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ABSTRACT

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

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

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

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

Introduction

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

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

1. What level of participation would be achieved during the first three years of the implementation of the program? Who are the adolescents who are most likely to choose to participate?

2. What is the impact of the IHAF program for adolescents living in the intervention neighborhood on (1)involvement with a pregnancy, (2) behavior which places them at risk for being involved with a pregnancy, (3) sexual and contraceptive knowledge, (4) attitudes and values regarding sexual behavior, (5) psychosocial maturity, (6) self-concept, (7) self-esteem, (8) prosocial attitudes, and (9) perceived life options?

3. Are some adolescents more likely to benefit from the IHAF program being offered in their neighborhood than others? Specifically, do adolescents who participate more actively in the program experience more positive outcomes than those who do not participate as much?

4. How were the effects achieved? What are the possible processes which could explain how the IHAF program influences adolescents?

METHODS AND MEASURES

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

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

T_1 data were collected in the housing projects from October, 1987 through January, 1989[1]. Youth were recruited through door-to-door leafleting. They were tested in group settings with the questions being read to the group. Those who had difficulty reading or completing the questionnaires were given individual attention. Youth received $10.00 for completing the questionnaires at each of the three time points. The testing sessions took approximately two hours to complete.

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

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

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

T_3 data were collected February through May of 1991, with data being collected at the comparison neighborhoods during the latter months of that time period. All youth who continued to live in the housing projects were contacted to participate in the survey. For this data collection period, limited resources were available to try to locate those youth who had moved away. School records were examined and contacts were attempted with up to three people whom the youth had identified at the T_2 assessment as likely to know where the youth would have moved. Letters were sent to the old address should a forwarding address have been left with the Post Office. These procedures were unsuccessful in locating youth no longer living in the housing projects. In a few cases, the youth were actually still living in the housing projects although they were not "official" residents according to MDHA records. Instead of completing the survey in group settings, the adolescents were individually interviewed during the third data collection period. This procedure was implemented in order to have more complete data, limit the number of random responses, and to get more detailed information regarding dates and outcomes of pregnancies from those youth who had been involved with one or more pregnancies[2].

Demographic and Baseline Behavioral Variables

The following variables were measured at T_1 via the Minnesota Adolescent Health Survey developed by the University of Minnesota Adolescent Health Program (1987): (1) age; (2) marital status of parents (married/not married); (3) mother's employment status (employed at least part-time/unemployed); (4) how long at their current address (measured on a four-point scale with 1 being less than a year and 4 being three years or more) (5) sexual behavior (pregnancy risk score based on frequency of sexual intercourse and contraceptive behavior, described in more detail in dependent measures section); (6) delinquent behavior; (7) substance use; (8) academic attitudes and behavior; (9) plans for attending college; (10) degree of religiosity (five-point ordinal scale), and (11) youth employment status, and (12) self-concept.

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

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

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

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

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

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

Dependent Measures

Involvement with one or more pregnancies. At the T_3 interview, youth who had had sex were asked how many times they had been pregnant or gotten someone pregnant. Youth who were involved with one or more pregnancies were asked the date of the resolution of that pregnancy. They were also asked how many months pregnant they or their partner had been at the time of resolution. From this information, the approximate month and year of conception was determined. Conceptions occurring prior to T_1 were not considered in these analyses[3]. Three dependent variables were calculated from this information:

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[3]Of the 58 pregnancies between T_1 and T_3, 62.1% (n=36) resulted in live births; 25.9% (n=15) were currently pregnant; 6.9% (n=4) were aborted; 3.4% (n=2) were miscarriages; and 1.7% (n=1) were stillbirths.

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

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

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

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

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

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

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

two items from the tolerance dimension were chosen[5]. Each item has a four-point agree/disagree response format. The sum of each subscale was computed and then each subscale was summed for a total PMT score with a range of 32 to 128. The alpha reliabilities for the PMT scale for T_2 and T_3 were .85 and .90, respectively.

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

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

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

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

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

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

Participation Data

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

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

Data Analysis and Results

Participation Analyses

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

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

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

	n	M	SD	Range	% Enrolled at T_1	% Enrolled at T_2
Phase 1	326	7.99	11.57	1-83	79.75	20.25
Phase 2	301	28.75	50.80	1-295	57.14	42.86
Total	436	25.82	47.64	1-321	67.89	32.11

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

Based on their participation rates, youths in the intervention sites were classified as active participants or low-level participants[6]. Active participation was defined as participation in at least 15 sessions of the Core modules. Ninety (90) youth were identified as active participants. The majority of the active participants had attended more than 15 sessions across the two phases of the program. Table 3 reports the average participation rates of active participants and low-level participants in each of the three types of activities during the two phases of the program. Participation in all three types of activities increased for active participants from Phase 1 to Phase 2; it remained essentially the same for low-level participants.

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

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

Note. The unit of measurement for time is hours.

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

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

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

Note. The unit of measurement for time is hours.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 7. Means, Standard Deviations, and Correlations with Discriminant Function for Discriminant Analysis of Participation Groups using T_1 Variables

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

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

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

Table 8. Means, Standard Deviations, and Correlations with Discriminant Function for Discriminant Analysis of Participation Groups using T_2 Variables

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

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

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

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

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

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

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

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

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

Effects of the IHAF Program

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

Table 9. Number of Subjects by Test Status By Neighborhood

	Neighborhood	
Test Status	Intervention	Comparison
T_1 only	271	207
T_2 only	50	2
T_1 and T_2 only	102	59
T_1 and T_3 only	24	37
T_2 and T_3 only	113	2
T_1, T_2, and T_3	154	132
Total	714	439

Sample sizes will vary for the different analyses depending upon the time period being studied and the variables incorporated into the analyses. Analyses utilizing data from T_1 and T_3, for example, would have a potential maximum sample size of 329; whereas, analyses utilizing data from T_1 and T_2 would have a potential maximum sample size of 429. Occasionally subjects would skip questions or answer them inappropriately and could not be included in specific analyses for variables measured by those questions, which results in reduced sample sizes for these variables.

Additionally, 18 youth were inconsistent in their responses to sexual behavior and pregnancy questions at T_1 and T_3. Inconsistent responses include (1) reporting having had sexual intercourse at T_1 and reporting not having ever had sexual intercourse at T_3 and (2) reporting involvement with fewer pregnancies at T_3 than at T_1. These 18 youth were eliminated from all of the analyses. Five of these inconsistent youth were residents of the intervention sites and 13 were from the comparison sites.

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

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

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

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

Table 10. Means, standard deviations, and test statistics for comparisons between neighborhoods on T_2 and T_3 dependent variables

	Intervention Neighborhood			Comparison Neighborhood			
Variable	n	M or %	SD	n	M or %	SD	test statistic
Time 2							
Life Options	363	0.03	0.8	179	-0.05	0.8	ns
Attitudes	362	3.35	0.5	180	3.31	0.5	ns
PMT	362	101.56	18.2	177	93.36	17.6	4.97***
Knowledge	364	42.15	21.2	180	37.26	19.7	2.59**
Self-Concept	364	60.21	11.0	180	58.54	11.5	ns
Self-Esteem	361	3.57	0.8	179	3.55	0.9	ns
NGS	361	109.93	16.3	179	104.15	13.6	4.34***
Pregnancy Risk	358	3.98	4.7	176	3.51	4.6	ns
Pregnancy (T_1 to T_2)	286	4.9%		158	3.8%		ns
Time 3							
Life Options	286	0.02	0.8	157	-0.06	0.9	ns
Attitudes	285	3.56	0.4	157	3.52	0.4	ns
PMT	281	104.65	20.8	158	103.40	18.5	ns
Knowledge	286	50.90	21.0	158	48.23	21.6	ns
Self-Concept	286	63.73	9.6	158	63.85	9.8	ns
Self-Esteem	284	3.78	0.6	158	3.74	0.6	ns
NGS	285	112.39	12.2	157	109.65	11.3	2.32*
Pregnancy Risk	260	4.38	4.6	149	4.30	4.6	ns
Pregnancy (T_2 to T_3)	286	6.6%		158	10.8%		ns
Pregnancy (T_1 to T_3)	286	10.8%		158	12.7%		ns

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

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

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

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

Table 11. Correlations between Number of Pregnancies and Potential Covariates

Potential Covariate	Total Pregnancies	Pregnancies between T_1 & T_2	Pregnancies between T_1 & T_2
Age (n=444)	.37***	.26***	.28***
Alcohol Use (n=321)	.06	.12*	-.01
Self-Concept (n=383)	.02	.04	.00
Religiosity (n=328)	-.03	-.03	-.02
Delinquency (n=326)	-.01	-.02	-.01

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

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

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

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

	Total Pregnancies			Pregnancies Between T_1 and T_2			Pregnancies Between T_2 and T_3		
Potential Covariate	M	SD	t	M	SD	t	M	SD	t
Gender									
Male (n=155)	.13	.39		.04	.25		.09	.29	
Female (n=174)	.20	.44	1.44	.08	.27	1.52	.11	.32	0.73
Parental Marital Status									
Not Married (n=283)	.16	.42		.06	.25		.10	.30	
Married (n=45)	.18	.44	0.23	.06	.25	0.16	.11	.32	0.18
Mother's Employment Status									
Not Employed (n=206)	.16	.40		.04	.19		.12	.32	
Employed (n=121)	.18	.45	0.55	.10	.33	1.85*	.08	.28	0.97
College Plans									
No (n=87)	.25	.51		.08	.31		.17	.38	
Yes (n=237)	.14	.38	1.96**	.05	.23	0.70	.08	.27	2.08**
Behind in School									
No (n=229)	.16	.41		.07	.27		.10	.30	
Yes (n=93)	.18	.44	0.41	.05	.23	0.37	.13	.34	0.87
Youth Employment Status									
Not Employed (n=266)	.16	.43		.06	.26		.10	.30	
Employed (n=62)	.18	.39	0.27	.05	.22	0.44	.13	.34	0.73

*$p < .10$
**$p < .05$

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

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

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

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

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

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

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

Dependent Variable	n	Beta Weight	semi-partial r^2
Time 2			
Life Options	411	.05	.00
Attitudes	411	.01	.00
PMT	408	.25	.06***
Knowledge	413	.08	.01
Self-Concept	413	.13	.02**
Self-Esteem	410	.01	.00
NGS	410	.15	.02**
Pregnancy Risk	404	.07	.00
Pregnancy (T_1 to T_2)	315	Odds Ratio: 1.11	.00
Time 3			
Life Options	314	.02	.00
Attitudes	314	-.02	.00
PMT	310	.04	.00
Knowledge	315	.11	.01*
Self-Concept	315	.03	.00
Self-Esteem	313	.05	.00
NGS	313	.09	.01
Pregnancy Risk	293	.10	.01*
Pregnancy (T_2 to T_2)	315	Odds Ratio: 0.99	.00
Pregnancy (T_1 to T_2)	315	Odds Ratio: 1.08	.00

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

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

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

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

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

	Active Participants			Low-Level Participants			
Variable	n	M or %	SD	n	M or %	SD	test statistic
Time 2							
Life Options	83	0.23	0.7	280	-0.03	0.8	2.67**
Attitudes	83	3.34	0.6	279	3.35	0.5	ns
PMT	83	104.39	19.6	279	100.72	17.6	ns
Knowledge	83	42.09	19.2	281	42.17	21.8	ns
Self-Concept	83	61.51	10.5	281	59.82	11.2	ns
Self-Esteem	83	61.51	10.5	281	3.57	0.8	ns
NGS	83	113.08	16.8	278	108.99	16.5	2.01*
Pregnancy Risk	80	3.25	4.4	278	4.19	4.8	ns
Pregnancy (T_1 to T_2)	76	1.3%		210	6.2%		2.85**
Time 3							
Life Options	76	0.24	0.6	210	-0.06	0.9	3.17**
Attitudes	76	3.57	0.4	209	3.55	0.4	ns
PMT	73	107.86	21.3	208	103.53	20.5	ns
Knowledge	76	52.73	20.0	210	50.24	21.4	ns
Self-Concept	76	66.01	7.7	210	62.9	10.0	2.76**
Self-Esteem	76	3.95	0.6	208	3.72	0.6	2.70**
NGS	76	113.74	110.8	209	111.90	12.3	ns
Pregnancy Risk	72	4.10	4.6	188	4.49	4.6	ns
Pregnancy (T_2 to T_3)	76	0.0%		210	9.0%		7.36**
Pregnancy (T_1 to T_3)	76	1.3%		210	14.3%		9.71**

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

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

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

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

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

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

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

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

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

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

Table 18. Means, Standard Deviations, and Test Statistics for Comparisons Between Active Participants in the Intervention Neighborhood and the Comparison Neighborhood Subjects on T_2 and T_3 Dependent Variables

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

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

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

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

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

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

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

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

Dependent Variable	n	Beta Weight	semi-partial r2
Time 2			
Life Options	221	.10	.01
Attitudes	222	.05	.00
PMT	219	.28	.08***
Knowledge	222	.11	.01
Self-Concept	222	.14	.02*
Self-Esteem	221	.01	.00
NGS	221	.25	.06***
Pregnancy Risk	215	.09	.01
Pregnancy (T1 to T2)	194	Odds Ratio: 0.91	.00
Time 3			
Life Options	193	.13	.02*
Attitudes	194	.04	.00
PMT	191	.10	.01
Knowledge	194	.20	.04**
Self-Concept	194	.11	.01
Self-Esteem	194	.19	.03**
NGS	193	.10	.01
Pregnancy Risk	184	.07	.01
Pregnancy (T2 to T3)	194	Odds Ratio: 0.02	.00
Pregnancy (T1 to T3)	194	Odds Ratio: 0.54	.00

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

Evaluation of How the Effects are Achieved

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

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

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

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

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

	Preg. Risk (T_2)	Preg. Risk (T_3)	Pregnancy (T_1-T_2)	Pregnancy (T_2-T_3)	Pregnancy (T_1-T_3)
Time 2	r	r	r	r	r
Life Options	-.27***	-.25***	-.12*	-.21*	-.24***
Attitudes	-.18***	-.21***	-.03	-.05	-.05
PMT	.01	-.03	.08	-.10*	-.03
Knowledge	.41***	.29***	.15**	.16**	.21***
Self-Concept	.05	.03	.03	-.01	.01
Self-Esteem	.02	-.07	.04	-.05	-.01
NGS	.01	-.04	.02	-.08	-.05
Pregnancy Risk	.46***	.48***	.21***	.21***	.29***
Time 3					
Life Options	-.29***	-.32***	-.19***	-.19***	-.26***
Attitudes	-.13**	-.31***	-.03	-.04	-.04
PMT	.10	.08	.15**	.04	.13**
Knowledge	.36***	.31***	.17***	.16***	.21***
Self-Concept	.07	-.03	.00	-.09	-.06
Self-Esteem	.18**	.04	.11*	-.05	.02
NGS	.08	-.04	.00	-.05	.00
Pregnancy Risk	.48***		.20***	.24***	.29***

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

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

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

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

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

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

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

Table 22. Standardized Canonical Discriminant Function Coefficients and Wilk's Lambda for Dicriminant Analysis Comparing Subjects who were Lost-to-Follow-up before T_3 and Subjects who were Followed through T_3 by Neighborhood

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

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

Summary

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

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

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

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

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

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

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

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

References

Card, J.J. (Ed.) (1989). Evaluating programs aimed at preventing teenage pregnancies. Data Archive on Adolescent Pregnancy and Pregnancy Prevention, sociometrics Corporation, Los Altos.

Greenberger, E., Josselson, R., Knerr, C., & Knerr, B. (1975). The measurement and structure of psychosocial maturity. Journal of Youth and Adolescence, 4 , 127-143.

Kirby, D. (1984). Sexuality education: An evaluation of programs and their effects. Santa Cruz: Network Publications

Piers, E.V., & Harris, D.B. (1964). Age and other correlates of self-concept in children. Journal of Educational Psychology, 55, 91-95.

