

Reducing Infant Mortality

and

Providing Better Birth Experiences for Every Baby

Infant Mortality in the United States

According to the CIA World Factbook, 25-30,000 babies born in the United States in 2009 will not live to see their first birthday.

The United States ranks first in:

- military technology and exports,
- Gross Domestic Product (GNP),
- defense expenditures,
- the number of millionaires and billionaires, and
- per capita spending on health care.

When it comes to infant mortality, the United States ranks 45th.

In other words, forty-four other countries have lower infant mortality rates (less deaths per every 1000 born) than the United States. By way of comparison, and to illustrate what is already being achieved, the five countries listed with the fewest annual infant deaths each has less than half the amount of the US. Our current health care system is failing babies and families before, during and after birth.

Not only are babies dying needlessly, but many of those who survive this failing system are also adversely affected by unnecessary procedures and separation from mother and family. In the following information you will see that the solutions most likely to reduce infant mortality and improve health care include more accessible and comprehensive prenatal care, more comprehensive breastfeeding during the first year of life, and more attention to keeping the mother and baby together during the first hours and days after birth. Research has been done which shows how introducing more midwives into the health care system addresses many of these issues simultaneously.

While we recognize and appreciate the critically important role played by modern medicine and physicians, many maternity practices that were originally used to address specific problems, have come to be used routinely in healthy women who are not in need of such interventions. Unnecessary procedures are costly financially, and compromise the quality of the

birthing experience for both mother and baby, opening the possibility of further complications and potential dangers.

The film, *Reducing Infant Mortality*, advocates for a health care system in which it will be standard procedure for mothers and babies to thrive, and not merely survive, through birth and early life. Introducing more midwives into the health care system would save our country many millions of dollars each year as well as providing better options for all expectant mothers.

While the following is not intended to cover the subject matter exhaustively, it is meant to give the reader a good overall introduction to some of the relevant information. A link is provided for each of the documents we used extensively so that you may gather more information from those sources as well as finding more information regarding the sources to which they refer.

**The following is taken from *March of Dimes Data Book for Policy Makers*.
<http://www.marchofdimes.com/files/MOD-STATBOOK-2007-final.pdf>**

Page numbers follow each excerpt.

African-American infants are more than twice as likely as non-Hispanic white infants to die in the first year of life. [page 8]

The 2004 infant mortality rate for African-American babies was 13.6 per 1,000 live births, compared with 5.7 for whites, 8.6 for Native Americans, and 4.6 for Asian/Pacific Islanders. [page 8]

For Hispanics, the 2004 infant mortality rate was 5.5 per 1,000 live births. Within this group, Puerto Rican mothers had the highest rate of 7.8. [page 8]

The Causes

One in five infant deaths is due to birth defects, making this the leading cause of infant mortality. [page 16]

The second most common cause of infant mortality in our country is prematurity/low birthweight. [page 10]

The two leading causes of infant deaths are responsible for 37 percent of all infant mortality. Other causes include sudden infant death syndrome (8.1%), maternal complications (6.1%), placenta/cord complications (3.7%), and respiratory distress syndrome (3.2%). [page 11]

About one in eight infants is born preterm (before 37 weeks gestation). [page 26]

Premature infants are 15 times more likely to die in the first year of life than those not born preterm. [page 26]

Prematurity/low birthweight is the leading cause of death for African American infants. [page 32]

Nearly 82,000 babies were born very preterm (before 32 completed weeks gestation) in 2004. These babies are 75 times as likely to die in the first year of life as those not born preterm. [page 26]

Premature babies who survive may suffer lifelong consequences, such as mental retardation, blindness, chronic lung disease, and cerebral palsy. [page26]

Risk Factors for Preterm Birth and Birth Defects

One of the factors associated with preterm birth is maternal age. In 2004, more than 16 percent of births to teenage mothers under 18, and nearly 17 percent of births to women 40 and older were preterm. [page 30]

About every minute, a baby is born in the United States to a teen mother. [page 3]

Multiple births are another factor associated with premature birth. In 2004, nearly 60 percent of twins and about 93 percent of triplets and higher-order births were preterm. [page 30]

Other possible risk factors include certain infections, smoking, illicit drug use, extremes of maternal weight, and stress. [page 30]

Women who receive early and continuous prenatal care are more likely to have access to screening and diagnostic tests that can help to identify problems early. Therefore they are more likely to have access to services to manage developing and existing problems by means such as education, counseling, and referral to reduce risky behaviors like substance abuse and poor nutrition. Such care can improve the health of both mother and child. ([age 39]

