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D

Divider Title: _____

FAX COVER

TO: JOHN PODESTA
FROM: ALAN HOFFMAN
DATE: March 9, 1995
NUMBER OF PAGES: 12-EXCLUDING COVER
RE: INFORMATION PERTAINING TO THE
COMMISSIONED CORPS
RECIPIENT'S FAX: 456-2215
SENDER'S TELEPHONE: 690-6786

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Q. What will be your priorities with regard to the Public Health Service's Commissioned Corps?

A. The Corps consists of health professionals with expertise in biomedical research, health care administration, epidemiology, sanitation and so on. They are in 600 locations here and abroad.

The Corps' primary mission, really, is to attract highly qualified health professionals for many key posts in the PHS agencies -- and elsewhere. About 1,000 of the 6,300 officers of the Commissioned Corps are assigned outside the Public Health Service -- to the Bureau of Prisons and Coast Guard, for example, and to provide public health expertise within the Environmental Protection Agency. Others have led the research within the Public Health Service -- from that on Rocky Mountain fever to today's war on AIDS.

Contingents of Corps officers have also been quickly on the scene to help in emergencies -- the Northridge earthquake, the Midwest flooding, and Hurricanes Andrew and Hugo, to name several recent examples. As a uniformed service with a structure similar to the Armed Services, the Corps gives the Public Health Service management a great deal of flexibility in meeting needs quickly.

I'm pleased to have the opportunity to serve as head of the Corps, and to join its members in wearing the uniform with pride and spirit.

As I learn more about the Commissioned Corps, my priorities will be to make sure the men and women of the Corps are used in the most effective manner we can -- and that their expertise is focused on pressing public health priorities. I will certainly welcome Congress's views in any area of particular concern.

Q. How will your role be different than the previous surgeons general? To whom will you report: Secretary Shalala? Dr. Lee?

A. More than a century ago, the first Surgeon General directed a group of hospitals for sick and disabled seamen. Dr. John Maynard Woodworth was the first such Supervising Surgeon in 1671, but under his tenure the post became known as Supervising Surgeon General and then in 1875, Surgeon General. The Public Health Service was already broadening to meet new needs. Today, it includes eight agencies of importance to the health of the American people. For example, the original PHS research laboratory has grown into the National Institutes of Health, the largest of those agencies. The PHS' work on tracking and identifying infectious diseases has grown into the Centers for Disease Control and Prevention, another PHS agency -- and there are the FDA, the Indian Health Service and others with unique missions in reaching the underserved, the mentally ill and drug-dependent, and in studying the most effective medical practices.

Since the 1960s, the Assistant Secretary for Health has directed the Public Health Service under the supervision of the Secretary for Health and Human Services, Donna E. Shalala.

Today, the Surgeon General reports to the Assistant Secretary for Health, and supervises the PHS' Commissioner Corps, which was established in 1889 as a mobile corps that could be assigned as needed as disease detectives, in fighting infection, and helping in natural and man-made disasters, such as the California earthquake and the Midwest floods. They have led the assault on Rocky Mountain fever, the elimination of smallpox from the world and of polio from the Americas, and they are in the forefront of the battle against AIDS today.

Today's Surgeon General also works with the Centers for Disease Control and Prevention and other PHS agencies and offices in the development of special reports on smoking and other habits that affect one's own health and others'. And the Surgeon General has a strong educational role in these areas... an educator and health advocate.

To the degree that the Surgeon General earns the respect and the ears of Americans, he or she is often called "the people's doctor" -- a physician who recommends, preaches a bit and espouses the health habits and policies that will benefit all Americans.

Finally, the Surgeon General carries out additional activities that the President, the Secretary and the Assistant Secretary for Health request.

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AT A GLANCE: ADVANTAGES OF THE COMMISSIONED CORPS

Several aspects of the Corps make it valuable to PHS management. The Corps provides the PHS with mobile, flexible, and responsive staff who can meet a range of public health needs, such as providing emergency medical services during natural disasters and developing public policy on health care issues.

Administrative Authority. Although the President retains some authority, the Commissioned Corps is administered entirely within DHHS. This is particularly important in satisfying the changing roles and demands of the PHS. Departmental authority permits timely development and revision of regulations, policies, and procedures. The President may, by Executive Order, militarize the Corps in times of war or emergencies involving national security. The Corps was militarized during the First and Second World Wars and the Korean Conflict.

Structure. The active duty force of the Commissioned Corps includes two components: the regular component, whose officers have made a career commitment to the PHS, and the reserve component, which increases or decreases to meet Service needs. The regular component has an authorized strength of 2,800. Its officers are appointed through presidential nomination and Senate confirmation.

The inactive reserve includes more than 6,000 health professionals who can meet the changing needs of the PHS. Approximately 1,000 inactive reserve officers have indicated their willingness to participate in short tours of active duty each year to meet acute staffing shortages. These "ready reserve" officers are used primarily by the Indian Health Service, the National Health Service Corps, and the Bureau of Prisons.

Mobility. Each officer is sworn to serve in any position or area required by the exigencies of the Service. The PHS has broad authority to reassign commissioned officers to meet personnel needs.

Flexibility. Commissioned officers retain their rank or grade regardless of assignment. They are able to readily accept new assignments without fear of losing grade or compensation.

Emergency Response. Commissioned officers may be called to duty 24 hours a day. If necessary, they are required to work irregular and prolonged hours under adverse, physically demanding conditions, without special consideration. The Corps has been the primary source of health professional personnel deployed by the PHS during national and international emergencies.

Training. The Corps has been the training ground for many health professionals who have gone on to assume leading roles throughout the country: in Federal, State, and local public health agencies; in the foreign service; and in health and medical education positions in the private sector.

Coordination. Commissioned officers enjoy a variety of assignments that expose them to health problems and issues throughout the country. As a result, they understand health issues that arise at the State and local level. They work closely with State and local health officials, and are often able to engage them in cooperative and coordinated public health efforts.

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**MISSION STATEMENT FOR THE
COMMISSIONED CORPS OF THE UNITED STATES
PUBLIC HEALTH SERVICE**

The mission of the Commissioned Corps of the Public Health Service is to provide highly-trained and mobile health professionals who carry out programs to promote the health of the Nation, understand and prevent disease and injury, assure safe and effective drugs and medical devices, and deliver health services to Federal beneficiaries, and who furnish health expertise in time of war or other national or international emergencies. As one of the seven uniformed services* of the United States, the Commissioned Corps is a specialized career system designed to attract, retain, and develop health professionals who may be assigned to Federal, State, or local agencies or international organizations to accomplish its mission.

*Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service, National Oceanic and Atmospheric Administration

**APPROVED BY RADM JAMES O. MASON
ACTING SURGEON GENERAL
8 NOVEMBER 1989**

03/09/95 22:44

002

QUESTIONS AND ANSWERS ABOUT THE
COMMISSIONED CORPS OF THE PUBLIC HEALTH SERVICE

- Q: What is the mission of the PHS Commissioned Corps?
- A: See attached official mission statement.
- Q: How many officers are on active duty in the PHS Commissioned Corps?
- A: As of March 1, 1995, there were 6,257 officers on active duty. Approximately, 2,400 officers are assigned to the Indian Health Service to provide health services to Native Americans and Alaska Natives. In addition to the officers assigned to each of the eight PHS Agencies, approximately 1,000 officers are detailed to non-PHS Agencies including the Bureau of Prisons, U.S. Coast Guard, Environmental Protection Agency, and the Health Care Financing Administration. Officers are often detailed to international health organizations, States, and localities to provide public health expertise.
- Q: How are commissioned officers paid?
- A: As one of the seven Uniformed Services of the United States, along with the Army, Navy, Air Force, Marine Corps, Coast Guard, and Commissioned Corps of the National Oceanic and Atmospheric Administration, PHS officers are paid on the bases of the uniformed services pay scale. Under that pay scale, officers are paid based on their grade and length of service. In addition, medical officers, dental officers, veterinarian officers, optometry officer, and certain nurse and engineer officers receive various types of special pay that are designed to decrease the gap between uniformed services and private sector pay rates.
- Q: May the PHS Commissioned Corps be militarized?
- A: Pursuant to 42 U.S.C. 217, the President, by Executive Order, can make the PHS Commissioned Corps a branch of the land and naval forces of the United States. The PHS Commissioned Corps was militarized during World War I, World War II, and the Korean Conflict.

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Q: Have PHS commissioned officers been utilized in national emergencies?

A: In the history of the Commissioned Corps which spans more than 100 years, PHS officers have often been utilized during emergency situations. Most recently, for example, PHS officers assisted in the aftermaths of Hurricanes Hugo and Andrew, provided health expertise in the wake of the Midwest and Georgia floods, rendered health services and guidance following the Northridge earthquake, tracked the Hanta virus outbreak in the Southwest, and provided nursing services in Rwandan refugee camps in Goma, Zaire.

Office of the Assistant Secretary for Health

Public Health Service Commissioned Corps

Retirement Pay and Medical Benefits for Commissioned Officers Appropriation

	<u>FY 1994</u>	<u>FY 1995</u>	<u>FY 1996</u>	<u>Change</u>
Retirement Payments	\$114,630,000	\$124,213,000	\$129,808,000	+\$5,595,000
Survivors' Benefits	7,399,000	8,826,000	9,208,000	+382,000
Medical Care Benefits ..	22,283,000	23,844,000	25,108,000	+1,264,000
Military Service Credits	<u>2,879,000</u>	<u>2,438,000</u>	<u>2,801,000</u>	<u>+363,000</u>
Total, BA	147,191,000	159,321,000	166,925,000	+7,604,000

Women and Minorities in the Corps

- The numbers of Public Health Service commissioned officers by gender:

	<u>March 1987</u>		<u>February 1995</u>	
	<u>Number</u>	<u>Percentage</u>	<u>Number</u>	<u>Percentage</u>
Female	1,194	22.3%	2,033	32.4%
Male	<u>4,172</u>	77.7%	<u>4,244</u>	67.6%
Total	5,366		6,277	

- The numbers of PHS commissioned officers by race/ethnicity:

	<u>March 1987</u>		<u>February 1995</u>	
	<u>Number</u>	<u>Percentage</u>	<u>Number</u>	<u>Percentage</u>
Native American ..	235	4.4%	374	6.0%
Asian	145	2.7%	226	3.6%
Black	227	4.2%	372	5.9%
Hispanic	122	2.3%	213	3.4%
White	4,516	84.2%	5,067	80.7%
No Data	<u>121</u>	2.3%	<u>25</u>	0.4%
Total	5,366		6,277	

Officers Currently On-Duty

- Active duty officers as of February 1, 1995:

<u>Agency</u>	<u>Officers</u>
AHCPR	23
SAMHSA	114
CDC	708
FDA	510
HRSA (includes Coast Guard and BOP)	1,112
IHS	2,413
NIH	927
OASH	130
HCFA	89
ASTDR	52
EPA	186
OS	<u>13</u>
Total	6,277



THE COMMISSIONED CORPS OF THE UNITED STATES PUBLIC HEALTH SERVICE

The PHS Commissioned Corps is a uniformed service of the United States that consists of health professionals in 11 different categories. The Corps is led by the Surgeon General who in turn reports to the Assistant Secretary for Health. As a uniformed service, the grade structure, compensation and benefit system, and mobility requirements of the PHS Commissioned Corps are the same as those established for the Armed Forces.

Active duty commissioned officers are assigned to each of the eight PHS agencies. The largest contingent -- approximately 40 percent of the 6,500 officers -- are assigned to the Indian Health Service where they provide health care to American Indians and Alaska Natives in field locations which are often in very remote and isolated areas of the country. In addition, approximately 1,000 officers are detailed to other agencies such as the United States Coast Guard, Bureau of Prisons, Environmental Protection Agency, Health Care Financing Administration, and the District of Columbia Mental Health Commission.

The origins of the Commissioned Corps go back to 1798 when the Congress enacted legislation to establish a Marine Hospital Service under the Treasury Department to protect ill and injured seamen. In 1809, the Congress officially established the Commissioned Corps along military lines, and in 1912 the powers of

the Corps were enlarged and the Service was renamed the Public Health Service.

Today the Corps consists of approximately 6,500 officers divided into the "Regular Corps" and the "Active Reserve Corps". The Regular Corps is the career component of the corps and currently includes about 2,250 officers. Its size is established annually in the HHS Appropriations Act. The active reserve corps supplements the regular corps and its size depends on the needs and resources of the PHS. At present, the active reserve corps consists of about 4,250 members.

Corps officers are placed in professional categories depending on qualifying degrees as follows:

Category	Abbrev.	Code	Approximate Active Duty
Medical Officers	MED	01	1780
Dental Officers	DENT	02	710
Nurse Officers	NURSE	03	1010
Engineers	ENG	04	510
Scientists	SCIEN	05	280
Sanitarians	SAN	06	340
Veterinary Officers	VET	07	110
Pharmacists	PHARM	08	720
Dietitians	DIET	09	90
Therapists	THER	10	100
Health Services Officers	H&O	11	800

Each commissioned officer holds a permanent grade; many also hold higher temporary grades. The grades currently range from 1 to 10, preceded by the letter "O" signifying "officers". Officers holding temporary grades above O-6 are referred to as flag grade officers. The grades and titles with Navy equivalents are as follows.

Designation of Grade within the Public Health Service			Equivalent Designation of Grade within the Navy	
Code	Full Title	Abbrev.	Full Title	Abbrev.
Flag Grades				
O-10	Assistant Secretary for Health	SG	Admiral	ADM
O-9	Surgeon General	SG	Vice Admiral	VADM
O-8	Deputy Surgeon General	DSG	Rear Admiral	RADM
O-8	Assistant Surgeon General	ASG	Rear Admiral	RADM
O-7	Assistant Surgeon General	ASG	Rear Admiral (lower half)	RADM
Other Grades				
O-6	Director	DIR	Captain	CAPT
O-5	Senior	SR	Commander	CDR
O-4	Full	O	Lieutenant Commander	LCDR
O-3	Senior Assistant	SA	Lieutenant	LT
O-2	Assistant	A	Lieutenant (Junior Grade)	LTJG
O-1	Junior Assistant	JA	Ensign	ENS

At present, the Deputy Assistant Secretary for Health (and acting Assistant Secretary for Health, Dr. Manley), the Surgeon General, (Dr. Novello), and the following PHS Agency Heads are commissioned officers: Dr. Harmon-HRSA; Dr. Rhoades-IHS; Dr. Roper-CDC, and Dr. Clinton-AHCPR. Examples of other high ranking PHS officials in the Commissioned Corps are:

Dr. Broder
Director, National Cancer Institute, NIH

Dr. Fauci
Director, National Institute for Allergy and Infectious Diseases, NIH

Dr. Gaston
Director, Bureau of Primary Health Care, HRSA

Dr. Paack
Director, Center for Drug Evaluation and Research, FDA

Dr. Whitney
Deputy Surgeon General, OSG/OASH

Dr. Miller
Director, National Institute for Occupational Safety and Health

Mr. Mansland
Director of Headquarters Operations, IHS

An active duty officer is entitled to full medical and dental care at hospitals and clinics of the uniformed services. Dependents are treated on a space available basis for medical care but have access to private providers through CHAMPUS which is a shared-cost insurance program for the uniformed services.

Officers are in a non-contributory, non-vested retirement system and except for unusual circumstances, can not retire before 20 years of service. All officers accrue 30 days annual leave in a year with unlimited sick leave.

Officers receive a Basic Allowance for Quarters (BAQ) which is tax free and are eligible, based on actual expenses, for a Variable (VHA) which is established with a maximum for each grade and location. If

government housing is available, the officer may opt to occupy it and in return surrenders the two allowances. Both the ASH and SG are eligible for housing on the government reservation at NIH in Bethesda.

June 25, 1993

The Honorable Claiborne Pell
United States Senate
Washington, D.C. 20515

Dear Senator Pell:

Thank you for your recent letter, and for taking time out of your busy schedule to meet with me.

I have been working on the homework assignments which came up during our discussions and would offer the following information in response to your questions. If you would like further information concerning the office of Surgeon General, or the Public Health Service, please feel free to contact me.

First, in response to your question about personnel in the commissioned Corps, all Commissioned Corps personnel are officers. There are currently 6,500 commissioned officers employed by the eight Public Health Service Agencies. Approximately 40 percent of these officers work for the Indian Health Service. In addition, about 1,000 officers are detailed to other agencies, such as the United States Coast Guard (which you mentioned during our discussion), Bureau of Prisons, Environmental Protection Agency, Health Care Financing Administration and the District of Columbia Mental Health Commission. The eleven categories of officers are listed below:

CATEGORY	ACTIVE DUTY (APPROXIMATELY)
Medical Officers	1780
Dental Officers	710
Nurse Officers	1010
Engineers	510
Scientists	280
Sanitarians	340
Veterinary Officers	110
Pharmacists	720
Dietitians	90
Therapists	100
Health Service Officers	800

In response to your question regarding the relationship between the Office of Surgeon General and the Public Health Service, in 1968, the Secretary of the Department of Health, Education and Welfare, revoked all of the Surgeon General's authorities and re delegated them to the Assistant Secretary for Health and Scientific Affairs (the precursor of the Assistant Secretary of Health [ASH]). Prior to that time, the Surgeon General was responsible for the administration of the Public Health Service.

The Honorable Claiborne Pell, page 2

In 1977, Dr. Julius B. Richmond served as both the Assistant Secretary for Health, and the Surgeon General of the Public Health Service (PHS). In 1982, the dual title was, again, divided. In 1987, the Assistant Secretary for Health amended 52 FR 9219 to establish a separate Office of Surgeon General. The Assistant Secretary for Health is now the head of the United States Public Health Service, while the Surgeon General manages the PHS Commissioned Corps personnel system and serves as the health advisor to the nation.

As I indicated during my visit with you, if confirmed, I will have several programs within the Public Health Service under my supervision. These programs are:

Office of Women's Health
Office of Minority Health
Office of Disease Prevention and Health Promotion
Office of Population Affairs.

I hope this information is responsive to your questions. Again, please feel free to contact me if I can be of any service to you, or your staff.

Sincerely,

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M. Joycelyn Elders, M.D.

#14 Marcia Cove
Little Rock, Arkansas 72206

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United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES

WASHINGTON, DC 20510-6300

March 16, 1995

The Honorable Abner Mikva
Counsel to the President
The White House
Washington, D.C. 20500

Dear Judge Mikva:

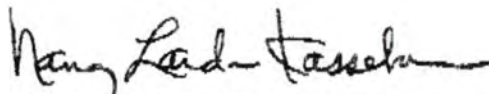
As you are aware, the Labor and Human Resources Committee is considering the President's nomination of Dr. Henry Foster to be Surgeon General of the United States. In connection with our Committee's review of the nomination, a matter has been brought to our attention which we believe the FBI should review further.

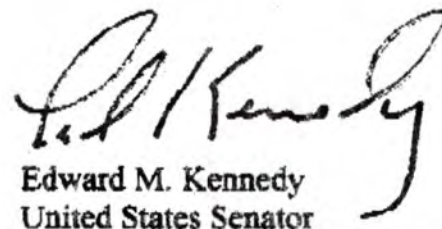
The matter involved is described in the enclosure to this letter. The description in the enclosure is not intended to suggest that we believe any impropriety has taken place. It is simply to direct the FBI's inquiry to specific persons and records and is not intended to limit in any way the scope of the inquiry or the leads developed or pursued regarding this or any other issue.

We are available to meet with you or the FBI should you wish to discuss this matter or any related issue and to provide any additional information that may be necessary. Committee staff are also available to meet with you or the FBI. Because of the importance of this nomination, we respectfully request that the FBI review begin immediately and proceed in a prompt manner. If possible, we would like FBI's findings by no later than March 30.

Thank you very much for your attention to this matter.

Sincerely,


Nancy Landon Kassebaum
United States Senator


Edward M. Kennedy
United States Senator

Enclosure

TUSKEGEE SYPHILIS STUDY

In 1932, the Venereal Disease Division of the United States Public Health Service began a study in Macon County, Alabama, to evaluate the effect of untreated syphilis in African American males. The study, commonly known as the Tuskegee Syphilis Study, was composed of 412 men who were believed to have untreated cases of syphilis and another 204 men who formed the control group. To the best of our knowledge, the study was concluded in 1973.

The Senate Committee on Labor and Human Resources is requesting that the Federal Bureau of Investigation investigate the Tuskegee Syphilis Study to determine the following:

1. Is there any evidence placing Dr. Foster at a 1969 meeting between the PIIS officials and the Macon County Medical Society? If so, what is it?
2. Is there any evidence on the scope and details of the presentation by the PHS officials to the Medical Society in the 1969 meeting?
3. If Dr. Foster did not attend the 1969 briefing, is there any evidence indicating that he knew about the study prior to 1972? If so, what is it?

In conducting the investigation, the Senate Committee on Labor is requesting the FBI interview a number of persons familiar with the Study and review relevant records from 1967 to 1973.

The individuals the Senate Committee on Labor is requesting be interviewed are:

1. Peter Buxton-- (415) 398-7363
2. Dr. James H. Jones--author, Bad Blood--(713) 521-3152
3. All living members of the Macon County Medical Society (1969-1972)
 - a) Dr. L.C. McRae--(912) 583-2229
 - b) Dr. S.H. Settler, Jr.--(334) 727-6553
 - c) Dr. Calvin Dowe--(334) 727-2792
 - d) Dr. John Hume--(334) 727-2046
 - e) Dr. Robert Story--(334) 727-5900
 - f) others??

Tuskegee Syphilis Study**Page 2**

4. Vanessa Gamble-- Historian of Medicine--(608) 262-5319
5. Jean Heller-- AP Writer--(813) 893-8215
6. Dr. David J. Sencer--Former NCDC Director--
7. Dan Fox--Milbank Fund--(212) 570-4800
8. Nurse Elizabeth Kennebrew
9. Dr. C. L. Hopper--Ex-Medical Director at Tuskegee--(510) 987-9028
10. Dr. Ira Meyers--Ala. State Health Official--(334) 272-0827
11. Wendell Morgan--Ala. State Medical Association--(205) 263-6441
12. Dr. Alfonso Holguin--former PHS official--(210) 492-9236
13. Fred Gray, Sr.--lawyer for study survivors--(334) 727-4830
14. Broadus Butler--Head of HEW's Ad Hoc Commission--(301) 431-0643
15. Merlin Duval--Asst. Sec. of HEW in 1972--(602) 954-6349
16. Dr. Leslie Norins--former PHS official--(813) 263-0605

The relevant records from 1967 to 1973 the Senate Committee on Labor is requesting be reviewed are:

1. PHS records related to the Tuskegee study.
2. Macon County Medical Society records related to the Tuskegee study.
3. Alabama State Medical Society records related to the Tuskegee study.
4. Alabama State Health Board records related to the Tuskegee study.
5. Milbank records on the Tuskegee Study.
6. John Andrews Hospital pathology records related to the Tuskegee study if segregated.
7. Tuskegee Institute records related to the Tuskegee study if segregated.

AGENDA
Labor Committee Democrats Meeting
April 26, 1995

1. White House supported events:

A. Thursday, April 27 -- Doctors trained at Meharry Medical Center who are now practicing doctors in many different states will come to Washington for an 11AM press conference followed by Senate visits to provide testimonials on behalf of Dr. Foster as a remarkable trainer of physicians. While in town they will do regional and national media.

B. Monday, May 1 -- Students from Dr. Foster's "I Have A Future" program will depart Nashville Sunday [media coverage] and arrive on Capitol Hill to be greeted by Vice President and Mrs. Gore and senators [**need senators to participate**]. Students will do national and regional media and will accompany Dr. Foster into the hearing. The students will stay to be available during the hearing on Tuesday.

2. Basic message supporting Dr. Foster for members in radio/tv appearances between now and the hearing: (see attached talking points)

A. Dr. Foster is highly qualified for the position of Surgeon General.

B. Dr. Foster deserves to have a fair hearing and to have his nomination voted on on the floor of the full Senate.

3. Format for the hearing:

A. Hearing to be held in Hart 216, PBS and National Public Radio may be covering the hearing live.

B. Opening statements delivered by the Chairman and Ranking Member. Other Democratic senators should have statements which will be distributed to the press and included in the Record.

4. Possible hearing outcomes:

A. Report nomination favorably -- requires all Democrats plus Senator Jeffords, with Senator Frist either voting for or abstaining.

B. Report to floor without recommendation.

C. Report to floor with negative recommendation.

D. Defeat nomination in Committee

5. Major areas where Republicans are likely to attack Dr. Foster and the senator taking the principal responsibility to respond to the charges:

Sen. Mikulski -- women's health and abortion related issues

Sen. Dodd -- the "I Have A Future" program, including issues of teen pregnancy, infant mortality, prenatal care, and sterilization

Sen. Simon -- abortifacients (prostaglandin research)

Sen. Kennedy -- the Tuskegee syphilis study, Meharry accreditation, other

6. Democratic senators need to be available to meet with press during the hearing and during the breaks in the hearing.

A. Consistent message should be delivered.

B. Senators should agree to be available for these interviews in advance.

NANCY LANDON KASSEBAUM, KANSAS, CHAIRMAN

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United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES

WASHINGTON, DC 20510-6300

March 16, 1995

The Honorable Abner Mikva
Counsel to the President
The White House
Washington, D.C. 20500

Dear Judge Mikva:

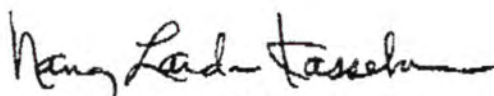
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The matter involved is described in the enclosure to this letter. The description in the enclosure is not intended to suggest that we believe any impropriety has taken place. It is simply to direct the FBI's inquiry to specific persons and records and is not intended to limit in any way the scope of the inquiry or the leads developed or pursued regarding this or any other issue.

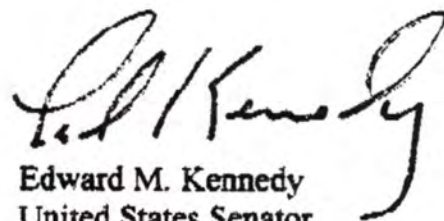
We are available to meet with you or the FBI should you wish to discuss this matter or any related issue and to provide any additional information that may be necessary. Committee staff are also available to meet with you or the FBI. Because of the importance of this nomination, we respectfully request that the FBI review begin immediately and proceed in a prompt manner. If possible, we would like FBI's findings by no later than March 30.

Thank you very much for your attention to this matter.

Sincerely,



Nancy Landon Kassebaum
United States Senator



Edward M. Kennedy
United States Senator

Enclosure

TUSKEGEE SYPHILIS STUDY

In 1932, the Venereal Disease Division of the United States Public Health Service began a study in Macon County, Alabama, to evaluate the effect of untreated syphilis in African American males. The study, commonly known as the Tuskegee Syphilis Study, was composed of 412 men who were believed to have untreated cases of syphilis and another 204 men who formed the control group. To the best of our knowledge, the study was concluded in 1973.

