

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 86/2

1550 SHESS SB 747 (#3) - SB 754

This reluctance of the established medical care system to provide care to women who have elected a home birth may in part explain the lower level of prenatal care received by some of the respondents (37), as contrasted with the level of prenatal care reported for Michigan residents in 1976 (see Table 12). Interestingly, when total care is reviewed, the percentage of those having 20 or more prenatal visits is more than three times as great in the home birth group as in the total state population. Those receiving between 15 and 19 visits is twice as great in the home birth group as in the total state population (13.2% compared to 7.1% respectively). Reasons for this may be varied. It may be attributed to recognition of the need for careful risk assessment for planned home births and comprehensive prenatal care in order to detect and/or avoid complications.

TABLE 12

Frequency of Prenatal Care for Planned Home Birth Sample as Compared to Prenatal Care for Michigan Residents, 1976†

Frequency of Visits for Prenatal Care	Planned Home Birth Sample		Michigan Residents	
	Number	Percent	Number	Percent
No care	6	8.1	923	0.7
Under 5	8	10.8	6,993	5.3
5-9	17	23.0	30,670	27.9
10-14	25	33.8	71,075	54.1
15-19	9	12.2	9,377	7.1
20 or more	4	5.4	2,273	1.7
Not stated	5	6.8	4,067	3.1
Total	74	100.1	131,378	99.9

† Information regarding Michigan residents obtained from the Office of Vital and Health Statistics, Michigan Department of Public Health, Lansing, Michigan.

Sixty-six (97.1%) of the 68 women who received prenatal care had their blood pressure checked at each prenatal visit. Sixty-four women (94.1%) reported that the fetal heart was

checked at least once after the fifth month of pregnancy.^o Fifty-seven women (83.8%) said their urine was checked at every visit. These assessments are valuable in the early detection of some complications of pregnancy such as preeclampsia or urinary tract infection. Prompt treatment of complications can help reduce perinatal mortality and morbidity. The fact that all women did not have these assessments routinely may be due to the varying philosophies of the practitioners from whom the women received care.

While the value of prenatal care is recognized by the majority of women in the sample, the six women who did not receive prenatal care are of special interest, and it is important to recognize who they are. All of the women who did not have prenatal care had previously uncomplicated, easy births. Five had delivered in a hospital before 1976 and their descriptions of the experience were fairly representative.

. . . I don't have anything against the medical staff, but I didn't like my experiences in the hospital. Both of my children were born half an hour after I got to the hospital. I had no problems while pregnant, no problems in delivery. . . . In the hospital I felt uninvolved. You lay on the table and they do everything . . . it is all very cold. They took my child away and I didn't see her for two days. I felt more comfortable at home. . . . After all, having a baby is not a sickness or a disease.

The only woman who had not had a hospital birth delivered her first child at home in 1975 and had been counseled by a physician at the time.

Contrary to what one might expect, the lack of prenatal care among the respondents was not related to low educational achievement or low income. All of the mothers finished high school, at least two attended college and one did postgraduate work. Of the six women not receiving prenatal care, one was a

^o During the interview, respondents were asked if anyone listened to the fetal heart after the fifth month. They were not asked if it was assessed at each visit nor were they asked if they had abdominal palpation at each visit. Hence, it is not possible to compare this with the ACOG standard.

chiropractor, and one was a nurse. Moreover, two others were married to health professionals, a chiropractor and a physician. It is interesting to speculate why these women did not have any prenatal care. The women married to health care professionals may have received care from their husbands but not reported it as such. The nurse and chiropractor may have felt they could take care of themselves.

Those not receiving prenatal care had varied incomes. There were two low income families. One woman, who was separated from her husband, earned between \$4,000—\$8,000, received Medicaid assistance and was included in this group. The second family had recently immigrated from Korea and earned between \$7,000 and \$8,000 yearly for a family of six. Neither mentioned financial factors as motivating their decision. Two other families reported earning between \$13,000 and \$20,000 and the fifth between \$20,000 and \$30,000. Finally, one family in which both the husband and wife were chiropractors earned over \$50,000. Interestingly, it was this family who mentioned financial factors as influencing their decision to have a home birth.

Four of the women without prenatal care took childbirth preparation classes, usually Lamaze. All of them read some literature on the subject and/or had special instructions and "pointers" from friends who had delivered at home. The nurse from Korea had attended other births in Korea. Several of her relatives and her mother-in-law delivered their children at home.

Reading

Reading is a means by which many women in today's society take an active role in preparing themselves for childbirth, and the women in the sample were no exception. Almost all (68 of 74) did some reading in preparation for the birth. For some, this was a casual perusal of pamphlets and magazines^o, but most of the 68 read books such as *Birth Without Violence*, *Childbirth Without Pain*, *Inmaculate Deception*, *Common-sense Childbirth* and *Thank You, Dr. Lamaze*.

^o One woman stated she became interested in the idea of a home birth from an article in *Vogue Magazine*.

Childbirth Preparation Classes

In addition to reading, some women find prenatal education classes helpful in preparing for childbirth. In the sample, 46 women (62.2%) attended such classes. The majority of them (32) studied the Lamaze method. One woman attended classes at Planned Parenthood, another at a feminist health center and a third at the Childbirth Without Pain Association. A few of the women had exposure to birth preparation in their professional nursing education.

Special Instructions

In addition to childbirth classes, some women received special instruction for the home birth. These special instructions often included a discussion of problems associated with pregnancy, labor and delivery and, in each case, provided the woman with an opportunity to ask questions. Some of the issues discussed were problems that may arise during the actual birth (e.g., hemorrhaging, positions of the newborn), those associated with the newborn (e.g., apnea, respiratory distress, prematurity) and the infant (e.g., birth defects).

Table 13 shows the relationship between the number of women who had special instructions and the number of women who attended birth preparation classes. While 26 women received special instructions in addition to attending birth classes, 15 women received only special instructions and 13 received no instruction of any kind. In 19 cases, the instructor was a physician, in 9 cases, a midwife and in another

TABLE 13
**Number of Women Who Attended Childbirth Classes
and Had Special Instructions**

Preparation	Respondents	
	Number	Percent
Childbirth classes and special instruction	26	35.1
Childbirth classes	20	27.0
Special instruction only	15	20.3
Neither	13	17.6
Total	74	100.0

9 instances, licensed practical nurses. Four others had instructions from registered nurses.

Since 19 of the respondents were having their first baby, it is interesting to note their specific preparations in these areas. Table 14 illustrates these preparations.

TABLE 14
Preparation of Primiparas

Preparation	Respondents
Reading only	4
Classes only	0
Special instruction only	0
Reading and special instruction	6
Classes and special instruction	1
All three	8
Total	19

Additional Preparations

In addition to educating themselves, many women prepared their homes and assembled equipment. When the women in the survey were asked what they did to get ready for the home delivery, answers ranged from "shampooing the rug" to "praying everyday." They were most concerned with acquiring general supplies, such as plastic sheets, pads and bulb syringes for the newborn, and with their own personal, physical and emotional preparation for the event. The following quotes are representative of the answers obtained.

I studied, did breathing and physical exercises. Collected various items necessary to have on hand listed by the H.O.M.E. book. I saw the doctor every three weeks. I cleaned the house and collected baby clothes and knit a baby blanket.

I exercised daily and was very careful about my diet. I went to the doctor regularly. Read books about what was happening . . . so we could be aware. We got the child's environment ready. We were living in a one bedroom apartment which we rearranged for him. He got the best of everything.

Some women did not make any specific preparations, leaving the provision of equipment to the attendant.

Preparation for Possible Complications

During pregnancy most women can anticipate and plan for a normal labor and delivery. However, they must consider the possibility of complications. Seventy-one of the 74 women in this study had done so and said they would have gone to the hospital in the event that complications arose. Twenty-four of these women gave general responses when asked under what circumstances they would go to a hospital; they felt they would make the decision at the time. Nineteen others stated that they would go to the hospital "for any problems" or if they felt a sense of "lacking control" in the situation. Seventeen of the 71 women who had backup plans responded that they would rely on the judgement of their doctor or midwife. The remaining 11 women listed specific complications, such as abnormal presentation, slow progress in labor or hemorrhage, that would cause them to seek hospital care. Forty-one of the women would have gone by car to the hospital. Others stated they would have called an ambulance or the fire department.

The possibility of complications during the home birth appeared to be the area in which the respondents had made the least definite plans. In contrast to the specificity of their responses to other questions, their replies to questions about complications and backup plans were general. There may be several reasons for this. First, there had been a significant time lapse between the home birth and the interview. Secondly, most had a positive experience. The negative potential may have been minimized or discarded in the women's recollection. Finally, the women may have found it difficult to contemplate truly significant complications, because this would have prevented them from following through on their plans for a home birth.

CARE DURING LABOR AND DELIVERY

The impersonal, technical, routine-laden atmosphere of the hospital has been cited in the literature (Hazell, 1974, Lubic, 1976, Cook, 1977), as well as by the respondents in this study,

as being an important reason women and their families are turning to home birth. In fact, what care did our respondents receive during their labor and delivery?

We asked questions about specific aspects of conventional obstetric practices during labor and delivery, as we had regarding prenatal care. Twenty-six of the women (35.1%) had their blood pressure assessed during labor. Time intervals cited by the respondents were "hourly," "once during labor," and "occasionally" (that is, less frequently than once per hour). Responses were almost equally distributed in these categories. Three of the 74 respondents had their urine tested in labor and 46 (62.2%) had the fetal heart rate monitored at least once during labor and delivery. Eleven of the women (14.9%) stated that they used some type of tranquilizer or medicine for pain; however, in at least two cases this consisted of calcium tablets.

It is evident that respondents also took advantage of their freedom from conventional hospital routines, which often dictate the positions a woman may or may not assume in labor and delivery. Women in the study experimented with different positions in both their labor and delivery. Some chose to walk about in labor or to squat and support themselves with pillows. Thirty-four (45.9%) were lying down, propped with pillows during delivery. Only 7 women (9.6%) chose to be flat on their backs, while 17 (23%) delivered in a sitting position. Others opted for positions on their hands and knees.

The majority of the delivering women consumed some type of liquids or foods during labor. Tea, juices, water, yogurt, cereal and fruit were most often listed. Sixty-six women (89.2%) utilized massage or breathing exercises to manage the discomfort of contractions. This figure is especially noteworthy in light of the fact that only 46 of the women attended birth training classes.

After the birth, most of the women held the infant immediately. Of the six who did not, several said that their husband or other family member held the child. In one case the mother did not hold her newborn until after she was sutured.

When respondents were asked if they nursed the child "immediately" after delivery, there were different responses depending on their interpretation of "immediately." For ex-

ample, some answered, "yes, after the cord was cut. . . ." Others answered, "no, I had to wait until the cord was cut". However, it is clear that most women breastfed soon after delivery.

In descriptions of their deliveries, the women generally mentioned the presence and support of their friends and family whose participation was a major incentive for the home birth. A wide range of people were with the women during the event (see Table 15), but most noteworthy is the fact that the father of the newborn was present in almost all instances.

TABLE 15

Non-Health Professionals Present During Labor and Delivery†

Individual Present	Women Reporting Presence	
	Number	Percent
Husband/father of newborn	71	95.9
Mother	18	24.3
Friends	10	13.5
Brother/Sister	10	13.5
Children	10	13.5
Mother-in-law	7	9.5
Others	11	14.9

†Q: Who was with you during labor and delivery?

TABLE 16

Health Care Practitioners Who Attended the Home Delivery‡

Health Care Practitioner	Number	Percent
Doctor	10	13.5
Doctor and nurse	21	28.4
Doctor, nurse and lay midwife	2	2.7
Doctor and lay midwife	2	2.7
Nurse	7	9.5
Lay midwife	8	10.8
Birth attended by practitioner	50	67.6
No health care practitioner present	24	32.4
Total	74	100.0

‡Q: Who was with you during labor and delivery?

PRESENCE OF HEALTH CARE PRACTITIONER AT DELIVERY

One of the critical variables during the delivery is the presence of a physician or other health professional. Fifty of the respondents had at least one attendant who was a member of a health care profession, while 24 did not. There was a discrepancy between the birth attendant identified on the birth certificate and during the interview. According to the interviews, 35 of the women (47.3%) delivered in the presence of a physician (see Table 16). According to the birth certificates, a physician was present in 48 of the deliveries (64.9%).*

The relationship between physician attendance and a number of socioeconomic characteristics and health care variables was examined. Education, income and hospital insurance were unrelated to physician attendance. However, as Table 17 indicates, women who reported either no prenatal care or a

TABLE 17

Frequency of Prenatal Visits by Physician's Attendance at Delivery

Physician Attendance	Number of Prenatal Visits							Total
	None	1-3	4-6	7-8	9-10	11 or more	Not Ascertained	
Yes	0	1	6	2	3	22	1	35
No	6	7	3	2	4	12	5	39
Total	6	8	9	4	7	34	6	74

* There may be several explanations for this discrepancy. Some believe that a physician must sign the birth certificate as the attendant or certifier for legal reasons. Hence, a physician may sign the certificate even if he was not present at the delivery. The fact that physicians occasionally do this has been argued by Sartwell. (Sartwell, Philip E., ed., *March-Rosenau Preventive Medicine and Public Health*, New York, 1973, p. 779). It is also possible that because the question was open ended - "Who was with you during the delivery?" - some women may have forgotten to mention that a physician was present. It is noteworthy that even if one was to consider the birth certificate information to be more accurate than the respondents' replies, one-third of the women delivered their babies without a physician.

minimum number of visits also were more likely to deliver without a physician. Note that the six women who reported not receiving prenatal care were all in the latter category. Furthermore, seven of the eight mothers whose infants had not been seen by a physician or clinic since birth were unattended by a physician during delivery.

POSTPARTUM CARE

Follow-up care immediately after the birth and in succeeding weeks is as critical to the well being of mother and child as the events during labor and delivery. Sixty-two women (83.8%) received some type of care the same day of the birth. The answers to a question regarding this care included some very general and some more specific replies. They are summarized in Table 18.

TABLE 18
Care for the Mother Immediately After Delivery†
(Multiple Responses)

Type of Care	Number	Percent
Measures related to the removal and examination of the placenta	27	43.5
Suture for tears	16	25.8
Injection to control or prevent hemorrhage from the uterus	13	21.0
Massage of the uterus	13	21.0
A general, possibly superficial, examination	12	19.4
One of the vital signs taken (temperature, pulse, respiration or blood pressure)	12	19.4
Examination for tears	8	12.9
Other (herbal teas or douching)	17	27.4
Women who received immediate care	62	

†Q: Right after the baby was born, was any particular care given to you (the mother) to make sure you were alright?

In the weeks following delivery, 54 of the women (73.0%) received postpartum care. Physicians provided the majority of this care, and a chiropractor provided care to one woman. Those who had received prenatal care from lay midwives, and

the woman who received care from a Christian Science practitioner, did not report receiving postpartum care from them.

Sixty-one mothers (82.4%) stated that some type of care was provided to the infant immediately after birth. The specific measures mentioned are listed in Table 19, but these findings should be read with caution. For example, note a dramatic discrepancy between the information obtained in the interviews and that gathered from birth certificates regarding silver nitrate treatment to the infant's eyes. The birth certificates show that silver nitrate was used in 50 of the 74 cases studied. However, during the interview only 15 women specifically mentioned the use of silver nitrate. Sixteen women mentioned eye care in general, and three mentioned other types of eye care. This example is of special interest because silver nitrate treatment to the eyes of newborn infants is mandatory in Michigan.