University of Minnesota Adolescent Health Program (1987). Adolescent Health Survey, University of Minnesota, St. Paul, MN.

Zabin, L.S. & Hirsch, M.B. (1988). Evaluation of pregnancy prevention programs in the school context. Lexington, MA: Lexington Books.

"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

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Overview

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

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

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

1. To engender a more positive self-concept and constructive attitude towards the community, family life, and the future;

2. To increase socially adaptive/appropriate behaviors with particular focus on school achievement, pre-vocational skill development, and delinquency rates; and to enhance the ability of high-risk adolescents to overcome environmental barriers in attaining the skills necessary to pursue meaningful employment and educational opportunities with the promise of upward mobility;

3. To provide greater access to and increase the use of, comprehensive adolescent health and social services, including contraceptive availability;

4. To stimulate measurable improvement in the participants' level of psychosocial development; and

5. To expand educational opportunities for health-professional students through a community-based program that serves high-risk adolescents and children.

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

Service Configuration

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

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

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

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

Current Clientele

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

Program Administration and Organization

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

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

Networking and Collaboration

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

1. The Annie Casey Foundation's Tennessee KIDS COUNT Technical Advisory Committee;

2. A planning committee for the Center for Social Science Research--an organization which studies the urban underclass;

3. The Steering Council for the TENNESSEE VOICES FOR CHILDREN--a coalition founded by Tipper Gore, wife of Vice-President Albert Gore, JR. which promotes the development of services for children and youth with serious behavioral, emotional, substance abuse, or other mental health problems;

4. The Tennessee Health Department's Black Health Care Task Force which oversees several health promotion projects across the state targeting African American adolescents who are considered at-risk for serious health problems;

5. The State Commission for Children and Youth which monitors services for youth and adolescents, especially the juvenile justice system;

6. United Way's SUCCESS BY SIX Initiative which focuses on families with children under the age of six;

7. The Nashville Prevention Partnership--a collaboration of alcohol and drug prevention programs in Metropolitan Nashville working together to plan and develop alcohol and drug prevention strategies for the community; and

8. The Teenage Pregnancy Prevention Council which monitors and develops strategies to reduce adolescent pregnancy.

Additional Activities

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

Evaluation

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

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

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

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

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

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

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

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

Funding

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

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

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

Future Directions

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

SUCCESSFUL TEEN SEX PROGRAMS

THE DOOR- Provides a comprehensive range of services in an exciting youth oriented environment. The door is able to provide comprehensive health benefits without red tape and enjoys a large, dedicated and diverse teen membership and has had a measurable impact on teen pregnancy among its members.

COMMUNITY SCHOOL PREGNANCY INTERVENTION PROGRAM- Administered by the John Hopkins School of Medicine. The theory behind the program was to reach students who were already sexually active and teach them about prevention. A control group of schools with similar sexual activity in its student population were chosen for comparative purposes. In the test school, nurse practitioners and health educators targeted these students for intense prevention information. At the end of the test period, these students were far more successful in avoiding pregnancy than their counterparts in the control group. This kind of program points to early prevention and the need to have trained healthcare personnel located in the school to provide comprehensive health and preventive education services.

GRADY MEMORIAL TEEN INTERVENTION- This program initiated by Grady Memorial Hospital in Atlanta, Ga. was designed to reach eight graders using health educators and peer counselors. The program was successful for students who had not participated in the program were as much as five times more likely to have sexual intercourse than those not in the program.

DRAFT

TEEN PREGNANCY RATES: AN AMERICAN EPIDEMIC

OVERVIEW: Today's teenagers, regardless of race, gender or economic circumstances are living in a more troubled time than previous generations:

-- The onetime norm of a stable two-parent family is becoming less common across all racial and income groups-- Between the 1950's and the 1980's the number of 14 yr. old girls who did not live with both parents rose from 21% to 38%..most with their unmarried mother.

-- Our children live in a far more violent society than previous generations-- 2 million cases of child abuse, including sexual abuse are reported annually...adolescents (teens) are more likely to be abused than younger children.

-- The risk of violent death has been on the upswing among teens...a report for calendar year 1988 found 10% of adolescents had been physically assaulted in school... one half of the deaths of African-American men age 15-19 are homicides...and black teenage women are more than 4 times as likely to be murdered as their white counterparts...

-- Alcohol and drug abuse coupled with risky behavior is taking its toll on our youth....17% of those classified as heavy smokers are under 19 years of age;...One-third of the students in grades 9-12 are considered heavy drinkers.... and by grade 12, 8% of the students have tried cocaine and 14% have used marijuana in the last 30 days....

The Teen Sex Crisis: The social and cultural norms under which our young people are behaving is reflected in the teen sexual crisis we are experiencing; here is what we now know:

-- Sex is still very rare among young teenagers, however among 16-18 year old it increases significantly.

-- While intercourse among teens increases with age...20% of teens do not have sex at all during their teen years.

-- But there are some disturbing statistics.....at each age between 15 and 20, higher proportions of teenage men and women are sexually experienced today than they were in the early 70's.

-- More than half of the adolescent girls and three-quarters of the males have had intercourse before their 18th birthday.

-- Adolescent male and females are experiencing sexual activity roughly eight years before marriage.

-- The likelihood of a white teenage women to have sex before marriage more than doubled between the 1950's and the 1980's.

--The proportion of white male teens 17-19 never married rose from 65% to 73% in 1988.

-- Among never married african-american teens (17-19) went from 65% to 73% in the same period.

TEEN PREGNANCY: The current crisis in teen pregnancies can be easily defined and quantified through statistics-- Overall teen pregnancy rates for teen who have had intercourse has declined; however, since more proportionately more adolescents are having intercourse, the pregnancy rates among all teens has increased.

--Nearly two thirds of teenage pregnancies occur among 18-19 year-old women.

-- The proportion of sexually experienced teenagers, who become pregnant increase with age are more likely to be fertile and to want to get pregnant.

-- Pregnancy rates vary by considerably by race and ethnicity:

-- Black teenagers have higher pregnancy rates than their Hispanic and white peers. This can be attributed to earlier sexual experiences and failure to use contraception.

-- Young black women who teenagers in general who are poor or low-income are especially likely to get pregnant early in life

-- Typically, there is a gap of three years between first intercourse and first pregnancies for the poor, higher income teens have a four year gap on average; blacks and hispanics more often fit the three year period.

-- Unintended pregnancies are highest among higher income teens than they are among poorer and lower income persons

-- Hispanics are more likely to have intended pregnancies than blacks or whites.

-- Only 26% of the men involved in the pregnancies of women under 18 are themselves under 18. The majority of men involved in these pregnancies are between 18-20 years of age.

-- However, of all births in U.S., only 4% are to those under 18.

-- In the period of the early 1960's 59% of first births occurred to women outside of marriage, however, 29% of those teen mothers married before delivery. By the late 1980's 95% of the births occurred outside of marriage and only 11% elected to marry among teen 15-17 years of age. Out-of-wedlock births account for 7 in 10 teen birth. In 1990, nine out of ten black teens were not married at the time of delivery.

-- However, only half of teen births are out of wedlock for low income teens, as opposed to three fourths of the births to high income and poor teens.

-- White adolescents and those from more affluent backgrounds tend to terminate their pregnancies leaving teen childbirth who are poor and disproportional black.

TEEN SEXUAL BEHAVIOR NORMS: There are some normative behavior associated with teen sexuality that may guide future planning"

-- We know that half of the sexually experienced teen women wait 18 months between their first sexual encounter and their second encounter; the wait is almost two years for another 25% of teen women.

-- Teen women who have sex at an earlier age move more quickly to a second partner than others who have not had sex as early.

-- U.S. unintended pregnancy rates are higher than those of other industrialized nations.

-- Today there is little distinction between rural and urban unintended birth rates.

April 29, 1995

NOTE TO JOHN PODESTA:

RE: Publication of Mortality Rates by HCFA

Attached is a short note written to me by Joanne Pokaski, Bruce Vladeck's (HCFA Administrator) Special Assistant, regarding how Hubbard did on HCFA's reports (done between 1986-91) of mortality rates. I am told the data is in my office at HHS. I have not seen it. Joanne's note gives the gist of the data.

You may want to give this to Childress since he asked me about it.

Andrew D. Hyman

For each year, 1986 to 1991, the Hubbard Hospital's overall mortality rate was within the range predicted for mortality for that hospital. Range is predicted based on a number of factors, including demographic characteristics and previous medical histories of patients.

The hospital's performance was in the predicted range. It wasn't worse, it wasn't better. It would be hard to use the overall data against you, but I advise against using the data in the hospital's defense.

Bruce stopped the publication of these reports shortly after becoming Administrator. He felt that the data in these reports were only one indicator of quality and were being wrongly interpreted by the public as the only quality indicator.

MEHARRY MEDICAL COLLEGE
Office of the General Counsel

TO: Mr. Steven Bignell
Journeyworks Publishing

FROM: Richard F. 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.**

Suite 504 Kresge Bldg., 1005 D.B. Todd Blvd.
Nashville, TN 37208
(615) 327-6102 327-6151 (FAX)

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95 MAY 2 PM 8:27

TO: JOHN PODESTA

Firm Name: WHITE HOUSE

FAX Number: 202-456-2215

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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Dr Lorraine W Greene
"I Have A Future" Program
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

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ITEMS ORDERED	DISCOUNT %	DISCOUNT AMOUNT	TOTAL AFTER DISC.	ADJUSTMENT	STATE TAX	LOCAL TAX	SHIP/HAND	INSURANCE	SERVICE
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STATE TAXABLE	LOCAL TAXABLE	TOTAL	PAST DUE	INVOICE TOTAL	RECEIVED	REFUND/CREDIT	PAYMENT DUE
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MEHARRY MEDICAL COLLEGE

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[redacted]					

ITEM NO.	DESCRIPTION OF ITEMS ORDERED	UNIT	OBJ.CODE	QUANTITY	UNIT COST	EXTENSION
1	#502-100-J5 Abstinence Pamphlet Set	Pkg/ 600		1	125.00	125.00
2	#5035-J5 Am I Ready to Be A Dad? Pamphlet	Each		100	.25	25.00
3	#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 & Handing (10%)					22.50

[redacted]

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Signature Ken Knight Date 3/9/95 Page

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#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			
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5053-J5	How to Talk With Your Partner About Condoms		100	25.00
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CA Residents add 7.25% Sales Tax	
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MALPRACTICE RECORD

Dr. Foster has been named as a defendant only once in his 38-year career in a malpractice suit. For an obstetrician/gynecologist, this number falls well below the average. On average, obstetrician/gynecologists have had almost three lawsuits filed against them, according to the American College of Obstetricians and Gynecologists. Moreover, nearly eighty per cent of all obstetricians/gynecologists have had at least one lawsuit filed against them.

In the 1984 lawsuit where Dr. Foster was named as a defendant, the defendants included other physicians and Meharry Medical College/Hubbard Hospital. Any claims against Dr. Foster were dismissed without prejudice by agreement of the parties. No money was paid on Dr. Foster's behalf to the plaintiffs. In that case, parents complained that Dr. Foster and the other physicians at Meharry Medical College had negligently delayed performing a caesarean section and had failed to take proper care of an infant who died less than twenty four after being delivered. The case was settled and dismissed by the remaining parties.

For a career in which Dr. Foster has delivered thousands of babies, including many in high-risk situations, this record is remarkable. Obstetrician-gynecologists have been plagued by vulnerability to lawsuits, forcing many family physicians to discontinue obstetrics because of the high cost of liability insurance. As of 1992, over twelve per cent of obstetrician-gynecologists had given obstetrics due to the liability concerns and nearly twenty three per cent had decreased the level of high-risk obstetric care they provide (according to the American College of Obstetricians and Gynecologists). In his teaching and in his commitment to providing quality maternal and child health care to underserved populations, Dr. Foster has served as a role model for those entering his profession.

MIKE DEWINE
OHIO

United States Senate

WASHINGTON, DC 20510-3503

95 APR 29 P2:28

April 27, 1995

John Podesta
Assistant to the President
The White House
Washington, D.C. 20500

Dear John:

In order to fully prepare for the confirmation hearings for Dr. Henry Foster, Jr., nominee for Surgeon General which will begin May 2, 1995, I would be appreciative if you could assist with obtaining supplementary background information. Please provide a written response to the following questions:

1) Has Dr. Foster ever been sued for malpractice?

2) Has any medical professional corporation or practice to which Dr. Foster belonged ever been named in a malpractice suit?

3) Has any doctor affiliated with a medical professional corporation or practice to which Dr. Foster belonged ever been sued for malpractice?

For each lawsuit referred to in numbers 1-3, please provide the following:
- the substance or claim of the lawsuit,
- the date the lawsuit was filed and date it was closed,
- how the case was resolved,
- whether damages were paid, either in court or out of court, and the amount of the damages, and
- any other remedy awarded, or cost or penalty imposed.

4) Please provide detailed information relating to any other legal or professional investigations or actions which have been taken against Dr. Foster during the course of his career, including, but not limited to, actions by governmental and professional associations.

Thank you in advance for your time and cooperation. Your prompt response to my request is greatly appreciated.

Very respectfully yours,

Mike DeWine
United State Senator

THE WHITE HOUSE

WASHINGTON

April 28, 1995

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

Dear Senator DeWine:

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

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

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

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

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

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

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

We look forward to working with you on this matter.

Sincerely yours,

John D. Podesta
Staff Secretary and
Assistant to the President

Enclosure

State Volunteer Mutual Insurance Company

PERSONAL & ~~CONFIDENTIAL~~

February 23, 1995

Henry W. Foster, M.D.
c/o Ms. Stacy Reynolds
Office of the White House Counsel
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

RE: Request for Claims History

Dear Dr. Foster:

Pursuant to your faxed request of February 23, 1995, the following is a brief summary of the litigation that has been filed against you under your coverage with this company.

SVMIC File 4794 - Suit filed October 5, 1984 under action number 3-84-1070 in the United States District Court for the Middle District of Tennessee at Nashville. Suit alleged delay in performance of a cesarean section with fetal distress, resulting in death of the infant. The plaintiff voluntarily dismissed this action against you, with Order of Dismissal Without Prejudice being entered on the Docket November 12, 1985. Our file indicates that Meharry/Hubbard Hospital, a co-defendant, may have subsequently made a compromise settlement with the plaintiffs. Our file was closed without any loss payment.

I hope this is responsive to your request.

Sincerely,

James W. Howell
Vice-President, Claims
Assistant Claims Manager

JWH/pgp

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MEHARRY FINANCES-ACCREDITATION

Meharry Medical College plays a special role in American medical life, educating 40 percent of the nation's black doctors and medical faculty, and sending 75 percent of its graduates to provide medical care to underserved areas. As President Reagan wrote in 1983, "the contributions of Meharry Medical College to the health and welfare of this country over the past one hundred years are immeasurable. You have surmounted obstacles that would have defeated lesser institutions and leaders." The leadership Dr. Foster displayed in surmounting those obstacles illustrates his fitness to be Surgeon General.

From its founding, Meharry has faced severe financial pressure as a result of external forces. The years prior to integration forced the school to undertake costly, duplicative burdens, including running Hubbard Hospital, where unreimbursed care for indigent patients was the source of a $2 million annual deficit by the time Dr. Foster arrived in 1973. Declining downtown population and the movement of doctors and patients to convenient suburban hospitals, together with the high number of hospitals in Nashville -- the fourth highest ratio of any major U.S. city -- drove down patient volume. One-way integration added to patient loss, with some whites reluctant to use the historically black facility.