The Senate Committee on Labor and Human Resources is requesting that the Federal Bureau of Investigation investigate the Tuskegee Syphilis Study to determine the following:

1. Is there any evidence placing Dr. Foster at a 1969 meeting between the PIIS officials and the Macon County Medical Society? If so, what is it?
2. Is there any evidence on the scope and details of the presentation by the PHS officials to the Medical Society in the 1969 meeting?
3. If Dr. Foster did not attend the 1969 briefing, is there any evidence indicating that he knew about the study prior to 1972? If so, what is it?

In conducting the investigation, the Senate Committee on Labor is requesting the FBI interview a number of persons familiar with the Study and review relevant records from 1967 to 1973.

The individuals the Senate Committee on Labor is requesting be interviewed are:

1. Peter Buxton-- (415) 398-7363
2. Dr. James H. Jones--author, Bad Blood--(713) 521-3152
3. All living members of the Macon County Medical Society (1969-1972)
 - a) Dr. L.C. McRae--(912) 583-2229
 - b) Dr. S.H. Settler, Jr.--(334) 727-6553
 - c) Dr. Calvin Dowe--(334) 727-2792
 - d) Dr. John Hume--(334) 727-2046
 - e) Dr. Robert Story--(334) 727-5900
 - f) others??

Tuskegee Syphilis Study**Page 2**

4. Vanessa Gamble-- Historian of Medicine--(608) 262-5319
5. Jean Heller-- AP Writer--(813) 893-8215
6. Dr. David J. Sencer--Former NCDC Director--
7. Dan Fox--Milbank Fund--(212) 570-4800
8. Nurse Elizabeth Kennebrew
9. Dr. C. L. Hopper--Ex-Medical Director at Tuskegee--(510) 987-9028
10. Dr. Ira Meyers--Ala. State Health Official--(334) 272-0827
11. Wendell Morgan--Ala. State Medical Association--(205) 263-6441
12. Dr. Alfonso Holguin--former PHS official--(210) 492-9236
13. Fred Gray, Sr.--lawyer for study survivors--(334) 727-4830
14. Broadus Butler--Head of HEW's Ad Hoc Commission--(301) 431-0643
15. Merlin Duval--Asst. Sec. of HEW in 1972--(602) 954-6349
16. Dr. Leslie Norins--former PHS official--(813) 263-0605

The relevant records from 1967 to 1973 the Senate Committee on Labor is requesting be reviewed are:

1. PHS records related to the Tuskegee study.
2. Macon County Medical Society records related to the Tuskegee study.
3. Alabama State Medical Society records related to the Tuskegee study.
4. Alabama State Health Board records related to the Tuskegee study.
5. Milbank records on the Tuskegee Study.
6. John Andrews Hospital pathology records related to the Tuskegee study if segregated.
7. Tuskegee Institute records related to the Tuskegee study if segregated.



Nancy Landon Kassebaum

United States Senator
Kansas

For Immediate Release

KASSEBAUM REQUESTS WRITTEN TESTIMONY ON FOSTER NOMINATION BY MARCH 24

WASHINGTON, D.C.--March 8, 1995--Sen. Nancy Landon Kassebaum, R-Kan., announced today that organizations and individuals who want to submit written testimony on the background and qualifications of Dr. Henry Foster to be U.S. Surgeon General must send it to the Senate Labor and Human Resources Committee by the close of business on March 24.

"Hearings on Dr. Foster's nomination will be scheduled as soon as the committee has been able to review all the written testimony and after the White House provides the committee with Dr. Foster's financial disclosure statement and other documents that have been requested," said Kassebaum, chairman of the Labor and Human Resources Committee.

Kassebaum said the committee would maintain its past policy of receiving oral testimony only from the nominee at the confirmation hearing.

"I believe it is important that there be fair hearings that allow Dr. Foster to present his case to the committee," Kassebaum said. "The committee also needs time to review written testimony from those who oppose or support this nomination."

Written testimony should be sent to:

June Lawrence
Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

###

Contact: Mike Horak - Press Secretary
Joel Bacon - Deputy Press Secretary
202-224-4774

11-11-11

62604

THE WHITE HOUSE

WASHINGTON

April 28, 1995

The Honorable Mike DeWine
United States Senate
Washington, D.C. 20510-3503

Dear Senator DeWine:

This letter responds to your letter of April 27, 1995, requesting information pertaining to Dr. Henry Foster, Jr., the Administration's nominee to be Surgeon General. This letter addresses each of your questions in turn.

(1) Dr. Foster was named, along with Meharry Medical College d/b/a George Hubbard Hospital and numerous other physicians, in a suit filed in federal district court in Nashville. The plaintiffs were parents of an infant who died fewer than 24 hours after being delivered by a caesarean section by Dr. Foster and other physicians. Plaintiffs claimed that Dr. Foster and other physicians negligently failed to perform the caesarean section earlier, failed to monitor properly the condition of the mother prior to delivery, and failed to provide proper care to the infant after delivery.

The lawsuit was filed on October 5, 1984 and was dismissed on November 19, 1985. The parties stipulated to the dismissal of Dr. Foster and several other physicians who were defendants on November 4, 1985. On November 11, 1985, the district court ordered that the action be dismissed without prejudice to Dr. Foster and another physician. That order was entered into the record on November 12, 1985.

The attached letter from the State Volunteer Mutual Insurance Company to Dr. Foster indicates that, in connection with this lawsuit, no payments were made to the plaintiffs on behalf of Dr. Foster.

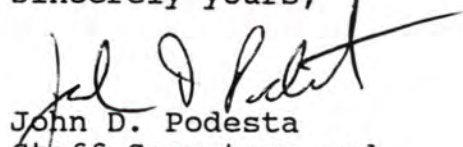
(2) Dr. Foster has been affiliated with the Meharry Medical Group since its inception in 1981. This group is an academic health center-based, multi-specialty practice corporation. We have been advised by the General Counsel to Meharry Medical College that he has no knowledge of the Meharry Medical Group having been named in any other lawsuit (other than the one mentioned in #1) on the basis of allegations of malpractice by Dr. Foster.

(3) We do not have the legal records for all physicians affiliated with the Meharry Medical Group and therefore cannot provide the information regarding any lawsuits involving its members. Moreover, we do not believe that we would be entitled to obtain the legal records for matters unrelated to the conduct of Dr. Foster.

(4) Other than the lawsuit described in #1 above, there is no record of any other legal or professional investigations or actions taken against Dr. Foster during the course of his career.

We look forward to working with you on this matter.

Sincerely yours,



John D. Podesta
Staff Secretary and
Assistant to the President

Enclosure



DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FACSIMILE

95 MAY 4 All : 47

DATE MAY 4 1995

TO: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):
John Podesta
Assistant to the President and
Staff Secretary
The White House

PHONE: 456-2702

FROM: (NAME, ORGANIZATION, CITY/STATE AND PHONE NUMBER):
Kevin Thurm
Chief of Staff
DHHS

PHONE: 690-6133

RECIPIENT'S FAX NUMBER: () 456-2215

NUMBER OF PAGES TO SEND (INCLUDING COVER SHEET): 8

COMMENTS:



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Assistant Secretary
for Legislation

Washington, D.C. 20201

MAY 7 1995

Honorable Nancy Landon Kassebaum
United States Senate
Washington, D.C. 20510-1602

Dear Senator Kassebaum,

I am writing for my colleague, Philip Lee, to whom you directed questions in correspondence on Friday, April 27. Dr. Lee has been on travel since that date and is currently in Geneva as the Chief Delegate to the World Health Assembly. I am authorized by Dr. Lee to transmit to you the following which are his answers to your questions.

Dr. Lee was first appointed at the Department of Health Education and Welfare [HEW] as Deputy Assistant Secretary in the Summer of 1965. He was appointed as Assistant Secretary for Health and Scientific Affairs in November 1965.

In answer to your first and second questions, during the period 1965 through his departure from HEW in February 1969, Dr. Lee did not learn by any means, personal or official, of the Tuskegee syphilis study. Dr. Lee's best current recollection is that, while he was on the faculty at the University of California at San Francisco, years after he left HEW, he learned about the Tuskegee syphilis study from a newspaper report published, he believes, in 1972.

Your third question contains a mis-statement in its premise. Dr. Lee was not throughout his HEW service "the official directly in charge" of the Public Health Service and the CDC or of the development by PHS of informed consent guidelines. Indeed, the departmental organization plan showed that the Assistant Secretary for Health and Scientific Affairs was a staff position, not a line job with organizational responsibility for the Public Health Service. Line responsibility rested with the Surgeon General.

In 1968, Secretary Wilbur Cohen reorganized the Department and, for the first time, the Assistant Secretary for Health and Scientific Affairs became the official responsible for the Public Health Service. [See attached excerpts from the Historical Profile of the Leadership of the Public Health Service published in July 1988.]

Page 2

The Surgeon General, previously having had that responsibility, reported to the Assistant Secretary. During 1968, the plan adopted by Secretary Cohen, was progressively implemented.

Given the foregoing, in answer to your third question, though informed consent guidelines were under development in the late 1960s at HEW, Dr. Lee, to the best of his recollection, was not either directly or indirectly involved in work on their formation or implementation. Thus, in answer to your fourth question, Dr. Lee is unaware whether the Tuskegee syphilis study was ever raised during that process.

As earlier described, your assumption in the fifth question -- that Dr. Lee was the supervisor of activities at the CDC prior to implementation of the Cohen reorganization plan -- is plainly incorrect. He was not, and did not know of CDC's Tuskegee syphilis study.

In answer to your sixth question, Dr. Lee did not know about the Tuskegee syphilis study prior to his departure from HEW in February 1969, nor did he know of any meetings planned to address it.

I hope that this information is useful to you. Dr. Lee will be on official travel during the remainder of this week. You can reach him through the United States Mission in Geneva, or our office will seek to make that connection for you should you so wish.

Sincerely,

Jerry D. Klepper

Attachments

TABLE

Leadership of the PHS: Evolution and Change

Year	PHS Line Management	Significant Staff Positions
1944	Surgeon General (SG)	
1953	Surgeon General	Special Assistant for Health & Medical Affairs (established in Office of the Secretary)
1965	Surgeon General	Assistant Secretary for Health and Scientific Affairs (previous staff position noted above is retitled)
1968	* Assistant Secretary for Health and Scientific Affairs (ASHSA)	** Surgeon General (as Principal Deputy to ASHSA)
1972	Assistant Secretary for Health (ASH)	Surgeon General (Office of Surgeon General; a component of OASH)
1973	*** Assistant Secretary for Health	Surgeon General (staff position in the immediate office of ASH; Office of Surgeon General eliminated)
1977	Assistant Secretary for Health	Surgeon General (staff position in the immediate office of ASH; ASH also served as SG)
1981	Assistant Secretary for Health	Surgeon General (staff position in the immediate office of ASH)
1987	Assistant Secretary for Health	Surgeon General (Office of Surgeon General established as a component of OASH)

- * Previous role of staff advisor to the Secretary was changed to line manager over PHS, but administrative and financial management authorities were withheld.
- ** Role of Surgeon General was simultaneously removed from line management and made a staff position.
- *** Administrative and financial management authorities were restored.

1968—PHS Following Major Reorganization— Establishment of the Health Services and Mental Health Administration

In the summer of 1965, HEW Secretary John W. Gardner appointed an external ad hoc committee, chaired by Dr. John Corson of Princeton University, to make a detailed study of the Department's health functions. Also at this time, in order to permit modernization of the PHS structure without statutory constraints, President Lyndon B. Johnson sent to Congress his Reorganization Plan which became effective in June 1966 and empowered the HEW Secretary to reorganize PHS without formal approval of Congress.

Based on the Corson Committee's report, Secretary Gardner established a new organizational structure for PHS effective January 1, 1967. As reconfigured, the new organization consisted of (a) five operating bureaus: National Institutes of Health, Bureau of Disease Prevention and Environmental Control, National Institute of Mental Health, Bureau of Health Services, Bureau of Health Manpower; (b) two specialized activities: National Center for Health Statistics and National Library of Medicine; and (c) Office of the Surgeon General. (Chart D)

Although the previous "four bureau" organization had endured for more than 23 years, the new organization was to last only 15 months. In August 1967, Secretary Gardner launched another study, again chaired by Dr. Corson, to consider a new

organizational structure for PHS. The Corson Committee declared that the Secretary needed a principal line officer to aid him in setting standards and in interrelating the several health programs of the Department, and recommended that this responsibility be given to the Surgeon General. However, in March 1968, Acting Secretary Wilbur J. Cohen, who had just succeeded Secretary Gardner, delegated to the Assistant Secretary for Health and Scientific Affairs, then Philip R. Lee, line responsibility for the program direction of PHS as well as the Food and Drug Administration (FDA previously reported directly to the Secretary). The formal program delegation of authority went from the Secretary to the Assistant Secretary for Health and Scientific Affairs who redelegated authorities to the Surgeon General and the Commissioner of Food and Drugs. For the first time, a noncareer official became the Federal Government's top health officer.

Organization: Less than one month after the Assistant Secretary for Health and Scientific Affairs was put in charge of PHS and FDA, another sweeping reorganization took place. In April 1968, Acting Secretary Cohen, by Reorganization Order, reconstituted PHS by transferring FDA to PHS, abolishing the Office of the Surgeon General, and creating a new agency within the Public Health Service called the Health Services and Mental Health Administration (HSMHA). HSMHA consisted of all that

previously had been the PHS, except for NIH, the Bureau of Health Manpower, and the National Library of Medicine. The newly established National Center for Health Services Research and Development was also placed in HSMHA. (The Bureau of Health Manpower and the National Library of Medicine were added to NIH thereby bringing together the principal activities dealing with and supporting the medical schools and universities.) (Chart E)

Roles of the Assistant Secretary for Health and Scientific Affairs and the Surgeon General: As of March 1968, all of the Surgeon General's authorities to administer PHS were revoked. The PHS agencies were placed under the line authority of the Assistant Secretary for Health and Scientific Affairs, who was also assigned explicit responsibility for health policies governing Medicare and Medicaid. The Assistant Secretary for Health and Scientific Affairs was responsible for policy direction and control over the program activities of PHS; the FDA Commissioner, the NIH Director, and the HSMHA Administrator reported directly to the Assistant Secretary.

When the Surgeon General's authorities were revoked, the Secretary did not redirect the delegations for administrative and financial management authority through the Assistant Secretary for Health and Scientific Affairs. The revocation of the Surgeon General's authorities did not disturb the administrative and financial management authorities that were in place to the agency heads. As a result, these authorities flowed from the staff assistant secretaries in the Office of the Secretary (Administration and Comptroller) directly to the PHS agency heads.

The Surgeon General was declared to be the "principal deputy to the Assistant Secretary for Health and Scientific Affairs" and, in the absence of the As-

Remarks: Questions arose after this reorganization regarding the revocation of the Surgeon General's authority and the future of the "Service." The Assistant Secretary, Dr. Lee, responded that he (as a Presidential nominee) would set PHS policy, while the Surgeon General would be the Assistant Secretary's chief deputy and the senior career health professional in the Service.

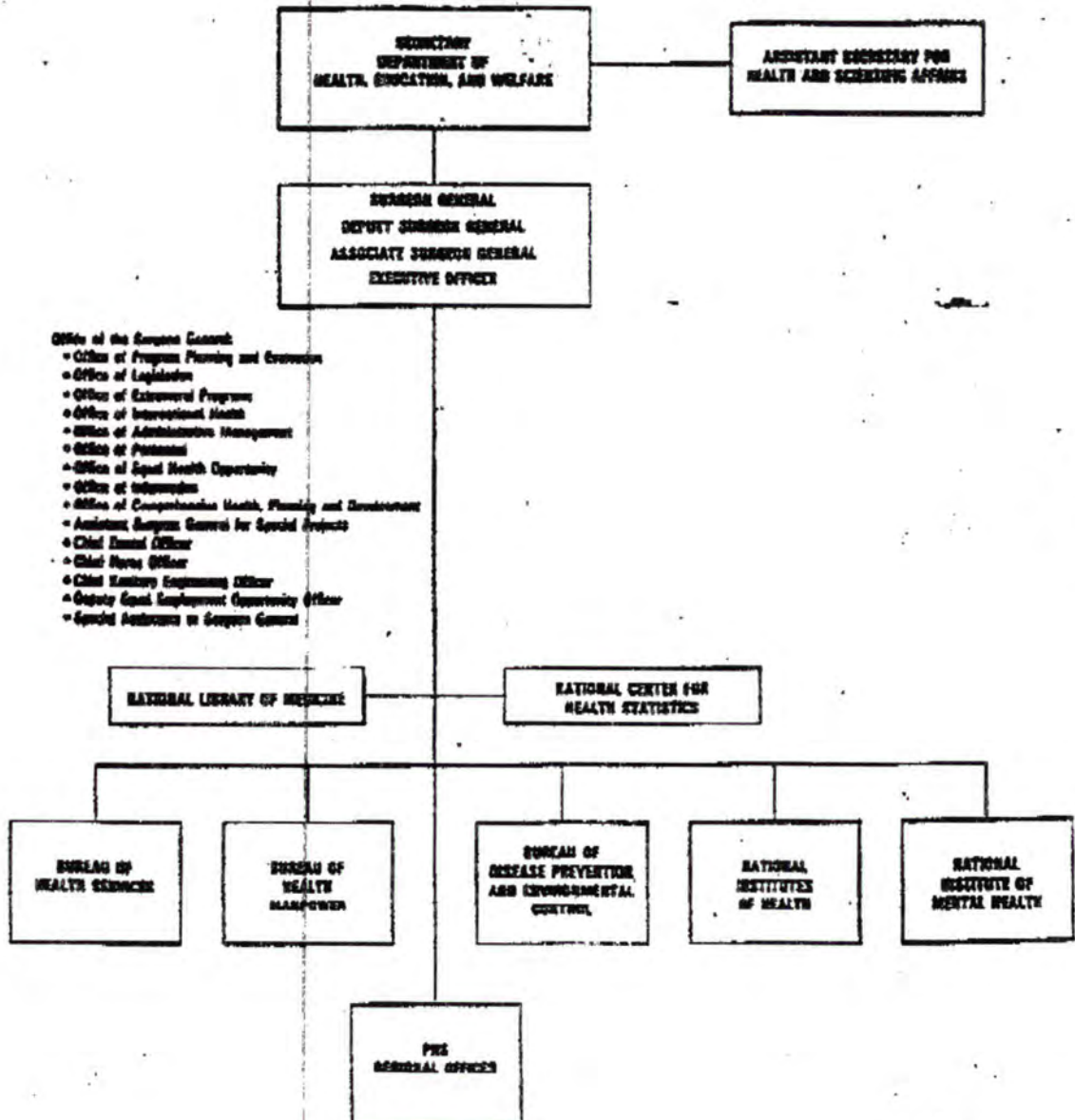
When the Office of the Surgeon General was abolished in 1968, the staff resources were split between the newly created HSMHA Office of the Administrator and the Office of the Secretary. The 1968 Reorganization Order stated that the Assistant Secretary for Health and Scientific Affairs would be "served by the other components of the Office of the Secretary." Pursuant to this concept, that portion of the resources of the former Office of the Surgeon General which were transferred to the Office of the Secretary were not assigned to the Assistant Secretary for Health and Scientific Affairs, but rather to the other staff Assistant Secretaries (Administration, Comptroller, and Planning and Evaluation). Therefore, the Assistant Secretary for Health and Scientific Affairs was not provided with staff to conduct functions such as budget management, personnel management, organizational review and systems analysis.

Program authorities flowed through the Assistant Secretary for Health and Scientific Affairs, but the administrative and financial management authorities flowed directly from the staff Assistant Secretaries in the Office of the Secretary to the PHS agency heads. Consequently, the Assistant Secretary for Health and Scientific Affairs had minimal control over management policies or activities. Since the responsibility and resources for carrying out PHS management functions were assigned to the staff Assistant Secretaries (Administration, Comptroller, and Planning and Evalu-

Scientific Affairs" and, in the absence of the Assistant Secretary for Health and Scientific Affairs, would serve as the Acting Assistant Secretary. The Surgeon General would assist the Assistant Secretary and would be the chief career health professional in the Department responsible for the administration of the PHS Commissioned Corps.

Extended Page
(Administration, Comptroller, and Planning and Evaluation), the PHS agencies began relating directly with these OS staff. The result of this situation was that the Assistant Secretary for Health and Scientific Affairs was unable to effectively exercise line authority over the PHS agencies.

1967-PHS FOLLOWING REORGANIZATION



ON DOLE
KANSAS

United States Senate

OFFICE OF THE REPUBLICAN LEADER
WASHINGTON, DC 20515-7010

May 4, 1995

The Honorable Thomas A. Daschle
Democratic Leader
United States Senate
Washington, D.C. 20510

Dear Tom:

Thank you for your letter of April 27th concerning the nomination of Dr. Henry Foster.

In your letter, you state that Dr. Foster "deserves a full and fair hearing." Now that Dr. Foster has completed his two days of testimony before the Labor Committee, I am sure you agree that he has received such a hearing.

As you may know, there is plenty of precedent for nominations not making it to the Senate floor for a vote. For example, on November 14, 1991, President Bush nominated Frank Keating, now Oklahoma's governor, to a seat on the 10th Circuit Court of Appeals, one of the highest courts in the United States. The Keating nomination was ultimately returned to the President on October 8, 1992, after the Senate failed to take action.

According to the Congressional Research Service, at least 161 Republican nominations were returned to the President from 1987 through 1992, a six-year period when the Democrats controlled the Senate. In fact, during the Bush Administration, 54 nominations to the federal judiciary and at least 34 non-judicial nominations did not even receive a committee hearing. During the last two years of the Reagan Administration, the numbers were similarly high: 9 nominations to the federal bench and at least 37 non-judicial nominations were transmitted to the Senate, but no committee hearing was convened on any one of them.

The Congressional Research Service also tells me that during the Bush Administration and the last two years of the Reagan Administration, committee hearings were held on 15 nominations, but no further action was taken by the Senate on them.

In addition, during the Bush Administration, five nominations were reported out of committee, but failed because of inaction by the full Senate.

Finally, I am reminded of William Lucas, who was nominated to head up the Justice Department's Civil Rights Division during the Bush Administration. By a 7-7 vote, the Judiciary Committee

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rejected a motion to report the Lucas nomination favorably. By the same 7-7 vote, the Committee also rejected a motion to report the Lucas nomination without recommendation, thereby preventing consideration of the Lucas nomination by the full Senate.

Although I may not have liked any of these outcomes, it is my understanding that each of these nominations was considered in a way that was consistent with Senate rules. I might add that I do not recall many of my Democrat colleagues expressing the same level of concern about the disposition of these nominations as they are now expressing about the disposition of the Foster nomination.

Tom, I appreciate your thoughts and will be back in touch when I decide how best to proceed on the Foster nomination.

Sincerely,



BOB DOLE

cc: The Honorable Barbara Boxer
The Honorable Dianne Feinstein
The Honorable Barbara A. Mikulski
The Honorable Carol Moseley-Braun
✓ The Honorable Patty Murray

THE WHITE HOUSE

WASHINGTON

May 10, 1995

Honorable Nancy Landon Kassebaum
United States Senate
Chair, Committee on Labor and
Human Resources
835 Hart Senate Office Building
Washington, D.C. 20510

Dear Madam Chair:

I would like to thank you again for the open, even-handed manner in which you conducted the hearings on Dr. Foster's nomination to be Surgeon General. We feel that Dr. Foster was given a fair opportunity to present himself and make his case to the Committee and the American people, and that you were successful in having the hearings generate more light than heat. Dr. Foster, the Committee, and the public were well served by your leadership.

We also appreciate the kind remarks in your opening statement at Dr. Foster's confirmation hearings that, "Dr. Foster, the White House, and the Department of Health and Human Services have cooperated fully with the Committee in answering our inquiries and providing information." We certainly acknowledge the initial miscommunications in connection with Dr. Foster's nomination, and have been eager to work to resolve them.

We have tried to be as forthcoming as possible in responding to requests from the Committee. We responded promptly, for example, to staff requests for materials on the Tuskegee Study outside the scope of your original requests, and have kept your staff fully informed. Under these circumstances, we particularly regret the apparent misimpression that has arisen concerning documents relating to the "I Have a Future" program.

Much of the misunderstanding appears to have arisen from the direction of requests to various persons without the involvement of the White House or Dr. Foster. We believe that the only documents regarding the "I Have a Future" program which the White House or Dr. Foster was specifically requested to provide to the Committee related to the teaching modules used in "I Have a Future." When asked for help in obtaining copies of the modules at a meeting attended by Committee staff and Senator Kennedy's staff, we promptly provided the modules.

It was our understanding that your investigators were making direct requests for documents from a variety of sources, and that as a matter of policy they were not seeking our help in obtaining documents other than by specific request. For example, we understand from the "I Have A Future" Director, Dr. Lorraine Williams Greene, that the Committee staff early on contacted her directly for general materials, and that she responded promptly with the standard packet of materials sent in response to first-time requests for information. Dr. Greene tells us that she was not contacted again by the Committee staff for additional information until the week before the hearing. At that time, on April 26, 1995, she advised us that a Committee investigator had specifically requested the videotapes used in connection with the previously supplied teaching modules. No other materials were requested by the investigator. Upon learning of the request, we worked with Dr. Greene to insure that the videotapes were sent on the following day.

Similarly, the only written request for information to Meharry Medical College appears to have been the attached handwritten request. This request was not provided to the White House or Dr. Foster by the Committee staff. Indeed, no one ever appears to have written or telephoned the White House or Dr. Foster to alert us to the difficulties that the Committee staff appears to have been experiencing in obtaining materials. Had we known, we would have provided immediate assistance. We are and have been as anxious as the Committee to get the complete story of Dr. Foster's life and work before the public.

I have discussed these matters with Ed Bolen, and we have agreed on a procedure which we both hope will avoid such problems in the future. Mr. Bolen and I have agreed that, in the future, requests for information from the Committee directed to the Administration or the nominee will be made in writing through the White House. We are hopeful that this procedure will result in the complete record which both you and we desire.

We have attached a considerable amount of material which we believe responds to the Committee's request, and which is the product of an exhaustive search of the "I Have a Future" files. A number of the materials are originals, and others are copyrighted program materials. The "I Have a Future" program has requested that they be returned once the Committee has completed its review. If we learn of any additional materials, we will forward them to you promptly. We look forward to working cooperatively with the Committee and will attempt to respond as promptly as possible to any future requests on matters that come before your Committee.

