MEHARRY MEDICAL COLLEGE

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

"I HAVE A FUTURE"

April 13, 1992

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Dear Dr. Sherrod:

Herewith enclosed is the final narrative report of Meharry Medical College's "I Have A Future" Program. This report describes our research activities during the final year of funding from the William T. Grant Foundation. Once you and your staff have reviewed this document, I believe you will agree that we have been productive with this program in this very difficult population.

Briefly, I would like to highlight our most recent finding in regard to pregnancy comparing experimental and control groups. As you are aware, we have three data collection periods spanning a three-year period, with Time Three data collection ending July, 1991. We have found that there is a statistically significant difference in the number of pregnancies among adolescents actively enrolled in IHAF and youth in comparison groups (control groups). Active participants reported no pregnancies and those in the comparison groups reported a total of 59 new pregnancies between baseline and Time Three data collection. This finding is most encouraging and it seems apparent that we are on the right track in demonstrating that a culturally sensitive community-based life enhancement program works in reducing the number of unplanned pregnancies among high-risk adolescents.

We will continue our analyses of the data while seeking new funding to continue our research. We would like to thank you and the William T. Grant Foundation for your support and confi-

dence during the past three years. If any additional information is needed, please do not hesitate in contacting Dr. Greene or me.

Sincerely,

Henry W. Foster, Jr., M.D.
Dean, School of Medicine and
Vice President for Health Services

lw

cc: President David Satcher, M.D., Ph.D.
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SYNOPSIS OF ACTIVITIES

OF

RESEARCH TEAM OVER THE PAST YEAR

Submitted By

"I HAVE A FUTURE" PROGRAM
Meharry Medical College
Nashville, Tennessee

APRIL 1992

SYNOPSIS OF ACTIVITIES OF RESEARCH TEAM OVER THE PAST YEAR

The data entry and cleaning of the Phase 2 data and the third wave of data collection were completed by the Research Coordinator and Research Assistant between September, 1990 to December, 1991. Data entry for this third wave of data has recently been completed and the majority of the data cleaning has been conducted. In addition, the participation data have been thoroughly cleaned and the preliminary work on data reduction for these data has been completed as well as initial descriptive statistics. Dave Cordray, Ph.D., has been providing consultation on data analysis strategy. The following report describes the results of these activities in more detail.

The analyses reported here will describe the participation of the youth in the program across the three years. After the discussion of participation, analyses will be reported on the sexual and contraceptive behavior of the youth at the Time 2 data point and at the Time 3 data point and on the number of reported pregnancies occurring during the duration of the program across the different groups.

Participation Analyses

Data are collected on all of the activities and services delivered by IHAF through the Direct Client Service System. The participation of each client in the IHAF program is recorded by the counselors. Counselors complete rosters which describe each activity and the youth who have participated. From the roster, the counselors complete a Direct Client Service form, which is used for reentering the participation data into the database system. The information recorded on this form includes the youth who 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 have been aggregated according to the time period in which they occurred. The amount of time represented in each phase is variable. Phase 1 is approximately 13 months. Time 2 is 17 months and Phase 3 is 11 months. The first phase extends from July 1988 to the end of August 1989. This time period represents the earliest stages of the program from the beginning of service delivery to the collection of Phase II data, a little over one year later. The second time period extends from September, 1989 to the end of December of 1991. This time period represents the current status of the program. The third phase of data collection occurred at the end of Phase 2; therefore, the effectiveness of the program will be tested for the first two phases of the program. The third phase extends from February, 1991 through December, 1991. The data on the participation in the third phase of the program are presented for descriptive purposes.

The following results are of the participation data collected across these three time periods. Table 1 reports analyses examining the number of enrolled youth who participated in the program at some level across each of the three time periods. Enrollment was defined as having been tested and living in the housing sites during that time period. The total number enrolled, according to this definition, declined as time progressed because youth moved from the sites and also became too old to participate. Also as time progressed, a core group of approximately 60 active participants developed. Although the percentage of enrolled youth who participated declined, the amount of time that participants spent with the program increased substantially over time.

Table 1. Participation Rates Across the Three Phases of the Program

	Total Enrolled	Participants	Time (Hours) x	Time (Hours) sd
Phase 1	574	267 (46.5%)	15.7	20.7
Phase 2	455	282 (62.0%)	70.6	121.1
Phase 3	300	103 (34.3%)	134.7	146.9
Total	730	454 (62.2%)	86.7	186.6

The type of participation also varied across the three time periods as the program developed new services and curricula. Table 2 reports the number of youth who attended at least one session of each activity, the mean number of sessions, and the standard deviations for each activity across the three time periods. In just about every activity, the percentage of those who participated increased from Phase 1 to Phase 2. Job Readiness, which was a poorly attended module in the early stages of the program, Karate, and special events were the only activities in which attendance decreased somewhat. By Phase 3, the case management procedure had been implemented. This resulted in youth being assigned to attend particular modules based upon their needs. Limits on the number who could participate in a module were also established in order to facilitate the best group interaction possible. Consequently, the percentage of youth participating is reduced in Phase 3. Once again, however, the effectiveness of the program will be tested for Phase 1 and Phase 2 only.

Table 2. **Percentages who Participated in each Activity Across Three Phases with Range of Participation Reported in Parentheses**

Activity	Phase I (N=574)	Phase 2 (N=455)	Phase 3 (N=300)
Alcohol & Drug Module	9.1 (1-11)	24.0% (1-18)	Incorporated in Prosocial
Prosocial	Not Offered	14.5 (1-17)	9.3 (1-8)
Family Life Education	4.5 (1-4)	31.4 (1-25)	18.7 (1-17)
Entrepreneurship	Not Offered	17.1 (1-53)	21.0 (1-63)
Tutoring	11.5 (1-31)	38.7 (1-68)	29.7 (1-57)
CHARM/MATURE	2.1 (1-11)	26.6 (1-27)	20.7 (1-12)
Dance	12.5 (1-26)	26.4 (1-17)	6.0 (1-2)
Karate	10.6 (1-14)	3.4 (1-3)	Not Offered
Job Training Partnership	Not Offered	Not Offered	14.3 (1-67)
Job Readiness	6.6 (1-12)	4.0 (1-3)	Incorporated In Entrepreneurship
Sports	9.2 (1-22)	26.8 (1-15)	12.3 (1-17)
Conflict Resolution	Not Offered	4.6 (1-3)	13.7 (1-17)
Peer Counselor & Related Activities	Not Offered	14.1 (1-33)	10.0 (1-6)
Recreational Field Trips	9.6 (1-4)	27.9 (1-18)	13.7 (1-5)
Educational Field Trips	13.4 (1-8)	32.5 (1-27)	20.7 (1-19)
Special Events	33.4 (1-8)	30.5 (1-12)	18.7 (1-3)
Total	46.5 (1-81)	63.0 (1-295)	34.3 (1-210)

Table 7. Means and Standard Deviations for Participation in Activities Between Baseline and Wave 2 Data Collection by Participation Group

Activity	Participation Group: Active (n=65) X	SD	Low-Level (n=665) X	SD	t
Alcohol & Drug Module	6.76	7.00	0.37	1.13	5.22***
Prosocial Skills Module	1.94	1.66	0.01	0.09	6.69***
Family Life Education	7.91	7.70	0.60	1.05	5.45***
Entrepreneurship	8.30	6.46	0.18	1.04	7.19***
Tutoring	13.33	14.27	1.60	3.90	4.71***
CHARM/MATURE	5.18	4.78	0.34	0.95	5.79***
Dance	4.45	7.67	1.18	3.84	2.37*
Karate	1.12	3.15	0.37	1.23	1.34
Job Readiness	1.27	3.21	0.14	0.43	2.02
Sports Activities	5.21	3.19	0.69	1.79	7.81***
Peer Counselor Activities	4.48	5.71	0.06	0.27	4.45***
Recreational Field Trips	8.82	4.73	1.41	1.78	8.83***
Educational Field Trips	6.45	5.44	0.72	1.61	5.99***

Note. T-tests were conducted using separate variance estimates due to significant differences between groups on variances.

*$p<.05$

***$p<.001$

Table 8 and Table 9 report similar information as that of Table 6 and Table 7 except that only those youth who have participated in the evaluation for all of the three data collection periods were included. The two participation groups differed on attendance at all of the activities with the exception of Karate. Karate was an intermittent activity and is no longer being offered. The Job Readiness Module was poorly attended at one of the sites, as was mentioned earlier and therefore, shows one of the lower participation scores even among the active participants.

Table 8. Maximum and Minimum Participation Rates and Median Participation Level for Each Activity by Participation Group for Those Tested Across All Three Time Points

	Participation Group					
	Active (n=39)			Low-Level (n=218)		
Activity	Min	Max	Median	Min	Max	Median
Alcohol and Drug Module	0	24	5	0	8	0
Prosocial Skills Module	0	7	2	0	1	0
Family Life Education	0	25	8	0	4	0
Entrepreneurship	0	21	6	0	10	0
Tutoring	0	63	9	0	32	0
CHARM/MATURE	0	19	4	0	11	0
Dance	0	32	2	0	36	0
Karate	0	14	0	0	12	0
Job Readiness	0	13	0	0	3	0
Sports Activities	0	16	5	0	12	0
Peer Counselor Activities	0	25	3	0	7	0
Recreational Field Trips	0	21	7	0	8	1
Educational Field Trips	0	23	5	0	11	0

Table 9. Means and Standard Deviations of Particular Rates In Activities between Baseline and Wave 2 Data Collection by Participation Group for Those Tested Across all Three Time Points

	Participation Group				
	Active (n=39)		Low-Level (n=218)		
Activity	X	SD	X	SD	t
Alcohol and Drug Module	7.33	7.07	0.39	1.11	6.11***
Prosocial Skills Module	2.00	1.70	0.01	0.12	7.29***
Family Life Education	8.97	7.86	0.53	0.94	6.70***
Entrepreneurship	7.33	6.56	0.12	0.81	6.85***
Tutoring	13.64	13.46	1.31	3.82	5.68***
CHARM/MATURE	5.21	4.61	0.33	1.13	6.57***
Dance	4.62	7.27	1.26	4.27	2.80**
Karate	1.28	3.49	0.37	1.30	1.62
Job Readiness	1.49	3.54	0.13	0.44	2.39*
Sports Activities	4.85	3.42	0.55	1.70	7.67***
Peer Counselor Activities	4.38	5.49	0.11	0.56	4.86***
Recreational Field Trips	8.44	4.56	1.22	1.61	9.77***
Educational Field Trips	6.46	5.19	0.66	1.43	6.94***

Note. T-tests were conducted using separate variance estimates due to significant differences between groups on variances.

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

Outcome Analyses

The following section describes the analyses conducted thus far on the Time 2 and Time 3 data regarding sexual and contraceptive behavior and pregnancies.

Subjects

The original baseline sample represented approximately 70% of the 10-17 year-olds living in each of the four targeted housing project sites, based on Metropolitan Development and Housing Association (MDHA) records. The age and sex breakdown of the sample is described in Table 10. These same youth were contacted again for the Time 2 data collection if they still lived in the housing projects. Due to resource constraints and the community-based nature of the intervention only those subjects who continued to live in the housing projects could be recontacted for the second survey. Table 11 describes the age and sex breakdown for the sample at Time 2. Several youth in the intervention sites completed the survey for the first time at Time 2 because they had become involved with the program but were not available for the baseline survey. Most of these new subjects (n=165) lived at the experimental sites. Forty-five (45%) percent were female; 63.9% were between the ages of 10 and 12, 20.1% were between 13 and 14, and 16.0% were 15 to 17 years old. Time 3 data were collected in the winter and spring of 1991. Table 12 reports the age and sex breakdown for the Time 3 data collection period.

Not all subjects were tested at all three time points. As mentioned earlier, some were not tested at baseline because they were not available for testing at that time yet had become involved with the program. Attrition also accounted for a substantial amount of the variability in the number of times each youth was tested. Table 13 shows the breakdown of the sample sizes for each pattern of testing. The attrition and the different baseline assessments for some subjects presents some issues for choosing which groups are the most equivalent groups for comparison. Those youth who were surveyed at all three time points are likely to be the most similar as well as having the most complete data. Consequently, this project will initially use only this group of subjects for data analysis. Table 14 describes the sex and age breakdown for this group.

TABLE 10
Age and Sex Distribution of Entire Baseline Sample

	Experimental		Comparison	
	Male	Female	Male	Female
10 - 12	103	116	103	101
13 - 14	77	80	66	49
15 - 17	98	92	67	59

TABLE 11

Age and Sex Distribution for Entire Time 2 Sample

	Experimental		Comparison	
	Male	Female	Male	Female
10 - 12	90	92	49	30
13 - 14	56	50	33	37
15 - 17	51	60	25	16
18 - 19	9	18	2	6

TABLE 12

Age and Sex Distribution for Entire Time 3 Sample

	Experimental		Comparison	
	Male	Female	Male	Female
10 - 12	34	37	14	13
13 - 14	44	49	30	31
15 - 17	53	55	37	26
18 - 20	9	20	10	10

TABLE 13

Sample Sizes for Each Pattern of Testing by Baseline and Site

	Experimental	Comparison
ested All 3 Times	154	130
ested 1 and 2	103	60
ested 1 and 3	27	37
ested 2 and 3	119	6
ested 1 only	269	209
ested 2 only	50	2

TABL

Sex and Baseline Age Breakdown of Subjects Followed for All Three Data Collection Periods

	MALE			FEMALE		
	10-12	13-14	15-17	10-12	13-14	15-17
High Participation	14	4	0	12	3	0
Low Participation	28	13	3	43	22	12
Comparison	44	19	13	38	12	4

Time 2 Analyses

The procedures and measures for this data collection have been described in previous reports and will not be repeated here. The Time 2 data collection period began in August, 1989 and ended in June, 1990. Data entry and cleaning of the Time 2 data continued through December, 1990. Scale construction and analyses have been conducted. Scales that needed to be constructed included the Piers-Harris Children's Self-Concept Scale, the psychosocial maturity subscales, the attitude and value scales, sexuality and contraceptive knowledge scales, Family Adaptability and Cohesion Scales, and the behavioral scales with respect to substance use, delinquency, academic behavior, and sexual behavior.

Experimental site youth were placed into low and high participation groups based on their participation over the entire project period up to the point of the third phase of data collection as described above. Analyses were then conducted using those subjects who had participated in all three periods of data collection.

Sexual and Contraceptive Behavior: Time 2

The differences between the two participation groups and the comparison site youth on reproductive behavior were analyzed. In the first analysis, a composite variable representing pregnancy risk was the dependent variable. This composite is a multiplicative score combining frequency of sexual intercourse, frequency of birth control use, and adequacy of most frequently used form of contraception. The possible range for this variable is 0 to 100. Higher scores indicate greater risk. For those who have never had sexual intercourse, pregnancy risk is scored as 0.

The three groups varied significantly on age, $F(2,442)=15.91$, $p<.001$. The mean age for the active participation group at the Time 2 data point was 13.03; for the low-level participation group, mean age was 14.40, and for the comparison group, mean age was 13.33. The groups also varied on sex, X^2 $(2)=6.52$, $p<.05$ (See Table 15 for a breakdown of subjects by sex and participation group). Age and sex were also related to the composite pregnancy risk variable. Age was correlated .18 ($p<.001$) with pregnancy risk. Males had an average pregnancy risk score of 15.08 while females had an average score of 7.50. This difference was statistically significant, $t(427)=3.84$, $p<.001$. Because age and sex were related to pregnancy risk and the three groups also varied significantly on age and sex, these two variables served as covariates in the analysis. A oneway analysis of covariance was conducted. There were no significant differences between the three groups on pregnancy risk at either Baseline or at Time 2. (See Table 16 for the means, standard deviations, and adjusted means).

Table 15. Gender by Group Sample Sizes

Group	Male	Female
Active	20	19
Low-Level	91	127
Comparison	103	87

Table 16. **Means, Standard Deviations, and Adjusted Means For Pregnancy Risk at Baseline and Time 2**

	Pregnancy Risk Baseline			Pregnancy Risk Time 2		
Group	X	SD	Adjusted X	X	SD	Adjusted X
Active	5.10	11.68	6.94	11.37	20.65	12.30
Low-Level	8.92	18.65	7.91	11.51	19.47	10.65
Comparison	8.49	20.08	7.65	10.67	22.33	10.60

The specific reproductive behaviors that comprise the pregnancy risk variable were examined next through chi-square analyses and analysis of variance. These behaviors included (1) whether or not they had had sexual intercourse, (2) frequency of sexual intercourse, (3) frequency of birth control use, and (4) adequacy of contraception. For those who had not had sex at the baseline survey, the number of youth who had had sexual intercourse by the Time 2 survey was compared across the three groups. For those who first had sexual intercourse in the time period between Baseline and Time 2, the first they used contraception was another dependent variable.

The only baseline difference between the groups was on frequency of sexual intercourse, X^2 (4)=11.55, $p<.05$. The active participants who had had sexual intercourse were less likely to report having sex frequently (See Table 17). There were no other baseline differences between the groups on this set of variables.

Table 17. **Percentage of Sexually Experienced Subjects Indicating That They Have Sexual Intercourse Never, Sometimes, or Frequently at Baseline**

Group	Never	Sometimes	Frequently
Active	71.4%	28.6%	0.0%
Low-Level	54.1%	35.1%	10.8%
Comparison	38.8%	28.6%	32.7%

For the Time 2 analyses, there was a significant difference between the three groups on whether or not they had had sexual intercourse, X^2 (2)=0.08, $p=.01$. Sixty-one percent (60.5%) of the active participants reported having had sexual intercourse; 55.6% of the low-level participants reported having had sexual intercourse, and 42.1% of the comparison site youth reported having had sexual intercourse. More of the intervention site youth as compared to the comparison site youth appear to have initiated sexual intercourse. There also continued

to be a significant difference between the groups on how frequently the sexually active youth reported having sex, X^2 (6)=13.44, $p<.05$. Those youth living in the comparison site were more likely to report having sex frequently (See Table 18). There were no other significant differences between the groups on reproductive behavior.

Table 18. Percentage of Sexually Experienced Subjects Indicating That They Have Sexual Intercourse Never, Sometimes, or Frequently at Time 2

Group	Never	Sometimes	Frequently
Active	54.5%	31.8%	39.7% 13
Low-Level	43.2%	39.0%	23.1%
Comparison	39.7%	23.1%	37.2%

For those youth who had not had sex at the Baseline survey, a chi-square analysis was conducted comparing the three groups on how many of these youth reported having had sex by the Time 2 survey. There was a significant difference between the groups on this change in status, X^2 (2)=7.93, $p<.05$. More of the active participants (51.6%) were likely to report having first had sex between the baseline and the Time 2 surveys than the low-level participants (39.6%) and the comparison site youth (27.8%). Although it was not a significant difference, there were fewer active participants (17.9%) who reported having had sex at the baseline survey than the low-level participants (34.7%) and the comparison site youth (29.3%). Thus, there was a greater opportunity for change among the active participants than the other two groups. This may account for the significant difference in change in status.

For those youth who did engage in first intercourse during the period between baseline and Time 2, an analysis of variance was conducted with the time period between first intercourse and first use of contraception as the dependent variable. There were no significant differences between the groups on this variable. On average all three groups report using birth control for the first time between 9 and 12 months following first intercourse.

Pregnancy

The final analysis involves the number of youth who either cause or experience a pregnancy between Baseline and Time 2. Table 19 reports the number of youth in each group who had one and two pregnancies within that time period. There were no significant differences between the groups on this variable; although, within the active participant group only two pregnancies occurred as compared to a total of 43 pregnancies that occurred in the other two groups combined. Ten youth in the low-level and comparison site groups experienced more than one pregnancy within that time period. The time period between Baseline data collection and Time 2 data collection was also longer for the experimental site youth as compared to the comparison site group. There

was more time for an adolescent to become pregnant or cause a pregnancy in the experimental site. Keeping this factor in mind, the lower number of pregnancies in the active participants is even more encouraging.

Table 19. Number of Youth Experiencing or Causing Pregnancies Between Baseline and Time 2 by Group

Group	Number of Pregnancies		
	0	1	2
Active	37	2	0
Low-Level	189	13	4
Comparison	160	10	6

Time 3 Analyses

Time 3 data collection began in February, 1991 and was completed in July, 1991.

Measures

The survey instrument for Time 3 included the same measures as Time 2 with some refinement of scales and some additional questions added concerning sexual behavior. Respondents were asked to recall the month and year of first intercourse. If they have been pregnant or caused a pregnancy, they were asked to recall the month and date of the outcome of each pregnancy. The Youth Needs Assessment was eliminated from the survey for Time 2.