These national trends drained the school finances and pulled patients from both Meharry and the competing city-run downtown hospital, and led to a withdrawal of accreditation of three of Meharry's residency programs, including OB/GYN in 1991. The loss was due to the low patient volume, not to the quality of teaching. Accreditation specifically requires that residents handle a large patient volume and are exposed to a wide variety of medical procedures. The Meharry student body doubled from 1966-1976, the time of Dr. Foster's arrival, at the same time the inner city patient base was shrinking, compounding the problems of patient volume.

Facing an array of structural problems, Meharry devised a structural solution. Dr. Foster took charge of a plan to merge Hubbard and the city's downtown hospital into a single, Meharry-staffed facility. The plan saved the city the cost of replacing an aging physical plant.

Many opposed the plan, doubting that Meharry, as a black institution, could attract enough additional high-quality doctors to provide a high standard of care. Meharry asked for a chance to prove itself. The city set detailed quality recruitment goals and a rigorous timetable for meeting those goals. The responsibility fell on Dr. Foster to meet those goals. He succeeded. The new staff is excellent, and includes nationally recognized physicians. Dr. Foster's role in addressing these complex, potentially divisive issues demonstrates qualities that will make him an outstanding Surgeon General.

THE MEHARRY-METRO GENERAL MERGER

Since its founding in 1876, Meharry Medical College has dedicated itself to providing health care to the poor and underserved and to educating health care professionals who would carry on this tradition. Because of its unique and critical role in American medical education, Meharry has been recognized as a "national resource," and in 1983, President Reagan wrote: "The contributions of Meharry Medical College to the health and welfare of this country over the past one hundred years are immeasurable. You have surmounted obstacles that would have defeated lesser institutions and leaders."

Unfortunately, Meharry's commitment to serving those most in need brought with it tremendous financial insecurity. Due to segregation policies, Meharry's repeated requests for staffing and teaching privileges at the city hospital were rebuffed, and, therefore, Meharry was forced to build and operate its own facility, the George W. Hubbard Hospital. It was not until 1948, when Meharry threatened to close Hubbard, that the city agreed to reimburse Meharry for indigent care. But the city's payments were never adequate, causing Meharry to lose millions of dollars every year in unreimbursed care for its indigent patients. Meharry was in danger of following the lead of dozens of other collapsing health care institutions.

The solution to Meharry's problem of maintaining an inner-city hospital while competing with the city-financed Metro General was clear: the two institutions must merge. The merger would benefit both Meharry and the city. Metro General was an old facility which the city needed to replace. The merger, therefore, would save the taxpayers the cost of building a new hospital, roughly $100 million. At the same time, Meharry would be relieved of its financial drain associated with caring for Nashville's poor, and it would gain an increased patient volume. Most significantly, this important institution's survival would be ensured.

Meharry proposed the merger to the Nashville city council in 1988: in essence, the city would lease Hubbard from Meharry and Meharry, replacing Vanderbilt's School of Medicine, would staff the merged hospital. Dr. Henry Foster, named Dean of Meharry's School of Medicine and Vice President for Health Services in 1990, worked with then Meharry President Dr. David Satcher to negotiate with the city council and Metro General.

Initially, the city council opposed the merger primarily because it doubted whether Meharry could attract sufficient staff to serve the institution's expanded patient pool. In light of these concerns and at the suggestion of Nashville Mayor Philip Bredesen, the city council would test Meharry's mettle by making final acceptance of the merger contingent on Dr. Foster's recruiting a full faculty of 56 physicians and 18 residents to staff the consolidated hospital. The plan was accepted by the city council in August 1992, and Dr. Foster was given one year to accomplish the task.

Dr. Foster played a key role in every element of the process: communicating with medical school deans throughout the nation and attracting an applicant pool of over 400 physicians,

interviewing candidates, and working to ease the transition of the prospective faculty members and their families. Keeping within the timetable set by the city council, Dr. Foster recruited top-flight physicians from throughout the country and assured the council that the merged hospital would provide the people of Nashville with the high quality of patient care it demanded while preserving the city's resources. The merger marked the first time a public hospital merged with a historically black hospital.

The people most familiar with the merger, attribute the merger's success to Dr. Foster's leadership.

> Dr. John Maupin, Meharry's current President, said, "Dr. Foster led that recruitment and brought some outstanding physicians from around the country who were dedicated to the mission of Meharry to serve the underserved. . . Many people didn't believe we would be able to recruit people like that."
>
> Dr. Cleo Carter, a former chief of Obstetrics at Meharry who trained under Dr. Foster, recognized, "Probably without him or somebody with his abilities . . . the merger would have fallen by the wayside."
>
> Henry A. Moses, Meharry's Director of Continuing Education said, "It's unbelievable . . . the people he brought on. It's a tribute to his leadership."
>
> Even opponents of the merger, such as William Willis, a Nashville lawyer and former chairman of Metro General, applauded Dr. Foster's tenacity and negotiating skills.

Largely due to Dr. Foster's leadership and vision, the merger of Meharry and Metro General will succeed, resulting in the establishment of a thriving health services campus pledged to providing the highest quality health care to the citizens of Tennessee. Meharry continues to be a national resource, and the city of Nashville will be more prepared than ever to meet its responsibilities to its poorest citizens.

MEHARRY/HUBBARD HOSPITAL

October 5, 1994

Henry F. Barbour III
Acting Director
Investigations Division
Office For Civil Rights
Region IV
101 Marietta Tower
Atlanta, GA 30323

Dear Mr. Barbour:

Re: Compliance Review No. 04-94-7842

This is in response to the allegations that this facility have denied and/or delivered differential services to Mr. Charles Dezurn due to his HIV/AIDS status.

A review of his medical record and staff review showed that Mr. Dezurn was admitted to this facility on January 8, 1994 at 12:55 p.m.

The patient was seen by a physician on admission, noted to be in respiratory distress and his condition deteriorated rapidly.

Appropriate treatments were done based on his condition.

Enclosed are copies of the requested information:

a. Policy and procedure for admitting and providing services to patients with communicable/infectious disease.

b. List of HIV positive/AIDS patients admitted to the facility since Jan. 1, 1993.

c. Policy and procedure in the care and treatment of patients who are HIV-positive and/or who have AIDS.

d. Current one-day patient census.

We do not have any HIV-positive/AIDS patients admitted in our facility at this time.

I hope that the above information will clarify the issue and will be glad to meet with you or your representative if an on- site investigation is needed.

Very Truly Yours,

Andre Lee, DPA
Hospital Administrator

Copies attached - from IC Manual

1. Universal Precautions - p. 32 of Exposure Control Plan
2. Patient Placement
3. AIDS Procedural Policies - p. 21 24
4. Universal Precautions - p. 25
5. Precautions for Invasive Procedures 60A

DEPT. HEALTH & HUMAN SERVICES

Office for Civil R

Region IV
101 Marietta
Atlanta GA 303

CERT RETURN RECEIPT REQUESTED

SEP 20 1994

Dr. An
Admin
McHar d Hospital
1005 D. Todd Boulevard
Nashville, Tennessee 37208

Dear Dr. Lee:

Re: Compliance Review Number 04-94-7842

The Office for Civil Rights, United States Department of Health and Human Services has responsibility for the enforcement of regulations implementing Title VI of the Civil Rights Act of 1964, 45 C.F.R. Part 80, Section 504 of the Rehabilitation Act of 1973, 45 C.F.R. Part 84 and Title II of the Americans with Disabilities Act (ADA), 28 C.F.R. Part 36. The foregoing regulations require this office to conduct periodic compliance reviews of facilities participating in Federally assisted programs. Your facility is a recipient of Federal funds and therefore, may be included in such compliance activities.

The regulation implementing Title VI of the Civil Rights Act of 1964 as found at 45 C.F.R. Section 80.7, provides that the responsible Department official or his designee (OCR) shall, from time to time, review the practices of recipients to determine whether they are in compliance with the Act. This periodic review authority under Title VI is incorporated by reference in the regulations implementing Section 504 at 45 C.F.R. Subpart G Section 84.61.

Pursuant to the foregoing authorities, you are hereby notified that OCR is initiating a review of your facility to assess its compliance with the same. In particular, on April 14, 1994, this office received information from another Federal agency suggesting possible civil rights violations by your facility relating to the denial of admission/services and/or differential treatment accorded to Mr. Charles Dezurn on or about January 5, 1994, when he appeared at your facility for medical services related to his disability (HIV/AIDS). The allegations suggest that the denial of and/ or delivery of differential services was based solely on Mr. Dezurn's HIV/AIDS status. Both HIV and AIDS are disabilities covered under Section 504 and ADA. Therefore, we will be conducting a review of your facility to determine the extent to which Mr. Dezurn and other similarly situated prospective patients who are HIV or have AIDS have access to your program. Our immediate focus will be to ascertain whether your admission policies, practices and procedures discriminate against prospective and/ or admitted patients who are HIV or have AIDS.

This letter is to request the data necessary to make a determination about the issue in this case. This request is not subject to the Paperwork Reduction Act (P.L. 96-511). This request is made pursuant to Section 504 of the Rehabilitation Act of 1973 at 45 C.F.R. Section 84.61 incorporated by reference to Title VI of the Civil Rights Act of 1964 at 45 C.F.R. Section 80.6. The data provided will be used to evaluate your facility's compliance with 45 C.F.R. Part 84 (Section 504) and 28 C.F.R. Part 36 (ADA). After a review of the data, Mr. James Price of my staff will contact you to establish a mutually agreeable date for an on-site investigation. The requested data should be submitted to this office within fifteen (15) days after the receipt of this letter.

Please provide the following data:

1. A copy of the facility's policies and procedures for admitting and providing services to patients with communicable/infectious diseases. If a separate policy exist with respect to HIV infection or AIDS, please provide a copy of that policy.

2. A written statement regarding the facility's actions with regards to admitting or not admitting Mr. Dezurn.

3. A list of persons who were HIV positive or had AIDS who sought admission to the facility for the period of January 1, 1993 to the present. Please identify the disposition of each request.

4. A list of HIV/ AIDS patients currently in the facility.

5. A copy of any policy, practice or procedure pertaining to the care and treatment of patients who are HIV- positive and/ or who have AIDS.

6. A current one-day patient census. (Forms enclosed).

If you have any questions about the content of this letter, please contact Mr. James Price of my staff at (404) 331-5964.

Sincerely yours,

H. F. Barbour, III

Henry F. Barbour, III
Acting Director
Investigations Division
Office For Civil Rights
Region IV

Enclosure

III. METHODS OF COMPLIANCE FOR EXPOSURE CONTROL PLAN

A. UNIVERSAL PRECAUTIONS:

Since medical history and examination cannot reliably identify all patients infected with HIV or other bloodborne pathogens, blood and body fluid precautions shall be consistently used for all patients. This approach, previously recommended by the CDC and referred to as "Universal Precautions", shall be used in the care of all patients. The following points are emphasized by the CDC's Universal Precautions recommendation.

1. All Health Care Workers shall routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves must be worn for touching blood and body fluids, mucous membranes or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids and for performing venipuncture and other vascular access procedures. Gloves must be changed after contact with each patient.

2. To prevent exposure of mucous membranes of the mouth, nose and eyes, masks and protective eye wear or face shields must be worn during procedures that are likely to generate droplets of blood or other body fluids. Gowns must be worn during procedures that are likely to generate splashes of blood or other body fluids.

3. Hands and other skin surfaces must be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands must be washed immediately after gloves are removed.

4. All Health Care Workers must take precautions to prevent injuries caused by needles, scalpels and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. (i.e. needles must not be recapped).

5. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags or other ventilation devices must be available for use in areas where the need for resuscitation is predictable.

6. Health Care Workers who have exudative lesions or weeping dermatitis must refrain from all direct patient care and from handling patient care equipment until the condition is resolved.

* Updated from Exposure Control Plan April 1992

INFECTION CONTROL
DEPARTMENTAL POLICIES AND PROCEDURES

SUBJECT: PATIENT PLACEMENT	Approved_____Infection Control Revised_____Committee

PATIENT PLACEMENT

When admitted, the patient is assessed either by diagnosis, physicians' orders, or surgical procedure as to appropriate category into which he/she will be placed. If this is not feasible at the time of admission, accommodations should be made as soon as possible.

PATIENT CLASSIFICATION

1. High Risk Patients - those who have a greater susceptic bility for developing and acquiring infections.

They may require reverse (protective) isolation, but only if ordered by the physician. However, they may be placed with other high-risk patients, uninfected and clean surgicals, without a physician's order. They should never be placed with "suspected" patients or patients known to have an infection or contagious disease. Therefore, the nursing supervisor or Nurse Epidemiologist should be consulted by the Admitting Office before patient placement.

Examples of high-risk patients:

Agranulocytosis (low white count)
Burns
Cancer
Diabetes
Pregnancy
Post-operative patients
Sickle cell anemia

2. Suspect patients - Those who could possibly "spread" infection but do not warrant isolation precautions.

Those patients should only be placed with patients who do not fall into the high risk category.

Examples of suspect patients:

Bedsores, open but not infected
Chronic lung disease
Conjunctivitis, draining
Cysts, draining
Diarrhea if possibly contagious
Urinary tract infections
Pneumonia, bronchitis, severe upper respiratory infections
F.U.O. (Unless physician documents that patient is not contagious)

INFECTION CONTROL
DEPARTMENTAL POLICIES AND PROCEDURES

SUBJECT: AIDS PROCEDURAL POLICIES	Approved_____ Infection Control Revised_____ Committee

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 infection. 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. Universal Precautions are to be strictly complied with.
2. Portable cardiopulmonary resuscitation equipment should be immediately accessable.	2. Obviates concerns about mouth-to-mouth respiration
a. Order disposable ambu-bag and oral airway from CPD.	
3. Use masks when indicated, and until tuberculosis has been ruled out.	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, and until a negative AFB has been obtained.

INFECTION CONTROL
DEPARTMENTAL POLICIES AND PROCEDURES

SUBJECT: AIDS	Approved_____ Infection Control Revised_____ Committee

PROCEDURE	COMMENTS
4. The use of gowns is recommended	4. Especially when soiling with blood or body fluids is anticipated.
5. Gloves must be worn as indicated. (nonsterile)	5. Gloves must be worn if contact with blood or body fluids, secretions, or excretions is anticipated. IT IS EXTREMLY IMPORTANT FOR PERSONNEL WHO HAVE CUTS OR ABRASIONS ON THEIR HANDS TO WEAR GLOVES WHEN CARING FOR AIDS PATIENTS. (HANG-NAILS, SCRATCHES, ETC.)
6. <u>Wash hands thoroughly before and after patient care.</u>	6. Hands must be washed routinely when caring for AIDS patients, especially if they are contaminated with blood, body fluids, secretions, or excretions. <u>The precaution is to be observed regardless of the use of gloves.</u>
7. Protective eyeware (goggles) are to be worn in the performance of Special procedures.	7. In the performance of Endotracheol intubation, bronchoscopy, and GI endoscopy. Recommended for the protection of splatter with blood, bloody secretions, or body fluids when such is a possible occurence.