Thank you again for the fairness with which you conducted the hearings, and again we regret any confusion which has arisen in the course of the Committee's efforts to obtain documents and information. We appreciate the cooperation of the Committee staff, and hope that you will extend our thanks and gratitude to Dave Bartel, Susan Hattan, and Ed Bolen for their professionalism and cooperation.

Sincerely,


John D. Podesta
Assistant to the President
and Staff Secretary

cc: Honorable Edward M. Kennedy

04-13-95 02:52PM FROM USSEN LABOR MAJORITY TO 316153276224

P001/002

FAX

Majority Staff
Labor and Human
Resources Committee

Nancy Landon Kassebaum
Chairman

Phone: (202) 224-6770

Fax: (202) 224-6510



Date: 4/13/95

To: George Williams

From: J.C. Wade

Page 1 of: 2

Message: Per our telephone conversation.

1. I need information on the grants listed.

(A) Budget & expenditure of funds

(B) Proposal summary of scope of project

(C) If required, I would appreciate

the summary ~~propos~~ of the
~~present~~ projects findings

RESPONSE TO LABOR COMMITTEE REQUEST

May 10, 1995

REQUEST #1: TEACHING MATERIALS

- *Staff Manual: Conflict Resolution Module* [October 1993]
- *Staff Manual: Family Life Education Module* [September 1994]
- *Staff Manual: Pre-Employment Module* [October 1994]
- *Staff Manual: Pro-Social Skills Module*¹ [October 1994]
- *Staff Manual: Alcohol and Drug Module* [April 1989]
- *Staff Manual: Family Life Education Module* [September 1989]
- *Staff Manual: Pre-Employment Module* [June 1991]
- *Staff Manual: Pro-Social Skills Module* [November 1991]
- *Staff Manual: Family Life Education Module* [November 1991]
- *Staff Manual: Pre-Employment/Job Readiness Module* [June 1990]
- *Staff Manual: Pre-Employment/Job Readiness Module* [September 1990]
- *Video: "Clear Vision" and Pamphlet* [March of Dimes]
- *Game: Crossroads -- Teen Relationships & Teen Sexuality Game*
- *Video: "Smart Talk"*
- *Video: "Who Do You Listen To? Choosing Sexual Abstinence"*²
- "Many Teens Are Saying No," U.S. Dept. of HHS, 1986
- "Sexually Transmitted Diseases," March of Dimes, 1986
- Breast Self-Examination Monthly Reminder [American Cancer Association]
- "AIDS and Sex: What You Should Know," Tennessee Responds to AIDS [1992]
- "AIDS: What You Should Know," Tennessee Responds to AIDS [1989]
- "AIDS and the Black Community: What You Should Know," Tennessee Responds to AIDS [1991]
- "AIDS and Teens: What You Should Know," Tennessee Responds to AIDS [1991]
- Having Your Period [1989]
- Facts about Tuberculosis [1991]
- "A Message for Teens from Teens," March of Dimes, 1986
- "A Parent's Guide to the Facts: To Help Mothers and Fathers Talk to their Teenagers About Sexual Responsibility" [ACOG]
- Body Awareness Resource Network Software [1985]
- UMOJA [Unity] Handout [1989]
- How to Use a Condom [*Note: Only distributed to participants who have requested condoms*]
- "The Hassles of Becoming a Teenage Parent," U.S. Department of HEW, 1977
- Who Is At Risk for AIDS? [Mirror]
- *Poster: AIDS, Tennessee Responds to AIDS* [September 1989]

¹Currently includes material relating to Alcohol and Drug Abuse Prevention [formerly a separate module].

²There is no date on the invoice [which is enclosed.] A fax -- apparently sent to the program from the video company -- is dated 8-21-92.

I HAVE A FUTURE MATERIALS: *List*

Page 2

REQUEST #1: TEACHING MATERIALS [Continued]

- *Staff Manual: Tentative MATURE Outline* [1989]
- "Stay Healthy! Learn About Uterine Cancer," American Cancer Society, 1989
- *Staff Manual: Tentative CHARM Outline* [September 1989]
- "How Do You Feel Today?" Wholistic Stress Control Institute, 1986
- "Great African Americans You Should Know," The Black Collegian, January/February 1993
- Black Quest
- "America's First Freeborn Black," Instructional Fair, Inc., 1989
- "Slaves and Civil Rights Workers," Instructional Fair, Inc., 1989
- "Chronic Disease Control: High Blood Pressure," Tennessee Department of Health and Environment, Black Health Care Task Force, 1990
- "Blacks and High Blood Pressure," Tennessee Department of Health and Environment, Black Health Care Task Force, 1990
- "Lung Cancer: Race for Health," Tennessee Department of Health and Environment, Black Health Care Task Force, 1990
- "Diabetes: Race for Health," Tennessee Department of Health and Environment, Black Health Care Task Force, 1990
- "The Safe Food Book, United States," Department of Agriculture, June 1985
- "Questions about Weight, Salt, and High Blood Pressure," NIH, May 1986
- 101 Questions on the African World Experience, The Black Collegian, January/February 1993
- "Lung Cancer: Smoking Increases the Chances," Tennessee Department of Health and Environment, Black Health Care Task Force, 1990
- "High Blood Pressure: Race for Health," Tennessee Department of Health and Environment, Black Health Care Task Force, 1990
- "Taking the HIV/AIDS Test," NIH, September 1992
- "The Brain Infection TOXO," NIH, September 1992
- "HIV-Related TB," NIH, September 1992
- "AIDS and You," CDC, April 1991
- "Nutrition and Your Health: Dietary Guidelines for Americans," U.S. Department of Agriculture/U.S. Department of Health and Human Services
- "Food Facts: Calcium" [General Foods Consumer Center]
- "Saying No and Feeling Fine," Syndistar, Inc., 1991
- "Healthy Bodies Don't Need Drugs," Syndistar, Inc., 1991
- "Conflict and Me," Grace Contrino Abrams Peace Education Foundation, Inc., 1985
- "I am Me," Virginia Satir
- "Strength or Weakness," Positive Action Publishing, 1989
- Tom Bradley
- "The Right To Be Free," Instructional Fair, Inc., 1989
- Jesse Owens
- "Still I Rise" and Other Poems by African American Writers

I HAVE A FUTURE MATERIALS: *List*

Page 3

REQUEST #1: *TEACHING MATERIALS [Continued]*

- Light a Candle for the Day, 1992
- George Washington Carver, Cuion Bluford, Alex Haley, Shirley Chisholm, Marian Anderson, and other African-Americans
- Wilma Rudolph
- "Ice: The Cold Hard Facts," Syndistar, Inc., 1990
- "Inhalants: What You Should Know," The National Federation of Parents for Drug Free Youth, 1992
- Ray Charles
- "Drugs of Abuse," Syndistar, Inc., 1987
- "Facts About the TB Skin Test," American Lung Association, March 1992
- "A Parent's Guide to Drinking, Driving, and Drugs," Syndistar, Inc., 1992
- *Poster*: Celebrate Prom and Graduate With Style
- *Poster*: High Style
- *Game*: In Search of Identity, An Exciting Way to Discover Black Heritage
- *Game*: The Black Explorers, A Math Adventure Game

REQUEST #2: *PROMOTIONAL MATERIALS*

- Current IHAF Information Packet with Fact Sheet
- Nguzo Saba Poster
- Entrepreneur Program -- Kwanzaa Cards [1990]
- IHAF's first promotional materials were designed to attract participants and involve families from the community. Therefore, early promotional materials were photocopies that were posted in the housing projects.

REQUEST #3: *EVALUATIONS, CRITIQUES, OR REVIEWS*

- Correspondence to Josephina J. Card, Sociometrics Corporation [February 25, 1994]
- Eric Lang, Ph.D., Sociometrics Corporation Evaluation Review [March 12, 1994]
- Presentation: Smith, Greene, Peters. "The Influence of Family Characteristics on Sexuality Knowledge, Attitudes and Behavior" [American Psychological Association, March 1992]
- From Carnegie Corporation of New York [May 3, 1995]
- From Carnegie Corporation of New York [January 30, 1992]
- Presentation: Peters, Shakir, Starks, Peters, Cogger, Johnson, Nelson, Pannell, Williams. "Teenage Pregnancy Prevention Workshop -- Summer 1991" [Journal of Health Care for the Poor and Underserved, Vol. 2, No. 1.

REQUEST #3: EVALUATIONS, CRITIQUES, OR REVIEWS [Continued]

- Statistical Abstract -- IHAF Evaluation [*Note: This is an unpublished draft being prepared for publication*]
- Urban Institute: "Comprehensive Services Integration Program for At-Risk Youth: FINAL REPORT," Chapter on "*I Have A Future*" [December 7, 1992]

REQUEST #4: CORRESPONDENCE

- From Carnegie Corporation of New York [March 26, 1986]
- To Carnegie Corporation of New York [August 19, 1986]
- From Carnegie Corporation of New York [November 13, 1989]
- To Carnegie Corporation of New York [January 29, 1990]
- To Carnegie Corporation of New York [April 12, 1990]
- From Milton Little, V.P. Manpower [August 2, 1990]
- Letter from Technical Assistance Team, Michael P. White [March 1, 1990]
- Final Narrative Report and Letter to W.T. Grant Foundation [April 13, 1992]
- From W.T. Grant Foundation [February 26, 1988]
- Annual Report: William T. Grant Foundation [December 1, 1989]
- Renewal Proposal: William T. Grant Foundation [April 1991]
- To William T. Grant Foundation [August 8, 1990]
- To William T. Grant Foundation [March 3, 1989]
- Proposal: William T. Grant Foundation [May 1988]
- Proposal: William T. Grant Foundation [November 1987]
- Final 1994 Progress Report: Carnegie Corporation of New York [November 1994]
- To Carnegie Corporation of New York [July 1989]
- IHAF Progress Report, July 1992 - June 1993 to Carnegie Corporation of New York [July 1, 1993]
- From Carnegie Corporation of New York [May 16, 1989]
- IHAF Entrepreneurship Annual Report, February 1, 1994 [sic. 1993?] - January 31, 1994 to William & Flora Hewlett [February 1994]
- Final Report: Kaiser Foundation [December 10, 1992]
- Proposal: IHAF Entrepreneurship Grant to William & Flora Hewlett Foundation [September 20, 1989]
- Progress Report: IHAF Entrepreneur Program to William & Flora Hewlett Foundation [July 22, 1991]
- Annual Report & Proposal: IHAF Entrepreneur Program to William & Flora Hewlett Foundation [August 31, 1992]
- Proposal: Carnegie Corporation of New York [May 1986]
- First Progress Report: Carnegie Corporation of New York [no date]
- Supplemental Progress Report: Carnegie Corporation of New York [January 19, 1988]
- Progress Report: Carnegie Corporation of New York [March 17, 1989]

REQUEST #4: CORRESPONDENCE [Continued]

- Progress Report: Bill & Camille Cosby [May 1992]
- Progress Report: Bill & Camille Cosby [October 13, 1989]
- Final Report: Health of the Public [October 1992]
- Letter to William T. Grant [March 3, 1989]
- Letter to Carnegie Corporation of New York [March 3, 1989]
- Letter to Michael White, Carnegie Technical Assistance Team [April 19, 1990]
- Letter from Louis Sullivan, M.D., Secretary of Health and Human Services [March 22, 1991]
- Letter from Technical Assistance Team, Linda Dusenbury, Ph.D. [August 8, 1990]
- Columbia Site Visit, April 6-9 [1988 Report]
- Letter to Pearla Brickner Namerow, Ph.D., Columbia University [September 7, 1988]
- Columbia Site Visit, July 27-28 [July 21, 1988 Memorandum]
- Quality of Life Needs Assessment [Blank -- May 1987; Final Report; Final Results]

REQUEST #5: CORRECTION OF TYPOS ON FEB. 3, 1992 LETTER

- The document itself was never corrected. It appears that the error was noticed by neither Carnegie nor "I Have A Future" until attention was called to it in Dr. Foster's 5/2/95 hearing before the Labor Committee.

REQUEST #6: GRANT PROPOSALS MENTIONED IN FEB. 3, 1992 LETTER

- National Institute of Health for the Minority Youth Health Research: The Development and Evaluation of Interventions due May 1992 [Our name: "I Have A Future": Comprehensive Afrocentric Health Care] and Pink Slip: NIMH Priority Score, September 3, 1992
- ADAMHA Grant -- "Model Prevention Drug Abuse Treatment Programs for Adolescents/Juvenile Justice" -- Summary Statement [7/29/91 -- 8/01/91]
- National Institute of Nursing Research -- "Community Interventions in Adolescent Health Promotion" -- Summary Statement [8/18/93]

REQUEST #7: TUSKEGEE SYPHILIS STUDY – TREATMENT

- Attached please find a copy of one additional news article which references the initiative of Dr. Foster and the Macon County Medical Society to locate and treat the study subjects after the disclosure of the study in 1972. We have not located any records of the Macon County Medical Society from that period. As we previously have discussed, all minutes and other records of the Society from the 1970s and earlier appear to have been lost.
- The papers of the Ad Hoc Advisory Panel established by HEW in 1972 do show communication with the Society, and an apparent eagerness on the part of the Macon County medical community and the HEW representatives with whom they were speaking to see that the men were treated. See attached draft Report of Delegation II.

NOTE: FOLLOWING YOUR REVIEW, PLEASE RETURN ALL MATERIAL – DOCUMENTS, VIDEOS, POSTERS, PAMPHLETS, ETC. – TO THE "I HAVE A FUTURE" PROGRAM

ADDRESS:

**Meharry Medical Center – Department of Obstetrics and Gynecology
"I Have A Future" Program
1005 D.B. Todd Blvd.
Nashville, TN 37208**

May 11, 1995

The Honorable John Ashcroft
United States Senate
705 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Ashcroft:

I appreciate the opportunity to respond to your questions during the recent hearings of the Senate Labor and Human Resources Committee on my nomination to become Surgeon General. I hope that the information was helpful to you, and I appreciate your kind remarks in closing.

In the course of reviewing the transcript of the hearings, I noted one instance in which I may have misconstrued one of your questions, and may not have given a complete answer. I am particularly anxious to clear up any misunderstanding, and take the liberty of writing you to do so.

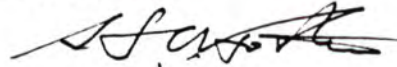
During the second day of hearings, you asked (at pages 87-88 of the transcript) whether there had been other statistical evaluations of the "I Have a Future" program. I stated that there had not. Speaking as a researcher, I answered based on the statistical evaluation we did of the program involving data collection at three points in time over a period of 30 months.

I want to make absolutely clear, however, that Dr. Greene's February 3, 1992 letter was an interim portion of that 30-month evaluation, and that there was a final report at the end of the process. As I stated in my response to you, we gathered data for this ongoing evaluation at three points in time (T1, T2 and T3), over the 30 month period. I hope that it was clear that the initial letter by Dr. Greene, to which you referred, reflected some preliminary analysis of the data collected at the first two points (T1 and T2). As I indicated in response to your questions, we also gathered data at a third point (T3). Those data, together with the T3-stage evaluation and summary by Dr. Greene, have been provided to the Committee, and I enclose a separate copy for you here. This represents the final stage of the 30-month statistical evaluation. I believe that you will find that this final report is somewhat more positive than the interim letter, although I continue to stress the need for a multi-centered, longitudinal study before any statistically valid conclusions can be drawn concerning "I Have a Future" or other "life option" programs in terms of reducing teen pregnancy.

While it may not be responsive to your questions, also I have enclosed a brief review of the 30-month evaluation by Dr. Eric Lang of Sociometrics. This is not a separate evaluation of the program, but rather an outside critique of the existing methodology used in Dr. Greene's evaluation. While quite technical, it paints a positive picture of the "I Have a Future" evaluation methodology.

I hope that this information is helpful to you.

Sincerely,

A handwritten signature in dark ink, appearing to read 'H. Foster', with a stylized, flowing script.

Henry W. Foster, M.D.

cc: Chairman Nancy Landon Kassebaum
Senator Edward M. Kennedy

"I HAVE A FUTURE"

ADOLESCENT HEALTH PROMOTION PROGRAM

FINAL 1994 PROGRESS REPORT

Submitted By

"I Have A Future" Adolescent Health Promotion Program
of
Meharry Medical College



MEHARRY MEDICAL COLLEGE
NASHVILLE, TN

Submitted To

Carnegie Corporation of New York

November 28, 1994

Carnegie Corporation Progress Report 1994

Overview

Meharry Medical College's "I Have A Future" Adolescent Health Promotion Program (IHAF) initially began as an adolescent pregnancy prevention program that used a comprehensive approach toward addressing the many health and social-related issues associated with the problems of teenage pregnancy. Today the program continues to be a year-round comprehensive, community-based health initiative that focuses on inner-city African-American males and females, ages 10-17, who live in public housing and are at-risk for: early pregnancy, HIV and other sexually transmitted diseases, alcohol, tobacco and other substance abuse, homicide and violence, school dropout, and unemployment. Its mission is to prevent these any problems that confront inner-city youth and its goal is to develop a replicable community-based, life-enhancement program that promotes a significant reduction in the incidence of early pregnancy, childbearing, and other harmful behaviors that occur among high-risk male and female adolescents.

The program not only focuses on the risky behavior patterns often found among inner-city youth; it also deals with the many psychosocial issues that are often associated with them--poverty, limited community resources, unemployment, and hopelessness.

Based on the Hawkins and Weis theoretical model, **IHAF** teaches skills that facilitate the involvement of adolescents in alternative, life-enhancing activities. The program provides positive reinforcement for a young person's participation and offers ongoing opportunities for him/her to stay involved. There are five objectives:

1. To engender a more positive self-concept and constructive attitude towards the community, family life, and the future;
2. To increase socially adaptive/appropriate behaviors with particular focus on school achievement, pre-vocational skill development, and delinquency rates; and to enhance the ability of high-risk adolescents to overcome environmental barriers in attaining the skills necessary to pursue meaningful employment and educational opportunities with the promise of upward mobility;
3. To provide greater access to and increase the use of, comprehensive adolescent health and social services, including contraceptive availability;
4. To stimulate measurable improvement in the participants' level of psychosocial development; and
5. To expand educational opportunities for health-professional students through a community-based program that serves high-risk adolescents and children.

To accomplish these objectives, **IHAF** uses Afrocentric specialized modules and activities that teach decision-making/problem-solving skills, develop self-esteem, and promote a positive outlook toward the future.

Service Configuration

The overall program plan for IHAF has not changed. The curriculum modules are still delivered to participants in small groups. Assessment of the participants' progress, case management, and a tracking system are also still employed. On-site primary health care continues to be offered two days per week at both program locations and the community high school where many participants attend.

Participants continue to sign a contract upon entering the program and must have a physical within 60 days. They must also participate in the core modules. In addition to this, participants are also given many opportunities to involve themselves in the community. For instance, they may be selected to be peer counselors who are trained to give health promotion presentations in the community as well as help with the program's latchkey project for youth 6-10 years of age. Peer counselors are also taught to assist in health screenings at the IHAF community health fairs where they record blood pressure readings. Peer counselors are paid for their time and work 10-15 hours per week.

Most program participants are active in IHAF's entrepreneur component. This special initiative offers young people opportunities to learn business skills, operate a business, and earn money. To be enrolled they must attend the Family Life Education Module, the Prosocial Skills Module, and the Pre-Employment Module. They must also maintain passing grades or run the risk of being placed on probation. Finally, they must open savings account at a local minority owned bank, deposit 10% of their earnings every pay period and keep it there for a minimum of two years.

Through the support of the William and Flora Hewlett Foundation, the entrepreneur component has expanded to serve 100 youth. Due to limited space at the program's sites, one of the three entrepreneur module segments is taught after school at the community high school and an advanced tutoring modules (for those in college preparatory classes) is conducted at the IHAF office on the Meharry Campus. The program has become so popular that it is listed as a club in the community high school's yearbook. Due to its popularity, the entrepreneur component maintains a constant waiting list during the school year.

Current Clientele

IHAF provides services to any youth 10 to 17 residing in or in close proximity to the John Henry Hale or Preston Taylor public housing communities. On the average, 150 different youth participate each week. All of the participants are African Americans and 54% of them are males. Most youth are self-referred; however, juvenile court, schools, and the probation office refer young people to attend the program.

Program Administration and Organization

There have been no modifications made in the organization of the program and no changes in staff, with the exception of Dr. Lorraine Williams Greene becoming the Director of the program. Additional staff members continue to be hired for the IHAF Summer JTPA program. Through the support of "Health of the

Public" a PEW and Robert Wood Johnson Foundation Initiative, we have added an administrative assistant who is employed 32 hours per week.

Networking and Collaboration

IHAF staff members continue to serve on several special committees and boards:

1. The Annie Casey Foundation's Tennessee KIDS COUNT Technical Advisory Committee;
2. A planning committee for the Center for Social Science Research--an organization which studies the urban underclass;
3. The Steering Council for the TENNESSEE VOICES FOR CHILDREN--a coalition founded by Tipper Gore, wife of Vice-President Albert Gore, JR. which promotes the development of services for children and youth with serious behavioral, emotional, substance abuse, or other mental health problems;
4. The Tennessee Health Department's Black Health Care Task Force which oversees several health promotion projects across the state targeting African American adolescents who are considered at-risk for serious health problems;
5. The State Commission for Children and Youth which monitors services for youth and adolescents, especially the juvenile justice system;
6. United Way's SUCCESS BY SIX Initiative which focuses on families with children under the age of six;
7. The Nashville Prevention Partnership--a collaboration of alcohol and drug prevention programs in Metropolitan Nashville working together to plan and develop alcohol and drug prevention strategies for the community; and
8. The Teenage Pregnancy Prevention Council which monitors and develops strategies to reduce adolescent pregnancy.

Additional Activities

At the present time, IHAF staff members are developing plans to replicate the program in other communities and are involved in training and educating health care and social service professionals in the health care of at-risk adolescents. Last spring, IHAF staff members along with representatives from Meharry's Institute on Health Care for the Poor and Underserved and the Lloyd C. Elam Mental Health Symposium began planning a national conference on violence prevention to be held on the Meharry campus. The three-day conference which took place in October of this year featured a special day on the prevention of adolescent violence in poor communities (see Attachment). The IHAF program and other adolescent health care programs in New York City, San Francisco, New Jersey, and the Boston area, were presented as methods toward preventing the rise in juvenile crime. As a result of conference publicity, over ten additional organizations from as far away as New Hampshire, Louisiana, and Georgia expressed an interest in replicating the IHAF program in their communities. Limited funding is an issue for most organizations as it is for IHAF.

Evaluation

The evaluation of the "I Have A Future" (IHAF) program on Pregnancy Risk addressed four areas:

1. participation level and characteristics of active participants
2. the effects of the program at the neighborhood level
3. determine if active program participants were more likely to benefit than low-level program participants
4. the possible mechanisms through which the program operates

The design of the evaluation was a quasi-experimental with two housing project sites receiving the intervention program and two housing projects operating as comparison sites. Youth who continued to live in the housing projects were followed for approximately 30 months and surveyed on psychosocial variables, pregnancy risk behavior, and involvement with a pregnancy. Counselors in the program kept records of participation. There were an equal number of male and female participants. The program had positive effects on prosocial attitudes (i.e., a sense of responsibility for community and family well being), sexual and contraceptive knowledge, self-esteem, and perceived life options. Pregnancy risk behavior (i.e., type of contraception, frequency of use and frequency of sexual intercourse) was not found statistically significant with one exception. At the neighborhood level, the intervention site youth had higher scores on pregnancy risk behavior than the comparison site youth. This difference was not evident, however, when only the active participants from the intervention neighborhood were compared with the comparison site youth.

There were 59 known pregnancies among the comparison site youth and only one known pregnancy among the active program participants. Only one active participant was involved with a pregnancy in the first phase of the program; however, this low level of involvement with a pregnancy as not significantly different when baseline difference between the groups were covaried. The effects of the program on involvement with a pregnancy were unclear. The low involvement with a pregnancy could be accounted for by age. The effects of the IHAF program on pregnancy risk behavior may become more evident as the active youth become older, which cannot be currently assessed. Therefore, a continued longitudinal study of the program is warranted.

The possible mechanisms through which the program operates were evaluated through an examination of correlations between the psychosocial variables, pregnancy risk behavior, and pregnancy involvement.

Overall, the most interesting finding is that there were statistically significant differences between the intervention and comparison communities. Young people who resided in the intervention site had higher self-esteem, greater knowledge about sexuality and contraception, had more prosocial attitudes and beliefs--a stronger sense of community and a greater belief in the responsibility one has for self, family and community. Most importantly they believed they had more life-options--compelling futures.

In 1993 nine participants graduated from high school and seven attended college and remained enrolled. In 1994, of the 150 different weekly participants, 24 graduated from high school, 16 were accepted into post-secondary education. Twelve are attending 4-year colleges and 4 are

attending vocational/junior colleges. Four participants entered the Armed Forces. Also very strikingly is the fact that eight (8) of the college students are African American males.

Funding

New funds to help sustain the program have been received from United Way of Middle Tennessee (\$35,000). The Alcohol and Drug Bureau of the Tennessee Department of Health has continued its financial support (\$40,000). Funds have also been solicited from the Tennessee National and Community Service Commission, and the March of Dimes. All of the proposals to these organizations are under serious consideration.

Recently, the Higher Education Committee of the Tennessee Legislative Black Caucus adopted a proposal for an appropriation to replicate IHAF across the State of Tennessee. In January 1995, it will be brought forth to the Tennessee General Assembly and we hope they will adopt the proposal.

The Carnegie Corporation of New York has been our primary funding source with the William and Flora Hewlett Foundation providing significant financial support. We have contacted a number of foundations (e.g., Kellogg and William T. Grant) and there does appear to be some interest in supporting the evaluation or some aspect of the program. However, general operating funds are needed to operate the program. We will continue to try to secure long-term funding.

Future Directions

We are hoping to continue the program and replicate it in other cities. We would also conduct a longitudinal study to follow participants up to 21 years of age.

SOCIOMETRICS

March 12, 1994

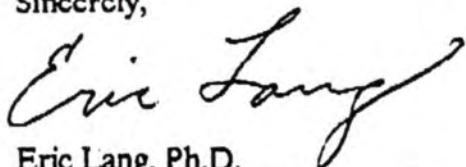
Dr. Lorraine Williams Greene
Deputy Director (IHAF)
Meharry Medical College
1005 Todd Blvd.
Nashville, TN 37208

Dear Ms. Greene,

Enclosed is my review of the Evaluation Report of the "I Have a Future" (IHAF) Program on Pregnancy and Pregnancy Risk, conducted per your request of Dr. J.J. Card. The review is a free service of the NationalNet project at Social Research Applications (Los Altos, CA).