The Psychosocial Maturity Test (PMT) and the Attitude and Value Inventory were refined for the Time 3 data collection based on scale analyses conducted with Time 2 data. The original PMT and Attitude and Value Inventory were too lengthy. It was necessary to eliminate those items which reduced the internal consistency of the subscales and which presented some difficulty for the youth to understand. Subscales which were specifically related to the **IHAF** goals were retained for Time 3. These subscales were (1) self-reliance, (2) work orientation, (3) identity, (4) communication, (5) social commitment, and (6) knowledge of roles. These subscales were more closely related to the goals of the **IHAF** project and were the most internally consistent across the three forms. Internal consistency coefficients ranged from .42 to .76.

The Attitude and Value Inventory was also too lengthy. Subscales were chosen based on their relationships to **IHAF** objectives. The subscales retained at Time 2 were (1) clarity of long-term goals, (2) clarity of personal sexual values, (3) attitudes toward contraception, (4) attitudes toward premarital sex, (5) attitudes toward the use of pressure or force, and (6) self-esteem. Internal consistency coefficients ranged from .42 to .73.

Procedure

Due to the complexity and length of the interview instrument, the procedure for the data collection changed from group administration to individual interviews. Each youth was assigned to one of 18 interviewers (as the data collection period continued, the number of interviewers reduced to approximately 10 active interviewers). The interviewer was responsible for making contact with the youth and his/her parent or guardian, obtaining consent, and conducting the interview. This procedure assured that each youth was individually contacted so that no youth who still lived in the housing projects was missed simply because he or she was not informed of the survey. If a youth was not interviewed, it was because he/she no longer lived at the site or he/she refused. Interviews took place at the IHAF apartments at the intervention sites or the Resident Association offices at the comparison sites.

Individual interviews do have the problem of not providing the same level of anonymity as group administered questionnaires and the desire to appear socially desirable may influence the answers of some of the youth. However, individual interviews also reduce the problem of youth randomly responding to questions or not following the skip pattern correctly. We are also able to collect better information on the dates of specific events such as when they first had sexual intercourse or when a pregnancy occurred. Individual interviews allow for more probing to assist the youth to remember these key dates. Interviewers explain in detail the importance of giving honest answers and the confidentiality of those answers. Each youth is then asked to agree or promise to give honest answers.

The interview lasted approximately one to one and a half hours. Youth were paid $10.00 for their time participating in the interview.

x[redacted]nd Contraceptive Behavior: Time 3

An analysis of variance was conducted with the composite pregnancy sk variable (described above) for Time 3 as the dependent variable. e independent variable was Group--active participants, low-level rticipants, and comparison site youth. Age and sex were covaried. is analysis was conducted twice, once with all available subjects d again with only those subjects who were tested across all three data ints. There were no significant differences on pregnancy risk by oup for either of the analyses. (See Table 20).

ble 20. Means, Adjusted Means, and Standard Deviation for Pregnancy Risk by Group

	All Subjects			Subjects Tested 3 Times		
	x	sd	Adjusted x	x	sd	Adjusted x
tive Participants	10.26 (n=53)	14.23	9.89	10.91 (n=32)	15.21	10.78
w-Level rticipants	7.01 (n=215)	14.33	7.94	8.33 (n=140)	15.34	9.31
mparison Site u[redacted]	9.21 (n=136)	19.47	8.66	9.94 (n=126)	20.05	9.09

Another series of analyses were conducted for each of the variables at comprise the pregnancy risk score. These variables are how often e adolescent has sex, how frequently he/she used contraception, and e adequacy of the most frequently used form of birth control. Change status from virgin to non-virgin from Time 2 to Time 3 was also amined. A chi-square analysis was conducted for each of these riables using all available subjects and again with only those ojects who were tested across all three time points (See Tables 21 to).

Table 21. Cell Sizes and Percentage of Group for How Frequently Have Sex by Group

	Active Participants	Low-Level Participants	Comparison Site Youth
All Subjects			
Never	17 (30.9%)	106 (44.4%)	78 (44.6%)
Rarely	15 (27.3%)	64 (16.8%)	39 (22.3%)
Frequently	19 (34.5%)	49 (20.5%)	43 (24.6%)
Very Frequently	4 (7.3%)	20 (8.4%)	15 (8.6%)
Subjects Tested 3 Times			
Never	9 (28.1%)	40 (33.3%)	56 (44.1%)
Rarely	10 (31.3%)	38 (31.7%)	29 (22.8%)
Frequently	11 (34.4%)	30 (25.0%)	30 (23.6%)
Very Frequently	2 (6.3%)	12 (10.0%)	12 (9.4%)

s Percentage of Group for How Frequently Use
tion By Group

Active Participants	Low-Level Participants	Comparison Site Youth
9 (16.7%)	28 (11.7%)	23 (13.1%)
5 (9.3%)	19 (7.9%)	13 (7.4%)
23 (42.6%)	86 (36.0%)	62 (35.4%)
17 (31.5%)	106 (44.4%)	77 (44.0%)
imes		
6 (18.8%)	17 (14.2%)	19 (15.0%)
3 (9.4%)	9 (7.5%)	11 (8.7%)
14 (43.8%)	54 (45.0%)	42 (33.1%)
9 (28.1%)	40 (33.3%)	55 (43.3%)

aceptive for Youth Who

l nts	Comparison Site Youth
)	34 (34.7%)
)	41 (41.8%)
)	23 (23.5%)
)	22 (30.6%)
)	31 (43.1%)
)	19 (26.4%)

is set of analyses was subjects, $X^2(4)=11.41$, one of the most ntrol pills, IUD, or s, particularly the : types of contraception nat the active ithout spermicide) and ; birth control pills le receive a lower venting pregnancy, the e. The use of condoms, transmitted diseases pants in the program ndom if they are ncy and sexually ference on type of r those subjects who ed in the analysis.

Table 24. Percentage of Subjects Using Different Types of Contraception By Group

	Active Participants	Low-Level Participants	Comparison Site Youth
Withdrawal	2.6%	0.8%	1.0%
Foam Only	2.6%	0.0%	1.0%
Condoms	68.4%	47.0%	41.8%
Condoms with Spermicide	5.3%	0.8%	2.0%
Birth Control Pills	5.3%	31.3%	32.7%
IUD	0.0%	0.2%	0.0%
No Method	18.4%	20.5%	21.0%

Pregnancy

The pregnancy data were examined in several different ways. The occurrence of a pregnancy between Baseline and Time 3 was one dependent variable. The number of pregnancies between Baseline and Time 3 was a second dependent variable. The occurrence of a pregnancy between Time 2 and Time 3 and the number of pregnancies between Time 2 and Time 3 were additional dependent variables. First chi-square analyses were conducted to examine the differences between groups. Second, a series of analyses of variance were conducted in order to include age, sex, and time between measurement period as covariates. Subjects with inconsistent reports of pregnancy (n=4) (i.e., reported a pregnancy at an earlier data point and reported no pregnancy at a later data point) were not included in these analyses.

The Chi-square analyses of number of pregnancies revealed a significant difference between groups for number of pregnancies between baseline and Time 3, $X^2(4)=9.65$, $p<.05$, as well as between Time 2 and Time 3, $X^2(4)=9.54$, $p<.05$ (See Table 24 and Table 25). Active participants reported no pregnancies as compared to low-level participants and comparison site youth, who reported a total of 59 new pregnancies across both groups between baseline and Time 3. Between Time 2 and Time 3, the low-level participants and the comparison site youth reported 36 pregnancies. There is a great deal of overlap of pregnancies between these two analyses, but the subjects included in the two sets of analyses are not exactly the same.

Table 25. **Number and Percentages of Youth Reporting Zero, One, or Two Pregnancies by Group Between Baseline and Time 3**

	Pregnancies		
Group	**None**	**One**	**Two**
Active Participants	33 (100%)	0 (0.0%)	0 (0.0%)
Low-Level Participants	115 (79.3%)	26 (17.9%)	4 (2.8%)
Comparison Site Youth	141 (86.5%)	19 (11.7%)	3 (1.8%)

Table 26. Number and Percentage of Youth Reporting Zero, One, or Two Pregnancies by Group Between Time 2 and Time 3

	Pregnancies		
Group	**None**	**One**	**Two**
Active Participants	53 (100%)	0 (0.0%)	0 (0.0%)
Low-Level Participants	190 (90.9%)	15 (7.2%)	4 (1.0%)
Comparison Site Youth	110 (89.4%)	13 (10.6%)	0 (0.0%)

The analysis of variance with the covariates (age, sex, and time between data collection) indicate that the difference between groups from baseline to Time 3 were modified by age but not by time between data collection and sex (See Table 27). Group was no longer significant. When the dependent variable was simply whether a new pregnancy had occurred (regardless of the number), the results were essentially the same (See Table 28). Age was the only significant covariate and group was not significant.

Table 27. **Means, Standard Deviation, and Adjusted Means for Number of Pregnancies Between Baseline and Time 3**

Group	n	x	sd	Adjusted x
Active Participants	31	0.00	0.00	0.05
Low-Level Participants	141	0.24	0.49	0.19
Comparison Site Youth	163	0.15	0.41	0.15

Table 28. **Percentages and Adjusted Percentages for Whether or Not A Pregnancy Occurred Between Time 1 and Time 3**

Group	n	Percentage Reporting Pregnancy	Adjusted Percentage Reporting Pregnancy
Active Participants	31	0.0%	4.0%
Low-Level Participants	141	21.3%	17.7%
Comparison Site Youth	163	13.5%	12.7%

The analysis of variance for the pregnancy data between Time 2 and Time 3, however, revealed that the group difference remained significant even with the covariates included, $F(2,370)=3.56$, $p<.05$ (See Table 29 and 30). This was true for the analysis which examined information on the number of pregnancies and for the analysis which examined whether a pregnancy had occurred or not, $F(2,374)=3.73$, $p<.05$. Age was only significant covariate.

Table 29. **Means, Standard Deviation, and Adjusted Means for Number of Pregnancies Between Time 2 and Time 3**

Group	n	x	sd	Adjusted x
Active Participants	50	0.00	0.00	0.00
Low-Level Participants	206	0.11	0.37	0.12
Comparison Site Youth	122	0.11	0.31	0.10

[illegible]nd Adjusted Percentages for Whether or Not A [illegible]urred Between Baseline and Time 3

	n	Percentage Reporting Pregnancy	Adjusted Percentage Reporting Pregnancy
ts	50	0.0%	0.0%
pants	206	9.2%	10.2%
outh	122	10.7%	10.3%

s are very encouraging, although further work is still
ne the comparability of the groups. The program
ing a significant effect on the ultimate dependent
ing pregnancies. The fact that the significant effect
ost strongly between Time 2 and Time 3, when the
ding more services lends credence to the conclusion
has demonstrable effectiveness. The mechanisms through
is effective needs to be examined further,
e there were no apparent differences in sexual or
avior between the three groups. Further work also
termining who is best served by the program and
utilize its services.

n for a poster presentation was made to the annual
he Society for Research on Adolescence in March, 1992.
as accepted and presented (See Appendix A for summary of
ntation.)

MEHARRY MEDICAL COLLEGE

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

"I HAVE A FUTURE"

Henry W. Foster, M.D.
Director

Lorraine Williams Greene, Ph.D.
Deputy Director

DATE: 2-23-95

TIME: _____

IHAF FAX NUMBER: (615) 327-6992

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Number of pages (including transmittal sheet) 11

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INTRODUCTION

This Family Life Education Module is designed to increase African-American adolescents' awareness of human sexuality issues, responsible sexual activity, and positive family dynamics. In addition to providing essential basic information regarding human sexuality, this curriculum focuses on the unique experience of African-American adolescents living in an urban low income environment. Adolescents living under these perplexing conditions are at risk for choosing negative social behaviors which will increase their susceptibility to early pregnancies, sexually transmitted diseases and AIDS, alcohol, tobacco and other substance abuse, homicide and other crimes, illiteracy and unemployment.

Adolescents living in low-income communities are ostracized often by society because of the diversity of family patterns within their communities. Frequently, their family are typified as "broken" homes and these adolescents as "illegitimate" children. Through the use of "Seven Principles or Nguzo Saba Principles" (Karenga, 1966), this curriculum serves as a mechanism for integrating the Afrocentric value system into the communication and teaching of positive sexually responsible behavior. These principles are utilized as a mechanism for enhancing participants' self identity, self-knowledge and commitment to negating the stereotypes which are repeatedly used to label their communities and families.

This culturally sensitive model serves as a tool for identifying and clarifying the sexuality concerns of these adolescents. All adolescents need a nurturing environment which allows them the opportunity to inquire, share, and grow. With the pervasive daily absence of the African-American male in impoverished communities, it is essential that these adolescents are challenged with the realities of their home environments and its impact on the family and community. They can not be allowed to develop values which perpetuate the multi-generational pattern of teenage pregnancy without being confronted with the potential lifelong barriers which may result from this behavior. The ability to produce a child does not necessarily equate with the ability to function as a nurturing, responsible parent.

Consequently, another method of inquiry is the creation of a **FAMILY GENOGRAM.** Some adolescents will reconstruct a family tree while others will create a family photo album depicting their family's life. Neither activity allows the adolescent to totally deny the existence of their father. In high risk communities, there may exist family secrets to protect offspring from the realities of the environment. This family project activity poses the possibility of a

heightened need for support in confronting critical issues. Therefore, group facilitators should encourage participants to rely upon counseling staff and family support.

Other important issues include sexuality, decision-making, birth control, pregnancy and parenting, and STDs and AIDS. **Responsible sexual behavior is defined as abstinence or acting upon the decision to participate in sexual intimacy while maintaining a healthy body and exercising assertive family planning.**

Sexuality **Values Supported by this Curriculum**

In preparing to conduct family life education programs, facilitators are trained to avoid imposing their personal sexual values on youth. For example, facilitators practice ways to avoid passing on their individual values regarding premarital sex, abortion, specific sexual behaviors, and so on. However, this curriculum takes a stand on the following sexuality and parenting behaviors:

o It is wrong to force or pressure another person to engage in sexual behavior against their will.

o It is important for people to practice responsible sexual behavior. There are two ways to be responsible: 1) refrain from having sexual intercourse (oral, anal or vaginal) or 2) decide to have sexual intercourse and use birth control (correctly and consistently) to prevent pregnancy and/or condoms to prevent sexually transmitted disease. However, it is best for children to postpone initiating sexual intercourse and other risky sexual behaviors beyond the early adolescent years.

o Parenthood should be postponed until adulthood or until individuals have the capacity to nurture a child financially, spiritually and emotionally.

In addition, the following basic attitudes about the family and sexuality are embraced by the program and promoted with the youth it serves:

o The African-American family in all of its diversity should be respected, acknowledged for its strengths and not compared negatively to Eurocentric family standards.

o Sexuality is a positive and natural component of the total human being, focusing on who we are as males and females, our attitudes about our own bodies, our romantic and sexual attractions to others, as well as specific sexual behaviors and their consequences.

o Stereotypes are harmful, whether applied to African-Americans, public housing residents, men, women or

any other group. It is wrong to put people in "boxes".

o The human body (including the genitals), with all of its individual variations, is not to be ashamed of nor exploited.

o Sexual behavior refers to more than just having sexual intercourse.

Incorporating the Nguzo Saba Principles

This family life education curriculum promotes the positive impact the family system may have on the development of the individual's ability to make positive life decisions. To understand your heritage and the relationships between family members are two explicit goals for individuals who participate in this curriculum design. The primary value orientation focuses on the integration and implementation of the Nguzo Saba Principles into each participant's role as a positive family member and in their practice of responsible sexual behaviors. These principles and their application to family development and responsible sexual behaviors are illustrated in the following manner.

1. **Nia** (Purpose) to make our collective vocation the building and developing of our communities in order to restore them to their traditional greatness.

   The purpose of this module is to provide a viable mechanism for addressing participants' attitudes and values toward sexuality. This module is viewed as a springboard for serious discussion about family life issues confronting adolescents. The Afrocentric world view depicts the family as a unit in which all members along the family developmental life cycle are valued and respected. Therefore, the transition into puberty is viewed as a critical developmental period in which positive emotional growth is critical in adjusting to this period of rapid physical growth. Adolescents need to be equipped with positive decision-making skills as they confront the pressures of inevitable sexual contact.

2. **Umoja** (Unity) to strive for and maintain unity in the family, community, nation, and race.

   The positive functioning of the family is depicted as a supportive unit. Without family members seeking to function positively within their roles (mother, father, child, etc.), the family becomes susceptible to prolonged conflict and perplexing obstacles. The Afrocentric world view emphasizes the survival of the family unit as a problem for not only the family, but the community. If African-American male children and

adolescents are considered an endangered species, then the African-American family is an endangered species. All family members must understand the challenges of their family role. For the adolescent, his/her responsibility is to learn how to make decisions leading to responsible sexual behavior. If, in many cases, the adolescent is unable to discuss these sensitive issues with a parent or another adult relative, the adolescent is strongly encouraged to seek out the answers to these perplexing questions by turning to professionals in the school or community.

3. **Kujichagulia** (Self-Determination) to define ourselves, name ourselves and speak for ourselves instead of being defined and spoken for by others.

It is critical that the many differentiations within family units are considered as barriers to overcome, rather than fatalistic stereotypes. If a grandparent functions as the primary caretaker or if one parent has exclusive responsibility for family management, these individuals' strengths under such circumstances are highlighted and evaluated. In communities with high adolescent pregnancy rates, adolescents should be confronted with their responsibility in breaking the cycle of high adolescent pregnancy and infant mortality rates. Despite the family composition, each participant should be encouraged to gain insight into the survival strategies of his/her kinship. The Afrocentric world view stresses that each family member's worth is not determined by his/her developmental role. From the infant to the esteemed elder, each family member's responsibility is to build upon the strengths rather than succumb to the weaknesses of the family. Each family member has the unique decision of when and what age to engage in sexual activity. Family members' values do not have to mold the values of the developing adolescent. If adolescents' parents did not have access or choose to receive family life planning training, that does not mean that these adolescents are wrong if they choose to become fully informed.

4. **Ujima** (Collective work and responsibility) to build and maintain our community together and to make our brothers and sisters' problems our problems and to solve them together.

Family life planning issues for participants are the issues for the entire community. All families experience strengths and weaknesses and can benefit from community support. The community shares the role of promoting responsible sexual behaviors to all community members. Each community member is challenged

with becoming fully informed about sexuality and sexually transmitted diseases. As adolescents become more informed about sexuality issues, it is their responsibility to share this valuable information with their peers and other friends and family members. Group leaders need to remind adolescents that sexuality is a sensitive issue and some persons may be closed to the idea of discussing these issues.

5. **Ujamma** (Cooperative Economics) to build and maintain our own stores, shops, and other businesses.

The economic issues which confront the family and the community represent a daily struggle for low-income African-American adolescents. Participants are encouraged to support community businesses which provide for the total needs of the family. Businesses which adhere to positive family value systems (for example, merchants which strictly enforce the selling of products to minors) or support responsible sexual behaviors through providing access to contraceptive products, are valued as contributing to the development of the family. Participants are encouraged to re-evaluate their spending habits in businesses which promote sexual promiscuity in their products, advertisements, and/or policies. The group leader is encouraged to share with participants that the African-American community is typically recognized as a significant group of consumers. Advertisers target the African-American by associating success and acceptance through the use of certain products African-American adolescents are a part of this consumer population. They are encouraged to use their spending power by voicing their displeasure with business practices which do not promote sexual responsibility. Leaders should share information regarding the use of economic boycotts during the civil rights movement and current efforts.

6. **Kuumba** (Creativity) to do always as much as we can, in the way we can, to leave our community more beautiful and beneficial.

Despite the myriad of family issues, participants are encouraged to seek creative ways of confronting the barriers in their relationships with family members. Participants are encouraged to exercise personal flexibility and openness in building and maintaining effective methods of communication with siblings, parents, and elders. Participants are encouraged to seek creative and effective ways of developing and maintaining responsible sexual behaviors. The Afrocentric world view emphasizes that each family member seeks to nurture peaceful relations within the

family and the community. And this peaceful existence is and can be maintained through creative flexibility on the part of each family and community member. Group leaders should encourage participants to use creative methods in communicating responsible sexual behavior with their peers, family, and others. If persons do not easily receive these positive messages, adolescents are encouraged to seek out other methods of communicating this message (T-shirts, rap and other forms of music, posters, etc.).

7. **Imani** (Faith) to believe with all our hearts in our parents, our teachers, our legitimate leaders, our people and the rightness and victory of our struggle.

An outlook of optimism and stability for the family is illustrated by this principle. Although the family unit may experience periods of strife and turmoil, the family can return to a peaceful state of stability. By demonstrating responsible sexual behaviors, participants are reinforced for preventing the transmissions of STDs and infant mortality. The Afrocentric world view emphasizes that the current family unit is the legacy of centuries of family development and growth. Sometimes adolescents may feel rejected and alone because others will not openly support their values of sexual responsibility. Adolescents should keep the faith and remember that sexual responsibility begins with them.

Group Format

The primary structure of this curriculum represents an educational format with a variety of experiential exercises to evoke self-exploration and self-knowledge by the participants. The suggested group size is 10-15 participants and two group leaders. Larger groups are encouraged to use the skills of several group leaders. In order to facilitate this learning environment, group leaders are urged to adhere to the following guidelines:

Guidelines for Group Facilitation

1. The group will establish group rules during the initial session. These rules will be distributed to all participants at the next session and a poster-size copy will be displayed during each group session.

