence to disagreement among agencies about how to improve the health of adolescents, the lack of compelling incentives for youth to cooperate, and a lack of leadership on adolescent issues. Thus far, there aren't any incentives or rewards at the federal level to encourage

collaboration among agencies, and a mechanism for sharing information has not been established. In some states, relatively new efforts have been made to improve coordination. At the community level, grass-roots attempts to create collaborative relationships between schools and community agencies and between adolescents and their families appear to be developing successfully as more institutions recognize that individually they are unable to adequately respond to the complex psychosocial and health problems affecting adolescents.

While coordination may not necessarily identify new or additional funds for condom availability programs, increased collaboration may contribute to the development of joint projects with shared funds from several sources. For example, one source might pay the health education staff, another might fund technical assistance and consultation, and a third source might pay for supplies. A number of existing condom availability programs, including those operating in schools in New York City and Philadelphia, are structured this way. Sharing the economic burden greatly facilitates the development of joint programs; it not only extends and leverages available funding and resources but also improves coordination of services. For example, while one agency may provide funding for developing and printing an educational brochure on condom use, another agency may be able to purchase condoms at a reduced rate and a third agency can distribute the educational materials and the condoms. Staff representatives from each agency meet regularly to plan and participate in cross-agency training. They also monitor the progress of a project as it is implemented.

Maximizing Available Resources. Increasingly, school districts are opening their doors to community health-education resources, and they are using multiple funding bases to support internal, district-sponsored, health-education efforts. An examination of health education programs at a number of schools clearly shows that problem areas often receive special attention. A careful needs assessment to identify resources and gaps can help commu-

nities identify potential consolidations that won't weaken educational efforts. In maximizing available resources, some funds may be reallocated for alternative efforts, including condom availability programs. In New York City, for example, health education programs

It is important to make condoms available through channels other than health care providers, because students may shy away from direct contact with providers.

are dispersed throughout the central school system. One division is responsible for alcohol and drug education while other, distinctly separate divisions are each responsible for HIV/AIDS, teen-pregnancy prevention, and sex education and family living. Officials are re-examining health education programs to provide a coordinated system, eliminate duplication, and establish links among related subject areas. They anticipate that this process will make funds available to defray the costs of operating the condom availability program.

Because the funding source is a principal factor that often determines the type and frequency of health services youth seek and receive, a nominal user fee is an option that can help defray the costs of condoms, especially when existing resources help pay for staff. While students need not be denied services because of inability to pay, most adolescents can afford condoms sold at a reduced price.

It is important to make condoms available through channels other than health care providers, because students may shy away from direct contact with providers. Vending machines in restrooms that dispense condoms at a significantly reduced price (cost is an important factor in the success of such machines) can be an important supplemental source. Small pamphlets or instruction cards accompanying the condoms can reinforce classroom education. Schools must explore ways to minimize vandalism of vending machines and should consider other availability points for free or

low-cost condoms, such as the school nurse's office. Installing machines on campus requires the consensus of school administrators, teachers, parents, and students.

Expanding Existing School-based Health and Social Services. School-based or school-linked health centers provide a potential opportunity for implementing or expanding condom availability programs. The number of such centers still is relatively small, but many communities are attempting to launch them.¹ Fewer than 20% of these programs dispense condoms and/or other contraceptives. Communities that already sponsor school-centered clinics are likely candidates for condom availability programs. Strengthening HIV/AIDS prevention efforts at these sites, including the provision of condoms, can be assessed.

A major factor that inhibits expansion of school-based centers is the lack of available funding; clinics have had limited success instituting the extensive billing systems that are necessary to obtain reimbursement.

Medicaid is a potentially important funding source for condom availability programs at school-based clinics. The largest Medicaid barriers are (1) students not knowing if their families are eligible for Medicaid; (2) the costs and paperwork associated with billing Medicaid; (3) the refusal by some state Medicaid offices to pay for school-based clinic services; and (4) confidentiality issues, such as securing parental consent to use Medicaid benefits, with the exception of funding for the provision of sensitive services,² like those for pregnancy and pregnancy prevention, drug use, and mental health counseling without parental consent. In addition, it is important to find ways to obtain reimbursement for components of the program, such as prevention education, outreach, and counseling, that traditionally are not reimbursed unless they are directly connected to clinical services. Reimbursement for outreach is particularly valid because outreach is indispensable in attracting adolescents to other primary care services.

States must identify and examine these Medicaid barriers. They also must consider whether Medicaid funding for con-

dom availability programs need be linked directly to medical visits.

Data collected at school-based centers in California indicate that 15% to 30% of all students who use these centers are also enrolled in a health maintenance organization (HMO), although these students tend to rely on the school clinic primarily for mental health services, which often are difficult to obtain through many HMOs.⁵ Because of the supplemental services that school-based centers provide, HMOs should give the clinics partial support or in-kind contributions, including supplies such as condoms.

Model Programs and Their Funding Streams

The seven condom availability programs described below illustrate the variety of funding and personnel resources. The type of program to be implemented—whether it is one aspect of a comprehensive framework of medical services, for example, or consists of counseling-only programs—often depends on what is politically acceptable in the community. Factors affecting the cost of such programs include:

- How and where condoms are purchased (discounts may be available through bulk purchases) and how they are distributed (for example, by means of vending machines).
- The training and education of staff teachers or counselors, or of community-agency staff who will be stationed on the school campus.
- The training of new staff if school health programs aren't already in place.
- Other health education efforts on campus, whether they receive support from the school district or other community resources.
- The space, either existing or new, for educating and counseling.

- The legal advice necessary to protect school districts when they establish a program.
- Educational materials and resources, such as videotape players.
- The level of continuity and follow-up necessary to ensure students use condoms appropriately and consistently over time.
- Research on condom availability programs to learn which models are most effective.

New York, N.Y.

Condom availability programs in New York City have evolved as an integrated part of the school district's AIDS education. The New York City School District is the largest in the country. In 1991, Chancellor Joseph Fernandez presented to the board of education a comprehensive plan to expand and improve the HIV/AIDS education program in response to statistics showing that New York City teen-agers were at high risk of HIV infection. The expanded HIV/AIDS education program encompasses:

- A comprehensive K-12 HIV/AIDS curriculum that includes the latest information on HIV-infection as well as prevention strategies.
- At least five instruction sessions per grade level in grades K-6, and six sessions per grade level in grades 7-12.
- In every high school, HIV/AIDS education teams that include parents, students, and faculty.
- The distribution of condoms at high schools.

The K-6 curriculum was adopted only after nearly a year of debate and discussion. The minimum curriculum for these grades has not been set, though soon the educational program is likely to become mandatory rather than recommended, as it is now. Condoms are available on a confidential basis to any student who requests them; parental consent is not necessary. Trained volunteer staff members make condoms available at health resource sites in the high schools, and provide counseling and referrals to other

services upon request. Because students need not receive counseling to obtain condoms, program costs are probably lower than they would be if counseling were mandatory.

The condom availability program is funded in part by contributions from outside organizations, including Carter-Wallace (makers of Trojan condoms) and Schmid Laboratories (Ramses condoms), who donate condoms. Carter-Wallace also has provided a \$100,000 grant to launch a small-grants program for student-developed HIV/AIDS projects. Private foundations, such as the Diamond Foundation, provide funds for the HIV/AIDS Technical Assistance Project. The project consists of six HIV/AIDS clinical experts who help train school-based teams and help fully implement high school projects. Schools provide in-kind contributions, including space and maintenance of the health resource centers. The New York City Department of Health provides additional resources, including education pamphlets and other written materials, technical assistance, and training. Public funds totaling \$815,000 support central-office health staff who work exclusively on HIV/AIDS. However, costs exceed this sum, so the program also relies on private and in-kind contributions from such entities as the New York City Department of Health, the New York State AIDS Institute (part of the New York State Department of Health), the New York State Education Department, the American Foundation for AIDS Research, and other community-based organizations that work on HIV and adolescent health issues. Medical schools and hospitals near some of the high schools provide in-kind contributions by "adopting" a school; they serve as health advocates on campus, provide technical assistance, and help train staff.

Santa Monica, Calif.

The condom availability program in Santa Monica began in April 1992 and is funded by school district general funds. The program, supervised by the school nurse, costs only about \$1,600 a year, primarily for the purchase of condoms (sold for eight cents

each by Carter-Wallace) and the printing of educational materials. Condoms are available to students in grades nine through twelve. Education covers the appropriate use of condoms and resources for more information on HIV testing, AIDS, STDs, and pregnancy prevention. Trained staff and peer counselors are available through the program, though counseling is not a requirement to receive condoms. The program costs relatively little because it is part of staff activities and is built into an existing expense.

Los Angeles, Calif.

The school board in Los Angeles recently approved a policy to establish condom availability programs in the schools. At three high schools, the program works with school-based health centers that have been dispensing all types of contraceptives since 1987. Initial costs of \$600 have supported the purchase of 15,000 condoms. Two condoms are distributed per request. The Los Angeles Health Department provides in-kind support for program start-up, training of staff, and technical assistance. Passive parental consent is required for participation. With the aid of school nurses, each school is developing an implementation committee to help conduct the program.

San Francisco, Calif.

The San Francisco Unified School District and the AIDS Office in the San Francisco City and County Health Department are working together to make condoms available in each of the city's seventeen high schools. Each district school has been paired with a private health care agency that will provide in-kind services by distributing condoms on high school campuses.* The only funding allocated for the program is \$10,000, which the AIDS Office is providing for the purchase of condoms. One teacher at

*Staff from these agencies will provide information on the school campus regarding how to reduce personal risk to exposure to HIV infection and other STDs. Information topics will include the choice of abstinence and the failure of condoms.

each high school will receive eighteen hours of overtime to oversee the program; the city's school superintendent office will pay the overtime as in-kind support.

Before the program is instituted in the schools beginning March 1, 1993, each school will sponsor a parent information meeting. While services to students will be confidential, parents will have the option of requesting that students not participate in the program. After an initial information and counseling session, students will be able to receive additional condoms over time. Referrals to care, such as health, substance abuse, and counseling, also will be made available to students. An evaluation component will document the numbers of students receiving condoms, but it will not track individual students over time, as tracking would require additional written consent of parents or guardians.

Chicago, Ill.

Although Chicago schools do not have an entire condom availability program, there is HIV/AIDS education and initial exposure of students to the availability of condoms, funded by a number of channels. Federal dollars through the CDC help support HIV/AIDS education, which Illinois requires for grades six through twelve. Funding from the state Office of Health Education supplements the federally funded curriculum. The Office of Health Education offers condoms to schools that request HIV/AIDS education, but individual schools must decide whether to distribute condoms and how to implement a program. Health educators normally bring condoms to distribute to students at health or Reserve Officer Training Corps classes. Additionally, the Office of Health Education provides movies on HIV/AIDS and condom demonstrations to every physical education and health education department in the Chicago schools.

Chicago also has four school-based health clinics; contraceptives are available at three. These clinics are funded by the private Harris Foundation and the Chicago Department of Public Health. Also under consideration is a condom availability program in the schools that would receive some of the \$25 million that Cook

County Hospital received from the Ryan White Foundation for the AIDS Center of Excellence.

Commerce City, Colo.

The oldest documented condom availability program in the country was implemented in 1989 and operates at two schools. It trains 20 staff members who are on campus. The school district pays for training, but staff members volunteer their time. The Colorado Health Department receives money from the HIV Prevention Program funded by the CDC Center for Prevention Services. Condoms are provided by the State Health Department through its funding of Commerce City Community Health Services, a community-based, nonprofit organization that is under contract with the school district to furnish the services of school nurses, who distribute condoms. The Colorado Department of Education also receives CDC funds to provide AIDS education to children and youth. Students receive up to five condoms per request, and can make as many follow-up requests as they desire; schools provide 500 to 700 condoms per year. Additional funding comes from the Commerce City School District Committee on AIDS Education. No school district funds can be used for condoms, but funds that pay for staff development can be applied to training costs, and educational materials are paid for with the school board's special purchase funds. Parents may choose not to allow their children to participate in the program.

Philadelphia, Pa.

Philadelphia's condom availability program is a collaborative effort of the school district, the city's Department of Public Health, the Family Planning Council of Southeast Pennsylvania, and community health centers and hospitals in the city. Nine schools have a program. In seven, health resource centers were created to provide students with education, referrals to health and other community agencies as needed, and condoms. The centers are managed by health care providers who offer a range of services to adolescents. Health educators staff the centers and a physician

supervises the activities of each. The annual operating cost of each center is about \$30,000. At two schools, the school-based health center provides students with education and condoms, along with other health services.

The oldest documented condom availability program in the country was implemented in 1989 and operates at two schools.

All staff members and funding sources address training needs and discuss service delivery. Eventually, all forty of Philadelphia's public high schools will participate in the program.

Funding for these services comes from a number of sources. One is the Family Planning Council, which taps Title X and Health Resource and Services Administration (HRSA) monies and covers the operational costs of five of the health providers. One provider has received aid from the Private Industry Council, and a community health center uses its own Federal 330 Community Health Center funds. The Philadelphia Department of Public Health, using monies that originated at the CDC, has provided \$60,000 to purchase educational materials and 500,000 condoms for all of the centers.

Lessons Learned

As the programs operating in New York City, Philadelphia, and other cities demonstrate, creative combinations and use of existing resources and personnel can spawn innovative programs. Still, it is important to identify additional funding mechanisms to sustain and replicate these pioneering efforts, and to provide communities with the necessary leadership, policy formulation, and technical help.

The experience of school-based health clinics consistently has shown that a mix of financial resources is needed to sustain programs, even though this multiplicity creates a patchwork of administrative challenges that places an extra burden on staff. The

multiple sources that typically finance school health programs include state and local education agencies, maternal- and child-health block grants, foundations, and third-party public payers, such as Medicaid.