Overall, I was very impressed with the IHAF project and Evaluation Report. My review outlines several comments, suggestions, and questions for your consideration. If you have any questions, I can be reached at Sociometrics Corporation by phone: 415.949.3282, fax: 415.949.3299, or Internet: XB.ELL@FORSYTHE.STANFORD.EDU.

Sincerely,



Eric Lang, Ph.D.
Director, Research Support Group

Copy: J.J. Card
Encl: Review of IHAF Evaluation Report

Review of: Evaluation Report of the "I Have a Future" (IHAF) Program on Pregnancy and Pregnancy Risk

Overall, the "I Have a Future" (IHAF) program evaluation report is well-written, clear, and thorough. In particular, the report presents complete univariate descriptive statistics on program participation and major measures at each time point of the project. Other statistical information and supporting text, such as regression coefficients, test statistics, and interpretations are well organized and readable.

The eight points outlined below include a range of comments, suggestions, and questions that may serve to further improve the evaluation report.

1. Are the baseline measures described on pages 4 and 5 of the report, such as the "academic variables" (e.g., school grades and attendance) and the "delinquency measure" (e.g., arrests) all obtained through self-report? Some of this information might be available from formal records. Obtaining such information on all participants might increase the validity of the associated measures. Alternatively, obtaining the information on a random subset of participants would afford an assessment of the validity of some of the self-report measures.
2. Much of the recent literature on reducing sex-related risk behavior highlights the importance of training and measuring targeted self-efficacy behaviors. For example, improved knowledge and attitudes about condom use are more likely to benefit adolescents when they are combined with specific behavioral training, and associated confidence, in broaching the topic with a partner and following through with effective action. Although the titles of some of the IHAF "core modules" suggest that they include targeted behavioral training, the IHAF dependent measures assess attitude/personality factors, risk behaviors, and actual pregnancies, but not whether specific communication and behavior skills have been developed. Constructing additional dependent measures that more directly assess the self-efficacy skills taught in the core activities might improve the evaluation component of the project.
3. The cutoff point defining low-level versus high-level IHAF participation was 15 sessions of the core modules. This cutoff distinguished 90 of 714 youth as "active participants". How was the cutoff point determined? There are at least three justifiable methods for determining such a cutoff point, for example: (a) choosing an empirical point of segregation in the distribution of participation, i.e., if the distribution appears to be bimodal with most values located on either side of the value 15, (b) using theoretical criteria, an apriori administrative minimum, or mandate to replicate a similar cutoff point employed by other researchers, and (c) maximizing statistical comparisons by selecting the median value as the cutoff point. Since several parts of the Evaluation Report involve statistical comparisons and interpretations of active versus low-level participants, it may be informative to further investigate how these two groups can be defined.
4. Issues regarding the statistical assumptions that underlie the appropriate application of discriminant analysis are not presented. Violations of assumptions can affect statistical estimates and their interpretation. Although discriminant analysis is robust to certain degrees of violations, results in the report suggest the possibility of unequal group covariance matrices.

5. The untested hypothesis on page 18 is very interesting:

as the core group develops an identity as IHAF participants, it may become more difficult to recruit new participants, who will have to "break into" an already formed group. [Early] members may actively try to restrict who becomes a new member of the group in order to protect their ingroup.

It seems that this could be assessed, at least through several informal interviews. It may then become possible to design a core module that helps and encourages initial participants to recruit and "mentor" new participants.

6. When performing multiple non-orthogonal tests of significance, the alpha level of the test statistics should be modified to reflect the increased likelihood that one or more of the tests will result in an incorrect rejection of the null hypothesis. In other words, if many non-orthogonal statistical tests are performed, chance alone suggests that one in every 20 tests is likely to yield a statistically significant result at the .05 alpha level. The Bonferroni method, or a similar method, (see Rosenthal and Rosnow, 1991, *Essentials of Behavioral Research: Methods and Data Analysis*, pages 329-332) can be used for the modification. Note: the modification is unlikely to alter any of the findings or interpretations and, with respect to the majority of published research, goes "beyond the call of duty".
7. A diagram of the intervention model, showing the theoretical relationships among the main endogenous and exogenous factors, and covariates might help readers.
8. It's not clear whether "changes" in dependent measures (aside from pregnancy) were assessed between T1 and T2 or between T2 and T3. Furthermore, these changes should be assessed in a statistical model that reflects the theoretical relationships outlined on pages 37 to 40 of the report. Although the authors are probably correct that the sample size is too limited to perform complete path analyses or structural equations (latent factor) models, the sample size may support path analysis of "change scores", i.e., modeling difference scores between two time points for independent and dependent variables. Change score analysis can reduce the influence of some kinds of measurement error over time. Although the statistical literature includes many years of debate over the appropriate conditions for modeling change scores, it may be worth investigating. There is an excellent recent book on this topic titled *Best Methods for the Analysis of Change*, by Collins & Horn (1991).

Post-Note. The IHAF project and Evaluation Report are very well done. The points outlined above are meant only to assist the program developers and evaluators. No changes are mandatory. *Good luck with the rest of the project!*

ABSTRACT

THIS IS AN UNPUBLISHED DRAFT
BEING PREPARED FOR PUBLICATION.

The evaluation of the "I Have A Future" (IHAF) program on Pregnancy and Pregnancy Risk addresses four areas:

1. participation level and characteristics of active participants
2. the effects of the program at the neighborhood level
3. determine if active program participants were more likely to benefit than low-level program participants
4. the possible mechanisms through which the program operates

The design of the evaluation is quasi-experimental with two public housing development sites receiving the intervention program and two public housing developments operating as comparison sites. Youth who continued to live in the housing projects were followed for approximately 30 months and surveyed on psychosocial variables, pregnancy risk behavior, and involvement with a pregnancy. Counselors in the program kept records of participation. There were an equal number of male and female participants. The program had positive effects on prosocial attitudes (i.e., a sense of responsibility for community and family well being), sexual and contraceptive knowledge, self-esteem, and perceived life options. Pregnancy risk behavior (i.e., type of contraception, frequency of use and frequency of sexual intercourse) was not found statistically significant with one exception. At the neighborhood level, the intervention site youth had higher scores on pregnancy risk behavior than the comparison site youth. This difference was not evident, however, when only the active participants from the intervention neighborhood were compared with the comparison site youth.

There were 59 known pregnancies among the comparison site youth and only one known pregnancy among the active program participants. Only one active participant was involved with a pregnancy in the first phase of the program; however, this low level of involvement with a pregnancy was not significantly different when baseline differences between the groups were covaried. The low involvement with a pregnancy could be accounted for by age. (The effects of the program on involvement with a pregnancy were unclear). The effects of the IHAF program on pregnancy risk behavior may become more evident as the active youth become older, which cannot be currently assessed, therefore a longitudinal evaluation of this comprehensive program is warranted. The possible mechanisms through which the program operates were evaluated through an examination of correlations between the psychosocial variables, pregnancy risk behavior, and pregnancy involvement. Other analyses addressing this question could not be conducted due to a limited sample size of those who were followed for the entire evaluation period.

Introduction

The I Have A Future (IHAF) program is a life-options enhancement program. It is based on the premise that to decrease the pregnancy rates of high-risk, African-American adolescents it is necessary to enhance their perceived life options. The strategy for enhancing life options includes teaching them how to avoid high-risk behaviors, what the possibilities are for their lives if they avoid early pregnancy, and how to develop the necessary skills to complete their education and function effectively in the working world. IHAF provides programs designed to assist these adolescents in making responsible sexual decisions, in avoiding the use of illegal substances, in improving their academic performance, in relating positively with other people, and in developing positive work-related attitudes and skills, including skills related to running their own business. IHAF also provides basic sexual and contraceptive information and access to the appropriate health care. An important premise behind the IHAF program model is that services should be provided through facilities in close proximity to the adolescents' residences. Consequently, the IHAF program is located in apartment units in the housing projects themselves.

An evaluation of the early years of the IHAF program was designed to address the following four questions:

1. What level of participation would be achieved during the first three years of the implementation of the program? Who are the adolescents who are most likely to choose to participate?
2. What is the impact of the IHAF program for adolescents living in the intervention neighborhood on (1) involvement with a pregnancy, (2) behavior which places them at risk for being involved with a pregnancy, (3) sexual and contraceptive knowledge, (4) attitudes and values regarding sexual behavior, (5) psychosocial maturity, (6) self-concept, (7) self-esteem, (8) prosocial attitudes, and (9) perceived life options?
3. Are some adolescents more likely to benefit from the IHAF program being offered in their neighborhood than others? Specifically, do adolescents who participate more actively in the program experience more positive outcomes than those who do not participate as much?
4. How were the effects achieved? What are the possible processes which could explain how the IHAF program influences adolescents?

METHODS AND MEASURES

NOTE:

THIS IS AN UNPUBLISHED DRAFT
BEING PREPARED FOR PUBLICATION.

The design of the evaluation study is quasi-experimental. Four housing projects from the Nashville, Tennessee metropolitan community were chosen as study sites. The IHAF program was implemented in two of the housing projects and the other two housing projects served as comparison neighborhoods. The four housing projects were similar with respect to the number of 10-17 year old residents, the ethnic make-up of the community, and the socioeconomic status of the residents. The two housing projects chosen for the intervention were located nearest Meharry Medical College. The Metropolitan Development and Housing Authority (MDHA) assisted in selecting comparable sites.

Adolescents between the ages of 10 and 17 and living in one of the four sites were eligible to participate in the IHAF program and the evaluation study. Efforts were made to test as many of the 10 to 17 year old residents of the four housing projects as possible at baseline (T_1). Approximately 70% of the 10 to 17 years old, based upon the MDHA records, completed the baseline survey. The adolescents completed the survey two more times following the baseline assessment. The second survey (T_2) occurred approximately 13 months after the implementation of the program and the third assessment (T_3) occurred approximately 17 months after the second survey.

T_1 data were collected in the housing projects from October, 1987 through January, 1989¹. Youth were recruited through door-to-door leafleting. They were tested in group settings with the questions being read to the group. Those who had difficulty reading or completing the questionnaires were given individual attention. Youth received \$10.00 for completing the questionnaires at each of the three time points. The testing sessions took approximately two hours to complete.

T_2 data were collected August through December, 1989, with data collection occurring in the comparison neighborhoods in the latter months of that time period. MDHA records were examined to determine which youth continued to live in the targeted neighborhoods and these youth were contacted to be surveyed again. Due to resource constraints and the community-level focus of the intervention, only those subjects who continued to live in the housing projects were recontacted for the second survey. In addition, several youth in the intervention sites completed the survey for the first time during T_2 because they had become involved in the IHAF program but were not available for the T_1 survey. Adolescents completed the surveys in small groups of

¹Data collection occurred later in the comparison neighborhoods by as much as 16 months due to limited resources. This systematic difference in T_1 testing dates between the intervention neighborhoods and the comparison neighborhoods affects the analyses comparing these subjects at later time points while controlling for age at baseline. How this problem is dealt with is discussed in the data analysis section in the results section.

similar age and gender with the questions being read to the group and those having difficulty being given individual attention.

T₃ data were collected February through May of 1991, with data being collected at the comparison neighborhoods during the latter months of that time period. All youth who continued to live in the housing projects were contacted to participate in the survey. For this data collection period, limited resources were available to try to locate those youth who had moved away. School records were examined and contacts were attempted with up to three people whom the youth had identified at the T₂ assessment as likely to know where the youth would have moved. Letters were sent to the old address should a forwarding address have been left with the Post Office. These procedures were unsuccessful in locating youth no longer living in the housing projects. In a few cases, the youth were actually still living in the housing projects although they were not "official" residents according to MDHA records. Instead of completing the survey in group settings, the adolescents were individually interviewed during the third data collection period. This procedure was implemented in order to have more complete data, limit the number of random responses, and to get more detailed information regarding dates and outcomes of pregnancies from those youth who had been involved with one or more pregnancies².

Demographic and Baseline Behavioral Variables

The following variables were measured at T₁ via the Minnesota Adolescent Health Survey developed by the University of Minnesota Adolescent Health Program (1987): (1) age; (2) marital status of parents (married/not married); (3) mother's employment status (employed at least part-time/unemployed); (4) how long at their current address (measured on a four-point scale with 1 being less than a year and 4 being three years or more) (5) sexual behavior (pregnancy risk score based on frequency of sexual intercourse and contraceptive behavior, described in more detail in dependent measures section); (6) delinquent behavior; (7) substance use; (8) academic attitudes and behavior; (9) plans for attending college; (10) degree of religiosity (five-point ordinal scale), and (11) youth employment status, and (12) self-concept.

Academic variables consisted of (1) current grades (eight-point scale with higher scores representing a higher average); (2) grades in comparison to

²Training of interviewers involved a week-long series of training sessions including role plays and homework assignments. Interviewers also completed brief assessments of their impressions of how well the subjects understand and responded to the questions and indicated any problems that arose. Additionally, the interviewers recorded the starting and finishing time of each interview. At this point, these quality-control data have not been formally analyzed. Reading through the interviewers comments reveals very few problems with the interviews.

friends (measured on a five-point scale with higher scores representing better grades than friends); (3) feelings about school (measured on a five-point scale with higher scores representing a more positive attitude toward school), (4) whether the youth was behind in school (two or more grades below the grade appropriate for their age); (5) whether or not they had skipped school in the last four weeks (measured on a five-point scale from never to 11 or more times), (6) whether or not they had ever gone to school but skipped classes in the last four weeks (measured on a five-point scale from never to 11 or more times); and (7) whether they had plans to go to college.

Substance use variables included: (1) alcohol use, which consisted of a combination of how often the youth drinks, how much they drink at one time, how often they get drunk, and when was the last time they got drunk, with a possible range of 0 to 36; (2) regular use of tobacco (coded as a regular user if tobacco was used monthly); and (3) experimentation with hard drugs (coded as having experimented if they had ever used any drugs other than alcohol or tobacco).

The delinquency measure was a composite measure of how often the youth participated in several different delinquent behaviors. These behaviors included vandalism, hitting or beating up another person, participating in a group fight, shoplifting, forced sex, running away from home, stealing from home, and involvement in prostitution. Each of these behaviors were measured on a five-point scale (1=Never; 2=Once or Twice; 3=Three to Five times; 4=Six to Ten times; 5=11 or more times). In addition, this composite score included information on whether the youth had ever been arrested, detained in the juvenile detention center, and/or convicted of a crime. The possible range for this scale is 0 to 10.

Self-concept was measured with the Piers-Harris Self-Concept Scale for Children, which is described below in the dependent measures section (Piers & Harris, 1964).

Dependent Measures

Involvement with one or more pregnancies. At the T₃ interview, youth who had had sex were asked how many times they had been pregnant or gotten someone pregnant. Youth who were involved with one or more pregnancies were asked the date of the resolution of that pregnancy. They were also asked how many months pregnant they or their partner had been at the time of resolution. From this information, the approximate month and year of conception was determined. Conceptions occurring prior to T₁ were not considered in these analyses³. Three dependent variables were calculated from this information:

³Of the 58 pregnancies between T₁ and T₃, 62.1% (n=36) resulted in live births; 25.9% (n=15) were currently pregnant; 6.9% (n=4) were aborted; 3.4% (n=2) were miscarriages; and 1.7% (n=1) were stillbirths.

(1) whether or not the youth had been involved with one or more pregnancies between July, 1988 and the date of T_3 testing (the entire time period of the IHAF program); (2) whether the youth had been involved with one or more pregnancies between July, 1988 and August, 1989 (the first phase of the IHAF program); and (3) whether the youth had been involved with one or more pregnancies between September, 1989 and the date of T_3 testing for each youth (the second phase of the IHAF program). A pregnancy did not have to result in a live birth to be counted. Pregnancies which were conceived during the targeted time periods described above were counted.⁴

Pregnancy Risk Behavior. At all three survey periods, the adolescents were asked whether or not they had ever had sexual intercourse. If they had had intercourse, they were asked how frequently they had sexual intercourse with response categories of rarely (a few times per year or less), sometimes (1-4 times per month), several times per week, just about everyday, and not sure. These subjects were also asked how frequently they used birth control with five response categories of always, quite often, sometimes, rarely, and never. They were also asked what method of birth control they or their partner used most often.

A composite pregnancy risk score ranging from zero to 10 was assigned based upon this information. Any youth who had not had sexual intercourse was given a score of zero (0). Youth who had had sexual intercourse were assigned scores between one and 10 based upon their responses to the above three questions. Two raters independently rated the riskiness of the reported behavior of the adolescents on a 10-point scale. Correlations between the two raters were .93 for T_1 ratings, .90 for T_2 ratings, and .78 for T_3 ratings. One rater gave consistently more risky scores and put less emphasis on the frequency of reported use of birth control. These ratings were more strongly related to future involvement with a pregnancy than those of the other rater. Consequently, the rating scheme of this rater was utilized for determining the pregnancy risk behavior score.

⁴Individuals who either caused or experienced a pregnancy were not asked if their partner was participating in the research study. Some of the pregnancies could be "duplicates," meaning that a pregnancy is reported by both the mother and the father. The dependent variable is not how many different pregnancies occurred, but whether or not an individual had been involved in a pregnancy. For each pregnancy, two people are affected. If they both are participating in the study, then each of their experiences is counted separately. Subjects were asked if the partner involved in the pregnancy with them also lived in the housing projects. This question cannot address how many of the pregnancies are duplicates, but it can address how many of the pregnancies are definitely not duplicates. Thirty-seven (63.8%) of the 58 pregnancies included in these analyses involved partners who did not live in the housing projects. Of the remaining 36.2%, it is possible that some of those pregnancies were duplicates.

Perceived Life Options. Enhanced life options was operationalized as the youths' plans for their education and their current attitudes and behaviors toward school since most jobs require a high school degree and usually some further education or training. This variable consists of three items which were measured at T_2 and T_3 . The first item is current behavior and attitudes toward school, which itself consists of five items: (1) current average grades, (2) number of times skipped school in the last month, (3) number of times skipped class in the last month, (4) how well they do in relation to their friends, and (5) how they feel about school. The possible range on this scale is 0 to 28 with high school dropouts receiving a score of 0. The other two items in the life options scale measure ask how far the subject plans to continue his/her education. The responses on these two scales range from 1 to 5. The three components of the life options scale were standardized and averaged together. The Cronbach's alpha for this scale is .73 for T_2 and .77 for T_3 .

Sexual Attitudes and Values. This variable consists of six scales--(1) benefits of having sex, (2) attitudes toward the importance of birth control, (3) attitudes toward premarital sex, (4) attitudes toward the use of pressure or force to have sexual intercourse, (5) clarity of personal sexual values, and (6) beliefs against having sexual intercourse as a teenager. These scales were chosen from the CDC Evaluation of Sex Education Programs scales (Kirby, 1984). Each individual scale consists of five Likert-type items with a five-point agree/disagree response format. For each scale, the mean of the five items was computed. For data reduction purposes, these six smaller scales were averaged together to form a total attitude and values scale, with a range of one to five. The alpha reliabilities for T_2 and T_3 , were .59 and .61, respectively. A higher score on this scale indicates more positive attitudes, beliefs, and values toward behaviors that would lead to preventing early pregnancy.

Psychosocial Maturity (PMT). The psychosocial maturity scale was derived from The Psychosocial Maturity Inventory (Greenberger, Josselson, Knerr & Knerr, 1975). The original scale measured nine dimensions of psychological and social maturity and consisted of 89 to 93 questions depending upon the age of the respondent. The length of the entire scale was prohibitive for the current study; therefore, seven dimensions that were most closely related to the goals of the IHAF program were chosen out of the nine. The chosen dimensions were self-reliance, identity, work orientation, communication skills, knowledge of roles, social commitment, and tolerance of individual and cultural differences. Five items from each of the first six dimensions and

two items from the tolerance dimension were chosen⁵. Each item has a four-point agree/disagree response format. The sum of each subscale was computed and then each subscale was summed for a total PMT score with a range of 32 to 128. The alpha reliabilities for the PMT scale for T_2 and T_3 were .85 and .90, respectively.

Sexual Knowledge. Knowledge of reproduction and contraception was assessed through two scales. The first scale consisted of five multiple choice questions and the second scale consisted of 18 true-false questions. The first scale was adapted from a scale used by Planned Parenthood of Nashville, Tennessee. Each item has three choices and an "I don't know" option. The second scale consisted of items from the National Survey of Adolescent Males (Sonenstein, et al., 1988 as cited in Card, 1989) and from the Evaluation of the Baltimore Pregnancy Prevention Program (Zabin & Hirsch, 1988). Each question from these scales also had an "I don't know" option. The score for the knowledge scale is the percentage of correct answers, possible range of 0 to 100%.

Self-Concept. Self-concept was measured using the Piers-Harris Children's Self-Concept Scale for Children (Piers & Harris, 1964). It is an 80-item questionnaire with a yes/no response format. There are six underlying dimensions to the scale--(1) behavior, (2) intellectual and school status, (3) physical appearance and attributes, (4) anxiety, (5) popularity, and (6) happiness and satisfaction. A total self-concept score is obtained by counting the number of responses that indicate a positive self-concept. The range of scores on this scale is 0 to 80.

Self-Esteem. The self-esteem scale is a five-item scale with a five-point Likert-style format. The items were selected from the CDC Evaluation of Sex Education Programs scales (Kirby, 1984). The mean of the five items was computed for a scale with a possible range of one to five. The alpha reliabilities for this scale at T_2 and T_3 were rather low, .48 and .57, respectively.

Prosocial Attitudes. Prosocial attitudes were measured with the Nguza Saba Scale (NGS). This scale was developed by the IHAF program staff and was designed to measure the youths' acceptance of the seven principles promoted by the IHAF program, which are known as the Nguza Saba. These principles promote self-respect, and commitment to and support for developing a positive community. The scale consists of 31 items with a five-point agree/disagree response format. The alpha

⁵Only two items were chosen from this scale because these two items dealt specifically with interactions that the youth were most likely to encounter. The other items were less directly related to IHAF goals.

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reliabilities for this scale for T_2 and T_3 were .81 and .83 respectively. The possible range is 31 to 155.

Participation Data

In the intervention sites, data were collected on all of the activities and services delivered by IHAF between T_1 and T_3 . Counselors recorded the participation of each client in the IHAF program through the Direct Client Service System. The information recorded on these forms included which youth participated, one or two codes describing the service or activity, the amount of time spent in the activity, where it took place, and which counselors were involved.

These data were aggregated according to the time period in which they occurred in order to describe the participation level of intervention site adolescents. The amount of time represented in each phase of the program was variable. Phase 1, occurring between July, 1988 and T_2 data collection period, was approximately 13 months and Phase 2, occurring between T_2 and T_3 data collection periods, was approximately 17 months. Phase 1 represents the earliest stages of the program while modules were being developed and activities were focused on attracting adolescents to the program. During Phase 2, more content-oriented modules were offered, the on-site clinics were opened, a computer lab was installed, and the entrepreneurship program began. In order to illustrate the development of the program, a timeline indicating when content-oriented modules and other significant service-related activities occurred was developed (See Figure 1).

Data Analysis and Results

Participation Analyses

An adolescent was considered enrolled in the IHAF program if they lived in one of the two intervention sites and had completed a survey. Not all youth who completed surveys participated in the IHAF program and some youth who began to participate had not been surveyed at the baseline testing period. Due to staffing limitations, survey administration had to occur at specific times during the duration of the project; therefore, approximately 20% of the youth who participated during Phase 1 completed their first survey at T_2 . Participation data on these youths were still collected even though they did not fit the criteria for "enrollment." These data are included in the participation analyses.

The first step in the participation analyses is descriptive. These analyses address the question regarding the level of participation achieved. Table 1 indicates the number of youth who participated at least once in IHAF activities; the average number of times they participated, the range of participation, and the percentage of participating youth who were officially enrolled at each phase of the program.

Table 1. Number of Participants and Participation Level across Two Phases of the IHAF program

	n	M	SD	Range	% Enrolled - at T ₁	% Enrolled at T ₂
Phase 1	326	7.99	11.57	1-83	79.75	20.25
Phase 2	301	28.75	50.80	1-295	57.14	42.86
Total	436	25.82	47.64	1-321	67.89	32.11

Activities were classified into three different categories--(1) Core Activities; (2) Elective Activities; and (3) Enticements. The Core Activities were those modules and services that were considered a requirement for successfully completing the program. Core Activities included Family Life Education (FLE), Alcohol & Drug (A&D)/Prosocial Skills Module (PSM), Job Readiness Module (JRM), Tutoring, and the CHARM/MATURE/MODULES. Elective activities were those modules and services that provided information and training in content areas but were optional for participants. Elective activities may be recommended as part of the case management for an individual client. Elective activities include Conflict Resolution, Entrepreneurship Program, Peer Counselor Activities, Educational Field Trips, and Job Training Partnership Act (JTPA) activities. Enticements were those services and events that were designed to attract youth into the program and to keep them interested in returning. These activities included sports, dance classes, karate classes, recreational field trips, parties, and banquets. Table 2 reports the average participation in these three types of activities across the two phases of the program for those youth who participated at least once. Average level of participation increases for all three types of activities during Phase 2, both in terms of the average number of times participating and the amount of time. The number of participants also increases with the exception of Enticement Activities. These increases are due, in part, to the program offering more activities during Phase 2 and four additional months in the time period of Phase 2. Core Activities attracted the most youth during Phase 2 and Enticement Activities attracted the most youth during Phase 1. During Phase 1, Enticements were a substantial proportion of the activities offered. The goal was to pique the interest of as many youth as possible before implementing the content-oriented modules. In addition, content-oriented modules were still being developed and modified. Earlier versions of the modules were offered during Phase 1.

Based on their participation rates, youths in the intervention sites were classified as active participants or low-level participants⁶. Active participation was defined as participation in at least 15 sessions of the Core modules. Ninety (90) youth were identified as active participants. The majority of the active participants had attended more than 15 sessions across the two phases of the program. Table 3 reports the average participation rates of active participants and low-level participants in each of the three types of activities during the two phases of the program. Participation in all three types of activities increased for active participants from Phase 1 to Phase 2; it remained essentially the same for low-level participants.

Table 2. Participation in Core, Elective, and Enticement Activities

	Phase 1			Phase 2		
	n	M	SD	n	M	SD
Core Activities	149	6.3	9.6	251	16.2	25.7
Time in Core Activities	149	10.6	15.5	251	27.1	42.1
Elective Activities	92	2.2	1.4	168	16.8	22.9
Time in Elective Activities	92	4.8	3.1	168	52.2	71.9
Enticement Activities	295	5.0	6.4	228	7.5	9.5
Time in Enticement Activities	295	10.5	13.0	228	19.1	25.6

Note. The unit of measurement for time is hours.