2. The group leader should record these rules in the participants own language style including slang expressions. As the group develops group guidelines, the following concepts should be incorporated into their organizational structure:

a. What each member expresses in the educational module is held in strictest confidence by other group members. No spreading rumors or gossip.

b. Each member's contribution to the group is honored with attentive ears and respect by other members.

c. When an individual is sharing information, other group members remain silent.

d. Each group member takes the responsibility for arriving to group on time. Every participant has a right to his/her own opinions and values.

e. A group member who is disruptive during a session may be asked to leave the group. In order to return to this current group or a subsequent group, this disruptive group member must ask permission from the group to return. (Note: Group leaders are encouraged to rely on their co-leader to intervene with a disruptive participant when removal from the group is necessary.

f. Each participant is encouraged to participate fully and ask questions concerning information that is unclear. All questions are important. There are no dumb questions except the unasked question.

g. If a participant needs to leave the group session early, the participant must notify the group at the beginning of the session.

h. If a member feels uncomfortable about participating in a specific activity or discussion, they may choose to pass.

i. Participants are to share information about their personal feelings and circumstances. They are not to make comments about other participants' family life issues. They should not use someone's name when sharing information. They should not discuss their own sexual behavior within the group. They are encouraged to use the group leader, counselors, or clinic staff to discuss personal matters.

j. Participants should not use stereotypical

language or assume that all group members should or do think as they do. Everyone has a right to their opinion. No put-downs are allowed.

3. A different participant will be identified at the beginning of the group session as a participant-leader. This individual will lead the group in the recitation of the Nguzo Saba Principles. A variety of formats may be utilized in this opening ritual. For example, seven participants may be selected to recite one of the principles, one participant may recite all of the principles, or the entire group may stand with their right arm raised above their head and their hand in a fist position as they recite the principles in unison.

Set Up

Each group is arranged in a circle with each group leader and the participant-leader strategically seated around the circle (See Figure 1). As each participant arrives to group, he or she selects a chair and brings this to the group setting. In case of a large group size, participants are encouraged to begin to form a smaller circle seated on mats within the larger circle. This curriculum is designed for a group size of 10-15 participants. All individuals are seated during the presentation of information. If a group leader needs to stand in order to properly manipulate an educational aid, the leader's standing posture should be kept to a minimum.

Figure 1
Group Format

X = Group leader(s) and participant-leader
O = Participants

Question Box

A Question Box will be introduced to the group during the initial session. This box will be used as a mechanism for participants to ask questions they are either reluctant or unable to express verbally in the large group. This box will be maintained in a safe place within the group meeting room. Group leaders will review the questions in the Question Box prior to each group. If a participant has not had an opportunity to contribute a question, an opportunity to do so should be made early in the session. Group leaders are encouraged to maintain the value of sexual responsibility and the Nguzo Saba Principles the responses provided to the group.

Group leaders function as facilitators and not experts. If a group leader is unable to fully answer a question, he or she is encouraged to say: "I'll need to find out more about this topic. I'll provide this additional information in our next session." Group leaders do not want to give the participants the idea that they have all the answers--they do have access to resources and keep themselves as fully informed as possible.

Pre-testing:

Participants will be administered a pre-test to determine their initial knowledge regarding sexuality issues and family life planning. The time for this testing will be announced to all participants. In order to be officially enrolled in this module, all participants must complete this pre-test prior to attending a group session. No participant will be permitted to enroll in this module after Session III has been completed. (Appendix)

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Date: 02/23/95 Time: 17:40

Anti-Abortion Group Says It Will Be Shut Out of Foster Hearing

WASHINGTON (AP) An anti-abortion group promised an aggressive campaign against surgeon general nominee Dr. Henry Foster Jr. after the Senate committee that will hold confirmation hearings said the group's president could not testify in person.

For his part, the Tennessee obstetrician-gynecologist continued fighting for his nomination, attending a lunch with Democratic senators.

''I only ask for an open and fair, objective hearing,'' Foster said. ''I want everyone to understand that health care in this country is nonpartisan, it's for everyone,''

The American Life League issued a statement calling the Senate Labor and Human Resources Committee's decision to accept only written testimony from public witnesses ''an outrage.''

''I can promise that the offices of the committee will be flooded with letters of protest against the nominee,'' Judie Brown, the league's president, said in a statement. ''Pro-life Americans will be heard.''

The committee said its new chairwoman, Sen. Nancy Kassebaum, R-Kan., is only following longstanding tradition.

''The Labor Committee has had a longstanding policy of allowing nominees and members of Congress to testify at confirmation hearings,'' said Kassebaum's press secretary, Mike Horak. ''We will take written testimony from any group that would like to provide it and we're more than happy to make that testimony part of the record.''

The nomination of the 61-year-old doctor has been under attack by anti-abortion groups since it was revealed that Foster had performed some abortions.

Some have questioned his credibility, too, on the grounds that he has given conflicting information about the number of abortions for which he is responsible.

''We're hopeful that Dr. Foster can be given a fair hearing,'' Senate Minority Leader Tom Daschle, D-S.D., said after the Democratic Policy Committee luncheon with Foster.

''He talked about things that he believed in that every American should be able to hear,'' said Sen. Harry Reid, D-Nev., after meeting Foster for the first time.

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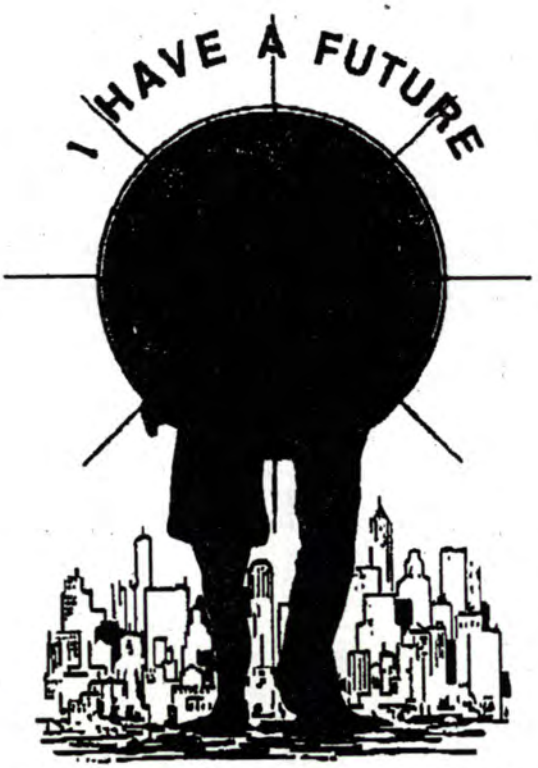
"I HAVE A FUTURE"

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 IHAP 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.

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!*

February 27, 1995

MEMORANDUM TO JOHN PODESTA

FROM: **MEEGHAN**

RE: **"I Have A Future" Vet: *Possible Issues***

As requested, I have read all of the material sent by the *I Have A Future* program and made a note of anything that could be misconstrued, distorted, or taken out of context. I flagged some items -- however reasonable most people would find them or however rational the explanation -- on the premise that it is better to be prepared for every possible charge, no matter how outlandish.

The following specific areas were addressed:

- Afro-Centric "Bias" of the Program
- Drugs
- Emphasis on Abstinence vs. Contraception
- Evaluation / Results / Number of Pregnancies

In each section, I outline the possible charge that might be leveled against the program, followed by all the evidence that could be presented to support that charge.

I begin to outline possible responses, drawing primarily from material in the Modules themselves. We've been working on some of these answers already and more detailed responses will certainly need to be developed.

OVERALL ANALYSIS

A careful and fair analysis of the Modules from the *I Have A Future* program reveals that it is a very thoughtful and moderate approach to addressing the many problems teenagers face. The program seeks to teach values -- in open acknowledgment of the "real world" of the housing projects in which these teenagers live. It tries to help the teenagers develop a value system of their own and then give them the tools they need to uphold that value system. One of the primary lessons stressed throughout is -- *"the need to make your own decisions and to take responsibility for the outcome."*

The value system encouraged by IHAF is based on the Nguzo Saba principles, also called the Seven Principles of Blackness. These principles -- *purpose, unity, self-determination, faith, creativity, collective work and responsibility, cooperative economics* -- are used to promote self-esteem, encourage responsibility and impart a sense of community -- within the context of the youth's socio-economic situation and the historical struggles of the black people. This feature of the program could be deliberately misinterpreted although IHAF takes pains to define the terms themselves to prevent this.

Many of the sessions have a "role-playing" component: they outline a tough social situation and together walk through the different ways youths can choose to deal with it. It teaches how to say "no" in many ways -- to sex, to drugs, to alcohol. They encourage teens to be assertive and stand up for what they believe in: *"developing skills to resist group pressure."* These exercises are also used to help teens identify and learn to positively deal with their emotions -- anger, embarrassment, rejection, need to be loved.

The stated goal of the program is to reduce teenage pregnancy and they do this in several ways. *"The need to be sexually responsible"* is defined in the program as choosing abstinence or regularly using birth control. They first encourage abstinence -- and give teenagers the skills and confidence to enforce this -- but they also proivde extensive education about contraceptive use. And, they take pains to describe the responsibilities of parenting and the limiting effect having a baby can have on the future.

Frankly the jury is out on the degree of success they've had so far. Results are preliminary -- based on limited data and largely anecdotal evidence. The anecdotal evidence indicates that the program has positive effects on the youth's self-esteem and sense of positive options for the future. The program is actively seeking funding for longer-term outside research.

AFRO-CENTRIC BIAS OF PROGRAM

CHARGE: ***Afro-centric focus / Farrakhan / Franz Fanon***
What would be your response if we were teaching kids Euro-centric history? How is this better than any group that tries to teach the superiority of white culture? [Seen as different, exclusionary, not mainstream, anti-American]

EVIDENCE:

- Mentions "Afro-Centric" focus repeatedly -- 10 times in first 10 pages of the Family Life Module.
- The precepts of Nguzo Saba -- used extensively throughout the program -- are often referred to as the "Seven Principles Of Blackness." A couple of these could be particularly misconstrued:
  - -- *Imani [Faith]: To believe with all our hearts in our parents, our teachers, **our legitimate leaders**, our people and **the righteousness and victory of our struggle**.*
  - -- *Nia [Purpose]: to make as our collective vocation the building and developing of our communities in order **to restore our people to their traditional greatness**.*
  - -- *Ujamaa [Cooperative Economics]: To build and maintain **our own** stores, shops, and other businesses and to profit together from them."*

RESPONSE:
[NOTE: To address any charges leveled at this facet of the program, I encourage you to refer to Ann Walker's Kwanza memo. Although I have not been able to see it, I imagine it describes the value-based nature of this philosophy and the positive life choices that stem from them. If it lays out the response of the black community to extreme reactions to Kwanza, they would be helpful here.]

- Nguzo-Saba is a culturally sensitive approach to communicating with African American teenagers by create a greater understanding of their history and what effect it has on their lives today.
  - -- Their target population is almost entirely African American [98% of respondents in *Head of Household Survey*, perhaps more teens]
  - -- It seeks to impart *"knowledge of the historical struggles and victories of one's ethnic culture"* because *"If you know your history, you can be content in the present."*

[Continued]

- When referring to the Nguzo Saba principles, the authors seem to make a particular effort to define the terms for themselves -- related to the particular focus of the exercise -- so that they will not be misunderstood. They appear to consciously reject the opportunity to make extreme or radical points.
  - -- *"When we restore our people to their traditional greatness, we acknowledge that African Americans have been oppressed during slavery, stifled by black on black crime, and many live in high crime neighborhoods."* [Conflict Resolution, p. 1]

CHARGE: ***An extreme interpretation could accuse these type of exercises as inciting teens to hate or be resentful.***

EVIDENCE:

- The following poem -- "I am a Black Man," a poem by Nathan Hare -- is distributed in one of the sessions: ***"I have lost by force my land, my language, in a sense my life. . . I will seize it back so help me . . . If necessary, I will crush the corners of the earth and this world will surely tremble*** *until I, the black man, the first and original man, can arm in arm with my woman, erect among the peoples of the universe a new society . . . out of which at long last will emerge . . .the first truly human being that the world has ever known."* [Conflict Resolution, Appendix]
- One "Discrimination" exercise divides the group into "oppressors" and "oppressed". The oppressors take advantage of the oppressed and then both sides talk about how they felt and how this *"experience related to days of slavery."* [Conflict Resolution, p.]
- Referring to black alcoholism as a *"pattern was established during slavery and racial segregation and still continues today."* [Pro-Social, p. 10]
- *"African American History is largely missing from many history books. Years of slavery and discrimination has hampered the achievements of some African Americans. Much of the violence and "Black on Black" crime exists because many people have given up hope. Some see violence as the only means of survival."* [Conflict Resolution, p.]
- A goal of one session is defined as: "*Explain that the high unemployment rate within our community, which could be the result of major changes in the labor market,* ***racism,*** *etc. . . . "* [Job Readiness, p. 32]

RESPONSE:

- These principles are used to specifically respond to feelings of low self worth that result when many African American teenagers internalize the stereotypes society typically applies to people of their race and social situation.

{Continued]

- -- *[Nguzo Saba] principles are utilized as a mechanism for enhancing participants self identify, self-esteem, self-knowledge and commitment to negating the stereotypes which are unjustly associates [sic] with their communities and families."* [Job Readiness, p. 1]
- -- *"By understanding African-American heritage and having faith in families who have struggled through slavery and racial discrimination in America, participants may begin to appreciate the different coping mechanisms of their family units."* [Family Life Module, p. 28]
- -- *"The African-American family in all of its diversity should be respected, acknowledged for its strengths and not compared negatively to Eurocentric family standards."* [Family Life Module, p. 2]

- Nguzo Saba is -- at its core -- a value-based orientation.
  - -- The values are: *purpose, unity, self-determination, faith, creativity, collective work and responsibility, cooperative economics.*
  - -- IHAF relates these values to each specific Module: conflict resolution, family values, job skills, etc. These values are used to empower teens to make their own choices and accept the consequences, discourage drug use, teach alternatives to violence, stress need to graduate, encourage volunteerism, and advocate responsibility for families and community.

CHARGE: ***Weird cultish ritual; used to indoctrinate kids***

EVIDENCE: The Nguzo Saba principles are recited in a self-described ritual at the beginning and end of each section. At times the entire group *"will stand with their right arm raised above their head and their hand in a fist position as they recite the principles in unison."*

RESPONSE: Nguzo Saba is, at it core, a value system and this seeks to actively promote those moderate, socially responsible values. "*Explain that rituals are an essential part of the African experience. Through rituals such as the recitation of the Nguzo Saba Principles, the group or the community can receive constant reinforcement for positive community and family values.*" [Family Life Module, p. 14]

DRUGS

CHARGE: ***Program trivializes drugs use – making explicit and offhand references to drugs.***

EVIDENCE: Many of the "role-plays" and exercises reference passing around "a joint" or "being offered a joint"

RESPONSE: The program has a strong anti-drug message. All of these exercises are used to teach teens strategies for resisting and avoiding drugs.

ABSTINENCE VS. CONTRACEPTION

CHARGE: ***Gary Bauer has said the IHAF approach "is to say abstinence is best and in the next breath make it clear that birth control pills and condoms are available." Even a cursory look through the Family Life Module indicates this is true.***

EVIDENCE:

- Many statements present sexually responsible behavior as one of two choices: abstinence or birth control. *"It is important for people to practice responsible sexual behavior. There are two ways to be responsible: 1) refrain from having (oral, anal or vaginal) sexual intercourse . . . 2) decide to have sexual intercourse and use birth control."*

  It does go on to say *"However it is best for children to postpone initiating sexual intercourse and other risky sexual behavior beyond the early childhood years."* [Family Life Module, p. 2]

- *"Young men and women can say "no" and postpone sexual intercourse. But if they do intend to have sex, they must be informed of the possible consequences of sexual behavior. If participants are not ready for the responsibility of parenthood, they must consider the various ways of acting sexually responsible."* [Family Life Module, p. 58]

- Beginning another section: "*Key Concepts: There are two ways of exercising responsible sexual behavior: 1) Abstain from sexual intercourse or 2) Use contraceptives/condoms effectively."* [Family Life Module, p. 75]

RESPONSE:

- This is what it means to work to deal with the real issues of teens in these projects -- 75% of whom have sex before they are 15.

[Continued]

- In a *Head Of Household Survey* filled out by parents before the program started, over 70 percent of the parents reported getting pregnant between the ages of 13 and 19. And 91% of these parents asked that a program to prevent teen pregnancy make contraceptives available for sexually active teens.
- Louis Sullivan, President Bush's Secretary of Health: *"It turns young people's lives around. [It's] the kind of program that the country needs."* [*"Teens Have A Future, Thanks to Foster Program,"* USA Today, 2/9/95]
- President George Bush: Selected IHAF to be one of America's *"Thousand Points of Light"* [The above two may be used in a general response to all criticisms.]

CHARGE: ***[General gratuitous quote of] "oral, anal or vaginal" sex***

EVIDENCE: [Family Life Module, p. 2]

RESPONSE: This is proof that the program does not just "mention abstinence in one breath" and move on. It stresses that any form of early sexual activity should be postponed until a more appropriate time.

CHARGE: ***Despite the abstinence and life options rhetoric, IHAF is basically a birth control program – aggressively and actively promoting the use of birth control.***

EVIDENCE:

- Their literature clearly states -- in brochure and other places -- the five objectives of the program. One of these is: *"3. To provide greater access to and increase the use of comprehensive adolescent health and social services,* ***including contraceptive availability.***"[1]
- ***"Businesses which support responsible sexual behaviors through providing access to contraceptive products are valued as contributing to the development of the family."***
- A *"Key Concept"* in the first session of the Family Life Module is to *"1) Assist participants about contraceptives,* ***the application of contraceptives,*** *and their effectiveness."* This concept is mentioned twice on the same page [accidentally I presume.]

[Continued]

[1]This is already well within the public domain. The White House has sent out a brochure and a fact sheet containing the statement.

- *"**Condom Exercise:** Each participant is to open the condom and place two fingers within the condom. They are encouraged to explore the condom and feel its texture. The group leader will discuss how to select condoms, check the expiration date., and **the application of condoms.** Group leaders need to emphasize the importance for **both males and females to become comfortable with handling condoms.** For example, it is not enough for a female to carry a condom, but she needs to be informed on how to use a condom in case her partner is unaware."* [Family Life Module, p. 59]
- One session has the following *"Goals: 1) To educate participants on the multiple forms of birth control. 2) To sensitize participants to the need for contraception in helping participants achieve life-long goals. 3) To identify barriers to adolescents' use of contraception."* [Family Life Module, p. 67]
- *". . . the leader must arrange . . . 2) a presentation by a health care professional who is employed in a health clinic in which the participants have access to services including contraceptives."* [Family Life Module, p. 40]
- *"Discussion on how to use community resources: Various community agencies could provide help to adolescents regarding sexuality, contraceptive use, and pregnancy.* ***Brochures distributed.***" [Family Life Module, p. 76]
- Myth Information Game: *"It's aim is to sensitize participants to the probability of a pregnancy without the use of birth control methods. Also, to reinforce the value of birth control use as a form of sexual responsibility."* The exercise involves participants drawing squares -- marked *"Pregnant"* and *"Not Pregnant"* -- from a bag to show effectiveness of birth control. [Family Life Module, p. 54]
- *"The birth control pill is the most effective method for most young women; and the condom, if used properly, is the best method for young men while protecting both partners from AIDS and other STDs."* [Family Life Module, p. 58]
- *"Adolescents should take time to consider their sexual behavior and the use of contraceptives before they are confronted with a difficult situation. It could be too late otherwise."* [Family Life Module, p. 67]
- Group leaders are asked to *"stress the fact that while some of the contraceptives are not suitable and not very effective for young people, the birth control pill and condoms are the most effective methods for young women and men respectively."* [Family Life Module, p. 68]
- *"Each community member is challenged with becoming fully informed about sexuality. It is their responsibility to share this valuable information with their peers and other friends and family members."*

[Continued]

RESPONSE:

- Program always mentions abstinence first [i.e., Counter the charge with long list of abstinence quotes]
- In a *Head Of Household Survey* filled out by parents before the program started, teen pregnancy was listed as one of the top three problems in the community. 99% of parents said too many teens were getting pregnant and 91% of the parents asked that it be easier for sexually active teenagers to get birth control.
- Irresponsible as adults not to -- pregnancy / AIDS / STDs
- IHAF involves families in these discussions at all levels. One "Key Concept" of Session V of the Family Life Module is that: *"Each participant is encouraged to discuss values around sexuality with their parents and/or other adults whose values are important to the participant."*

EVALUATION / RESULTS / NUMBER OF PREGNANCIES

Note: This material is not found in the modules we send. There is one exception which I can point out. It is confidential and they do not want it distributed.