Most school-based clinics around the country are making a major effort to establish reliable, continuous billing mechanisms. These mechanisms are a particularly important part of condom availability programs when schools require that a health professional provide the education and counseling. Models with other kinds of staffing necessitate other models of reimbursement. Many clinics are discovering that by having a Medicaid eligibility clerk on site for a certain number of hours each week (with school-clinic staff handling much of the necessary paper work), more students can be enrolled in Medicaid. Clinics operated by community health centers and hospitals have been most successful in establishing billing channels, although the level of reimbursement remains far below the level needed to fully sustain school-based health centers. Therefore, at least partial reliance on private foundation support still is the norm.

When schools consider the potential use of Medicaid funding to support condom distribution programs, they must be aware of the "patient mix," including socioeconomic status, of students. If only a modest number is eligible for Aid to Families with Dependent Children or free/low-cost school lunch programs, thereby meeting Medicaid eligibility, there may not be enough students to generate an appreciable Medicaid income.

Beginning in fiscal 1989, several changes at the federal level mandated the expansion of services to children in families with incomes at or below 200% of the federal poverty level. These changes could impact the development of school-based or school-linked programs by offering more funding options. The Omnibus Reconciliation Act of 1989 (OBRA 89) expands the federal Early Periodic Screening, Diagnosis, and Treatment program, which provides comprehensive health screenings and assessments to all Medicaid-eligible children and youth. The program

originally was designed to provide comprehensive, well-child health screening and assessment to detect children who previously had undiagnosed developmental delays or problems; identifying children who are at risk

for serious immediate or long-term health problems may be a channel for the initial screening and education related to condom use. While Early Periodic Screening, Diagnosis, and Treatment was not initially intended to provide long-term treatment or primary health care, OBRA 89 expanded the program to include diagnosis and follow-up services. The expansion allows more annual visits and periodic screening.⁶

OBRA 89 also has enabled schools to play a greater role in delivering health services to young people by giving schools their own billing number. This change could boost the number of school sites eligible to receive reimbursement for various services, including health promotion and education. Depending on local policies, funds could be used to educate students on condom use and to provide outreach and counseling services.

OBRA 89 also opened up the possibility of presumptive eligibility, essentially giving an authorized health or social services agency the capability to determine or presume that, based on an interview, a potential beneficiary is medically eligible for services before the application process is completed. Eligibility criteria can be based on the numbers of children who qualify for Aid to Families with Dependent Children or school lunch programs. Service providers can then deliver services and be certain that reimbursement is forthcoming.

OBRA 90 extended Medicaid eligibility to all children younger than eighteen with incomes below the federal poverty level. This new program requires that 30% of funds be devoted to increasing access to primary and preventive health services, and

OBRA 90 extended Medicaid eligibility to all children younger than eighteen with incomes below the federal poverty level.

The increasing risk of HIV/AIDS is one of many adolescent health concerns that must receive special attention now and in the foreseeable future.

that another 30% be spent on developing services for children and youth with special health needs. The latter services must be community-based, family centered and coordinated, and culturally sensitive. Using any of these funds to sustain condom availability

programs would require policies to that effect. The many health and social needs of youth to whom these health services previously were inaccessible have had high priority.

The complicated system of reimbursement for school-based health centers reflects the complexities of the system of care. It means schools must track different funding streams and collect revenues from third-party payers.⁷ Given the fragmented and categorical eligibility requirements, matching the types of clients and services with the types of funding streams most likely to provide reimbursement is a time- and staff-intensive challenge. Completing forms and tracking paper work to ensure collections complicates the billing effort and requires a special commitment of staff. The administrative expense of tapping resources for condom availability programs can greatly boost the cost of these programs. A reimbursement system needs to be established that fully recognizes the need to invest in specific components of comprehensive condom availability programs, such as health education, outreach, and counseling, which are believed to enhance effective use of condoms.

New Financial Resources

Given the urgency of educating and providing services to youth, more attention is focusing on the need to expand financial resources directed at adolescents. A recent study by the federal

Office for Technology Assessment (OTA) on the health status of American adolescents gives Congress several options.⁷ One is developing ways to improve adolescents' access to appropriate health services; another is restructuring and invigorating federal efforts to improve adolescent health. Strategies for improving access include supporting the development of centers in schools and/or at community sites that provide comprehensive and accessible services specifically designed for adolescents. These strategies might also include federal seed money and continuation funding, and removal of financial barriers. Expanding Medicaid to immediately include all poor adolescents, increasing Medicaid outreach efforts, and increasing access to private insurance also would help. Education would empower adolescents to gain access to health and related services, and encourage them to participate in the design of services. A strong federal role in addressing adolescent health issues would advance the cause for youth services. It would strengthen executive-branch activities in developing programs for promising or neglected areas of intervention, in research, and in data collection. The OTA study notes that apart from whatever strategies the federal government may adopt to improve the health of American adolescents, a basic change in how we confront adolescent health issues is necessary so "adolescents are approached more sympathetically and supportively, and not merely as individuals potentially riddled with problems and behaving badly."⁸

The increasing risk of HIV/AIDS is one of many adolescent health concerns that must receive special attention now and in the foreseeable future. The OTA's recommendation to emphasize school-based and school-linked services should encourage creative ways to deliver services that include strong health education and age-appropriate counseling. The OTA report also documented the multiplicity of federal agencies and departments that set policies and/or provide direct services to adolescents. If Congress provides new funding for condom availability programs, agencies like the Department of Health and Human Services, the Public Health Service, the CDC, and the Health Resources and Services Admin-

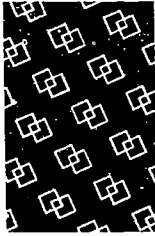
istration would be appropriate sponsors. Current federal policies—regardless of whether they are explicitly stated in law—relating specifically to adolescents limit the types of services adolescents receive. For example, the Bush Administration's emphasis on abstinence from sexual intercourse placed significant restrictions on services that sexually active adolescents could obtain.

Federal support of condom availability programs is more likely under the current administration. The acceptance of family planning services, a strong pro-choice position, and a commitment to AIDS prevention activities greatly facilitate efforts by the Clinton Administration to identify federal funds that can be formally utilized for condom availability programs. However, because health care reform is high on the administration's agenda and competition for existing but diminishing health and education resources also is prevalent, advocates for condom availability programs may still need to explore other funding channels. Thus, the role of the private sector, including condom manufacturers, community and national foundations, and private donors, may still be needed to support these programs, helping to defray supply, training, and technical-assistance costs.

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LEGAL ISSUES

Barbara Solomon, J.D.

Deputy City Attorney

Office of the City Attorney

San Francisco, Calif.

Introduction

This paper discusses the legal issues regarding condom availability programs in public schools. The issues turn mostly on matters of state law—that is, statutes, administrative regulations, and court decisions in each state. There is no overriding federal law or policy in this area, aside from issues involving federal constitutional rights, such as due process or privacy, or federal statutes governing funding of health and welfare programs. Traditionally and by law, the responsibility for providing a public education is left to the states and local school systems, and is considered one of the most important functions of state and local government. (See 20 U.S.C., §§ 3401, 3403, subds. (a),(b); *Brown v. Board of Education* (1954) 347 U.S. 483, 493.) Thus, resolution of the issues varies from state to state.

I have not attempted to review pertinent statutes or case law in all fifty states; such a task would be insurmountable. Instead, I discuss the issues generally confronting schools across the country, give examples of how those issues have been resolved, and suggest

where the relevant legal authority might be found. I also discuss any legal challenges to those programs. Because I am most familiar with California law, I focus on resolution of the issues under California law.

Only a handful of schools across the country have begun to provide condoms, so there are no legal precedents; we are in uncharted waters. I strongly urge school officials who are interested in starting a condom program to consult with their attorneys before taking any action.

Discussion

In a typical condom availability program, the governing board of a local school district becomes alarmed by the public health crisis surrounding the human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) epidemic and by recent studies showing high rates of teenage sexual activity and infection with sexually transmitted diseases (STDs). Seeking to protect students from these serious or even life-threatening illnesses, the school board decides to make condoms available to its students on school grounds. Initially, the program is limited to high school students. The purpose of the program is to educate students about the risks involved in unprotected sexual activity, instruct students regarding the proper use and effectiveness of condoms, and provide protection against HIV/AIDS, STDs, and pregnancy. The program is voluntary; students are not required or pressured to participate. Although students may obtain condoms upon request, they are advised that abstinence from sexual activity is the only fully effective way to prevent HIV/AIDS, STDs, and pregnancy.

The program may be treated as an educational matter—that is, as part of a comprehensive health education and HIV/AIDS prevention policy offered by the school district. The program also may be treated as a health service offered by the school district, either alone or in conjunction with local public health authorities.

hospitals, or clinics. In any case, the goal is to make condoms and related counseling available, in an effective way, to those students most at risk of contracting or transmitting HIV/AIDS or STDs. The program should be structured so it reduces opposition from parents and the community, and limits the district's exposure to liability.

Students can obtain condoms from a variety of sources: vending machines in school bathrooms, teachers in classrooms, counselors in counseling offices, nurses in nursing offices or "health resource" rooms, and health care workers in school health clinics.

Legal Issues

Does the school board have the express or implied legal authority to adopt the program?

This issue clearly turns on matters of state law. In general, the state legislature has comprehensive control over public education, limited only by state or federal constitutional provisions. (See *Hall v. City of Taft* (1956) 47 Cal.2d 177, 179; *Board of Education v. State Board of Education* [Ohio Ct. App. 1962] 189 N.E.2d 81, 83-84.) The state may delegate its control in a variety of ways. Traditionally, local school districts have required specific authorization from the legislature to enact or implement a program. Now, however, courts are finding that school districts have the implied powers and authority that are necessary or proper to carry out their purposes and statutory duties. (See 1 Education Law (Matthew Bender & Co. 1992) ch. 3, Governance of Education, § 3.05[3][b], pp. 3-58 to 3-60.) In some states, this implied authority is codified. (See, for example, Cal. Ed. Code, §§ 35160, 35160.1.) The degree to which the state exercises control over local educational policies through state agencies, boards, and officials varies considerably from state to state. (See 1 Education Law, *supra*, § 3.02[4][c], pp. 3-18 to 3-20.)

State law may require school districts to provide accurate information to students regarding the nature of HIV/AIDS and methods of transmission and prevention.

State statutes, regulations, or constitutional provisions may prescribe or limit the authority of individual school districts to adopt a health-related or sex education program. Few states have statutes that expressly authorize or prohibit condom availability programs in schools. (See, for example,

Ark. Code Ann., § 6-18-703 [allowing a local school board to decide whether to distribute contraceptives in school-based health clinic, requiring parental consent for services, and prohibiting use of state funds for dispensing contraceptives]; La. Stat. Ann.-Rev. Stat., tit. 17, § 281 [no contraceptive drug or device shall be distributed at any public school, and no sex education course may use any sexually explicit material], *id.*, tit. 40, § 31.3 [health centers in public schools are prohibited from distributing contraceptives]; Md. Code 1957, art. 27, § 41A [prohibiting sale of contraceptives by means of vending machine or other automatic device at schools]; Mich. Comp. Laws Ann., § 380.1507, subd. [6] ["A person shall not dispense or otherwise distribute in a public school a family planning drug or device"]; S.C. Code Ann., § 59-1-405 [no contraceptive device or medication may be distributed on school grounds].)

However, most states have statutes or administrative regulations requiring school districts to maintain or give care to the general health of students. (See, for example, 8 N.Y.C.R.R., § 136.3[a][10]; Cal. Ed. Code, § 49400.) These statutes or regulations may be used as authority for adopting a program that serves to protect students from a potentially life-threatening virus such as HIV/AIDS.

State law may require school districts to provide accurate information to students regarding the nature of HIV/AIDS and

methods of transmission and prevention. (See, for example, 8 N.Y.C.R.R., § 135.3[b][2] and [c][2].) State law also may require that sex education courses include statistics on the success or failure rates of condoms in preventing AIDS, STDs, and pregnancy. (See, for example, Cal. Ed. Code, § 51553, subd. [b].) Providing condoms along with this information not only serves to underscore the dangers of unprotected sexual activity but also helps to ensure that students will use condoms. These statutes or regulations may be used as further authority for adopting the program.

In California, public schools are of statewide rather than local concern. (See Cal. Const., art. IX; *Hall v. City of Taft*, *supra*, 47 Cal.2d 177, 181.) However, the Legislature has delegated to local school boards the broad authority to adopt programs and engage in activities designed to meet their unique needs, as long as those programs or activities do not conflict with any law or the purposes for which school districts were established. (Cal. Ed. Code, §§ 35160, 35160.1.) So if a California school district believes it has a unique and compelling need for a condom program, it has the authority to adopt one. Because of potential challenges, the school board should carefully document and make specific findings regarding the need for such programs by relying on published medical or public health reports or studies. Relevant statistics also should be cited, including the incidence of HIV/AIDS in the community, the percentage of high school students who are sexually active, the percentage of high school students who use condoms, and the effectiveness of condoms in preventing the spread of HIV/AIDS and other STDs.

If a school board acts without express or implied legal authority, the program may be challenged administratively and/or legally. A typical legal challenge is a petition for injunctive or declaratory relief. In California, this challenge might take the form of a taxpayer suit alleging the illegal expenditure of public funds. (See, for example, Cal. Code Civ. Proc., § 526a; *McKinny v. Board of Trustees* (1982) 31 Cal.3d 79, 91.)

Condoms are nonprescription, noninvasive items that play a critical role in worldwide efforts to stop the spread of the deadly HIV/AIDS virus. Given the magnitude of the epidemic, it seems that on balance a court would find that a local school board has the implied authority to make condoms available, either as part of its AIDS prevention instruction or as a separate health service.

Does the condom program conflict with other provisions of state law, such as penal laws prohibiting sex with minors, or child-abuse reporting laws?