⁶At this early stage of the program, no youth had completed the program in its entirety. Although there is a set of criteria by which an adolescent can be identified as having "completed" the program, IHAF is not the type of program which participants finish. They continue to participate in ongoing activities.

Table 3. Participation of Active and Low-level Participants Groups in Core, Elective, and Enticement Activities

	Active (n=90)				Low-Level (n=624)			
	Phase 1		Phase 2		Phase 1		Phase 2	
	M	SD	M	SD	M	SD	M	SD
Core Activities	7.4	12.2	38.5	32.4	0.4	1.4	1.0	2.3
Time in Core Activities	12.4	19.6	64.0	52.7	0.7	2.5	1.7	3.9
Elective Activities	1.0	1.7	28.2	26.0	0.2	0.6	0.4	2.0
Time in Elective Activities	2.1	3.8	86.9	81.8	0.4	1.4	1.5	8.4
Enticement Activities	5.6	7.3	14.5	11.8	1.5	4.0	0.7	1.7
Time in Enticement Activities	12.2	15.6	38.1	31.8	3.2	8.1	1.5	4.0

Note. The unit of measurement for time is hours.

In order to provide a more complete description of the participation of active participants, the total participation was broken down into the percentage accounted for by the three different types of activities during each of the two phases of the program (See Table 4). Participation in Core Activities during Phase 2 accounts for the greatest percentage of the total participation. Phase 2 activities account for 79% of the overall participation.

Table 4. Percentage of Total Participation in Core, Elective, and Enticement Activities for Active Participants (n=90)

	Phase 1	Phase 2	Total
Core Activities	11.9%	39.5%	51.5%
Elective Activities	1.1%	25.0%	26.1%
Enticement Activities	7.9%	14.5%	22.4%

Table 5 reports the breakdown of Phase 1 participation for those active youth who participated during Phase 1 (n=67). Not all of the youth who were classified as active based on their total participation in Core Activities across the two phases of the program participated during Phase 1. Table 5 also reports the breakdown of Phase 2 participation into Core, Elective, and Enticement Activities for all active participants (n=90). Enticement activities constitute the greatest proportion of the Phase 1 activity for

active participants, followed closely by Core Activities. Elective Activities are only a very small percentage of the participation. Few of the elective modules and programs had been developed during Phase 1. During Phase 2, however, Core Activities represented over 50% of participation, followed by Elective Activities. Less than 20% of participation was in Enticement Activities. This pattern illustrates the shift in focus from attracting youth to the program to providing more content-oriented services.

Table 5. Percentage of Participation in Core, Elective, and Enticement Activities during Each Phase for Active Participants

	Phase 1 (n=67)	Phase 2 (n=90)
Core Activities	40.1%	52.9%
Elective Activities	6.8%	28.3%
Enticement Activities	53.1%	18.2%

Participation in Core Activities of the active participants was broken down further into the specific Core Modules. Table 6 reports the percentages for each module across the two phases and overall. Tutoring accounts for 50% of the total participation, primarily due to tutoring being offered four times per week throughout the school year. The other Core Modules are only offered once a week, on average, during a limited number of weeks depending upon the length of the module.

Table 6. Percentage of Total Core Activity Accounted for by Each Type of Core Module

Core Module	Phase 1	Phase 2	Total
Prosocial/A & D	4%	15%	20%
Family Life Education	0.4%	12%	12%
Job Readiness	3%	0.4%	3%
CHARM/MATURE	2%	13%	15%
Tutoring	11%	39%	50%

The next step in the analyses was to determine what factors distinguish active participants from low-level participants at baseline on demographic variables, behavioral variables, and self-concept. A discriminant analysis was conducted with participation group as the grouping variable and baseline demographic, self-concept, and behavioral measures as the predictors. The first discriminant analysis was conducted using T_1 data. The groups were active participants versus low-level participants based on overall participation in Core Activities across the two phases of the program. Table 7 presents the means and standard deviations or the percentages (depending upon the level of measurement of the variable) for each variable for active and low-level participants. Due to missing data, the number of subjects included in the analysis was greatly reduced; therefore, these analyses should be interpreted with some caution.

The discriminant function was significant $\chi^2 (21) = 35.23, p < .05$. The canonical correlation, however, was not large, $r = .33$, and Wilks' Lambda was .89. The correct classification rate for cases included in the analysis was 74.6%, and for all cases it was 69.4%. Classification rates should be interpreted cautiously because it is possible for there to be a high correct classification rate simply due to a reduced number of subjects in a particular group, as is the case in the present analysis. Based on this discriminant analysis, the active and low-level participation groups do not appear to be dramatically different from one another. Age is the most important difference between the two group. Age is correlated with substance use, pregnancy risk, and youth employment status. Differences on these variables may be partially due to the differences in age between the two groups. The difference in the percentage of youth who are behind in school is fairly large, although the Wilks' lambda was not very small.

The second discriminant analysis was conducted with T_2 data. This analysis was conducted because so many of the active youth became active during the second phase of the program. Also many of these youth had not

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completed a T_1 survey and could not be included in the first discriminant analysis. The same variables, measured at T_2 , were used in this analysis as in the first. Table 8 reports the descriptive statistics and the correlation of the variable with the discriminant function.

The discriminant function for this analysis was not significant, $\chi^2(21)=17.25$, $p=.70$. The canonical correlation was .27 and the Wilks' lambda was .93. The discriminant function correctly classified 62.3% of the cases included in the analysis and 75.1% of all the cases. The lack of significance of the discriminant function indicates that the two participation groups did not differ at T_2 on demographic variables and risk factors associated with teen pregnancy.

Table 7. Means, Standard Deviations, and Correlations with Discriminant Function for Discriminant Analysis of Participation Groups using T₁ Variables

Variable	Active (n=25)		Low-Level (n=294)		r
	M or %	SD	M or %	SD	
Age**	12.0	1.2	14.1	2.0	.81
Sex (% Male)	60.0		57.8		-.03
Mother' Age	34.8	5.2	36.0	6.4	.14
Parents' Marital Status (% Married)	20.0		18.4		-.03
Mother Employed Full-time or Part-time (%)	36.0		48.3		.19
Length of time at current address	3.2	1.1	3.1	1.1	-.06
Current Grades	4.9	1.9	4.7	1.9	-.09
Grades compared to friends	3.3	0.8	3.4	0.8	.15
Feelings about school	3.8	1.3	3.7	1.2	-.04
Behind in school* (%)	12.0		31.3		.33
Skipped school	4.8	0.6	4.6	0.8	-.20
Skipped classes*	5.0	0.2	4.6	0.8	-.33
Plans for College (%)	80.0		67.0		-.22
Alcohol Use*	0.0	0.0	2.2	4.9	.36
Regular user of tobacco (%)	0.0		9.5		.26
Ever experimented with drugs (%)	8.0		13.3		.12
Delinquency	0.7	0.8	0.8	0.9	.15
Working* (%)	8.0		25.0		.31
Self-concept	61.3	6.9	59.3	10.5	-.15
Pregnancy Risk*	2.8	4.6	4.9	4.8	.34
Ever been pregnant or caused a pregnancy	0.0		7.8		.23

**Individual Wilks' Lambda (.93) was significant at $p < .001$

*Individual Wilks' Lambdas (.99) were significant at $p < .05$

Table 8. Means, Standard Deviations, and Correlations with Discriminant Function for Discriminant Analysis of Participation Groups using T₂ Variables

Variable	Active (n=49)		Low-Level (n=190)		r
	M or %	SD	M or %	SD	
Age*	13.2	1.6	13.9	2.4	.46
Sex (% Male)	65.3		56.8		-.25
Mother's Age	36.0	5.8	35.2	6.0	-.20
Parents' Marital Status (% Married)	14.3		13.2		-.05
Mother Employed Full-time or Part-time (%)	57.1		48.4		-.25
Length of time at current address	3.2	1.2	3.3	1.1	.17
Current Grades	5.0	1.8	5.0	2.0	.04
Grades compared to friends	3.5	0.7	3.5	0.8	-.13
Feelings about school	4.0	1.1	3.8	1.2	-.22
Behind in school (5)	32.7		28.4		-.13
Skipped school	4.9	0.5	4.7	0.7	-.34
Skipped classes	4.8	0.7	4.7	0.7	-.22
Plans for College (%)	91.8		84.7		-.29
Alcohol Use	0.3	1.0	1.0	3.1	.36
Regular user of tobacco (%)	2.0		5.8		.25
Ever experimented with drugs (%)	0.0		1.6		.20
Delinquency	0.8	1.7	0.9	1.2	.11
Working (%)	22.4		20.0		-.09
Self-concept	63.2	9.9	60.9	11.0	-.30
Pregnancy Risk	4.1	4.6	4.7	4.8	.20
Ever been pregnant or caused a pregnancy	2.0		8.4		.36

*Individual Wilks' Lambda (.98) was significant at the $p < .05$.

The two participation groups may differ on variables which were not measured and could not be included in the analysis. These analyses, however, include many of the important variables associated with risk for teen pregnancy. Participation in the program was partially due to where the youth lived in the housing projects relative to the other participants. For example, a number of active participants at Preston Taylor lived on the same

circle or very near it within the project. Apartment assignment is based on availability rather than tenant characteristics; therefore, youth participation may be due primarily to the location of his or her apartment rather than to some personal characteristic(s) which may have an influence on the outcome variables. This phenomenon illustrates one of the underlying premises of the IHAF program--the need for proximity of services. Even within the restricted area of the housing projects, those adolescents living in closer proximity to the IHAF program were more likely to participate.

In summary, the process analysis of the IHAF program included three facets--(1) a description of the development of the program over time; (2) a description of the level of participation of youth and in which activities; and (3) an analysis of differences between youth who chose to participate and those who did not. The IHAF program is a complex and comprehensive intervention. Its implementation requires a substantial amount of time and coordination among a number of different agencies. Future replications of IHAF should be aware of this factor and develop their plans accordingly. Because the curricula have already been developed, replications may take a little less time than the two years required for this demonstration project.

Because the program is community-based rather than school-based adolescents must be attracted to the program and retained. IHAF was able to attract 90 active participants over the three years described in this evaluation. The involvement of these youth gradually increased over time as more services and activities were implemented. The type of participation also changed over time, with more participation in content-oriented activities in the latter months of the program. Enticement activities are very important for introducing youth to the program and for keeping them involved. Replications should anticipate offering a number of enticement activities at the beginning of the program and continue to offer enticement activities as a core group of active youth begins to develop. The number of these activities may become less frequent as the core group of youth become more committed to the program. One important caution should be noted--as the core group develops an identity as IHAF participants, it may become more difficult to recruit new participants, who will have to "break into" an already formed group. Older members may actively try to restrict who becomes a new member of the group in order to protect their ingroup.

Long-term, community-based programs will always manifest some degree of selection bias. Certain youth will be attracted to the program and others will not. Determining which types of youth are attracted to such programs as IHAF is important. If these programs demonstrate success at reducing risky behaviors and their outcomes, this information will help determine for whom the program is most effective. Based on the analyses presented here, the most significant difference between the adolescents who participated and those who

did not was age. The IHAF program, in its early years, appears to be most attractive for the younger adolescent. Working adolescents are less likely to become involved, which may be due to their lack of free time. Although a higher percentage of the low-level participants were behind in school, other variables related to academic behavior and attitudes were not significantly different from active participants. In fact, active participants were more likely to have skipped classes than low-level participants. All of these differences occurred at T_1 . The T_2 analyses indicated that the only difference between the two groups was a fairly small age difference.

A very encouraging result of these analyses is that the program appears to be as attractive to males as to females. Most teen pregnancy prevention programs have focused on females. Attracting males to such programs has been very difficult, particularly if the programs are clearly identified as pregnancy prevention programs. Male counselors, sports activities, and the entrepreneurship program are probably some of the factors that have facilitated the recruitment and participation of young males.

Effects of the IHAF Program

Before reporting the results of the impact analyses, a few issues regarding sample sizes need to be mentioned. First, not all youth were tested at all three data collection periods due to attrition and to adolescents becoming involved with the program who were not originally tested at T_1 . The number of youth with each pattern of testing by neighborhood is reported in Table 9. The test status group are mutually exclusive.

Table 9. Number of Subjects by Test Status By Neighborhood

Test Status	Neighborhood	
	Intervention	Comparison
T ₁ only	271	207
T ₂ only	50	2
T ₁ and T ₂ only	102	59
T ₁ and T ₃ only	24	37
T ₂ and T ₃ only	113	2
T ₁ , T ₂ , and T ₃	154	132
Total	714	439

Sample sizes will vary for the different analyses depending upon the time period being studied and the variables incorporated into the analyses. Analyses utilizing data from T₁ and T₃, for example, would have a potential maximum sample size of 329; whereas, analyses utilizing data from T₁ and T₂ would have a potential maximum sample size of 429. Occasionally subjects would skip questions or answer them inappropriately and could not be included in specific analyses for variables measured by those questions, which results in reduced sample sizes for these variables.

Additionally, 18 youth were inconsistent in their responses to sexual behavior and pregnancy questions at T₁ and T₃. Inconsistent responses include (1) reporting having had sexual intercourse at T₁ and reporting not having ever had sexual intercourse at T₃ and (2) reporting involvement with fewer pregnancies at T₃ than at T₁. These 18 youth were eliminated from all of the analyses. Five of these inconsistent youth were residents of the intervention sites and 13 were from the comparison sites.

Neighborhood Level Effects of IHAF. The first set of analyses will compare adolescents who live in the housing projects where the IHAF program was offered with those adolescents living in the housing projects where the program was not offered. These analyses will be referred to as the "between neighborhood" comparisons and they address Question Two. Not all of the surveyed adolescents who lived in the intervention site neighborhoods actively participated in the IHAF program. Some did not participate at all. Consequently, these analyses will examine whether the intervention had a strong enough effect to be detected at the neighborhood level. Such a strong

effect of the program is unlikely given the low percentage of youth who participated heavily in the program (12.6%; 90 active participants out of 714 youth tested at the intervention sites.)

T-tests were calculated with neighborhood as the independent variable and the psychosocial, knowledge, and behavioral measures as the dependent variables. A chi-square analysis was computed for involvement with a pregnancy. Both T_2 and T_3 variables were included. Table 10 reports the descriptive statistics and the test statistic for each variable. From these analyses, the IHAF program appears to have an effect at the neighborhood level on psychosocial maturity, sexual knowledge at T_2 , and the Nguza Saba measure at T_2 and T_3 . In all cases, the program's effects are in a positive direction. There are no effects on the behavioral measure and the pregnancy rate. Interestingly, the greatest effects appear to occur after the first, less well-developed phase of the program than after the second phase.

These direct comparisons between the neighborhoods do not consider the possibility of baseline differences between the neighborhoods on important related variables. The next set of between-neighborhood analyses control for baseline differences between the neighborhoods and then consider the effects of the IHAF program on the dependent variables.

Table 10. Means, standard deviations, and test statistics for comparisons between neighborhoods on T₂ and T₃ dependent variables

Variable	Intervention Neighborhood			Comparison Neighborhood			test statistic
	n	M or %	SD	n	M or %	SD	
Time 2							
Life Options	363	0.03	0.8	179	-0.05	0.8	ns
Attitudes	362	3.35	0.5	180	3.31	0.5	ns
PMT	362	101.56	18.2	177	93.36	17.6	4.97***
Knowledge	364	42.15	21.2	180	37.26	19.7	2.59**
Self-Concept	364	60.21	11.0	180	58.54	11.5	ns
Self-Esteem	361	3.57	0.8	179	3.55	0.9	ns
NGS	361	109.93	16.3	179	104.15	13.6	4.34***
Pregnancy Risk	358	3.98	4.7	176	3.51	4.6	ns
Pregnancy (T ₁ to T ₂)	286	4.9%		158	3.8%		ns
Time 3							
Life Options	286	0.02	0.8	157	-0.06	0.9	ns
Attitudes	285	3.56	0.4	157	3.52	0.4	ns
PMT	281	104.65	20.8	158	103.40	18.5	ns
Knowledge	286	50.90	21.0	158	48.23	21.6	ns
Self-Concept	286	63.73	9.6	158	63.85	9.8	ns
Self-Esteem	284	3.78	0.6	158	3.74	0.6	ns
NGS	285	112.39	12.2	157	109.65	11.3	2.32*
Pregnancy Risk	260	4.38	4.6	149	4.30	4.6	ns
Pregnancy (T ₂ to T ₃)	286	6.6%		158	10.8%		ns
Pregnancy (T ₁ to T ₃)	286	10.8%		158	12.7%		ns

*p<.05

**p<.01

***p<.001

Variables measured at T_1 that represent factors associated with risk for teen pregnancy were considered as potential covariates. These variables were (1) age⁷; (2) marital status of parents; (3) mother's employment status; (4) self-concept; (5) delinquent behavior; (6) alcohol use; (7) behind in school; (8) plans for attending college; (9) degree of religiosity, and (10) youth employment status. The relationship of each of these variables to number of pregnancies reported at T_3 was tested. Pearson product moment correlations were computed between number of pregnancies and the continuous variables-- age, self-concept, religiosity, delinquent behavior, and alcohol use. T-tests were conducted with number of pregnancies as the dependent variable for the following dichotomous variables: (1) marital status of parents; (2) mother's employment status; (3) behind in school; (4) plans for attending college; and (5) youth employment status. All subjects with data on the relevant variables were used in these analyses. Age and alcohol use were significantly correlated with number of pregnancies between T_1 and T_3 , number of pregnancies between T_1 and T_2 , and number of pregnancies between T_2 and T_3 (See Table 11). The older adolescents were, the greater the number of pregnancies they reported. The greater the alcohol use the greater the report of pregnancies between T_1 and T_2 .

⁷The lag period between T_1 and T_2 is longer for intervention site subjects than for the comparison site subjects by as much as 16 months because of the long baseline data collection period. Age at baseline, therefore, cannot be used as a covariate because similar cohort groups in the comparison and intervention sites at T_2 would have different baseline ages. Data were collected in a much shorter time period at T_2 . In order to address the need to include a variable which appropriately represents age, age at T_2 was used instead. Age at T_2 was calculated for those subjects who were not tested at T_2 but were tested at T_1 and T_3 .

Pregnancy risk at T_1 , which is strongly correlated with age, cannot be used as a covariate for the same reason. However, pregnancy risk at T_2 cannot be included as a proxy measure of pregnancy risk at T_1 because it is an outcome variable and the relationship between pregnancy risk at T_1 and pregnancy risk at T_2 is not as strong as the relationship between age at these two time points. A t-test comparing the baseline pregnancy risk of the younger youth (10-14 years old, the age range of the active participants at T_1) from the intervention sites with the pregnancy risk of the younger youth from the comparison sites revealed that there was no significant difference between these two different cohorts of 10 to 14 year olds, $t(166)=0.68$, $p=.50$. Based on this analysis, it is assumed that subjects in the comparison sites who were in the same cohort as subjects at the intervention sites also probably did not differ significantly on pregnancy risk at T_1 for the intervention sites. The fairly strong correlation between age and pregnancy risk ($r=.50$) also indicates that age would account for a substantial amount of the variance in dependent variables that would have been accounted for by baseline pregnancy risk.

Table 11. Correlations between Number of Pregnancies and Potential Covariates

Potential Covariate	Total Pregnancies	Pregnancies between T ₁ & T ₂	Pregnancies between T ₁ & T ₂
Age (n=444)	.37***	.26***	.28***
Alcohol Use (n=321)	.06	.12*	-.01
Self-Concept (n=383)	.02	.04	.00
Religiosity (n=328)	-.03	-.03	-.02
Delinquency (n=326)	-.01	-.02	-.01

*p<.05
 **p<.01
 ***p<.001

The t-tests revealed significant differences in number of pregnancies depending upon the adolescent's college plans. There was a trend for a difference ($p<.10$) between youths with employed mothers and those with unemployed mothers. Adolescents with plans for college reported fewer pregnancies and those with employed mothers had more pregnancies (See Table 12)⁸. Based on these analyses the following variables were included as covariates and were used to determine the propensity score: (1) age, (2) alcohol use, (3) mother's employment status, and (4) college plans.

⁸Number of pregnancies is a highly skewed variable because the majority of youth do not report having been involved with a pregnancy. A second set of analyses were conducted in which the pregnancy variables were dichotomized into not involved with a pregnancy and involved with at least one pregnancy. A series of t-tests were conducted with the new dichotomized pregnancy variable as the independent variable and age, pregnancy risk, alcohol use, delinquency, religiosity, and self-concept as the dependent variables. The results of these analyses were very similar to the correlational analyses described previously.

Table 12. Means, Standard Deviations, and t-tests for Number of Pregnancies by Potential Covariates

Potential Covariate	Total Pregnancies			Pregnancies Between T ₁ and T ₂			Pregnancies Between T ₂ and T ₃		
	<u>M</u>	<u>SD</u>	<u>t</u>	<u>M</u>	<u>SD</u>	<u>t</u>	<u>M</u>	<u>SD</u>	<u>t</u>
Gender									
Male (n=155)	.13	.39		.04	.25		.09	.29	
Female (n=174)	.20	.44	1.44	.08	.27	1.52	.11	.32	0.73
Parental Marital Status									
Not Married (n=283)	.16	.42		.06	.25		.10	.30	
Married (n=45)	.18	.44	0.23	.06	.25	0.16	.11	.32	0.18
Mother's Employment Status									
Not Employed (n=206)	.16	.40		.04	.19		.12	.32	
Employed (n=121)	.18	.45	0.55	.10	.33	1.85*	.08	.28	0.97
College Plans									
No (n=87)	.25	.51		.08	.31		.17	.38	
Yes (n=237)	.14	.38	1.96**	.05	.23	0.70	.08	.27	2.08**
Behind in School									
No (n=229)	.16	.41		.07	.27		.10	.30	
Yes (n=93)	.18	.44	0.41	.05	.23	0.37	.13	.34	0.87
Youth Employment Status									
Not Employed (n=266)	.16	.43		.06	.26		.10	.30	
Employed (n=62)	.18	.39	0.27	.05	.22	0.44	.13	.34	0.73

*p < .10

**p < .05

A logistic regression was conducted with neighborhood as the dependent variable in order to determine if neighborhood membership could be predicted from the covariates. With logistic regression, a significant goodness-of-fit chi-square indicates that the model being tested and the data are significantly different from one another; therefore, a nonsignificant goodness-of-fit chi-square indicates that the predictor variables explain the variance in the dependent variable adequately. Table 13 reports the results of these analyses. The highly significant chi-square indicates that the covariates as a group do not predict neighborhood membership significantly better than chance. Only age is a significant predictor. A propensity score, indicating the probability of belonging to the comparison neighborhood, was computed for each subject based upon this analysis. The propensity score will be included as an additional covariate in the next set of analyses in order to model baseline group differences between the neighborhoods.

Table 13. B weights, Partial Correlations, and Wald statistics for logistic regressions comparing neighborhoods on baseline variables (n=471)

Variable	B	R	Wald Statistic
Age	0.15	.12	11.76***
Gender	0.17	.04	3.14
Mother's Employment	-0.19	-.04	3.49
Alcohol Use	0.03	.00	0.53
Plans for College	0.04	.00	0.04
-2 Log Likelihood Fit. of Model	$\chi^2=625.23$	df=465	p<.001
% Correctly Classified:	55.63		

*p<.05
 **p<.01
 ***p<.001

To test the neighborhood effect after adjusting for covariates and the propensity score, a series of ordinary least squares regressions were conducted for the continuous dependent variables and logistic regressions were conducted for pregnancy variables. All regressions were hierarchical regressions with the covariates entering at the first step, the propensity score at the second step, and neighborhood at the final step. The critical step in these analyses is the third step, which indicates the amount of variance accounted for by the neighborhood variable over and above that which is accounted for by baseline differences. Table 14 reports the beta weights and the squared semi-partial correlations for the neighborhood variable for each of the continuous dependent variables, the odds ratio rather than the beta weight for the pregnancy variable, and the total explained variance. Neighborhood continues to explain a significant proportion of the variance in psychosocial maturity and the Nguza Saba measure at T_2 . The difference in sexual knowledge at T_2 ceases to be significant; however, sexual knowledge at T_3 becomes significantly different between the neighborhoods. The intervention neighborhood performs better on this knowledge measure. Self-concept at T_2 also is significantly different, with the intervention neighborhood having a more positive self-concept. Neighborhood is also a significant predictor of pregnancy risk, but unfortunately, the intervention neighborhood predicts to higher pregnancy risk behavior.

From these analyses, the IHAF program does appear to have a significant positive effect on a limited number of psychosocial variables and on knowledge at the neighborhood level. The Nguza Saba measure is directly related to the values being promoted by the IHAF program and was developed by IHAF staff so it is not too surprising that this variable demonstrates the most consistent effects. The lack of influence on attitudes, self-esteem, and perceived life options is disappointing but not surprising given that the low percentage of participating adolescents of those who lived in the neighborhoods. Examining the frequency distributions for the three variables that are a part of pregnancy risk reveals that intervention and comparison site subjects were not substantially different on frequency of birth control use or frequency of intercourse. They were different on the type of birth control used most frequently. For both sites, the condom alone was the modal response, followed by the birth control pill. However, comparison site youth reported a slightly higher use of the birth control pill (34.8%) than the intervention site youth (23.7%). The converse was true of the condom--40.2% of the comparison site youth vs. 52.7% of the intervention site youth. The birth control pill receives a better rating than the condom as far as pregnancy prevention is concerned. The intervention site youth may be responding to the disease prevention message by utilizing the condom more.

Table 14. Sample Sizes, Beta Weights, and Squared Semi-partial Correlations for Neighborhood Variable for Hierarchical Regressions with Adjusted Dependent Variables

Dependent Variable	n	Beta Weight	semi-partial r^2
Time 2			
Life Options	411	.05	.00
Attitudes	411	.01	.00
PMT	408	.25	.06***
Knowledge	413	.08	.01
Self-Concept	413	.13	.02**
Self-Esteem	410	.01	.00
NGS	410	.15	.02**
Pregnancy Risk	404	.07	.00
Pregnancy (T ₁ to T ₂)	315	Odds Ratio: 1.11	.00
Time 3			
Life Options	314	.02	.00
Attitudes	314	-.02	.00
PMT	310	.04	.00
Knowledge	315	.11	.01*
Self-Concept	315	.03	.00
Self-Esteem	313	.05	.00
NGS	313	.09	.01
Pregnancy Risk	293	.10	.01*
Pregnancy (T ₂ to T ₂)	315	Odds Ratio: 0.99	.00
Pregnancy (T ₁ to T ₂)	315	Odds Ratio: 1.08	.00

*p<.05
 **p<.01
 ***p<.001

Effects of IHAF on Active Participants. The third question addressed in this evaluation is whether adolescents who actively participate in the program benefited more than those who lived in the same neighborhood but did not participate actively. Youths living in the two sites where the IHAF program was implemented were divided into two groups based on their participation in Core activities as described above in the participation analyses. The analysis strategy for these comparisons is the same as that employed in the between-neighborhood comparisons. First, the direct comparisons were made with dependent variables unadjusted for covariates or group differences. Second, group differences on baseline variables were examined and finally, the effects of group membership were tested with dependent variables adjusted for covariates and baseline group differences.