The women were asked about immediate follow-up care to assess their awareness of the newborn's adaptations to extrauterine life, specifically their breathing patterns, skin color and alertness. For example, did the attendants keep the infant warm and dry? As shown on Table 19, respondents noted some of these aspects of care. On the other hand, no respondent referred to any of the profound cardiovascular changes infants experience at birth. Were they unaware of them? The time lapse between the birth and interview and the large number of successful outcomes may account for the low number of responses to this open-ended question.

The majority of the infants (66 or 89.2%) had been taken to the doctor or the hospital between the time of birth and the interview. The reasons for these visits were, in order of frequency with which they were mentioned, checkups, immunization, circumcision, illness or accidents.

Eight infants had not seen a physician or been to a clinic or hospital since birth. Upon closer examination it is clear that five of these eight had some contact with a health professional. In three cases the father of the infant was a chiropractor, and two other families were visited by a public health nurse. Five of the mothers whose infants had no follow-up care did not receive postpartum care themselves. However, since two of these women were married to chiropractors, they may have had some form of care. Only one of the eight

TABLE 19
Special Care for the Infant Immediately After Delivery†
(Multiple Responses)

Type of Care	Number	Percent
Infant cleaned, washed and dressed	37	60.7
General check-up	21	34.4
Unspecified care to eyes	16	26.2
Silver nitrate treatment to eyes	15	24.6
Special care to the cord	14	23.0
Infant weighed and measured	12	19.7
Infant's heart rate, breathing, state of alertness noted	10	16.4
Special care to nose and throat with suctioning explicitly mentioned	10	16.4
Special care to nose and throat but suctioning not explicitly mentioned	6	9.8
Eyes washed with warm water, boric acid or antibiotics	3	4.9
Total number of infants who received immediate care 61		

†Q: Right after the baby was born, was any special care given to him/her?

mothers reported that she delivered the child in the presence of a physician. The three who were married to chiropractors were attended by their husbands. The other four deliveries were attended by nurses or a nurse midwife. Thus, upon closer examination of the interviews, the total number of infants without care is reduced. However, there remain several women who had neither a physician present at their delivery nor contact with a health professional afterward for purposes of postpartum or pediatric care. In our entire sample 12 mothers were visited by a public health nurse.

OUTCOMES OF THE HOME BIRTH

It is apparent both in the amount and in the nature of their preparation that the planned home births presented considerable emotional and psychological investments for the women interviewed. Though many of them had been warned of potential dangers in delivering outside a hospital, each woman had a clear concept of the advantages and positive psychological effects of a home birth. How did these women feel about the experience in retrospect?

WOMEN'S FEELINGS ABOUT THE HOME BIRTH

When discussing the details of the delivery, 66 of the women (89.2%) in the study described their home delivery in distinctly positive terms. Of these women, 16 described it with superlatives such as "beautiful," "wonderful," and "great"; 39 spoke in terms of a "smooth," "fast," "easy" birth. Eleven of the women were not so exuberant in their descriptions but felt that their experience had definitely been positive. The remaining eight felt their delivery had been slow or difficult, but they did not necessarily perceive it as a negative experience. None of the respondents described their deliveries in strong,

negative terms. In fact, 73 of the 74 women answered that they felt "very positive and enthusiastic" about their home birth in retrospect.

Seventy-one of the women (95.9%) said they would have another home birth; however, nine of these women qualified their responses. These unsolicited qualifications were related to good prenatal care, the absence of complications and the presence of a physician during delivery. One woman stated that she would have an out-of-the hospital delivery only if it was to occur in the doctor's office, as had her first.*

Thirty-four of the women (45.9%) stated they would enthusiastically recommend a home delivery to others. Twenty-eight women (37.8%) would recommend a home delivery, though somewhat less enthusiastically than the others. Ten of the respondents (13.5%) hesitated to make a recommendation, stating that the decision should be an individual one based on personal circumstances. One woman said she would not recommend a home delivery.

All three of the women who would not plan another home birth for themselves recommended that others consider it an option. They had very unique reasons for their personal decisions against another home birth. One of the women had a very long and difficult labor and delivery during the 1976 birth of her sixth child. In addition, she felt that her age (she was 38 years old) would make a home delivery prohibitive. The second woman would not deliver at home again because she felt that she would need a "break and besides, hospitals are becoming more lenient." The third had gone against her mother's wishes in delivering at home and did not wish to do so again. The latter two women spoke enthusiastically about their experience at home.

BIRTH WEIGHTS

In the recent past, a 5.5 pound weight limit was one major criterion in the diagnosis of prematurity. With the advances in neonatology, it is now known that mature infants may be very small as a result of maternal conditions, such as hypertension, and immature babies may be very large due to ma-

* Seven women in the sample had arranged for their 1976 deliveries to occur in a physician's office. In our screening process these were considered planned out-of-hospital deliveries, hence their inclusion.

ternal diabetes. Though gestational age is increasingly emphasized in newborn assessments, weight continues to be a significant factor. Babies born after uncomplicated pregnancies to parents of average build range from 2500 grams to 4300 grams (5.5 lbs. to 9.5 lbs.). The average weight of newborns is 3400 grams or 7.5 lbs.

Table 20 illustrates the importance of distinguishing between planned and unplanned home births. The birth weights of planned home births are higher than those of unplanned ones, and they even surpass those of the total population. For unplanned home births, 26.3% of the newborn weights fall below 2500 grams as compared with only 1.3% for planned home births. The difference between planned and unplanned birth weights is of high statistical significance. The weights for the birth-certificate-derived categories of non-hospital and home-births have been included to show their inappropriateness as indicators of the birth weights of planned home deliveries. They are misleading because they combine the weights for planned and unplanned home deliveries, yielding the interpretation that planned home births have lower weights than hospital births.

MATERNAL AND INFANT MORBIDITY

None of the women described the occurrence of any complications for themselves during delivery. Although 16 of the women required sutures, none of them viewed this as a complication. Could this be a reflection of the natural orientation of the home birth mothers and their attendants?

In interpreting highly favorable feelings about the home birth and the low incidence of complications during delivery, it is important to recall the nature of the sample. The women interviewed were those who actually had their babies at home. The sample did not include women who planned a home birth but were hospitalized in the course of the delivery because of serious complications.^o Obviously, these would have been

^o Edwards reports that in a study of 38 women who had planned a home birth in California, 11 had to go to the hospital because of suspected complications. Mehl's study of elected home births reported that "of the 1,146 women beginning labor at home with the intention of delivering there, 136 (12%) were sent to the hospital to complete their delivery, for treatment of intrapartum (11%) or postpartum problems."

TABLE 20
Birth Weights for Michigan Residents, Non-Hospital Births and Home Births¹ for 1976² as well as for Unplanned and Planned Home Deliveries of the 1976 Study Population

Birth Weight in Grams	MICHIGAN RESIDENTS						1976 STUDY POPULATION			
	Total Population		Non-Hospital		Home Births		Planned		Unplanned	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
500 or below	186	0.1	2	0.4	0	0.0	0	0.0	0	0.0
501-1,000	642	0.5	11	2.0	7	1.9	0	0.0	4	5.3
1,000-1,500	877	0.7	10	1.9	8	2.1	0	0.0	2	2.6
1,501-2,000	1,974	1.5	18	3.3	15	4.0	0	0.0	4	5.3
2,001-2,500	6,105	4.6	45	8.3	35	9.3	1	1.3	10	13.2
2,501-3,000	21,761	16.6	80	14.8	58	15.5	6	8.1	11	14.5
3,001-3,500	48,018	36.6	168	32.1	117	31.2	25	33.8	20	26.3
3,501-4,000	37,577	29.6	125	23.2	83	22.1	26	35.1	15	19.7
4,001-4,500	11,657	8.8	58	10.8	35	9.3	11	14.9	9	11.8
4,501 and over	2,501	1.9	13	2.4	9	2.5	5	6.8	0	0.0
Not Stated	80	0.1	9	1.7	8	2.1	0	0.0	1	1.3
Total	131,378	100.0	539	100.0	375	100.0	74	100.0	76	100.0

1—Where place of birth and address of mother match.

2—Data from Michigan Vital Statistics System.

recorded as hospital deliveries on the birth certificates.

During one interview, the mother reported complications for the newborn.

There was a lot of meconium on her so they had to clean her up. . . They cut the cord and laid her beside me; she started breathing, then faded away. The heart stopped — the doctor did artificial respiration then placed her in warm water because she went into shock. He (the doctor) felt she had a slow start, later she had hyaline membrane disease. He thought there were too many people in a small room and not enough ventilation. (It) would have happened in the hospital.

The mother reported the infant had increasing respiratory difficulties and was admitted to the hospital the next day, placed in an isolette and given I.V. therapy.

UNANTICIPATED OUTCOMES OF THE STUDY

As a result of the home interviews, two special health problems were brought to the attention of community health nurses. Both referrals were made to local public health departments with parental permission. In one family the interviewer noted that the infant was unable to hold up his head or to sit, both of which would have been developmentally appropriate for his age. This family, with annual income of less than \$8,000, had recently immigrated from Korea. The mother had not received prenatal care. There was some difficulty in communicating during the interview. However, the interviewer learned that the baby did not breathe immediately after birth. The family was grateful to be referred to a health agency that could help them, because they did not know where to go for care. The child was subsequently diagnosed as having cerebral palsy.

The second referral was also from a low-income home in which two children appeared unable to speak. In addition, the mother had delivered another child at home weeks prior to the interview and the infant appeared to the interviewer to be in need of physical attention. The public health nurse who followed up the referral reported that the two older children

were able to speak, though they had difficulty with enunciation and it was hard to understand them. The same nurse has not heard the child born in 1976 speak, however, she is reportedly very shy. She appears to be normal. The family lives in the country and their life style is simple and basic. Although their location may be socially isolating for the children, the parents are said to be very caring and protective. The public health nurse has assisted the family in updating the children's immunizations and continued follow-up is anticipated.

SUMMARY

This study has explored the reasons why women decide to deliver their babies at home rather than in a hospital. Specifically, the study addressed itself to several broad questions: Who are the women who choose to have a home birth? What motivated their decision? How did they prepare for the birth? What were the circumstances under which it took place, and what care did the mother and child receive? The study has focused on planned home births in Michigan in 1976. A systematic effort was made to have a representative sample of women who chose to deliver at home. However, it must be remembered that the study excludes births to unwed mothers because those birth certificates were not available for purposes of a study such as this one.

BACKGROUND

While essentially homogeneous in racial background, the home birth parents in the sample came from a cross-section of socio-economic groups. A substantial number of the women were college educated as were the majority of their husbands. Some of these couples identified with religions that reject

certain forms of modern medical and health care, but essentially, a wide range of religions were represented in the sample. The majority of the women had spent most of their lives in an urban area, but women with rural backgrounds were also represented in a fairly substantial proportion.

PREVIOUS HOSPITAL EXPERIENCE AND THE DECISION TO DELIVER AT HOME

More than half of the women in our study had delivered in a hospital prior to 1976, and most of them described their hospital experience in negative terms. Such issues as the loss of control, separation from the baby, and impersonal relationships with the hospital staff concerned them. Similar issues were cited in response to the question, "Why did you decide to deliver at home?" Five reasons emerged as major influences in the decision: (a) these women viewed pregnancy and delivery as a healthy life process rather than a disease; (b) they had a strong negative orientation toward hospitals; (c) they were committed to assuming an active role in the birth process; (d) they desired emotional support and involvement of friends and relatives in the experience; finally, (e) economic factors appeared to be an additional reason for some. The father usually participated in this decision. Most of the women were exposed to efforts to dissuade them from proceeding with their plans for a home delivery. However, in general, the respondents did not believe that there were major risks attached to having a home birth, especially if the mother had prenatal care.

OBSTETRICAL HISTORY, PREPARATION FOR HOME BIRTH, AND CARE DURING LABOR AND DELIVERY

Based on their reported obstetrical histories, only two of the women who had a hospital delivery previous to 1976 would have been considered at risk.

Preparation for the home birth assumed various forms: prenatal care, participation in childbirth classes, reading, special instructions, and preparation of the physical environment. While the overwhelming majority of women (68) had prenatal care, the percentage of women without prenatal care was higher for the sample than for the total population of

women who delivered in 1976 in Michigan. Sixty-eight women read books about childbirth, and 61 either attended birth preparation classes, had special instruction about the birth process or both. Most women indicated they would have gone to the hospital in case of an emergency.

Perhaps the most noteworthy finding concerning the care during labor and delivery is that only 35 of the 74 women said they delivered in the presence of a physician. Fifteen of the women who delivered without a physician present were attended by a nurse or a midwife; 24 delivered without either a physician or any other health professional. As a result, conventional medical monitoring of blood pressure, urine, etc. was less extensive and frequent than it would have been in a hospital. Women experimented with different positions and food consumption patterns during labor and delivery. They also took advantage of the home situation by allowing their husband, relatives and friends to attend the birth. The majority of the women and their infants received follow-up care in the weeks or months after the birth; however, in eight cases it was reported that, as of the date of the interview, the baby had not been seen by either a physician or a clinic since birth.

OUTCOMES

While it was not the intent of this study to evaluate the risks of planned home births, a few observations were made concerning birth weights, infant and maternal morbidity and the women's retrospective feelings about home births.

A large majority of the women described the experience of the home birth in distinctly positive terms, and almost all said they would have another home birth. The majority would also recommend a home birth to others. One woman, however, stated explicitly that she would not recommend a home birth. A comparison of birth weights of babies born outside of the hospital and those in the sample generally show a marked difference. Birth weights included in the sample of planned home deliveries are significantly higher than those of all out-of-hospital or home births as defined by birth certificates. The birth weights of the babies born to women in the sample were also higher than those for all Michigan births in 1976. Two referrals were made to community health nurses as a

result of the interviews. In both cases the referrals were based on the interviewer's observation that the child did not appear to function normally and seemed to be in need of health care.

OVERVIEW AND RECOMMENDATION

Today, women who decide to deliver their baby at home are non-conformers; they have made a decision that the majority of women and health care professionals would probably regard as ill-advised and dangerous. In light of this, it is not surprising that women who carry through with their plans for a home birth have strong views supporting the decision they have made. The women interviewed had a holistic perception of the birthing process. They viewed pregnancy as a well condition rather than a disease, and delivery as a joyful occasion in the life of women and their families. By contrast, hospital care was perceived as being compartmentalized, often separating the woman from her family and the newborn from its mother, in a highly technological, routinized environment. These women preferred the home as the location for birth because there they were able to experience childbirth as a family event in which they were active participants. Most of them argued that, with medical screening, good prenatal care, and adequate preparation for the home birth, it does not involve major risks. In fact, some of them suggested, a home birth may present fewer hazards to the mother and her infant than a hospital.

The emphasis upon pregnancy and delivery as a healthy life process for which the woman herself assumes responsibility, the rejection of current hospital practices and costs, and the low assessment of the risks of a home birth form a logically coherent attitudinal profile. This profile bears much resemblance to a variety of other, more general efforts directed at seeking alternatives to the established health care facilities. While the individuals in the sample were not necessarily active in the women's health movement or holistic health approaches, there is a strong similarity of purpose which links the decision to have a home birth to such movements.