A school board also should consider whether state law prohibits or restricts sexual activity with minors. The U.S. Supreme Court has suggested that states have more leeway to regulate the sexual behavior of minors than that of adults. (See *Carey v. Population Services International* (1977) 431 U.S. 678, 692, 694, fn. 17 [plurality opn. of Brennan, J.].) Some states still have statutory rape laws on the books, whereby a male may be criminally prosecuted for having sex with a female under a certain age, regardless of whether the sex was consensual, on the theory that a minor is not competent to give legal consent. (See, for example, Cal. Pen. Code, § 261.5; Mass. Gen. Laws Ann., ch. 265, § 23.) If such a law exists, a decision to provide condoms to minors at school could be challenged on grounds that it encourages minors to engage in unlawful sexual activity. Further, it is possible that employees who furnish the condoms could be criminally charged as accessories or aiders and abettors to a crime.

For example, California Penal Code section 261.5 prohibits a male of any age from having sexual intercourse with a female under eighteen years old to whom he is not married. This statute has been upheld against an equal protection challenge based on gender. (*Michael M. v. Superior Court of Sonoma County* (1981) 450 U.S. 464 [plurality opn.].) Theoretically, a school employee who furnishes a condom to an unmarried girl under eighteen or to an unmarried boy of any age could be charged with aiding and abetting unlawful sexual intercourse. Such a prosecution seems

unlikely, given that Penal Code section 261.5 is rarely enforced and that public and private health clinics in California have been giving condoms to minors for years without legal problems.

Even if charges are filed, the prosecution has a difficult burden of proof. Under California law, the aider and abettor must not only have knowledge of the perpetrator's unlawful purpose but must have the intent or purpose to encourage or facilitate the crime, and must do something by act or advice to aid, promote, or encourage the crime. (*People v. Beeman* (1984) 35 Cal.3d 547, 561.) Mere knowledge that a crime is being committed and failure to take steps to prevent it do not amount to aiding and abetting. (See, for example, *Pinell v. Superior Court* (1965) 232 Cal.App.2d 284, 287; *in re Michael T.* (1978) 84 Cal.App.3d 907, 911.)

In this context, the prosecution would have to prove beyond a reasonable doubt that the school employee knew the condom would be used during sexual intercourse with an unmarried female minor, that the employee intended to encourage or facilitate such an act, and that the employee by act or advice promoted or encouraged the act. The threat of prosecution is reduced if the employee took care to advise the student not to engage in unlawful sexual activity, as required by other provisions of state law. (See Cal. Ed. Code, §51553, subd.(b).) The defense would be that the intent is not to condone or encourage sexual activity among minors; rather, the intent is to protect sexually active minors from pregnancy, AIDS, and other STDs. If the board of education made a finding that there was a high rate of sexual activity among students in the district, and if the program was intended only to reduce risks associated with existing patterns of sexual activity, there is little chance a court or jury would find that a school official who carried out the program intended to promote sex.

State law may also prohibit other types of sexual activity with minors. In California, it is unlawful to engage in lewd or lascivious conduct, sodomy, or oral copulation with a minor. (See, for example, Cal. Pen. Code, §§ 288, 288a, subd. (b), 286.

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subd. (b)(1).) Again, there is a slight chance that a school official who provides condoms to minors could be subject to prosecution as an aider and abettor to such crimes. The defense would be that the official lacked the

requisite knowledge and intent, and did nothing by act or advice to encourage such sexual activity.

School board members also should consider whether the condom program conflicts with child-abuse reporting laws. For example, California law requires that teachers and health practitioners file a child abuse report when the teacher or practitioner knows or reasonably suspects that a minor has been the victim of sexual abuse. (See Cal. Pen. Code, § 11165, *et seq.*) The current statutory definition of sexual abuse does not include statutory rape or unlawful sexual intercourse (*Id.*, § 261.5) but does include lewd or lascivious acts committed on a child under the age of fourteen, as defined in Penal Code section 288 (*Id.*, § 11165.1, subs. (a)(b)). California courts have restricted the scope of this reporting law. Given the minor's right of sexual privacy and right to independently consent to reproductive health care, only abusive or coercive sexual activity of minors must be reported. (*Planned Parenthood Affiliates v. Van de Kamp* (1986) 181 Cal.App.3d 245, 255, 269-270, 276; *People ex rel. Eichenberger v. Stockton Pregnancy Control Medical Clinic, Inc.* (1988) 203 Cal.App.3d 225, 233, 239.) Even when one of the minors is under age fourteen, voluntary and consensual sexual activity between minors of a similar age need not be reported. (*Ibid.*) Massachusetts law requires a child abuse report whenever a school or health worker reasonably believes that a child under eighteen years old is being abused, maltreated, or neglected. (See Mass. Public Laws Ann., ch. 119, §§ 1, 51A (Bancroft-Whitney supp. 1990).) This statutory scheme focuses on the relationship between the child and parent. (*Id.*, § 1.)

Mere knowledge that a minor is engaging in consensual sexual activity with another minor would not trigger a report of abuse and neglect. Apparently, the school or health worker need not file a report unless he or she reasonably believes that the child is being coerced into sexual activity, or that there is such a lack of parental supervision that the child is being neglected.

Depending on how strictly child-abuse reporting laws are written and construed, they do not preclude the adoption of a condom program. However, these laws may spur providers to be alert to situations of potential child or sexual abuse. Providers who are health care professionals—particularly those who have experience prescribing or giving contraceptives to minors—will be aware of their professional responsibilities in this regard.

Does state law restrict the way condoms are made available or the kind of advice given? May a teacher or a volunteer provide the condoms and related advice to students, or is that task restricted to health care professionals? What kind of advice is required and must the advice stress abstinence?

State law may severely limit a district's options with regard to dispensing contraceptives on school grounds. Some statutes prohibit the distribution of contraceptives in school-based health clinics (see, for example, La. Stat. Ann.-Rev. Stat., tit. 40, § 31.3) while others prohibit distribution anywhere on school grounds. (See, for example, *id.*, tit. 17, § 281; Mich. Comp. Laws Ann. § 380.1507, subd. (6); S.C. Code Ann., § 59-1-405.) At least one state prohibits dispensing condoms from vending machines in schools. (See Md. Code 1957, art. 27, § 41A.)

State law also may control the type of advice given. Sex education provisions may require that providers stress abstinence and give accurate information on the effective use and failure rates of condoms.

The most obvious place to make condoms available is in sex education classes. Yet various factors may weigh against using this

setting. First, the program must be consistent with state guidelines on sex education; state law may expressly prohibit teachers from discussing contraceptives or providing condoms during sex education instruction. Even if state law does not authorize a school district to provide condoms in the classroom, the district may be able to justify making condoms available outside the classroom, as a health service.

California statutes governing sex education neither specifically authorize nor prohibit providing condoms to students as part of that instruction. However, state law does strictly limit the content of and procedures for sex education courses. (See Cal. Ed. Code, §§ 51550, 51553, 51820, 51240, 51201.5, 48980, 60650.) For example, courses that discuss sexual intercourse also must include statistics on the success and failure rates of condoms in preventing pregnancy, AIDS, and other STDs; stress that abstinence from sexual intercourse is the only 100%-effective method of protection against pregnancy, AIDS, and other STDs; stress that pupils should abstain from sexual intercourse until they are ready for marriage; and advise pupils that it is unlawful for males of any age to have sexual relations with females under eighteen years old to whom they are not married. (*Id.*, §51553, subd. (b).)

Because the California Legislature has so strictly prescribed the nature of sex education and has so strongly stressed abstinence, it seems inconsistent with legislative intent to provide condoms in sex education classes.*

Nonetheless, a school district has options other than the classroom. Under the school board's broad authority to adopt programs designed to protect the health and welfare of its students (Cal. Ed. Code, §§ 49400; 35160, 35160.1), a board

* Legislation pending as of June 1992 would have prohibited or restricted the nonsale distribution of condoms to anyone under eighteen on or within 1,000 feet of school grounds (Assem. Bill No. 3230 [1991-92 Reg. Sess.]). This bill did not make it out of committee.

may decide to make condoms available at a school-based health clinic. In addition, subject to certain restrictions, a school board may choose to make condoms available outside of the clinic. In this setting, the school district relies on state law providing for the medical emancipation of minors and giving minors the right to obtain sexually related medical care without parental consent. (See Civ. Code, § 34.5 [minors may consent to hospital, medical, or surgical care related to the prevention or treatment of pregnancy], § 34.7 [minors age twelve and over may consent to medical treatment for reportable infectious or communicable diseases and related STDs]; *Planned Parenthood Affiliates v. Van De Kamp*, *supra*, 181 Cal.App.3d at pp. 269-271.) If the school district is offering condoms as a health service, the condoms, at least initially, should be provided by public health authorities or licensed health care professionals.

Three California school districts—the San Francisco Unified School District, the Los Angeles Unified School District, and the Santa Monica-Malibu Unified School District—recently implemented condom programs. San Francisco and Los Angeles began by providing condoms at their school-based health clinics and will gradually expand beyond the clinics. Santa Monica makes condoms available in the nurse's office, in several classrooms, and in the school office. The condoms are packaged with explicit warnings and instruction. Students have access to the condoms on their own or may seek advice from school staff (the nurse, administrators, or several teachers who have received special training). Consistent with state law, the advice in all three programs stresses abstinence and focuses on the proper use of condoms and the effectiveness of condoms in preventing HIV/AIDS, other STDs, and pregnancy. In Los Angeles and San Francisco, parents are notified of the program and can exclude their children. In Santa Monica, parents are notified of the program but may not prevent their children from participating.

Does the school district have the duty or the authority to require parental consent or notification before students can participate in the program?

This is the most difficult and sensitive issue. Districts may either require parental consent or notify parents of the program and allow them to exclude their children from participation. The latter option is more likely to withstand judicial scrutiny.

Though parental consent and notification requirements often are lumped together, they are functionally different. (See *Bellotti v. Baird* (1979) 443 U.S. 622, 640 [lead opn. of Powell, J.], 657 [dis. opn. of White, J.].) Parental consent is more stringent, as the consent must be in writing. Intentionally or unintentionally, it may exclude a large number of students from the program. Parental notification/exclusion, sometimes referred to as parental veto or opt-out, requires only that parents be notified of the program and be given the opportunity to exclude their children. It puts the burden on parents to take affirmative steps to prevent their children from participating.

In general, parental consent and notification requirements are limited to unmarried and unemancipated minors. In most states, a minor is a person under the age of eighteen. (See, for example, Cal. Civ. Code, § 25.) A decision to include a parental consent or parental notification/exclusion component in the program involves consideration of parental rights (of due process and free exercise of one's religion), minors' privacy rights, and the district's ability to use certain funds.

The first question is whether state law requires parental consent or notification. The answer depends on how the program is set up. If condom availability is treated as an educational matter and condoms are to be distributed by teachers and health educators, then state education guidelines on sex education and AIDS prevention should be consulted. In California, the Education Code requires parental notification/exclusion for courses that discuss venereal disease and sexual intercourse (see Cal. Ed. Code, §§ 48980, 51240, 51550, 51553, 51820) and written parental

consent for any test or questionnaire containing questions about a student's or parents' beliefs or practices in sex, family life, morality, or religion (*Id.*, § 60650). Education Code section 51201.5 allows a local school board to decide whether to require consent of the parent or guardian before it provides instruction on AIDS prevention to any minor pupil.

If the program is treated as a health matter, one could argue that parental consent is necessary. Most states require parental consent for general health care for children under a certain age. (See Cal. Civ. Code, §§ 25-34.10; New York Public Health Law, § 2504.) State education codes also may require parental consent for medical care rendered at school. (See Cal. Ed. Code, §§ 49403 [parental consent required for immunizations]; 49407 [school district is not liable for reasonably necessary medical treatment of a child that is provided without parental consent, if parent cannot be reached, unless parent has filed written objection to medical treatment]; 49451 [parent may file annual statement of refusal to consent to physical exam of child].)

Parents may argue that omitting a parental consent or notification requirement violates their due process right to control their children's education or upbringing (See *Pierce v. Society of Sisters* (1925) 268 U.S. 510, 534-535) or First Amendment right to freely exercise their religion (*Wisconsin v. Yoder* (1972) 406 U.S. 205). The rationale would be that, particularly in the sensitive area of adolescent sexuality, parents should be able to control their children's access to contraceptives and related information.

On the other hand, students may argue that requiring parental consent or notification infringes on their right of privacy in matters affecting birth control and procreation, under the federal and some state constitutions. The U.S. Supreme Court has made clear that while the state has broader authority to regulate the conduct of minors than it does of adults, minors have a constitutionally protected right of privacy, including the right to obtain contraceptives. (*Carey v. Population Services International, supra*, 431 U.S. 678, 692-693 [plurality opn.]; *Bellotti v. Baird, supra*,

443 U.S. 622; *Planned Parenthood of Central Missouri v. Danforth* (1976) 428 U.S. 52, 74–75; see also *Doe v. Irwin* (6th Cir. 1980) 615 F.2d 1162, 1166, cert. den. 449 U.S. 829 (1980).)

In *Carey*, the U.S. Supreme Court invalidated a New York state law that prohibited anyone from selling or distributing any contraceptive to a minor under the age of sixteen. The lead opinion made clear that because minors as well as adults have a privacy right to make decisions affecting procreation, state restrictions on these rights are valid only if they serve a significant state interest. (431 U.S. at p. 693.) “Since the state may not impose a blanket prohibition, or even a blanket requirement of parental consent, on the choice of a minor to terminate her pregnancy, the constitutionality of a blanket prohibition of the distribution of contraceptives to minors is *a fortiori* foreclosed.” (*Id.*, p. 694.)

Carey rejected the state’s bare, unsupported assertion that allowing minors access to contraceptives would result in increased sexual activity of minors; this was not a significant policy that would justify burdening the exercise of a fundamental right. (431 U.S. at pp. 694–696.) Moreover, a narrow exception allowing a physician to supply his patients with drugs he deemed proper did not save the statute. (*Id.*, at p. 697.) “Appellants assert no medical necessity for imposing a medical limitation on the distribution of nonprescription contraceptives to minors.” (*Ibid.*) The state may not delegate its authority to disapprove of minors’ sexual behavior to physicians, who might exercise it arbitrarily. (*Id.*, at pp. 679–699.)