INFECTION CONTROL
DEPARTMENTAL POLICIES AND PROCEDURES

SUBJECT: AIDS	Approved_____ Infection Control Revised_____ Committee

PROCEDURE	COMMENTS
8. Do not recap syringe needles after use.	8. Needles and syringes are disposable and are to 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.
9. Plan in order to keep parenteral injections at a minimum.	9. Extraordinary care should be to avoid accidental wounds from needles or other sharp instruments.
10. Employ Universal Precautions. Place all specimens in a plastic bag after obtaining and label before transporting to lab.	10. All specimens must be 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 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-Ray's, 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

INFECTION CONTROL
DEPARTMENTAL POLICIES AND PROCEDURES

SUBJECT: AIDS	Approved_____Infection Control Revised_____Committee

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

INFECTION CONTROL
DEPARTMENTAL POLICIES AND PROCEDURES

SUBJECT: UNIVERSAL PRECAUTIONS: SPECIMEN COLLECTION	Approved _____ Infection Control Revised _____ Committee

PROCEDURE	COMMENTS
1. Gloves are to be worn for the collection of specimens for laboratory analysis.	1. Prior to the procedural collection of blood Urine, Feces and Sputum gloves are to be doned.
2. The use of gowns is recommended.	2. Especially when soiling with blood or body fluids is anticipated.
3. Place <u>all</u> specimens, regardless of source in the plastic bags provided. (Zip lock bags).	3. All blood specimens must be must be placed in a second container for transport promptly.
4. LABEL ALL SPECIMENS OBTAINED FROM KNOWN INFECTION PATIENTS "BLOOD AND BODY PRECAUATIONS IMMEDIATELY." All other specimens are to be bagged and appropriately labeled for transporting to the LAB.	4. Specimens from patients with Hepatitis A, B; AIDS patients with respiratory infections, and suspected bacteremia and bacteriuria patients are positively to be bagged and labeled appropriately.
5. Wash hands thoroughly after handling specimens.	5. Wash hands using the soap provided, warm water and vigorous friction for 15 seconds.

MEHARRY/HUBBARD HOSPITAL
INFECTION CONTROL
DEPARTMENTAL POLICIES AND PROCEDURES

PRECAUTIONS FOR INVASIVE PROCEDURES

Departments that perform invasive procedures (an entry into tissues, cavities, or organs or repair of major traumatic injuries) such as in the following areas: O.R., E.R., vaginal or cesarean delivery, outpatient surgery, cardiac catherization or angiographic procedures should follow the Universal "Body Substance Precautions" listed above, as the minimum, and combined with the precautions listed below for all such invasive procedures:

1. All health care workers who participate in invasive procedures must routinely use appropriate barrier precautions to prevent skin and mucous-membrane contact with blood and other body fluids of all patients. Gloves and surgical masks must be worn for all invasive procedures. Protective eyewear or face shields should be worn for procedures that commonly result in the generation of droplets, splashing of blood or other body fluids, or the generation of bone chips. Gowns should be worn during invasive procedures that are likely to result in the splashing of blood or other body fluids. All health care workers who perform or assist in vaginal or cesarean deliveries should wear gloves and gown when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin and should wear gloves during post-delivery care of the umbilical cord.

2. If a gloves is torn or a needlestick or other injury occurs, the glove should be removed and a new glove used as promptly as patient safety premits; the needle or instrument involved in the incident should also be removed from the sterile field.

Confidentiality

The commitment to protect the rights and confidentiality of all individuals concerned will be followed as usual. The release of information to persons outside the center other than the Tennessee Department of Health & Environment will require the usual authorization for release of information by the patient.

May 1, 1995

NOTE TO JOHN PODESTA:

Stephanie Goodman of Senator Kennedy's staff asked for the attached memorandum, which summarizes an external nonfederal audit of Meharry Medical College for the year ending June 30, 1993.

Also attached is a background paper, prepared by HHS' Office of Inspector General, which explains the purpose of the audit and assesses Meharry's financial status in light of the audit.

Andrew D. Hyman

MEHARRY MEDICAL COLLEGE
FACT SHEET

Meharry Medical College (Meharry) has had serious financial problems for a number of years. As a result of continued operating losses over many years, the operating deficit of Meharry, exclusive of Federal, endowment and other funds restricted by the donor, totaled $49.4 million.

A-133 Background Audit Statement

Under Office of Management and Budget Circular A-133, colleges and universities and other nonprofits are required to have annual financial statement audits of all Federal money they receive. These audits are conducted by nonfederal auditors, such as public accounting firms. Audit quality is reviewed by the Department of Health and Human Services' Office of Inspector General which issues these nonfederal reports to the Department's managers and, as appropriate, alerts them to any significant funding concern. This paper is a summary of nonfederal audits conducted at Meharry for Fiscal Years 1991, 1992 and 1993.

GEORGE W. HUBBARD HOSPITAL

The principal cause of Meharry's financial problems has been the operation of Meharry's George W. Hubbard Hospital (the Hospital). For Fiscal Years 1991, 1992 and 1993, the Hospital had operating losses of $7.8 million, $3.5 million, and $.5 million respectively. Despite these losses, Meharry, as a whole, earned a profit in Fiscal Year 1993 of $1.3 million.

Lease

The notes to the financial statements in the 1991, 1992, and 1993 reports state that the Metropolitan Government of Nashville and Davidson County (the County) are planning to lease the facilities of the Hospital and purchase physician services from Meharry. According to the notes, the contracts with the County will provide funding for clinical faculty currently being paid by Meharry and rental income. As of the date of the 1993 report, the lease transaction had not been finalized.

According to Mr. George R. Williams, Meharry's Director of Grants and Contracts, Meharry entered into a 30-year lease agreement with the County with lease payments accruing from December 1, 1994 (the effective date of the lease). The operations of the County hospital are to be consolidated with the Hospital operations.

The lease of the Hospital should improve the financial position of Meharry. As stated in the notes to the financial statements, the contracts with the County will provide funding for clinical faculty (which had been funded by Meharry) and rental income from the lease of the Hospital.

Penalties and Interest on Delinquent Payments

As of June 30, 1993, the Hospital was delinquent in making payments to the State of Tennessee and owed $1.6 million in delinquent license fees spanning Fiscal Years 1990-91 and 1991-92. In addition, Meharry was assessed penalties and interest of $3.9 million.

Meharry has taken the following actions:

(1) Paid the license fees for Fiscal Year 1992-93 on a timely basis.

(2) Submitted a proposed payment plan to the State of Tennessee.

(3) Paid $505,063 relating to the license fees for Fiscal Year 1990-91.

No provision for any interest or penalties that may result upon the final determination of this matter has been recognized in the financial statements.

ABILITY TO CONTINUE

Meharry has managed to continue operations by:

- Borrowing from endowment accounts (funds restricted by the donor) to fund the operating deficit. For Fiscal Years 1991, 1992, and 1993, Meharry used borrowings from the endowment accounts to finance the current fund deficits. The borrowings as of Fiscal Year 1993 were $20.3 million of the $30.2 million balance in the endowment accounts. Meharry will have to repay the endowment accounts in order to comply with the legally binding, externally imposed restrictions.

- Obtaining short term bank loans. The year-end balance of notes payable to banks increased $.7 million in Fiscal Year 1992 and $3.8 million in Fiscal Year 1993.

- Overdrawing checking accounts in each of the 3 years. In Fiscal Year 1993, Meharry had written checks in excess of deposits of $.5 million. Although this was an improvement from the prior 2 years, there is a risk that Meharry's accounts will not cover the amount of checks presented for payment.

SUMMARY

Meharry has had serious financial problems for a number of years. The principal cause of these financial problems has been the operation of Meharry's Hospital.

The 30-year lease of the Hospital should eliminate the principal cause of the prior financial difficulties. However, Meharry's efforts to reduce the significant deficit, interfund and short-term borrowings incurred to cover many years of operating losses, will need to be closely monitored.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandum

Office of Audit Services, NEAR
Lucas Place, Room 514
323 West 8th Street
Kansas City, Missouri 64105

Date : JAN 12 1995

From : Manager, National External Audit
Review Center

Subject : National External Audit Review Center Alert--Meharry Medical College, for the year ended June 30, 1993
(CIN A-04-95-33092)

To : See Attached Distribution

Our desk review of the nonfederal audit report on Meharry Medical College identified the following conditions we believe should be brought to your attention:

-The College is operating with a $49,403,989 deficit unrestricted fund balance. Although this is a small improvement when compared to the deficit for the fiscal year ended 1992, the situation still presents a going concern issue. Management is of the opinion that with the continued support of the Federal government and other sources, an improved development program, and the lease of the Hospital facilities the College will be able to repay interfund borrowings and overcome its long-standing financial problems.

-As discussed in note 13 to the financial statements and on page 1, the College has been assessed penalties and interest of $3,871,203 by the State of Tennessee relating to the non-payment of hospital services license fees. The College has proposed a payment plan to the State of Tennessee which would abate all penalties and interest due. However, an agreement with the State has not been finalized.

No findings related to these items were identified. However, the serious nature of these weaknesses leads us to conclude there is more than a relatively low level of risk associated with the entity. We are highlighting this entity for closer monitoring and increased attention by grants management staff to protect the Federal interest. We suggest the entity be considered for high risk (or "exceptional") status.

We are also bringing this information to the attention of the OIG management for consideration in the work planning process. Should you have any questions regarding this report, please contact our office at (816) 374-6714.

Manager

Attachment

REPORT DISTRIBUTION SCHEDULE

CIN A-04-95-33092
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Genesis...

... an innovative curriculum coming into being!

a Publication of the Meharry Medical College School of Medicine
Office of Student/Academic Affairs

Vol. 2, No. 4 June 1993

MERGER RECRUITMENT: THE PROCESS, THE EDUCATIONAL IMPLICATIONS

by Henry W. Foster, Jr., M.D., Dean, School of Medicine
andVice President for Health Services Meharry Medical College

As most Nashvillians now know, Meharry has successfully recruited its 74 physicians needed for the merger process — 56 staff physicians and 18 resident physicians.

Recently, I have been frequently asked, "How were you able to recruit such highly qualified physicians in such a short period of time?" It is a fair question and I can assure it did not occur by happenstance. The process was divided into the following three operational phases: 1) awareness, 2) engagement and 3) placement.

The "awareness" phase had as its goal to make known as widely as possible in the best environs our recruitment needs. This included placing ads in national medical journals; sending 1,500 recruitment flyers to the other 125 deans of medical schools; sending letters of solicitation from all of our chairs to all 125 of their counterparts; attendance and advertisement at national medical meetings; and visiting and working closely with Meharry's National Alumni Association. After 6 months, virtually everyone in this country in academic medicine was aware of Meharry's recruitment campaign.

The "engagement" phase began basically when a prospective faculty member made contact with me. The routing sequence was designed such that virtually all correspondences and curricula vitae came to my attention first. Having mutually developed the staffing document and its criteria with city and Vanderbilt officials, I was better positioned to screen the applicants. This initial contact was followed by a detailed letter from me to the inquirer describing Meharry's history, present events attendant to the merger and our aspirations for the future. Once curricula vitae had been screened, they were placed into the hands of the various Chairpersons; most of the subsequent recruiting responsibility then fell to them. During this engagement phase, I cannot stress too strongly how much emphasis was placed on recruitment of spouses. This was viewed as paramount. In addition to aiding spouses who sought employment, information on schools, churches, parks, museums, libraries and yes, shopping centers, was always made available.

The final phase which was the "placement" phase, dealt mostly with the logistics of securing all needed supports for those physicians who had agreed to join our faculty, e.g. moving, selecting schools for children, assistance in locating housing, securing medical licenses, banking facilities, medical liability insurance, hospital privileges, etc. I view it extremely important, in fact absolutely mandatory, to maintain the same level of interest in candidates after they have signed up (placement), as was maintained during the phase of engagement. This level of attention reduces the level of anxiety which, understandably is attendant to any change of venue. During the

whole of this recruitment process, 408 physicians contacted Meharry. It was from this pool that we derived the 56 staff physicians' slots. The pool size was a major determinant as to the high quality of the faculty.

Now, what does all of this mean for Meharry's teaching goals and objectives? Starting with the basic sciences departments, this new cadre of clinical faculty now available will expand on what we have characterized as "clinical correlation." This is the process wherein students are exposed to a "tie-in" of basic and clinical sciences in an effort to bridge that artificial pedagogical gap, that we in academia have erected in an attempt to effect order in teaching.

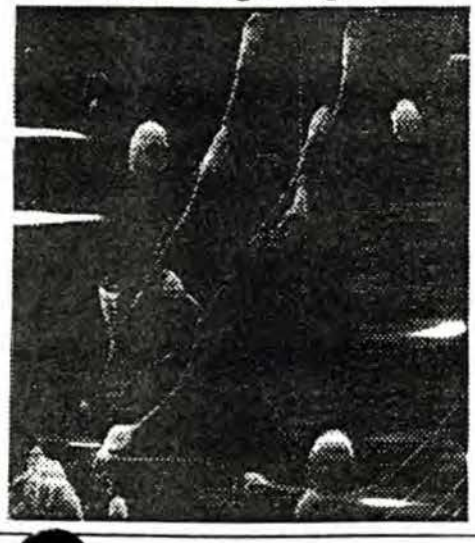
As we address curriculum reform, venture into the realm of Problem Based Learning (PBL), strengthen our board review courses, seek more mentors for our students and enhance our Summer Biomedical Sciences Program, the acquisition of this diverse pool of new faculty for Meharry is most timely. But be reminded that their presence is process; the true measure of the value and effectiveness of these faculty members will be determined by defined outcome measures. Among our most important outcomes for our students are better performance on outside objective examinations, greater success at obtaining residency choices and most important, becoming effective committed members of the health care profession.

The role of these new clinical faculty will be more evident on the clinical side. The improved teaching that will result from having these new faculty will occur in the classroom, as well as in the hospital and in out-patient settings.

In order to help better hone the teaching skills of these new faculty, Richard T. Williams, Ph.D., of the office of Academic Development & Support Services has structured a retreat for this purpose. Twenty to twenty-five medical faculty new to Meharry will participate July 16, 17 and 24, 1993. The retreat is designed to help physicians improve their teaching skills. This interactive program will provide the means by which novice instructors will be able to improve the quality of the decisions that they make about teaching activities in three important areas: curriculum, instruction and evaluation, according to Dr. Williams.

Efforts such as this retreat should strengthen our faculty's teaching ability. If faculty are successful, our students will prosper academically, become superb physicians and will be imbued with the quest for lifelong learning, which is Meharry's ultimate goal for all of its graduates.

In the Beginning....



Workshops of Note

Remember PROBLEM BASED, STUDENT CENTERED LEARNING (PBL)? If so, and if you have an interest in being a group facilitator/tutor, check out the Tutor Training Workshop on June 28-30, 1993 in the Orange Room of the cafeteria. You will get the opportunity to see what being a group facilitator is all about. There will be training on how to keep a group on track, how to handle a student who wants to control the group or a student who doesn't want to talk. There will also be a chance to work with groups of faculty and students. The workshop leaders are Kirk Smith, Biochemistry, Cheryl Hamberg, Library, and Richard Williams, ADSS. For more information and registration call x-5753.

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

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Divider Title: _____

PLANNED PARENTHOOD

Planned Parenthood is a health care organization which manages nearly 1,000 health centers in 49 states and the District of Columbia. Planned Parenthood serves four million women and men each year, making it the nation's largest provider of comprehensive reproductive health care, including breast examinations, PAP tests, testing and treatment for sexually transmitted diseases, infertility services, birth control methods and counseling, and comprehensive sexuality education. Dr. Foster has served on local and national Planned Parenthood boards since 1974.

Planned Parenthood and Dr. Foster share the mission of resolving our nation's most troubling health crises by providing effective solutions which focus on prevention and responsibility. Throughout his career, Dr. Foster has been a driving force in the prevention of teen pregnancy and a leader in the field of public health. The highly effective, "I Have a Future" program, which Dr. Foster developed, stresses sexual responsibility, self-control, education, and job skills and provides positive alternatives to having children. Similarly, Planned Parenthood's medical and educational services help prevent nearly half a million unintended pregnancies each year.

Although Dr. Foster does not advocate abortion as a substitute for family planning, he supports Planned Parenthood's efforts to provide abortion services when a woman chooses to have the legal, constitutionally-protected procedure. Dr. Foster has repeatedly voiced his concern that all women have access to reproductive health care, including abortion. He also has supported Planned Parenthood's efforts to secure the passage of the Freedom of Access to Clinic Entrances Act, legislation designed to protect patients and staff at women's health care centers.