CHARGE: ***There is no credible evidence that the IHAF has had any positive affect on teen pregnancy.***

EVIDENCE: The only evaluation was internally monitored and sponsored. It is not independent and not necessarily scientific. IHAF refers to it as "quasi-experimental" and admit that there was a one year age difference between the control and intervention sites that could explain away some or all of the positive results.

- *"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 effects of the program on involvement with a pregnancy are unclear.*** *The low involvement with a pregnancy could be accounted for by age."* [Final 1994 Progress Report, p. 4]

RESPONSE: IHAF acknowledges that the program needs more analysis and the staff is actively seeking funding for it. *"The effects of the IHAF 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."* [Final 1994 Progress Report, p. 4]

CHARGE: ***In fact, teens in the program have higher risks of pregnancy – according to your own evaluation.***

EVIDENCE: *"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."* [emphasis added]

RESPONSE: The evaluation goes on the say that *"This difference was not evident however, when only the active participants from the intervention neighborhood were compared with the comparison site youth"*

FOLLOW UP: BUT even if there is no difference in the IHAF teens' pregnancy risk behavior -- never mind a higher risk -- this seems to indicate a lack of success. ***Wouldn't you expect much less pregnancy risk behavior if the program were successful??***

CHARGE: ***Teens in the program seem to be having sex as much as teens who are not in the program. This is the strongest evidence that you do nothing to encourage abstinence. [In fact, IHAF teens are not even any more responsible about using birth control. So the program does not even accomplish your own left wing anti-family goals.]***

EVIDENCE:

- *"When the IHAF teens were compared to teens in the other projects "there were no differences in frequency of intercourse and frequency of birth control use."*

RESPONSE: The higher scores of IHAF teens on "pregnancy risk behavior" -- although their frequency of intercourse and use of birth control was same -- can be explained by the greater use of condoms, rather than birth control pills, by IHAF youth. The third component of pregnancy risk evaluation is "type of contraception" and the birth control pill is given a higher scoring -- i.e., more effective at preventing pregnancy -- than condoms.

- Program has shown marked success in some areas: *". . . statistically significant differences . . . Young people who resided in the intervention site had higher self esteem, greater knowledge about contraception and sexuality, had more pro-social 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."* [Final 1994 Progress Report, p. 4]

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 ~~proposal~~ of the ~~document~~

PAST GRANT AND CONTRACT AWARDS
Henry W. Foster, Jr., M.D.

Maternity and Infant Project #556 (Title V) 1970-73	$ 3,300,000	
Jesse Smith Noyes Foundation, 1973-1978	449,000	
Upjohn Clinical Trials, 1979-1982	909,000	
March of Dimes Prenatal Clinic, 1979-1988	22,600	
Cayce Homes Clinics, 1979-1981	2,500	
Planned Parenthood Teen Clinic, 1979-1987	40,600	
Pregnancy and Substance Abuse, 1986-1988	330,000	
Robert Wood Johnson Foundation, High Risk Youth Program, Director	1,275,000	
Matthew Walker Health Center, 1973 - 1990	768,000	
Carnegie Teen Pregnancy, 1987-1992	1,750,000	
W.T. Grant Teen Pregnancy, 1987-1991	229,000	
Bill/Camille Cosby, 1989 - 1990	600,000	
Subtotal	$ 9,475,700	$ 9,475,70

CURRENT GRANT AND CONTRACT AWARDS

Perinatal Outcome, HHS, 1989-1994	$ 1,017,000	
PEW Charitable Trusts - Teen Pregnancy/ Prevention, 1993-96	250,000	
Alcohol/Substance Abuse in Pregnancy (ASAP), 1990-95	2,800,000	
Subtotal	$ 4,067,000	$13,542,700

*INSTITUTIONAL GRANTS

Centers of Excellence, HHS/HRSA 1991-1994	$15,923,077
Minority Clinical Research Center, NIH,	

MEHARRY MEDICAL COLLEGE

AND

HUBBARD HOSPITAL

****

HIV/AIDS POLICIES

****

AUGUST 1, 1991

Meharry Medical College and Hubbard Hospital

Policies relating to

Acquired Immune Deficiency Syndrome

Sections

1. Patient Consent Form
2. Policies Governing Employees
3. Student/Trainee Specific Provisions
4. Patient Care Procedural Policies
5. General Institutional Policies
6. Dental School Policy on the Handicapped and Medically Compromised Patient

HUBBARD HOSPITAL
ADMISSION CONSENT FORM
--ADDENDUM--

To protect against possible transmisison of blood-borne diseases, [such as Hepatitis-B, Acquired Immunodeficiency Syndrome (AIDS), etc.,], I understand that it may be necessary to test my blood while I am a patient in Hubbard Hospital. If, for example, a hospital employee is stuck by a needle while drawing blood or sustains a scalpel injury involving me, I understand, and consent, that my blood, as well as the employee's blood, will be tested.

I understand that the potential side effects of this testing are no more than those encountered during the routine obtaining of blood specimens. The normal complications include discomfort from the needle stick and slight burning, bleeding, and/or soreness where the blood was obtained.

I understand further that the results of any such confidential test will be contained in my medical records maintained by Hubbard Hospital along with the physician's (or designee's) order for the test, and a copy of this consent, and as such will be available to any person or entity possessing a legitimate authorization for release of information signed by me including insurance companies, self-funded (employer) health benefit plans, and Medicare and/or Medicaid.

I also understand that my blood will not be routinely tested for these diseases and that the results of any testing will be kept confidential and will be disclosed to persons or entities, other than those involved with my care at Hubbard Hospital, only pursuant to my written authorization or as required by state and/or federal law.

_____
Patient Signature

_____
Date

eff. 1/91
Rev. 8/1/91

Meharry/Hubbard Hospital
Infection Control
Acquired Immune Deficiency Syndrome

AIDS POLICIES

A. Employees with AIDS

1. When an employee (which includes all faculty and staff) is symptomatic of AIDS, the employee will not be involved in direct patient care.

2. Each asymptomatic AIDS employee (HIV positive) shall be considered on a case by case basis, with intervention by the Chief of Infectious Diseases, as well as the individual's private physician. It shall be determined that:

   a. the employee in the conduct of their normal duties is free from transmissible infection, and

   b. the employee is not duly susceptible to infections he/she might come in contact with, in the line of performing patient care duties.

3. Patient care responsibilities shall be assigned according to an ongoing clinical evaluation of the AIDS employee's status.

4. Meharry Medical College reserves the right to evaluate and determine appropriate action on a case by case basis, instances involving an AIDS employee's refusal (or restriction by their personal physician) to perform his/her duties.

B. <u>Employees Working with AIDS Patients/Employees</u>.

1. Pregnant employees must not engage in direct care of patients with AIDS because of the possible risk of acquiring cytomegalovirus.

2. Employees sustaining a needle puncture associated with the care of AIDS patients shall be treated according to the protocol for needle puncture exposure for potential hepatitis.

3. Meharry Medical College reserves the right to evaluate and determine appropriate action on a case by case basis, instances involving an employee's refusal to perform his/her work duties which require interaction with an AIDS patient and/or employee.

C. To prevent the risk of transmission of AIDS from the employee to the patient, the patient to the employee, and/or employee to employee;

1. Employees diagnosed by their personal physician (or other treating physician) as having AIDS or indicating the probability of its development of HIV have a responsibility to notify one of the physicians on the Employee Health Services staff. The notified physician shall collaborate with the Chief of Infectious Diseases and the employee's personal physician in determining whether the employee can continue to carry out their normal work responsibilities and what, if any, reasonable accommodation can be made.

2. Employees who believe they are at high risk for infection from AIDS patients because of their immune status, shall be (and are) encouraged to discuss their work responsibilities with their personal physician, along with their immediate supervisor. The nurse epidemiologist should also be notified, should a circumstance such as this arise.

3. If the above-referenced physicians determine that there are certain assignments, positions or duties which are inappropriate for the employee, this shall be communicated in writing to the appropriate parties, and

a determination made whether reasonable accomodations would permit the employee to continue employment in a currently open position for which the employee is otherwise gratified.

D. Student AIDS Specific Provisions

1. Admission of Students: The existence or diagnosis of HIV infection shall not be a factor in decisions regarding admission to Meharry Medical College, so long as the individual's physical condition is such that he or she can participate fully in the required activities of the school to which application is made. It is recognized, however, that this later proviso might prevent acceptance of certain infected persons, particularly those with clinically evident AIDS. Meharry Medical College at this time does not undertake programs of routinely screening students for antibody to HIV.

2. Managing Students with positive antibody tests for HIV: During the student orientation process all students shall be informed of their responsibility, if they know themselves to be antibody positive, to report this fact to a physician on the Health Services staff, in order to obtain medical treatment and consultation for their protection and that of others. This same responsi-

bility is applicable to students who are diagnosed as HIV positive or develop symptomatic AIDS infection at anytime during their course of study. Every effort will be made to preserve the confidentiality of the student's medical record. Information concerning a student's positive HIV antibody status shall be limited to those with a demonstrable need to have such information.

3. Curricular Implications of HIV Infection:

Any student known to have a positive HIV antibody test shall be counseled regarding the transmission of this virus and the means to minimize risk of such transmission. The recommendations of the U.S. Public Health Service regarding prevention of HIV transmission must be scrupulously observed by all health science professionals and students. Students known to have asymptomatic HIV infection or AIDS shall be counseled as to the potential risks to themselves posed by exposure to certain infectious agents, such a Mycobacterium- tuberculosis. The need, if any, for restrictions of clinical assignments will be made on a case-by-case basis. Given the implications of a diagnosis of AIDS -- as regards physical vigor, mental acuity, and longevity -- strong consideration may be given to granting the student who develops this disorder an indefinite leave of absence.

Because of their special curriculum needs, health professional students may be required to obtain and process the blood and other body fluids of patients. Persons responsible for teaching laboratory techniques will establish guidelines for safe conduct of experiments involving blood and body fluids when such experiments are a part of the curriculum.

Meharry Medical College subscribes to the safety guidelines proposed by the Public Health Service for protection of personnel in its hospitals, clinics, clinical laboratory techniques, and day care facilities.

The appropriate infection control committees or other responsible groups in college-operated health care facilities will establish guidelines and procedures to assure the protection of students and patients against the possible transmission of HIV virus.

Faculty responsible for educational training activities for students in hospitals, clinics, and day care facilities will establish guidelines to assure that students-in-training are required to perform possibly hazardous procedures only if appropriate to their level of training and experience.

In general, all statements made here with regard to students also apply to other trainees at higher levels, e.g. residents and fellows. However, because the duties of residents, unlike students, vary greatly with the particular department with which they are associated, it is required that each department establish its own discipline specific written guidelines.

4. **IN ADDITION TO SPECIFIC PROVISIONS LISTED IN THIS SECTION, ALL HIV/AIDS POLICIES LISTED UNDER EMPLOYEES AND PATIENT CARE PROCEDURES ARE GENERALLY APPLICABLE TO STUDENTS AND TRAINEES.**

EFF. 4-25-91

REV. 8-01-91

INFECTION CONTROL

MEHARRY-HUBBARD HOSPITAL

ACQUIRED IMMUNO DEFICIENCY SYNDROME (AIDS)

PATIENT CARE PROCEDURAL POLICIES

PROCEDURE	COMMENTS
1. Place patient in a private room. a. Isolation room desirable on specialty unit.	1. It will frequently be necessary to care for Aids patients, particularly those with Pneumocystis carinii Pneumonia or other serious opportunistic infections, in intensive care units. Particular care must be used not to deny AIDS patients the potential benefits of intensive care facilities if medically indicated. If ICU care is required, an isolation room in the ICU is desirable; a bed in open ICU may also be used; however, as long as the additional requirements of blood and body fluid precautions can be observed.
2. Portable cardiopulmonary resuscitation equipment should be immediately accessible. a. Order disposable ambu-bag and oral airway from CPD.	2. Obviates concerns about mouth-to-mouth respiration
3. Use masks when indicated.	3. Masks are not routinely necessary for the care of AIDS patients. The use of mask is indicated for health care personnel who have direct sustained contact with a patient who is coughing extensively or a patient who is intubated and being suctioned.

	PROCEDURE		COMMENTS
4.	The use of gowns is recommended	4.	Especially when soiling with blood or body fluids is anticipated.
5.	Gloves are to be worn as indicated. (nonsterile)	5.	Gloves must be worn if contact with blood or body fluids, secretions, or excretions is anticipated. IT IS EXTREMELY IMPORTANT FOR PERSONNEL WHO HAVE CUTS OR ABRASIONS ON THEIR HANDS TO WEAR GLOVES WHEN CARING FOR AIDS PATIENTS. (HANGNAILS, SCRATCHES, ETC.)
6.	Wash hands thoroughly after patient care.	6.	Hands must be washed routinely when caring for AIDS patients, especially if they are contaminated with blood, body fluids, secretions, or excretions. The precaution is to be observed regardless of the use of gloves.
7.	Protective eyeware (goggles) are to be worn in the performance of Special procedures.	7.	In the performance of Endotracheol intubation, sronchoscopy, and GI endoscopy. Recommended for the protection of splatter with blood, bloody secretions, or body fluids when such is a possible occurrence.
8.	Do not recap syringe needles after use.	8.	Needles and syringes should be disposable and should be disposed of in rigid, puncture-resistant containers. Needles should not be recapped and should not be purposely bent or broken by hand, since accidental needle puncture may occur. The use of needle-cutting devises is not recommended.

PROCEDURE	COMMENTS
9. Plan in order to keep parenteral injections at a minimum.	9. Extraordinary care should be taken to avoid accidental wounds from needles or other sharp instruments.
10. Label all specimens "Blood and Body precautions," immediately.	10. All blood specimens must placed in a second container, such as an impervious bag, for transport, promptly.
11. Double bag all linens.	11. Soiled linens and other laundry must be bagged promptly. Water soluble bags are to be used.
12. Double bag all waste materials.	12. Disposable items must be double bagged. The RED bag is the outer bag. Once the outer bag has been closed and properly labeled, do not reopen.
13. Order specified diets for "Isolation Rooms".	13. Dispose of tray promptly and correctly.
14. Patients may be transported for procedures (x-Rays, etc.)	14. Personnel in the area to which the patient is to be taken should be notified of precautions to be used.
15. Sterilization of all invasive equipment is required. *Use disposable equipment whenever possible.	15. Decontamination of surgical equipment, endoscopes, etc. should be accomplished by the same sterilization procedures (for such equipment used on patients with AIDS) as those currently recommended for equipment used for patients with hepatitis B.
16. Schedule surgical procedures last, if possible.	16. Surgical procedures on AIDS patient should be scheduled at the end of a day, to allow sterilization of endoscopes overnight (shorter-term procedures result in high

PROCEDURE	COMMENTS
	level disinfection, rather than sterilization).
17. Diluted bleach must be readily available.	17. Blood spills should be cleaned up promptly with a solution of bleach (any brand), diluted 1:10 water (prepared daily).

EFF. 9/85
REV. 8/1/91

MEHARRY MEDICAL
COLLEGE

Subject: Institutional Policy, Acquired Immune Deficiency Syndrome

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Policy: This policy will be utilized as an institutional guide for all persons believed to be in the above referenced diagnostic category, or a similarly related category.

N.B. The guidelines enumerated below are based on the most current recommendations of the American College of Health Association (ACHA).

Policy/Procedures To Be Followed:

1. Persons who have AIDS, ARC, or a positive HTLV-III antibody test, whether they are symptomatic or not, should be allowed regular classroom attendance in an unrestricted manner as long as they are physically able to attend classes. See also Recommendation #12.

2. There is no medical justification for restricting the access of persons with AIDS, ARC, or a positive HTLV-III antibody test to student unions, theatres, restaurants, cafeterias, snack bars, gymnasiums, swimming pools, recreational facilities, or other common areas.

3. In the program of education that the institution provides, it should emphasize the following recommendations of the Public Health Service:

   a. Even though they may be asymptomatic, persons with confirmed positive HTLV-III antibody tests may transmit infection to others through anal or vaginal sexual intercourse, the sharing of needles, and possibly, exposure to others through oral-genital contact or intimate kissing.

   b. Persons with AIDS, ARc, or confirmed positive HTLV-III antibody tests should not donate blood, plasma, other body organs, other body tissue, or sperm. The American College Health Association also endorses the request of the American Red Cross that persons who fall into defined risk categories for AIDS not donate blood or plasma.

   c. If persons with confirmed reactive (positive) antibody tests have accidents involving bleeding, contaminated surfaces should be cleaned with household bleach freshly diluted 1:10 in water.

   d. When seeking medical, dental, or eye care, these persons should advise the practitioner of their positive antibody

status so that appropriate evaluation can be undertaken and precautions can be taken to prevent transmission to others.

4. Meharry Medical College residents and students should receive education about AIDS.

5. Consideration of the existence of AIDS, ARC, or a positive HTLV-III antibody test should not be part of the initial admission decision for those applying to attend the institution.

6. Students shall not be asked to respond to questions about the existence of AIDS, ARC, or a positive HTLV-III antibody test. It is, however, appropriate to encourage new students to inform campus health authorities if they have AIDS, ARC, or positive HTLV-III antibody test in order that the institution can provide them proper medical care and education. This, like all other medical information, must be handled in a strictly confidential manner in accordance with the procedures and requirement sin effect in the institution.

7. Meharry Medical College officials should not undertake programs of screening newly admitted or current students for antibody to HTLV-III; neither should mandatory screening of employees be implemented. Especially, institutions should not attempt to identify those in high risk groups and require screening only of them.

8. Meharry Medical College health services should be familiar with sources of testing for antibody HTLV-III, and should be able to refer students or employees requesting such testing. Health care providers should understand the capabilities and limitations of the test, and should be able to counsel those desiring to be tested or to refer them to counseling sources elsewhere. Testing should only be done where it is confidential or anonymous, where positive results can be confirmed by specific tests, and where both pre- and post-test counseling are available.

9. Guidelines concerning the handling of confidential medical information about students with AIDS, ARC, or a positive HTLV-III antibody test follow the general standards included in the American College Health Association's Recommended Standards and Practices for a College Health Program, Fourth Edition, 1984:

> In general, it is recommended that no specific or detailed information concerning complaints or diagnosis be provided to faculty, administrators, or even parents, without the expressed written permission of the patient in each case. This position with respect to health records is supported by amendment to the Family Education Rights and Privacy Act of 1974.

Certainly no person, group, agency, insurer, employer, or institution should be provided any medical information without the

prior specific written consent of the patient. Given the possibility of unintended or accidental compromise of the confidentiality of information, health officers should be carefully weigh the importance of including any specific information regarding the existence of AIDS, ARC, or a positive HTLV-III antibody test in the medical record except in circumstances of medical necessity created by the evaluation of an illness. At minimum, the inclusion of any such information in the medical record should be discussed with the patient prior to its entry.

Health officials and other institutional officers must remember that all confidential medical information is protected by statutes and that any unauthorized disclosure of it may create legal liability. The duty of physicians and other health care providers to protect the confidentiality of information is superseded by the necessity to protect others only in very specific, threatening circumstances. The number of people in the institution who are aware of the existence and/or identity of students or employees who have AIDS, ARC, or a positive HTLV-III antibody test should be kept to an absolute minimum, both to protect the confidentiality and privacy of the infected persons and to avoid the generation of unnecessary fear and anxiety among other students and staff. The ACHA is now developing a statement specifically addressing the handling of confidential medical information about students with AIDS, ARC, or a positive HTLV-III antibody test in more detail.

10. The responsibility to provided a safe living environment is best dealt with by educational programming, as discussed earlier in this statement. Similarly, college and university officials should make no attempt in any other setting to identify those students or employees who have AIDS, ARC, or a positive HTLV-III antibody test.

11. Meharry Medical College health policy should encourage regular medical follow-up for those who have AIDS, ARC, or a positive HTLV-III antibody test. Special precautions to protect the health of immunologically compromised individuals should be considered during periods of prevalence of such contagious diseases as chicken pox and measles.

12. Those who are known to be immunologically compromised should be excused from institutional requirements for certain vaccinations, notably measles and rubella vaccines, as those vaccinations may lead to serious consequences in those with poorly functioning immune systems.

13. Meharry Medical College shall adopt safety guidelines as proposed by the Public Health Service for the handling of blood and body fluids of persons with AIDS, ARC, or a positive HTLV-III antibody test. Those institutions which operate health care clinics and clinical laboratories providing services for students or employees should implement those Public Health Service guidelines and take measures to see that they are observed. In addition, the institu-

tion should provide educational programs about AIDS and the reduction of risk to health care providers for clinical personnel. The following articles in Morbidity and Mortality Weekly Reports provide detailed guidelines that should be generally followed:

A. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staffs. MMWR 1982; 31:577-580.

B. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): Precautions for Health Care Workers and Allied Professionals. MMWR 1983; 32:450-425.