Carey relied heavily on the seminal case of *Roe v. Wade* (1973) 410 U.S. 113, 153, which held that the right of privacy encompasses a woman’s decision whether to terminate her pregnancy by obtaining an abortion. *Carey* also relied on *Griswold v. Connecticut* (1965) 381 U.S. 479, which found that a statute prohibiting the use of contraceptives unconstitutionally intruded on the right of privacy of married persons, and on *Eisenstadt v. Baird* (1972) 405 U.S. 438, 453–455 [plurality opn.], which made clear that this right of privacy also applies to

unmarried individuals. "If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." (*Eisenstadt v. Baird*, *supra*, at p. 453, citations omitted.)

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The U.S. Supreme Court has not addressed the issue of minors' access to contraceptives since the 1977 *Carey* case. However, in the abortion context, the high court has made clear that a parental consent requirement does not unconstitutionally burden a minor's right to abortion as long as the state provides a reasonable alternative procedure whereby authorization may be obtained. (*Bellotti v. Baird*, *supra*, 443 U.S. 622, 643.) According to that procedure, the minor is entitled to show that either (1) she is sufficiently mature and informed to make her own decision about abortion, in consultation with her physician, or (2) regardless of whether she can make this decision independently, the abortion would be in her best interests. (*Id.*, pp. 643-644.)

Recent federal cases have upheld or invalidated statutes requiring parental consent based on whether there was an adequate judicial bypass procedure. (See, for example, *Planned Parenthood League of Mass. v. Bellotti* (1st Cir. 1989) 868 F.2d 459, 469 [upheld statute requiring consent of both parents based on availability of a proper judicial bypass].) In 1990, a closely divided U.S. Supreme Court invalidated a two-parent notification requirement for a minor seeking an abortion, finding that it did not reasonably further any legitimate state interest, but a different majority of the court upheld the statute to the extent it provided a judicial bypass. (*Hodgson v. Minnesota* (1990) 497 U.S. 417 [110 S.Ct. 2926, 2945-2949, 2950-2951 [conc. and dis. opn. of O'Connor, J.]

2951 [conc. and dis. opn. of Marshall, J.], 2961 [conc. and dis. opn. of Kennedy, J.].) The key is that states may not give a third party absolute and potentially arbitrary veto power over an individual's right to make such a fundamental decision. (See *Planned Parenthood of Central Missouri v. Danforth*, *supra*, 428 U.S. at p. 74.)*

A school district also should consider the potential impact on state constitutional rights. Recently, a California court permanently enjoined enforcement of an amendment to Civil Code section 34.5 that required unemancipated minors to obtain parental consent for an abortion, on grounds the amendment violated minors' rights of privacy and equal protection under the California Constitution. (See *American Academy of Pediatrics, California District IX, et al. v. Lungren, et al.* (Super. Ct. City and County of San Francisco, 1992, No. 884-574) 92 C.D.O.S. 4515, 4522.)

It is difficult to discern a clear rule regarding the extent of a state's authority to require parental consent or notification in the abortion context. For our purposes, however, the U.S. Supreme Court has indicated that a state has more leeway to burden a minor's right to abortion than it does to burden a minor's access to nonprescription contraceptives, such as condoms. (See *Carey*, *supra*, 431 U.S. at p. 694 ["The state's interests in protection of the mental and physical health of the pregnant minor and in protec-

* The U.S. Supreme Court recently reviewed the constitutionality of a statute that requires minors to obtain parental consent (or a judicial bypass) and requires all women to notify their spouses, to be informed of certain information, and to wait twenty-four hours before obtaining an abortion (*Planned Parenthood of Southeastern Pennsylvania v. Casey* (1992) ___U.S.___ [112 S. Ct. 2791]). In a splintered decision filed on June 29, 1992, the Supreme Court upheld all provisions of the statute except for the spousal notification requirement. The lead opinion (by Justices O'Connor, Kennedy, and Souter, joined in part by Justices Blackmun and Stevens) reaffirmed the essential holding of *Roe v. Wade*. That holding has three parts: (1) prior to viability of the fetus, a woman has a right to obtain an abortion without undue interference from the state; (2) after viability, a state may restrict abortions except when the pregnancy threatens the woman's life or

tion of potential life are clearly more implicated by the abortion decision than by the decision to use a nonhazardous contraceptive”].) As *Bellotti v. Baird*, *supra*, 443 U.S. 622 made clear, the need for parental guidance, based on the minor’s lack of experience, perspective, and judgment to recognize and avoid detrimental choices, is particularly acute in the abortion context. (Pp. 640–641.) There is less need for parental guidance in the decision whether to obtain condoms for possible use as barrier protection during sexual intercourse.

The federal courts have made clear that a state may not impose a parental consent or notification requirement as a precondition for the provision of federally funded birth-control or family-planning services to minors. (*Doe v. Pickett* (S.D. W. Va. 1979) 480 F.Supp. 1218, 1220 [state requirement of parental consent for family planning services is contrary to federal statutes and implementing regulations].) Moreover, parents do not have a constitutional right to be notified of their children’s voluntary decision to participate in the services of a birth control clinic. (*Doe v. Irwin*, *supra*, 615 F.2d 1162, 1168–1169.)

The issue here is not whether a state may restrict a minor’s access to birth control services but rather whether a school district may decide as a matter of policy to allow parents to control their children’s access to condoms at school. In light of the unique school setting, the traditional emphasis on parental involvement in sex

health; and (3) throughout the pregnancy, the state has a legitimate interest in protecting the health of the woman and the life of the fetus (___ U.S. ___, [112 S. Ct. 2791]). Consistent with this holding, the court devised a new test for abortion regulations. A state law imposes an undue burden and is unconstitutional if it “has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.” (112 S. Ct. at 2820.) For our purposes, the lead opinion reaffirmed the decisions of *Carey*, *Griswold v. Connecticut* and *Eisenstadt v. Baird* insofar as they protect the individual’s personal decisions regarding contraception. (*Id.*, at 2807). Four members of the court would have overruled *Roe v. Wade* and upheld the entire statute under a rational basis test. (*Id.*, at 2855, 2867 [conc. and dis. opn. by Rehnquist, C.J.]])

education, the absence of a duty to provide condoms in schools, and the broad discretion given to most local school districts to fashion programs unique to their needs, a district has the prerogative to include a parental consent or notification component in the program.

Allowing parents to exclude their children's participation accommodates the conflicting concerns of parents, students, and the community, and may well forestall or defeat any claims of interference with parental rights. (See *Citizens for Parental Rights v. San Mateo County Board of Education* (1975) 51 Cal.App.3d 1, app. dism., 425 U.S. 908 (1976) [relying on statutory parental notification/exclusion system to reject claims that family life and sex education program violated parents' or students' rights to free exercise of religion, privacy, equal protection or due process].) Yet a student who is so excluded has no basis for claiming denial of his/her right to privacy, given the limited nature of the medical care involved, the existence of public and private health clinics and facilities where such medical care may be obtained without parental consent or notice, and the fact that condoms may be purchased in many stores. Absent an unconstitutional interference with students' or parents' rights, a court need not consider whether a compelling state interest is involved. (See *Doe v. Irwin, supra*, 615 F.2d at p. 1169.) In addition, as demonstrated in a legal challenge to the New York City program (See *infra.*), in the absence of a constitutional violation, courts are reluctant to intervene in the setting of educational policy. (See *Board of Education v. Nyquist* (1982) 57 N.Y.2d 27, 38-39; 453 N.Y.S.2d 643, app. dism., 459 U.S. 1138 (1983).)

Nonetheless, a decision to require parental consent or notice may prevent a school district from using certain funds, such as those slated for family planning services. (See Title X of the Public Health Service Act, 42 U.S.C., § 300, *et seq.*) (*Doe v. Pickett, supra*, 480 F.Supp. at p. 1270.)

There is no ideal resolution of the parental consent/notice issue. Parental notification/exclusion or opt-out seems preferable to parental consent, as the former imposes less of an administrative

burden and excludes only those children whose parents affirmatively object to the program. Most existing programs have a parental opt-out component. Nonetheless, a school district also may elect to omit a parental role and to require neither parental consent nor opt-out. At least two boards of education (in New York City and Santa Monica, Calif.) have taken this approach, presumably to facilitate access for those students most at risk. Ironically, parents in those two districts may exclude their children from the AIDS prevention instruction portion of the program but not from condom availability.

What is the scope of liability of the school board or school district stemming from the condom program?

The question is whether a school board or district is liable for injuries allegedly stemming from the condom program, such as when a student contracts a disease or HIV/AIDS, becomes pregnant as a result of a defective condom, or receives erroneous or inadequate advice from a school employee or volunteer. Again, the answer turns on state law, which governs the availability of tort claims and remedies. By way of example, I will focus on potential liability under California law.

In California, government liability for torts, such as negligence, is governed entirely by statute. (*Swaner v. City of Santa Monica* (1984) 150 Cal.App.3d 789, 797; *Peterson v. San Francisco Community College Dist.* (1984) 36 Cal.3d 799, 809.) Under the California Tort Claims Act (Cal. Gov. Code, § 815.2, subd.(a)):

A public entity is liable for injury proximately caused by an act or omission of an employee of the public entity within the scope of his employment if the act or omission would, apart from this section, have given rise to a cause of action against that employee or his personal representative.

A public employee is liable for injuries caused by his or her act or omission to the same extent that a private person is, except as otherwise provided by statute. (*Id.*, §820, subd. (a).)

Assuming the entity or employee is liable in tort, the next question is whether governmental immunity bars the suit. The public entity is protected by the same statutory immunities covering the employee, unless otherwise provided by statute. (*Id.*, § 815.2, subd. (b).)* Even if a school district is not directly sued, it may be financially liable because of its statutory duty to indemnify employees against personal loss for their torts committed in the scope of employment, unless the employees acted with actual fraud or malice. (*Id.*, §§ 825–825.6.) Thus, the district could be liable under the Tort Claims Act for injuries proximately caused by acts or omissions of staff in the condom availability program.

In general, government officials are not liable for acts deemed discretionary, as opposed to acts deemed ministerial or operational. (57 Am.Jur.2d (1988) Municipal, County, School and State Tort Liability, §§ 111, 113, pp. 124–126.) School board members would be immune from liability for adopting the condom program because the decision to adopt such a program is a discretionary act within the scope of their employment or office. (Cal. Gov. Code, § 829.2.) In addition, California Government Code section 855.4 confers immunity from tort liability upon public entities and employees for injuries resulting from decisions about whether:

to perform or not to perform any act to promote the public health of the community by preventing disease or controlling the communication of disease within the community if the decision whether the act was or was not to be performed was the result of the exercise of discretion vested in the public entity or the public employee, whether or not such discretion be abused.

* However, in some states the purchase of liability insurance may result in a waiver of immunity, at least to the extent of insurance coverage. (See 3 Education Law, *supra*, ch. 12, General Liabilities and Litigation, § 12.02[2][c], pp. 12–31 to 12–33.)

By the same token, the public entity or employee is immune from liability for carrying out such a decision "with due care." (*Id.*, subd. (b).)

For purposes of tort liability, volunteers who are carrying out a school district function are treated like school employees. (See Cal. Gov. Code, § 810.2 ["employee" includes an officer, employee, or servant, whether or not compensated, but not an independent contractor].) Hence, a school district is potentially liable for injuries caused by the acts or omissions of volunteers. To ensure control over the program and the advice given, a district may want to initially refrain from using volunteers and limit future volunteer participation to licensed health care professionals.

One possible basis for a suit against a district is negligence—that is, failing to advise the student properly regarding the use or effectiveness of condoms. To show negligence, the plaintiff must allege facts showing a duty of care, a breach of that duty, and injury to the plaintiff as a proximate result. (See *Peter W. v. San Francisco Unified Sch. Dist.* (1976) 60 Cal.App.3d 814, 820, citation omitted.) Several California cases have made clear that school districts are not liable for educational negligence or malpractice—that is, for failing to educate a student properly by teaching him or her to read or develop basic job skills. (See *Peter W.*, *supra*; *Chevlin v. Los Angeles Community College Dist.* (1989) 212 Cal.App.3d 382, 389–390.) However, school authorities do have a duty to exercise reasonable care for the physical safety of students under their supervision. (See *Dailey v. Los Angeles Unified Sch. Dist.* (1970) 2 Cal.3d 741, 747–749; *Hoyem v. Manhattan Beach City Sch. Dist.* (1978) 22 Cal.3d 508, 513.)

A school district could be liable for the negligence of a health care provider employed by the district. Yet a plaintiff claiming negligent advice regarding condom use, a form of medical malpractice, would have a difficult burden of proof, especially with respect to causation. The burden seems insurmountable in the context of AIDS infection, given the virus has an incubation period of three years to seven years. (See Cal. Health & Saf. Code,

§ 199.46, subd. (c).) School districts may feel some assurance knowing that public health clinics in California have provided condoms for years without legal problems.

There also is a possibility that a parent could bring suit alleging that a school district's violation of criminal statutes, on an aiding-and-abetting or conspiracy theory, constitutes negligence per se or creates a rebuttable presumption of negligence. (See Cal. Evid. Code, § 669.) Given the difficult burden of proof, it seems unlikely such a suit would prevail.

Students or parents also could bring suit claiming injury from a defective product. These suits might be based on theories of strict liability, breach of warranty, or failure to warn of the risks associated with using the product. Strict liability holds a manufacturer, seller, or distributor liable when there is a flaw in the manufacturing process, a design defect, or inadequate instructions or warnings. (See *Brown v. Superior Court* (1988) 44 Cal.3d 1049, 1057, citing *Barker v. Lull Engineering Co.* (1978) 20 Cal.3d 413.) Most states have adopted some form of strict liability. (Prosser and Keeton on Torts (5th ed., 1984) § 99, p. 694.) A warranty may be express or implied; breach of express warranty means the seller has not kept his promises concerning a product, and breach of implied warranty means the product is not fit for its intended purpose. (*Brown v. Superior Court, supra*, at p. 1071.)