In light of the strongly non-conformist position these women have taken with regard to birthing, it is important to note that the home birth movement is spread over a fairly broad section of society. It is not limited to women in counter-culture or unusual religious groups as some writers have earlier assumed. The trend toward home births must also be viewed as a criticism of rising hospital costs. While economic factors were by no means the main motivation behind the decision to deliver at home, they were an important element for some of the respondents. The criticism of the existing health care facilities and an active search for alternatives has thus reached a wide cross section of Americans. This suggests that responses to this phenomenon deal with it not as an aberration but as a serious criticism of existing obstetrical services. This study has several implications for policy and research.

POLICY RECOMMENDATIONS

Care For Women Who Choose a Home Birth

The decision to deliver at home is not a casual one. Most of the women had a consistent set of beliefs to explain the decision and persisted in their plans in the face of considerable efforts on the part of health care professionals, relatives or friends to dissuade them. Given the strength and consistency of these attitudes, and given the fact that the trend toward home births is continuing, it is important to examine the health care needs of home birth mothers and to implement health care strategies designed to meet these needs. Although a systematic assessment of the hazards of planned home births should be encouraged, an emphasis upon the risks is, by itself,

an inadequate response. As long as there are women who choose to deliver at home, it is important to assure that they do so with as much preparation, professional guidance and backup as possible.

The respondents differed in the extent to which the home birth was conducted under professional medical and health supervision. Although the majority of the women had fairly regular prenatal care, were attended by a physician, had postpartum care for themselves and follow-up for their infants, others lacked one or more aspects of such professional attention. For example, the two infants who were referred to public health nurses as a result of the interview were born to women who had essentially no prenatal care and delivered without a physician. These referrals illustrate perfectly the fact that some families are in need of health care, sometimes urgently, but do not know where or how to get it. While it may be that some women reject various dimensions of medical attention, before, during or after delivery, it is equally plausible that such care is simply unavailable to them. It is essential that prenatal care and medical attendants be readily accessible to women who choose home birth. It is also important that women who deliver at home are contacted by a public health nurse in order that appropriate medical and health services be arranged for parents who wish it. This applies equally to both planned and unplanned out-of-hospital births.

Alternative Birth Settings

It is important to provide a setting, whether within or affiliated with hospitals, where women can deliver in situations which provide not only the comforts of the home, but allow them to play a more active role in the birthing process. Successful experiments with such arrangements have been cited in the literature on birthing centers. Women are sufficiently close to the hospital to allow speedy access to all its technological facilities, but they are also sufficiently remote from it to protect the patient from its overbearing routines and procedures. Some of the women who now elect a home birth may see birthing centers as an attractive alternative to a home delivery. Such birthing centers also might respond to the needs of many other women who now deliver in hospitals but react

to their hospital experience in ways that are similar to those of the home birth parents.

Critical Evaluation of Existing Hospital Settings

In spite of the increasing trend toward home births, most women continue to deliver in a hospital. However, it is suspected that women who do so share to one degree or another the criticisms that mothers of this study expressed. A careful re-evaluation of hospital obstetrics is indicated. There certainly are ways in which patients can be provided with continuity of care from familiar health professionals. For example, hospitals are discovering that birthing rooms are a popular, viable alternative to segmented, compartmentalized care. In these comfortable, home-like settings, labor and delivery, which are traditionally separated, are brought together because the women can stay in one room for the entire birth.

Hospital administrators and personnel must express a willingness to take seriously the patient's needs for involvement in decisions regarding her care. They also must recognize that the presence of family members is an important ingredient in making the hospital delivery a satisfying experience.

It is relatively easy to make recommendations about the changes that are required if the existing health care system is to accommodate patients who have a view of health, their bodies, and birth that is almost diametrically opposed to current norms and practices. The more difficult chore is to suggest how such changes are to come about. This study of home birth illustrates a principle that has been observed for many other change efforts as well: good plans or recommendations also should indicate how they can be implemented. This latter criterion is very difficult to satisfy because the recommendations which are listed imply a dramatic change in attitude and behavior on the part of health care professionals. One can only hope that the very dramatic rejection of the existing care facilities implied in the home birth movement provides a stimulus for genuine change.

RECOMMENDATIONS FOR RESEARCH

Several methodological issues for the study of home births have been illustrated by this study; foremost among them is the importance of distinguishing between planned and un-

planned home births. Both are important topics for study, but they present distinct phenomena with very different origins and implications. This study has focused on planned home births on the assumption that planned, and not unplanned, home births account for the increase in home births. However, unplanned home births should be a critical area of concern. Why does the unplanned home birth occur? Could it have been prevented?

A second major methodological issue pertains to the difficulty of obtaining a representative sample of women who enter labor with the intention of delivery at home whether or not they do so. It is extraordinarily difficult to obtain a representative sample of this universe. If birth certificates are used as the starting point, women who plan a home birth but have to go to the hospital on an emergency basis during labor or delivery are excluded. These cases cannot be identified on the birth certificates. Contacting a sample of hospital births to discover what percentage of the women had intended to deliver at home is totally unfeasible given the small numbers of home births. On the other hand, studying the patients of health providers who are known to serve women planning home births has the limitation of being unrepresentative.

In the absence of entirely satisfactory procedures for studying the home birth phenomenon, it is necessary to be content with second best solutions and try to learn from a variety of approaches.

APPENDIX A:
Non-Hospital† and Home Births in Michigan, 1970-1976

Year of Birth	Total Number	Michigan Births		Home	
		Non-Hospital Number	Percent	Number	Percent
1970	170,515	360	0.21	271	0.16
1971	161,142	393	0.24	311	0.19
1972	146,016	355	0.24	283	0.19
1973	140,359	376	0.27	282	0.20
1974	136,418	369	0.27	282	0.21
1975	132,777	418	0.31	313	0.24
1976	130,253	539	0.41	375	0.29

†Home births are included in non-hospital births.

APPENDIX B:

Section of the Vermont Birth Certificate Requesting Information Regarding Planned Site of Birth (Refer to Q. 30)

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY; NOT FILED AS PART OF THE PUBLIC RECORD
(Health Department personnel: detach for statistics; destroy after one year.)

CHILD		NAME		FIRST		MIDDLE		LAST		BIRTH WEIGHT		14b	
FATHER		RACE		EDUCATION—SPECIFY HIGHEST GRADE COMPLETED		15a		15b		LIVE BIRTHS (Do not include stillbirths)		17a	
14a		WHITE, NEGRO, AMERICAN INDIAN, ETC (Specify)		Elementary or Secondary (0-12)		College (14 or 15+)		17a		None		17b	
MOTHER		RACE		EDUCATION—SPECIFY HIGHEST GRADE COMPLETED		16		16		None		17c	
15		WHITE, NEGRO, AMERICAN INDIAN, ETC (Specify)		Elementary or Secondary (0-12)		College (14 or 15+)		17c		None		17d	
18		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
19		MONTH DAY YEAR		20		21		22		23		24	
20		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
21		MONTH DAY YEAR		20		21		22		23		24	
22		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
23		MONTH DAY YEAR		20		21		22		23		24	
24		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
25		MONTH DAY YEAR		20		21		22		23		24	
26		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
27		MONTH DAY YEAR		20		21		22		23		24	
28		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
29		MONTH DAY YEAR		20		21		22		23		24	
30		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
31		MONTH DAY YEAR		20		21		22		23		24	
32		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
33		MONTH DAY YEAR		20		21		22		23		24	
34		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
35		MONTH DAY YEAR		20		21		22		23		24	
36		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
37		MONTH DAY YEAR		20		21		22		23		24	
38		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
39		MONTH DAY YEAR		20		21		22		23		24	
40		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
41		MONTH DAY YEAR		20		21		22		23		24	
42		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
43		MONTH DAY YEAR		20		21		22		23		24	
44		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
45		MONTH DAY YEAR		20		21		22		23		24	
46		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
47		MONTH DAY YEAR		20		21		22		23		24	
48		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
49		MONTH DAY YEAR		20		21		22		23		24	
50		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
51		MONTH DAY YEAR		20		21		22		23		24	
52		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
53		MONTH DAY YEAR		20		21		22		23		24	
54		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
55		MONTH DAY YEAR		20		21		22		23		24	
56		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
57		MONTH DAY YEAR		20		21		22		23		24	
58		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
59		MONTH DAY YEAR		20		21		22		23		24	
60		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
61		MONTH DAY YEAR		20		21		22		23		24	
62		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
63		MONTH DAY YEAR		20		21		22		23		24	
64		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
65		MONTH DAY YEAR		20		21		22		23		24	
66		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
67		MONTH DAY YEAR		20		21		22		23		24	
68		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
69		MONTH DAY YEAR		20		21		22		23		24	
70		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
71		MONTH DAY YEAR		20		21		22		23		24	
72		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
73		MONTH DAY YEAR		20		21		22		23		24	
74		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
75		MONTH DAY YEAR		20		21		22		23		24	
76		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
77		MONTH DAY YEAR		20		21		22		23		24	
78		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
79		MONTH DAY YEAR		20		21		22		23		24	
80		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
81		MONTH DAY YEAR		20		21		22		23		24	
82		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
83		MONTH DAY YEAR		20		21		22		23		24	
84		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
85		MONTH DAY YEAR		20		21		22		23		24	
86		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
87		MONTH DAY YEAR		20		21		22		23		24	
88		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
89		MONTH DAY YEAR		20		21		22		23		24	
90		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
91		MONTH DAY YEAR		20		21		22		23		24	
92		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
93		MONTH DAY YEAR		20		21		22		23		24	
94		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
95		MONTH DAY YEAR		20		21		22		23		24	
96		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
97		MONTH DAY YEAR		20		21		22		23		24	
98		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
99		MONTH DAY YEAR		20		21		22		23		24	
100		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
101		MONTH DAY YEAR		20		21		22		23		24	
102		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
103		MONTH DAY YEAR		20		21		22		23		24	
104		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
105		MONTH DAY YEAR		20		21		22		23		24	
106		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
107		MONTH DAY YEAR		20		21		22		23		24	
108		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
109		MONTH DAY YEAR		20		21		22		23		24	
110		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
111		MONTH DAY YEAR		20		21		22		23		24	
112		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
113		MONTH DAY YEAR		20		21		22		23		24	
114		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
115		MONTH DAY YEAR		20		21		22		23		24	
116		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
117		MONTH DAY YEAR		20		21		22		23		24	
118		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
119		MONTH DAY YEAR		20		21		22		23		24	
120		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
121		MONTH DAY YEAR		20		21		22		23		24	
122		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
123		MONTH DAY YEAR		20		21		22		23		24	
124		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
125		MONTH DAY YEAR		20		21		22		23		24	
126		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
127		MONTH DAY YEAR		20		21		22		23		24	
128		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
129		MONTH DAY YEAR		20		21		22		23		24	
130		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
131		MONTH DAY YEAR		20		21		22		23		24	
132		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
133		MONTH DAY YEAR		20		21		22		23		24	
134		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
135		MONTH DAY YEAR		20		21		22		23		24	
136		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
137		MONTH DAY YEAR		20		21		22		23		24	
138		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
139		MONTH DAY YEAR		20		21		22		23		24	
140		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
141		MONTH DAY YEAR		20		21		22		23		24	
142		DATE LAST NORMAL MENSTRUATION BEGAN (Month, Day, Year)		WEEKS OF GESTATION		20		21		22		23	
143		MONTH DAY YEAR		20									

APPENDIX C:

Letters from Families.

The following two letters are examples of those which were received from families who were contacted for the study but had left Michigan following their 1976 home birth.

Dear Mary Conklin:

We received your letter concerning home deliveries the other day. We have moved to Kansas, so were late in receiving it.

We were glad to hear that your department is taking an interest in this. Jill is our 7th child and the only one born at home. It was a wonderful delivery — the easiest I have had and the most enjoyable. The Doc did not arrive until after delivery. My husband had never been allowed in the delivery room so had always been a stranger to the other children until they had been home a while. Jill has been his baby from the moment he first saw her. It was wonderful for me to hold her and see her lift her head and smile at me even before the cord was cut. Before I was never allowed to touch my baby until after they had been washed and dressed.

The main reason we decided to have our baby at home was because of the high cost of hospital care. Really, what do you get for \$1,000?

If we ever had another baby we would have it at home even if the hospital was free, because we realize now that a home delivery is so much for the mother, father and baby and the other children in the home.

I think it would be wonderful if each county could have some one trained to assist in home deliveries. Of course I feel that good doctors care before delivery is very important. If we can be of any help please let us know.

P.S. Our next youngest is 14.

Dear Mary Conklin:

We have since moved to Idaho as you can see, but we would be willing to answer any questions you have. Technically speaking though ours wasn't a home birth, since

Naomi was born at the doctor's office with his assistance. We had planned it that way.

Hopefully our next child (if and when we have one) will be born at home. Preferably with a practiced midwife present. We would almost certainly never give birth to a child in a hospital again as we did with our first child, Joshua.

Departments such as yours could do good things for parents and their babies by educating and encouraging hospital folks to think of birth as a more natural, emotion-filled, and meaningful occasion rather than thinking of birth in terms of clinical efficiency as seems to be the case now. But more importantly I think you could do more good by encouraging midwives in their training, legalizing midwife activity if it is not legal now, and encouraging classes in prepared childbirth such as Lamaze. I do not think it wise for untrained and unprepared parents to give birth by themselves at home, but given the present state of hospital care, I think even that is preferable to enduring the assault on body and soul which is presently called medical care.

But anyway, let the questions come, and if your intentions are to be helpful to expectant parents we will answer them gladly. If on the other hand your questionnaire is designed only to find ways to prevent the present hospital care system from losing more "patients" well then we may not be so polite.

APPENDIX D:

The Questionnaire

One female interviewer conducted the entire fieldwork. She was trained by individual instruction in interviewing techniques and aspects of pregnancy and the birth process. The interviews were conducted in each family's residence with the interviewer filling in the form with verbatim comments. Both mother and father were requested to be present at the interview.

SECTION I — BACKGROUND INFORMATION

The following questions pertain to all of your pregnancies.

1. How many children do you have?

2. What are their birth dates?

3. Have you had any other pregnancies?

Yes

No

IF YES:

4. What happened to these pregnancies?

1. Stillbirth (fetal death after 20 weeks)

2. Child deceased

3. Voluntary abortion

4. Involuntary abortion (miscarriage)

5. Adoption

5. You told me that you have _____ children. The last one was born at home, right?

Yes

No

Now we'll talk about the others.

6. How about the oldest child, where was he/she born?
Was it at a hospital? At home? Or someplace else?
 1. Hospital
 2. Home
 3. Other (SPECIFY)

7. Who delivered this child?

8. Who else was present? (IDENTIFY PROFESSION OR RELATIONSHIP)

9. The second oldest child?
 1. Home delivery
 2. Hospital
 3. Other (SPECIFY)

10. Who delivered this child?

11. Who else was present? (IDENTIFY PROFESSION OR RELATIONSHIP)

12. The third oldest child?
 1. Home delivery
 2. Hospital
 3. Other (SPECIFY)

13. Who delivered this child?

14. Who else was present? (IDENTIFY PROFESSION OR RELATIONSHIP)

(IF ANY PREVIOUS CHILDREN WERE BORN IN A HOSPITAL, ASK:)

15. You said that _____ of your children were delivered in a hospital. How did you feel about your hospital delivery?
(IF MORE THAN ONE HOSPITAL DELIVERY, ASK ABOUT EACH ONE.)