While Dr. Foster was a member of the organization's Board of Directors, the Nashville affiliate filed a lawsuit challenging a Tennessee law requiring parental notice before a teenage girl could obtain an abortion. Dr. Foster has sought to involve parents in their children's decisions to obtain contraceptive or abortion services and strongly believes that parents should be involved in these decisions. He has worked to limit the number of abortions performed on teenagers by promoting abstinence and alternatives to having children through programs such as the "I Have a Future" program. Dr. Foster realizes, however, that some young women cannot notify their parents, because they come from homes where physical violence or emotional abuse is prevalent or because their pregnancy is the result of incest. Dr. Foster opposed the Tennessee law because it required parental notice for a minor seeking abortion with no exception for minors from abusive homes and no bypass mechanism as required by the United States Supreme Court.

To prevent unwanted pregnancies and to provide alternatives to sexual activity, Dr. Foster looks primarily to parents and families. He encourages parents to educate their children about sexuality and reproductive health and to promote the need to postpone premature sexual activity. Dr. Foster also realizes that schools may play an important role in the process and advocates developing age-appropriate educational programs which promote abstinence and which prepare teenagers for responsible sexual involvement as adults.

Planned Parenthood
OF MIDDLE TENNESSEE
HEALTH SERVICES

95 White Bridge Road, Ste. 312
Nashville, Tennessee 37205
615 353-0755 Administration
615-356-6326 Education
615-356-6616 Fax

4/14/95

TO: Todd Stern

FR: Shelby Tabeling
Associate Executive Director

RE: Malpractice Suit Against Planned Parenthood of Middle Tennessee

The Sunday, April 9, 1995 edition of the New York Times referred to a suit alleging abortion malpractice by Planned Parenthood of Middle Tennessee which is currently under litigation.

Dr. Foster was a member of the Planned Parenthood Board of Directors at the time the alleged malpractice occurred, and at the time the suit was filed. His attention during that time frame was consumed by the merger of Meharry and General Hospitals, and he may not be fully aware of the litigation. I am forwarding information about the suit both to you and to him so that we may be prepared in case he is asked about it at any time.

We have talked with the attorney handling the case, Steven Heard, who advised that any response should be primarily limited to "I cannot discuss the affiliate's pending litigation." and "Planned Parenthood looks forward to having the matter resolved in court.". If you need to contact Mr. Heard, he may be reached at Heard, Estes and Donnell (615-244-6538).

Please let us know if we can be of further help.

ment fire

bles, and fled.
re on the scene for nearly three
to District Chief Charles Hudson.
two ladder trucks responded.
been worse," he said.
and only two apartments
Four others were dam-
nd water, Hudson said.
concealed in the crawl space,
through the building, he said.
pulled ceilings down from the
." he said. "And we were pretty
g that."
he fire is under investigation.

Rick Musacchio ● Staff

Firefighters battle the airport-area blaze at Hidden Valley Apartments. They pulled down ceilings to reach the fire, which raced through the building's crawl space.

Ricky Rogers ● Staff

se on Cross Plains Road
tle.

the county's control, county
y officials are also helping
the seeds of population

recently concluded a study
ed to determine what the
needs to attract more indus-
the area.
study — co-sponsored by
Central Bell and the Tennes-

to PAGE 2B, Column 1

2/28/94 Tennessean

Girl given abortion she didn't want, suit charges

Family accuses boy, mother of pressure

By KIRK LOGGINS
Staff Writer

A woman has charged that her 14-year-old granddaughter was pressured to have an abortion by her boyfriend and his mother, who works as a counselor for Planned Parenthood of Middle Tennessee.

The girl, now 15, became depressed and suicidal two weeks after having an abortion at Planned Parenthood's clinic here last Jan. 27, her grandmother, Clara Smotherman of La Vergne, said in a lawsuit filed Wednesday in Davidson County Circuit Court.

The girl, Charity Edmonds, is now in the custody of the Tennessee Department of Human Services and is living in an unnamed DHS group home, according to the suit.

It blamed the girl's subsequent psychological problems, including "increasing alcohol and drug abuse," on the abortion.

Smotherman charged that Planned Parenthood officials performed the abortion without considering the girl's psychological history — including the suicides of her mother, stepfather and father — and her boyfriend's threats of suicide if she did not have an abortion.

Smotherman said in the lawsuit that her granddaughter's boyfriend, Jason Millikan, then 17, drove Edmonds to a Planned Parenthood clinic on Jan. 19, 1993, for a pregnancy test. The test showed that Edmonds was 11-12 weeks pregnant, according to the lawsuit.

Millikan called Edmonds every night for the next week, urging her to have an abortion and threatening to kill himself if she did not do so, Smotherman said in the lawsuit.

Millikan's mother, Sandy Millikan, who works as a Planned Parenthood counselor, told Edmonds that her refusal to abort the fetus "would impair her and Jason's prospects of future education," Smotherman said in the lawsuit.

Jason Millikan drove Edmonds to Planned Parenthood's main Nashville clinic, at 211 21st Ave. S., on Jan. 25 and Jan. 27, 1993, where

Turn to PAGE 2B, Column 2

OWN

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-809
Tommy Gold-
-8095; Robert

-8090; Dwight
. 259-8090;
9093.

MIDSTATE

Brace yourself. Another blast of cold air is headed for Middle Tennessee. But it won't be nearly as cold as last week's single-digit lows. The National Weather Service is predicting snow late Saturday and early Sunday, but it's too soon to guess at accumulation. "It's looking pretty likely...," said Ralph Troutman, a weather service specialist. Temperatures are expected to drop from the 50s this morning to the 40s this afternoon and close to freezing tonight.

— LINDA A. MOORE

RUTHERFORD

He still needs support. Sgt. Lee Winnett of the Murfreesboro Police Department is battling soft-cell sarcoma, a cancer that destroys the body's soft tissues, with experimental medical treatments. The Rutherford County NAACP is sponsoring a fund-raiser to offset Winnett's medical bills beginning at 10 a.m. tomorrow at the Patterson Center Pavilion, 604 E. Castle St. Hot dogs, hamburgers, fish sandwiches and cold drinks will be sold. For information, call 895-8555.

— JENNIFER GOODE

Nashville Banner 1/28/94

...partment fire ... no one hurt

...fighters said, it began in apartment L-101. Fire officials were still investigating the cause.

"I think it started in the apartment beside us," Armstrong said. "Smoke was coming through the kitchen ceiling. My husband grabbed the fire extinguisher, but what do you spray?

"We never saw flames, but the smoke kept coming out of the roof."

The fire was "sneaky," Hudson said, not sending flames through the walls or roof, but hiding and burning.

"At first, we thought we had it confined in a closet area," Hudson said. "We had a problem with it. There was a lot of fire in the concealed spaces between apartments."

When the nature of the fire became apparent, Hudson called in more equipment, eventually filling the parking lot with more than 10 firefighting units.

Teen forced to have abortion; suit

By Toni Dow
Banner Staff Writer

A Rutherford County women's $15.5 million lawsuit against Planned Parenthood of Middle Tennessee alleges that a teen-age relative was forced to have an abortion against her will.

The suit filed Wednesday in Davidson County Circuit Court alleges Planned Parenthood officials violated state law by failing to notify the teen's legal guardian concerning the abortion.

Clara Smotherman's suit also alleges officials broke the law by pressuring the girl into the abortion and by performing the procedure without her consent.

Shelby Tabling, an official with Planned Parenthood, said of the suit: "We've not seen it, so really, until we see it, we really can't comment."

J. Thomas Smith, the Franklin attorney representing the plaintiff, also refused comment on the case.

According to the lawsuit, the girl's stepfather murdered her biological mother and then committed suicide after sexually abusing the girl's sister.

In 1990, the girl's biological father killed himself after the girl refused to live with him.

At that point, the girl went to live with the plaintiff.

In January 1993, the girl learned she was pregnant and told her boyfriend of one year, who took her to Planned Parenthood for a pregnancy test.

The test indicated she was 11 to 12 weeks pregnant.

"At that time, she told (Planned Parenthood) that she did not want to have the abortion," the suit states.

After that visit, her boyfriend called her "every night urging her to get an abortion during which he repeatedly threatened to commit suicide if she did not have an abortion," the suit states.

The suit alleges the boy's mother, an employee of Planned Parenthood, told the girl she was "not thinking of the best interests of her son" and that her refusal to have an abortion "would impair her and (her boyfriend's) prospects of future education."

On Jan. 25, 1993, the boyfriend again took the girl to Planned Parenthood, where she talked to another counselor.

But again the girl said she didn't want to have an abortion, the suit states.

Two days later, her boyfriend again took her to Planned Parenthood, where the suit alleges clinic officials performed an abortion on her without her consent.

In February 1993, the girl's relative learned the girl had had an abortion after meeting with school officials concerning her repeated absences.

By Feb. 10, 1993, the girl "became increasingly depressed and suicidal," so she was admitted to Tennessee Christian Medical Center until March 9, 1993.

After being discharged from the hospital, "disruptions in the family relations" prompted her to be placed in temporary custody of the Department of Human Services.

The girl visits her family but still does not live with them, her attorney said.

...pen new $1M chapel to public

RELIGION
Frances Mee...

She says women of the church are planning an event soon of "food, fun and entertainment" for homeless women and their children in keeping with the 1994 focus of women's work, which is to aid the homeless.

Heralds sing

The acclaimed Heralds Quartet will perform at Madison Campus Seventh-day Adventist Church, 319 Hospital Drive in Madison, at 7 ... Monday.

... will be a big-screen television, and members are asked to bring containers of soup to be served at 5 p.m. A worship service will follow.

■ Lincoya Hills Baptist Church will host a "Super Bowl Spectacular" at 5 p.m. at Donelson Station Center. A highlight will be the showing of a video in which National Football League players share their Christian testimonies.

Food is free, but reservations must be made ... ing 883-7111.

■ First Ba... urch, Frank... will hold "Super

Girl, 14, given abortion she didn't want, suit charges

FROM PAGE 1B

she finally had an abortion, "despite [her] repeated statements" that she did not want to go through with it, the lawsuit said.

The lawsuit charged that Planned Parenthood violated a Tennessee statute requiring that a minor's parents or legal guardian be given two days' notice before an abortion is performed.

Davidson County Circuit Judge Hamilton Gayden affirmed the parental notification requirement when Planned Parenthood challenged parts of the Tennessee abortion statute in 1992.

But Gayden said the parental notification rule could be waived if a minor's life or health — including "emotional and psychological factors" — would be endangered by delaying an abortion.

Smotherman sued Planned Parenthood of Middle Tennessee, its local medical director, Dr. Peter Cartwright, who performed the abortion; and Planned Parenthood Federation of America Inc. for $3.5 million in compensatory and $12 million in punitive damages.

Elena Love, director of Planned Parenthood of Middle Tennessee, said yesterday that she had not received a copy of the lawsuit and could not comment on it.

Love refused to comment on Sandy Millikan's involvement in the case, or to confirm that Millikan still works for Planned Parenthood of Middle Tennessee.

Neither Sandy nor Jason Millikan could be reached yesterday for comment on the lawsuit.

The lawsuit was prepared by attorneys Theodore H. Arnshoff Jr. of Louisville, Ky., who specializes in abortion malpractice litigation, and J. Thomas Shinn Jr. of Franklin.

Smaller

ar welcome

By TAMAR LEWIN

PHOENIX — Dr. Brian Finkel, whose practice consists mostly of performing abortions, sounds matter of fact when he talks about the bullet-proof window in his office, the bullet-proof vest and helmet he wears walking to his car, the guns he carries, the years of demonstrations outside his office and the threats he has received.

But he sounds thoroughly outraged — and, in his own bluff way, hurt — when he gets on to the subject of John Joseph Jakubczyk, general counsel to Arizona Right to Life, and the newest anti-abortion strategy:

A New Weapon In an Old War

A special report.

malpractice suits against the doctors who perform abortions.

"John Jakubczyk is a lawyer, an officer of the court, who has abused his professional power to harass me and intimidate my patients," Dr. Finkel said. "The suits he filed against me have dirtied my name. They have made me uninsurable for most insurance carriers. They made me pay legal fees to defend myself. I am committed to providing women with a service they need, but I have begun to wonder if it's worth it. You get hit about the head with a two-by four long enough and you finally say ouch, that hurts."

While abortion-malpractice lawsuits are a new phenomenon in much of the country, they are almost routine for Mr. Jakubczyk, who has filed nine of them in the last decade. Besides two against Dr. Finkel, Mr. Jakubczyk has also filed malpractice claims against the local Planned Parenthood affiliate, the A-Z Wom

Continued on Page 14, Column 1

NY Times National Sunday 4/9/95

14 Y

New Tactic on Abortion: Malpractice Accusation

Continued From Page 1

en's Center, a doctor at Abortion Services of Phoenix, a doctor at the Family Planning Institute.

So far, Mr. Jakubczyk has had little success. He lost the only case that went to trial. Most have been dismissed or withdrawn. And in one case against Dr. Finkel, the judge thought the charges so flimsy that he fined Mr. Jakubczyk for filing a frivolous suit, but the fine was later overturned by an appeals court.

"The problem is, even if they lose, they win," said Dr. Finkel, who has faced six abortion malpractice suits, some filed by other lawyers than Mr. Jakubczyk, which were all dismissed. "Whatever happens in court, they've had the press conference, and I've been damaged. I'm paying $25,000 a year for insurance now, and I'm not allowed to practice out of state, all because of this developing art form of legal misconduct."

In response to Dr. Finkel's complaint, the Arizona bar is investigating whether Mr. Jakubczyk's lawsuits violate ethical standards.

Like any other surgery, abortion carries its risks. And there is nothing new about an occasional malpractice suit when a doctor's bad care has caused severe injury or death.

What is new is the number of abortion malpractice suits now being filed — and who is filing them. Increasingly, lawyers associated with anti-abortion groups, rather than malpractice specialists, are seeking out claims against doctors who do abortions.

According to J. Thomas Smith, a partner in a new law firm devoted to abortion malpractice, only 86 abortion-malpractice verdicts have been issued in the last 10 years. While no one knows how many current cases will end in verdicts, Life Dynamics Inc., an anti-abortion group in Denton, Tex., that is encouraging such suits, says it is involved in 90 cases.

Pamela Maraldo, president of Planned Parenthood Federation of America, "Where there is malpractice, where a bad doctor is injuring women — of course we want that stopped. But in the current war-zone climate of bombings and shootings at abortion clinics, with the active campaigns to threaten doctors who perform abortions, I can't believe these lawsuits are aimed at protecting women. I believe they are part of an overall strategy to take away women's right to choose."

In a 1992 anti-abortion manual, Mr. Crutcher urged support for abortion malpractice suits "to protect women, but also to force abortionists out of business by driving up their insurance rates."

But the lawyers who handle abortion-malpractice cases — Mr. Crutcher is not a lawyer — say filing lawsuits to harass doctors would be an abuse of the courts. They say they are filing the cases not as anti-abortion advocates, but simply as advocates for injured women.

And, they say, they have a strong incentive to avoid frivolous claims, or harassment suits, since the cases are handled on a contingency basis, with the lawyers getting paid only if they win money for their clients.

"I bring cases only where there was a failure to meet the standard of care, and a woman was injured as a result," said Mr. Jakubczyk, who spoke at the Life Dynamics seminar. "For every woman for whom I file a claim, there are many more I tell that no matter how bad their abortion left them feeling, they don't have a case. People see me as John Jakubczyk, pro-life advocate. But in these cases, I'm just John Jakubczyk, representing a woman."

Ted Amshoff, a Louisville, Ky., a partner in Swendsen, Amshoff, who would not discuss his his personal views on abortion, calling them irrelevant to his legal work, said some of the women he represents had found

Photographs by Jeff Topping for The New York Time

John Joseph Jakubczyk, general counsel to Arizona Right to Life, who has filed nine suits against abortion doctors in the past decade.

women who have chosen abortions to lawyers who oppose them, who must then argue to the jury that the women should not be judged harshly for having an abortion.