Possible barriers to prenatal care include:

- Lack of insurance
- Problems with transportation, child care, and the hours of health care providers
- Maternal age, income, education, and cultural and personal factors. [page 39]

Native American, African-American, and Hispanic women are most likely to receive inadequate care. [page 42]

Folic Acid and Neural Tube Defects

Insufficient folic acid in women's diets before and during pregnancy can lead to birth defects of the brain and spinal cord, known as neural tube defects. These are among the most serious birth defects in the United States. [page 44]

Each year, about 3,000 pregnancies are affected with neural tube defects. Studies have shown that up to 70 percent of these could be prevented if women consumed sufficient folic acid before pregnancy and during early pregnancy. [page 44]

A systematic review summarized results of studies that evaluated whether prenatal folic acid-fortified multivitamins were protective against congenital anomalies. Use of multivitamin supplements was consistently protective against neural tube defects, cardiovascular defects, and limb defects (Goh et al. 2006). [page 52]

Only 18 percent of women of childbearing age know that folic acid prevents birth defects, and only 12 percent know it should be taken before pregnancy. [page 44]

Of the women who are aware of folic acid, 54 percent learned about it from the media, but only 33 percent from their physician or other health care provider. [page 44]

Smoking

Women who smoke during pregnancy are more likely than nonsmokers to have a low birthweight or preterm baby. On average their babies weigh 200 grams less than nonsmokers' babies. [page 46]

Studies show that women who stop smoking before becoming pregnant, or early in pregnancy, decrease their risk of having a low birthweight baby to nearly that of women who have never smoked. [page 46]

Studies suggest that every \$1 spent on smoking cessation programs for pregnant women could save about \$3 in reduced neonatal intensive care costs. [page 46]

While pregnant women on Medicaid are statistically more likely than other pregnant women to smoke, Medicaid in 22 states does not cover tobacco cessation counseling, the treatment of choice for all pregnant smokers. [page 46]

Alcohol and Substance Abuse

Heavy alcohol consumption during pregnancy can lead to a combination of physical and mental birth defects called fetal alcohol syndrome (FAS), which affects roughly one in 1,000 newborns annually. Alcohol abuse is the leading known preventable cause of mental retardation. [page48]

Four percent of pregnant woman reported using illicit drugs in the past month during 2005-2006. [page 48]

In 1992, about one-third of women who reported using at least one illicit drug during pregnancy also smoked cigarettes and drank alcohol. [page 48]

Obesity

Obesity can cause serious pregnancy-related medical complications such as hypertension and diabetes that contribute to prematurity and cesarean section. [page 50]

Babies born to mothers who are obese are more likely to have health problems including increased risk of neural tube defects, higher rates of birth injuries, low APGAR scores, more admissions to neonatal intensive care units, and higher rates of prenatal death. [page 50]

The proportion of women ages 18 to 44 who were obese increased from 12.6 percent in 1995 to 21.7 percent in 2005. [page 50, see graph]

Interventions from the individual, provider, health system, and community levels are being developed to address this problem. These efforts may help to inform state maternal and child health programs to assist women in achieving and maintaining recommended weight and body mass index before, during and after pregnancy. [page 50]

The following information is taken from *Evidence-Based Maternity Care: What It Is and What It Can Achieve*. This report was written by Carol Sakala and Maureen Cory of Childbirth Connection and co-published by Reforming States Group and the Milbank Memorial Fund, copyright: 2008 Milbank Memorial Fund. The entire document can be found through the following links:

<http://www.childbirthconnection.org/pdf.asp?PDFDownload=evidence-based-maternity-care> and

<http://www.milbank.org/reports/0809MaternityCare/0809MaternityCare.html>

Page numbers follow each excerpt.