16. Now your last baby was born at home. Thinking about your pregnancies prior to this one, did you have any problems while you were pregnant?

Yes

No

IF YES:

17. What were these problems?

18. What about during your labor and delivery, did you have any complications?

Yes

No

IF YES:

19. What were these problems?

**SECTION II—THE DECISION TO HAVE THE BABY
AT HOME**

As I told you earlier, I am really interested in home deliveries and why people are having their babies at home.

20. Why did you decide to deliver at home?

(THIS QUESTION IS INTENDED TO REFER TO THE ORIGINAL DECISION; NOT NECESSARILY TO THE LAST BABY.)

21. When did you decide to have the baby at home rather than in a hospital?

22. Was the father of the baby involved in deciding to have a home delivery?

Yes

No

IF YES:

23. Who suggested it first, he or you?

(REMEMBER FATHER AND RESPONDENT TOGETHER.)

24. What about other people, did anyone else encourage you in making this decision?

Yes

No

IF YES:

25. Who?

Friend

Neighbor

Relative (SPECIFY WHO) _____

Medical person (SPECIFY WHO) _____

Other

26. What was said to encourage you to have a home delivery?

27. Did you ask for this encouragement or was it given without your asking for it?

I asked for it.

It was given without asking.

Both

28. Did anyone discourage you from having a home delivery?

Yes

No

IF YES:

29. Who discouraged you?

30. What was said to discourage you from having a home delivery?

31. Did you ask for this opinion or was it given without your asking for it.

I asked for it.

It was given without asking.

Both

32. Did anyone you know ever have a home delivery?

Yes

No

IF YES:

33. Who was it?

(PROBE: HOW ABOUT A RELATIVE SUCH AS
A GRANDMOTHER, AUNT, ETC.)

34. Have you ever been present at a home delivery other than your own?

Yes

No

35. Have you ever seen a movie or a TV program about a home delivery?

Yes

No

SECTION III — PREPARATIONS FOR THE HOME DELIVERY

Now, we'll talk about the preparations you made for the home delivery.

36. Have you ever read any books about childbirth?

Yes

No

IF YES:

37. Which ones did you read?

38. Have you ever attended any birth training classes?

Yes

No

IF YES:

39. What type of class?

40. Did you attend classes for this last pregnancy?

Yes

No

IF YES:

41. What type of class?

42. Did anyone give you any special instruction to prepare for the home delivery?

Yes

No

IF YES:

43. Who taught you? (THEN SKIP TO NO. 45)

Physician

M.D.

D.O.

R.N.

L.P.N.

Lay/Granny Midwife

Other

IF NO:

44. How did you know how to get ready for having the baby delivered at home?

(THEN SKIP TO NO. 49)

45. In the classes or special instruction that you took, did the instructor talk about problems associated with pregnancy, labor and delivery?

Yes

No

IF YES:

46. What problems were discussed?

47. Do you think the treatment of problems was adequate?

Yes

No

IF NO:

48. What problems were left out?

49. What did you actually do to get ready for the home delivery?

(PROBE — HOW ABOUT THE HOME OR HOW ABOUT YOURSELF, DID YOU DO ANYTHING TO PREPARE YOURSELF?)

50. Did you need to get any special equipment?

Yes

No

IF YES:

51. What type of equipment?

SECTION IV — PREGNANCY OF BABY LAST DELIVERED AT HOME

The following questions pertain to the months before your last baby was born and to the care you received during this pregnancy.

52. Did you have any health problems or conditions during that pregnancy?

Yes

No

IF YES:

66. Did anyone monitor your (the mother's) blood pressure during labor and delivery?

Yes

No

Don't know

IF YES:

67. How often?

68. Did anyone test your (the mother's) urine during labor and delivery?

Yes

No

Don't know

69. Did anyone listen to the baby's heart beat during labor?

Yes

No

Don't know

70. Did anyone do a vaginal (or internal) exam during labor?

Yes

No

Don't know

71. Who was with you during labor and delivery?

72. In what position were you most comfortable during your labor and delivery?

73. Did you eat and/or drink during labor?

Yes

No

IF YES:

74. What did you have?

75. Did you take anything during labor like tranquilizers or medicine for pain?

Yes

No

76. Did you do anything to ease the pain like massages or breathing exercises?

Yes

No

77. What position did you deliver in?

Lying down, propped with pillows _____

Squatting _____

Knees to chest _____

Hands and knees _____

78. How did the delivery go? (PROBE: WAS IT EASY OR DIFFICULT?)

79. Were you able to hold the baby immediately after delivery?

Yes

No

IF NO:

80: Why not?

81. Did you nurse the baby immediately after delivery?

Yes

No

82. Right after the baby was born, was any particular care given to you (the mother) to make sure you were all right?

Yes

No

IF YES:

83. What was done?

84. Did you receive any care in the weeks following the birth of the baby?

Yes

No

IF YES:

85. By whom?

86. Right after the baby was born, was any special care given to him/her?

Yes

No

IF YES:

87. What kind of care? (PROBE: WHAT ABOUT EYE CARE?)

88. Where was it given?

89. What medicine was used?

90. Have you taken the baby to a doctor, clinic or hospital since birth?

Yes

No

IF YES:

91. Where was he/she taken?

92. What was the reason(s) for the visit?

93. Did the public health nurse call at any time during the 1st month after delivery?

Yes

No

SECTION VI — AWARENESS OF RISK

94. Some people think there are special problems or risks for the mothers who deliver at home. Others disagree and think that there are no special problems or risks. What do you think?

IF YES:

95. What are the problems or risks?

96. How about for the baby? Do you think there are any special problems or risks in delivering a baby at home?

Yes

No

IF YES:

97. What are they?

98. If you or your baby had had any problems during labor and delivery, would you have gone to the hospital?

Yes

No

IF YES:

99. For what kind of problems?

100. Did you have any plan as to how you would get to the hospital if you needed to go?

Yes

No

IF YES:

101. How would you have gone?

IF NO:

102. Why would you not have gone to the hospital?

SECTION VII — FEELINGS ABOUT HOME DELIVERY

103. Looking back, how do you (the mother) feel about your home birth? Would you say you are:

Very positive and enthusiastic

Positive with some reservation

Neutral

Negative but with some positive feelings

Negative

(EXPLAIN RESPONSE)

104. If you were to have another baby, would you have it at home?

105. Would you recommend a home delivery to others?
Would you:
- Strongly recommend
 - Recommend
 - Neutral
 - Discourage
 - Strongly discourage

106. As I told you at the beginning of the interview, this study is conducted by the Public Health Department. We are interested in finding out what needs to be changed in hospitals to make delivery a better experience for women and would like to know your views on this subject. What do you think needs to be changed in hospitals to make delivery a better experience for women?

SECTION VIII — GENERAL INFORMATION

107. Have you lived most of your life in a rural or urban area?

Rural

Urban

108. In what state?

109. Occupation of mother _____

110. Occupation of father _____

111. Do you have hospitalization insurance?

Yes

No

IF YES:

112. Was this pregnancy covered?

Yes

No

113. Total family income:

1000— 3999

13000—19999

4000— 7999

20000—29999

8000— 9999

30000—49999

10000—12999

50000 & over

114. Number supported _____

115. Religious affiliation _____

BIBLIOGRAPHY

Annas, George J. "Medicolegal Aspects of Homebirth and Alternative Birth Methods." Paper presented at the annual meeting of the American Public Health Association. (Washington, D.C.) Oct. 31, 1977.

The author points out that while the home birth movement has made some impact on hospital practices—the attitudes and laws regarding "husband-coached" labor for example—acceptance is by no means universal. This is symbolized in a Montana court ruling that denied the constitutional right of a woman to have the father of her child with her during delivery. This and other medicolegal aspects of birth in this country are a result not only of the limited rights of women, but also of conventional medical rationale that regards childbirth as "comparable to other serious hospital procedures." These forces are powerful even in the censure of physicians who practice homebirths. The author concludes that the burden of proof necessary to create change is on the advocates of alternatives. Dr. Annas proposes a national demonstration project to prove that alternatives in and out of the hospital are reasonable, as well as safe and cheap.

Bing, Elizabeth D. "Progress in Low-Risk Normal Childbirth Care." *Birth and the Family Journal* 2(1975):109, 143.

According to the author, the philosophy of the Non-Hospital Maternity Center (opened in New York City by the Maternity Center Association in October 1975) is one in which the pregnant woman and her family make significant decisions regarding their care. This is provided for in a home-like environment that emphasizes prenatal care, education and screening for women under 35 years of age who live in three boroughs of New York. The Maternity Center Association hopes to show that the emphasis on screening will result in a small number of emergency transfers to hospitals. The intention of the Maternity Center is to "foster in expectant parents confidence in their own ability to bear and raise healthy children."

"Births at Home Create Debate on Safety." *The Nation's Health* 7(Feb. 1977):12.

This article outlines the opposing positions in the debate on home births, characterized by Dr. Lewis Mehl on one side and the American College of Obstetrics and Gynecology and other physicians on the other. Dr. Mehl has done several studies of

home births that are favorable. In contrast to Mehl, Dr. Jean Pakter of the New York City Department of Health suggests that the home trend may "be more talk than actuality." All agree that there may be negative outcomes in home births that may have been avoided in the hospital. This is summed up in a statement by the American College of Nurse Midwives that does not prohibit nurse-midwife involvement in home births but says that maternity centers and hospitals are more appropriate places.

Burnett, Claude, et al. "Home Delivery and Infant Mortality in North Carolina." Paper presented at the 105th American Public Health Association Annual Meeting. Nov. 1977.

This study compares the characteristics of the 340 home births in North Carolina in 1975 to a matched hospital population and to all births in the state. Its results illustrate that the home birth population is disproportionately black (80%), illegitimate (40%), and undereducated (21% have less than a ninth grade education). There was also an above average incidence of birth weights below 2500 grams and neonatal mortality rates were 7.5 times greater than those of the infants born in hospitals. Furthermore, the authors report that the gestational age of the home delivery population was lower than that of their hospital counterparts. The pregnant women who were to deliver at home started prenatal care later and had fewer prenatal visits. Because this population was concentrated in five socio-economically depressed counties in the state, the authors feel safe in concluding "that the study group had less access to medical care."

Carlson, Billie and Sumner, Philipe. "Hospital At Home Delivery: A Celebration." *JOGN Nursing* 5(Mar. Apr. 1976):21-27.

By providing continuity of the labor-delivery sequence in the Lamaze rooms, the obstetric staff at Manchester Memorial Hospital in Manchester, Connecticut seek to achieve a balance between the emotional and medical aspects of birth. Balance is achieved in the home-like rooms by special Lamaze trained nurses (montrices) who provide continuous uninterrupted physical and emotional support, as well as manage the labor, blood pressure checks, sterile vaginal examinations and fetal heart monitoring. They are also responsible for administering medications and keeping the physician informed.

Dingley, Erna F. "Birthplace Alternatives." *Oregon Health Bulletin* 55(Oct. 1977). Oregon State Health Division, Portland, Oregon.

In Oregon the number of out-of-hospital births increased 50% between 1975-1978. In 1976, 959 births occurred outside the hospital; 74% of these were specified as home deliveries, 18% were delivered in clinics and 8% in residences other than the mother's. A review of birth records also shows that women who delivered at home had above average levels of education, and 12% of the out-of-hospital births had no prenatal care compared to the respective figure of 1% for the total population.

Edgar, Linda. "Home Delivery Dutch Style." *Canadian Nurse* 71(Oct. 1975):36-8.

The author, a nurse, delivered her second child at home when she was living in Holland—where 70% of all births occur at home and the infant mortality rate is the lowest in the world (9.1 per 1000 births versus 19.1 in the United States). In Holland, nursing services are available to the woman and her family before, during and after the birth on a full or part-time basis. And it is common practice for doctors to attend home births and make regular house calls afterward. Despite these excellent services and her positive experience, Linda Edgar remains frightened by possible risks and suggests that a modified hospital environment might "combine the best of both worlds."

Edwards, Margot E. "Unattended Home Birth." *American Journal of Nursing* 73(Aug. 1973):1332-35.

Written from the perspective of a nurse and childbirth educator, this article discusses the attitudes of couples who opt for a home birth unattended by either a nurse or physician. The sample discussed in the article seems to be composed primarily of couples who have a "hip" lifestyle, value involvement of friends and family and personal responsibility for their decisions. These couples "express to a greater and more extreme degree the attitudes of those who seek family-centered maternity care." In addition to a discussion of important issues in childbirth education of home birth couples, this article includes results of a survey of 38 women who choose unattended home birth in two California counties.

Emrey, Margaret A. "Home Births in California." Unpublished report by the California State Department of Health.

There has been a sharp increase in the incidence of home birth in California since 1975 when there were 3,516 out-of-hospital births. They appear to be clustered in the north and central counties of the state. In Marin County, for example, 7.8% of the births were out-of-hospital as opposed to a rate of 1.1% for the entire state. Though no distinction is made between planned and unplanned births, a review of the birth records showed a correlation between out-of-hospital deliveries and late or absent prenatal care. The author, a nursing consultant for the state department of health, believes that these trends are a reflection of (a) the shortcomings of MediCal; (b) lack of knowledge on the part of consumers; (c) costs of medical care; (d) the reluctance or refusal of physicians to serve families who want a home birth; and (e) distrust of traditional medical practice and practitioners. The article also reviews the roles of physicians, nurse-midwives and lay midwives in home births.

Epstein, Janet E. and McCartney, Marion. "A Home Birth Service That Works." *Nursing Care* 9(Dec. 1976):30-1, 34.

The authors are registered nurses who assisted local obstetricians with home births before they became certified midwives and started the Maternity Center Association, Ltd. in Bethesda, Maryland in 1975. The home services they provide have the support of the physicians, any one of whom is on call during all the home births the midwives conduct. Couples who avail themselves of home delivery services must meet certain medical and non-medical qualifications. In addition to having completely normal histories and laboratory results, clients must receive prenatal care as recommended by ACOG, live a certain distance from the hospital, agree to be transferred there if necessary and make arrangements for the infant to be seen by a pediatrician within 24 hours. The philosophy of Maternity Center Associates, which stresses education and post partum follow-up, is to assist couples committed to home birth in achieving their own goals.

"Fathers in the Delivery Room." *Briefs* 40(Mar. 1976):38-9.

This is a brief outline of two court cases (in Montana and Indiana) and legislation before Congress regarding the right of fathers to attend the hospital delivery of their children. Representative James C. Corman of California has introduced legislation to permit the fathers' presence during delivery in all hos-

pitais that receive federal funding or benefit from federally guaranteed loans. This contrasts with the prevailing practice in which hospital administrators and trustees make decisions regarding fathers' attendance on an individual basis with medical advice.

Hazell, Lester. *Birth Goes Home: An Ethnographic and Attitudinal Study of 300 Couples Electing Home Birth in the San Francisco Bay Area*. Seattle, Washington, Catalyst Publishing Co., 1974.