Strict liability for a defective product is the most worrisome theory, as the injured party need not show negligence, only that there was a defect in or failure of the product and that such defect or failure proximately caused the injury. (See *Brown v. Superior Court, supra*, 44 Cal.3d at p. 1056.) Again, however, public entity liability in California is governed by statute. No statute imposes strict liability on public entities for defective products. By analogy, in the context of dangerous public property, the public entity is not subject to strict liability. (See Van Alstyne, Cal. Government Tort Liability Practice (C.E.B. 1980) § 3.3, pp. 180-181; *Newson v. Oakland* (1974) 37 Cal.App.3d 1050, 1054-1055.)

The manufacturer, rather than the health care provider, is the logical defendant in a suit for damages arising from a defective condom.* Even liability for the manufacturer appears remote.** The printed instructions found in condom packages are intended to insulate the manufacturer from liability for failure to warn of the risks.

To minimize potential liability, the condoms should be provided in their original packaging. Out of caution, a school district also may decide to limit providers to licensed health care professionals. The providers should adhere to manufacturers' instructions and give uniform, carefully prescribed advice. That advice, to be provided to students both orally and in written form, should focus on proper use of condoms and their effectiveness in preventing pregnancy and HIV/AIDS. Consistent with state law, the advice should stress that abstinence is the only fail-safe method of protection against pregnancy, AIDS, and other STDs. The advice should not condone or encourage sexual activity among or with minors, and it should warn students that state law prohibits a male of any age from having sex with a female under eighteen years old to whom he is not married.

Given the remote chance of liability, this issue should not preclude a school district from adopting a condom program.

* A school district could insulate itself from liability by including an indemnification provision in any purchase or donation agreement with a condom supplier.

** The author's research has turned up only one case, in New Jersey, involving a negligence/products liability action against the manufacturer and retailer for a defective condom. (*J.P.M. and B.M. v. Schmid Laboratories Inc.* (1981) 178 N.J. Super. 122, 428 A.2d 515.) A couple who became pregnant with twins despite use of a condom sued the manufacturer and retailer, alleging breach of warranties, negligence, and strict liability. The decision is of little help, as it merely held that interspousal immunity did not preclude the manufacturer's counterclaim against the husband for negligent use of the condom. There is no record showing that plaintiffs received damages.

Legal Challenges

New York, N.Y.

The New York City Public Schools began providing condoms at several high schools on November 26, 1991. As of May 1992, most of the city's 120 high schools were eligible to participate. Condoms are available upon request in school health resource rooms. Teachers and school staff, who must complete two days of training, provide counseling and advice. Parental consent is not required nor may parents exclude their children.

The program has been challenged legally and administratively. The lawsuit claimed that the program violates state law in that Public Health Law section 2504 requires parental consent for a "health service," such as condom availability. The suit also claimed that the program violates parents' due process rights to raise their children as they see fit. (See *Pierce v. Society of Sisters*, *supra*, 268 U.S. 510; *Meyer v. Nebraska* (1923) 262 U.S. 390, 399.) Finally, the suit claimed that the program violates parents' rights to free exercise of religion under the First Amendment. (See *Wisconsin v. Yoder*, *supra*, 406 U.S. 205, 213-214; *Ware v. Valley Stream High Sch. Dist.* (1989) 75 N.Y.2d 114, 551 N.Y.S.2d 167.)

The Supreme Court of the State of New York, County of Richmond, dismissed the suit in an opinion dated April 23, 1992. The court ruled that although the condom availability program is health related, it is not a health service within the meaning of Public Health Law section 2504 and, therefore, parental consent is not required (pp. 4-5). The court further ruled that because the program is completely voluntary, it does not violate parental rights of due process or burden parents' exercise of religion under the state or federal constitutions. (Pp. 6, 12.)

During oral arguments, petitioners conceded they did not seek to invalidate the entire program but rather to impose a parental opt-out provision based on parents' due process rights to raise their children as they see fit. The court declined to rule on the constitutionality of a parental opt-out provision, as that issue was not properly before it. In any event, the court noted, it is up to the board of education, not the courts, to set educational policy. (P. 9, citing

Lipsman v. New York City Board of Education (1987, 2d Dept.) 133 A.D.2d 810, 520 N.Y.S.2d 190; *Matter of Board of Education v. Ambach* (1987) 70 N.Y.2d 501, 510-511, 522 N.Y.S.2d 831 [517 N.E.2d 509]; *Board of Education v. Nyquist, supra*, 57 N.Y.2d 27, 38-39, 453 N.Y.S.2d 643.) The court further noted that parental involvement is a critical component of the HIV/AIDS education plan. (P. 10). As of May 1992, this decision had not been appealed.

The administrative challenge was filed with the state education department by two dissenting members of the board of education who claimed that the program violates the department's own guidelines on condom programs. The state commissioner of education issued a statement in 1991 to the effect that schools can provide condoms as long as they use "competent health professionals." The argument is that teachers are not in this category. As of May 1992, this challenge had not been resolved.

Philadelphia, Pa.

In early January 1992, the Philadelphia School District implemented a condom program at four high schools using neighborhood health care providers on contract. Providers must stress abstinence and effective use of condoms. The program has a parental notification/opt-out provision. Parents of students brought a petition for declaratory and injunctive relief in the state trial court. The petition claims that the program usurps parental rights, violates the district's own policy to teach abstinence, and conflicts with various criminal statutes, such as statutory rape and prohibitions against the deviant sexual conduct of minors. As of May 1992, the suit was pending.

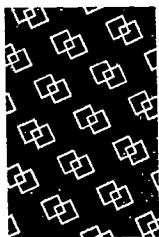
Conclusion

Assuming state law gives local school districts the authority to adopt programs unique to their needs and does not expressly prohibit condom distribution at school, a school district has the legal authority to adopt a condom availability program. In deciding how to structure the program, a district must balance the conflicting rights of parents, students, and the community. A school district also may have to resolve conflicting statutes and court decisions regard-

ing a minor's constitutional and statutory right to obtain reproductive health care, penal statutes prohibiting the sexual activity of minors, and state guidelines on sex education. To reduce potential challenges, the program should be completely voluntary; students should not be compelled or pressured to participate.

State law and concerns about civil and criminal liability may dictate that providers stress abstinence and provide detailed information on the proper use and effectiveness of condoms. These same concerns and questions about the district's authority to adopt the program may weigh in favor of treating the program as a health service offered by the district and requiring, at least initially, that providers be licensed health care professionals. The threat of liability for a defective condom or improper advice about condoms also weighs in favor of using experienced health care professionals. Liability concerns should not preclude the adoption of a condom program.

The most difficult and controversial issue is whether to require parental consent or notification. There is no ideal resolution of this issue. U.S. Supreme Court decisions appear to preclude states from requiring parental consent or notification for a minor's access to reproductive health care. Even so, a school district may decide as a matter of policy to give parents the right to exclude their children from participating in a school condom program. Parental notification/opt-out is preferable to parental consent, as the former accommodates parents' rights to raise their children as they see fit but also ensures that only those students whose parents affirmatively object will be excluded from the program. Most existing programs have a parental opt-out component. One of the few programs to omit a parental role—New York City's—was challenged on this ground. The New York court dismissed the challenge based on the voluntary nature of the program and the established rule that education authorities, not the courts, set policy in education matters. While a state trial court decision is not considered legal precedent for other states, the court's reasoning is instructive as to how the issue may be resolved in other jurisdictions.



RESEARCH AND EVALUATION

Douglas Kirby, Ph.D.

Director of Research

ETR Associates

Scotts Valley, Calif.

Introduction

The availability of condoms in schools is a recent phenomenon. Remarkably little is known about the most effective ways to make condoms available to students or about the impact that such availability has on sexual behavior and condom use. Consequently, there is a dramatic need for well-designed research.

It is also true that these budding programs need time to develop creative and effective strategies before they are subject to overly critical scrutiny. Thus, at this stage, research should be formative and the results should be used to improve the effectiveness of programs. After programs are better established and distribute substantial numbers of condoms, more formal evaluations should focus on their impact upon sexual behavior and condom use.

This paper addresses three critical questions: (1) What do preliminary data and previous research tell us about the probable effectiveness of condom availability in schools? (2) What are some of the important questions that must be answered? (3) What are feasible and valid ways to measure the effects of condom availability?

Evidence from Previous Research

Previous research is worth examining for at least three reasons: (1) It is a gauge of the probable effectiveness of condom availability; (2) it provides an indication of how sensitive, statistically powerful, and accurate methods must be if they are to measure program-induced behavioral changes; and (3) it reveals methodological problems that, if possible, should be avoided in subsequent research.

Data regarding condom availability in schools come from preliminary, unpublished research focusing on schools that have made condoms available and from research on school-based clinics that have provided contraceptives.

Student Receipt of Condoms

The primary purpose of making condoms available to students is to increase condom use. Two very important questions are: (1) If schools make condoms available, how many condoms will be given out to the students, and (2) how many students will obtain them from the schools?

Thus far, there is some but not a great deal of evidence to answer these questions, partly because condoms only recently have been made available on school campuses, and partly because where condoms are given out anonymously, it is difficult to count the number of students who have obtained them.

Several schools in Canada and the United States have sold condoms through vending machines. During an eighteen-month period at thirty-four high schools in Toronto, ten or fewer condoms per month per school were sold through vending machines.¹ One possible reason for the relatively low number of condoms sold in Toronto was the cost. In the school vending machines, the condoms cost one dollar each, whereas in Toronto drug stores the cost is three condoms for about two dollars. Similarly, in an Ottawa school, two condom vending machines in a male and female restroom also sell an average of ten condoms a month.²

The importance of cost is also supported by the experience of Falmouth, Mass. Its high school made condoms available in vending machines at a cost of 75 cents each and through the school nurse free of charge. Students purchased about sixty condoms per month from the vending machines but obtained about 350 per month from the nurse.³

Cost, however, is not the only factor affecting program use. At a Colorado high school providing free condoms, only sixteen students obtained condoms two or more times from the school during the first year of distribution. However, two years later, after additional school staff began making condoms available to students, 171 students obtained condoms from the school two or more times.⁴

The Los Angeles School District has been making condoms available to students for nearly a year. Currently, the schools distribute about fifteen to twenty condoms per month per school.⁵

Nearby, in Santa Monica, Calif., a high school with approximately 2,700 students distributes about 1,300 to 1,500 packages of condoms per month.⁶ Each package contains two condoms and instructions. This large number of condoms distributed makes this program more effective than many other programs in the country. Notably, there are no parental consent requirements and high school students can obtain condoms from a variety of sources, including teachers, counselors, nurses, and condom bowls located in designated areas of the campus. Although twenty-five cent donations are requested for each package, students can take them free of charge, and many do so.

Some school-based health clinics have prescribed or dispensed contraceptives since 1973 and are a natural location in schools to distribute condoms. In six Baltimore school-based clinics, many condoms have been distributed to the students through the school-based health clinics.⁷ During a five-month period beginning in the fall of 1992, the mean number of condoms distributed monthly ranged from about 100 per school to almost 600 per school. Given the numbers of students enrolled in these

... selling condoms through vending machines is not an effective method of making condoms available, but ... providing them free of charge through numerous school staff and condom bowls and through school-based health centers may be very effective approaches.

schools, these condoms would have provided protection for one act of intercourse per month for 9% to 52% of the students, depending upon the school, or protection for more acts of intercourse among fewer students.

In Oregon, sixteen school-based clinics gave out more than 200 condoms per school per month.⁸ In Florida, the school clinic distributed about 1,500 con-

doms per month to the 1,300 students in its school.⁹ This is the only known school that distributes on a monthly basis more condoms than students in the school. Thus, those condoms may substantially reduce the amount of unprotected intercourse. In addition, according to the clinic nurse, students claim they sometimes use two condoms at a time to be safer in case one condom breaks during intercourse.

Little of this evidence has been published and some has been based upon personal communication; thus, it should be viewed cautiously. However, it does indicate a considerable range in the number of condoms distributed through schools; in some schools only a few condoms were distributed monthly, while in others enough condoms for half or all the students were given out. These data suggest that program characteristics and usage patterns may have a large influence on the number of condoms distributed. For example, they suggest that selling condoms through vending machines is not an effective method of making condoms available, but that providing them free of charge through numerous school staff and condom bowls, and through school-based health centers may be very effective approaches. Of course, other factors

undoubtedly also affect the numbers of condoms given out (for example, student need, alternative sources of condoms, type of parental consent, and other aspects of the program).

Impact on Sexual and Contraceptive Behavior

Obviously, the ultimate purpose of making condoms available in schools is not simply to give them to students but rather to reduce unprotected sexual activity by increasing the use of condoms. Proponents believe that condom availability in schools increases overall condom use, while opponents believe that it hastens the onset of intercourse and increases the frequency of intercourse. Some health professionals are concerned that greater use of condoms may lead to less use of oral contraceptives, which prevent pregnancy more effectively. All of these outcomes need to be examined.

There hasn't been any research to date on the impact that condom availability in schools has on the onset or frequency of intercourse or on overall use of condoms. However, researchers have measured the impact that contraceptives provided by school-based clinics have on sexual and contraceptive behaviors. This research should be viewed cautiously, partly because it involves clinics and partly because program impact on female use of oral contraceptives may differ considerably from program impact on male use of condoms.