The direct comparisons revealed significant differences between active participants and low-level participants on perceived life options, the Nguza Saba measure, and pregnancy rates at T_2 (See Table 15). At T_3 , significant differences exist between the groups on perceived life options, self-concept, self-esteem, and pregnancy rates. The direction of the effect for all of these variables indicates more positive outcomes for active participants than low-level participants. Particularly encouraging, are the large differences on pregnancy rates. The lack of effects on the pregnancy risk behavior variable is interesting given the large differences on pregnancy rates.

The active participants and the low-level participants are self-selected. Baseline differences between participation groups may account for the significant differences found between the groups in the direct comparisons. A logistic regression was conducted with participation group as the dependent variable and the covariates discussed above as the predictors (See Table 16). The test for the fit of the model is non-significant indicating that the covariates are able to predict group membership significantly better than chance. Eighty percent of the subjects were correctly classified. Age, however, is the only significant predictor. Active participants are more likely to be younger than low-level participants. A propensity score was computed for membership in the low-level participation group to be included in the analyses with adjusted dependent variables.

Table 15. Means, Standard Deviations, and Test Statistics for Comparisons between Active Participants and Low-Level Participants within the Intervention Neighborhood on Dependent Variables

	Active Participants			Low-Level Participants			
Variable	n	M or %	SD	n	M or %	SD	test statistic
Time 2							
Life Options	83	0.23	0.7	280	-0.03	0.8	2.67**
Attitudes	83	3.34	0.6	279	3.35	0.5	ns
PMT	83	104.39	19.6	279	100.72	17.6	ns
Knowledge	83	42.09	19.2	281	42.17	21.8	ns
Self-Concept	83	61.51	10.5	281	59.82	11.2	ns
Self-Esteem	83	61.51	10.5	281	3.57	0.8	ns
NGS	83	113.08	16.8	278	108.99	16.5	2.01*
Pregnancy Risk	80	3.25	4.4	278	4.19	4.8	ns
Pregnancy (T ₁ to T ₂)	76	1.3%		210	6.2%		2.85**
Time 3							
Life Options	76	0.24	0.6	210	-0.06	0.9	3.17**
Attitudes	76	3.57	0.4	209	3.55	0.4	ns
PMT	73	107.86	21.3	208	103.53	20.5	ns
Knowledge	76	52.73	20.0	210	50.24	21.4	ns
Self-Concept	76	66.01	7.7	210	62.9	10.0	2.76**
Self-Esteem	76	3.95	0.6	208	3.72	0.6	2.70**
NGS	76	113.74	110.8	209	111.90	12.3	ns
Pregnancy Risk	72	4.10	4.6	188	4.49	4.6	ns
Pregnancy (T ₂ to T ₃)	76	0.0%		210	9.0%		7.36**
Pregnancy (T ₁ to T ₃)	76	1.3%		210	14.3%		9.71**

*p<.05
 **p<.01
 ***p<.001

Table 16. B weights, Partial correlations, and Wald statistics for logistic regressions comparing within-neighborhood participation groups on baseline variables (n=263)

Variable	B	R	Wald Statistic
Age	.32	.21	13.48***
Gender	.11	.00	0.43
Mother's Employment	-0.04	.00	0.06
Alcohol Use	1.01	.00	1.58
Plans for College	0.06	.00	0.09
-2 Log Likelihood Fit of Model	$\chi^2=229.99$	df=257	p=.89
% Correctly Classified	79.85		

*p<.05
**p<.01
***p<.001

To test the effects of the IHAF program controlling for baseline differences between groups, ordinary least squares hierarchical regressions were conducted for the continuous variables and hierarchical logistic regressions were conducted for the pregnancy variables. As in the between-neighborhood analyses, the covariates entered at the first step, the propensity score at the second step, and participation group at the third step. Table 17 reports the beta weights and squared semi-partial correlations for the continuous dependent variables. The odds ratio is reported for the pregnancy variables rather than a beta weight.

Table 17. Sample Sizes, Beta Weights, and Squared Semi-partial Correlations for Participation Group for Hierarchical Regressions with Adjusted Dependent Variables

Dependent Variable	n	Beta Weight	semi-partial r^2
Time 2			
Life Options	240	.18	.01
Attitudes	239	.07	.00
PMT	239	.09	.01
Knowledge	241	.06	.00
Self-Concept	241	.03	.00
Self-Esteem	239	.02	.00
NGS	239	.13	.02*
Pregnancy Risk	236	.03	.00
Pregnancy (T_1 to T_2)	164	Odds Ratio: 1.07	.00
Time 3			
Life Options	164	.17	.03*
Attitudes	163	.05	.00
PMT	159	.09	.01
Knowledge	164	.16	.02*
Self-Concept	164	.10	.01
Self-Esteem	162	.23	.05**
NGS	163	.02	.00
Pregnancy Risk	150	-.02	.00
Pregnancy (T_2 to T_3)	164	Odds Ratio: 0.02	.00
Pregnancy (T_1 to T_3)	164	Odds Ratio: 0.41	.01

* $p < .05$
 ** $p < .01$
 *** $p < .001$

The participation group effect remains for the Nguza Saba measure at T_2 ; however, the perceived life options and pregnancy rate differences are no longer significant. At T_3 , the perceived life options and self-esteem effects remain significantly higher for active participants. Participation group becomes a significant predictor of sexual knowledge at T_3 , with active participation being a predictor of higher knowledge scores. Participation group is no longer a significant predictor of involvement with a pregnancy based upon the Wald statistic for the participation group; however, the improvement in the fit of the model at the third step, when group was added, was significant for involvement with a pregnancy between T_2 and T_3 , $\chi^2(1)7.71$, $p<.01$, and for involvement with a pregnancy between T_1 and T_3 , $\chi^2(1)=4.24$, $p<.05$. In addition, the odds ratios for both of these pregnancy involvement variables are fairly small, particularly for pregnancy involvement during the the second phase of the IHAF program. The stronger effects of the program appear to be during the second, more fully implemented phase of the program.

A second set of analyses was conducted comparing the active participants from the intervention neighborhoods with the comparison site subjects. This set of analyses provides another test of the effects of active participation in the IHAF program with a different comparison group. Consistent results between these two sets of analyses will provide additional evidence for the effects of the IHAF program. The direct comparisons between the groups are reported in Table 18. Similar to the previous analyses, active participants score higher on perceived life options and the Nguza Saba measure at T_2 and perceived life options, self-esteem, and pregnancy involvement at T_3 . In addition, active participants score higher on psychosocial maturity and self-concept at T_3 and the Nguza Saba measure at T_3 . Pregnancy involvement at T_2 is not significantly different as it was in the previous set of analyses.

Table 18. Means, Standard Deviations, and Test Statistics for Comparisons Between Active Participants in the Intervention Neighborhood and the Comparison Neighborhood Subjects on T₂ and T₃ Dependent Variables

	Active			Comparison			
Variable	n	M or %	SD	n	M or %	SD	test statistic
Time 2							
Life Options	83	0.23	0.7	179	-0.05	0.8	2.67**
Attitudes	83	3.31	0.5	83	3.34	0.6	ns
PMT	83	104.39	19.6	177	93.36	17.6	4.53***
Knowledge	83	42.09	19.2	180	37.26	19.7	ns
Self-Concept	83	61.51	10.5	180	58.54	11.5	1.99*
Self-Esteem	83	3.57	0.9	179	3.55	0.9	ns
NGS	83	113.08	16.8	179	104.15	13.6	4.23***
Pregnancy Risk	80	3.25	4.4	176	3.51	4.6	ns
Pregnancy (T1 to T2)	76	1.3%		210	3.8%		ns
Time 3							
Life Options	76	0.24	0.6	157	-0.06	0.9	2.99**
Attitudes	76	3.57	0.4	157	3.52	0.4	ns
PMT	73	107.86	21.3	158	103.40	18.5	ns
Knowledge	76	52.73	20.0	158	48.23	21.6	ns
Self-Concept	76	66.01	7.7	158	63.85	9.8	ns
Self-Esteem	76	3.95	0.6	158	3.74	0.6	2.54*
NGS	76	113.74	11.8	157	109.65	11.3	2.55*
Pregnancy Risk	72	4.10	4.6	149	4.3	4.6	ns
Pregnancy (T2 to T3)	76	0.0%		158	10.8%		8.82**
Pregnancy (T1 to T3)	76	1.3%		158	12.7%		8.08**

*p<.05
 **p<.01
 ***p<.001

The logistic regression predicting membership in the two groups based on the baseline covariates was non-significant, indicating a good fit to the model, and 80% of the cases were correctly classified (See Table 19). None of the individual predictors, however, were significant, although age had the strongest relationship. Once again, a propensity score was computed based upon this analysis.

Table 19. B weights, Partial Correlations, and Wald Statistics for Logistic Regressions Comparing Active Participation Group with Comparison Neighborhood Subjects on Baseline Variables (n=260)

Variable	B	R	Wald Statistic
Age	-0.13	-.04	2.34
Gender	0.15	.00	0.85
Mother's Employment	-0.02	.00	0.02
Alcohol Use	-0.75	.00	1.17
Plans for College	0.03	.00	0.03
-2 Log Likelihood Model Fit	$\chi^2=250.07$ df=254		p=.56
% Correctly Classified:	80.00		

*p<.05
 **p<.01
 ***p<.001

Hierarchical regressions and logistic regressions were conducted with the covariates entered at step 1, propensity score at step 2, and group membership at step 3. Table 20 reports the beta weights or odds ratios and the squared semi-partial correlations for the group membership variable. At T_2 , perceived life options is no longer related to group membership. Psychosocial maturity, the Nguza Saba measure, and self-concept remain significantly related to group membership, with active participants scoring more positively. At T_3 , perceived life options and the Nguza Saba measure remain significantly related to group membership and sexual knowledge becomes significantly related to group membership. Once again, membership in the active participation group predicts to more positive scores on each of these measures. Involvement with a pregnancy is no longer significantly predicted by group membership based on the Wald test for the group membership variable; however, the improvement in the model fit was significant at this step, $\chi^2(1)=4.62$, $p<.05$, for involvement with a pregnancy during the second phase of the IHAF program. The odds ratio is also very low for active participants being involved in a pregnancy. There appears to be no effect on pregnancy risk behavior. In this set of analyses comparing the comparison neighborhood to a subset of the intervention neighborhood, at least, the pregnancy risk behavior is not significantly higher for the youths exposed to the IHAF program.

Table 20. Sample sizes, Beta Weights, and Squared Semi-partial Correlations for Group Variable (active participants vs. comparison site subjects) for Hierarchical Regressions with Adjusted Dependent Variables

Dependent Variable	n	Beta Weight	semi-partial r ²
Time 2			
Life Options	221	.10	.01
Attitudes	222	.05	.00
PMT	219	.28	.08***
Knowledge	222	.11	.01
Self-Concept	222	.14	.02*
Self-Esteem	221	.01	.00
NGS	221	.25	.06***
Pregnancy Risk	215	.09	.01
Pregnancy (T1 to T2)	194	Odds Ratio: 0.91	.00
Time 3			
Life Options	193	.13	.02*
Attitudes	194	.04	.00
PMT	191	.10	.01
Knowledge	194	.20	.04**
Self-Concept	194	.11	.01
Self-Esteem	194	.19	.03**
NGS	193	.10	.01
Pregnancy Risk	184	.07	.01
Pregnancy (T2 to T3)	194	Odds Ratio: 0.02	.00
Pregnancy (T1 to T3)	194	Odds Ratio: 0.54	.00

*p<.05
 **p<.01
 ***p<.001

Evaluation of How the Effects are Achieved

The fourth question addresses how the program may be working. The processes through which the IHAF program works could best be tested longitudinally through path analysis or structural modeling. The number of subjects who have sufficient data across the three data collection points to be included in such analyses is too limited for these analytical procedures. An examination of the pattern of effects and the correlations between the psychological and knowledge variables, the behavioral variable, and the final outcome of pregnancy rate may provide some information of how the program may work.

The program model of IHAF is that the program activities would have an effect primarily on the psychosocial and knowledge variables, particularly the perceived life options variable. These variables and the availability of health care would influence the sexual and contraceptive behavior of the adolescents. Finally, less risky sexual behavior would translate into lower pregnancy rates. If the program is operating according to these mechanisms, then one would expect to see the strongest effects on the psychosocial and knowledge variables, which are the most direct measures of the proximal goals of the program. The next strongest effect would be on pregnancy risk behavior. The weakest effect of the IHAF program should be on pregnancy rate, which is the most distal goal of IHAF. Weaker effects for pregnancy rates could also be due to the low incidence of pregnancy in the sample.

Based on the results discussed in the previous section, IHAF effects can be seen most consistently on a few of the psychosocial variables and the knowledge variable. Only one analysis reveals a significant effect on behavior, which was in the opposite direction expected. The effects of the program on pregnancy rates are rather difficult to interpret due to the inconsistency between statistical indicators. The rate of pregnancy is obviously substantially lower for the active participants, but whether other variables, mainly age, explain the lower rate other than the IHAF program is difficult to determine at this point. This pattern of effects partially supports the IHAF model, however.

The correlations between the dependent variables are presented in Table 21. Many of the psychosocial variables are related to pregnancy risk and involvement with a pregnancy and the inverse or direct effect of the relationship is consistent with the IHAF model. Perceived life options is negatively correlated with pregnancy risk and involvement with a pregnancy. Psychosocial variables are more strongly and consistently related to pregnancy risk behavior than to involvement with a pregnancy. Pregnancy risk behavior is positively correlated with involvement with a pregnancy.

Table 21. Correlations of Psychological Variables with Pregnancy Risk and Involvement with a Pregnancy

	Preg. Risk (T ₂)	Preg. Risk (T ₃)	Preg- nancy (T ₁ - T ₂)	Preg- nancy (T ₂ - T ₃)	Preg- nancy (T ₁ -T ₃)
Time 2	r	r	r	r	r
Life Options	-.27***	-.25***	-.12*	-.21*	-.24***
Attitudes	-.18***	-.21***	-.03	-.05	-.05
PMT	.01	-.03	.08	-.10*	-.03
Knowledge	.41***	.29***	.15**	.16**	.21***
Self-Concept	.05	.03	.03	-.01	.01
Self-Esteem	.02	-.07	.04	-.05	-.01
NGS	.01	-.04	.02	-.08	-.05
Pregnancy Risk	.46***	.48***	.21***	.21***	.29***
Time 3					
Life Options	-.29***	-.32***	-.19***	-.19***	-.26***
Attitudes	-.13**	-.31***	-.03	-.04	-.04
PMT	.10	.08	.15**	.04	.13**
Knowledge	.36***	.31***	.17***	.16***	.21***
Self-Concept	.07	-.03	.00	-.09	-.06
Self-Esteem	.18**	.04	.11*	-.05	.02
NGS	.08	-.04	.00	-.05	.00
Pregnancy Risk	.48***		.20***	.24***	.29***

*p<.05
 **p<.01
 ***p<.001

The psychosocial variables on which IHAF tends to have the most consistent effects are the Nguza Saba measure and sexual knowledge. Unfortunately, the Nguza Saba measure is not significantly related to either pregnancy risk behavior or involvement with a pregnancy. The same is true of self-concept and self-esteem as well, two variables on which the IHAF program may have some, although inconsistent, effects. Knowledge is positively related to pregnancy risk behavior and involvement with a pregnancy, indicating that the greater knowledge of the IHAF participants could put them at greater risk rather than less risk. Sexual knowledge, however, is also strongly related to age ($r=.57$ for T_2 and $r=.54$ for T_3) and age is also positively correlated with pregnancy risk behavior. The IHAF active participants have more knowledge

than the low-level participants and the comparison site subjects, yet they are younger in age and their pregnancy risk is not significantly higher. A valuable contribution to the evaluation of this project would be to follow these active participants for a longer period of time to determine what the effects are of this increased knowledge.

Perceived life options is another variable on which the IHAF program appears to have a positive influence during the second phase of the program. Perceived life options is consistently one of the psychosocial variables that is inversely related to both pregnancy risk behavior and involvement with a pregnancy. Of the psychosocial variables, it also tends to have the strongest set of correlations with these two variables. These relationships fit very well with the IHAF model. Of course it is important to recognize that these correlations do not indicate the direction of the effect.

Based on these correlations, there is some evidence that the IHAF program may be operating according to its model; however, more research is needed to determine if this is truly the case. There are a number of alternative models which could explain these results. For example, the IHAF program attracted younger youth, at least during these early years. The incidence of pregnancy among this group may be underestimated as a result. The active participants may have some underlying characteristic which was not measured but which explains the positive effects of the program better than their involvement with IHAF.

Another point to consider is the generalizability of the results. A substantial number of subjects were lost-to-followup. Most of these subjects moved from these particular housing projects; however, others simply chose not to participate in the survey anymore. Youth who leave the housing projects and those who were no longer interested in completing the survey could be different from those who continued to participate in the survey. One method for determining systematic differences is to examine differences between those who were followed and those who were not on variables measured at T_1 . Discriminant function analyses were conducted with the following predictor variables measured at T_1 : age, gender, parents' marital status, mother's employment status, youth's employment status, religiosity, pregnancy risk, delinquency behavior, alcohol use, behind in school, plans for college, and involvement with a pregnancy. Separate analyses were run for the comparison sites and the intervention sites. The results of these analyses are reported in Table 22. The discriminant function was significant for both neighborhoods and the significant predictors were the same with one exception. Significant predictors were age, youth's employment status, pregnancy risk, alcohol use, plans for college (for the intervention neighborhood only), and involvement with a pregnancy. Those subjects lost-to-follow-up were older, more likely to be employed, had a higher pregnancy risk score, used alcohol more, fewer had

plans for college (intervention neighborhood), and were more likely to have been involved with a pregnancy than those who were not lost to follow-up. These data indicate that higher risk youths were more likely not to be included in the evaluation. Consequently, the effects of the IHAF program has demonstrated thus far are for younger youths who currently are involved in fewer of the riskier behaviors. Because this evaluation was of limited duration, the impact of the program on the behavior of the active participants as they get older could not be observed. The effectiveness of the IHAF program could diminish as the youth get older or stronger positive effects of the program could become more evident as the young participants get older and are compared with youth who are also older and more likely to be engaging in high risk behavior.

Table 22. Standardized Canonical Discriminant Function Coefficients and Wilk's Lambda for Discriminant Analysis Comparing Subjects who were Lost-to-Follow-up before T₃ and Subjects who were Followed through T₃ by Neighborhood

Variable	Intervention		Comparison	
	Standardized Canonical Discriminant Function Coefficient	Wilk's Lambda	Standardized Canonical Discriminant Function Coefficients	Wilk's Lambda
Age	0.75	0.890***	0.72	0.884***
Gender	0.21	0.999	0.01	0.999
Parent's Marital Status	0.12	0.998	0.20	0.996
Mother's Employment Status	0.14	0.993	0.24	0.995
Subject's Employment Status	0.05	0.983*	0.04	0.981*
Religiosity	-0.12	0.998	0.13	0.995
Pregnancy Risk	0.14	0.958***	0.03	0.952***
Alcohol Use	0.27	0.958***	0.26	0.945***
Delinquent Behavior	0.01	0.998	0.20	0.989
Behind in School	0.18	0.993	-0.23	0.998
Plans for College	-0.04	0.988*	0.10	0.998
Involved in Pregnancy	0.22	0.971**	0.36	0.913***
	Canonical Correlation: .39		Canonical Correlation: .46	
	Wilks' Lambda=0.85 $\chi^2(12)=52.68$ ***		Wilks' Lambda=0.79 $\chi^2(12)=57.90$ ***	

*p<.05
**p<.01
***p<.001

Summary

The evaluation of the IHAF program addressed four sets of questions. The participation analyses addressed the the first set of questions regarding the level of participation and the characteristics of the adolescents who became actively involved with the program. During the time period of the evaluation,

IHAF made contact with over 400 adolescents. Ninety of these youth became the core participants in the program. This core group represents 12.6% of those who completed an evaluation survey at one of the three data collection periods of the evaluation. The level of participation of this core group was quite high, with an average participation level of almost 216 hours when participation in Core, Elective, and Enticement activities are added together. With approximately two and half years of service delivery, the average number of hours in contact with the IHAF program is a little over seven hours. Average contact time per month actually increased to about 11 hours per month during Phase 2 of the program from about two hours per month during Phase 1.

The adolescents who chose to participate in the program were younger than low-level participants and had engaged in fewer risky behaviors. They were also less likely to be working. Working youth have less free time to participate in programs like IHAF and have access to other opportunities for entertainment due to greater financial resources. IHAF was able to attract a significant proportion of male adolescents, a very positive aspect for the program. The reasons for attracting more males than most teen pregnancy prevention programs cannot be determined definitively at this time. Male counselors, sports activities, and the entrepreneurship program are probably the most likely reasons males became involved. Pregnancy prevention is also embedded within a number of other goals that male may identify with more easily than pregnancy prevention.

The second set of questions dealt with the impact of the IHAF program on psychosocial variables, pregnancy risk behavior, and involvement with a pregnancy. Effects were tested at the neighborhood level. The third set of questions addressed whether the effects were more evident with those adolescents who participated actively. Two sets of analyses were conducted comparing the active participants to the low-level participants in the intervention sites and comparing active participants to comparison site youths. With respect to the psychosocial variables, the comparison site adolescents were lower on the acceptance of the prosocial values espoused by the Nguzo Saba, psychosocial maturity, and self-concept after Phase 1 of the program. These differences were evident in both the comparison at the neighborhood level and the comparison with the active participants. Active and low-level participants were not significantly different from one another on these variables. There were no other differences on psychosocial variables after the first phase of the program. Knowledge after the second phase of the program was significantly better for the intervention site youth. The more specific analyses comparing the active participants with the low-level participants and then with the comparison site youth revealed that active participants were significantly more knowledgeable than both of the other groups. Active participants also scored significantly more positively on the

life options variable and the self-esteem variable after Phase 2 of the program than both the low-level participants and the comparison site youth. All of the above differences were significant after baseline differences between groups were covaried.

Analyses of pregnancy risk behavior indicated that there were no differences at the neighborhood level after Phase 1. After Phase 2, however, the intervention site adolescents were significantly higher than the comparison site youth on pregnancy risk behavior. This difference was no longer significant when only the active participants and the comparison site youths were compared. The higher pregnancy risk was probably due to the low-level participants. Comparisons between the active and low-level participants, however, did not reveal any differences on pregnancy risk.

The final variable examined in these analyses was whether or not the adolescent had been involved with a pregnancy. After covarying baseline differences, there were no significant differences on this variable at either time points for any of the group comparisons. Active participants had only one member involved with a pregnancy. Rates among the other groups were much higher. The lack of differences after covariates is due to the younger age of the active participants. Since age could account for the lower involvements with pregnancy, it is unknown at this time whether the IHAF program has an effect on pregnancy. A longer time period for following the active participants is necessary to determine if, as they get older, they are less likely to become involved with a pregnancy. At this point, it is unclear whether the age difference is solely responsible for the lower involvement rate or if the IHAF program is responsible.

This evaluation is of the early stages of a comprehensive program. All features of the program were not in place from the beginning. The results of these analyses should be treated as indicators of the possible effects of the IHAF program rather than a definitive answers to the effectiveness of the program. Encouraging indicators are the attractiveness of the program for male adolescents and the effects on the psychosocial variables. Positive effects of the program on actual behavior and pregnancy involvement are not as evident. More profound effects on these variables may be evident as the youth get older and have more opportunity to demonstrate whether participation in IHAF has been of benefit to them.

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Stick with the Facts: Dr. Foster deserves a Vote

The real numbers on Republican nominees in the Senate 1986-92

(Source: LEGIS)

The Majority Leader has said that he may deny the U.S. Senate the opportunity to vote on the nomination of Dr. Henry Foster to be Surgeon General even if the Senate Labor Committee recommends to the Senate that he be confirmed, and claims that this is business as usual in the Senate. But the facts tell a different story.

- **FACT:** During the 101st Congress (1989-91), only *two* nominations sent to the floor with a favorable recommendation by Senate committees failed to have a vote on the floor of the Senate, and neither was for a position as prominent as Surgeon General. 119 nominations were returned to the President without confirmation, but many of these (more than one-third) were sent to the Senate in August of 1990 or later, giving the Senate little chance to get the confirmation process started before adjournment.
- In contrast, during the same Congress the Senate *confirmed* the nomination of Clarence Thomas to be a Supreme Court Justice after the Judiciary Committee voted to send the nomination to the floor *without* a recommendation. The final vote of 52-48 also would not have broken a *filibuster*, if Senators had tried to block a vote on the Thomas nomination as some Republican members have threatened with Dr. Foster. The process was allowed to go forward by then-Majority Leader Mitchell, and Thomas was given the opportunity for an up or down vote by the full Senate. **Dr. Foster and the American People deserve the same opportunity.**
- **FACT:** These numbers are consistent with other years in which a Republican President faced a Democratic Senate. In the 102nd Congress (1991-93) only *three* nominations were not voted on after favorable recommendation by Senate committees, and none were for positions as prominent as Surgeon General. The same is true of the 100th Congress (1987-89), when only *seven* failed to receive a vote, and, again none were for positions as prominent as that to which Dr. Foster is nominated.
- During these years, some nominees were not acted upon by committees, but none were actively blocked from coming to a vote by Majority Leader Mitchell. The two nominations that did fail on the floor -- Robert Bork and John Tower -- both had the opportunity of an up or down vote, even though both nominees were *unfavorably* recommended by Senate committees. **Dr. Foster and the American People deserve the same opportunity.**
- ***Stick with the facts, Mr. Leader. This may be your idea of business as usual, but it is not for the U.S. Senate. If the Labor Committee thinks Dr. Foster is right for the job and deserves a vote, don't you think you owe him the same opportunity as Clarence Thomas?***

ADDITIONAL QUESTIONS SUBMITTED
TO
HENRY W. FOSTER, JR., M.D.
BY
CHAIRMAN NANCY LANDON KASSEBAUM

ACCREDITATION

1. You indicated during your confirmation hearing that the OB\GYN residency program at Meharry Medical College was placed on accreditation probation in 1984 because of insufficient patient numbers. In that case, why was the Internal Medicine program at Meharry--which would be drawing from the same adult population--able to retain its full accreditation?
2. As OB\GYN Department Chairman at Meharry for six of the seven years its residency program was on probationary status, what actions did you take to try to correct any deficiencies necessary to regain full accreditation, and when did you take them?
3. From information provided to the committee, it appears that other residency programs at Meharry besides OB\GYN were also having problems. Once you took over as Dean in 1990, what actions did you take to make across-the-board improvements in and regain accreditation for Pediatrics, Psychiatry, Surgery, and Family Medicine?
4. You said during your February 8, 1995, appearance on ABC's "Nightline" that Meharry's participation in the abortifacient research study for the Upjohn Company (1979-82) was necessary to maintain your accreditation status because "We have a responsibility to teach all residents how to manage the complications of abortion." Would you please explain the connection between the two?