Hosford, Elizabeth. "Alternatives in Nurse Midwifery Care: III. The Home Birth Movement." *Journal of Nurse Midwifery* 21(Fall 1976):27-30.

The author, coordinator of the Childbearing Center of the Maternity Center Association in New York, believes that trends in alternative birthing practices are positive in terms of their significance to national health, maternity care, and individual families. These trends reflect the greater responsibility individuals are taking for their own health. Furthermore, as birth centers and home services are created to respond to the needs of families, hospitals are being forced to offer a wider spectrum of services, such as family-centered care. According to the author, more studies need to be done in areas such as a woman's subjective experience of birth and its outcomes, and the effects of breast feeding on the later emotional development of the child.

Huygen, Frans J. "Home Deliveries in Holland." *Journal of the Royal College of General Practitioners* 26(1976):244-48.

This is a discussion of the philosophy and practice of obstetrics in Holland where normal deliveries are at home, attended by a midwife or general practitioner, and high risk births take place in the hospital attended by a specialist or gynecologist. Professor Huygen addresses the issues of national health insurance and the distinctive roles of midwives, general practitioners and gynecologists in a comparison of perinatal mortality rates for Great Britain and the Netherlands and on analysis of deliveries in Holland.

Lee, Cynthia. "Delivering a Baby at Home: The Rewards Vs. the Risks". *The Detroit News*, 21 Sept. 1977.

According to the author, a woman who wants a home delivery has three options: finding a cooperative physician, locating a trained midwife practicing illegally or visiting Birthcenter, a Highland Park organization of self-taught midwives. The general

discussion on home births mentions studies on the subject being done in Michigan, Minnesota and California, and it includes two accounts of home deliveries—one successful, the other unsuccessful.

Long, Phyllis and Jefferis, Clara. "Home Deliveries." *Frontier Nursing Service Quarterly Bulletin* 50(Spring 1974):33-36.

This article outlines the preparation, management and post-partum follow-up of deliveries by the Frontier Nursing Service over the past 50 years. In the last 25 years the FNS has served 2,669 women at home without a maternal death. This statistic supports others suggesting that home deliveries are as safe as hospital deliveries and that there is a relationship between nurse midwifery care and a reduction of maternal and infant mortality.

Lubic, Ruth Watson. "Alternative Patterns of Nurse-Midwifery Care: I. The Childbearing Center." *Journal of Nurse-Midwifery* 21(Fall 1976):24-5.

According to the author and director, the Maternity Center Association created the Childbearing Center as a direct alternative to "impersonalized interventionist, pathologized, technology-oriented, unresponsive and costly in-hospital care." The Center is staffed by physicians, nurse-midwives, nurse-midwife attendants and visiting nurses who provide follow-up visits to the home. The philosophy of the Childbearing Center emphasizes educational prenatal care and screening in an environment where professionals and consumers alike struggle to shed the orientation of modern obstetrics toward pathology.

Matousek, Irene. "Homebirths—Myths or Message?" *Journal of Nurse Midwifery* 19(Spring 1974):24-29.

In addressing herself to so-called myths surrounding home deliveries, the author illustrates that cultural pressures in favor of hospital deliveries and economics are making home deliveries increasingly impractical. Statistics from other countries and the examples of the Frontier Nursing Service and the Maternity Center Association in this country illustrate the importance of cultural or economic factors in responding to patients' needs for family-centered care in maternity facilities.

Maynard, Fredelle. "Home Births vs. Hospital Births." *Woman's Day*, 28 June 1977.

This article focuses on the psychological aspects of home births,

pointing out that many women believe that these benefits outweigh the risks and that hospital births pose risks also. At home the parents retain control in a peaceful, familiar environment. Without hospital interferences, the experience is enhanced because the family is together. It is true that many hospitals are introducing some of these aspects of the home experience and they deserve consideration, especially by women who for medical, psychological, or insurance reasons are not candidates for home births. It is important to have adequate preparation and a competent attendant to help insure that the out-of-hospital experience will be a successful and dignified one.

Mehl, Lewis. "Home Delivery Research Today — A Review." *Women's Health* 1(Sept./Oct. 1976):3-11.

This article divides the literature on homebirths into three categories: (1) Medical outcome studies generally report low levels of complications for home birth populations in Great Britain, California, Oklahoma and Washington, D.C.; (2) home-hospital comparison studies attempt to match home and hospital populations and conclude that the latter has a higher incidence of fetal distress, birth injuries, neonatal infections, post partum hemorrhages and depression; and (3) the conclusions about post partum depressions are further substantiated in psychological outcome studies that focus on parental attitudes and self esteem in comparing the home and hospital groups. This review of the literature is put into a political and social context by beginning and ending with a discussion of the history of modern obstetrics, its control by male physicians and their resistance to out-of-hospital alternatives. The position paper published by ACOG on the subject characterizes this resistance.

Mehl, Lewis E., et al. "Outcomes of Elective Home Birth: A Series of 1146 Cases." Unpublished Study, California Department of Health, Maternal and Child Health, 1975.

This study compares data from five home delivery services, including three physician groups and two lay midwife services. The women seeking home births appear to be a self-selected healthy group, and partly because of this, their births compare favorably in relation to the complication rates of the California population at large. Virtually all the women in this study had prenatal care, attended birth preparation classes and attempted to breast feed. Those delivered by midwives had a lesser number of episiotomies and lacerations requiring repair because the midwives practice techniques of perineal massage and gentle delivery. Further, the authors conclude that hospitals and physicians should

be encouraged to adopt some of these techniques and "generally provide a supportive, friendly and comfortable environment for labor and delivery."

Meyer, Barbara J. "Childbirth at Home — A Family Centered Affair." *JOGN Nursing* 5(Mar./Apr. 1976):20, 28-31.

This account of the author's experience and feelings surrounding the planned home delivery of her eighth child conveys the richness of her family life and the place the birth assumed in it. The birth was a happy family experience: The children had none of the fears associated with separation from the hospitalized mother and both parents marvelled at the changes in their child as they watched her continuously.

Miller, C. Arden. "What Technology Breeds: A review of recent U.S. Experience with Cesarean Section." Speech delivered at the John Sundwell Memorial Lecture. (Ann Arbor, Michigan) Mar. 20, 1978.

In 1965 the national cesarean rate was 4.5% of all live births. Today the figure is 12%, and in major medical facilities the figure is 25%. Prompted by these figures and, in part, by his friendship with Ruth Lubic of the Maternity Center Association in New York, Dr. Miller questions this trend in terms of the technical-medical justifications for cesarean section in terms of social economic factors. He explores the possibility of economic incentives for cesareans at a time when birth rates are declining and the number of obstetricians is increasing. Hence, there is a decline in the ratio of the number of live births to the number of physicians: from 260.7 in 1963 to 144.9 in 1975. Dr. Miller's observations of the psychoemotional experience of a cesarean birth for women and the concerns of the women's health movement in the U.S. reflect a humanist-feminist perspective.

Moawad, Atef H. "Some Problems of Professionally Attended Home Births." *The Journal of Reproductive Medicine* 19(Nov. 1977):298.

Dr. Moawad discourages home deliveries because of risk factors, unexpected problems that may occur during labor and possible post partum complications. Based on statistics regarding a higher incidence of death from neonatal pneumonia and infections among home birth infants in Great Britain, he encourages instead the development of a home-like atmosphere in hospitals rather than a total return to home births.

"New Interest in Home Deliveries." *Maternal & Child Health Information*. Health Services and Mental Health Administration Newsletter (Rockville, Maryland) 29 Jan. 1973.

According to this report excerpted from a speech by Dr. Kathleen Kendall (Chief Nursing Consultant, Maternal and Child Health Service), the interest in home deliveries seems to exist principally among "the communes or counter-cultural groups," as well as among well-educated women. The resurgence of home deliveries seems concentrated on the West coast. In contrast, the South, for example, is continuing determined efforts to decrease the number of deliveries by lay midwives. Accordingly, state health departments are gathering data on these trends.

Newton, Michael. "Woman, Wife, Mother." *Family Health* 9(Jan. 1977):19, 64.

This is an anecdotal account of the factors that went into this doctor's decision not to do home deliveries. It is the author's hope that more obstetrical units in hospitals will be transformed into a home-away-from-home where in a more personal, supportive environment a woman will have access to professional care and to an adjacent "high risk suite." He cites as examples the Family Hospital in Milwaukee and the Maternity Center Association's Childbearing Center in New York.

Petty, Carolyn. "No More Home Deliveries!" *RN* 43(Oct. 1972): 68-73.

This is an autobiographical account of a mother of three — all born by natural childbirth — who planned a home delivery to be attended by a nurse and a doctor. During labor, complications necessitated her transfer to a hospital where an emergency cesarean was done.

Petty, Roy. "Home Birth Movement Showing Signs of Growth, Respectability." *American Medical News*, 23 June 1978, p. 13.

Though the "alternative birth movement springs from a single source—a strong disenchantment with standard hospital and obstetrician childbirth methods," a broad spectrum of alternative birth advocates attended the NAPSAC conference entitled, "Compulsory Hospitalization or Freedom of Choice in Childbirth?" Some of the hospital practices that came under fire at the Atlanta conference in May, 1978 were electronic fetal monitoring, routine episiotomies, the high rate of cesarean sections, and oxytocin-induced labor, among others.

Popins, Lillian Saltzman. "Preparation for Premature Delivery at Home." *Nursing Care* 6 (Dec. 1973):29-30.

In the event that premature labor is too far advanced, transportation is poor, or the infant is almost full term, Ms. Popins states that "everything should be done to promote safe delivery at home." Her article outlines the materials and procedures necessary for the preparation and delivery and follow-up care for mother and infant.

Rising, Sharon Schindler. "Alternative Patterns of Nurse-Midwifery Care: II. The Consumer-Professional Balance," *Journal of Nurse Midwifery* 21 (Fall 1976):25-27.

The Childbearing-Childrearing Center (CCC) at the University of Minnesota was created as a result of consumer and professional dissatisfaction with the orientation of health practice toward sickness care. This service provides nurse-midwifery care within a hospital setting. It is consumer oriented in areas such as husband involvement, labor room delivery, no routines, immediate and continuing contact with the baby, and early discharge. Two other unique aspects of the CCC are provision for support groups during childbearing (several which have continued for two years) and pediatric nurse associates who provide early well-child care. Data from a survey of the first 137 women who participated in the services shows that 81% of them were "highly satisfied."

Ritchie, C. Ann and Swanson, Lee Ann. "Childbirth Outside the Hospital—the Resurgence of Home and Clinic Deliveries." *Maternal Child Nursing* 1 (Nov./Dec. 1976):373-77.

Beginning with an account of a young couple's pleasant delivery in a doctor's clinic, the authors discuss the growing trend toward out-of-hospital deliveries in terms of a comparison between the obstetric practices in other countries with those of the United States, which ranks 15th in infant mortality rates. In addition to disenchantment with hospital procedures, there are more positive reasons for the home birth trends, such as the desire for harmonious, natural births.

Sauer, Mark. "Birth, 'No Big Deal': 'Just Let Your Body Do it'." *The State Journal* (Lansing, Michigan), 8 May 1977.

This article presents the attitude towards birth held by a 19 year-old woman who is pictured jogging when she is eight months pregnant. She forthrightly articulates a rejection of standard hospital delivery practices and a philosophy of birth as a natural,

healthy event. Ms. Anderson does not completely reject the health care system. She visited a prenatal clinic regularly during her pregnancy and made arrangements for hospital back-up in the event of complications.

Stoltz, Marsha Kuhn. "Home Birth Safety Study Hit as Invalid." *Nursing Care Week* (Jan. 1978):2, 30.

An American College of Obstetricians and Gynecologists news release accuses home birth studies of statistical manipulation, but it agrees with those that report a two to five times greater rate of infant and neonatal mortality for home birth populations. This article presents the positions of physicians who agree with the ACOG report and those who do not. A major criticism of both groups is that the ACOG statistics are based on a small, perhaps unrepresentative sample of home births and makes no distinctions between those that are planned and those that are not planned out-of-hospital births. An ACOG representative says the college has no plans to release the full report.

Watkin, Brian. "Back to Home Deliveries." *Nursing Mirror* 144 (Feb. 1977):42.

Since the 1950's, health policies in England have aimed for greater percentages of hospital deliveries. Presently, the proportion of hospital deliveries is over 90%. Though stillbirth rates, deaths in the first week of life and maternal mortality rates have gone down, Marjorie Tews, a medical statistician has sought to demonstrate that there is a low correlation between these rates and the number of hospital deliveries. In fact, she has found that the hospital stillbirth rate was 14.8 per 1,000, while at home it was only 4.5 per 1,000. This remains a challenge to the national health policy.

White, Gregory. "A Comparison of Home and Hospital Delivery Based on 25 Years of Experience With Both." *Journal of Reproductive Medicine* 19(Nov. 1977):291.

In his presentation of the medical statistics of 100 women, 86 of whom wished to deliver at home, the author seeks to emphasize the importance of caution and conservatism necessary in home deliveries. Dr. White believes that it is the responsibility of the medical profession to see to it that "home deliveries become more accessible to those that want them."

Work, Bruce. "Home Birth: Technology vs. Togetherness." *Michigan Medicine* 76(Nov. 1977):590.

Dr. Work believes that the interest in home births, specifically the increased acceptance, may be a reflection of both economic and societal factors of "protesting the system." Though this "desire for increased freedom from institutionalized restraints" is understandable, it is also short-sighted because it rejects some of the technological advances available in hospitals. The author suggests that togetherness of the family and modern perinatology need not be mutually exclusive.

healthy event. Ms. Anderson does not completely reject the health care system. She visited a prenatal clinic regularly during her pregnancy and made arrangements for hospital back-up in the event of complications.

Stoltz, Marsha Kuhn. "Home Birth Safety Study Hit as Invalid." *Nursing Care Week* (Jan. 1978):2, 30.

An American College of Obstetricians and Gynecologists news release accuses home birth studies of statistical manipulation, but it agrees with those that report a two to five times greater rate of infant and neonatal mortality for home birth populations. This article presents the positions of physicians who agree with the ACOG report and those who do not. A major criticism of both groups is that the ACOG statistics are based on a small, perhaps unrepresentative sample of home births and makes no distinctions between those that are planned and those that are not planned out-of-hospital births. An ACOG representative says the college has no plans to release the full report.

Watkin, Brian. "Back to Home Deliveries." *Nursing Mirror* 144 (Feb. 1977):42.

Since the 1950's, health policies in England have aimed for greater percentages of hospital deliveries. Presently, the proportion of hospital deliveries is over 90%. Though stillbirth rates, deaths in the first week of life and maternal mortality rates have gone down, Marjorie Tews, a medical statistician has sought to demonstrate that there is a low correlation between these rates and the number of hospital deliveries. In fact, she has found that the hospital stillbirth rate was 14.8 per 1,000, while at home it was only 4.5 per 1,000. This remains a challenge to the national health policy.

White, Gregory. "A Comparison of Home and Hospital Delivery Based on 25 Years of Experience With Both." *Journal of Reproductive Medicine* 19(Nov. 1977):291.