Overused Medical Interventions

Although most childbearing women and newborns in the United States are healthy and at low risk for complications, national surveys reveal that essentially all women who give birth in U.S. hospitals experience high rates of interventions with risks of adverse effects. [page 4]

Many maternity practices that were originally developed to address specific problems have come to be used liberally and even routinely in healthy women. Examples include labor induction, epidural analgesia, and cesarean section. These interventions are experienced by a large and

growing proportion of childbearing women; are often used without consideration of alternatives; involve numerous co-interventions to monitor, prevent, or treat side effects; are associated with risk of maternal and newborn harm; and greatly increase costs. [page 4]

Available systematic reviews do not support the routine use of other common maternity practices including numerous prenatal tests and treatments, continuous electronic fetal monitoring, rupturing membranes during labor, and episiotomy. [page 4]

Cesarean Section and Induced Labor

When first measured nationally in 1965, the U.S. cesarean rate was 4.5 percent (Taffel, Placek, and Liss 1987). Since 1996, it has risen steadily from 20.7 percent to the provisional 2006 rate of 31.1 percent, a fifty percent increase (Hamilton, Martin, and Ventura 2007). A new record level has been reached every year in the present century, and the trend is for continued increase. [page 41]

Recent analyses substantiate the World Health Organization's recommendation that optimal national cesarean rates are in the range of 5 percent to 10 percent of all births and that rates above 15 percent are likely to do more harm than good (Althabe and Belizan 2006). [page 42]

Participants in two large prospective studies of American women experienced cesarean rates that were compatible with this recommendation: both low-risk populations experienced cesarean rates of 4 percent and no observed increase in harms (Johnson and Daviss 2005; Rooks et al. 1989). [page 42]

From 1990 to 2005, the proportion of medically induced labors rose by 135 percent, to 22.3 percent (Hamilton, Martin, and Ventura 2007; Martin et al. 2007) Moreover, validation studies suggest that these official rates—derived from aggregate birth certificates—identify just 45 percent of actual instances of induced labor (Lydon-Rochelle et al. 2005; Parrish et al. 1993; Piper et al. 1993; Yasmeeen et al. 2006). [page 36]

Meanwhile, in the quarter-century from 1981 to 2006, the national rate of preterm birth increased by 36 percent, and the proportion of low birthweight babies increased by 22 percent. [page 14]

As methods of estimating fetal gestational age are imprecise (Engle 2006), planned cesareans may inadvertently lead to medically caused prematurity. In Florida, between 1995 and 2003, 50 percent of the increase in the preterm birth rate among single births was associated with increasing numbers of cesarean births (Goodman, Sappenfield, and Thompson 2007). [page 43]

In comparison with vaginal or intended vaginal birth, delivery by elective cesarean is consistently associated with increased risk of respiratory morbidity in pre-term newborns and full-term newborns (Hansen et al. 2007). [page 43]

An analysis of nearly one-quarter million births in 124 facilities in 2004 found variation of 200 to 300 percent in primary cesarean rates within regions and concluded that “a pattern of almost random decision making” exists for use of this invasive procedure (Clark et al. 2007). [page 45]

The Listening to Mothers II survey, a project of Childbirth Connection, was conducted by Harris Interactive in January-February 2006 among 1,573 women across the United States aged eighteen through forty-five who gave birth to single babies in U.S. hospitals in 2005. [page 26]

Fully 41 percent of *Listening to Mothers II* participants reported that a health professional tried to induce labor, with 84 percent of those—34 percent of all women—reporting that the attempt did in fact start labor. [page 36]

Induction appears to increase the likelihood of cesarean in first-time mothers, when the cervix is not ready for labor and at earlier gestational ages (Kaufman, Bailit and Grobman 2002). [page 38]

Prenatal methods for estimating gestational age are imprecise and have a margin of error of up to two weeks (Engle 2006), so elective labor induction will in many cases lead to delivery at an earlier gestational age than intended. [page 37]

In just over ten years, from 1990 to 2002, with an increasing proportion of induced labors and planned cesarean sections, the most common gestational age among singleton births in the United States fell from forty to thirty-nine weeks (Davidoff et al. 2006). [page 16]

This shift in the duration of gestation appears to be continuing despite evidence for progressive fetal development of vital organs such as the brain and lungs after thirty-seven completed weeks of gestation (Kinney 2006; Morrison, Rennie, and Milton 1995; Stutchfield, Whitaker, and Russell 2005; Zanardo et al. 2004) the current definition of full term. [page 36]

Evolving understanding of normal fetal brain development has identified major changes continuing through forty-one weeks of gestation; for example, over one-third of brain volume increase takes place in the final six to eight weeks, and a five-fold increase in white matter volume occurs from thirty-five to forty-one weeks gestation. There is uncertainty about how extrauterine brain development compares to intrauterine development during similar time periods from conception (Kinney 2006). [pages 37–38]