STERILIZATION

5. You served as a member of the Department of Health, Education and Welfare (HEW) Ethics Advisory Board during the years 1978-80. That was the period during which HEW guidelines restricting federal funding of sterilizations were finalized. Were you as a Board member involved in any discussions on those guidelines, and if so, were you at odds with the outcome?

I HAVE A FUTURE

6. Does the "I Have a Future" program pay participants for coming to class? If so, please elaborate.
7. When the difficulties with "I Have a Future" identified in the Carnegie Corporation evaluation (February 3, 1992, letter from Dr. Greene) were brought to your attention at your confirmation hearing, you spoke prospectively of several changes that might be instituted to correct them. However, you said nothing of remedial actions that were taken *at the time they arose*. Exactly what did you do when you first became aware of these problems in 1992?
8. The "I Have a Future" program has been in existence for eight years. It has had over 700 study and control participants. It has had seventeen full or part-time staff. It has spent nearly \$3,000,000. Yet you said at your confirmation hearing that it needs more time, more participants, more staff, and more money before it can be fairly and effectively evaluated--and show some meaningful statistical results on teen pregnancy prevention. How much more time, staff, and money are needed?
9. During your confirmation hearing, I made reference to a community-wide (teens, parents, schools, churches, workplace, media, civic and professional groups) prevention program in my state (Topeka, Kansas) that succeeded in reducing the number of teenage pregnancies by 23% in one year (1991-92). This was accomplished by serving a greater number of participants than involved in "I Have a Future" with only one full-time staff person and a budget of \$50,000. Why is the "I Have a Future" program unable to demonstrate a comparable level of success?

TUSKEGEE SYPHILIS STUDY

10. You indicated you were "outraged" when you learned of the Tuskegee Syphilis study in 1972. Do you have anything in the way of contemporary media clippings, letters, memos, or other corroboration for that description of your reaction 23 years ago?
11. When asked at your confirmation hearing what action you took as President of the Macon County Medical Society to demonstrate your outrage, you said you immediately called a meeting of your members and issued a statement. That statement read, "The members of the Macon County Medical Society have unanimously agreed to identify the remaining living members of this study and make available forthwith appropriate therapy." How long was it before those victims were so identified and treated--and by whom?

ABORTION, SEX EDUCATION, AND FAMILY PLANNING

12. Near the end of a speech you gave to the Planned Parenthood Association of East Tennessee on September 7, 1984, you proclaimed that the future of abortion in this country may depend on the next nominee to the Supreme Court. That would seem to indicate that you have no problem with an abortion "litmus test" for Supreme Court Justices. Do you feel that such a "test" is equally appropriate for a Surgeon General nominee?
13. Since 1973, you have been associated with Planned Parenthood of Middle Tennessee. During the period 1975-1981, you also held national level leadership positions with the Planned Parenthood Federation of America. If confirmed by the Senate, to what extent do you plan to promote the Planned Parenthood agenda as Surgeon General?
14. What is your position on laws which require parental consent or notification before a minor may obtain an abortion? Please be specific.
15. Have you been associated at any point in the past with the Sex Information and Education Council of the United States (SIECUS)? If so, please elaborate regarding the nature and extent of your association.

OTHER

16. Can you assure the committee that rental property you own is well maintained and in compliance with health and safety codes?

QUESTIONS AND DOCUMENT REQUESTS FOR DOCTOR FOSTER
Submitted by Senator Abraham

Series I Questions

The following terms shall have the meanings set forth below whenever used throughout this document.

1. "Concern" or "concerning" means relating to, describing, evidencing, supporting, rebutting, or discussing the referenced matter.
2. "Document" means any writing or electronic transmission, which is or ever has been in your actual or constructive possession, custody, or control, or available or obtainable by you or of which you have knowledge, or other nonconforming copies of every kind.
3. "Identify" or "identity" means the following:
 - a. When used in reference to a natural person, it means to state the person's full name, present business address, and business affiliation, business address, and business telephone number;
 - b. When used in connection with a document that has been or is being produced to the Committee, it means a description sufficient to specify the document, including the bates number of the document, the document's date, author sender, recipient, number of pages, location, and identity of the person who currently has custody of the document.
4. "Communication" means any oral, written or electronic transmission of information, opinion, belief, idea or statement of any kind or character.

INSTRUCTIONS

1. Each question or request shall be construed independently, and no question or request limits the scope of any other question or request.
2. If it is known that any document responsive to a request for documents was, but no longer is, in your possession, custody or control, identify that document, state what disposition was made of that document(along with the reason for such disposition), and identify all persons who may currently have possession, custody or control of the document or any copies.
3. If any documents requested have already been provided to the Committee, you

may identify them in lieu of providing them again.

4. No question or request shall be construed to call for information that violates the lawful privacy rights of any patients. Where necessary, please redact patients' names and any other specific identifying information (e.g., address, social security number) from documents provided.

5. If you are not providing a document or documents on account of privacy concerns please indicate how many documents are not being provided. Summarize their contents to the extent consistent with the privacy concerns and indicate the theory behind, or basis on which you feel obliged to withhold them.

QUESTIONS AND DOCUMENT REQUESTS

1. An official transcript (page 180, lines 13-14) of a November 10, 1978 meeting of the Ethics Advisory Board of the U.S. Department of Health, Education and Welfare quotes you as stating: "I have done a lot of amniocentesis and therapeutic abortions, probably near 700."

The White House initially suggested that the transcript was a fraud. Only after the authenticity of the transcript was established did the White House retract its charges of fraud.

a. Please identify and provide all documents you provided the White House concerning the transcript.

When asked about the 700 therapeutic and amniocentesis abortions quote during your nomination hearings, you attributed the statement to the transcribers not being able to hear: "In the transcript, it was stated a couple of times that they had hired transcribers and they were having difficulty hearing." (FNH 5/2/95 at 121.) And you further said, "[T]he transcribers said that they were having trouble hearing. They said it. I did not. It was in the record. So you know it was there. And maybe they -- they were hired people." (FNH 5/3/95 at 115.)

b. Please identify all places in the transcript where it says the transcribers were having difficulty hearing.

c. Please identify all portions of the transcript that demonstrate inaccurate transcription.

Also on Tuesday of the hearings, you stated: "My honest feeling is the word 'I' should have been 'they,' and that makes all the sense in the world. It was Drew Hospital in Los Angeles that was applying for the grant."

But then on Wednesday of the hearing, you stated "[T]he people who were applying for the grant itself, that statement would have made all the sense in the world if it had said 'we have done' and did not just say abortions, but said amniocentesis, because that is what they were applying for the research for, and they did have a huge service where they were doing this. That is what I said."

2. Please explain the meaning of both "we" and "they" as a substitute for "I" in the context of the entire paragraph on page 180 of the transcript.

In particular:

a. Please identify and provide documents concerning the number of amniocentesis abortions and therapeutic abortions that Drew Hospital in Los Angeles had done by 1978 and your knowledge thereof in 1978.

b. Please identify and provide documents concerning your knowledge of the number of therapeutic and amniocentesis abortions that Drew Hospital had done by 1978.

c. Please explain the relevance of the number of abortions Drew Hospital had done, to the rest of your remarks, including: your opinion that the Hospital's proposed 24 hour delay in the abortion would be reasonable; your opinion that it was acceptable for the catheter to be left in place after the fetoscope is withdrawn; and your description of the techniques for continuous prostaglandin infusion.

d. If the word should have been "We," please explain why you would be referring to Drew Hospital in Los Angeles, where you have never worked, as "we."

3. Please state which word you now believe you said.

4. Did you compose the February 3, 1995, written statement on your abortion record, which the White House issued in your name to the national press, in which you stated that you had "performed fewer than a dozen" abortions?

5. If not, who did the drafting?

6. Please identify and provide all documents concerning this statement and its drafting.

7. That written statement also said that all the abortions you have performed "were

primarily to save the lives of the women or because the women had been the victim of rape or incest."

- a. How many of the 39 abortions you now state you performed were done to save the life of the mother?
 - b. How many of these 39 abortions were in cases where the pregnancy resulted from rape?
 - c. How many of these 39 abortions were in cases where the pregnancy resulted from incest?
 - d. How many of these 39 abortions were elective?
 - e. Could you please identify and provide relevant records concerning these 39 abortions?
8. Please explain why none of your various calculations of the number of abortions you have done includes the 55 chemical abortions and at least four D&C abortions done as part of the abortifacient suppository experiment in the early 1980s in which you were the principal investigator.
9. Did the woman who later gave birth give birth to a healthy child?
10. Following the failure of the abortifacient suppository, did you or anyone else advise this woman that she should consider submitting to a surgical abortion?
11. How many abortions or terminations of pregnancies were you in the operating room for?
12. Please identify and provide all documents concerning any procedures involving the termination of a pregnancy in which you have been involved in your 38 years of practice, including prior to 1973 and including cases in which you were not the physician of record.
13. Please identify and provide all calendars, appointment books, schedules, datebooks, and any other documents concerning your whereabouts during 1969.
- You have said: "In recent years, there has been an outcry by various groups that the intent of family planning is black genocide and that the ultimate effect will be black genocide. I must admit that these apprehensions are quite understandable and often not without foundation."
14. Please explain your statement that "these apprehensions are . . . often not without foundation."

In Obstetrics and Gynecology, you wrote that of the 60 patients in your abortifacient suppository experiment, 58 (97%) were black. Foster, et al., Postconception Menses Induction Using Prostaglandin Vaginal Suppositories O & G, 65: 683, 1985]

15. What percentage of the 39 abortions you have done involved African-American women seeking terminate a pregnancy?

16. In your 1984 keynote address to Planned Parenthood, you commended the Supreme Court for striking down hospitalization requirements for second trimester abortions. You then stated: "We must work to prevent the erection of such barriers to late abortion access."

a. Please state at what stage, if any, in the development of a fetus, an intentional termination of the life of the fetus should be legally prohibited.

b. Please state at what stage, if any, in a pregnancy, you believe elective abortions should be legally prohibited.

QUESTIONS SUBMITTED TO DR. HENRY FOSTER
by Senator Spencer Abraham

Series II Questions

I. 1978 H.E.W. ETHICS BOARD MEETING

A. Dr. Foster, with respect to the transcript from the 1978 H.E.W. Ethics Board meeting, you claim that you must have been misquoted when the transcript on page 180 quoted you as stating, "I have done a lot of amniocentesis and therapeutic abortions, probably near 700."

1) Do you also deny making the statement attributed to you on page 197, where you are quoted as saying, "Let me address one other question regarding therapy versus research. I have not seen the research proposals that John Hobbins had at Yale, or what Kan has done at U.S.C. But I do know that a lot of their fetoscopy was therapeutic. the work on thalassemia was clearly therapeutic. It was done for the same reasons we do amniocentesis, to decide whether or not the pregnancy should continue, and to provide a therapeutic abortion. In fact, I know much of that?"

2) If the answer to question #1 is "No," please provide a specific accounting (including date, location and your position at the time) of those instances in which you provided a therapeutic abortion after performing amniocentesis and what indications, based on the amniocentesis, warranted the performing of the ensuing therapeutic abortions.

B. Dr. Foster, on page 199 of the 1978 H.E.W. Ethics Review Board meeting transcript, you were quoted as saying, "The only thing that I do know is that the struggle has been to try and be able to diagnose sickle cell – homozygous at a point at which therapeutic abortions could be offered. Right now we don't have that capability, and it was my understanding that one of the thrusts of this research proposal was to help to try and find that capability."

3) Dr. Foster, do you deny making this statement at the 1978 meeting?

4) If the answer to Question #3 is "No," would you please provide a specific accounting of how many times you performed abortions after you had ascertained the existence of "sickle cell" disease.

5) If the answer to Question #3 is "No," would you please explain whether in those instances in which an abortion was performed following the diagnosis of sickle cell, did you ever counsel the women you were treating to obtain an abortion?

6) Have you ever performed "therapeutic abortions" after examining the results from amniocentesis in which you discovered indications of other genetic disorders such as Down Syndrome or Tay Sachs?

7) Dr. Foster, do you believe that "therapeutic abortion" is a legitimate form of therapy for preventing birth defects such as Down Syndrome?

8) Dr. Foster, please indicate where in the transcript -- other than page 323 -- there is any indication the transcription reporter was having difficulty hearing clearly the discussion taking place at the meeting?

II. STERILIZATION

Dr. Foster, in your testimony before the Labor Committee, you stated that, with respect to obtaining the informed consent for the purposes of sterilizing the individuals mentioned in your 1976 article, that you assiduously followed whatever Joint Commission on Accreditation of Hospitals guidelines were in place at the time.

9) Dr. Foster, would you provide for the committee the pertinent JCAH guidelines at the time you undertook the sterilization procedures and what specific actions you took in these cases to comply with those guidelines?

III. I HAVE A FUTURE PROGRAM

A. Dr. Foster, during the February 8th "Nightline" interview, you also made it clear that, even provided "parental involvement," you did not favor the widespread distribution of condoms. You also stated unequivocally, "I favor abstinence. Abstinence, that's what I favor. That's the bedrock of our program." However, in your article which appeared in the Summer 1990 issue of the Journal of Health Care for the Poor and Underserved, you described the "I Have a Future" program quite differently.

In that article, "A Model for Increasing Access: Teenage Pregnancy Prevention," you and two of your colleagues wrote that one of the principal objectives of the "I Have a Future" program was "to provide ready access to and to increase utilization of comprehensive adolescent health services." Later, you define "comprehensive health services" as "including contraceptive availability."

10) Dr. Foster, how do you square your strong pro-abstinence, anti-condom distribution comments on "Nightline" with this article which ignores abstinence

and promotes "ready access to" and "increase[d] utilization" of contraceptives for teenagers?

11) Dr. Foster, was contraception distribution to minors a component of the "I Have A Future" program under your tutelage?

12) If the answer to Question #11 is "Yes," please describe in detail the types of contraception made available to minors, the age range of the minors who were recipients of contraceptive devices, specific details as to what steps were taken to obtain parental consent or notification before contraception was distributed to minors participating in the program.

13) Were birth control pills ever distributed to minor females as part of the "I Have A Future" program,?

14) If the answer to Question #13 is "Yes," were parents ever notified before the birth control pills were dispensed to the minors involved and was a doctor's examination and/or prescription necessary before the pills were dispensed?

IV. DELETION OF PLANNED PARENTHOOD FROM BIOGRAPHY

15) Dr. Foster, at the time of the initial announcement of President Clinton's intention to nominate you, were you aware that your 17-year affiliation with Planned Parenthood had been deleted from the biography of you handed out to the press?

16) Whose decision was it to delete the reference to Planned Parenthood from your biography?

17) Did you ever inquire as to why this was being done or why it had been done?

18) What rationale was given to you as to why your affiliation with Planned Parenthood was deleted from your biography?

V. VETTING OF NOMINEE

19) Dr. Foster, in the course of your preliminary discussions with Administration officials about your being nominated to the position of Surgeon General, was the issue of you being an OB-GYN or your having performed abortions ever raised?

20) If the answer to Question #20 is "Yes," what information did you provide the Administration prior to your being publicly announced as the nominee for the position of Surgeon General.

21) Prior to the initial announcement ceremony at the White House, were you ever told by anyone in the Administration -- including the President -- that they desired to use your nomination as a referendum on choice or to raise the issue of abortion rights to a higher profile in our national political discourse?

Additional Questions For Dr. Henry Foster

SENATOR MIKE DeWINE

STERILIZATIONS

- A. In August, 1970, the executive board of the American College of Obstetricians and Gynecologists issued the following statement of policy:

"If an operation to accomplish sterilization is recommended by the physician for medical indications, the recorded opinion of a knowledgeable consultant should be obtained."

1. Were you aware of this statement of policy? If not, why not?
2. What is your understanding regarding the obligation of a member of the American College of Obstetricians and Gynecologists to be informed of, and comply with, the policy statements of American College of Obstetricians and Gynecologists?
3. Did you obtain the **recorded opinion** of a consultant prior to performing the sterilizations on the four mentally retarded women just prior to 1974?

- B. On July 19, 1973, in response to the public reaction to the involuntary sterilization of two young girls in Alabama, the U.S. Department of Health, Education, and Welfare (HEW) issued proposed guidelines for sterilization procedures. Those guidelines read, in part:

A review committee comprised of 5 individuals, must review and approve a sterilization of a minor or legally incompetent person, and consider:

- 1) the medical, social and psychological information regarding the patient, including the age, alternatives in family planning;
- 2) the sufficiency of consent; and
- 3) whether the proposed sterilization was in the best interest of the patient.

And, a court of competent jurisdiction must review the committee recommendation to permit sterilization if an individual was legally incompetent.

4. When did you become aware that two Alabama girls, Mary Alice Relf and Minnie Relf, were involuntarily sterilized?
 5. Were you aware of these proposed HEW guidelines for sterilization procedures? If not, why not?
 6. Do you know whether the sterilizations you performed on the four mentally incompetent women were provided under Medicaid or other federally funded programs?
- C. On January 8, 1974, U.S. District Judge Frank Johnson, in Wyatt v. Aderholt, entered an order setting sterilization standards for the state of Alabama that read in part:

A determination must be made that:

1. the proposed sterilization is in the best interest of the patient;
 2. the patient has consented in writing;
 3. if the patient cannot consent in writing, a court of competent jurisdiction must determine that the patient is, in fact, incompetent;
 4. a review committee must approve such sterilization; and,
 5. a court must find that the sterilization is in the best interest of the patient.
7. Were you aware of Judge Johnson's order regarding sterilizations? If not, why not?
 8. We understand fully that Judge Johnson's order dealt with Alabama state institutions. Understanding that Judge Johnson's order dealt with minimum acceptable standards for state action, what was the duty, if any, of an Alabama obstetrician-gynecologist -- practicing at that time -- to be informed of, and to meet, the standards enunciated by Judge Johnson?

PARENTAL CONSENT

In response to a question from Senator Abraham regarding parental consent with regard to abortion in the case of minors, you said:

"I am going to be honest with you, Senator. The concept, I support. I would have to see the legislation."

Attached is a copy of the Ohio statute regarding parental notification of an unmarried minor's intention to have an abortion.

9. Do you support this specific parental notification statute?
10. If not, which specific provisions do you find objectionable?
11. Do you support parental notification regarding the provision of contraceptives to minors?

TEEN PREGNANCY PROGRAMS

12. Do you believe that we could reduce teen pregnancy rates in the U.S. -- as a part of a larger effort that includes abstinence -- by making prescription contraceptives available over-the-counter?
13. Do you believe that we could reduce teen pregnancy rates in the U.S. -- as a part of a larger effort that includes abstinence -- by providing school-based contraceptive services?

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TITLE XXIX [29] CRIMES--PROCEDURE
CHAPTER 2919: OFFENSES AGAINST THE FAMILY
[ABORTION]

ORC Ann. 2919.12 (Anderson 1994)

§ 2919.12 Unlawful abortion.

(A) No person shall perform or induce an abortion without the informed consent of the pregnant woman.

(B) (1) (a) No person shall knowingly perform or induce an abortion upon a woman who is pregnant, unmarried, under eighteen years of age, and unemancipated unless at least one of the following applies:

(i) Subject to division (B) (2) of this section, the person has given at least twenty-four hours actual notice, in person or by telephone, to one of the woman's parents, her guardian, or her custodian as to the intention to perform or induce the abortion, provided that if the woman has requested, in accordance with division (B) (1) (b) of this section, that notice be given to a specified brother or sister of the woman who is twenty-one years of age or older or to a specified stepparent or grandparent of the woman instead of to one of her parents, her guardian, or her custodian, and if the person is notified by a juvenile court that affidavits of the type described in that division have been filed with that court, the twenty-four hours actual notice described in this division as to the intention to perform or induce the abortion shall be given, in person or by telephone, to the specified brother, sister, stepparent, or grandparent instead of to the parent, guardian, or custodian;

(ii) One of the woman's parents, her guardian, or her custodian has consented in writing to the performance or inducement of the abortion;

(iii) A juvenile court pursuant to section 2151.85 of the Revised Code issues an order authorizing the woman to consent to the abortion without notification of one of her parents, her guardian, or her custodian;

(iv) A juvenile court or a court of appeals, by its inaction, constructively has authorized the woman to consent to the abortion without notification of one of her parents, her guardian, or her custodian under division (B) (1) of section 2151.85 or division (A) of section 2505.073 [2505.07.3] of the Revised Code.

(b) If a woman who is pregnant, unmarried, under eighteen years of age, and unemancipated desires notification as to a person's intention to perform or induce an abortion on the woman to be given to a specified brother or sister of the woman who is twenty-one years of age or older or to a specified stepparent or grandparent of the woman instead of to one of her parents, her guardian, or her custodian, the person who intends to perform or induce the abortion shall notify the specified brother, sister, stepparent, or grandparent instead of the parent, guardian, or custodian for purposes of division (A) (1) (a) (i) of this section if all of the following apply:

(i) The woman has requested the person to provide the notification to the specified brother, sister, stepparent, or grandparent, clearly has identified the specified brother, sister, stepparent, or grandparent and her relation to that person, and, if the specified relative is a brother or sister, has indicated the age of the brother or sister;

(ii) The woman has executed an affidavit stating that she is in fear of physical, sexual, or severe emotional abuse from the parent, guardian, or custodian who otherwise would be notified under division (B) (1) (a) (i) of this section, and that the fear is based on a pattern of physical, sexual, or severe emotional abuse of her exhibited by that parent, guardian, or custodian, has filed the affidavit with the juvenile court of the county in which the woman has a residence or legal settlement, the juvenile court of any county that borders to any extent the county in which she has a residence or legal settlement, or the juvenile court of the county in which the hospital, clinic, or other facility in which the abortion would be performed or induced is located, and has given the court written notice of the name and address of the person who intends to perform or induce the abortion;

(iii) The specified brother, sister, stepparent, or grandparent has executed an affidavit stating that the woman has reason to fear physical, sexual, or severe emotional abuse from the parent, guardian, or custodian who otherwise would be notified under division (B) (1) (a) (i) of this section, based on a pattern of physical, sexual, or severe emotional abuse of her by that parent, guardian, or custodian, and the woman or the specified brother, sister, stepparent, or grandparent has filed the affidavit with the juvenile court in which the affidavit described in division (B) (1) (b) (ii) of this section was filed;

(iv) The juvenile court in which the affidavits described in divisions (B) (1) (b) (ii) and (iii) of this section were filed has notified the person that both of those affidavits have been filed with the court.

(c) If an affidavit of the type described in division (B) (1) (b) (ii) of this section and an affidavit of the type described in division (B) (1) (b) (iii) of this section are filed with a juvenile court and the court has been provided with written notice of the name and address of the person who intends to perform or induce an abortion upon the woman to whom the affidavits pertain, the court promptly shall notify the person who intends to perform or induce the abortion that the affidavits have been filed. If possible, the notice to the person shall be given in person or by telephone.

(2) If division (B) (1) (a) (ii), (iii), or (iv) of this section does not apply, and if no parent, guardian, or custodian can be reached for purposes of division (B) (1) (a) (i) of this section after a reasonable effort, or if notification is to be given to a specified brother, sister, stepparent, or grandparent under that division and the specified brother, sister, stepparent, or grandparent cannot be reached for purposes of that division after a reasonable effort, no person shall perform or induce such an abortion without giving at least forty-eight hours constructive notice to one of the woman's parents, her guardian, or her custodian, by both certified and ordinary mail sent to the last known address of the parent, guardian, or custodian, or if notification for purposes of division (B) (1) (a) (i) of this section is to be given to a specified brother, sister, stepparent, or grandparent, without giving at least forty-eight hours constructive notice to that specified brother, sister, stepparent, or

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grandparent by both certified and ordinary mail sent to the last known address of that specified brother, sister, stepparent, or grandparent. The forty-eight hour period under this division begins when the certified mail notice is mailed. If a parent, guardian, or custodian of the woman, or if notification under division (B) (1) (a) (i) of this section is to be given to a specified brother, sister, stepparent, or grandparent, the specified brother, sister, stepparent, or grandparent, is not reached within the forty-eight hour period, the abortion may proceed even if the certified mail notice is not received.

(3) If a parent, guardian, custodian, or specified brother, sister, stepparent, or grandparent who has been notified in accordance with division (B) (1) or (2) of this section clearly and unequivocally expresses that he or she does not wish to consult with a pregnant woman prior to her abortion, then the abortion may proceed without any further waiting period.

(4) For purposes of prosecutions for a violation of division (B) (1) or (2) of this section, it shall be a rebuttable presumption that a woman who is unmarried and under eighteen years of age is unemancipated.

(C) (1) It is an affirmative defense to a charge under division (B) (1) or (2) of this section that the pregnant woman provided the person who performed or induced the abortion with false, misleading, or incorrect information about her age, marital status, or emancipation, about the age of a brother or sister to whom she requested notice be given as a specified relative instead of to one of her parents, her guardian, or her custodian, or about the last known address of either of her parents, her guardian, her custodian, or a specified brother, sister, stepparent, or grandparent to whom she requested notice be given and the person who performed or induced the abortion did not otherwise have reasonable cause to believe the pregnant woman was under eighteen years of age, unmarried, or unemancipated, to believe that the age of a brother or sister to whom she requested notice be given as a specified relative instead of to one of her parents, her guardian, or her custodian was not twenty-one years of age, or to believe that the last known address of either of her parents, her guardian, her custodian, or a specified brother, sister, stepparent, or grandparent to whom she requested notice be given was incorrect.

(2) It is an affirmative defense to a charge under this section that compliance with the requirements of this section was not possible because an immediate threat of serious risk to the life or physical health of the pregnant woman from the continuation of her pregnancy created an emergency necessitating the immediate performance or inducement of an abortion.

(D) Whoever violates this section is guilty of unlawful abortion, a misdemeanor of the first degree. If the offender previously has been convicted of or pleaded guilty to a violation of this section, unlawful abortion is a felony of the fourth degree.

(E) Whoever violates this section is liable to the pregnant woman and her parents, guardian, or custodian for civil compensatory and exemplary damages.

(F) As used in this section "unemancipated" means that a woman who is unmarried and under eighteen years of age has not entered the armed services of the United States, has not become employed and self-subsisting, or has not otherwise become independent from the care and control of her parent, guardian, or custodian.