C. Centers for Disease Control: Acquired Immunodeficiency Syndrome (AIDS): MMWR 1985; 34:533-534.

14. Meharry Medical College health services should use disposable, one-user needles and other equipment whenever such equipment will puncture the skin or mucous membranes of patients. Health care officials should not rely on students or employees to identify themselves as having AIDS, ARCC, or a positive HTLV-III antibody test, since many infected persons are unaware of their status; safety precautions must be used in all cases. If disposable equipment is not available, any needles or other implements that puncture skin or mucous membranes should be steam sterilized by autoclave before re-use or safely discarded. Extreme caution should be exercised particularly in disposing of needles.

15. Meharry Medical College shall adopt safety guidelines for the handling of blood and body fluids of all students in other settings as well. Laboratories used in a teaching context, such as those required in biology courses, should be safe experiences. Given the fact that the existence and identity of those with AIDS, ARC, or a positive HTLV-III antibody test may not be known, procedures for the decontamination of environmental surfaces and objects soiled by blood or body fluids should be adopted and implemented. Laboratory courses requiring exposure to blood, such as finger pricks for blood typing or examination, should use disposable equipment and no lancets or other blood-letting devices should be re-used or shared. No student should be required to obtain or process the blood of others. The Public Health Service guidelines noted above include information about disinfection of environmental surfaces; a simple method they recommend is the cleaning of contaminated surfaces with a household bleach freshly diluted 1:10 in water.

16. Meharry Medical College health services must strictly observe public health reporting requirements for AIDS. patients who meet criteria for the revised surveillance definition of AIDS must be reported to the local public health authorities. (This function shall be performed by the nurse epidemiologist.)

EFF. 4/86
REV. 8/1/91

Dental School Policy
on the
Handicapped and Medically Compromised Patient

The faculty and student/practitioners of the School of Dentistry are sometimes requested to provide care for the handicapped including medically compromised patients. The Department of Hospital Dentistry is best equipped to compensate for compromised organ systems such as cardiovascular problems, respiratory problems, etc. It is also equipped to handle any emergencies or complications that may arise. Therefore, handicapped and medically compromised patients should be referred to and treated at that facility. The medically compromised patient shall not be treated in the regular dental clinics.

EFF. 4/91
REV. 8/1/91

Terry file

MEHARRY MEDICAL COLLEGE
Office of the General Counsel

TO: Mr. Steven Bignell
Journeyworks Publishing

FROM: Richard E. Jackson, J.D.
General Counsel

RE: Request for Copies of Purchase Orders & Invoices

DATE: May 2, 1995

As General Counsel for Meharry Medical College, I am hereby requesting that you provide me with copies of any and all purchase orders and invoices for materials provided to Meharry Medical College and/or its subsidiary, the "I Have A Future" program at any time during the preceding twenty-four (24) months. This information is needed to respond to an inquiry that arose during the current confirmation hearings for Surgeon General nominee, Dr. Henry Foster, a Meharry faculty member and Director of the "I Have A Future" program.

In light of the above, I am requesting your expeditious provision of this information to me via fax. Please fax this information to (703) 418-1289, which is the fax number for the Hyatt Regency Crystal City in Arlington, Virginia, where I am staying while in the Washington area for the confirmation hearings. I am further requesting that you provide an additional copy of this information to Mr. John Podesta of the White House staff at fax number (202) 456-2215.

Your prompt response is requested since the hearings are likely to conclude tomorrow, May 3, 1995. **TIME IS OF THE ESSENCE.**

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FROM: STEVEN BIGNELL

Total Number of Pages (including transmittal page): 4

Message: PER THE REQUEST OF RICHARD JACKSON
RE: DR. FOSTER NOMINATION

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Meharry Medical College
1005 D.B. Todd Blvd
Nashville, TN 37208

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3/20/95	3/20/95	3/23/95	011136	ann	PAYMENT NOW DUE	UPSC		

QUANTITY ORDERED	QUANTITY SHIPPED	BACK ORDERED	ITEM NO.	DESCRIPTION	PRICE	AMOUNT
1	1		502-100	Abstinence Pamphlet Set	125.00	125.00
100	100		5035	Am I Ready to Be a Dad?	0.25	25.00
100	100		5053	How to Talk/Condoms	0.25	25.00
100	100		5042	Birth Control/Ten Things a Man Can	0.25	25.00
100	100		5046	How to Talk/HIV and Safer Sex	0.25	25.00

REQUEST FOR SAMPLES OF THESE PAMPHLETS WAS MADE PRIOR TO MARCH 8TH (exact date not recorded)

thank you

COPY

ITEMS ORDERED	DISCOUNT %	DISCOUNT AMOUNT	TOTAL AFTER DISC.	ADJUSTMENT	STATE TAX	LOCAL TAX	SHIP/HAND	INSURANCE	SERVICE
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MEHARRY MEDICAL COLLEGE

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DATE: 3/8/95

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1	#502-100-J5 Abstinence Pamphlet Set	Pkg/ 600	[redacted]	1	125.00	125.00
[redacted]	#5035-J5 Am I Ready to Be A Dad? Pamphlet	Each		100	.25	25.00
	#5053-J5 How to Talk w/Partner Condoms	Each		100	.25	25.00
4	#5042-J5 Birth Control: 10 Things a Man	Each		100	.25	25.00
5	#5046-J5 How to Talk w/Partner HIV	Each		100	.25	25.00
	Shipping & Handling (10%)					22.50

[redacted] ORDER IS SUBJECT TO THE CONDITIONS ON THE REVERSE SIDE.

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TITLE #	NAME OF PAMPHLET		QUANTITY	TOTAL PRICE
#5029-P5	Talking Abstinence			
#5030-P5	Ten Great Ways to Show Love and Affection (Without Having Sex!)			
#5031-P5	How to Say No and Keep Your Boyfriend			
#5036-P5	Ten Good Reasons NOT to Be a Teenage Parent			
02-100-J5	Abstinence Pamphlet Set		600	125.00
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5053-J5	How to Talk With Your Partner About Condoms		100	25.00
5042-J5	Birth Control: 10 Things A Man Can Do.		100	25.00
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Senator Christopher Dodd
US Senate

Re: Foster Nomination for Attorney General
and the "abstinence pamphlets"

Dear Senator Dodd,

Yesterday you distributed copies of four of our pamphlets currently being used by Dr. Foster's "I Have A Future Program". I wanted to alert you to the fact that Senator Ashcroft's office has been calling all morning to pinpoint the date when Dr. Foster's program began purchasing abstinence materials from us. Since we are a new publisher and the pamphlets weren't published until the end of January, I had to honestly say his first contact with us did not come until late February/early March. I'm afraid they are going to try to use that information against Dr. Foster and may even quote me.

I would suggest two things:

1) If I do get quoted, you may counterquote with this line: Mr. Bignell, Publisher of Journeyworks Publishing and a long time health educator says that "Mr. Foster's program "I Have a Future" is well known for their emphasis on abstinence which is why we immediately sent samples to their program once our materials were produced"

2) I would also argue that that the "I have a Future" program has been using abstinence pamphlets for a long time (you might want to locate other samples) and the fact that he is using newly published materials is reflective of his interest in keeping his program up-to-date--and is a positive, not a negative indicator of his support for quality programs on abstinence.

Thanks. Good Luck. You may call me at 408-423-1400 with questions.

Steven Bignell
Publisher

cc. Richard Jackson
John Podesta
Senator Kennedy

Carnegie Corporation of New York

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For information:

Avery Russell
Director of
Publications

For Release Wednesday p.m., May 3, 1995

Carnegie Corporation of New York funded the "I Have a Future" program from its inception in 1986. "I Have a Future" is a life options program addressing the multiple risks that many young people face in adverse circumstances -- the risk of school failure leading toward dropping out, the risks of early pregnancy, the risks of drug abuse, and the risk of delinquency.

The program takes a comprehensive, problem-solving approach to the underlying factors involved in high-risk behaviors. It works to enhance young people's self-esteem, positive feelings toward family members, and a sense of responsiblity toward their community. It urges them to pursue their education through high school and beyond and tries to give them a real sense of future possibilities.

The program combines many of the elements that researchers and practitioners agree are found in successful intervention programs for high-risk youth. These include individualized attention, collaboration with other community agencies, staff with specialized training, social skills training that helps adolescents both resist negative peer influences and adopt health enhancing behaviors, peer support, the involvement of parents, career/life planning, and opportunities for community service.

By 1994, a significant proportion of the young people who received "I Have a Future Services" showed improvement on several measures of success, compared to a control group.
The Corporation has worked with Meharry Medical College in developing the program, and Meharry has been responsive to recommendations for ways to improve the research design and the curriculum. The Meharry team has courageously and thoughtfully tackled an important and difficult problem. "I Have a Future" should have useful lessons to impart to others attempting to enhance the life options of young people caught in adverse circumstances.

1 The February 3, 1992 Carnegie report which covers data collected from October 1987 through January 1989 gives the participation analyses for subjects who completed the baseline (Time 1) and the Time 2 surveys. At that time, two pregnancies were reported among those in the active participant group compared with 43 pregnancies reported in the low-level and comparison site groups.

By April of 1992, it was discovered that one of the pregnancies, allegedly caused by a male participant, was in fact a pregnancy caused by a male who was not participating in the program. (The pregnant female was not a program participant.) The other pregnancy has always caused confusion and is currently counted in the most recent evaluations distributed about the program. However, it has never been known if the female involved became pregnant while she was a program participant.

2 The April 13, 1992 final narrative report to the William T. Grant Foundation includes pregnancy information at baseline (Time 1), Time 2, and Time 3. It reveals significant differences between groups for numbers of pregnancies between baseline and Time 3. Active participants reported no pregnancies as compared to low-level participants and comparison site youth who reported a total of 59 pregnancies.

3 The final evaluation report in 1994 examines the effects of the program at the neighborhood level and covered data collected from October, 1987 through May, 1991 (Time 1, Time 2, and Time 3). Active

participation was defined as participation in at least 15 sessions of core models. Ninety youth were identified as active participants. There were 59 known pregnancies among the comparison site youth and only one known pregnancy among the active participants. This low level of involvement with a pregnancy among active participants could be accounted for by age. The low level of involvement with a pregnancy was not significantly different when baseline differences between the groups were covaried.

At the neighborhood level, intervention site youth had higher scores on pregnancy risk behavior than comparison site youth, however, this difference is primarily due to more active program participants using condoms more often than birth control pills versus the comparison youth using birth control pills more often than condoms. We realize that the use of condoms is a better method of STD prevention than birth control pills, but a poorer method of pregnancy prevention.

4 There were statistically significant differences between groups in a number of areas. Program participants and youth in the intervention neighborhood had higher self-esteem, a stronger sense of responsibility for family and community, sexual and contraceptive knowledge, and higher psychosocial maturity. More importantly, they believed they had more life-options (i.e., educational opportunities).

Lorraine,

I have included the write-up of the analyses that I have conducted today. I wrote up the change in status as well in case you want to use it. I have also included the grant to AHCPR as well as relevant correspondence. I chose to include all correspondence, memoranda, etc. which indicated Dr. Foster's involvement in the process. "Pink sheets" are included (although they are now white) as well as my answers to the questions that the site visit team posed. The letter to the grant officer indicating our decision not to resubmit is included as well. I think there is additional stuff. Send to Kassebaum what you see fit.

I have also included the a copy of the printout of the analyes that I ran, with notes written throughout. Good luck!!!

Shelton (& the little marachino cherry)

P.S. I've enclosed a copy of the W.T. Renewal Grant, although I expect you have a copy of that.

P.P.S. Dr. Foster needs to emphasize that both the program and the evaluation were essentially in a pilot stage at the time. The data, as you say, are cautiously optimistic. It would be inappropriate, however, to place too much emphasis on the evaluation either as an indicator of major success or lack of success. Basically, Nancy Kassebaum & Friends need to get a grip!

The following analyses are on the same variable as reported in the 1992 (?) report; however, I can't run the exact same analysis as before because I no longer have the variable that defined participation level using T2 criteria. I had to use the participation group criteria established at the end of the evaluation period. Some youth will have switched between active and low-level participation and vice versa. I don't expect this is a substantial number, however. Also, these analyses do not include subjects who gave answers at different time periods that were logically inconsistent. Additionally, subjects have been removed who were actually too young at baseline, too old, didn't actually live in the targeted sites, or turned out to be different people at the different assessment periods. Some of these subjects would have been included in the earlier analyses. This is the primary reason for the slight changes in percentages in the following analyses from the previous ones. Some subjects, of course, were not included due to missing data on this variable.

A significant difference between participation groups continues to exist on reported frequency of sexual intercourse among adolescents who have had sexual intercourse, $\chi^2(4)=14.04$, $p<.01$. The primary source of this significant difference is due to the comparison site youth reporting higher levels of frequent sexual activity and the low (or no-) level participants reporting higher levels of "sometimes" than expected. Active participants were not significantly different than expected (although somewhat more likely to indicate "rarely or not sure").

Level of Sexual Activity	Active	Low-Level	Comparison
Never, Rarely, Not sure	57.1% (n=16)	43.3% (n=61)	39.7% (n=27)
Sometimes	32.1% (n=9)	39.0% (n=55)	23.5% (n=16)
Frequently	10.7% (n=3)	17.7% (n=25)	36.8% (n=25)

Change in Sexually Active Status

Chi-square analyses were conducted to compare groups on change in sexual status (i.e. from never had sex to had sex) across the three data collection periods. Only subjects who indicated they had not had sex at T1 or T2, depending on the time frame being considered, were included in the analyses.

Between T1 and T2, there was a significant difference in status by group, $\chi^2(2)=6.68$, $p<.05$. This difference was due to the comparison site youth having fewer youth change status than expected. Active and low-level participants had changes in

status that were not significantly different than expected. Between T2 and T3, there were no significant differences in status between the three groups. Between T1 and T3, there was a significant difference in change in status, $\chi^2(2)=10.26$, $p<.01$. The difference was due to the comparison site youth and the low-level participants. There were a greater number of low- (or no-) level participants who changed status than expected and a fewer number of comparison site youth. Active participants were not significantly different from the expected.

Change in Status Between T1 and T2 by Group

Status	Active	Low-Level	Comparison
No Change	51.9% (n=14)	63.1% (n=82)	74.4% (n=90)
Changed	48.1% (n=13)	36.9% (n=48)	25.6% (n=31)

Change in Status Between T1 and T3 by Group

Status	Active	Low-Level	Comparison
No Change	33.3% (n=8)	32.6% (n=29)	54.7% (n=58)
Changed	66.7% (n=16)	67.4% (n=60)	45.3% (n=48)

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May 5, 1995

Dr. Lorraine Greene
"I Have a Future"
Meharry Medical College
1005 D.B. Todd Blvd
Nashville, TN 37208

Dear Dr. Greene,

I wanted you to see copies of the enclosed letters I sent to both Dr. Foster and to members of the US Senate. I'm sure you and your staff are also feeling the stress of the Surgeon General nomination process. Your program has an excellent reputation out here in California and we are honored to be a small part of it.

Sincerely,

Steven Bignell
Publisher

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May 5, 1995

Dr. Foster
c/o "I Have a Future" Program
Meharry Medical College
1005 D.B. Todd Blvd
Nashville, TN 37208

Dear Dr. Foster,

My name is Steven Bignell and I am publisher at Journeyworks Publishing in Santa Cruz, California. We publish the pamphlets that were displayed by Senator Dodd at your Senate Labor and Human Relations Committee "interrogation" on May 2nd and 3rd. My staff and I were at first proud when Senator Dodd held up our abstinence pamphlets as examples of your "I Have a Future" current program efforts, and then horrified to see their recent publication date used against you.

I've been in family planning and health education for over twenty years, first as Education Director for Planned Parenthood and later as co-founder of ETR Associates, a national health education organization. I left ETR last August to start a new health education publishing group. We are focusing on the same two areas that I know you are interested in: young people and the elderly.

I have long known of and admired your work with the "I Have a Future" program. We need more programs that take a wholistic approach to helping young people improve their lives.

Attached is a copy of a letter that I sent to members of the Senate Labor and Human Relations Committee and to other key members of the Senate. Our entire staff is behind your nomination for Surgeon General and we wish you the best of luck.

For your information, I've enclosed samples of a variety of our pamphlets. We are currently working on the development of four more abstinence pamphlets for the fall, including one aimed specifically at boys. In a few months, when they are ready for outside review, we would be honored if you would be willing to review them.

Best Wishes,

Steven Bignell
Publisher

cc. Dr. Lorraine Greene

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May 5, 1995

Senator Christopher Dodd
444 Russell Senate Office Building
Washington DC 20510

re: Foster Nomination for Surgeon General
and abstinence pamphlets

Dear Senator Dodd,

Enclosed are original copies of the four abstinence pamphlets you distributed during the May 2nd Senate Labor and Human Resources Committee hearings on the nomination of Dr. Foster for Surgeon General. **I am the publisher of all four pamphlets.**

The controversy about their publication and order date to me is disingenuous. I have long known Dr. Foster to be a strong advocate for abstinence and teen pregnancy prevention programs. When these pamphlets were first published in January of this year, I immediately requested my staff to send copies to his program because I knew they would be interested in seeing them. That his program immediately purchased and began using them to me is a positive, not negative, reflection of their concern and interest in keeping their program up-to-date. Certainly Dr. Foster's program has long used a variety of abstinence pamphlets--to attempt to undermine Dr. Foster by complaining that his programs are now using newly published ones with a 1995 copyright is ridiculous. It makes complete sense that the "I Have a Future" program would send the committee their most current and best materials. It is <u>good management</u> that Dr. Foster's program continues to change even while he is on sabbatical.

Leadership, wisdom and caring are probably the most important criteria for Surgeon General and Dr. Foster clearly represents all three. I strongly support the nomination of Dr. Foster for Surgeon General.

I would ask that you distribute the enclosed letters/samples to members of the Senate Labor and Human Relations Committee. I am also sending copies to other key Senate leaders. Thank You.

Sincerely,

Steven Bignell
Publisher

P.S. If you need additional copies, please feel free to call.

Table 4

Means and Standard Deviations for Participation in Activities Between Baseline and Wave 2 Data Collection by Participation Group for Subjects Tested at all Three Data Points

Activity	PARTICIPATION GROUP				
	Active (n=65)		Low-Level (n=665)		
	X	SD	X	SD	t
Alcohol and Drug Module	6.76	7.00	0.37	1.13	5.22***
Prosocial Skills Module	1.94	1.66	0.01	0.09	6.69***
Family Life Education	7.91	7.70	0.60	1.05	5.45***
Entrepreneurship	8.30	6.46	0.18	1.04	7.19***
Tutoring	13.33	14.27	1.60	3.90	4.71***
CHARM/MATURE	5.18	4.78	0.34	0.95	5.79***
Dance	4.45	7.67	1.18	3.84	2.37*
Karate	1.12	3.15	0.37	1.23	1.36
Job Readiness	1.27	3.21	0.14	0.43	2.02
Sports Activities	5.21	3.19	0.69	1.79	7.81***
Peer Counselor Activities	4.48	5.71	0.06	0.27	4.45***
Recreational Field Trips	8.82	4.73	1.41	1.78	8.83***
Educational Field Trips	6.45	5.44	0.72	1.61	5.99***

Note: T-tests were conducted using separate variance estimates due to significant differences between groups on variances.

*p<.05

***p<.001

Outcome Analyses Between Baseline and Wave 2

The next set of analyses examined the differences between the two participation groups and the comparison site youth on pregnancy and reproductive behavior. The first analysis involves the number of youth who either cause or experience a pregnancy between baseline and Wave 2. Table 5 reports the number of youth in each group who had one and two pregnancies within that time period. There were no significant differences between the groups on this variable; although, within the active participant group only two pregnancies occurred as compared to a total of 43 pregnancies that occurred in the other two groups combined. Ten youth in the low-level and comparison site groups experienced more than one pregnancy within that time period. Although not statistically significant, these results are promising enough to encourage continuation of the IHAF program, with its resultant refinement.

Table 5

Number and Percentages of Youth Experiencing or Causing Pregnancies Between Baseline and Wave 2 by Group

Group Participation	Number of Pregnancies		
	0	1	2
Active	37 (94.9%)	2 (5.1%)	0 (0.0%)
Low-Level	189 (91.7%)	13 (6.3%)	4 (1.9%)
Comparison	160 (90.9%)	10 (5.7%)	6 (3.4%).

In the second analysis, a composite variable representing pregnancy risk was the dependent variable. This composite is a multiplicative score combining frequency of sexual intercourse, frequency of birth control use, and adequacy of most frequently used form of contraception. The possible range for this variable is 0 to 100. Higher scores indicate greater risk. For those who have never had sexual intercourse, pregnancy risk is scored as 0.