And malpractice litigation has created some strange alliances. Dr. Warren Hern of Boulder, Colo., has for years been a prime target of the anti-abortion movement, both because he is an outspoken advocate of abortion rights and because he performs late abortions.

But Dr. Hern, who wrote the most widely used textbook on abortion, supports many malpractice claims.

"There's a lot of bad medicine being practiced out there in the name of choice," said Dr. Hern, who estimates that lawyers interested in filing abortion-malpractice suits now account for about 5 percent of the sales of his textbook. "I testified in an Oregon case against a doctor who really did not do well by a patient. As a society, I think we've

kill myself.' She wanted the baby, had already chosen a name. But she got pulled into having an abortion. Within a week she was admitted to the emergency room, crying uncontrollably. She's been in psychiatric care for more than a year now."

Planned Parenthood said it could not discuss the case while it was pending, but disputes the the lawsuit's account. And mental health experts say any girl who lost both parents so brutally might have emotional problems, abortion or no.

Mr. Smith said that, for him, abortion malpractice is both a legal specialty and a ministry.

"A great many women are injured by abortion, but in the past, very few have filed suit," Mr. Smith said. "So as a lawyer I see it as potentially a very lucrative specialty. And as a byproduct, it's a form of ministry. I've been working with this little 15-year old for a year, and it's a way of ministering to the second victims o

suits, says it is involved in 80 cases.

Legal Advice

A Wide Variety Of Services

Many new cases go beyond traditional malpractice claims. Life Dynamics, which attracted 125 people to Dallas for a two-day seminar last year on abortion malpractice, has provided much of the impetus and legal research for expanding the kinds of cases brought against doctors who do abortions.

For example, it offers research and expert witnesses on post-abortion trauma who say women often suffer the same kind of long-term psychological problems after abortions as soldiers do after wars, a concept that was examined and rejected by both former Surgeon General C. Everett Koop and the American Psychological Association.

Life Dynamics advises lawyers to consider charging doctors with battery if the woman's formal consent can be challenged.

In a mass mailing to doctors, Life Dynamics advised them to tell women of studies tying abortions to a higher risk of breast cancer and asked them to refer any patients who have had an abortion and are now diagnosed with breast cancer to Life Dynamics for "inclusion in a proposed class-action lawsuit."

Mark Crutcher, the president of Life Dynamics, said his group had more than 600 lawyers in its "Abmal" network, 40 percent of whom, he said, support abortion rights. The network offers lawyers ads soliciting clients ("Don't be a victim for the rest of your life"), expert witnesses, courses to teach women how to testify effectively, dossiers on abortion doctors and even a loan of the medical instruments used in abortion for lawyers to use in showing a jury what was done.

"There are more women than we ever dreamed of getting killed, raped, assaulted and severely injured by abortionists," Mr. Crutcher said. "We've got over 2,500 examples now."

Life Dynamics is not the only group encouraging these suits. In Pensacola, Fla., Mike Conroy says his organization, Legal Action for Women, gets about 10 calls a day on its toll-free line, 1-800-U-CAN-SUE, from women who say they have been injured by an abortion.

Mr. Conroy's group, like Life Dynamics, refers women to lawyers who will handle such cases, and both groups provide materials to hand out to women leaving abortion clinics.

Last year, several lawyers from different states established a firm, Swendsen, Amshoff, Donovan & Smith, to handle abortion malpractice work. Ted Amshoff, of Louisville, Ky., said the firm had 20 open cases, including 4 in which women died as a result of abortions.

Motives

Legal Harassment

Dr. Brian Finkel outside his office in Phoenix. He does abortions and has been accused of malpractice by an anti-abortion lawyer.

other lawyers unwilling to handle their cases for fear that they would be seen as opposing abortion.

"I would think it would be a meeting ground for both sides to try to identify doctors who are not providing good care to women," said Mr. Amshoff, who has served as counsel to Kentucky Right to Life. "If this office alone has four death cases, and others where a hysterectomy and colostomy were needed, there's something wrong."

No Man's Land

Personal Dilemmas Over Abortion

In the bitterly divisive landscape of abortion, there is a no man's land, occupied by women who oppose abortion on moral or religious grounds, but nonetheless choose it when they find themselves pregnant. Anti-abortion groups, doctors and abortion-rights groups alike say those women are most likely to sue.

The whole malpractice issue turns abortion politics on its head, sending patient. As a society, I think we've been in denial about the risks of abortion, both because of ideology, and because of economics. There are a lot of respectable doctors doing a lousy job. It's not a sin to have a complication, but it is a sin if you have not tried to prevent it. And it's a very serious sin if you abandon it."

Even with the best care, Dr. Hern and others said, 5 to 10 percent of first-trimester abortions are incomplete, leaving behind a few grams of tissue, or even the whole fetal sac. More rarely, abortion causes perforation of the uterus, hemorrhage or infection. Without proper follow-up care, such complications can cause serious injury.

Grounds to Sue

Lawsuits Focus On Emotions

Some anti-abortion lawyers are now filing claims based more on emotional than physical injuries. In one Phoenix case, for example, Mr. Jakubczyk charges that Dr. Joel Bettigole performed an abortion on a patient who did not want one.

"From her point of view, she went in, mixed up and confused, and didn't get any real counseling," Mr. Jakubczyk said. "From her point of view, she changed her mind, and withdrew her consent. She began to cry and scream, and they told her to shut up or she'd scare the other girls."

Dr. Bettigole would not discuss the case because it is in litigation.

"All I can say is that it never happened," he said. "I don't remember this particular patient, but I know it never happened because I have never treated any patient like that."

While that case and others like a pending Tennessee case against Planned Parenthood raise the question of valid consent, they are largely based on claims for emotional injuries and post-abortion trauma.

The Tennessee case involves a 15-year-old who became pregnant by the son of a Planned Parenthood official.

"The girl's mother had been shot and killed by her stepfather, and her grandmother got custody of her," said Mr. Smith, the Swendsen, Amshoff lawyer handling the case. "Her dad said come live with him or he would kill himself. She said she couldn't and he did kill himself. Four months later, she got pregnant, and the boy said, 'Have an abortion or I'll

ministering to the second victims o abortion, the women who've bee damaged."

The religious overlap was plain i a prayer request Mr. Smith made t Operation Prayer Storm, a group h describes as "a loose coalition of 2 ministries seeking revival and a end to abortion."

Last April, Operation Praye Storm sent out to those on its mailin list requests to pray for students wh want prayer at school graduation to stop the Federal Governmen from mandating "religion free" workplaces and for Swendsen, Am shoff to "get revelation of ALL infor mation they need in each abortio malpractice case."

"They request we PRAY for GO to raise up HIS strong plaintiff(s) t stop the deception in the abortio clinics," it said.

Swendsen, Amshoff lawyers hav appeared on the evangelist Pat Rob ertson's television show, the 70 Club, in a segment that also feature a Life Dynamics ad.

Just who provides the money fo the abortion-malpractice campaig of Life Dynamics remains a mys tery. Mr. Crutcher, 47, said his or ganization depended on donations He would not identify any donors, bu said some had gave more tha $100,000. He said the group spen more than $1 million last year t support a staff of seven and a steady barrage of mass mailings.

Mr. Crutcher said Life Dynamics would not take a share of the court awards in any cases it helps to prepare.

If the Phoenix experience is any guide, the new abortion-malpractice suits will take a toll, even on doctors who are not found to have committed malpractice and on their insurers.

"In the mid-80's, when John Jakubczyk was head of Right to Life here, we were one of the abortion clinics targeted to be closed down," said Constance Bennett, the former executive director of the Family Practice Institute. "It was like being under siege. Demonstrators hatcheted the roof, they Super Glue'd the doors shut, they broke in and chained themselves to the tables. We were burglarized. I got death threats, and my dog was drowned in the pool.

"In the middle of all that, John Jakubczyk filed his first abortion-malpractice case, against one of our doctors, for a perforated uterus. The doctor was investigated and exonerated, but the insurance company paid about $5,000 to settle."

By all accounts, that is the only money Mr. Jakubczyk has ever recovered in these cases.

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Mark Crutcher, the president of Life Dynamics, said his group had more than 600 lawyers in its "Abnet" network, 40 percent of whom, he said, support abortion rights. The network offers lawyers ads soliciting clients ("Don't be a victim for the rest of your life"), expert witnesses, courses to teach women how to testify effectively, dossiers on abortion doctors and even a loan of the medical instruments used in abortion for lawyers to use in showing a jury what was done.

"There are more women than we ever dreamed of getting killed, raped, assaulted and severely injured by abortionists," Mr. Crutcher said. "We've got over 2,500 examples now."

Life Dynamics is not the only group encouraging these suits. In Pensacola, Fla., Mike Conroy says his organization, Legal Action for Women, gets about 10 calls a day on its toll-free line, 1-800-U-CAN-SUE, from women who say they have been injured by an abortion.

Mr. Conroy's group, like Life Dynamics, refers women to lawyers who will handle such cases, and both groups provide materials to hand out to women leaving abortion clinics.

Last year, several lawyers from different states established a firm, Swendsen, Amshoff, Donovan & Smith, to handle abortion malpractice work. Ted Amshoff, of Louisville, Ky., said the firm had 20 open cases, including 4 in which women died as a result of abortions.

Motives

Legal Harassment Or Honest Claims?

Many abortion doctors, clinics and women's advocacy groups see the new malpractice suits as a form of harassment motivated by anti-abortion ideology

"...as a result," said Mr. Jakubczyk, who spoke at the Life Dynamics seminar. "For every woman for whom I file a claim, there are many more I tell that no matter how bad their abortion left them feeling, they don't have a case. People see me as John Jakubczyk, pro-life advocate. But in these cases, I'm just John Jakubczyk, representing a woman."

Ted Amshoff, a Louisville, Ky., lawyer in Swendsen, Amshoff, who would not discuss his personal views on abortion, calling them irrelevant to his legal work, said some of the women he represents had found

Dr. Brian Finkel outside his office in Phoenix. He does abortions and has been accused of malpractice by an anti-abortion lawyer.

other lawyers unwilling to handle their cases for fear that they would be seen as opposing abortion.

"I would think it would be a meeting ground for both sides to try to identify doctors who are not providing good care to women," said Mr. Amshoff, who has served as counsel to Kentucky Right to Life. "If this office alone has four death cases, and others where a hysterectomy and colostomy were needed, there's something wrong."

No Man's Land

Personal Dilemmas Over Abortion

In the bitterly divisive landscape of abortion, there is a no man's land, occupied by women who oppose abortion on moral or religious grounds, but nonetheless choose it when they find themselves pregnant. Anti-abortion groups, doctors and abortion-rights groups alike say these women are most likely to sue.

The whole malpractice issue turns abortion politics on its head, sending

for years been the anti-abortion movement, both because he is an outspoken adversary of abortion rights and because he performs late abortions.

But Dr. Hern, who wrote the most widely used textbook on abortion, supports many malpractice claims.

"There's a lot of bad medicine being practiced out there in the name of choice," said Dr. Hern, who estimates that lawyers interested in filing abortion-malpractice suits now account for about 5 percent of the sales of his textbook. "I testified in an Oregon case against a doctor who really did not do well by a patient. As a society, I think we've been in denial about the risks of abortion, both because of ideology and because of economics. There are a lot of respectable doctors doing a lousy job. It's not a sin to have a complication, but it is a sin if you have not tried to prevent it. And it's a very serious sin if you abandon it."

Even with the best care, Dr. Hern and others said, 5 to 10 percent of first trimester abortions are incomplete, leaving behind a few grams of tissue, or even the whole fetal sac. More rarely, abortion causes perforation of the uterus, hemorrhage or infection. Without proper follow-up care, such complications can cause serious injury.

Grounds to Sue

Lawsuits Focus On Emotions

Some anti-abortion lawyers are now filing claims based more on emotional than physical injuries. In one Phoenix case, for example, Mr. Jakubczyk charges that Dr. Joel Derngale performed an abortion on a patient who did not want one.

"From her point of view, she went in, mixed up and confused, and didn't get any real counseling," Mr. Jakubczyk said. "From her point of view, she changed her mind, and withdrew her consent. She began to cry and scream, and they told her to shut up or she'd scare the other girls."

Dr. Actigale would not discuss the case because it is in litigation.

"All I can say is that it never happened," he said. "I don't remember this particular patient, but I know it never happened because I have never treated any patient like that."

While that case and others like a pending Tennessee case against Planned Parenthood raise the question of valid consent, they are largely based on claims for emotional injuries and post-abortion trauma.

The Tennessee case involves a 15-year old who became pregnant by the son of a Planned Parenthood official.

"The girl's mother had been shot and killed by her stepfather, and her grandmother got custody of her," said Mr. Smith, the Swendsen, Amshoff lawyer handling the case. "Her dad said come live with him or he would kill himself. She said she couldn't and he did kill himself. Four months later, she got pregnant, and the boy said, 'Have an abortion or I'll

Planned Parenthood said it could not discuss the case while it was pending, but disputes the lawsuit's account. And mental health experts say any girl who lost both parents so brutally might have emotional problems, abortion or no.

Mr. Smith said that, for him, abortion malpractice is both a legal specialty and a ministry.

"A great many women are injured by abortion, but in the past very few have filed suit," Mr. Smith said. "So as a lawyer I see it as potentially a very lucrative specialty. And as a byproduct, it's a form of ministry. I've been working with this little 15-year old for a year, and she's now ministering to the second victim of abortion, the women who've been damaged."

The religious overlap was plain in a prayer request Mr. Smith made to Operation Prayer Storm, a group he describes as "a loose coalition of 9 ministries seeking revival and an end to abortion."

Last April, Operation Prayer Storm sent out to those on its mailing list requests to pray for students who want prayer at school graduations, to stop the Federal Government from mandating "religion free" workplaces and for Swendsen, Amshoff to "get revelation of ALL information they need in each abortion malpractice case."

"They request we PRAY for GOD to raise up HIS strong plaintiff(s) to stop the deception in the abortion clinics," it said.

Swendsen, Amshoff lawyers have appeared on the evangelist Pat Robertson's television show, the 700 Club, in a segment that also features a Life Dynamics ad.

Just who provides the money for the abortion-malpractice campaign of Life Dynamics remains a mystery. Mr. Crutcher, 47, said his organization depended on donations. He would not identify any donors, but said some had gave more than $100,000. He said the group spent more than $1 million last year to support a staff of seven and a steady barrage of mass mailings.

Mr. Crutcher said Life Dynamics would not take a share of the court awards in any cases it helps prepare.

If the Phoenix experience is any guide, the new abortion-malpractice suits will take a toll, even on doctors who are not found to have committed malpractice and on their insurers.

"In the mid-80's, when John Jakubczyk was head of Right to Life here, we were one of the abortion clinics targeted to be closed down," said Constance Bennett, the former executive director of the Family Practice Institute. "It was like being under siege. Demonstrators hatcheted the roof, they Super Glue'd the door's shut, they broke in and chained themselves to the tables. We were burglarized. I got death threats, and my dog was drowned in the pool.

"In the middle of all that, John Jakubczyk filed his first abortion-malpractice case, against one of our doctors, for a perforated uterus. The doctor was investigated and exonerated, but the insurance company paid about $5,000 to settle."

By all accounts, that is the only money Mr. Jakubczyk has ever recovered in these cases.