In his presentation of the medical statistics of 100 women, 86 of whom wished to deliver at home, the author seeks to emphasize the importance of caution and conservatism necessary in home deliveries. Dr. White believes that it is the responsibility of the medical profession to see to it that "home deliveries become more accessible to those that want them."

Work, Bruce. "Home Birth: Technology vs. Togetherness." *Michigan Medicine* 76(Nov. 1977):590.

Dr. Work believes that the interest in home births, specifically the increased acceptance, may be a reflection of both economic and societal factors of "protesting the system." Though this "desire for increased freedom from institutionalized restraints" is understandable, it is also short-sighted because it rejects some of the technological advances available in hospitals. The author suggests that togetherness of the family and modern perinatology need not be mutually exclusive.

"The Michigan Department of Public Health will not discriminate against any individual or group on the basis of race, color, religion, national origin or ancestry, age, sex, or marital status or handicap."

S B

754

Alternatives

1. Separate the membership by numbers whereby:
 - A. Commissioner appoints a certain number
 - B. Someone else appoints a certain number (Legislature)

2. Commissioner is final choice:
 - A. With caveat that he/she must review specific recommendations from a group
 - B. With caveat that he/she must select from a list of candidates from a group

3. Mayor offices may have a designated seat

4. Narrow the definition for membership to include membership from specific groups or types of representation:
Example: a consumer is — — — —
or a consumer is not a provider.

I hope this is helpful information for exploring alternatives.
The main decision to be made is WHO WILL MAKE THE FINAL SELECTION
AND WHY.

Karen W. Slack

TABLE 1. ANNUAL COSTS OF A LOWER BUDGET FOR A 4-PERSON FAMILY, 1/ AUTUMN 1976

AREA	TOTAL BUDGET 2/	FAMILY CONSUMPTION						
		TOTAL CONSUMPTION	FOOD			TOTAL 4/	HOUSING 3/ SHELTER 5/ (RENTER)	HOUSE- PURNISHINGS & OPERATIONS
			TOTAL	FOOD AT HOME	FOOD AWAY FROM HOME			
URBAN UNITED STATES-----	10041	8162	3003	2590	414	1964	1467	496
METROPOLITAN AREAS- ^{11/}	10189	8259	3046	2616	430	1995	1507	488
NONMETROPOLITAN AREAS- ^{12/}	9382	7726	2814	2472	342	1825	1289	535
NORTHEAST:								
BOSTON, MASS-----	11104	8800	3182	2766	416	2313	1806	507
BUFFALO, N.Y-----	10198	8225	3019	2590	429	1961	1442	519
HARTFORD, CONN-----	10601	8748	3184	2743	441	2272	1792	480
LANCASTER, PA-----	9799	7877	3053	2648	405	1932	1462	470
NEW YORK-NORTHEASTERN, N.J-----	10835	8645	3346	2869	477	2064	1565	499
PHILADELPHIA, PA-N.J-----	10343	8152	3257	2784	473	1827	1360	467
PITTSBURGH, PA-----	9697	7776	3024	2574	450	1767	1295	472
PORTLAND, MAINE-----	10412	8568	3123	2715	408	2267	1748	519
NONMETROPOLITAN AREAS- ^{12/}	9876	8036	3016	2664	352	1884	1410	474
NORTH CENTRAL:								
CEDAR RAPIDS, IOWA-----	9702	7848	2726	2323	403	2001	1522	479
CHAMPAIGN-URBANA, ILL-----	10564	8551	3023	2652	371	2281	1776	505
CHICAGO, ILL.-NORTHWESTERN IND	10380	8426	3110	2708	402	2040	1569	471
CINCINNATI, OHIO-KY,-IND-----	9448	7724	3066	2682	384	1631	1184	447
CLEVELAND, OHIO-----	10023	8234	3102	2617	485	1847	1369	478
DAYTON, OHIO-----	9466	7789	3011	2621	390	1725	1225	500
DETROIT, MICH-----	9865	7972	2960	2518	442	1738	1305	433
GREEN BAY, WIS-----	9626	7716	2768	2413	355	1971	1433	538
INDIANAPOLIS, IND-----	9876	8069	2981	2590	391	1859	1379	480
KANSAS CITY, MO.-KANS-----	9677	7946	3018	2605	413	1756	1266	490
MILWAUKEE, WIS-----	10306	8159	2889	2496	393	2045	1577	468
MINNEAPOLIS-ST. PAUL, MINN-----	10085	8002	2984	2565	419	1931	1466	465
ST. LOUIS, MO.-ILL-----	9612	7897	3127	2718	409	1732	1257	475
WICHITA, KANS-----	9816	8078	2910	2516	394	2028	1525	503
NONMETROPOLITAN AREAS- ^{12/}	9673	7900	2851	2529	322	1984	1473	511
SOUTH:								
ATLANTA, GA-----	9222	7685	2901	2509	392	1730	1231	499
AUSTIN, TEY-----	8887	7489	2671	2271	400	1691	1180	511
BALTIMORE, MD-----	10280	8115	2811	2387	424	2125	1591	534
BATON ROUGE, LA-----	8914	7510	2930	2574	356	1585	1117	468
DALLAS, TEX-----	9114	7666	2714	2255	459	1714	1239	475
DURHAM, N.C-----	9600	7788	2797	2422	375	1928	1434	494
HOUSTON, TEX-----	9532	7975	2924	2457	467	1821	1310	511
NASHVILLE, TENN-----	9102	7654	2797	2417	380	1784	1266	518
ORLANDO, FLA-----	9271	7770	2696	2297	399	2005	1492	513
WASHINGTON, D.C.-MD.-VA-----	10650	8472	3032	2586	446	2288	1796	492
NONMETROPOLITAN AREAS- ^{12/}	8828	7381	2702	2356	346	1652	1087	565
WEST:								
BAKERSFIELD, CALIF-----	9599	7964	2869	2471	398	1893	1411	482
DENVER, COLO-----	9765	7953	2953	2552	401	1731	1215	516
LOS ANGELES-LONG BEACH, CALIF--	10523	8568	2906	2457	449	2173	1702	471
SAN DIEGO, CALIF-----	10007	8264	2868	2395	473	2027	1582	445
SAN FRANCISCO-OAKLAND, CALIF--	10920	8845	3008	2604	404	2361	1862	499
SEATTLE-EVERETT, WASH-----	10770	8863	3131	2701	430	2319	1786	533
HONOLULU-----	12711	9875	3692	3278	414	2772	2190	574
NONMETROPOLITAN AREAS- ^{12/}	9996	8100	2841	2496	345	2033	1493	540
ANCHORAGE, ALASKA-----	16492	12730	3753	3325	428	4390	3499	891

SEE FOOTNOTES FOLLOWING TABLE 3.

LOWER BUDGET CONTINUED:

AREA	FAMILY CONSUMPTION							OTHER ITEMS ^{10/}	SOCIAL SECURITY & DISABILITY PAYMENTS	PERSONAL INCOME TAXES
	TRANSPORTATION ^{7/}		CLOTHING	PERSONAL CARE	MEDICAL CARE ^{8/}	OTHER FAMILY CONSUMPTION ^{9/}				
	TOTAL	AUTOMOBILE OWNERS								
URBAN UNITED STATES----- ^{11/}	767	1030	799	265	896	468	451	604	825	
METROPOLITAN AREAS----- ^{12/}	729	1066	804	273	925	487	454	615	861	
NONMETROPOLITAN AREAS----- ^{12/}	933	933	780	231	766	379	438	555	663	
NORTHEAST:										
BOSTON, MASS-----	878	1496	804	274	832	517	470	649	1185	
BUFFALO, N.Y-----	790	1097	932	272	763	488	453	612	908	
HARTFORD, CONN-----	776	1082	829	330	830	527	468	620	765	
LANCASTER, PA-----	695	930	796	255	712	434	442	573	907	
NEW YORK-NORTHEASTERN, N.J-----	670	1126	768	280	993	524	465	662	1063	
PHILADELPHIA, PA-N.J-----	678	1137	736	268	910	476	451	613	1127	
PITTSBURGH, PA-----	730	977	741	263	782	469	439	567	915	
PORTLAND, MAINE----- ^{12/}	704	971	894	249	834	497	463	608	773	
NONMETROPOLITAN AREAS----- ^{12/}	996	996	777	214	777	372	447	602	791	
NORTHCENTRAL:										
CEDAR RAPIDS, IOWA-----	655	913	921	281	789	475	441	567	846	
CHAMPAIGN-URBANA, ILL-----	683	952	947	275	877	465	463	620	930	
CHICAGO, ILL.-NORTHWESTERN IND	771	1253	757	279	967	502	459	608	887	
CINCINNATI, OHIO-KY,-IND-----	681	953	829	239	792	486	439	553	733	
CLEVELAND, OHIO-----	747	1041	831	325	882	500	453	585	751	
DAYTON, OHIO-----	695	933	801	255	807	495	440	556	681	
DETROIT, MICH-----	726	986	811	286	964	487	445	579	869	
GREEN BAY, WIS-----	677	944	803	280	738	479	437	562	911	
INDIANAPOLIS, IND-----	760	1023	851	252	873	493	448	579	780	
KANSAS CITY, MO.-KANS-----	745	992	826	299	825	477	444	565	722	
MILWAUKEE, WIS-----	716	961	898	275	857	479	451	603	1093	
MINNEAPOLIS-ST. PAUL, MINN-----	702	971	803	285	811	486	446	591	1046	
ST. LOUIS, MO.-ILL-----	759	1061	755	282	772	470	443	562	710	
WICHITA, KANS----- ^{12/}	708	979	826	279	855	472	448	573	717	
NONMETROPOLITAN AREAS----- ^{12/}	896	896	827	236	720	386	443	566	764	
SOUTH:										
ATLANTA, GA-----	674	929	786	269	839	486	437	538	562	
AUSTIN, TEX-----	699	987	841	269	836	482	431	521	446	
BALTIMORE, MD-----	725	997	781	262	934	477	449	603	1113	
BATON ROUGE, LA-----	686	950	776	280	772	481	431	521	452	
DALLAS, TEX-----	733	1012	723	274	1017	491	436	532	480	
DURHAM, N.C-----	655	920	757	282	886	483	440	562	810	
HOUSTON, TEX-----	720	984	788	276	983	463	445	556	556	
NASHVILLE, TENN-----	716	997	873	249	763	472	436	532	480	
ORLANDO, FLA-----	710	963	738	242	897	482	439	544	518	
WASHINGTON, D.C.-MD.-VA----- ^{12/}	736	1012	726	251	932	507	460	622	1096	
NONMETROPOLITAN AREAS----- ^{12/}	914	914	741	233	762	377	427	520	500	
WEST:										
BAKERSFIELD, CALIF-----	759	1080	725	251	1029	438	445	652	538	
DENVER, COLO-----	723	996	1014	246	827	459	445	573	794	
LOS ANGELES-LONG BEACH, CALIF-----	819	1132	817	260	1130	463	463	704	788	
SAN DIEGO, CALIF-----	772	1068	820	258	1070	449	454	675	614	
SAN FRANCISCO-OAKLAND, CALIF-----	791	1145	880	300	1021	484	471	728	876	
SEA TLE-EVEPETT, WASH-----	740	1049	932	291	966	484	472	632	803	
HONOLULU-----	789	1129	839	310	955	518	502	743	1591	
NONMETROPOLITAN AREAS----- ^{12/}	955	955	841	234	816	380	449	585	862	
ANCHORAGE, ALASKA-----	1298	1298	1036	335	1438	480	588	960	2214	

SEE FOOTNOTES FOLLOWING TABLE 3.

TABLE 4. INDEXES OF COMPARATIVE COSTS BASED ON A LOWER BUDGET FOR A 4-PERSON FAMILY, 1/ AUTUMN 1976
(U.S. URBAN AVERAGE COST=100)

AREA	TOTAL BUDGET	COST OF FAMILY CONSUMPTION											PERSONAL INCOME TAXES
		TOTAL CONSUMPTION	FOOD		HOUSING		TRANSPORTATION		CLOTHING	PERSONAL CARE	MEDICAL CARE	OTHER FAMILY CONSUMPTION	
			TOTAL	FOOD AT HOME	TOTAL	RENTER	TOTAL	AUTOMOBILE OWNERS					
URBAN UNITED STATES-----	100	100	100	100	100	100	100	100	100	100	100	100	100
METROPOLITAN AREAS-----	101	101	101	101	102	103	95	103	101	103	103	104	104
NONMETROPOLITAN AREAS-----	93	95	94	95	93	88	122	91	98	87	85	81	80
NORTHEAST:													
BOSTON, MASS-----	111	108	106	107	118	123	114	145	101	103	93	110	144
BUFFALO, N.Y-----	102	101	101	100	100	98	103	107	117	103	85	104	110
HARTFORD, CONN-----	106	107	106	106	116	122	101	105	104	125	93	113	93
LANCASTER, PA-----	98	97	102	102	98	100	91	90	100	96	79	93	110
NEW YORK-NORTHEASTERN, N.J-----	108	106	111	111	105	107	87	109	96	106	111	112	129
PHILADELPHIA, PA-N.J-----	103	100	108	107	93	93	88	110	92	101	102	102	137
PITTSBURGH, PA-----	97	95	101	99	90	88	95	95	93	99	87	100	111
PORTLAND, MAINE-----	104	105	104	105	115	119	92	94	112	94	93	106	94
NONMETROPOLITAN AREAS-----	98	98	100	103	96	96	130	97	97	81	87	79	96
NORTH CENTRAL:													
CEDAR RAPIDS, IOWA-----	97	96	91	90	102	104	85	89	115	106	88	101	103
CHAMPAIGN-URBANA, ILL-----	105	105	101	102	116	121	89	92	119	104	96	99	113
CHICAGO, ILL.-NORTHWESTERN IND	103	103	104	105	104	107	101	122	95	105	108	107	108
CINCINNATI, OHIO-KY,-IND-----	94	95	102	104	83	81	89	93	104	90	88	104	89
CLEVELAND, OHIO-----	100	101	103	101	94	93	97	101	104	123	98	107	91
DAYTON, OHIO-----	94	95	100	101	88	84	91	91	100	96	90	106	83
DETROIT, MICH-----	98	98	99	97	88	89	95	96	102	108	108	104	105
GREEN BAY, WIS-----	96	95	92	93	100	98	88	92	101	106	82	102	110
INDIANAPOLIS, IND-----	98	99	99	100	95	94	99	99	107	95	97	105	95
KANSAS CITY, MO.-KANS-----	96	97	100	101	89	86	97	96	103	113	92	102	88
MILWAUKEE, WIS-----	103	100	96	96	104	107	93	93	112	104	96	102	132
MINNEAPOLIS-ST. PAUL, MINN-----	100	98	99	99	98	100	92	94	101	108	91	104	127
ST. LOUIS, MO.-ILL-----	96	97	104	105	88	86	99	103	94	106	86	100	86
WICHITA, KANS-----	98	99	97	97	103	104	92	95	103	105	95	101	87
NONMETROPOLITAN AREAS-----	96	97	95	98	101	100	117	87	104	89	80	82	93
SOUTH:													
ATLANTA, GA-----	92	94	97	97	88	84	88	90	98	102	94	104	68
AUSTIN, TEX-----	89	92	89	88	86	80	91	96	105	102	93	103	54
BALTIMORE, MD-----	102	99	94	92	108	108	95	97	98	99	104	102	135
BATON ROUGE, LA-----	89	92	98	99	81	76	89	92	97	106	86	103	55
DALLAS, TEX-----	91	94	90	87	87	84	96	98	90	103	114	105	58
DURHAM, N.C-----	96	95	93	94	98	98	85	89	95	106	99	103	98
HOUSTON, TEX-----	95	98	97	95	93	89	94	96	99	104	110	99	67
NASHVILLE, TENN-----	91	94	93	93	91	86	93	97	109	94	85	101	58
ORLANDO, FLA-----	92	95	90	89	102	102	93	93	92	91	100	103	63
WASHINGTON, D.C.-MD.-VA-----	106	104	101	100	116	122	96	98	91	95	104	108	133
NONMETROPOLITAN AREAS-----	88	90	90	91	84	74	119	89	93	88	85	81	61
WEST:													
BAKERSFIELD, CALIF-----	96	98	96	95	96	96	99	105	91	95	115	94	65
DENVER, COLO-----	97	97	98	99	88	83	94	97	127	93	92	98	96
LOS ANGELES-LONG BEACH, CALIF-----	105	105	97	95	111	116	107	110	102	98	126	99	96
SAN DIEGO, CALIF-----	100	101	96	92	103	108	101	104	103	97	119	96	74
SAN FRANCISCO-OAKLAND, CALIF-----	109	108	100	101	120	127	103	111	110	113	114	103	106
SEATTLE-EVERETT, WASH-----	107	109	104	104	118	122	96	102	117	110	108	103	97
HONOLULU-----	127	121	123	127	141	150	103	110	105	117	107	111	193
NONMETROPOLITAN AREAS-----	100	99	95	96	104	102	125	93	105	88	91	81	104
ANCHORAGE, ALASKA-----	164	156	125	128	224	239	169	126	130	126	160	103	268

SEE FOOTNOTES FOLLOWING TABLE 6.