A study¹⁰ of school-based clinics in different parts of the country revealed that the clinics did not cause sexual activity to increase and had varying effects on contraceptive use. At one clinic that focused on high-risk youth, emphasized pregnancy prevention, and dispensed oral contraceptives, there was a significantly greater use of oral contraceptives among females than in the comparison school. The clinic made condoms available but did not emphasize them; there wasn't any significant difference in condom use between the clinic and comparison school. At two other clinics that dispensed condoms and oral contraceptives, there weren't any

significant differences between the clinic and comparison school (one site) in student use of condoms or oral contraceptives nor any significant differences in another school before the clinic opened and two years later (one site). A fourth school-based clinic did not dispense contraceptives but did refer students to Planned Parenthood, where they could obtain contraceptives free of charge. The clinic was also part of a more comprehensive program that included a strong educational component. The students in that school were more likely than students in the comparison school to use condoms and oral contraceptives, but they were not more likely to engage in intercourse.

A variety of data from that study indicated there was a very large substitution effect: Most but not all of the students who obtained contraceptives from the school clinics would have obtained contraceptives elsewhere if the clinics hadn't existed. The conclusion was that merely dispensing contraceptives isn't sufficient to markedly increase contraceptive use; more comprehensive approaches might have a greater impact.

A rural, isolated community in South Carolina implemented a comprehensive school and community campaign wherein condoms were made available to students, though such availability wasn't the focus.¹¹ Teachers, administrators, and community leaders received sex-education training; sex education was integrated into all grades; peer counselors were trained; the school nurse counseled students, provided condoms to male students, and took female students to a family planning clinic; and local media, churches, and other community organizations highlighted special events and reinforced messages about avoiding unintended pregnancy. After the program began, the pregnancy rate among those who were fourteen to seventeen years old declined significantly for several years. After parts of the program ended (for example, school policies prevented the school nurse from providing condoms, and some teachers left the school), the pregnancy rates returned to preprogram levels.¹² Whether the change in pregnancy rates was due to chance variations, to the availability of condoms and

transportation to nearby family planning clinics, or to other program components isn't known.

In sum, there has been little research on condom availability programs. Limited data indicate there is considerable variation in the number of condoms distributed to students and that the number varies greatly with the mechanisms for making them available. Research from school-based clinics suggests that condom availability will have a modest impact on condom use, because some but not all of those who receive condoms from the schools would have obtained them anyway from some other source. While the national and South Carolina studies of comprehensive programs are encouraging, they certainly aren't definitive. The studies suggest that comprehensive programs that include greater access to condoms may increase condom use. Currently, the impact of condoms per se within a larger, more comprehensive program is simply not known.

The study results are not definitive because all of the studies had important methodological limitations: (1) Schools were not randomly assigned to program and control conditions; (2) schools with clinics and comparison schools may have differed in important and unmeasured ways; (3) quasi-experimental designs were typically weak; pretest and posttest data from both treatment and comparison schools were not always collected; (4) school programs were always schoolwide, but students, not schools, were used as the unit of analysis; (5) the number of schools and programs in each study was very small, ranging from one to six; (6) often, there were problems collecting data.

Unanswered Questions

Even the most basic questions regarding condom availability have yet to be answered:

- Prevalence of programs: How many schools make condoms available and how rapidly is this number growing?

- Adoption of programs: What are the critical steps leading to approval? What are the critical legal issues? How do parents and students, both locally and nationally, perceive the programs? Who should take the lead in obtaining approval? What should be the role of public hearings?
- Program characteristics: What is the impact of different parent-consent options? What is the impact of optional or mandatory counseling? How many sources of condoms should there be in each school? How critical are anonymity (vs. confidentiality) and cost of condoms? How much staff training should there be?
- Program effectiveness: How many students—males and females—obtain condoms? What percentage of sexually experienced students obtain them? How many condoms are acquired? How do program characteristics, such as counseling or parental consent, affect these measures? When students have a choice, how many of them obtain condoms through a variety of sources, such as teachers, counselors, and vending machines?
- Program impact: Does condom availability in schools affect the onset or frequency of intercourse? Does it increase condom use during intercourse? Does it diminish the use of oral contraceptives? How much does it reduce unprotected intercourse?
- Program cost: How much do programs cost? Are they a cost-effective way to reduce unprotected intercourse? What are the best sources of funding?

Without accurate data on these issues, policy makers will have greater difficulty deciding whether to implement programs, proponents will have greater difficulty defending programs, and those who implement programs will have greater difficulty designing maximally effective programs.

Implications for Research

Preliminary data have important implications for future evaluation methods:

- Numerous studies employing a variety of research methods should be conducted.
- It is important to measure the number of condoms distributed and, if possible, the number of students receiving them.
- The effectiveness of programs, measured either by receipt of condoms or impact upon condom use, may vary considerably among schools, and the factors affecting this variation should be identified.
- Because of the substitution effect, it is important to measure the impact on condom use, not simply the number of condoms that students obtain from schools.
- The number of condoms obtained by students is neither so small that the impact is not worth measuring nor so large that crude methods can adequately measure the impact.
- Because condom availability may have a greater impact if it is part of a more comprehensive program, both its independent effect and its combined effect with other program components should be measured.
- The limitations of previous research methods need to be surmounted to measure the modest effects of condom availability on condom use.

Research Design

The Need for Multiple Methods

A wide variety of methods is necessary to address these issues. The methods include:

- National surveys of program prevalence.

- In-depth case studies of implementation strategies.
- Surveys of parents and students to measure their support and reactions.
- Student focus groups and individual interviews to better understand how condom availability fits into adolescent psychosocial development.
- Collection and analysis of records on condom distribution in many schools to assess the effectiveness of different approaches in different settings.
- More rigorous evaluation designs to measure the impact of condom availability in schools.

One study cannot encompass all of the above. Consequently, large districts that want to know more about condom availability in their schools should facilitate numerous studies. A good example is the New York City Public Schools, which are a leader in condom availability. All public high schools in that system must make condoms available as part of comprehensive programs to prevent transmission of the human immunodeficiency virus (HIV). The chancellor has brought together researchers with various backgrounds and is encouraging several multifaceted studies. There are internal evaluations under way, and external teams of researchers plan to evaluate various aspects of condom availability and the educational components.

A discussion of all evaluation methods and principles that could and should be applied in studying condom availability is beyond the scope of this paper. Instead, the paper briefly discusses the collection of condom-distribution data from clinics and then focuses on evaluation methods to measure impact.

Counting the Number of Condoms Distributed

A very important measure of effectiveness is simply the number of condoms distributed in a school during a specified period of time. If only a few condoms are handed out, then the

program obviously isn't effective; if large numbers of condoms are distributed, students at least are getting condoms, and may even be reducing the frequency of unprotected intercourse.

The number of condoms distributed is more meaningful when it is expressed as a ratio of the number of condoms over the number of students in the school. It is even more meaningful when it is expressed as a ratio of the number of condoms over the number of sexually experienced students in the school or as a ratio of the number of condoms over the number of acts of intercourse among those sexually experienced students. Of course, the number of sexually experienced students and the number of times they have intercourse can only be estimated from surveys of students. By calculating these ratios, the measures become standardized and facilitate more meaningful comparisons among programs.

The number of condoms distributed and the more refined measures mentioned above also can be used to create time-series data. That is, as the ways in which condoms are made available in a school change or as the educational components change, the changes in the number of condoms distributed can be assessed.

The number of condoms distributed—even by vending machines or other anonymous ways—is relatively easy to determine if the proper people keep track of condoms ordered and dispersed.

Measuring Impact

The goal of making condoms available on campus is to decrease unprotected intercourse, so a very important and challenging question is: What is the impact of condom availability on the use of condoms and the reduction of unprotected intercourse?

Impact should be measured only if substantial numbers of condoms are distributed to students and only if there is a reasonable chance that schoolwide use of condoms may be measurably affected. Measuring the impact of condom availability by examining important outcomes, such as the rates of pregnancy, birth, or sexually transmitted disease (STD), is tempting. However, this

temptation should be avoided in most instances unless the analysis is very rigorous, because pregnancy, birth, and STD rates fluctuate greatly from year to year. Data showing that the pregnancy rate increased or decreased by a substantial percentage after condoms were made available typically are meaningless because the rate is likely to have changed substantially anyway. Only when many schools are part of the analysis or when time-series data over many years are analyzed are the results significant.

The following is a discussion of ways to assess the impact of condom availability on unprotected intercourse. While it may read like an introductory text, it reflects the fact that research has demonstrated the importance of basic methodological principles and that all of the confounding problems that destroy the validity of conclusions really do arise. Thus, in some respects, it is "back to basics."

A Feasible but Minimally Valid Design. To assess the impact that any program has on participants' sexual and contraceptive behavior, it is critical to measure participants' actual sexual and contraceptive behavior, measure as validly as possible what their behavior would have been had they not participated in the program, and then compare the results. This is a fundamental principle in evaluation design.

One way to assess what the participants would have done had they not participated in the program is to administer questionnaires schoolwide before and after condoms are made available. A comparison of "before" and "after" behaviors provides some indication of program impact. However, other factors may intervene between the two questionnaires to reduce the credibility of the results. For example, condom use may increase in the interim because there is a gradual increase everywhere, due to the heightened awareness of HIV and the acquired immune deficiency syndrome (AIDS). Or the increase may be precipitous because someone like Magic Johnson, the professional basketball player, announces he is HIV-positive.

A better pretest-posttest design uses another school as a comparison and measures the change in both schools over time. This design eliminates the impact of events, such as Johnson's announcement, that affect the two schools equally. Still, events affecting condom use may occur at only one of the schools—for example, an outbreak of gonorrhea that leads to greater condom use, or students may learn that a classmate is HIV-positive. Other broader changes affecting one school might include modified school boundaries that alter the proportion of risk-taking students, an entering freshmen class that is more or less responsible than previous classes, or the arrival of lower-risk students, especially if the school is a magnet school or has open boundaries. Such events, which diminish the validity of sexual-behavior studies, are not hypothetical. The dramatic annual swings in the rate of unexpected births at any given school are a testimony to the impact of all of these "chance" factors. Another problem arises when schools with condom availability programs, like those in New York City, launch other sex-education efforts, making it difficult to isolate the impact of condom availability. Thus, data obtained from a study that uses a pretest-posttest comparison group design can provide greater insight into the impact of a condom program, but they still aren't entirely valid.

The chances that one or more events will occur in one school and affect the results disproportionately can be diminished by including numerous program schools and comparison groups (schools with and without condom availability). "Large" studies have collected data from four, six, or even eight schools. The more the better.

In multiple-school evaluations, the program schools and comparison schools must be well-matched. Often, schools with clinics or schools that have made condoms available are those with large numbers of high-risk students, who need services the most; comparison groups commonly include schools with less sexual risk-taking behavior. This should be avoided whenever possible.

Even studying eight schools doesn't prevent random events or other differences from unduly affecting the results, especially when the impact of condom programs is modest. A few of the program schools and comparison schools probably will have undergone changes over time that either reduce or increase unprotected sex, making it difficult to interpret the results with any confidence.

A More Challenging, More Valid Design. The following design is described in part because it is feasible and should be undertaken, and also because it embodies important characteristics that can and should be incorporated into less valid and less challenging designs. For example, if a researcher doesn't use random assignment but does increase the number of schools in the study to twenty from four, that is a great improvement.

A valid design capable of measuring modest program impact must have these characteristics:

- The proper unit of analysis. When a school makes condoms available to students, it makes them available to all students (or to all of those who have parental consent), not just to some classes or to a random sample of students. Thus, the school, by definition, is the unit of analysis.

This has dramatic implications. If each of eight schools has 1,000 students and all eight are included in the design, the sample size is eight, not 8,000. Suppose the design involves randomly assigning the eight schools either to the program group, which makes condoms available, or to the control group, which does not make condoms available. If just one of the eight schools has very-high-risk students and if that school happens to be in the program group, the program schools would have higher mean rates of unprotected sex and would incorrectly suggest that condom availability increased sexual activity and reduced condom use. If students rather than the school were the unit of analysis, the sample size would be 8,000, and any small difference would

be highly statistically significant, primarily as a function of the sample size. In contrast, if the school were the unit of analysis, then the sample size would be eight, and any small difference would not be statistically significant.

Fortunately, new types of statistics called multilevel or hierarchical analyses allow for multiple levels of clustering in the experimental design (for example, at the individual, classroom, and school levels). These statistical approaches can be substantially more powerful than standard statistics, which use the school as the unit of analysis. The additional power generated by using multilevel statistics is a function of several things, including the number of students sampled in each school and the distributional characteristics of the dependent variables.

Multilevel statistics should be used in certain circumstances, but until power calculations based upon multilevel statistics are completed, the school should be treated as the proper unit of analysis.

- Random assignment of schools. The best way to make two groups comparable before an intervention is to use random assignment. If there is considerable variation among the schools in risk-taking behaviors, random assignment can be improved by obtaining schoolwide data from the schools on risk-taking behavior, using these data to pair the schools, and then randomly assigning the schools in each pair. For example, if there are twenty schools in the study, they should be ranked according to risk-taking behavior. Of the top two, one should be randomly assigned to the program group and the other to the control group. The same applies to the next pair and subsequent pairs of schools until all of the schools are randomly assigned.

It isn't easy or always feasible to assign schools randomly. In New York City, all schools must make condoms available, so there aren't any schools to randomly assign to the

comparison group. In such cases, it may be possible to use a delayed treatment design in which the schools in the control group simply make condoms available two or more years later.

Randomly assigning schools can be a challenge, but it can be done. Dozens of U.S. schools are participating in studies in which they are randomly assigned to (1) program groups that will have HIV/AIDS prevention programs or to (2) control groups that will not have such programs or will continue to have existing programs.

- A sufficiently large sample size. The sample size needed depends on many things. Among them are the desired power (the probability of finding a statistically significant result given an actual impact of a specified amount), the expected impact, the distributional characteristics of the dependent variables, and the number of students surveyed at each school. For a reasonable chance of finding a modest effect to be statistically significant, twenty to forty or more schools may be necessary.

If the number of schools is insufficient, the chances of finding statistically significant results decline, even when the program has modest but programmatically significant results.