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Divider Title: _____

STATEMENT FOR COMPLETION BY PRESIDENTIAL NOMINEES

PART I: ALL THE INFORMATION IN THIS PART WILL BE MADE PUBLIC

Name: Foster, Jr. (LAST) Henry W. (FIRST) (OTHER)

Position to which nominated: Surgeon General Date of nomination: February 28, 1995

Date of birth: 8 (DAY) 9 (MONTH) 33 (YEAR) Place of birth: Pine Bluff, Arkansas

Marital status: married Full name of spouse: St. Clair Anderson Foster

Name and ages of children: Myrna Faye Foster, Age 32

Wendell Foster, III, Age 31

Education:

Institution	Dates attended	Degrees received	Dates of degrees
Morehouse College	1950 - 1954	B.S.	1954
*Univ. of Arkansas for Medical Sciences	1954 - 1958	M.D.	1958
Detroit Receiving Hosp.	1958 - 1959	Internship	1959
Malden Hospital	1961 - 1962	Residency	1962
George W. Hubbard Hosp. of Meharry Medical College	1962 - 1965	Residency	1965

*formerly University of Arkansas School of Medicine

Honors and awards: List below all scholarships, fellowships, honorary degrees, military medals, honorary society memberships, and any other special recognitions for outstanding service or achievement.

Please see Attachment A

Memberships: List below all memberships and offices held in professional, fraternal, business, scholarly, civic, charitable and other organizations for the last five years and any other prior memberships or offices you consider relevant.

Organization	Office held (if any)	Dates
Please See Attachment B		

Employment record: List below all positions held since college, including the title or description of job, name of employer, location of work, and dates of inclusive employment.

Please See Attachment C

Government experience:

List any advisory, consultative, honorary or other part-time service or positions with Federal, State, or local governments other than those listed above.

Please See Attachment D

Published writings:

List the titles, publishers and dates of books, articles, reports or other published materials you have written.

Please See Attachment E

Political affiliations and activities:

List all memberships and offices held in or financial contributions and services rendered to all political parties or election committees during the last five years.

Please See Attachment F

Future employment relationships:

1. Indicate whether you will sever all connections with your present employer, business firm, association or organization if you are confirmed by the Senate.

If my nomination is confirmed by the Senate, I will be on uncompensated leave of absence from Meharry Medical College.

2. State whether you have any plans after completing government service to resume employment, affiliation or practice with your previous employer, business firm, association or organization.

Yes

3. Has a commitment been made to you for employment after you leave Federal service?

Please See question 1 above.

4. Do you intend to serve the full term for which you have been appointed or until the next Presidential election, whichever is applicable?

Yes

Potential conflicts of interest:

1. Describe any financial arrangements, deferred compensation agreements or other continuing financial, business or professional dealings with business associates, clients or customers who will be affected by policies which you will influence in the position to which you have been nominated.

If my nomination is confirmed by the Senate, I will be on uncompensated leave of absence from Meharry Medical College.

2. List any investments, obligations, liabilities, or other financial relationships which constitute potential conflcts of interest with the position to which you have been nominated.

None

3. Describe any business relationship, dealing or financial transaction which you have had during the last five years whether for yourself, on behalf of a client, or acting as an agent, that constitutes a potential conflict of interest with the position to which you have been nominated.

None

4. List any lobbying activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat or modification of any Federal legislation or of affecting the administration and execution of Federal law or policy.

United States House of Representatives' Appropriations Subcommittee on Labor, Health and Human Services, Education-testimony supporting Meharry Medical College - May 5, 1994

5. Explain how you will resolve any potential conflict of interest that may be disclosed by your responses to the above items.

I will recuse myself from participating in my official capacity in any particular matters, such as grants, contracts, applications approvals, litigation, investigations, or enforcement actions, specifically involving Meharry Medical College. Furthermore, I will consult with the Department of Health and Human Services' Designated Agency Ethics Official about any unforeseen conflicts of interest and recuse myself from these matters if necessary.

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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

liations:

List the names of all corporations, companies, firms, or other business enterprises, partnerships, nonprofit organizations, and educational or other institutions:

—with which you are now connected as an employee, officer, owner, director, trustee, partner, advisor, attorney, or consultant. Any listed relationship or affiliation that you wish to continue during the term of your appointment should be noted with an asterisk.

—in which you have any financial interest through the ownership of stocks, stock options, bonds, partnership interests, or other securities, which you wish to retain during your period of government service should be noted with an asterisk.

Please See Attachment G

Personal Data:

1. Have your tax returns been the subject of any audit or investigation or inquiry at any time by Federal, State or local authorities, which resulted in a tax lien or other collection procedure?

No

2. Have you ever been convicted for violation of any Federal, State, county or municipal law, regulation or ordinance? If so, please give full details (do not include traffic violations for which a fine of $100 or less was imposed).

No

3. Are you currently under Federal, State, or local investigation of you for a possible violation of a criminal statute? If so, please provide full details.

No

4. Have you ever been disciplined or cited for a breach of ethics or unprofessional conduct by, or are you currently the subject of a formal complaint procedure in any court, administrative agency, professional association, disciplinary committee, or other professional group? If so, please give full details.

No

5. Have you ever been involved in civil litigation, or administrative, regulatory or legislative investigation of any kind, either as plaintiff, defendant, respondent, witness or party in interest, which may have a material effect on the position for which you are being considered?

No

AFFIDAVIT

y W. Foster,Jr.) ss

. being duly sworn, hereby states that he/she has read and signed the foregoing Financial Statement and that the information provided therein is, to the best of his/her knowledge and belief, current, accurate, and complete.

Henry W. Foster, Jr.

Subscribe and sworn before me this 17th day of March, 1995

Notary Public

My Commission Expires January 14, 1997

U.S. GOVERNMENT PRINTING OFFICE : 1992 0 - 47-001

ATTACHMENT A

YEAR	AWARD
1958	Alpha Omega Alpha
1958	Scholastic Achievement Award, Kappa Alpha Psi Fraternity, Little Rock Alumni Chapter
1976	One of Meharry's 100 Most Valuable Employees Award
1977	Professional Achievement Award, Kappa Alpha Psi Fraternity, Kappa Chapter
1978	Dean's Special Recognition Award, University of Arkansas
1980	Appreciation Award for Research and Teaching in Sickle Cell Anemia, Sisters United Social and Service Club, Tuskegee Institute
1982	Man of the Year, March of Dimes Birth Defects Foundation, Music City Chapter
1983	Who's Who in America
1988	Faculty Award for Excellence in Science and Technology, White House Initiative on Historically Black Colleges and Universities
1993	Meritorious Service Award, Nashville Mayor's Office of Drug Policy
1993	Boss of the Year Award, Meharry Association of Office Personnel
1993	Honorary Degree, Doctor of Science, University of Arkansas for Medical Sciences
1993	Physician, Teacher, and Scholar Award, National Medical Association, Obstetrics and Gynecology Scientific Assembly
1994	NAACP Image Award 1994, Nashville, Tennessee

ATTACHMENT B

ORGANIZATION	DATES OF MEMBERSHIP	OFFICES ONCE OR PRESENTLY HELD
National Medical Association	1965-present	Chair, Executive Committee for Scientific Assembly of OBGYN
American College of Obstetricians and Gynecologists	1965-present	• Vice Chair, Education Committee • Chair, ACOG/ORTHO Academic Training Award Committee
Macon County Medical Society	1966-1973	• President • Vice President
Southeastern Regional Council on the Development of Nurse Midwifery	1971-1973	
Institute of Medicine of the National Academy of Sciences	1972-present	Chair, Planning Committee on Communicating Health Promotion Disease Prevention to Underrepresented Minorities
Nashville Academy of Medicine	1972-present	Member of Ethics Committee
Southern Perinatal Association	1973-1975	
R.F. Boyd Medical Society	1973-present	Treasurer
Planned Parenthood of Middle Tennessee (Formerly Planned Parenthood Association of Nashville)	1973-present	• Board of Directors • Advisory Council
Volunteer State Medical Society	1974-present	
Association of American Medical Colleges	1975-1976	Editorial Board Member of Academic Medicine (formerly Journal of Medical Education)
Alan Guttmacher Institute	1975-1981	Board of Directors

Attachment B, continued

ORGANIZATION	DATES OF MEMBERSHIP	OFFICES ONCE OR PRESENTLY HELD
Planned Parenthood Federation of America	1975-1981	• Board of Directors • Chair, Nominating Committee
American Medical Association	1975-present	
Tennessee Medical Association	1975-present	Alternate Delegate
Nashville-Davidson County Obstetrical and Gynecological Society	1975-present	President
Tennessee Public Health Association	1975-present	
March of Dimes Birth Defects Foundation, Music City Chapter	1975-present	• Chair, Health Professional Advisory Committee
Southern Medical Association	1977-present	
Council on Resident Education in Obstetrics and Gynecology	1979-1985	Member of Board
American Association of University Professors	1980-present	
Society for Reproductive Medicine (formerly American Fertility Society)	1980-present	
Association of Professors of Gynecology and Obstetrics	1985-present	• President • Member of Board
Metropolitan Richland Village	1986-present	Member of Board
University School of Nashville	1987-present	Board of Directors
WDCN Nashville Telecommunication	1989-present	Board of Directors
Pathfinders International	1992-present	Board of Directors
YWCA, Nashville Chapter	1992-present	Member Community Advisory Board
Success by Six	1992-present	
American Cancer Society, Nashville Chapter	1993-present	Board of Directors
Nashville Chamber of Commerce's Partnership 2000	1993-present	

Attachment B, continued

ORGANIZATION	DATES OF MEMBERSHIP	OFFICES ONCE OR PRESENTLY HELD
100 Black Men of Middle Tennessee, Inc.	1994-present	

ATTACHMENT C

EMPLOYER	POSITION	LOCATION	DATES
Detroit Receiving Hospital	Internship	Detroit, Michigan	1958-1959
US Air Force	Captain, Medical Officer	Moses Lake, WA	1959-1961
Malden Hospital	Resident, General Surgery	Malden, Massachusetts	1961-1962
US Air Force Reserves	Medical Officer Reserve	Boston, Massachusetts	1961-1962
George W. Hubbard Hospital	Resident, Obstetrics and Gynecology	Nashville, Tennessee	1962-1965
John A. Andrew Memorial Hospital, Tuskegee Institute	Chief, Obstetrics and Gynecology	Tuskegee, Alabama	1965-1973
Tuskegee Institute	Director, Maternity and Infant Care Program	Tuskegee, Alabama	1970-1973
Meharry Medical College	Chair, Department of Obstetrics and Gynecology	Nashville, Tennessee	1973-1990
Meharry Medical College	Professor	Nashville, Tennessee	1973-present
National Board of Medical Examiners	Consultant, OB-GYN Test Committee	Philadelphia, Pennsylvania	1974-1977
Meharry Medical Group, PC	• Chair, Board of Directors • Vice Chair, Board of Directors • Director	Nashville, Tennessee	1975-present
Vanderbilt University	Clinical Professor	Nashville, Tennessee	1975-present
Accreditation Council for Graduate Medical Education	Consultant, Residency Review for Obstetrics and Gynecology	Washington, DC	1976
American Board of Obstetrics and Gynecology	Examiner	Dallas, TX	1976-1980

Attachment C, continued

EMPLOYER	POSITION	LOCATION	DATES
Robert Wood Johnson Foundation	Consultant, Advisory Committee Member, Program to Regionalize Perinatal Health Services	Princeton, New Jersey	1972-1975
Robert Wood Johnson Foundation	Consultant, National Advisory Committee of the Foundation's Rural Infant Care Program	Princeton, New Jersey	1979-1985
Robert Wood Johnson Foundation	Senior Program Consultant, Program to Consolidate Health Services for High-Risk Young People	Princeton, New Jersey	1981-1986
March of Dimes Birth Defects Foundation	Consultant, Medical Service Advisory Committee	Washington, DC	1983-1987
Robert Wood Johnson Foundation	Consultant, National Advisory Committee on Healthy Futures: A Program to Improve Maternal and Infant Care in the South	Princeton, New Jersey	1987-1988
Robert Wood Johnson Foundation	Consultant, The School-Based Adolescent Health Care Program Technical Review Committee	Princeton, New Jersey	1989-1992
GLAXO Pathway Evaluation Program Advisory Board	Consultant	Research Triangle Park, North Carolina	1989-1993
Meharry Medical College	Dean, School of Medicine and Vice President for Health Services	Nashville, Tennessee	1990-1993
Third National Bank Economic Development Council	External Council Member	Nashville, Tennessee	1990-present
Meharry Medical College	Acting President	Nashville, Tennessee	1993-1994

EMPLOYER	POSITION	LOCATION	DATES
Robert Wood Johnson Foundation	Consultant, National Advisory Committee of the Clinical Scholars Program	Princeton, New Jersey	1994-present
Association of Academic Health Centers	Senior Scholar-in-Residence	Washington, DC	1994-present

ATTACHMENT D

Alabama Advisory Council for Comprehensive Health Planning

Armed Forces Institute of Pathology, Obstetrics and Gynecology Advisory Committee

Cumberland Museum Health Hall Task Force Committee on the Human Growth and Development

Governor's Task Force on Healthy Children, Chair of Subcommittee on Nonwhite Infant Mortality (Tennessee)

Tennessee Department of Public Health, Perinatal Advisory Committee, Task Force on Genetics

Tennessee Maternal and Child Health Medicaid Advisory Committee

Tennessee State University Advisory Board on Medical Records Administration

Tuskegee Area Health Education Center Advisory Board

U.S. Department of Health, Education and Welfare Ethics Advisory Board

U.S. Department of Health and Human Services' Commission on Maternal and Child Health Research Committee

U.S. Department of Health and Human Services' Fertility and Maternal Health Drug Advisory Committee

U.S. Department of Health and Human Services' National Advisory Child Health and Human Development Council

Institute of Medicine of the National Academy of Sciences

ATTACHMENT E

Articles

Foster, H.W.: The Papanicolaou Smear and Early Cervical Cancer. Journal of the Volunteer Medical Association, 6:17-20, 1965

Foster, H.W., Moore, D.T.: Abdominal Pregnancy: Report of 12 Cases. Obstetrics and Gynecology, 30:249-252, 1967

Foster, H.W.: Toxemia of Pregnancy: A Continuing Challenge. Journal of the National Medical Association, 61:222-226, 1969

Foster, H.W.: Twin Pregnancy: A Three-Year Report. Journal of the National Medical Association, 62:139-141, 1970

Foster, H.W.: Meigs' Syndrome Complicated by Pregnancy. Journal of the National Medical Association, 63:372-373, 1971

Foster, H.W., Andrew, J.A.: Maternity and Infant Care at Tuskegee Institute. Journal of the Volunteer State Medical Association, 22:24-26, 1972

Foster, H.W.: A Rural Hospital and Family Planning. In: Emory University Family Planning Program: Family Planning in the South, Atlanta, Georgia, Emory University, School of Medicine, pp. 223-242, April 1972

Foster, H.W., Nwosu, S.S.O.: International Efforts in Family Planning Training. Southern Medical Journal, 67:1057-1060, 1974

Foster, H.W.: Staff Conference--Endometrial Stromal Sarcoma. Journal of the Tennessee Medical Association, 67:665-666, 1974

Foster, H.W.: "The Poor." In Experiments and Research with Human Values: Values in Conflict, pp. 151-153, published by the Academy Forum for the National Academy of Sciences, 1974 (Panel with Franz J. Ingelfinger and Jay Katz)

Hills, E.R., Foster, H.W.: Rupture of the Pregnant Uterus. Journal of the National Medical Association, 66:66-68, 1974

Das, S.K., Foster, H.W., Bhattacharyya, D.K.: Gestational Variation of Fatty Acid Composition of Human Amniotic Fluid Lipids. Obstetrics and Gynecology, 45:425-432, 1975

Foster, H.W.: Editorial--Biomedical Research Subjects: Who Should be Exempt? Journal of Medical Education, 50:1069-1079, 1975

Das, S.K., Foster, H.W., Bhattacharyya, D.K.: Gestational Age Assessment by Estimation of Palmitic Acid Content of Amniotic Fluid Lecithin. IRCS Journal of Medical Sciences, 3:175, 1975

Foster, H.W.: Removal of the Normal Uterus. Southern Medical Journal, 69:13-15, 1976