*Letter about Alaska Wellbeing
Box - 87 60023
Barrow*

January 25, 1982

Senator Charlie Parr, Chairman
Senator HESS Committee
Pouch V (MS3100)
Juneau, Alaska 99811

Senator Parr:

I am very Strongly going for the Proposal for the Northern Alaska Health Resources Association. I'm a Pass Member of the Board for NAHRA, Volunteer Counselor for Family Crisis, I really care for anyone who ask for help from me.

If I have never hear of NAHRA, I wouldn't know who to go to if I have needed help and NAHRA has make me learn more and get for me to go where the helps are needed, expectly when I don't know where to get the answer from. I may not be the only one who would of been lost, but with their information they mail out sure works for my community. That is with me.

The Commuinity Assistance, They have show that each representative care for their community and each past time they have meeting, things changes when they are in their community. To me I think the Commuinity Assistance is very helpful for different kind of information that each region has, They have to share with others, that way they know what to do if it ever come about it again.

The Prevention and Health. I know so many things has been stop, and you could see for yourself it has changes in your community, anything that has to do with health the prevention has work, and its take time for it to stop, It has work in my community, the time is a waste but we have no choice to keep on have it to happen.

Regional Respective, I know it is a long distance to go for a meeting that has to do with health, and with NAHRA each regional that has been working with the committee .t is very important for each region to put in input, for their community. That is just like the Community Assistance but their a different their. The Community Assistance you have to be in the community to work with the people, and Regional Prespective is for the member to come together and put in the input and see what has been going on in their community. If each respective don't share or let someone else hear it, it is not going anywhere, that is when the NAHRA comes in and try to help the different region.

Tele-Confers- I really like the tele-confers that way you get to know what kind of input the others have and hear how many people care in their community. I know how hard it's talk for your community, but if you have listen to the different in each region you have hear it all.

Senator Charlie Parr, Chairman
Senator HESS Committee
Pouch V (MS3100)
Juneau, Alaska 99811

I really *could* put in lots of others things in words, I hope this letter will be helpful for NAHRA, like i say i am very strcngly supporting NAHRA for their proposal. What would we have if NAHRA is not around in Northern Region? To me their would be NOTHING and no one wouldn't know where to get some information if we didn't have what we wanted here in Northern Area.

This letter is not just for Northern Alaska, I would like for any others who need some support in Health area. Because I know when we need some thing in bush area it take time for us to get some answer that has to do with any kind of Health.

Please feel free to call me, if you have any questions, my work phone number is 852-2611 EXT 286, home phone number is 852-8139. Thank you for your time to read this letter, If i didn't care for NAHRA or my community I wouldn't write a letter to you.

I CARE

Loretta Ahyakak Wilhelm
Loretta Ahyakak Wilhelm

cc: Paul Sherry, President NAHRA
All State Representative from Northern Alaska

Aleutian/Pribilof Islands Association, Inc.

1689 C Street
Anchorage, Alaska 99501
Phone (907) 276-2700

January 29, 1982

Senator Charles Parr
Senate HESS Committee
Pouch V (MS 3100)
Juneau, AK 99811

Dear Senator Parr:

I am writing to you regarding the cutbacks facing the Alaska Health Coalition this year. I think it is important for you to know that the Coalition serves a valuable function in the coordination of health services in our area. The health resources they provide prevents duplication of services and wast of valuable dollars in the development of health care to the Native and non-Native providers.

The regional data library which they maintain is an important part of this organization's health planning. It is our desire to let you know we support the Health Coalition position papers sent to you in December 1981.

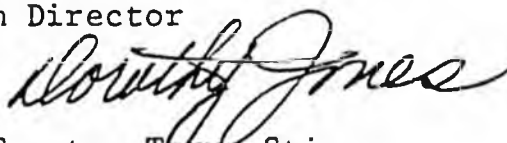
Although all of us must agree that cutbacks are necessary, it seems more reasonable to keep contributing organizations and not fund new ones.

Thank you for the opportunity to share my feelings with regard to the Alaska Health Coalition.

Sincerely,

Dorothy Jones
Health Director

DJ:el


cc: Senator Terry Stimson
Senator Mike Colletta
Senator Vic Fischer
Senator Tim Kelly

St. Paul

St. George

Nelson Lagoon

Sand Point

False Pass

Beikofski

Ring Cove

Akutan

Unalaska

Nikolski

Atka



8923 Tanis Dr
Juneau, AK 99801

January 30, 1982

Senator Charlie Parr
Alaska State Legislature
Pouch J (ms 3100)
Juneau, AK 99811

Dear Senator Parr:

I want to express my appreciation for the attention that you and the Senate HESS Committee have been giving to the future of health planning in our State.

It's been interesting to watch health planning develop in Alaska over the years. It started with nothing, moved to worse than nothing and then fairly gradually changed to a rather mature and effective system.

The Feds, of course, gave it the big boost through funding the Health Systems Agency concept. With that came some bureaucratic hassle that didn't always make sense but in the main things got better. Order began to develop out of chaos, medical services and facilities emerged more logically, the decision makers had something to go on and the guy at the end of the line, the consumer, benefited.

To me it seems like the Feds gave us a medical delivery wagon. Now they're telling us to buy our own gas and oil. Well, I think we should. The wagon's working well and we need it. If we junk it I'll bet we end up kicking ourselves as we look around for the parts to rebuild it.

I've been aware of Chuck Kaltenbach's contact with your office representing the Alaska Health Coalition. Sounds like they're on the right track.

Again, thanks for your concern. It's reassuring to know that the Senate HESS Committee recognizes the problem and is facing it head on.

Sincerely,



William Diebels

January 28, 1982

Senator Charlie Parr
Chairman
Senate HESS Committee
Pouch V (MS 3100)
Juneau, AK 99811

Dear Senator Parr:

This letter represents my support for the development of the Regional Health Resources Organizations. The importance of an organization coordinating efforts regarding health-related issues is particularly essential in Alaska where communities are so widely spread apart. The link in gathering and analyzing data throughout the separate regions in the state can be an asset in identifying community and/or statewide needs.

You have a very important position as chairman of the HESS committee. Health-related issues tend to be of great value to most Fairbanksians and probably Alaska citizens as a whole. I urge you to seriously assess the importance of this organization and the potential deteriorating effects if such an organization would cease to exist.

Your consideration and support is appreciated.

Sincerely,

Cindy K.R. Crook

Cindy K.R. Crook
S.R. Box 40020
Fairbanks, AK 99701

HOLMES JOHNSON CLINIC

Box 1727

Kodiak, Alaska 99615
486-3237

January 29, 1982

Senator Charlie Parr, Chairman
Senate HESS Committee
Pouch V (MS 3100)
Juneau, AK 99811

Dear Senator Parr:

This letter is written in support of the proposal for Regional Health Resources Organizations.


I have more than one reason for supporting this proposal. I had experience as a member of the South Central Health Planning and Development Cooperation for a couple of years, and was impressed with the capability of the Health Planners who were involved in the staff. I felt that the approach, particularly in the area of health promotion, was sound and effective. This is to be retained as one of the three primary functions of the RHRO's.

As Chairman of the Review Board on Alcoholism, I have found the independent analysis of the alcohol programs provided by the HSA Reviews to be of inestimable value. We, as members of the Board, are responsible for grant awards to each of the treatment programs in the state. In making judgements regarding these programs, we rely upon the audits of the State Office of Alcoholism and Drug Abuse and our own knowledge in the matter. In the light of there being so many programs available, we would almost be solely influenced by the SOADA were it not for the fact that we also have verbal analysis of each program presented by the HSA Review people at the time of the grant awards. This gives us a second and unbiased opinion which often coincides with the analysis of the state office but sometimes gives us a different slant. I would miss this service.

In another regard, the HSAs have functioned as a check on the ADHHS. An example of this would be SCHPD's opposition to the states reissuing a CON to Dr. Burn and another example would be their opposition to allowing pioneer homes to install health care beds that do not come under the CON requirements. Whether one agrees or disagrees with these particular stands, I find it extremely useful to have an independent agency acting as a sounding board for the state.

In addition, we need some regional subdivision of the state, for the problems of the northland differ from the problems of southeast and southcentral Alaska. I feel that the subdivision that now exists or something quite close to this is reasonable.

Sincerely


R. Holmes Johnson, M.D.

Senate Hess Committee
cc: Helen D. Beirne
James M. Armbrust
Bob Cole
Charles M. Kaltenbach
Ron Hammett

January 27, 1982

General Delivery
Kotzebue, Alaska 99752

Senator Charlie Parr
Chairman
Senate HESS Committee
Pouch V (MS3100)
Juneau, Alaska 99811

Dear Senator Parr:

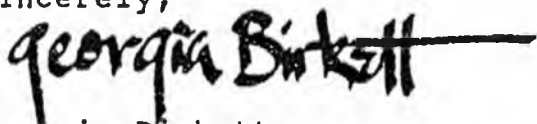
I would like to offer my support of the proposal for Regional Health Resources Organizations as prepared by the Alaska Health Coalition and as reviewed by the Board of Directors of Alaska's Health Systems Agencies.

As an appointed provider member of Northern Alaska Health Resource Association, Inc., the Health Director of Maniilaq Association and a citizen of Alaska living in a remote part of the state, I can attest to the need of a regional center which will provide technical assistance to local areas. Specifically, the activities outlined by the Alaska Health Coalition are germane to the needs of northwest Alaska. Of ultimate importance is the need for local review of projects, for as the funding decreases, the burden is on the leaders of the local areas to creatively address the needs of the locale and the region as well as promote self-care and provide direct services.

Please note that the Alaska Health Coalition has suggested a sunset provision. The original HSA legislation has produced varying results depending on the state in question. Alaska certainly is unique, and where the state stands in the provision of health services is still being decided. Now is the time for the state to act on this health planning issue. During the next few years, therefore, a need exists for a regional entity to assist both the State and federal governments and the local areas to design an appropriate health delivery system. The proposal for Regional Health Resources Organizations as presented by the Coalition is sound and reasonable.

I urge you to support the proposal for Regional Health Resources Organizations. And, I would appreciate knowing your stand on this issue. If you have any questions or want more information from this region, please feel free to contact me.

Sincerely,



Georgia Birkett

cc: Northern Alaska Health Resource Association



UNIVERSITY OF ALASKA, FAIRBANKS
Fairbanks, Alaska 99701

January 27, 1982

Senator Charles Parr
Chairman, Senate HESS Committee
Pouch B (MS3100)
Juneau, AK 99811

Dear Senator Parr:

I would like to inform you and other members of the Senate Health Education and Social Services Committee of my support of the concepts proposed in the discussion paper prepared by the Alaska Health Coalition. The proposals developed and presented in that paper were discussed in some depth by the Northern Alaska Health Resources Association meeting on December 5, 1981, and I participated in that discussion. I believe it is extremely important for us to maintain a regional health perspective for planning purposes and the suggestions contained in that paper give us a vehicle for continuing with the better aspects of the health systems agencies. This may be particularly important in view of the most recent federal policies in which more responsibilities will be handled by the state government agencies. The Northern Alaska Health Resources Association has been through a remarkable period of growth and development and is now at the stage where it can function effectively based on past experiences. I would strongly urge your committee to help develop a proposal to introduce committee sponsored legislation along these lines.

Sincerely yours,

Philip O. Nice, M.D.
Professor of Medical Science

PON/bm

Yukon-Koyukuk Mental Health Program

P.O. Box 17
Galena, Alaska 99741
(907) 656-1617



January 27, 1982

Senator Charlie Parr
Chairman
Senate HESS Committee
Pouch V (MS3100)
Juneau, Alaska 99811

(Serving the Surrounding Villages)
Hughes, Huslia, Kaltag
Koyukuk, Nulato, Ruby

Dear Senator Parr:

I'm writing to urge you to support the proposal for Regional Health Resources Organizations.

I have been employed by the YKMHP for almost two years and have been received technical assistance from the staff at NAHRA in helping us in reviewing our grant application for our mental health program.

By the help that we received from NAHRA, we have been able to continue our professional and paraprofessional services to the City of Galena and six surrounding villages: Hughes, Huslia, Nulato, Koyukuk, Kaltag, and Ruby.

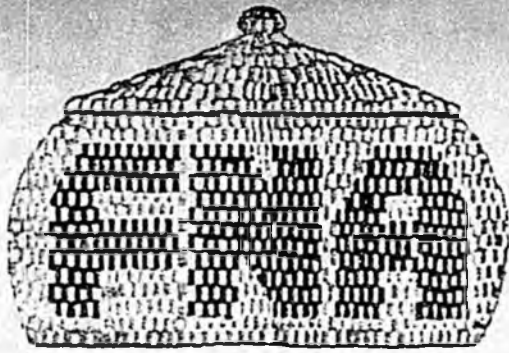
I again urge you to support the proposal for Regional Health Resources Organizations. I will wait patiently for a response from you on this important matter.

Sincerely,

Mary Jane Derendoff

Mary Jane Derendoff,
Counselor Trainee

cc: Paul Sherry, NAHRA president



FAIRBANKS NATIVE ASSOCIATION, INC.

310½ First Avenue
Fairbanks, Alaska 99701

Phone: (907) 452-1648 / 456-5151

January 21, 1982

Senator Charlie Parr, Chairman
Senate HESS Committee
Pouch V (MS 3100)
Juneau, Alaska 99811

RE: Proposal for Regional Health Resources Organizations

Dear Senator Parr,

As the Fairbanks community Native organization and as an agency concerned with the well-being of all people, Fairbanks Native Association offers this letter of support for the concept of regional health resources organizations.