- A design that measures the independent effect of condom availability and other components. The requirement in New York City that all high schools make condoms available and create a comprehensive program for reducing unprotected intercourse reflects a political reality and the difficulty of changing adolescent sexual behavior. Many people recognize that comprehensive programs may be more effective than single components, such as condom availability.

This has important implications for evaluation. It means that both the independent effect of condom availability and the effect of condom availability as a part of a comprehensive program should be measured.

In many schools that make condoms available, the second important component in a comprehensive program is an educational component, and that will be assumed in the example that follows. The most direct way to measure the independent and combined effects of condom availability and an educational component is by using a 2 x 2 factorial design:

2 X 2 FACTORIAL DESIGN

		Educational component	
		Yes	No
Condom availability	Yes		
	No		

This is an ideal design for two-way analysis of variance. This design does not markedly increase the number of schools that must participate, but it does mean schools must agree to random assignment to all four conditions. Whether principals prefer to be randomly assigned in this design or in a design involving only condom availability is unclear. After all, in 2 x 2 design they would have a 75% chance of having some intervention, whereas in a design involving only condom availability, they would have only a 50% chance.

- Appropriate cross-sectional or longitudinal surveys. If a study is to use the school as the unit of analysis, there are two appropriate ways to collect data: by means of a cohort design or a cross-sectional design. In the former, a random sample of students (presumably ninth graders) is selected in each of the schools and tracked for about three years. In the cross-sectional design, a random sample of students (presumably those in the ninth through twelfth grades) is selected in each of the schools each year for one or more years before the intervention was implemented and for two or more years after the intervention was implemented. In this design, not

all of the same students are surveyed each year; rather, a random sample of students in each school is surveyed.

Each of the two designs has its advantages and disadvantages. Cross-sectional designs of all students in the ninth through twelfth grades measure schoolwide impact, are easier to carry out, and are less costly because students need not be tracked. However, they do not automatically adjust for students who leave or join the school after program implementation nor do they control as effectively for baseline differences.

Cohort designs are more costly because students must be tracked. However, such designs can measure the timing of participation in program activities more accurately and the behavior change over time in individual students. Further discussion of the relative strengths of cohort and cross-sectional designs is beyond the scope of this paper.

If cross-sectional designs are implemented, it is very important that students be surveyed each spring. First, it is important that pretest and posttest surveys be administered during the same month, because student behaviors vary throughout the academic year. In the fall, more students are in school; by late spring, many have dropped out, thereby eliminating from the remaining school sample some of those students who are likely to engage in sexual risk-taking behavior. Also, of course, as students mature, they are more likely to have intercourse, then to use condoms, and finally to use oral contraceptives. Second, if surveys are going to be administered at any time of the year, it is best to administer them in the spring, after the freshman class has been exposed to the intervention and before the senior class graduates and is lost from the sample.

- Reliable measurement of important behaviors. During the last decade, some measurement issues have been rather well resolved. There currently exists a variety of questions measuring behavior that have been standardized and used in

many studies. Such questions should ask respondents if they have ever had intercourse, how old they were when they first had intercourse, how often they have intercourse, whether they used a condom the last time they had intercourse, where or from whom they obtained the condom, how frequently they used condoms in a given time interval, and whether they used other contraceptives the last time they had intercourse. Because the goal of many programs is not to increase condom use per se but rather to reduce unprotected intercourse, direct measures of such intercourse can be included. Logically, the single measure most highly correlated with pregnancy is the number of times the respondent has engaged in unprotected intercourse, protection meaning condoms and other types of contraceptives. The single measure most highly correlated with transmission of STD is the number of sexual partners with whom the respondent did not always use condoms. Finally, because HIV transmission between individuals who have intercourse once is relatively low, the measure most highly correlated with such transmission is the number of acts of intercourse without a condom. The latter two measures can be refined to include only intercourse with infected partners, though most youth do not know if their partners are infected. All of these measures should be based on a reasonable time period, such as three or six months, depending on the sample's frequency of sexual activity.

Conclusion

Making condoms available in schools is a potentially important method of reducing unprotected intercourse, unintended pregnancy, HIV/AIDS, and other STDs. Research of one kind or another should be conducted as soon as schools begin serious consideration of condom availability. For example, focus groups of students should be held to learn their insights into whether and how condoms should be made available, and surveys of parents can

be conducted to determine the amount of support for condom availability. Schools also should collect data on the number of condoms distributed; this is an important measure of program effectiveness that can be easily calculated. Some but not all schools should design or be involved in well-designed studies that rigorously measure the impact of condom availability programs on sexual and contraceptive behaviors.

Research on previous pregnancy prevention programs has been very revealing and constructive. Among other things, it has demonstrated that early expectations for some pregnancy prevention programs were naive—for example, early sex education programs and school-based clinics did not markedly reduce unprotected intercourse. It appears unlikely that there are any “silver bullets” that will dramatically increase condom use or decrease unprotected sex. However, it also appears likely that some programs do have a modest effect and can somewhat reduce unprotected intercourse. Thus, it is very important to identify, evaluate, and replicate promising approaches.

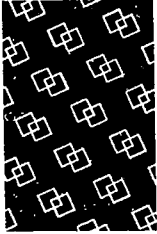
Formative research must be completed so the effectiveness of programs can be improved. Then, summative research must be completed so the impact of these programs on behavior can be accurately and validly measured.

In the last fifteen years, methods for evaluating programs that seek to reduce unprotected intercourse have advanced enormously. Such state-of-the-art, more sensitive, and more valid methods should be used to measure the impact of condom distribution. Only then will critically important questions be answered definitively and only then will policy makers and those who implement programs have the answers they need.

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APPENDIX I FORUM PARTICIPANTS

June 16, 1992

Robert W. Baillie

Project Director
Teen Peer Counselor Program
University of California, San Francisco
3130 20th St./Harrison St., Room 377
San Francisco, Calif. 94143-0898
(415) 476-8623

Jill Blair

Special Assistant to the Deputy Chancellor for Operations
New York City Public Schools
110 Livingston St., Room 1020
Brooklyn, N.Y. 11201
(718) 935-5433
FAX: (718) 935-5728

Peter Bonaker

Principal
Hanson Elementary School
7133 E. 73rd Ave.
Commerce City, Colo. 80022
(303) 288-9715
FAX: (303) 288-5578

Beverly Bradley, CHES, Ph.D.

Supervisor of Health Programs
San Francisco Unified School District
1512 Golden Gate Ave.
San Francisco, Calif. 94115
(415) 749-3400
FAX: (415) 749-3420

Claire D. Brindis, Dr. P.H.

Co-director
Center for Reproductive Health Policy Research
Institute for Health Policy Studies
University of California-San Francisco
1388 Sutter St., 11th Floor
San Francisco, Calif. 94109
(415) 476-5254
FAX: (415) 476-0705

Patti O. Britton

Executive Director
Sex Information and Education
Council of the United States (SIECUS)
130 West 42nd St., Suite 2500
New York, N.Y. 10036
(212) 819-9770
FAX: (212) 819-9776

Peter L. Clark, Ph.D.

Assistant Superintendent
Falmouth Public Schools
340 Teaticket Highway
East Falmouth, Mass. 02536
(508) 540-0151
FAX: (508) 457-9032

Julie Convisser

Project Director/Portland
Population Services International
1120 19th St. N.W., Suite 600
Washington, D.C. 20036
(202) 785-0072
FAX: (202) 785-0120

Ramon C. Cortines

Superintendent
San Francisco Public Schools
135 Van Ness Ave., Room 209
San Francisco, Calif. 94102
(415) 241-6121
FAX: (415) 241-6060

Karen Coyle, Ph.D.

Associate Director of Research
ETR Associates
4 Carbonero Way
Scotts Valley, Calif. 95066
(408) 438-4060, Ext. 140

Father Rodney DeMartini

Archdiocese of San Francisco
445 Church St.
San Francisco, Calif. 94114
(415) 565-3613

Joy Dryfoos

Consultant
20 Circle Drive
Hastings on Hudson, N.Y. 10706
(914) 478-3489

Abigail English, J.D.

National Center for Youth Law
114 Sansome St., 9th Floor
San Francisco, Calif. 94104
(415) 543-3379
FAX: (415) 956-9024

Jacqueline D. Forrest, Ph.D.

Vice President for Research
The Alan Guttmacher Institute
111 Fifth Ave.
New York, N.Y. 10003
(212) 254-5656
FAX: (212) 254-9891

Beth Gallegos

Board of Education
Adams County School District 14
230 W. 6th Ave.
Denver, Colo. 80204
(303) 892-1158
FAX: (303) 893-8562

Brenda Greene

Manager HIV and AIDS Education
Research and Management Services Department
National School Boards Association
1680 Duke St.
Alexandria, Va. 22314-3493
(703) 838-6722
FAX: (703) 683-7590

Sally Guttmacher, Ph.D.

Associate Professor
Department of Health Education
New York University
35 W. Fourth St., 12th floor
New York, N.Y. 10003
(212) 998-5780
FAX: (212) 995-4192

Charlene Harven, R.N., M.P.A.

Community Health Nursing Supervisor
Comprehensive School Health Services
Baltimore City Health Department
303 E. Fayette St., 2nd Floor
Baltimore, Md. 21202
(410) 396-3185
FAX: (410) 727-2722

Pamela Haughton-Denniston

Director of Public Affairs
Center for Population Options
1025 Vermont Ave. N.W., Suite 210
Washington, D.C. 20005
(202) 347-5700
FAX: (202) 347-2263

Ruby Hearn, Ph.D.

Vice President
Robert Wood Johnson Foundation
College Road East
U.S. Route 1
Princeton, N.J. 08543-2316
(609) 243-5915
FAX: (609) 452-1865

Karen Hein, M.D.

Director
Adolescent AIDS Program
Department of Pediatrics
Montefiore Medical Center
111 E. 210th St.
Bronx, N.Y. 10467-2490
(212) 920-6612
FAX: (212) 920-4351

Pamela Hillard

Comprehensive Health Specialist
Seattle School District
1330 N. 90th St., Room 101
Seattle, Wash. 98103
(206) 298-7987
FAX: (206) 298-7241

James C. Hoyle, Jr., M.D.

Chairman, Department of Pediatrics
Kelsey-Seybold Clinic, P.A.
111 Augusta Drive
Houston, Tex. 77057
(713) 780-1661
FAX: (713) 780-0397

Robert L. Johnson, M.D.

Director of Adolescent Medicine
UMDNJ - New Jersey Medical School
Department of Pediatrics
185 S. Orange Ave.
Newark, N.J. 07103-2714
(201) 456-5277
FAX: (201) 504-7597

Douglas Kirby, Ph.D.

Research Director
ETR Associates
4 Carbonero Way
Scotts Valley, Calif. 95066
(408) 438-4060
FAX: (408) 438-4284

Howard Klink

Public Affairs Director
Multnomah County Health Department
421 S.W. 5th, 6th Floor
Portland, Oreg. 97204
(503) 248-3782/(503) 248-3308
FAX: (503) 248-3828

Jane Kramer, Ph.D.

Program Officer
Bay Area Foundation for Human Resources
850 California St.
San Francisco, Calif. 94108
(415) 781-1662

Suzi Landolphi

Speaker/Performer

Amy Loomis

Program Officer
The Stuart Foundations
425 Market St., Suite 2835
San Francisco, Calif. 94105
(415) 495-1144
FAX: (415) 495-0439

Sharon Lovick Edwards

Senior Associate
The Annie E. Casey Foundation
One Lafayette Plaza
Greenwich, Conn. 06830
(713) 666-3250

Wendy Mahoney

Director of Patient Services
Family Planning Council of Southeastern Pennsylvania
260 S. Broad St., Suite 1900
Philadelphia, Pa. 19102
(215) 985-2600
FAX: (215) 732-1252

Karen Maiorca

Communicable Disease School Nurse
Los Angeles Unified School District
Senior High Division, Senior 11
644 W. 17th St., Room 210
Los Angeles, Calif. 90015
(213) 765-3480
FAX: (213) 742-8368

Faith Mitchell, Ph.D.

Program Officer
Hewlett Foundation
525 Middlefield Road, Suite 200
Menlo Park, Calif. 94025
(415) 329-1070
FAX: (415) 329-9342

Jacob Moody, M.S.W.

Director
Balboa Teen Health Center
San Francisco Department of Public Health
101 Grove St., Room 115B
San Francisco, Calif. 94102
(415) 586-5890

Susan Newcomer, Ph.D.

Demographics and Behavior Sciences
Center for Population Research, NICHD
National Institutes of Health
Executive Plaza North, Room 611
Bethesda, Md. 20892
(301) 496-1174
FAX: (301) 496-0962

Lynn Paltrow, J.D.

Litigation Director
Center for Reproductive Law and Policy
120 Wall St.
New York, N.Y. 10005
(212) 514-5534

Geri Peak, M.P.H.

Research Associate
Center for Population Options
1025 Vermont Ave. N.W., Suite 210
Washington, D.C. 20005
(202) 347-5700
FAX: (202) 347-2263

Gloria Primm-Brown

Carnegie Corporation of New York
437 Madison Ave.
New York, N.Y. 10022
(212) 371-3200
FAX: (212) 754-4073

Harlan Rotblatt

Director of Adolescent STD/HIV Services Project
STD Program
Los Angeles County Department of Health Services
12838 Erickson Ave.
Downey, Calif. 90242
(310) 940-8011
FAX: (310) 803-1628

John S. Santelli, M.D., M.P.H.

Division of STD/HIV Prevention
Centers for Disease Control
1600 Clifton Road N.E., Mail Stop E44
Atlanta, Ga. 30333
(404) 639-0848
FAX: (404) 639-0868

Mark Schuster, M.D., M.P.P.

RAND
P.O. Box 2138
Santa Monica, Calif. 90407-2138
(310) 393-0411, Ext. 7217
FAX: (310) 393-4818

Barbara Solomon, J.D.

Deputy City Attorney
Office of the City Attorney
City Hall, Room 206
San Francisco, Calif. 94102
(415) 554-4239
FAX: (415) 554-7716

Freya Sonenstein, Ph.D.