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United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES

WASHINGTON, DC 20510-6300

May 4, 1995

95 MAY 6 P 1:27

Mr. John D. Podesta
Assistant to the President
and Staff Secretary
The White House
Washington, D.C. 20500

Dear Mr. *John* Podesta:

Per our conversation, the Senate Committee on Labor and Human Resources hereby requests the following information related to the nomination of Dr. Henry W. Foster for the position of Surgeon General:

1. All teaching materials used by the I Have A Future (IHAF) program since its inception in 1987, which to date have not been provided to the Majority Staff of the Senate Committee on Labor and Human Resources.
2. All promotional materials used by the IHAF program since its inception in 1987, which to date have not been provided to the Majority Staff of the Senate Committee on Labor and Human Resources.
3. Any evaluations, critiques, or reviews of the IHAF program including but not limited to those produced by the IHAF Program, its funding entities such as the Carnegie Corporation of New York, or other reviewers.
4. Any correspondence between the I Have a Future program and its funding entities including but not limited to the Carnegie Corporation of New York, which contains recommendations for improving the program or places conditions or restrictions on funding to the program.
5. Any correspondence which corrects the typographical errors that appear in the February 3, 1992, letter from Dr. Lorraine Williams Greene, IHAF Deputy Director, to Ms. Gloria Primm-Brown of the Carnegie Corporation.

Mr. John D. Podesta
May 4, 1995
Page 2

6. Copies of the IHAF grant proposals that are referenced on page 13 of the February 3, 1992, letter from Dr. Lorraine Williams Greene to the Carnegie Corporation. Specifically, the grant proposals submitted to the National Institute of Health for the Minority Youth Health Research; the Department of Health and Human Services Office of Treatment Improvement of ADAMHA; the National Institute of Health Agency for Health Care Policy and Research; and the National Institute of Mental Health (NIMH), Perpetrators of Violence Research Program. Please include the reviewer pink slips, NIH priority scores, and funding award decisions on these proposals.
5. Any documents related to the actions of Dr. Henry W. Foster in response to news articles including one that appeared in the July 31, 1972, edition of the **Montgomery Advertiser** on the Tuskegee Syphilis study.

Please send the above referenced items to Ms. June Lawrence, the Senate Committee on Labor and Human Resources, Room 835 of the Hart Senate Office Building, Washington, D.C. 20510.

I appreciate your prompt attention to this request.

Sincerely,



Edward M. Bolen
General Counsel

EMB:dw

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United States Senate

WASHINGTON, DC 20510-1403

May 9, 1995

Dear Colleague:

On May 3, 1995, the Labor and Human Resources Committee concluded its hearings into the nomination of Dr. Henry W. Foster for Surgeon General. As has been widely reported in the media, Senator Kassebaum conducted a courteous and fair confirmation hearing. Most will agree that Dr. Foster handled himself with dignity and a sense of humor as he described his service to underserved populations in America.

However, it appears that as a result of media reporting of the hearings, there is a fairly widespread perception that Dr. Foster has satisfactorily answered the many disturbing questions surrounding this nomination. In several respects, I don't believe this is true, and I ask you to carefully examine the record itself, especially as it relates to the allegations concerning Dr. Foster's knowledge of the Tuskegee Syphilis Study.

Many, of course, continue to be troubled by Dr. Foster's performance of abortions, believing that a pro-abortion surgeon general would be divisive, rather than unifying Americans on important public health issues. Equally troubling has been Dr. Foster's changing accounts of the number of abortions he performed (1, 12, 39, 55, or 700 -- take your choice), raising legitimate questions as to Dr. Foster's credibility and candor on this issue.

In addition, several on the Committee remain unconvinced that Dr. Foster was in the "mainstream" of medical practice when he performed hysterectomies on mentally retarded persons without securing written, independent-party consent, even years after Alabama courts, the Department of Health, Education, and Welfare, the Supreme Court, and others proscribed these and similar practices. Moreover, a program evaluation of the I Have a Future program, probably the single most touted aspect of Dr. Foster's resume, revealed that the program, instead of dissuading teen sexual activity and pregnancy, may actually have encouraged such activity. The actual results of the program do not support the widely publicized "success" of this program in reducing teen pregnancy. And abstinence material presented on behalf of Dr. Foster as the "bedrock" of his program was in fact not printed until early January and not even ordered until a month after the nomination was announced.

BUT ANOTHER EXTREMELY TROUBLING AND, SO FAR, LITTLE-DISCUSSED ISSUE IS THE ONE SURROUNDING DR. FOSTER'S RESPONSES IN CONNECTION WITH THE TUSKEGEE SYPHILIS STUDY. The Washington Post wrote in a March 1, 1995, editorial:

Recently, ... Dr. Foster's name has become linked to the infamous 40-year Tuskegee experiment in which hundreds of black men with syphilis were deliberately left untreated in the name of medical research. At issue is what and when Dr. Foster knew about the study before it was publicly exposed in 1972. We hope the answer is, as Dr. Foster and the White House maintain, that he was not informed about the study until the story broke. To have known earlier and not insisted on proper treatment for the innocent patients would disqualify any candidate for the surgeon general's post. ... No doubt this is a difficult matter to resolve. But it is crucial to pin down when Dr. Foster learned about the study. The question of his fitness for the job hangs on it. (Emphasis added.)

In the confirmation hearing, I questioned Dr. Foster in some detail about this difficult matter. In my opinion, Dr. Foster's responses left this highly troubling issue unresolved. By hearing's end, members were left to weigh a substantial stack of depositions, statements, letters, and government documents that raise serious doubts as to the nominee's categorical denial of any knowledge of the existence of the study. As Dr. Foster stated in the hearing, "if anyone in Tuskegee had known about it, Senator, I think the place would have gone ballistic. ... No one knew about that study until 1972." (Hearing transcript, May 2, 1995, at 101.) Dr. Foster also said that 1972 was "the first time I ever heard of the Tuskegee study in any kind of shape, form, or fashion. And I was outraged." (Hearing transcript, May 3, 1995, at 142-143.)

Although Dr. Foster has denied having any information about the study prior to 1972, a variety of documentary sources and statements by witnesses suggest he almost certainly had earlier knowledge. Numerous individuals and institutions with whom Dr. Foster associated in Macon County were familiar with or participated in the study. Dr. Foster was chief of obstetrics at Tuskegee Institute, which provided services in connection with the study and whose physicians knew of the study.

Further, Dr. Foster was vice president and later president of the medical society that was consulted regarding the study and that agreed to cooperate with the PHS. Dr. Foster may, as at least one other member of the medical society recalls and no others dispute, have attended a meeting at which the medical society was notified by Dr. Holguin or Dr. Brown of the study. It is also reasonable to assume that Dr. Foster almost certainly would have heard of the nature of the meeting later by virtue of his prominent position in the society and the county. In any event, the PHS later provided each member of the medical society a list of surviving participants in the study.

Foster also spoke with a state health official, Dr. Myers, about the study as early as 1970, having sufficient knowledge of the study to urge treatment for the subjects. Yet, Dr. Foster also concedes that he and the medical society provided no treatment to the patients but relied on the CDC to provide it almost seven months after the publicizing of the study.

I believe the record that follows demonstrates without a doubt that others in Tuskegee knew of the study. In addition, the record casts great doubt as to whether Dr. Foster first learned of the study in 1972 only after it became public knowledge; and the record raises new questions about Dr. Foster's diligence in seeking treatment for patients after he learned of the study.

I ask you to examine closely the significant discrepancies that exist between Dr. Foster's public statements and numerous public documents. In my opinion, I do not believe it is possible to conclude that Dr. Foster did not know of the Tuskegee Syphilis Study before 1972.

FOSTER TESTIMONY: "NO ONE KNEW ABOUT THAT STUDY UNTIL 1972"

During his confirmation hearing, Dr. Foster testified "if anyone in Tuskegee had known about it, Senator, I think the place would have gone ballistic. ... No one knew about that study until 1972." (Hearing transcript, May 2, 1995, at 101.) However, the record demonstrates without a doubt that others in Tuskegee knew of the study and even helped carry out the study as early as the 1930s.

THE PUBLIC RECORD: LOCAL RESIDENTS KNEW OF AND TOOK PART IN THE STUDY

Bad Blood, James Jones' seminal and highly regarded work on the Tuskegee study (the book appeared on the New York Times Best Books of 1981 list; the Washington Post called it "valuable, superbly researched, fair-minded") and numerous public documents detail the extensive participation in the study of many local residents. For example, Eunice Rivers Laurie, R.N., served from 1933 to 1965 as the local contact with the Public Health Service physicians conducting the study, arranged periodic physical examinations for subjects, sent subjects to Tuskegee Institute's John Andrew Hospital, and organized yearly roundups in which the subjects were studied by the U.S. Public Health Service (PHS). (See James Jones, Bad Blood, at 113-16, 128-30, 133-37, 141-42, 145, 148-61, 172, 175, 177, 183-84, 187, 197-199, 202, 219.)

Four trip reports from Dr. Joseph Caldwell of the PHS provide additional, extensive documentation of the role of Nurse (Rivers) Laurie in the roundups and arranging of autopsies, (as well as Dr. Adams, pathologist, in performing autopsies). (Memorandum from Dr. Joseph Caldwell, PHS, to Dr. Schroeter, PHS, April 9, 1970; Memorandum from Dr. Joseph Caldwell, PHS, to Dr. William J. Brown, Chief, VD Branch, Centers for Disease Control (CDC), April 22, 1970; Memorandum from Dr. Joseph Caldwell, PHS, to Dr. William J. Brown, Chief, VD Branch, CDC, May 4, 1970; Memorandum from Dr. Joseph Caldwell, PHS, to Dr. William J. Brown, Chief, VD Branch, CDC, and others, April 22, 1970.)

In addition, a letter from Dr. Caldwell to Dr. Brown on Macon County Health Department stationery states

There are some of us -- particularly Mrs. Laurie -- to whom the Study has become a way of life.

(Letter from Dr. Joseph Caldwell, PHS, to Dr. William J. Brown, Chief, VD Branch, CDC, June 29, 1970.)

A memorandum from the Director of the CDC states that the role of local residents was discussed at a meeting of an ad hoc committee examining the study. For example, Dr. Sidney Olansky, Professor of Medicine, Emory University,

told about Nurse Rivers and the active part she has played in the Study.

(Memorandum from Dr. David Sencer, Director of CDC, to the Record, at 4.)

In addition, a memorandum summarizing the ad hoc committee meeting looking into the study suggests that Dr. Ruth R. Berrey, a Macon County health officer, be called on to help set up the May 1969 briefing of the Macon County Medical Society of which Dr. Foster was a member.

Dr. Myers [State Health Officer] remarked ... 'I think we should establish rapport with the County Medical Society; talk to one physician in the Society before you talk to them as a group.' Dr. Sencer then asked, 'What about the medical officer [who was an ex officio member of the medical society]?' Dr. Myers said she may lean toward treatment. 'Dr. Barrett [sic] is a good pediatrician; -- very interested in research.' Dr. Sencer then asked how she was accepted by the local medical group. Dr. Myers said she had very good relations with them. ... Dr. Sencer then asked if this would be a good place to start -- with her. Dr. Myers answered by saying ... he would find out.

(Memorandum of Dr. David Sencer, Director of CDC, to the Record, at 11, 12; see also James Jones, Bad Blood, at 197-198.)

And, Elizabeth M. Kennebrew, R.N., assumed Nurse Rivers' duties in 1970 and remained with the study until its conclusion. (James Jones, Bad Blood, at 199-200.)

A memorandum from Dr. James Lucas, Assistant Chief of the VD Branch, CDC, to Dr. William Brown, Chief, VD Branch, CDC, Sept. 10, 1970) refers to the

long continued assignment of Mrs. Laurie and now Mrs. Kennebrew to Tuskegee.

(Cited in James Jones, Bad Blood, at 204.)

THE PUBLIC RECORD: THE TUSKEGEE INSTITUTE KNEW OF AND TOOK PART IN THE STUDY

Moreover, despite Dr. Foster's assertion that "no one knew about the study," the Tuskegee Institute, of which Dr. Foster was the chief of obstetrics, and physicians at the Institute, were provided with information about the study and participated in the study. A memorandum from the Director of the Centers for Disease Control summarizing a February 6, 1969, meeting of an ad hoc panel of experts from PHS and state officials and others, states that

the Tuskegee Institute [has] been fully cognizant of the study. ... Dr. Kaiser [a senior member of the Milbank Memorial Fund] asked what Tuskegee Institute thought of this study. Dr. Olansky [Professor of Medicine, Emory University] explained they knew of the study; the patients had been taken to the Institute's hospital. ... Physicians at the Institute knew of the study.

(Memorandum from Dr. David Sencer, Director of CDC, to the Record, at 3 (summary) and at 9 (emphasis added).)

A Trip Report prepared by Dr. Caldwell of the PHS sheds light on the role of the Tuskegee Institute in the study.

After meeting with Nurse Laurie, the three of us met with Mr. Luis A. Rabb, Administrator of John Andrews Memorial Hospital and the orthopedic surgeon who serves as Medical Director of the Hospital. When we explained our mission, Mr. Rabb indicated willingness to cooperate and specifically seemed to agree with our proposal to contract for radiological services from his Hospital during the upcoming survey. He indicated that the Hospital would respond to a letter stating our proposal by submitting a fee schedule. Mr. Rabb then conducted us on a guided tour ...

(Memorandum from Dr. Joseph Caldwell, PHS, to Dr. Schroeter, PHS, April 9, 1970.)

And a background paper from the Venereal Disease Branch of the CDC notes that

The Tuskegee Institute assisted with the administration of Milbank funds [used for autopsies], and the Institute's hospital has provided care to persons referred from the study group.

(Background Paper on Tuskegee Study, Venereal Disease Branch, CDC, July 27, 1972.)

THE PUBLIC RECORD: THE MACON COUNTY MEDICAL SOCIETY WAS INFORMED OF THE STUDY

In further contrast with Dr. Foster's assertion that "no one knew about that study" until 1972, the record demonstrates first-hand knowledge of members of the Macon County Medical Society. Dr. Foster, despite his early denials (Washington Post, Feb. 25, 1995, at A-10), was vice president of the medical society in 1969 and president beginning in 1970. A number of public documents written contemporaneous with the study suggest that the state's Department of Public Health and the PHS sought to notify and did notify the medical society of the study.

For example, the minutes of an Alabama State Board of Censors meeting state

The Macon County Medical Society has completely changed. The old Society was disbanded several years ago and a new one has been organized. The State Health Officer [Dr. Ira Myers] has suggested to the Public Health Service that continuity of the program and patient care should be discussed with local physicians before a decision is made. Dr. Bush made a motion that this matter be referred to the Macon County Medical Society as suggested by Dr. Myers; Dr. Collier seconded the motion, which carried unanimously.

(Minutes, State Board of Censors meeting, Feb. 19, 1969.)

A summary of a meeting between PHS and state officials and others, indicates that PHS officials, at various times throughout a February 6, 1969, meeting, determined that their policy would be to provide the Macon County Medical Society, of which Dr. Foster was vice president, detailed information about the study and to secure their consent to continuing the study. According to the summary,

[the PHS] should increase its contact with both the Macon County Health Department and the Macon County Medical Society to help them to assist more fully in the continuance of the study. ... Dr. Myers thought it a good idea to keep the local medical society informed as to what we were doing and what we wished to achieve; 'work closely with them and keep them informed of everything that we do.' ... Dr. Sencer said if we established good liaison with the local medical society there would be no need to answer criticisms. ... [I]f this study is to be continued, CDC has to establish a relationship with the medical men in the area ... Dr. Smith suggested a doctor go to the county medical society meetings, bring up these point, pro and con. 'They might think the same way.' 'If the local physicians agree there is no need for treating these patients, this would be good public relations.' ... Dr. Sencer then said he gathered that the group felt ... Better rapport should be established as soon as possible with the local medical society, as well as the health department, to enlist their cooperation in furthering the study. ... Dr. Sencer continued, 'First and foremost, we have to establish rapport with the County Medical Society and the Health Department.' Dr. B. Brown asked how we answer criticisms. Dr. Sencer replied that people outside Atlanta do read medical journals, and this could be blown up out of all proportions, but if we established rapport with the local health officials, he did not think we would have a problem."

(Memorandum from Dr. David Sencer, Director of CDC, to the Record, at 3, 8, 11, 13, 14.)

In correspondence with a former PHS employee concerned about the course of the study, Dr. William Brown, Chief of the VD Branch, stated

We will be working with the State Health Department, the Macon County Health Department and the local Medical Society of Tuskegee to assure that all possible individual attention be given to people who participated in the study.

(Letter from Dr. William J. Brown, Chief, VD Branch, CDC, to Mr. Peter J. Buxtun, Feb. 27, 1969.)

THE PUBLIC RECORD: THE MACON COUNTY MEDICAL SOCIETY COOPERATED WITH THE STUDY

PHS documents show that the May 19, 1969, meeting resulted in the medical society's acquiescence in the study or consent to cooperate with the PHS. For example, a letter from Dr. Brown of the PHS, to Dr. Alexander Robertson, with the Milbank Memorial Fund, dated Nov. 19, 1969, states that the medical society, on which Dr. Foster served as Vice President at the time,

assured [PHS officials] of their cooperation.

(Letter from Dr. William Brown, Chief, VD Branch, CDC, to Dr. Alexander Robertson, Executive Director, Milbank Fund, Nov. 19, 1969.)

Further, the summary of the February 6, 1969, meeting shows that Dr. Myers said the medical society

had been very reasonable to work with; some of the fears of real trouble making have not come to pass.

(Memorandum from Dr. David Sencer, Director of CDC, to the Record, at 8.)

Dr. William Brown, of the PHS, who helped give the presentation to the medical society, reported that the medical society

volunteered cooperation and approval and support.

(James Jones, Bad Blood, at 198.)

FOSTER TESTIMONY: 1972 WAS "THE FIRST TIME I EVER HEARD OF THE TUSKEGEE STUDY ..."

Dr. Foster testified that "the first time I ever heard of the Tuskegee study in any kind of shape, form, or fashion" was 1972. (Hearing transcript, May 3, 1995, at 142-143.) But the public record strongly suggests he may have known of the study substantially earlier.

THE PUBLIC RECORD: DR. FOSTER MAY HAVE ATTENDED THE MEDICAL SOCIETY MEETING

A letter from Dr. Sencer, Director of the CDC, to Dr. McRae, President of the Macon County Medical Society indicates that the PHS understood that the medical society "would be interested in hearing a review of the details" of the Tuskegee Study. It was agreed that this "review of the details" would be provided at the medical society's May 19, 1969, meeting. (Letter from Dr. David Sencer, Director of CDC, to Dr. Luther McRae, President, Macon County Medical Society, April 15, 1969.)

It is widely known that the medical society did in fact meet with the PHS and receive information regarding the study. For example, a deposition of Dr. Sencer taken in September of 1974 in connection with a lawsuit filed against the federal government quotes Dr. Sencer as saying

for the first time in a good number of years, the Macon County Medical Society was brought on board. We had lost communication with the Macon County Medical Society over the years and after the meeting of 1969, we did meet with the physicians who would be treating the bulk of these individuals.

(Deposition of Dr. David Sencer, Sept. 19, 1974, at 116; see also 117.)

However, Dr. Foster has said that he has "no recollection of attending" the medical society meeting on May 19, 1969, with PHS officials, and has gone so far as to state "my knowledge and memory begin in 1972." (Washington Post, Feb. 25, 1995, at A-10.) No minutes of the meeting are available, but Dr. McRae, the president of the medical society at the time, specifically recalls that Dr. Foster was present at that meeting. (Statement of Dr. Luther McRae, Feb. 28, 1995.)

Further, no other member of the medical society has been able to say that Dr. Foster was not at the meeting. (Washington Post, Feb. 25, 1995, at A-10.) A statement by the woman whose baby Dr. Foster delivered that evening is not inconsistent with Dr. Foster's having attended the meeting.

THE PUBLIC RECORD: EACH SOCIETY MEMBER WAS FURNISHED A STUDY LIST

Regardless of whether Dr. Foster actually attended the meeting, there is evidence that he may have or should have received information about the study. For example, a letter from Dr. Brown to Dr. Robertson indicates that the Public Health Service

furnished each of (the Macon County Medical Society's) members with a list of surviving participants in the Tuskegee study.

(Letter from Dr. William Brown, Chief, VD Branch, CDC, to Dr. Alexander Robertson, Executive Director, Milbank Fund, Nov. 19, 1969) (emphasis added).

In addition, Dr. Foster may have been notified of the nature of the meeting. A letter from Dr. Myers to Dr. William Brown, dated March 13, 1969, states that the Alabama State Board of Health notified the Public Health Service that it was

refer(ring) this matter to the Macon County Medical Society for its decision regarding continuity. ... The present officers of the Society are as follows: ... Henry Wendell Foster, M. D., Vice-President. I shall attempt to discuss this matter and this action with Dr. McRae later today. You may proceed to make your contacts directly with local officers.

(Letter from Dr. Ira Myers, State Health Officer, to Dr. William Brown, Chief, VD Branch, CDC, March 13, 1969.)

Finally, Dr. Foster was vice president of the small, ten-member Macon County Medical Society in 1969 and became its president in 1970. The PHS, during a meeting with the medical society, gave members information about the study and obtained assurance of its cooperation. Even if Dr. Foster were not at the meeting, it approaches the inconceivable that the members of such a small society, following a visit from federal officials regarding a controversial, racially explosive study of local patients with syphilis, would not in two years have discussed the meeting with the Vice President of the medical society and a prominent physician in the county.

THE PUBLIC RECORD: DR. FOSTER SPOKE WITH DR. MYERS ABOUT THE STUDY

Indeed, Dr. Foster may have conveyed his knowledge of the study to others prior to 1972, the time at which he admits having knowledge of the study. A contemporaneous deposition in connection with a lawsuit against the federal government indicates that Dr. Ira Myers of the state health board stated in an October 1974 deposition that he provided Dr. Foster with details of the study.

Now, Dr. Foster was the one that followed him [Dr. McRae]. . . . Because I discussed this matter with him on a subsequent time in connection with a comprehensive health planning meeting, as I recall now; and he says, 'well, we think we ought to treat them.' And I said, 'if you think we ought to treat them, then that's what you ought to do.'

(Deposition of Dr. Ira Myers, State Health Officer, Oct. 15, 1974, at 89; see also page 99.)

The discussion most likely occurred soon after Dr. Foster took over for Dr. McRae as president of the medical society in July 1970.

I don't have any idea [how long after the study was publicly revealed], but it is -- if my memory serves me, he was the president of the society at that time; so it may be that McCray [sic] was going out and that he came in that year. I don't know.

(Deposition of Dr. Ira Myers, State Health Officer, Oct. 15, 1974, at 90.)

This early contact by Dr. Myers with Dr. Foster would be consistent with his earlier efforts to keep the local medical society informed of the details of the study. For example, the summary of the Feb. 6, 1969, meeting states that

Dr. Myers thought it a good idea to keep the local medical society informed as to what we were doing and what we wished to achieve; 'work closely with them and keep them informed of everything that we do.'

(Memorandum from Dr. David Sencer, Director, CDC, to the Record, at 8.)

FOSTER TESTIMONY: "I WAS OUTRAGED."

Dr. Foster testified in his confirmation hearing that he was "outraged" on learning of the study in July of 1972 when it became public. (Hearing Transcript, May 3, 1995, at 142-143.) However, the public record shows that victims received no treatment for an additional seven to eight months.

THE PUBLIC RECORD: VICTIMS RECEIVED NO TREATMENT FOR AN ADDITIONAL EIGHT MONTHS

In spite of Dr. Foster's outrage over the study, there is no evidence that he provided treatment to the patients. In response to a question regarding what he did on learning of the study and did he demand treatment, he responded

I called a meeting ... of the physicians in the society, and I told them that we had learned that the CDC had agreed and would treat these men and that we should devise a mechanism to help them identify them. ... I thought the very best thing that I could, and that was to help identify the men. ... And of course, once that was done, Senator, quite honestly I had no reason to feel that the CDC would not follow through on its word. After all, that study had started even before I was born and I think the atmosphere -- and I went back to working 40 hours a day in trying to run my ob service. And, of course, you do know that a few months thereafter I left Tuskegee.

(Hearing Transcript, May 3, 1995, at 11-12.)

Dr. Foster's earlier statement to Dr. Myers urging treatment conflicts with this later focus on mere identification. In a deposition, Dr. Myers notes an exchange with Dr. Foster:

I had discussed the matter with him on a subsequent time ... and he says, 'Well, we think we ought to treat them.' And I said, 'If you think we ought to treat them, then that's what you ought to do.'

(Deposition of Dr. Ira Myers, State Health Officer, Oct. 15, 1974, at 89-90.)

Of course, there was only nominal value in the medical society "devising a mechanism" to identify the patients. Dr. Caldwell had already spent some months identifying patients in the 1970 roundup. (See four Memoranda from Dr. Joseph Caldwell, PHS, to Dr. William Brown, Chief, VD Branch, CDC, and others, April 9, 1970, April 22, 1970, May 4, 1970, and May 8, 1970 (all describing in multi-page detail efforts to identify study patients.)

Mr. James H. Jones, in his book Bad Blood, details how treatment to patients in the study was not provided until March of 1973.

The ad hoc panel [established to review the study], on the verge of releasing its final report, finally broke the impasse by appealing directly to Caspar Weinberger, the secretary of HEW. Secretary Weinberger announced on March 3, 1973, that he had instructed the PHS to provide all necessary medical care for the survivors of the study. Ironically, the only legal way he could authorize treatment was to reopen the experiment so that the men could receive health care as part of the official study.

(James Jones, Bad Blood at 211.)

CONCLUSION

Dr. Foster insists that he and others had no knowledge before 1972 of the study that he later called "a good program turned bad." Atlanta Constitution, Feb. 6, 1975. But the substantial number of government documents, depositions, statements, and letters, leave me deeply troubled by the significant disparity between Dr. Foster's public statements and the public record. I agree

with the Washington Post's editors that "To have known earlier and not insisted on proper treatment for the innocent patients would disqualify any candidate for the surgeon general's post." After a thorough examination of the public record, I must conclude that I can not support the confirmation of Dr. Foster as surgeon general. I urge you also to become familiar with this public record as you consider whether to support Dr. Foster's nomination.

Sincerely,

A handwritten signature in black ink, appearing to read "Dan Coats", written over a horizontal line.

Dan Coats
U. S. Senator

DOCUMENTS CITED HEREIN AVAILABLE UPON REQUEST: If you would like to view the documents cited in my letter, please contact me, or have your staff contact Vince Ventimiglia of my staff at 224-1133.