In the national *Listening to Mothers II* survey, childbearing women in the United States expressed a strong desire to know about all or most potential complications of labor induction before deciding to have one, yet their demonstrated knowledge of labor induction complications was quite poor, whether they had one or not (Declercq et al. 2006). This identifies the need for improved education and informed consent processes. [page 38]

Other Overused Medical Interventions and Practices

An evidence-based framework questions the wisdom of using interventions with a marginal expected benefit that is overshadowed by greater risk of established harm. Examples of such a situation include inducing labor by various means or hastening it with synthetic oxytocin for convenience and in the absence of a clear medical rationale (Grobman 2007; Simpson and Thorman 2005). [page 21]

Labor epidurals alter the physiology of labor and increase risk for numerous adverse effects. [page 39]

A number of co-interventions, which may further alter the course of labor and have their own side effects are used to monitor, prevent, and treat unintended consequences of the epidural. Continuous electronic fetal monitoring, intravenous infusions, and frequent blood pressure monitoring are standard precautions with epidural analgesia that would otherwise be unnecessary in healthy women. [page 39]

Most women who give birth in the United States lie on their backs while pushing their babies out (Declercq et al. 2006). However, in studies of women without epidurals, upright and side-lying positions are associated with less severe pain for mothers, less use of episiotomy, less use of vacuum extraction or forceps, fewer heartbeat abnormalities in babies, and a shorter pushing phase of labor (Gupta, Hofmeyr, and Smyth 2004). [page 55]

Larger studies are needed to clarify the value of upright positions in women with epidurals. [page 55]

Thirty-nine percent of Listening to Mothers II survey participants reported that their baby was primarily with staff for routine care during the first hour after birth (Declercq et al. 2006). Skin-to-skin contact between mothers and babies right after birth and during the first twenty-four hours postpartum, in comparison with usual care, was associated with improved performance on measures of breastfeeding status and duration, improved newborn temperature regulation, reduced newborn crying, and more affectionate maternal behaviors, with some evidence of long-term effects, and no evidence of harm (Moore, Anderson, and Bergman 2007; see also Winberg 2005). [page 55]

Adults who met diagnostic criteria for drug addiction were about five times as likely as sibling controls to have received three or more doses of opioid and barbiturate drugs within ten hours before birth (Nyberg, Buka, and Lipsitt 2000). [pages 32-33]

After adjusting for numerous potential cofounders, researchers found that men who committed suicide by violent means were about five times as likely as sibling controls to have experienced multiple trauma at birth (identified as events likely to cause pain to the baby). (Jacobson and Bygdeman 1998). [page 33]

The Need for Informed Consent

Studies of decision making in maternity settings consistently raise concerns about the adequacy of informed consent processes (e.g., Akkas et al. 2004; Dixon-Woods et al. 2006; O’Cathain et al. 2002; Turnbull et al. 1999). Among women who experienced episiotomy in U.S. hospitals in 2005, just 18 percent reported having had a say about the procedure (Declercq et al. 2006). In recent national surveys, virtually all women expressed the wish to know about the complications of labor induction, epidural, and cesarean before deciding to undergo these respective procedures, but mothers had poor knowledge of their actual side effects, whether they had experienced the specific intervention or not (Declercq et al. 2002; Declercq et al 2006). [page 66]

Industry Pressure and the Liability System

Industry pressure compromises maternity care. Drugs, devices, and other products with commercial value are more likely to be evaluated, adopted into practice, and promoted than simpler measures with little or no commercial value. [page 66]

The liability system continues to uphold current standards of care and use of professional experts without regard to lessons from the best scientific research (Massie 2004; Peters 2000). [page 61]

Financial Costs

With over 4.3 million births every year, childbirth is the leading reason for hospitalization in the United States, exceeding such prevalent conditions as pneumonia, cancer, heart failure, bone fracture, and stroke (Kozak, DeFrances, and Hall 2006). Maternity care is also a leading reason for out-patient medical visits. [page 10]

Cesarean section is the most common operating room procedure in the country. [page 2]

Hospitalization is by far the largest component of health care costs, and hospital charges for the current style of childbirth are considerable. Combined hospital charges for birthing women (about \$44 billion) and newborns (about \$35 billion) totaled \$79,277,33,843 and far exceeded charges for any other condition in 2005 (Agency for Healthcare Research and Quality 2008). [pages 10-11]

In 2005, private insurers paid for 51 percent of hospital stays for childbirth in the United States, and Medicaid paid for 42 percent of these stays, with variation in these proportions across states. These payers were responsible for markedly greater proportions of childbirth payments than for all other conditions combined. (Agency for Healthcare Research and Quality 2008). [page 11]