Senior Research Associate
The Urban Institute
2100 M St. N.W.
Washington, D.C. 20037
(202) 857-8546
FAX: (202) 223-3043

Mary Sosa

Assistant Director
National Education Association Health Education Network
1201 16th St. N.W.
Washington, D.C. 20036
(202) 822-7570
FAX: (202) 822-7775

Jeff Stryker

Center for AIDS Prevention Studies
University of California-San Francisco
74 New Montgomery St., Suite 600
San Francisco, Calif. 94105
(415) 597-9235
FAX: (415) 597-9213

Gary Yates

Senior Program Officer
The California Wellness Foundation
21550 Oxnard St., Suite 595
Woodland Hills, Calif. 91367
(818) 593-6600
FAX: (818) 593-6614

Kaiser Foundation Staff

Drew E. Altman, Ph.D.

President

Mark D. Smith, M.D., M.B.A.

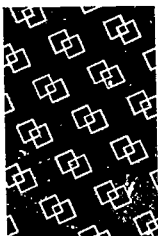
Vice President

Sarah E. Samuels, Dr. P.H.

Program Officer

Beverly Wright

Program Assistant



APPENDIX II FORUM AGENDA

THURSDAY, JUNE 18, 1992

7:45-8:30 Continental breakfast

8:30-9:00 Welcome

Drew E. Altman, Ph.D.
Henry J. Kaiser Family Foundation

Introductions

Moderator: Mark Smith

9:00-9:30 Dimension of the Problem: Teen-age Risk for STDs,
HIV/AIDS, and Pregnancy

Presenter: Robert L. Johnson, M.D.
New Jersey Medical School

Reactor: Sharon Lovick Edwards
Annie E. Casey Foundation

9:30-12:00 What is Occurring in the Nation's Schools

Presenter: Brenda Greene
National School Boards Association

Perspectives and discussion:

Beth Gallegos
Commerce City School District

Ramon Cortines
San Francisco Unified School District

Father Rodney DeMartini
Archdiocese of San Francisco

12:00-1:00 Lunch

1:15–5:00 Current School-based Condom Availability Programs

Moderator: Sarah E. Samuels, Dr.P.H.
Henry J. Kaiser Family Foundation

Teacher and school-operated:

Jill Blair
New York City School District

Peter Bonaker
Commerce City School District

Community and public health agency-operated:

Wendy Mahoney
Family Planning Council of Southeastern
Pennsylvania

Pamela Hillard
Seattle School District

Commercial marketing:

Peter L. Clark, Ph.D.
Falmouth School District

School-based clinics:

Charlene Harven, R.N., M.P.A.
Baltimore City Health Department

Howard Klink
Multnomah County Health Department

5:15 Van pick-up to hotel

6:30 Reception and dinner, Stanford Park Hotel, Palo Alto

Speaker/Performer: Suzi Landolphi

FRIDAY, JUNE 19, 1992

7:30 Van pick-up at hotel

7:45-8:30 Continental breakfast

8:30-10:00 Legal Issues

Moderator: Sarah E. Samuels, Dr.P.H.
Henry J. Kaiser Family Foundation

Presenter: Barbara Solomon, J.D.
Office of the City Attorney, San Francisco

Reactor: Abigail English, J.D.
National Center for Youth Law

Funding Streams for School-based Programs

Presenter: Claire D. Brindis, Dr.P.H.
Center for Reproductive Health
Policy Research, UC-San Francisco

Reactor: Amy Loomis
The Stuart Foundations

10:15-12:30 What Works

Joy Dryfoos
Consultant

Julie Convisser
Population Services International

Patti O. Britton
Sex Information and Education Council
of the United States

Geri Peak, M.P.H.
Center for Population Options

Teen Panel Discussion

Moderator: Robert W. Baillie
Teen Peer Counselor Program,
UC-San Francisco

Teen Panel: Lowanna Thomas
Robert Pineda
Christina Serrano
Emmet Foley

12:30-1:30 Lunch

1:30-3:30 Research and Evaluation

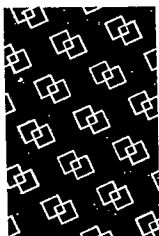
Moderator: Jeff Stryker
Center for AIDS Prevention Studies,
UC-San Francisco

Presenter: Douglas Kirby, Ph.D.
ETR Associates

Reactors: John S. Santelli, M.D., M.P.H.
Centers for Disease Control

Sally Guttmacher, Ph.D.
New York University

Closing Discussion



APPENDIX III DESIGN AND METHODOLOGY OF HARRIS SURVEY

Design

The sample of districts used in this study was based on a stratified probability selection of 300 school districts from the population of all public school districts that include middle schools and/or high schools in the forty-eight continental United States and the District of Columbia. Market Data Retrieval provided the basic sampling frame—that is, the listing of districts.

The sample of districts was selected in one stage. Before selection, all districts were divided into seven major strata on the basis of total number of students in the district: 1–599 students, 600–1,199 students, 1,200–2,499 students, 2,500–4,999 students, 5,000–9,999 students, 10,000–24,999 students, and 25,000 or more students. Each stratum was subdivided according to state.

Allocation of the 300 districts among the seven strata was proportional to the total number of students covered by the districts within each stratum. Selection of districts within each stratum was based on systematic random selection. Before they were selected, the districts in each stratum were sorted by state, which effectively created a geographic substratification within each of the seven major size strata. After the initial selection of districts, additional sample districts were selected in each substratum for use in case of final nonresponse and/or frame ineligibility.

To produce estimates that properly reflected the number of students (middle, junior, and senior high school) in each district, weights were applied to the information obtained for each district that appropriately reflected the number of nonelementary students

in the district. These weights were calculated by dividing the district size (number of nonelementary students) by the district's probability of selection. These weights were normalized to sum to the total number of sample districts.

Method

The survey was conducted by telephone from May 13 through June 5, 1992. Interviewers asked to speak with "your district's superintendent or the person in the administration who has the best understanding of and knowledge about districtwide policies related to health and social issues." Respondents and their districts were guaranteed anonymity. The overall response rate was 80%. Sixty-nine percent of the 299 completed interviews came from the primary sample; the remaining 31% came from the substitute sample in cases of nonresponse and/or frame ineligibility (each substitution was made with a district in the same size stratum—and, when possible, in the same state—as the district it replaced). Table IIIA profiles the respondents. Interviews lasted twelve minutes on average.

Potential Sampling Error

The results from sample surveys are subject to sampling error—the potential difference between the results obtained from the sample and those that would have been obtained had the entire population been questioned. The size of the potential sampling error varies with the size of the sample and the percentage giving a particular answer. Table IIIB sets forth the range of error in samples of different sizes at different percentage responses, at the 95% confidence level. For example, if the response for a sample size of 300 were 30%, the response would be between 25% and 35% in ninety-five of 100 identical samples drawn from the same population.

Sampling error is only one factor that can cause survey findings to vary from the findings that would result from

Table IIIA. Respondents

Base	Total 299 %
Job title	
Superintendent/assistant superintendent	53
Coordinator of health services	20
Director/coordinator of curriculum/instruction	6
Coordinator/director of pupil services	5
Other	13
Not sure/refused	3

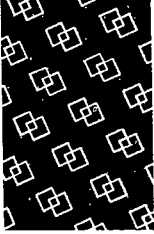
Median number of years in current position—4.91

interviewing the entire population under study. Survey research also is susceptible to human and mechanical errors, such as inaccurate interviewer recording and faulty data processing. However, the procedures used by Louis Harris and Associates keep such errors to a minimum.

Table IIIB. Approximate Sampling Tolerances to Use in Evaluating Percentage Results*

Number of people asked question on which survey result is based	Survey percentage result at 10% or 90%	Survey percentage result at 20% or 80%	Survey percentage result at 30% or 70%	Survey percentage result at 40% or 60%	Survey percentage result at 50%
300	3	5	5	6	6
200	4	6	6	7	7
100	6	8	9	10	10
50	8	11	13	14	14

*At the 95% confidence level



APPENDIX IV CONDOM AVAILABILITY PROGRAMS*

Programs at school-based health clinics in:

Baltimore, Md.
Cambridge, Mass.
Chicago, Ill.
Dallas, Tex.
Little Rock, Ark.
Los Angeles, Calif.
Miami, Fla.
Minneapolis, Minn.
New York, N.Y.
Philadelphia, Pa.
Portland, Oreg.
Portsmouth, N.H.
Quincy, Fla.

School or districtwide programs in:

Commerce City, Colo.
Culver County, Calif.
Falmouth, Mass.
Hatfield, Mass.
Los Angeles, Calif.
Martha's Vineyard, Mass.
New York, N.Y.
Philadelphia, Pa.
Santa Monica, Calif.
Washington, D.C.

* As of January 26, 1993

Programs approved and being designed in/at:

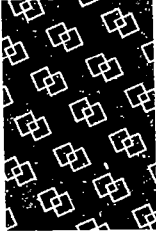
Amherst, Mass.
Chelsea, Mass.
Brookline, Mass.
Lincoln/Sudbury, Mass.
Newton, Mass.
Northboro, Mass.
Northhampton, Mass.
Provincetown, Mass.
San Francisco, Calif.
Seattle, Wash.
Sharon, Mass.
Somerville, Mass.
Wachusett Regional High School, Holden, Mass.

Programs rejected in/at:

Chester, Vt.
Canton, Mass.
Dedham, Mass.
Everett, Mass.
Grafton, Mass.
Greater New Bedford Regional Vocational High School,
New Bedford, Mass.
Hopedale, Mass.
Kennebunkport, Maine
Lake Washington, Wash.
Laurence, Mass.
Montachusets Regional Vocational High School,
Fitchburg, Mass.
North Andover, Mass.
North Shore, Wash.
Norwood, Mass.
Pathfinder Regional Vocational/Technical High School,
Palmer, Mass.

Pentucket Regional School Department, West Newbury, Mass.
Randolph, Mass.
Reading, Mass.
San Lorenzo Valley, Calif.
Southbridge, Mass.
Southwick-Tolland, Mass.
Springfield, Mass.
Swampscott, Mass.
Swansea, Mass.
Talbot County, Md.
Tamalpais High School, Marin County, Calif.
West Springfield, Mass.
Whitman-Hanson Regional School District, Whitman, Mass.
Winchester, Mass.
Worcester, Mass.
Weymouth, Mass.
Uxbridge, Mass.

Source: The Center for Population Options, 1025 Vermont Ave. N.W.,
Washington, D.C. 20005



APPENDIX V CONDOM HISTORY AND LORE

Ancient references to condom-like devices are sparse and ambiguous, but the Egyptians probably developed some type of condom for prophylaxis against tropical diseases. The only reference in Greek or Roman literature refers to King Minos of Crete, who had an unusual sexually transmissible condition: His semen allegedly contained serpents and scorpions. He used the bladder of a goat to protect his wife Pasiphaë, the daughter of the sun. Clearly, disease prophylaxis was paramount, as Pasiphaë went on to have eight children.

The first indisputable reference to a “condom,” described by the Italian anatomist Gabriello Fallopio in 1564, was a linen sheath moistened with lotion to protect against venereal diseases. Such a sheath was elegantly described in 1671 by Mme. Sévigné, a French writer, as “armor against love, gossamer against infection.”

The origin of the term “condom” isn’t definitive. The word first appeared in print in 1717, in an English publication on syphilis. Whatever its origin, no one is exactly fighting for credit. The French colloquially refer to the condom as *la capote anglaise* (the English cape) and the English dub it the “French letter.”

By the mid-1700s, condoms were openly sold in London, Paris, Berlin, and St. Petersburg, although not everyone approved. This is what Johaannes Astruc, King Louis XV’s physician, had to say about them:

[T]here are recently employed in England skins made from soft and seamless hides in the shape of a sneath...with which those about to have intercourse wrap their penis as in a coat

of mail in order to render themselves safe in the dangers of an ever-doubtful battle. They claim, I suppose, that thus mailed and with spears sheathed this way, they can undergo with impunity the chances of promiscuous intercourse. But they are greatly mistaken.

Condoms were first manufactured from rubber in the 1870s, thirty to forty years after the vulcanization of rubber. By the 1930s, 300 million were sold annually in the United States (today's manufacturing capacity is about 5 billion).

In *No Magic Bullet*, Allan Brandt chronicles the change in attitudes and practices regarding condoms between World War I and World War II. In World War I, exhortations and vice-squad sweeps were the first response to the threat of sexually transmitted diseases. By the end of the war, prophylactic kits were being distributed. But instead of condoms, the kits contained calomel ointment, carbolic acid, and camphor. Condom use was viewed as a threat to the integrity and moral fiber of the American family.

In World War II, the government adopted a different attitude toward the sexuality of soldiers. An educational program—"If you can't say no, take a pro"—created a climate in which 50 million condoms were given away or sold each month.

The advent of the acquired immune deficiency syndrome raised the stakes for condoms, yet since World War II, government agencies hadn't tested condoms for reliability. In the mid-1980s, *Consumer Reports* was the most definitive source on condom quality control, focusing mostly on the efficacy of condoms in preventing pregnancy. Since then, there have been a number of studies, both in laboratories and under conditions of use, of condom materials to learn which are effective barriers against viruses. Suddenly, condoms began to receive the same scrutiny as other life-saving medical devices regulated by the U.S. Food and Drug Administration (FDA). One of the most bizarre questions that confronted the FDA was whether condoms containing food coloring needed to be regulated as "food."

Condoms seldom escape controversy. Their very mention can provoke an uproar, as a story on the news wire a few years ago attests. A couple from the former Soviet Union was traveling on their honeymoon in Portugal when they realized they had left their contraceptives at home. Phrase book in hand, they asked a clerk in an airport drugstore for some "protection." They were swiftly surrounded by security guards, as their request had been interpreted as a plea for political asylum.

Jeff Stryker

Center for AIDS Prevention Studies,
University of California-San Francisco

THE HENRY
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