The three groups varied significantly on age, $F(2, 442)=15.91$, $p<.001$. The mean age for the active participation group at the Wave 2 data point was 13.03; for the low-level participation group, mean age was 14.40, and for the comparison group, mean age was 13.33. The groups also varied on sex, $\chi^2(2)=6.52$, $p<.05$ (See Table 6 for a breakdown of subjects by sex and participation group). Age and sex were also related to the composite pregnancy risk variable. Age was correlated .18($p<.001$) with pregnancy risk. Males had an average pregnancy risk score of 15.08 while females had an average score of 7.50. This difference was statistically significant, $t(427)=3.84$, $p<.001$. Because age and sex were related to pregnancy risk and the three groups varied significantly on age and sex, these two variables served as covariates in the analysis. A one-way analysis of covariance was conducted. There were no significant differences between the three groups on pregnancy risk at either baseline or at Wave 2. (See Table 7 for the means standard deviations, and adjusted means).

Table 6

Gender by Group Sample Sizes

Group	Male	Female
Active	20	19
Low-Level	91	127
Comparison	103	87

Table 7

Means, Standard Deviations, and Adjusted Means for Pregnancy Risk at Baseline and Wave 2

Group	Pregnancy Risk Baseline			Pregnancy Risk Wave 2		
	X	SD	Adjusted X	X	SD	Adjusted X
Active	5.10	11.68	6.94	11.37	20.65	12.30
Low-Level	8.92	18.65	7.91	11.51	19.47	10.64
Comparison	8.49	20.08	7.65	10.67	22.33	10.60

Specific reproductive behaviors were examined next through chi-square analyses and analysis of variance. These behaviors included (1) whether or not they had had sexual intercourse, (2) frequency of sexual intercourse, (3) frequency of birth control use and (4) adequacy of contraception. For those who had not had sex at the baseline survey, the number of youth who had had sexual intercourse by the Wave 2 survey was compared across the three groups. For those who first had sexual intercourse in the time period between Baseline and Wave 2, the first time they used contraception was another dependent variable.

The only baseline difference between the groups was on frequency of sexual intercourse, $\chi^2(4)=11.55$, $p<.05$. The active participants who had had sexual intercourse were less likely to report having sex frequently (See Table 8). There were no other baseline difference between the groups on this set of variables.

Table 8

Percentage of Sexually Experienced Subjects Indicating That They Have Sexual Intercourse Never, Sometimes, or Frequently at Baseline

Group	Never	Sometimes	Frequently
Active	71.4%	28.6%	0.0%
Low-Level	54.1%	35.1%	10.8%
Comparison	38.8%	28.6%	32.7%

For the Wave 2 analyses, there was a significant difference between the three groups on whether or not they had had sexual intercourse, $\chi^2(2)=9.08$, $p=.01$. Sixty-one percent (60.5%) of the active participants reported having had sexual intercourse; 55.6% of the low-level participants reported having had sexual intercourse, and 42.1% of the comparison site youth reported having had sexual intercourse. The intervention site youth as compared to the comparison site youth appear to have engaged in sexual intercourse more. There also continued to be a significant difference between the groups on how frequently the sexually active youth reported having sex, $\chi^2(6)=13.44$, $p<.05$. Those youth living in the comparison site were more likely to report having sex frequently (See Table 9). There were no other significant differences between the groups on reproductive behavior.

Table 9

Percentage of Sexually Experienced Subjects Indicating That They Have Sexual Intercourse Never, Sometimes, or Frequently At Wave 2

Group	Never	Sometimes	Frequently
Active	54.5%	31.8%	39.7%
Low-Level	43.2%	39.0%	23.1%
Comparison	39.7%	23.1%	37.2%

For those youth who had not had sex at the Baseline survey, a chi-square analysis was conducted comparing the three groups on how many of these youth reported having had sex by the Wave 2 survey. There was a significant difference between the groups on this range in status, $\chi^2(2)=7.93$, $p<.05$. More of the active participants (51.6%) were likely to report having first had sex between the baseline and the Wave 2 surveys than the low-level participants (39.6%) and the comparison site youth (27.8%). Although it was not a significant difference, there were fewer active participants (17.9%) who reported having had sex at the baseline survey than the low-level participants (34.7%) and the comparison site youth (29.3%). thus, there was a greater opportunity for change among the active participants than the other two groups. This may account for the significant difference in change in status.

For those youth who did engage in first intercourse during the period between baseline and Wave 2, an analysis of variance was conducted with the time period between first intercourse and first use of contraception as the dependent variable. There were no significant differences between the groups on this variable. On average all three groups report using birth control for the first time between 9 and 12 months following first intercourse.

There is an additional evaluation concern made by Reviewer #2 that needs to be addressed separately. Reviewer #2 comments upon the differential attrition that occurred between the baseline data collection and the second wave of data collection. There are several points that need to be made regarding this issue. First the greatest attrition occurred between baseline and Wave 2.

During that period, the program was in its earliest, planning, and developing stages. The attrition that occurred during this time period refers to the data collection sample and not to the active participants in the program. The majority of the subject lost were never involved with the program or had very limited involvement. The majority of the active participants have been followed for the three time periods. Second, the differential attrition occurred in a similar fashion across all the sites. It appears that the same mechanisms that led to attrition applied at both the intervention sites and the comparison sites. Concerns about the generalizability of the results to those youth who could not be followed may apply due to the differential attrition. However, the sample was not a randomly selected sample; therefore, generalizability has always been an issue. The issue of generalizability will apply to any situation in which subjects were not randomly chosen from a population. Caution will be taken when interpreting the results of the evaluation so that over-generalization does not occur.

The more important concern regarding evaluation the effectiveness of the intervention is whether the attrition reduced the comparability of the intervention site youth and the comparison site youth. The results reported in the proposal indicated that there were no interaction effects between site and follow-up group on the dependent variable. These results indicate that the attrition affected the intervention and comparison sites fairly equally. Consequently, the youth who could be followed at the intervention sites are similar to the youth who could be followed at the comparison sites.

Program Issues

There appears to be a misconception that health services are only provided by the nurse/midwife practitioner and the service provider is only working a total of two one-half days. Health services are also provided by male and female medical students. We also have a registered nurse who volunteers one afternoon a week to assist in the clinic coordination. In addition, a full range of services are provided to males by the nurse/midwife. It should not be assumed that the nurse/midwife practitioner would not be able to provide services to males. It is not outside of the norm for young males to seek advise from senior women who are considered informed elders in an African-American community. Ms. Vassal has over 30 years of experience working within the Meharry/Hubbard Hospital health care system. Our referral system is well structured and utilizes the full range of consultative services available at Meharry Medical College.

There was some concern about the number of hours the clinic staff provide services. First, the nurse/midwife works twenty hours per week, not eight hours as suggested by Reviewer #1. Most of the participants attend school during the day and clinic services are available when most needed (after 3:00 pm). The nurse/midwife practitioner is available four days per week. Second, we view clinic staff as a part of the multi- disciplinary team. The clinic coordinator attends staff and organization meetings in addition to client staffings which are held twice per week. Third, as coordinator, the nurse/midwife arranges and coordinates services as needed from the various hospital departments. Fourth, the nurse/midwife practitioner co-leads several sessions within the Family Life Education Module.

It was suggested by one reviewer that door-to-door leafleting was the major

recruitment mechanism. This was a major recruitment strategy by the research team, however, youth are self-referred into the program, referred by parents, peers, other agencies including the schools and Juvenile Court. Currently, the Nashville/Davidson County Juvenile Court is utilizing the program as an alternative to incarceration for first time offenders. IHAP staff alternate on the Nashville/Davidson School Board's Attendance and Review Board and youth are oftentimes flagged for enrollment in the program. Most importantly, many youth have referred their friends to the program. Our older high school participants have frequently asked staff to speak at their high schools about the program and issues surrounding teenage pregnancy. This has served as endorsement by participants.

Finally, it is a misconception that groups are the only mode of service delivery. We do provide individual counseling, as we have from the program conception, and view it as an important component of the program. The case management model requires that each counselor completes at least one individual counseling contact with their designated clients on a monthly basis. Individual counseling is provided on an as needed basis. In addition, when clients require more intensive counseling, counselors work collaboratively with other service providers in providing the necessary continuum of care. However, we are aware that group activities among youth who live in close proximity is an excellent mechanism to address negative peer pressure and more importantly, an arena to practice prosocial skills with peers. With the group emphasis it is necessary for preadolescents and adolescents to participate in a basic Prosocial Skills module in order to develop appropriate, supportive group behavior skills.

We disagree that the "diffuse offering of programs may dilute the effort to focus on adolescent pregnancy prevention" as suggested by Reviewer #1. We believe that teenage pregnancy must be addressed in its broader psychosocial context. Completion of school, employability, the ability to be alcohol and drug free, the ability to handle interpersonal conflict, the value of helping others, and sexual responsibility are all interrelated. Experts such as Joy Dryfoos and the Human Services Secretary's Panel on Teen Pregnancy Prevention all conclude that a multifaceted community approach is needed. As Reviewer #2 indicated, "there has been much rhetoric about he need for comprehensive, early, continuous and individualized interventions for youth, few programs incorporating these characteristics have actually been created. Meharry is correct in arguing that it must have been one of the first." We understand there is a need for a thorough evaluation to refine the program and determine if one needs "to do it all" to make a significant impact in young peoples' lives. We are attempting to find out what works but in our attempt we must address the pertinent problems facing our youth. It costs money to successfully accomplish our mission. With the assistance of the Technical Assistance Team, we now have a set of modules that have been refined and will effectively address the needs of participants. We are now in the position to determine their effectiveness. It will be such a loss if our efforts thus far are now truncated.

During the next two years we would like the opportunity to further determine the program's effectiveness by providing the services that we currently provide with a minimum of 200 participants. The staff will continue to provide group and individual health related services. As with any program that uses a case management approach, this project is labor intensive with a

number of services provided each day (See Appendix A for a copy of January 1992 Monthly Schedule of Activities). Community networking and collaboration will continue, especially with the local school system and youth correctional system. We are currently attempting to be an alternative school placement for young people living in the area. We have a number of participants who have been expelled or are not attending school and would like to be able to provide educational services since there are limited alternative school placements in Nashville.

We agree that adolescent involvement in programming can be enhanced. However, during 1990 an adolescent advisory council was formed and met sporadically during the past two years. When they did convene, they were very helpful and we agree that the youth advisory council needs to be better institutionalized. Outside of the advisory council, youth provide feedback on individual module sessions, program activities, site plans and incentive activities. Youth recommendations are incorporated into the ongoing program planning.

Currently, adolescents are actively involved in the Ujima Board, a disciplinary board composed of adolescents, staff and two community representatives (presidents of the public housing resident associations). Adolescents function as peer reviewers on a monthly rotation.

Volunteer support has been most helpful. As previously indicated, the volunteers have provided tutorial services, CHARM and MATURE module co-leadership, leadership in special cultural projects, supervision on field trips and recreational leadership. We receive volunteer support from several of the local universities. It was recommended by a reviewer that we establish linkages with other agencies with volunteers. We are a member of a mentoring coalition which attempts to share information on how to attract and maintain mentors for at-risk adolescents. This coalition is headed by the Buddies of Nashville. The dilemma is that these agencies too are struggling to maintain volunteers. The State Department of Mental Health and Retardation Volunteer Coordinator has volunteered to train and assist our public health education intern in formalizing our volunteer program. Currently, volunteers participate in an orientation seminar and additional training as needed, however, our tracking system and volunteer formalized recruitment program needs further development.

In response to the question of why are we considering replicating the program in Memphis and not Nashville, we would like to replicate in other housing developments in Nashville, however, currently, do not have the funding. The Kaiser Corporation has a special project targeting youth and families in North Memphis and there is no adolescent program there currently instituted to deal with issues of adolescent pregnancy. Subsequently, the Kaiser Foundation is interested in the feasibility of a similar program for adolescents in the North Memphis area.

Financial Resources

I have attached a list of our current funding resources (See Appendix B).

The following corporations, foundations and individuals have received proposals requesting support for the "I Have A Future" Program:

Metropolitan Life Insurance
Adolph Coors Company
Beatrice Foundation
Buffett Foundation
Clorox Company
Bill and Camille Cosby
The Harris Foundation
William and Flora Hewlett Foundation
William T. Grant Foundation
The Joyce Foundation
Henry J. Kaiser Family Foundation
Mattell Foundation
North Carolina National Bank
Pew/Rockefeller health of the Public
Public Welfare Foundation
The Skillman Foundation
The Tennessean
Toys R Us Company
UPS Foundation
Whirlpool Foundation

Additionally, the "I Have A Future" Program has been submitted to the Alma Haas Milham Trust for possible support. Meharry Medical College is one of four beneficiaries of this trust.

Currently, we are preparing several proposals for federal funding. First, we are submitting a proposal to the National Institute of Health for the Minority Youth Health Research: The Development and Evaluation of Interventions due May 15, 1992. They are interested in strategies for decreasing unwanted pregnancies, sexually transmitted diseases, violence-related injuries and death among minority youth 10-24 years old. We will also be submitting a proposal to the Department of Health and Human Services Office of Treatment Improvement of ADAMHA. They are interested in funding comprehensive programs for critical populations-adolescents and have funded similar programs in Chicago with a primary emphasis on alcohol and other substance abuse.

We are submitting a proposal to the National Institute of Health Agency for Health Care Policy and Research in March 1992 for a two-year grant for the continuation of the evaluation. The decision will be made within 90 to 120 days of submission.

We are also responding to a request for proposals by the National Institute of Mental Health (NIMH), Perpetrators of Violence Research Program due October 1992. The focus of this grant submission is to conduct an analysis of the conflict resolution strategies and values of adolescents residing in high crime communities. No intervention will be evaluated. A longitudinal analysis of responses to violence exposure, and conflict resolution values and attitudes will be conducted. We will also be submitting a proposal to the Office of Minority Health, African-American Male Initiative this Spring 1992. The major emphasis of this initiative is the evaluation of the implementation of the IHAF Conflict Resolution Module with new IHAF participants and other Nashville community agencies. We are currently contacting the Office of Juvenile Justice and Delinquency Prevention for information about their upcoming request for proposals.

We are hopeful that the State of Tennessee funding for the Parent Empowerment Program and Latchkey Program will continue. However, Tennessee like many other states experienced draconian fiscal constraints. The Pew and Rockefeller Health of the Public Program will have a request for proposals in the spring/early summer and we project that they would be a major source of funding for program replication given their interest in medical schools working in communities.

I hope that we have been able to answer your questions. We believe that we are providing a valuable and difficult service to the community, positively influencing young people's lives and contributing to the small body of knowledge available as to how to intervene in the lives of poor, inner-city youth who are considered at-risk for early pregnancy, alcohol/and other substance abuse, delinquency and school dropouts.

If you have any questions please do not hesitate in contacting me. Gloria, thank you and the Carnegie Corporation for all of your support.

Sincerely,

Lorraine

Lorraine Williams Greene, Ph.D.
IHAF Deputy Director

LWG/ajl

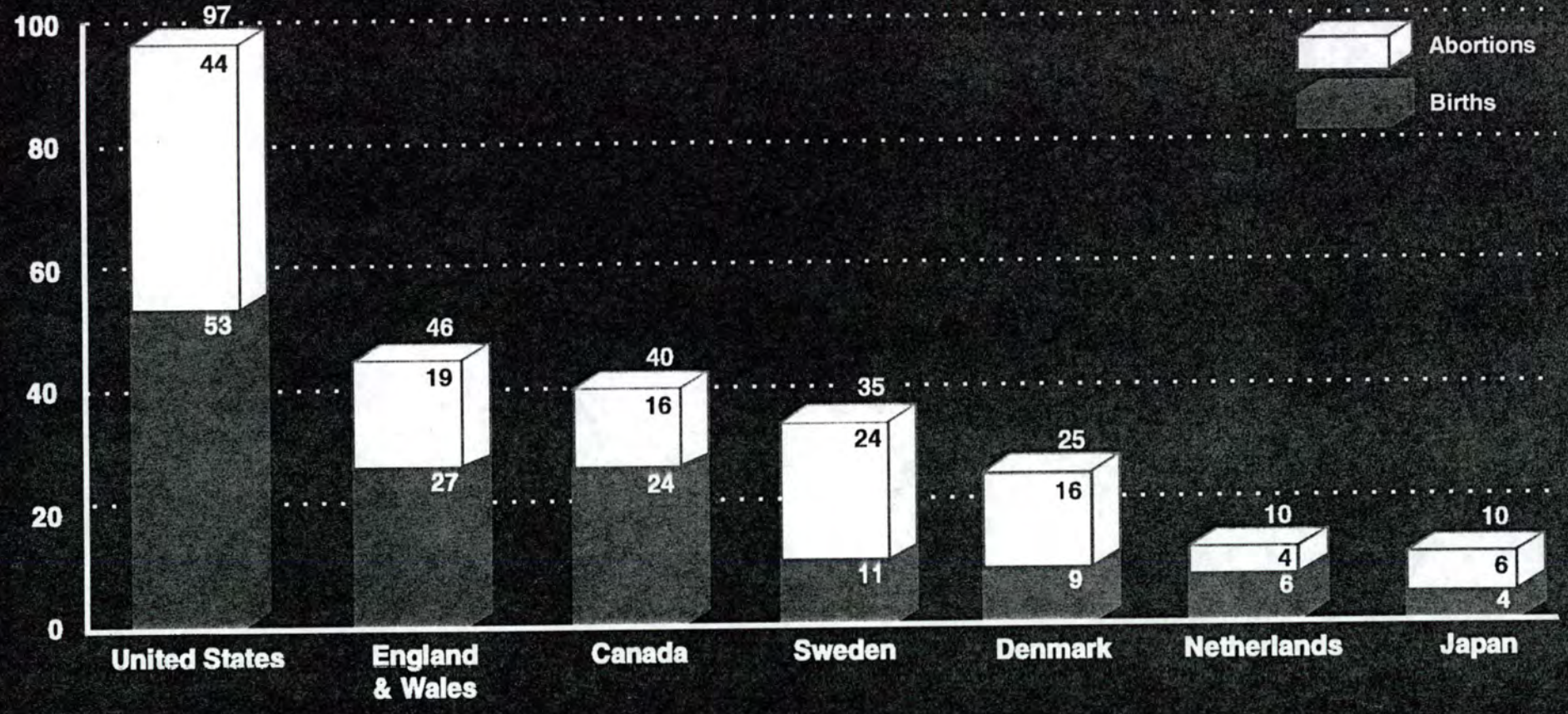
cc: Henry W. Foster, M.D.
Dean, School of Medicine

Washington Hill, M.D.
Chairman, Dept. of OB/GYN

An International Perspective on Teenage Pregnancy

The United States, compared with many other industrialized countries, has high adolescent pregnancy rates.

Pregnancies per 1,000 women aged 15-19 and younger, 1988



Sources:
United States: Birthrate–National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1988," *Monthly Vital Statistics Report*, Vol. 39, No. 4, Supplement, 1990, Table 3. **Abortion rate**–S.K. Henshaw, "Abortion Trends in 1987 and 1988: Age and Race," *Family Planning Perspectives*, 24:85-86, 1992, Table 1, p. 69.

England and Wales: Number of births–Office of Population Censuses and Surveys, "Birth Statistics, 1988," London, 1990, Table 3.1, p. 28. **Number of abortions**–Office of Population Censuses and Surveys, *Abortion Statistics, 1988*, Series AB, No. 15, London, 1989, Table 3, p. 6. Total women 15-19–Office of Population Censuses and Surveys, *Key Population and Vital Statistics, London, 1990, Table A1, p. 83.*

Iceland, Norway, Sweden, Finland and Denmark: Birthrates and abortion rates–Nordic Medico-Statistical Committee, *Health Statistics in the Nordic Countries, 1986-1991*, Copenhagen, 1991, Table 5.a, p. 121.

Canada: Birthrate–Statistics Canada, *Selected Birth and Fertility Statistics, Canada, 1921-1990*, Ottawa, 1993, Table 10, p. 46. **Abortion rate**–Statistics Canada, "Therapeutic Abortions, 1988," *Health Reports*, 2(1), Supplement, Ottawa, 2990, Table 6, p. 25.

Netherlands: Birthrate–Council of Europe, *Recent Demographic Developments in Europe, 1991*, Strasbourg, 1991, Table NL, p. 158. **Number of abortions**–J. Rademakers, *Abortus in Nederland 1987-1988*, Stimezo-Onderzoek, Utrecht, 1990, Tables 2.1 and 2.2, pp. 8 and 10. **Total women 15-19**–United Nations, *Demographic Yearbook, 1989*, New York, 1991, Table 7, p. 192.

Japan: Birthrate–United Nations, *Demographic Yearbook, 1989*, New York, 1991, p. 321, Table 11. **Abortion rate**–Kuno Kitamura, "Every Child Should Be a Wanted Child," *Integration*, Dec. 1991, Table 2, p. 42. **Total women 15-19**–United Nations, *Demographic Yearbook, 1989*, New York, 1991, Table 7, p. 184.

Note: Pregnancies are the sum of births and abortions and do not include miscarriages. For Japan, the numerator is births and abortions among all women aged 19 and younger in all other cases, the numerator is births and abortions among women aged 15-19. The denominator is women aged 15-19.

"I Have a Future" Abstinence Language Found in the Curriculum

Here are highlights of abstinence language from the "I Have a Future" program's curriculum. The additional 20 pages represent numerous references to abstinence in the program.