In the past, NAHRA has provided valuable services in the coordination of health programs development and as a link to the state concerning northern health needs. As individual citizens and as an organization we have benefitted from their expertise. This is especially true for the FNA alcoholism program which has worked closely with NAHRA on such projects as the Alcoholism Awareness Campaign, the Chronic Inebriate Program and the development of the Substance Abuse Plan for Northern Alaska.

FNA has reviewed the Discussion Paper prepared by the Alaska Health Coalition and supports the plan for provision of community assistance, health promotion and a regional perspective as outlined. Coordination and prioritization of the health needs of our community by a knowledgeable and unbiased agency is an especially imperative function given the current economic trends and diminishing federal dollars.

FNA appreciates your concern for the health of Alaska citizens as evidenced by your position on the HESS Committee and urges your support of the concept of regional health resources organizations to further that end.

Sincerely,

Sidney Stephens,
Proposal Coordinator

ADMINISTRATION
452-1648 or 456-5151

ACCOUNTING
452-1648

**JOHNSON O'MALLEY
EDUCATIONAL PROGRAM**
452-1648

SOCIAL SERVICES
452-1648

Counseling Services
452-1648

Child Welfare
452-1648

Work Experience Counselor
452-1648

Family Focus
452-1648

ALCOHOL AND DRUG ABUSE SERVICES

Director
452-1648

CAP Detox Center
456-1053

CAP Treatment Center
456-1045

CAP Halfway House
452-8761

Drop-In Center
456-7948

Out-Patient Services
456-1041

Court Counter-Measures Program
456-1101

Youth Drug Abuse Program
452-5085

UNIVERSITY OF ALASKA

516 Ambler Lane
112 Chapman Bldg.
Fairbanks, AK 99701

Senator Charlie Parr, Chair
Senate HESS Committee
Pouch V (MS 3100)
Juneau, AK 99811

Dear Senator Parr,

I am writing in support of the proposal for Regional Health Resources Organizations.

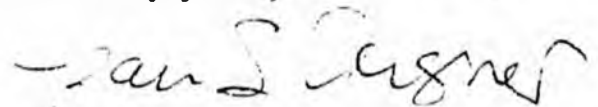
As a resident of northern Alaska I have been most impressed by the activities of NAHRA over the years in the areas of providing a community based mechanism for health planning, data upon which consumers may form valid opinions concerning various areas of health and health promotion, and information on health care costs, duplication of services, and upgrading of existing services.

Because it is imperative that regional community input is strongly voiced to the state, I support the establishment of Regional Health Resource Organizations to supersede the Health Systems Agencies. Only through regionally based organizations can the needs of rural and small urban sectors be adequately voiced. The needs of northern Alaska, for example, differ significantly from those of southcentral Alaska and southeastern. On a regional basis, as well, health promotion and prevention programs can be suited to the local needs--a regional health organization will insure that the special needs of northern Alaska are considered adequately.

In order to plan for the future needs of northern Alaskans, such a regional organization would insure that current information on our population, economy, health status and existing services and facilities is readily available. Within this same regional perspective accurate opinion and information could be conveyed to the Legislative and Executive branches of government. The regional organization would serve the key function of "watch-dog" over proposals for new institutions or health services which would be inappropriate or costly to consumers; at the same time, they could have data to verify which proposed services are indeed needed by the region.

I have been impressed by our local NAHRA organization in "taking on" local service providers whose past records demonstrate less than adequate results for the public monies provided. I have been impressed by their focus upon the cost-effectiveness of proposed new services. I am fully aware that I am paying for these services, indirectly, through increased insurance costs; I want to know that services will not be proliferated unnecessarily. I believe that local/regional organizations such as those proposed insure local and community input and review and offer protection to us all.

Sincerely yours,



Handwritten signature of Jean S. Aigner in cursive script.

Jean S. Aigner

HSA

January 25, 1982

Representative Charles Parr
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Parr,

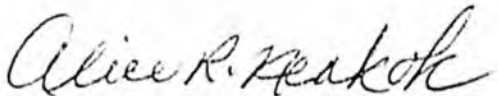
I am writing to you for your support for the Regional Health Organization developed by the Alaska Health Coalition.

I am a member of the Board of Directors of Northern Alaska Health Resources Association Inc. A member of the Barrow Health Board, a member of National Congress of American Indians. I am also a past member of the State Health Coordination Council. A past alternate member of the North Slope Borough Planning and Zoning Commission, and also a past alternate member of the North Slope Borough Overall Economic Development Committee.

I have been a resident in Alaska for 16 years. I feel very strongly that in order to have a better Health Care for all Alaskan now and in the future that we need every ounce of your support for Regional Health Resources Organization.

Thank you kindly for your assistance.

Sincerely yours,



Alice R. Neakok
Box 27
Barrow, Alaska 99723

cc: Northern Alaska Health
Resources Association Inc.
529 5th Ave. Suite 8
Fairbanks, Alaska 99701

128

MSG 82-00005167 PRTY 1 02/01/82 17:09:57 ORIG: LB00 IN= 0012 OUT= 0119
FROM: WALLY IN BETHEL TO: JUKEAU INFORMATION PAGE 0001
TARGET: LHM2 SUBJ: P O M

TO: SENATOR CHARLIE PARR
CHAIRMAN, SENATE HESS COMMITTEE

FR: MARY PAVIL
EXECUTIVE DIRECTOR, YUKON/KUSKOKWIM HEALTH CORP.
BETHEL, ALASKA 543-3321

THE YKHC WOULD LIKE TO FULLY SUPPORT THE DEVELOPMENT OF REGIONAL HEALTH
RESOURCES ORGANIZATION THROUGHOUT THE STATE OF ALASKA. FEDERAL BUDGET CUTBACKS
WILL DEFINATELY EFFECT REGIONAL HEALTH PLANNING DURING FY '83. BECAUSE OF THIS
THE STATE OF ALASKA SHOULD REASSESS THE RELATIONSHIP OF THE DEPT. OF HEALTH AND
SOCIAL SERVICES AND ITS CONSTITUENTS. WE ARE ESPECIALLY INTERESTED IN THIS
ORGANIZATION'S ESTABLISHMENT TO CONTINUE TO PROVIDE INPUT AND REPRESENTATION FOR
THE RURAL ALASKANS. WE UNDERSTAND THE CORE FUNCTIONS OF THE REGIONAL HEALTH
RESOURCES ORGANIZATION WOULD BE, 1) PROVIDE COMMUNITY ASSISTANCE, 2) PROMOTE
PREVENTION AND HEALTH PROMOTION ACTIVITIES AND, 3) PROVIDE A REGIONAL PERSPECTIVE
TO YOU TO SUPPORT ADOPTION OF SUCH AN ORGANIZATION. /S/ M. PAVIL



TANANA VALLEY MEDICAL-SURGICAL GROUP, INC.

(A PROFESSIONAL CORPORATION)

1001 NOBLE STREET • FAIRBANKS, ALASKA 99701 • PHONE 452-1611

STAFF MEMBERS

January 28, 1982

OBSTETRICS & GYNECOLOGY
LAWRENCE I. DUNLAP, M.D.
RICHARD C. HESS, M.D.
RALPH A. WELLS, M.D.
CLARICE DUKEMINIER, M.D.
BARBARA L. CLUTTER, M.D.
JAN SWANSON, RNP

Senator Charlie Parr
Chairman
Senate HESS Committee
Pouch V (MS 3100)
Juneau, AK 99811

SURGERY
ANCEL EARP, M.D.

ORTHOPEDIC SURGERY
JOHN W. JOOSSE, M.D.
GEORGE R. VRABLIK, M.D.

Dear Senator Parr:

INTERNAL MEDICINE
DANIEL C. DAVIS, M.D.
RICHARD J. BURGER, M.D.

I am writing to ask your support of the proposal for development of Regional Health Resources Organizations prepared by the Alaska Health Coalition (November 6, 1981).

PEDIATRICS
RICHARD C. REEM, M.D.
J. ALAN MAC FARLANE, M.D.
MARY C. MAC FARLANE, M.D.
NANCY J. SCHULTZ, M.D.
GAIL KELLEY, CPNP

I feel it is vital that there be some agency involved in health planning, as well as implementing the various plans which have been generated in the past. I feel that the Northern Alaska Health Resources Association, Inc. (northern Alaska's health planning agency) has made a valuable contribution to improved health in the northern part of the state. I have been very pleased with all of their contributions and input towards the development of the school health education curricula here in Fairbanks, and their successful efforts towards the development of an alternative birthing room at the hospital. I have been impressed that they not only help the community figure out what it needs, but also work hard to involve the community in implementing these programs.

GENERAL PRACTICE
& FAMILY MEDICINE
JAMES A. LUNDQUIST, M.D.
MARTHA G. KOWALSKI, M.D.
DONALDE THIEMAN, M.D.
JEFFREYS TRILLING, M.D.
JEAN M. WILBUR, M.D.

Because federal budget cutbacks will result in a significant decrease in federal funding to the three health system agencies in Alaska in the next year, and because all federal funds for regional health planning will be discontinued the following year, I think it is very important that the State of Alaska take over the funding.

PHYSICIANS ASSISTANTS
DAVID L. LEWIS, P.A.-C
ROYE HOWARD, P.A.-C
THOMAS H. WILSON, P.A.-C

I hope you will give serious consideration to proposing a Senate Bill for the development of Regional Health Resource Organizations as proposed by the Alaska Health Coalition.

URDLOGY
ROBERT W. TAYLOR, M.D.

Sincerely,

Barbara L. Clutter, M.D.

Barbara L. Clutter, M.D.
Obstetrics & Gynecology

ADMINISTRATION
G. A. SEELIGER, MGR
JAN WIESE, ASST. MGR
SANDRA J. FARMER,
COMPTROLLER

BLC/lm
cc: Paul Sherry, President
NAHRA

address
S.E. AK Health
Systems Agency
P.O. Box 7015
Ketchikan AK
99901

February 1, 1982

Senator Charlie Parr
Chairman Senate HESS Committee
Pouch V
Juneau, AK 99811

Re: "Regional Health Resources Organizations"

Dear Senator Parr:

The purpose of this letter is to urge you and the members of the HESS committee to introduce legislation that would give reality to the subject creative concept.

I served as a board member of the Southeast Alaska Health Systems Agency for nearly three years, and am presently a member of the Statewide Health Coordinating Council. I would call your attention to Exhibit I (Progress On Plan Objectives) in the enclosed "Southeast Alaska Health System Agency Highlights (1976-1981)" as exemplification of the effective efforts of that agency.

I believe that Alaska residents would directly benefit by the health promotion activities of regional health organizations. These regional organizations would amortize the state/federal financial investment, and more importantly, the time and talent investment of many volunteers across the state.

I urge you to introduce and support regional health resources organizations to supplant the health systems agencies.

Sincerely



Joe Cladouhos, Member
Statewide Health Coordinating Council

ALASKA LUNG ASSOCIATION, Inc.

February 1, 1982

Leo C. Kaye, *Executive Director*

The Honorable Charles Parr
Chairman, HESS Committee
Alaska State Senate
Pouch V (MS 3100)
Juneau, Alaska 99811

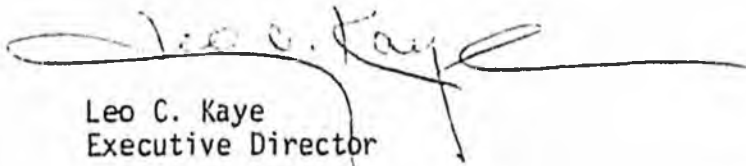
Dear Senator Parr:

The Alaska Lung Association has examined the "Discussion Paper" developed by the Alaska Health Coalition and wishes to express full support of the concept of Regional Health Resources Organizations.

Without doubt, Alaska needs central planning organizations to provide technical assistance in identifying health problems and assisting in the development of programs to solve these problems. Federal cutbacks will jeopardize and eventually destroy our present planning mechanism, the three HSA's.

I have been asked by my board to urge you to introduce appropriate legislation to foster and support the development of Regional Health Resources Organizations.

Respectfully,



Leo C. Kaye
Executive Director

/f

cc: Board of Directors
Senate Committee



Fairbanks Counseling and Adoption

1019 College Road
P.O. Box 1544
Fairbanks, Alaska 99707

February 2, 1982

The Honorable Charles Parr, Senator
Chairman, Senate HESS Committee
Pouch V (MS 3100)
Juneau, AK 99811

RE: Proposal for Regional Health
Resources Organizations

Dear Senator Parr:

As a not-for-profit private Family Counseling agency serving the Greater Fairbanks area, I encourage you to support the above proposal. To date I have found the Northern Alaska Health Resources Association, Inc. of extreme value to the interior and this local community. Their past efforts and current goals of 1) community assistance, 2) health promotion, and 3) regional perspective, greatly assist regions and local communities assess needs, develop quality program planning (which is cost-efficient), and provides direction in implementation of program plans. The technical assistance alone will assist State and local governments in gathering the necessary data for decision making with regard to appropriate allocations of funds. This is critical in light of the Federal cutbacks, "State Block Granting System", i.e. SB 168), Department of Health and Social Services adjustments, cuts, and new programming.

The HSA system itself, as it stands, is currently ready and operating. It appears to me that utilizing the current system with minor adaptations for State purposes is most cost-efficient and effective. The use of the



A United Way Member Agency

The Honorable Charles Parr, Senator
February 2, 1982

Page Two

current system will bring communities in this State
one step further in using available dollars wisely.

I would also hope that the definition of Health include
Human Service providers as well as the Mental Health
Center providers.

I urge you to support this proposal and request
notification of your stance.

Sincerely,

Sister Kathy McGinty, ACSW

Sister Kathy McGinty, A.C.S.W.
Director
Fairbanks Counseling and Adoption

SKM:mac

cc: HESS Committee:

Senator Terry Stimson, Vice-Chairman
Senator Mike Colletta
Senator Vic Fischer
Senator Tim Kelly

Northern Alaska Representatives:

Rep. Albert P. Adams
Rep. Robert H. Bettisworth
Rep. Fred E. Brown
Rep. Kenneth J. Fanning
Rep. H. Pappy Moss
Rep. Richard L. Randolph
Rep. Brian Rogers
Rep. Sarah J. Smith

Northern Alaska Senators:

Sen. Don Bennett
Sen. Bettye Fahrenkamp
Sen. Frank Ferguson
Sen. John Sackett

Northern Alaska Health Resources Assoc., Inc.

WIC-CA CENTER

302 Charles Street
Fairbanks, Alaska 99701
452-2293

February 5, 1982

Senator Charlie Parr, Chairman
Senate Hess Committee
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Senator Parr:

I received from NAHRA a copy of their discussion paper on Regional Health Resources Organizations. I am very supportive of this proposal. NAHRA's role has been effective and positive in the past. To discontinue the services of an agency which has provided such excellent co-ordinating and planning would result in poorer services and probably higher costs. I urge you to create the legislation necessary for funding to be available from the State.

Sincerely,


RUTH WILSTER
Director

RL/mw



women in crisis - counseling & assistance