Foster, H.W.: "Children and the Institutionalized Mentally Infirm." In: Research Involving Children, pp. 1-13 (Appendix, Section 6), published by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, Bethesda, Md., 1976

Foster, H.W.: Clinical Management: Sickle Cell State and Pregnancy. Urban Health, 6:20 and 52, 1977

Foster, H.W.: Book Review--Minorities in Science: The Challenge for Change in Biomedicine. Journal of Medical Education, 53:370-371, 1978

Foster, H.W.: Editorial--Why Bother with Informed Consent? Journal of Medical Education, 54:154-155, 1978

Foster, H.W.: Discussion of Paper Presented by Howard W. Ory. In: Contraception Science, Technology, and Application: Proceedings of a Symposium, Washington, D.C.: National Academy of Sciences, 1979

Foster, H.W.: Exclusive Review, Contemporary Management of Hemoglobinopathies in Pregnancy. OB & Gynecology World, 8:8-9, 1979

Morrison, J., Foster, H.W.: Transfusion Therapy in Pregnant Patients with Sickle Cell Disease: A National Institutes of Health Consensus Development Conference. Annals of Internal Medicine, 91:122-123, 1979

Singh, D.N., Hara, S., Foster, H.W., Grimes, E.M.: Reproductive Performance in Women with Sex Chromosome Mosaicism. Obstetrics and Gynecology, 55:608-611, 1980

Das, S.K., Foster, H.W.: Amniotic Fluid Lipids in Sickle Cell Disease. American Journal of Obstetrics and Gynecology, 136:211-215, 1980

Foster, H.W.: Interval Mini-Laparotomy: An Alternative to Laparoscopic Sterilization? Journal of the National Medical Association, 72:567-570, 1980

Dwivedi, C., Raghunathan, R., Joshi, B., Foster, H.W.: Effect of Mercury Compounds on Cholineacetyl Transferase. Research Communications in Chemical Pathology and Pharmacology, 30:381-384, 1980

Foster, H.W.: Managing Sickle Cell Anemia in Pregnant Patients. Contemporary OB/GYN, 16:21-23, 1980

Das, S.K., Foster, H.W.: Amniotic Fluid Lipids of Patients with Sickle Cell Disease (Letter). American Journal of Obstetrics and Gynecology, 138(5):591 November 1, 1980

Foster, H.W.: Maternal Death Associated with Sickle Cell Trait (Letter). American Journal of Obstetrics and Gynecology, 153(3):346-347, November 1, 1980

Foster, H.W.: Contraceptives in Sickle Cell Disease. Southern Medical Journal, 74:543-545, 1981

Foster, H.W.: Guest Editorial--Medical and Social Barriers to the Health of Urban Infants. Urban Health, 10:8 and 13, 1981

Raghunathan, R., Foster, H.W.: Phosphoenolpyruvate Carboxykinase in Human Amniotic Fluid. American Journal of Obstetrics and Gynecology, 139:939-941, 1981

Raghunathan, R., Foster, H.W., Das, S.K.: Phospholipase A2 Activity in Human Amniotic Fluid. Fed. Proc. 41:912, 1982

Foster, H.W.: Exchange Transfusion in Pregnant Women with Sickle Cell Disease. Western Journal of Medicine, 139:515-516, 1983

Raghunathan, R., Foster, H.W.: Gestational Changes in Pyruvate Carboxylase Activity of Human Amniotic Fluid. IRCS Journal of Medical Sciences, 11:75-76, 1983

Foster, H.W., Das, S.K.: Study of Lipids in Human Amnion and Chorion. American Journal of Obstetrics and Gynecology, 149:670-673, 1984

Foster, H.W., Smith, M., McGruder, C.E., Richard, F.A., McIntyre, J.: Postconception Menses Induction Using Prostaglandin Vaginal Suppositories. Obstetrics and Gynecology, 65:682-685, 1985

Lear, J.G., Foster, H.W., Wylie, W.G.: Development of Community-Based Health Services for Adolescents at Risk for Sociomedical Problems. Journal of Medical Education, 60:777-785, 1985

Foster, H.W.: Maternal Death Associated with Sickle Cell Trait (Letter). American Journal of Obstetrics and Gynecology, 153:346-347, 1985

Foster, H.W., et al.: 2001: The Challenge in Education in Obstetrics and Gynecology. American Journal of Obstetrics and Gynecology, 159:13-21, July, 1988

Lear, J.G., Foster, H.W., Baratz, J.A.: The High-Risk Young People's Program--A Summing Up. Journal of Adolescent Health Care, 10:224-230, 1989

Foster, H.W., Greene, L.W., Smith, M.S.: A Model for Increasing Access: Teenage Pregnancy Prevention. Journal of Health Care for the Poor and Underserved, 1:136-146, 1990

Mukherjee, S., Foster, H.W., Das, S.K.: In Vivo and In Vitro Effects of 19-Nortestosterone on NA+, K+ -, Mg++ - Dependent and Independent Ca++ - At Pases in Guinea Pig Testis. The Faseb Journal, 4:1580, 1990

Foster, H.W.: Sickle Cell Anemia Not a Risk for PTL. Ask the Perinatologist Newsletter, 1:1-4, 1991

Foster, H.W., Seltzer, V.L.: Accommodating to Restrictions on Residents' Working Hours. Academic Medicine, 66:94-97, 1991

Foster, H.W.: Forward. Alive and Well?, Edited by Lorraine W. Klerman. National Center for Children in Poverty, Columbia University, School of Public Health, iii, 1991

Seltzer, V., Foster, H.W., Gordon, M.: Resident Scheduling: Night Float Programs. Obstetrics and Gynecology, 77:940-943, 1991

Foster, H.W.: Merger Recruitment: The Process, The Educational Implications. Genesis, 2:1-2, 1993

Foster, H.W., Thomas, D.J., Semenya, K.A., Thomas, J.: Low Birthweight in African Americans: Does Intergenerational Well-Being Improve Outcome? Journal of the National Medical Association, 85:516-520, 1993

Foster, H.W.: Teaching Obstetrics and Gynecology in a Managed Care Environment. The Quarterly Report: Association of Professors of Gynecology and Obstetrics, XX, 1993

Foster, H.W.: President Foster's Inaugural Report. The Quarterly Report: Association of Professors of Gynecology and Obstetrics, Vol. XX, No. 2, 1993

Foster, H.W.: The Times Interview - Meharry's Foster Foresees Hospital Transformation, Metropolitan Times, 13(31):1-3, June, 1993

Foster, H.W.: What Does Health Care Reform Portend for Undergraduate Medical Education? The Quarterly Report: Association of Professors of Gynecology and Obstetrics, Vol. XX, No. 3, Summer 1993

Chapters in Textbooks

Foster, H.W.: "Ambulatory Gynecologic Surgery." In: Ambulatory Obstetrics and Gynecology. Edited by Dr. George Ryan. Grune and Stratton, Inc., First Edition, pp. 399-422, 1980

Foster, H.W.: "Sickle Cell Disease in Pregnancy: An Update." In: Obstetrics and Gynecology Annual. Edited by Dr. Ralph M. Wynn. Appleton Century-Croft Publishers, pp. 147-163, 1982

Foster, H.W., Lownes, R.: "Thalassemia." In: Hematological Problems in Pregnancy. Edited by Dr. David Z. Kitay, Medical Economics Books, pp. 130-139, 1987

Foster, H.W.: "Sickle Cell Disease and Pregnancy: Management Controversies." In: Clinical Decisions in Obstetrics and Gynecology, Edited by Robert C. Cefalo. Aspen Publishers, pp. 92-96, January, 1990

Abstracts and Presentations
(While not required by the Committee, the following list of available abstracts and presentations is included to supplement the Committee's questionnaire.)

Foster, H.W.: "Family Planning and the Black Community," Second Annual Convention of the Southern Perinatal Association, Louisville, Kentucky, October 26, 1974

Foster, H.W.: "Statement: Study on Infant Mortality (SJR 96)" Presented at the Tennessee Legislative Council Committee, State Capitol Building, Nashville, Tennessee, August 6, 1974

Foster, H.W.: "Statement: House Bill 1348-A Position Paper on Contraceptive Availability." Presented at the General Welfare Committee, Tennessee House of Representatives, State Capitol Building, Nashville, Tennessee, March 3, 1976

Foster, H.W.: "Sickle Cell Disease Complicated by Pregnancy" Abstract of Presentation at the Palmetto Medical Society, Hilton Head Island, South Carolina, April 29, 1978

Foster, H.W.: "Consensus Development Conference on Transfusion Therapy in Pregnant Sickle Cell Disease Patients" Co-Chairman, Presented at the National Institute of Health, Washington, D.C., April 23-24, 1979, reprinted in National Institutes of Health Consensus Development Conference Summaries, Vol. 2, 1979

Foster, H.W.: "Maternal and Infant Health" Participant, The Surgeon General's Workshop, Reston, Virginia, December 14-17, 1980

Foster, H.W.: "Legislative Forum Statement on Teenage Pregnancy," July 20, 1984

Foster, H.W.: "Reproductive Trends: Implications for Planned Parenthood" A Keynote Address, Planned Parenthood Association of East Tennessee, Inc., 23rd Annual Meeting, Knoxville, Tennessee, September 7, 1984

Foster, H.W.: "Contraceptive Effects of Breastfeeding and Effects of Contraception on Breastfeeding," 40th Annual Food and Nutrition Institute, Tuskegee University (Formerly Tuskegee Institute), Tuskegee, Alabama, March 6, 1985

Foster, H.W.: "Key Note Address: Pre-Med Enrichment Program for Minority Students," University of Tennessee, Knoxville, Tennessee, August 8, 1986

Foster, H.W.: "Hemoglobinopathies in Pregnancies," Audio Cassette Transcript, American College of Obstetricians and Gynecologists, CME Series, Vol. 12, No. 6, 1987

Foster, H.W.: "Resident Working Hours" Presented at the Program Directors Retreat, Council on Resident Education in Obstetrics and Gynecology (CREOG), Park City, Utah, July 20-21, 1989

Foster, H.W.: "Health Care Reform and its Impact on the Medical Profession: Educating Physicians at Meharry Medical College in the 1990s," National Medical Association Annual Conference Region III, Hilton Head, South Carolina, June 19, 1993

Foster, H.W.: "What Does Health Care Reform Portend for Undergraduate Medical Education?" National Medical Association, July 12, 1993

Foster, H.W.: "Improving Access to Health Care Through Physician Work Force Reform: Direction for the 21st Century," Governor's Medicaid Task Force, Nashville, Tennessee, September 30, 1993

Foster, H.W.: "20/20 II Conference Keynote Speaker" Morehouse College Sponsored Health Sciences Minority Student Counselor Awareness Program, Atlanta, Georgia, November 11, 1993, summarized in President of Meharry Medical College Addresses Opening Symposium, Conference 20/20 II: Update, Vol.1, No. 2

Foster, H.W.: "The Chronology of Successful Grantsmanship," Postgraduate Seminar, Association of Professors of Gynecology and Obstetrics (APGO), Maui, Hawaii, January 10, 1994

Foster, H.W.: "Minority Academic Health Centers of the Future," Annual Meeting of the Association of Minority Health Professions Schools, Charles R. Drew University of Medicine and Science, Los Angeles, California, February 10-12, 1994

Foster, H.W.: "Will Health Care Reform Affect Undergraduate Medical Education?" Fifth Annual W.F. Bernell James Obstetrics and Gynecology Symposium, Nashville, Tennessee, February 11-13, 1994

Foster, H.W.: "Rural America: Health Care Access," 102nd Annual Farmers Conference, Tuskegee University Kellogg Conference Center, Tuskegee, Alabama, February 24-25, 1994

Foster, H.W.: "Presidential Address," Association of Professors of Gynecology and Obstetrics, Nashville, Tennessee, March 4, 1994

Foster, H.W.: "Career Opportunities in Biomedical and Public Health Sciences" Eighth Annual Symposium for the Association of Minority Health Professions Schools, Second General Session, Dr. Roy Hunter, Jr. Presiding, Nashville, Tennessee, March 31, 1994

Foster, H.W.: "Testimony: Support for Meharry Medical College," House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, Washington, District of Columbia, May 5, 1994

Foster, H.W.: "Introduction: U.S. Congressman Harold Ford," Meharry Medical College 119th Commencement, Nashville, Tennessee, May 22, 1994

Foster, H.W.: "How Can We Provide Good Health Care for Everyone?" Lonnie S. Burnett, Vanderbilt OB/GYN Society Meeting, Destin, Florida, June 18, 1994

Foster, H.W.: "Reaching Parity for Minority Medical Students: A Possibility or a Pipe Dream?" 105th Annual Meeting of the Association of American Medical Colleges, Boston, Massachusetts, November 1, 1994

Foster, H.W.: Description of Proposed Project: Gender Shift in Physician Work Force: Implications for Health Care Reform, 1994

Audiovisual Materials

Foster, H.W.: "The Behavioral Aspects of the Gynecological History and Pelvic Examination" Video Cassette. Department of Illustrations, Meharry Medical College, 1978

Foster, H.W.: "Sickle Cell Disease in Pregnancy: An Update" Video Cassette. Vanderbilt University, Department of Obstetrics and Gynecology, Nashville, Tennessee, October 28, 1992

Foster, H.W.: "Sickle Cell Disease in Pregnancy: Clinical and Molecular Realities" Postgraduate Course in Maternal-Fetal Medicine, Audio Cassette. 98th Annual Convention and Scientific Assembly of the National Medical Association, San Antonio, Texas, August 8, 1993

ATTACHMENT F

Democratic National Committee	March 21, 1992	$100.00
Tim Garrett, running for local office in Tennessee	March 29, 1993	$100.00
Democratic National Committee	July 23, 1993	$100.00
Alan Wheat Senatorial Campaign	August 30, 1993	$100.00
Democratic National Committee	October 17, 1993	$100.00
Democratic National Committee	November 8, 1993	$100.00
Eric Taylor, running for state office in Tennessee	November 10, 1993	$100.00
Democratic Victory Fund	September 28, 1994	$100.00
Phil Bredsen's Governor Campaign	January 24, 1994	$1000.00
Henry Hill State Senate Campaign	June 21, 1994	$150.00
Thelma Harper State Senate Campaign	June 21, 1994	$250.00
Democratic National Committee	September 16, 1994	$100.00

ATTACHMENT G

A. ORGANIZATIONS PRESENTLY AFFILIATED WITH

1. *Association of Professors of Gynecology and Obstetrics, Board Member
2. Association of Academic Health Centers Grant Project (funded by Robert Wood Johnson Foundation), principal investigator
3. Association of Academic Health Centers, Senior Scholar-in-Residence
4. Meharry Medical College, Professor
5. Meharry Medical College Perinatal Outcome Study, Department of Health and Human Services grant, principal investigator
6. Meharry Medical Practice Group, PC
7. Metropolitan Richland Village, Advisory Committee
8. Nashville Academy of Medicine, Ethics Committee Member
9. Nashville Chapter of the American Cancer Society, Board Member
10. Partnership 2000, Advisory Committee
11. Pathfinders International, Board Member
12. Planned Parenthood Affiliation of Nashville, Board Member
13. Robert Wood Johnson Foundation, Advisory Committee
14. Success by Six, Advisory Committee
15. Third National Bank Community Economic Development Council, External Council Member
16. University School of Nashville, Board Member
17. Vanderbilt University, Clinical Professor
18. WDCN Nashville Public Telecommunication, Board Member
19. YWCA of Nashville, Advisory Committee
20. *Institute of Medicine of the National Academy of Sciences, Human Rights Committee

B. ORGANIZATIONS WITH A FINANCIAL INTEREST IN

1. *Fortune Investment Corporation-150 shares of corporation that owns and operates apartment buildings in Tuskegee, Alabama

2. *DeVille Investment Corporation-5000 shares of corporation that owns and operates apartment buildings in Tuskegee, Alabama