- In the Staff Manual for IHAF's Family Life Module, the very first mention of sexually responsible behavior for teens states that the number one way is abstinence: "Responsible sexual behavior is defined as abstinence..." Staff are later instructed to teach teens how to say no and stand up for their beliefs:

  > "There is no reason for adolescents to feel different or strange if they say 'No'. Because of peer pressure, adolescents need to master the assertive communication skills of knowing how to say 'No'. They may often worry about hurting friends' feelings if they say 'No'. Hurt feelings go away but unintended pregnancy and a baby don't go away."

- Another Staff Manual -- the Prosocial Skills Module -- also teaches abstinence as a part of its message of responsibility and self-determination:

  > "Emphasize that when we choose tough values such as abstinence, our choice may not be the most popular choice. We are likely to receive little positive reinforcement of these choices. Therefore, we must develop the capacity to praise ourselves for courage in living the values we believe are best for us."

- The training manual for Meharry Medical College residents, who provide health services in the program, teaches residents how to counsel the teens against sexual activity and to "Legitimize [the] decision not to have sex..."

- Brochures distributed to the teens state that:

  > "[...if I decide not to have sex?] Congratulations!! Contrary to rumor, so have lots of other teens. It's not so hard to say "NO" and still remain friends if you are careful not to hurt the other person. For example you might say:..."I don't believe in having sex before marriage. I want to wait."

- And a game used by the program instructs teenagers that:

  > "Sexual abstinence is important because it provides an opportunity to practice self-control, self-respect, respect for others, and other important moral and religious values. It decreases the occurrence of teen pregnancy and sexually transmitted diseases and increases your opportunity to complete educational and vocational goals."

"I HAVE A FUTURE":
USING ABSTINENCE TO PREVENT TEEN PREGNANCY

An examination of *"I Have A Future's"* teaching modules -- as well as the many supplemental materials [brochures, videos, games, posters] they utilize -- evidences the strong abstinence message that is integral to the program. IHAF promotes abstinence to prevent teen pregnancy in several ways:

- First, by stressing the value of abstinence and explaining *why* it is so important.
- Second, by involving the family and community in promoting this value.
- Most important, the program does not just say the word "abstinence" a few times and leave it at that. IHAF devotes considerable time and effort to giving teens the tools they need to be responsible, to make good decisions and then stand up for what they believe in, and, most importantly, to resist social pressures to engage in sexual activity.

This compilation has been divided into the following categories:

I. IHAF'S CURRICULUM

A. FAMILY LIFE EDUCATION MODULE [Staff Manual]

Final Copyrighted Version; September 1994

Abstinence Message:

- *"Responsible sexual behavior is defined as abstinence or acting upon the decision to participate in sexual intimacy while maintaining a healthy body and exercising assertive family planning."* [p. 2]

- *"It is important for people to practice responsible sexual behavior. . . 1) Refrain from having sexual intercourse. . . However, it is best for children to postpone initiating sexual intercourse and other risky sexual behaviors beyond the early adolescent years."* [p. 2]

- Kujichagulia [Self-Determination] - *"...one needs to have Kujichagulia (Self-Determination) in order to cope with the negative peer pressure toward early sexual intercourse, and careless sexual activity."* [p. 58]

- *"Adolescents often have the impression that 'everyone is doing it'. Surveys show that more than half of all adolescents do indeed say 'No' to sex."* [p. 70]

- *"Discussion: `Encourage the participants to do their best to postpone having sex at an early age. Before making up their mind to have sex now or wait, they should ask themselves the following questions:*

  1. *"Can I take full responsibility for my actions?"*
  2. *"Am I willing to risk STDs, pregnancy, future infertility?"*
  3. *"Can I handle being a single parent or placing my child for adoption?"*
  4. *"Am I ready and able to support a child on my own?"*
  5. *"Can I handle the guilt and conflict I may feel?"*
  6. *"Will my decision hurt others? My parents? My friends?"*

  [p. 60]

- *"DECISIONS ABOUT SEX MAY BE THE MOST IMPORTANT DECISIONS ONE WILL EVER MAKE. SO, THINK BEFORE YOU ACT!"* [p. 60-1]

- One exercise is called the "STD Handshake." It asks the teens to pick an index card from a bag. Some say *"STDs"* and others say *"Abstinence."* The point of this exercise is that Abstinence is the only way to completely avoid the risk of Sexually Transmitted Diseases. [p. 65]

- ***"Young men and women can say 'no' and postpone sexual intercourse.*** *But, if they do intend to have sex, they must be informed of the possible consequences of sexual behavior. [If participants are not ready for the responsibility of parenthood, they must consider the various ways of acting sexually responsible.]"* [p. 58]

- *"There are two ways of exercising responsible sexual behavior. One can abstain from sexual intercourse or one can use contraceptives/condoms effectively."* [p. 75]

- *"In order to promote the value of sexually responsibility, it is critical that the community seeks to uplift this value in a unified manner.* [p. 32]

- *"Each participant is encouraged to discuss values around sexuality with their parents and/or other adults whose values are important to the participant."* [p. 32]

- *"Educate participants regarding responsible sexual decision-making."* [p. 11]

- *"The teenage years are a good time to assist others with child care responsibilities but not to take on the full responsibility of being a parent."* [p. 46]

- *"It is important to remember that the purpose of being a teenager is to finish the process of becoming an adult and not to create children before achieving adulthood."* [p. 53]

- **To show teenagers what having a baby can do to their lives, one of the exercises is a "*Job Interview for Parent.*" It discusses issues like financial resources, time required, emotional needs, etc. to try to convince teenagers** to postpone early sex and pregnancy until a more appropriate time. [p. 50]

Teaching Teens To Say No:

- *"There is no reason for adolescents to feel different or strange if they say 'No'. Because of peer pressure, adolescents need to master the assertive communication skills of knowing how to say 'No'. They may often worry about hurting friends' feelings if they say 'No'. Hurt feelings go away but an unintended pregnancy and a baby don't go away."* [p. 70]

- *"Goals: `Using assertiveness skills to avoid unwanted sexual behavior [and to insist that contraception be utilized.]'"* [p. 70]

- Motto: *"IF YOU DON'T STAND FOR SOMETHING, YOU CAN FALL FOR ANYTHING."* [p. 32]

- *"To provide participants with options for confronting pressure to do something that they are uncertain they want to do."* [p. 35]
- *"Definition of Assertive: `to exhibit confidence and adherence to decision despite others' opinion.'"* [p. 38]
- *"Example of an assertive technique is to `Use broken record technique (Keep repeating a simple* ***negative*** *response, don't provide excuses).'"* [p. 38]
- *"Emphasize that when a person feels good about him/herself, that person can express themselves openly, honestly, and assertively."* [p. 39]
- *"Remind participants that their purpose is to develop positive* ***assertive skills*** *for responding to pressure as an adolescent and an adult."* [p. 39]

B. FAMILY LIFE EDUCATION MODULE [Staff Manual][1]
November 1991

Abstinence Message:

- *"Responsible sexual behavior is defined as abstinence or acting upon the decision to participate in sexual intimacy while maintaining a healthy body and exercising assertive family planning."* [p. 3]
- **Kujichagulia [Self-Determination] -** ***"...one needs to have Kujichagulia (Self-Determination) in order to cope with the negative peer pressure toward early sexual intercourse, and careless sexual activity."*** [p. 58]
- ***"Adolescents often have the impression that 'everyone is doing it'. Surveys*** *show that more than half of all adolescents do indeed say 'No' to sex."* [p. 70]
- *"<u>Discussion:</u> `Encourage the participants that they should do their best to postpone having sex at an early age. Before making up their mind to have sex now or to wait, they should ask themselves these questions:*

  1. *"Can I take full responsibility for my actions?"*
  2. *"Am I willing to risk STD, pregnancy, future infertility?"*
  3. *"Can I handle being a single parent or placing my child for adoption?"*
  4. *"Am I ready and able to support a child on my own?"*
  5. *"Can I handle the guilt and conflict I may feel?"*
  6. *"Will my decision hurt others? My parents? My friends?"*

  [pp. 60-61]

[1]Many of these quotes also appear in the final [September 1994] version of the Family Life Module.

- *"DECISIONS ABOUT SEX MAY BE THE MOST IMPORTANT DECISIONS ONE WILL EVER MAKE. SO, THINK BEFORE YOU ACT!"* [p. 61]

- One exercise is called the "STD Handshake." It asks the teens to pick an index card from a bag. Some say *"STDs"* and others say *"Abstinence."* The point of this exercise is that Abstinence is the only way to completely avoid the risk of Sexually Transmitted Diseases. [p. 65]

- ***"Young men and women can say 'no' and postpone sexual intercourse. But, if they do intend to have sex, they must be informed of the possible consequences of sexual behavior. [If participants are not ready for the responsibility of parenthood, they must consider the various ways of acting sexually responsible.]"*** [p. 58]

- *"There are two ways of exercising responsible sexual behavior. One can abstain from sexual intercourse or one can use contraceptives/condoms effectively."* [p. 75]

- *"Educate participants regarding responsible sexual decision-making."* [p. 11]

- ***"The teenage years are a good time to assist others with child care responsibilities but not to take on the full responsibility of being a parent."*** [p. 46]

- ***"It is important to remember that the purpose of being a teenager is to finish the process of becoming an adult and not to create children before achieving adulthood."*** [p. 53]

- To show teenagers what having a baby can do to their lives, one of the exercises is a *"Job Interview for Parent."* It discusses issues like financial resources, time required, emotional needs, etc. to try to convince teenagers to postpone early sex and pregnancy until a more appropriate time. [p. 50]

Teaching Teens To Say No:

- *"There is no reason for adolescents to feel different or strange if they say 'No'. Because of peer pressure, adolescents need to master the assertive communication skills of knowing how to say 'No'. They may often worry about hurting friends' feelings if they say 'No'. Hurt feelings go away but an unintended pregnancy and a baby don't go away."* [p. 70]

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- Motto: *"IF YOU DON'T STAND FOR SOMETHING, YOU CAN FALL FOR ANYTHING."* [p. 32]

- *"To provide participants with options for confronting pressure to do something that they are uncertain they want to do."* [p. 35]

- *"Definition of Assertive: `to exhibit confidence and adherence to decision despite others' opinion.'"* [p. 38]

- *"Example of an assertive technique is to `Use broken record technique (Keep repeating a simple negative response, don't provide excuses).'"* [p. 38]

- *"Emphasize that when a person feels good about him/herself, that person can express themselves openly, honestly, and assertively."* [p. 39]

- *"Remind participants that their purpose is to develop positive assertive skills for responding to pressure as an adolescent and an adult."* [p. 39]

C. FAMILY LIFE EDUCATION MODULE [Staff Manual][1] September 1989

Abstinence Message:

- Suggests handing out pamphlet: *"Many Teens Are Saying No"*[2]

- ***"The Family Life Education Module is designed to help...generate attitudes and values positive toward contraception and abstinence."*** [1st page after course outline, no page #s]

- *"Deep love between close friends can exist without the presence of open or conscious sexual desire... Sex is not what makes a relationship work. Sharing thoughts, beliefs, feelings, and most of all, mutual respect, is what makes a relationship strong."* [Session IX]

- *"Sexual feelings may be expressed in a variety of ways, only one of which is sexual intercourse."* [Session IX]

- *"Decisions about sex may be the most important decisions you'll ever make. So, think before you act!"* [Decision-Making Handout]

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[2]This pamphlet -- produced by HHS in 1986 -- has been given to the Committee and is excerpted on pps. 10-11.

- *Should you have sex now or should you wait? Ask yourself these questions before making up your mind?*

  1. *"Can I take full responsibility for my actions?"*
  2. *"Am I willing to risk STD, pregnancy, future infertility?"*
  3. *"Can I handle being a single parent or placing my child for adoption?"*
  4. *"Am I ready and able to support a child on my own?"*
  5. *"Can I handle the guilt and conflict I may feel?"*
  6. *"Will my decision hurt others? My parents? My friends?"*

Teaching Teens To Say No:

- *"Let the youth know that it's okay to say 'no'. There is nothing wrong with saying it. Even more important, there is no reason for them to feel different or strange if they do say 'no'."* [Assertive Communication]

- *"Because of pressure from their friends (peer pressure) the youngsters need guidance in knowing how to say 'no'. Young people often worry about hurting friends' feelings if they say 'no'. Hurt feelings go away but an unintended pregnancy and a baby don't."* [Assertive Communication]

D. PROSOCIAL SKILLS MODULE [Staff Manual] October 1994

- *"Emphasize that when we choose tough values such as abstinence, our choice may not be the most popular choice. We are likely to receive little positive reinforcement for these choices. Therefore, we must develop the capacity to praise ourselves for courage in living the values we believe are best for us."* [p. 28]

- *"To provide a framework for adolescents to understand that to say 'no' is not abnormal but normal."* [p. 19]

- *"Emphasize the need to make your own decisions and to take responsibility for the outcome."* [p. 19]

- *"To assist participants in developing skills to resist group pressure."* [p. 28]

- *"To increase participants' positive refusal skills."* [p. 28]

- *"To teach participants how to look beyond the immediate benefits and consider the long-term consequences."* [p. 28]

- *"To assist participants in developing coping strategies when their peer group does not positively reinforce him/her for standing up for his/her beliefs."* [p. 31]
- *"To teach participants how to cope with group pressure."* [p. 33]
- Quote from Malcolm X: *'It is always better to form the habit of learning how to see things for yourself, listen to things for yourself, and think for yourself; then you are in a better position to judge for yourself.'* [p. 36]

E. PROSOCIAL SKILLS MODULE [Staff Manual][3] November 1991

- *"Emphasize that when we choose tough values such as abstinence, our choice may not be the most popular choice. We are likely to receive little positive reinforcement for these choices. Therefore, we must develop the capacity to praise ourselves for courage in living the values we believe are best for us."* [p. 28]
- *"To emphasize that even when you make a decision, you are not always totally locked into that decision if you have reservations."* [p. 19]
- *"To provide a framework for adolescents to understand that to say 'no' is not abnormal but normal."* [p. 19]
- *"Emphasize the need to make your own decisions and to take responsibility for the outcome."* [p. 19]
- *"To assist participants in developing skills to resist group pressure."* [p. 28]
- *"To increase participants' positive refusal skills."* [p. 28]
- *"To teach participants how to look beyond the immediate benefits and consider the long-term consequences."* [p. 28]
- *"To assist participants in developing coping strategies when their peer group does not positively reinforce him/her for standing up for his/her beliefs."* [p. 31]
- *"To assist participants in confronting those feelings which may prompt them into responding impulsively and giving in to the group."* [p. 31]

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[3]Many of these quotes also appear in the final [October 1994] version of the Prosocial Skills Module

- *"Emphasize that no one has to fall prey to persuasion. By getting the facts, one can make their own decisions and define for themselves what they will do and who they will be."* [p. 33]

- Quote from Malcolm X: *'It is always better to form the habit of learning how to see things for yourself, listen to things for yourself, and think for yourself; then you are in a better position to judge for yourself.'* [p. 36]

F. "I HAVE A FUTURE" PROGRAM EVALUATION: Renewal Grant Proposal to W.T. Grant Foundation April 1991

- One Goal [Hypothesis] of The Program: *"Active participants will delay the initiation of sexual intercourse longer than youth who do not participate and comparison site youth."*

II. BROCHURES

As Dr. Foster mentioned during his hearings, since its inception "I Have A Future" has distributed brochures to the teenagers -- and even to their parents -- that have a strong abstinence message. A variety of brochures have been used over the years, as can be seen below. IHAF staff is always looking for new brochures and teaching materials to catch the teens attention and get the message out in different ways.[4]

A. "MANY TEENS ARE SAYING `NO'" [*U.S. Department of Health and Human Services*, 1986][5]

- *"DON'T BE FOOLED into thinking most teenagers are having sex. THEY AREN'T!! There's a lot to know before you say 'yes' to having sex."*
- *"Face it! Sex for young people is pretty risky!"*
- *"Sexual feelings can be pretty strong! So think before you act. Think about your future. Think about the consequences. In other words,* ***think about yourself!*** *Ask yourself, 'Am I ready to have sex now?' To answer this question you need to decide which is more important to you --* ***giving in to*** *your sexual feelings or being true to your inner feelings that may be telling you to 'wait.'"*
- ***"There's a lot to know before making your decision about whether or not to say "yes" to sex:***
  - -- *Is having sex in agreement with my own moral values?*
  - -- *Would my parents approve of my having sex now?*
  - -- *If I have a child, am I responsible enough to provide for its emotional and financial support?*
  - -- *If the relationship breaks up, will I be glad I had sex with this person?*
  - -- *Am I sure no one is pushing me to have sex? [...]*

  If any of your answers are NO, then you'd better WAIT."

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[4]The new brochures Dr. Greene ordered in March 1995 were the first she had seen which a) showed African American role models; and b) had a message targeted specifically to teenage *males*. The publisher of the pamphlets said in a letter to Senator Dodd that *"I have long known Dr. Foster to be a strong advocate for abstinence . . . When these pamphlets were first published. . . I immediately requested my staff to send copies to his program because I knew they would be interested in seeing them... His program immediately purchased and began using them . . . reflection of their interest in keeping their program up to date..."* [May 5, 1995 letter from Journeyworks Publishing]

[5]This pamphlet is referenced in the September 1989 draft of the Family Life Education Module [Staff Manual] which was given to the Committee

- *"Decisions about sex may be the most important decisions you'll ever make. So, think before you act."*

- *"What should I know if I decide not to have sex? Congratulations... contrary to rumor, so have lots of other teens. It's not so hard to say "NO" and still remain friends if you are careful not to hurt the other person. For example you might say:*

  -- *`I like you a lot but I'm just not ready to have sex'*
  -- *`I don't believe in having sex before marriage. I want to wait.'*
  -- *`I enjoy being with you but I don't think I'm old enough to have sex.'*
  -- *`I don't feel like I have to give you a reason for not having sex. It's just my decision.'*

- *"Also, there are different ways to show affection for another person without having sexual intercourse."*

- *"Try to avoid situations where sexual feelings become strong. "Stopping" is much harder then."*

- *"Talk about your feelings and what seems right for you. If you and your partner can't agree, then maybe you need to find someone else whose beliefs are closer to your own."*

- *"Will having sex really make you more popular, more mature, more desirable? Probably not. In fact, having sex may even cause your partner to lose interest. The one sure thing about having sex is that you may be in for problems you don't know how to handle."*

- *"Sex is not what makes a relationship work."*

- *Watch out for lines like, "If you care about me, you'll have sex with me."*

  -- *You don't have to have sex with someone to prove you like them.*
  -- *Sex should never be used to pay someone back for something . . . all you have to say is, "Thank you."*
  -- *Sharing thoughts, beliefs, feelings and most of all mutual respect is what makes a relationship strong.*
  -- *Saying "No" can be the best way to say, "I love you."*

B. **"AIDS AND SEX: WHAT YOU SHOULD KNOW"**
[*Tennessee Responds to AIDS*, December 1992]

- *"WHAT DO I DO?: First, understand it's okay to say 'No' to sex. Get to know the person better. Date. Don't be afraid to talk about your choices with your friends. Have respect for your body. This way, you can avoid HIV and problems like unplanned pregnancy and other sexually transmitted diseases like gonorrhea and syphilis."*

C. **"AIDS: WHAT YOU SHOULD KNOW"**
[*Tennessee Responds to AIDS*, July 1989]

- *"HOW CAN I PROTECT MYSELF... The only way to be absolutely safe is to avoid all drug needles and not have sex until you are in a marriage or permanent relationship with a faithful, uninfected partner.*

  Until this is possible . . . Say 'No' to sex."

- *"REMEMBER: Alcohol and drugs make it harder to say no to dangerous behavior."*

D. **"AIDS AND TEENS: WHAT YOU SHOULD KNOW"**
[*Tennessee Responds to AIDS*, June 1991]

- *"HOW DO I PROTECT MYSELF? Don't have sex. Express your affection in other ways such as holding hands or hugging."*

- *"The safest way to protect yourself from becoming infected with HIV is by avoiding sex and drugs. Because this is your life and your body, you have a right to say NO. Remember, you can't tell by looking at someone if they are infected with the virus."*

- *"Remember the best protection against getting HIV is to avoid sex and drugs. Both drugs and alcohol will affect your judgment and you will be less likely to take steps to protect yourself."*

E. **"AIDS AND THE BLACK COMMUNITY: WHAT YOU SHOULD KNOW"**
[*Tennessee Responds to AIDS*, June 1991]

- *"HOW DO I AVOID HIV?*
  -- *Say `No' to sex.*
  -- *Alcohol and drugs make it harder to say no to dangerous behavior."*

F. **"A PARENTS' GUIDE TO THE FACTS:** ***TO HELP MOTHERS AND FATHERS TALK TO THEIR TEENAGERS ABOUT SEXUAL RESPONSIBILITY"***
[*American College of Obstetrics and Gynecology (ACOG)*, 1986]

- *THE FACTS: <u>NO. 1</u>: YOUNG PEOPLE CAN POSTPONE SEX.*

- *"Fact: Today's youngsters often have the impression that 'everyone is doing it.' Surveys show that more than half of all teenagers do indeed say 'no.' The 'everyone is doing it' comment is typical big talk by young people who want to make themselves look important in the eyes of their friends."*

- *"Let your children know that it's okay to say 'no.' There's nothing wrong with saying it. Even more important, there's no reason for your children to feel different or strange if they do say 'no'."*

- *"Because of pressure from their friends your children need guidance in knowing how to say 'no.' Explain to your children that the best way to say 'no' is to decide before they get into a situation that might force that decision."*

- *"Young people often worry about hurting friends' feelings if they say 'no.' Hurt feelings go away but an unintended pregnancy and a baby don't."*

- ***"WRAPPING UP THE FACTS: When parents can establish themselves as the best source of information on sex, the chances of misinformation are reduced. . . When they (your children) have the Facts, you can help guide them in making the decisions that are best for them. They can say 'no' and postpone having sex. . . "***

G. "A MESSAGE FOR TEENS FROM TEENS"
[*March of Dimes Birth Defects Foundation*, November 1986]

- *"We all know how difficult peer pressure can be -- people our own age telling us to do something that we don't really feel good about doing. We don't want to feel different. We don't want to feel left out. But there is such a thing as positive peer pressure. Our true friends wouldn't want us to do anything that would hurt us or get us into trouble."*

- *No one should try to rush you into anything. That's not the way to express your love for someone."*

- *"Guys take it less seriously because they're not the ones who get pregnant."*

H. "SEXUALLY TRANSMITTED DISEASES"
[*March of Dimes Birth Defects Foundation*, October 1986]

- *"Obviously, there is no risk of infection if there is no sexual contact."*

III. SUPPLEMENTAL TEACHING MATERIALS

A: GAME: CROSSROADS – *TEEN RELATIONSHIPS AND TEEN SEXUALITY*

1. OBJECTIVE:

- *"The objective of CROSSROADS is to encourage sexual abstinence, goal-setting, parent-teen communications, strong moral values, self-control, responsibility, self-respect, and respect for others."*

- *"Sexual abstinence is important because it provides an opportunity to practice self-control, self-respect, respect for others and other important moral and religious values. It decreases the occurrence of teen pregnancy and sexually transmitted diseases and increases your opportunity to complete educational and vocational goals."*

- *"Teens should be very careful about the selection of their peers. They should choose friends and dates who value sexual abstinence and other positive moral standards."*

2. SAMPLE GAME CARDS[6]

a. "If parents find out that their son or daughter is sexually active, they should discuss birth control because it is too late to discuss abstinence. TRUE OR FALSE

Answer: False...It is never to late to discuss abstinence."

b. "It is important for both males and females to keep their virginity because (a) it decreases the chances of getting sexually transmitted diseases (b) takes away the possibility of unwanted children (c) both a and b

Answer: (c)"

c. "What is the best method a teen may use to keep from getting a sexually transmitted disease? (a) condoms (b) abstinence (c) frequent visits to the doctor

Answer: (b)"

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[6]These are only a small selection of the cards focusing on abstinence. Many more were given to the committee. The game also had cards addressing AIDS and STDs.

d. *"Why do you think a male or female teen would choose to abstain from sex until marriage? Explain your answer..."*

e. *"Which two methods can be used to control your sexual feelings? (a) maintain the value of abstinence (b) take a cold shower (c) don't deny your feelings, talk to your parents (d) ignore your feelings, they will go away*

Answers: (a) and (c)"

f. *"What are the advantages for males and females who abstain from sex until marriage? (a) no advantages (b) they can set goals and achieve them through self-control (c) no children born before marriage"*
Which statement was INCORRECT?

Answer: (a)"

g. *"What is SEXUAL ABSTINENCE? Please explain your answer...*

Answer: Sexual abstinence means to refrain from sexual activities, including the more advanced stages of petting and sexual intercourse."

h. ***"Can you truly love someone and abstain from premarital sex with that person? Yes or No?***

Answer: Yes... Love is a strong affectionate bond that consists of respect, trust and commitment."

B. VIDEO: *"WHO DO YOU LISTEN TO? CHOOSING SEXUAL ABSTINENCE"*
Note: ***There is no date on the invoice (which was enclosed in the video sent to the Committee.) A fax – apparently sent to the program from the video company – is dated 8-21-92.***

- *"It gives them the facts and feelings teens must confront in order to take responsibility for their own sexual activity, and presents a healthy option for them to consider -- sexual abstinence before marriage."*

- *OBJECTIVES: "To help students: [...]*
  -- *Explain the physical, emotional, and psychological risks of premarital sexual activity.*

  -- *Make more responsible decisions about their sexual behavior."*

- *DISCUSSION TOPICS AND ACTIVITIES: [...]*

  4. *Psychological Risks: Consider the psychological risks involved in having sex before marriage, such as feelings of guilt, doubt, fear, disappointment and even the pain of being used. Why do these feelings often follow pre-marital sex? Could they possibly interfere with your ability to concentrate on other things, like building friendships, studying or working?*

  5. *Physical Risks: Consider some of the physical risks involved in having sex . . .*

  6. *Practicing Sexual Abstinence: Discuss the advantages and disadvantages of practicing sexual abstinence before marriage . List some concrete reasons for saying "no" to pre-marital sex that you have learned from the video. . . Why would it be a good idea to refrain from sexual activity, despite what your body may be saying to you? List four activities that can constructively channel your time and energy.*

  7. *Saying No: What are the most common ways others might try to convince you that you should have sex? Practice avoiding the pressure to have pre-marital sex by coming up with reasons to say "no".*

- *SUGGESTIONS FOR GROUP LEADERS*

  -- *Share some adult pressures that you face, such as belonging to a certain club, going out for a drink when you'd rather not, etc. Tell a story illustrating an effective way that you have handled peer pressure, and ask your group to tell you about situations they have seen or been involved in having to do with peer pressure.*

  -- *Encourage adolescents to talk to their parents, school counselors, health teachers or physicians . . . Offer a supportive environment for them to share the information they find. Encouraging them to discuss these issues with their parents can help bridge any embarrassment*

C. VIDEO: *"IT ONLY TAKES ONCE"*[7]

The main theme of this video is abstinence, following a young woman -- who has decided with her boyfriend not to be sexually active -- through a variety of social settings. She speaks to a group of teens saying that it's possible to be a virgin and still be cool. [referenced in Family Life Module, p.59]

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[7]The Committee has the only copy of this video so I was not able to quote directly.

D. <u>AIDS POSTER</u>: ***"WITH AIDS AROUND, GONORRHEA, SYPHILIS & HERPES ARE FAIR WARNING"***

- Poster shows a STOP sign and at the bottom it says: ***"You want to be risk-free from AIDS? Don't have sex.*** *And as long as you aren't* ***shooting drugs, you'll be fine. No worries about who's slept around, who's had blood*** *tests, and whether your condoms are latex are not."*

IV. MEDICAL STUDENT HANDBOOK

As "I Have A Future" falls under the Department of Obstetrics and Gynecology at Meharry Medical College, medical residents and students often rotate through the program's clinics. The IHAF staff prepared a handbook[8] to train the residents before they begin their rotation. The handbook gives specific guidelines for providing counseling -- stressing abstinence as the first and best option.

- *DISCUSSION OF QUESTIONS ON "PERSONAL INFORMATION FORM"*

  "The following questions are sensitive and emotional and could take much more time than is available at the clinic. It is important to schedule a special session with the client to talk in more depth if necessary." [...]

  "2. Have You Talked to Either of Your Parents About Coming Here?

  - *"Determine teen's comfort level in talking with parents" [...]*
  - *"Provide teen with "Can I Tell My Parents?" brochure and encourage her to tell her parents in the future. Emphasize that parents can be a source of support for them. If they can't talk to them now, maybe they will be able to some time later. (Don't give up!) [...]*

  "4. Have you ever had sexual intercourse?

  - *If yes, discuss how she made the decision to have sex and ask how often she has intercourse. If the teen felt pressure to have intercourse, let her know that she can stop if it doesn't seem right for her. You can say "no" after saying "yes".*

    ... 1) just for ... 2) to be like your friends. What you really want is most important. This is your decision. . .

  - *If no, discuss teen's feelings about her decision. Legitimize decision not to have sex . . ."*

  "15. The goal of this [sic] questions is to increase the client's realistic understanding of how a pregnancy would affect her life. . .

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[8] *Final Report To Health Of The Public;* Submitted by "I Have A Future", Department of Obstetrics & Gynecology, Meharry Medical College; October 1992

- *Have you thought about when you will be ready to have a baby? Deal with a pregnancy? When do you think you will be ready? Imagine for a moment that you were pregnant? How would you feel?*

- *Discuss wide range of emotions involved in hearing news like this. What kind of reaction would she have? Who could she turn to for information and support? What options would she have?*

- *Have she and boyfriend discussed possibility of pregnancy with sexual relationship?*

- *How would pregnancy/parenthood affect their goals?*

- *Possible role-play situation [unplanned pregnancy]*

"INITIAL VISIT INTERVIEW/COUNSELING SESSION

- *CONTRACEPTION AND STD'S (USING PROTOCOL GUIDELINES):*

The manual lists a number of options for avoiding Sexually Transmitted Diseases -- the first of which is *"abstinence."*

"Provide the following brochures for the teen to take with her:
-- *AIDS Brochure*
-- *What Every Teen Needs To Know*
-- *Your Pelvic Exam -- the 1st or 21st*
-- *Can I tell my Parents?*
-- *The Facts [STDs]*
-- *NO and Other Methods of Birth Control"*

V. LISTEN TO TEENAGERS WHO ARE IN THE PROGRAM...

"But if you let the youngsters tell it, there is less sexual activity among those in the program. Part of it is knowing they are not the only one deciding on abstinence. Part of it is having adults they can talk to openly. Part of it is realizing the repercussions of early sexual activity."
[The Tennessean, 2/5/95]

RHIANNON WILSON:

- *"In 'I Have A Future' I have learned why it's best to abstain from sexual activities through a class called Family Life. With me being a young lady, this class and all the other very positive things we do has helped me realize that I truly do have a future and a bright one at that."* [Personal Statement]

- *"Dr. Foster always tells us that abstinence is what we should follow."* [Testimony to Senate Committee]

JASON GORDON:

- *"The program stresses abstinence to the fullest extent, it is the major goal of the program."* [Testimony to Senate Committee]

- "The program taught him one thing most of all, [Jason Gordon, 18] said. *'I know I'm not ready to have a child.'"* [New York Times, 2/11/95]

- ***"I Have A Future tells inner-city youth that their futures can be more positive and more successful if they delay sex and pregnancy until they are adults and can handle the responsibilities of a family."*** [Statement at White House, 5/1/95]

- *"I know that I would not be where I am if I had gotten shot, gotten someone pregnant, or dropped out of school. That is what IHAF tells us -- if we stay out of trouble, abstain from sex, and avoid drugs and alcohol, our futures can be anything we want. Having a child can limit us forever. Taking responsibility for our lives puts us in charge and lets us define our lives ourselves."* [Statement at White House, 5/1/95]

- *"It's a lot more than just delaying pregnancy and not having sex. It's a lot about responsibility, about having dreams, about having goals."* [AP, 5/1/95]

DEANNA GARRETT:

- *"The 'I Have A Future' program tries to teach the teens that abstinence is the only way that we can put a stop to teen pregnancy, the spread of sexually transmitted diseases, and the transmission of the HIV virus."*. [Testimony to Senate Committee]

GARY HICKS:

- *"Dr. Foster is doing a good deal by teaching kids to wait before they have sex. He would rather the young kids not have sex at all, because they still have a lot of things to look forward to in life. The 'I Have A Future' program teaches you that you don't have to do what everyone else is doing."* [Testimony to Senate Committee]

TERRELL CARTER:

- Terrell Carter said the program has given him a new perspective on interaction between the sexes. *"I thought that having sex was part of everyday life. It showed me abstinence is cool . . ."* [The Commercial Appeal, 2/14/95]

- Terrell Carter, 18, credits the program for teaching him that fathering a child is *"nothing to be proud of."* He now has *"more respect for girls. They're not just sex objects."* [USA Today, 2/9/95]

CHARMAINE HARRIS:

- Charmaine Harris, 18, says that the program taught her skills she could use to resist pressure to have sex: *"Let's say you have a date, dancing, and things start getting hot. Are you going to be passive or stand up for what you believe in?"* [The Tennessean, 2/5/95]

- *"As a member of the 'I Have A Future' program, I have learned how to choose and make decisions that will have a positive effect on my life and benefit me as well as others around me. I learned that it is alright to be different because the only person I need to please is me."* [Testimony to Senate Committee]

TONYA RUTLEDGE:

- Tonya Rutledge, 17, thinks that her life would be different if she hadn't been in the program. *"I think I would probably be like my other friends which have children or they're about to have a child...."* [USA Today, 2/9/95]

AMELIA TURNER:

- *"When I first moved to Nashville. . . I was confronted daily with negative influences such as pressure to have sex and use drugs and alcohol. Fortunately, people like Dr. Foster realized those kinds of pressures, and they did something about it. Joining 'I Have A Future' gave me a safe alternative to doing those negative things. It taught me how to resist the peer pressures in order to be the best person I can be by not letting others pull me down."* [Statement at D.C. Arrival Event, 5/1/95]

- *"'It kept me busy. I had friends trying to take me in the wrong direction,"* said Amelia Turner, 18, who joined the program when her family moved to Nashville five years ago. *'[The program leaders] constantly stressed the importance of higher education... having a child is down the road.'"* [The Commercial Appeal, 2/14/95]

- *"This would be a nice program to have in other cities,"* said Amelia Turner, who wants to major in both medicine and biomedical engineering. *"In the little town I came from, there is nothing to do, so you may go over to your boyfriend's house. This takes you away from that. You don't have time to do crazy things."* [The Boston Globe, 2/10/95]

- Eighteen year old Amelia Turner says that in her life she is under *"a lot of pressure"* to have sex. I Have A Future counselors *"let us know that if you want to have sex, here's what you can use. But,* ***the best sex is no sex.***" [USA Today, 2/9/95]

FLOYD STEWART:

- Floyd Stewart has been in the "I have A Future" program for 4 years and says that unfortunately most people *"don't know about how [Dr. Foster] preaches abstinence."* [Testimony to Senate Committee]

JOHNETTA NELSON:

- Johnetta Nelson, a student, believes that the program taught her many things. *"I chose to further my education, and I knew that if I was to become impregnated that it would probably hold me back. And I know that I want a lot of things out of life, so I figured that it's not the time.* [CNN, 2/13/95]

- *"I owe a great deal of credit to "I Have A Future" for keeping me active and busy. The program helped me keep my focus on my future and kept me from straying away. It taught me that your education comes first and having children comes later."* [Statement at D.C. Arrival Event, 5/1/95]

MELISSA HUNTER:

- "Melissa Hunter . . . said [Dr. Foster's] brainchild gives her and her friends a choice they seldom had before. A few make it out of the projects and their teen-age years without a baby and the limitations that babies bring, purely on strength of character alone, she said. But it is hard. *'Here they keep you too busy to get into trouble.'"* [The New York Times, 2/11/95]

LATARA GOOCH:

- The "I Have A Future" program has *"taught me how to think of myself, and not let everyone think for me. It also has kept me from making a big mistake in my life. The mistake is having sex at an early age."* [Personal Statement]

TYRECA BOWERS:

- *"I have been in the 'I Have A Future' program for approximately 2 years. This program has helped me to prepare for the real world. It teaches me to be responsible."* [Personal Statement]

LASHONDA MARYLAND:

- *". . . the program helps build skills that are essential in everyday living. By acquiring these skills many of the children who go through the program have higher self-esteems, better manners, respect for themselves and others, excellent communication skills, and the ability to cope with problems."* [Testimony to Senate Committee]

TASAUNDRA DOOLEY

- "Tasaundra Dooley, 16, said, *`They taught us that we don't have to be pregnant.'* Although birth control and abstinence are part of this plan, what the program really does is give her a reason not to join the ranks of unwed mothers, she says." [New York Times, 2/11/95]

MELISSA HUNTER:

- *"'I Have A Future' has helped me escape the peer pressure that takes over most children in our community."* [Personal Statement]

NAKEETA HUNTER:

- *"I've been in 'I Have A Future' for 3 years. 'I Have A Future' has been a great help to me. We call it 'The Future'. 'The Future' talks about just what it says, 'The Future'"* [Personal Statement]

VI. QUOTES FROM MEDIA:
OBJECTIVE SOURCES CONFIRM IHAF'S ABSTINENCE FOCUS

Many members of the media -- objective voices in this ideological battle -- traveled to Nashville and interviewed the staff and students of the "I Have A Future" program. It was clear to all observers that abstinence is a major focus of the program.

- **The Tennessean:** *"R-E-S-P-E-C-T, It Means A Lot to 'Future' Kids,"* 11/14/94[9]

  "The goal was to get kids age 10-17 to **forgo risky behavior, like having sex** and using drugs, that could alter their lives forever. **In doing so, values like self-esteem, respect for others and responsibility are instilled...For example, Nelson said she learned a lot from an exercise where she cared for an egg as though it were a child. It** helped illustrate that she wasn't ready to have a baby."

- **The Tennessean:** *"Teens Say Foster's Vision Brightens Future,"* 2/5/95

  "We deal with issues such as how to be in relationships, how to be intimate with someone and not necessarily have intercourse, Green explained. *"How do you deal with social situations where you find yourself needing to refuse things?"* **Or as** Charmaine Harris, 18, said: *"Let's say you are on a date, dancing and things start getting hot. Are you going to be passive, or stand up for what you believe?"...Greene** says their message to the young people is simple: **Sex just doesn't fit into your lives right now. But it's not just talk, Greene added. Counselors give teens reasons to want to delay sex and parenthood. Youths are kept busy with field trips, after school activities such as dance and karate classes, support groups, tutoring sessions and** jobs... **But if you let the youngsters tell it there is less sexual activity among those in the program. Part of it is knowing they are not the only one deciding on abstinence. Part of it is having adults they can talk to openly. Part of it is realizing the repercussions of early sexual activity."**

- **National Public Radio:** *"Dr. Foster's Work In Nashville Praised,"* 2/17/95

  "NPR:. . . *Every day Joe Jenkins [IHAF Instructor] starts the class the same way.*

  JOE JENKINS: *Once again, welcome to Family Life Education. . . Everybody understand this is a teen pregnant prevention program? Everybody understand the best way to prevent pregnancy is --*

  STUDENTS IN CLASS: **Abstinence.**

  JOE JENKINS: *Abstinence. Once again, always understand, no matter what you hear from everybody else, there are more people not having sex than there are having sex."*

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[9]Pre Doctor Foster's February 1995 nomination.

- **New York Times:** *"Nominee's School Program Offers Alternatives to Teens,"* 2/11/95

  ". . . I Have A Future, an after-school program that teaches teen-agers to delay sex and childbearing, allowing them to build careers and lives...Dr. Lorraine Green, the project's director, stressed that the program does not work with pregnant girls or offer abortion counseling. Rather, she said counselors teach the young people about abstinence, responsibility and self-control. . . It addresses much more than sex, said Dr. Satcher and teen-agers involved in the program. It is based on common sense and self-esteem, and slowly, steadily -- through informal classes almost every day after school -- teaches them how a baby can forever limit their lives, and how to value their own lives...*'They felt that if they could do that, the teen-pregnancy problem would be taken care of, too, because the young people would have a reason for delaying sexual behavior. You weren't just saying, 'Say no to sex.' You were saying, 'You have a reason to value yourself.'"*

- **Washington Post:** *"In Nashville, A Portrait of Compassion,"* 2/12/95

  "Just two weeks ago, Foster was mainly known for the seven-year-old program preaching values such as cooperation and personal esteem that he had brought to teenagers . . . in Nashville's public housing projects. . . Again and again he heard the same story: Just as much as good health, the kids of the projects needed hope, a commodity in short supply in the drug-ridden, violent neighborhoods. . . Based in the housing projects it serves, **the program preaches sexual abstinence and a strong anti-drug message, and stresses such values as cooperation, personal responsibility and self-esteem. . . The program has earned national recognition. President George Bush named the program one of the thousand 'Points of Light.'"**

- **USA Today:** *"Teens Have A Future, Thanks to Foster Program,"* 2/9/95

  "A takeoff on Martin Luther King Jr.'s 'I Have a Dream,' the program was founded in 1988 to stress abstinence and responsibility to adolescents . . . When Foster and others started IHAF, says David Satcher, director of Centers for Disease Control and Prevention, *'They sat down with the parents and found out what they wanted. They came out really pushing abstinence, but they also had condoms available.' . . .* Amelia Turner, 18. Program counselors *'let us know that if you want to have sex, here's what you can use. **But the best sex is no sex.'***