Although most pregnant women in the United States are healthy and at low risk for complications, pathology- and surgery-oriented obstetric specialists are the lead caregivers for about 79 percent of women during both pregnancy and labor (Declercq et al. 2006). [page 62]

Among developed nations, only the United States and Canada rely to this degree on specialists rather than midwives to provide care to healthy birthing women. (Wagner 1998). [page 62]

In the United States, midwives are the lead caregivers for just 8 to 9 percent of mothers during pregnancy and childbirth (Declercq et al. 2006). [page 63]

Family physicians are the lead pregnancy caregivers for just about 8 percent of women and the birth attendant about 7 percent of the time in the United States (Declercq et al. 2006). [page 63]

Overall, the practice style of family physicians falls between those of obstetricians and midwives (Reime et al 2004). The most recent review comparing the process and outcomes of maternity care provided by family physicians and by obstetricians found that differences favor family physicians (Klein 1993). [page 63]

Charges for childbirth vary considerably depending on the type and place of birth. [page 2]

In one analysis, epidural was associated with as much as a 32 percent increase in the cost of care among low-risk first-time mothers and a 36 percent increase in cost among low-risk experienced mothers (Tracy and Tracy 2003). [page 40]

In 2005, the national average hospital charge for childbirth ranged from about \$7,000 to nearly \$16,000, depending on whether the birth was vaginal or cesarean and, further, was coded as uncomplicated or complicated. [page 12]

By contrast, childbirth charges in a national survey of out-of-hospital birth centers were about one-quarter of the birth charges of uncomplicated vaginal birth in hospitals (\$1,624 in 2003, when the national average charge for uncomplicated vaginal birth in hospitals was \$6,239). [pages 12-13]

The National Birth Center Study of nearly twelve thousand women found excellent outcomes and very high levels of satisfaction with birth center care (Rooks et al. 1989; Rooks, Weatherby, and Ernst 1992a, 1992b, 1992c); this comparison suggests that the level of resource use in hospitals for uncomplicated vaginal births could be much lower. At present, less than 1 percent of childbearing women in the United States experience the style of care and efficient use of resources of freestanding birth centers (Martin et al. 2007). [pages 12-13]

The relationship between poor quality and most expensive and intensive care has been consistently reported in many U.S. contexts. An analysis found that risk-adjusted cesarean rates varied by more than fourfold across the largest U.S. counties from 1995 through 1998, due primarily to nonmedical factors such as provider and health system supply. Higher rates were associated with more inappropriate care and use of surgery in healthy women, with increased costs and inevitable excess morbidity, but not with lower maternal or neonatal mortality (Baiker, Buckles, and Chandra 2006). Similar results have been found in large-scale analyses of Medicare, Veterans Health Administration, and private insurance beneficiaries. [page 45]

Providing Better Birth Experiences for All Mothers and Babies

The continual presence of a labor companion who has an exclusive focus on providing emotional support, comfort, and information has been found to foster important benefits to laboring women, in comparison with usual care. A friend, family member, or doula can assist women in this way. Benefits include reduced likelihood of the following interventions/conditions: pain medications, cesarean section, assisted delivery with vacuum extraction or forceps, and dissatisfaction with the childbirth experience. [pages 53-54]

Benefits were not found or were weaker when support was provided by a member of the hospital staff (Hodnett et al. 2007; Simkin and O'Hara 2002). [page 54]

A systematic review comparing midwifery care in freestanding birth centers to obstetrician-led care in hospitals found that differences favored the midwifery groups, including reduced likelihood of episiotomy and cesarean section (Walsh and Downe 2004). [page 51]

Nationally, risk-adjusted outcomes of care by certified nurse-midwives caring for women with single vaginal births at thirty-five to forty-three weeks of gestation demonstrated better outcomes than physician caregivers with respect to low birthweight and neonatal and infant mortality (MacDorman and Singh 1998; see also Raisler and Kennedy 2005). [pages 62-63]

Systematic reviews of drug-free measures, including hypnosis (Ceyna, McAuliffe, and Andrew 2004), immersion in water (Cluett et al. 2002; Simkin and O'hara 2002), acupuncture (Lee and Ernst 2004), and other methods (Simkin and O'Hara 2002), have found that these measures are helpful for many women, are associated with decreased use of medications, and appear to have excellent safety profiles. In addition, access to a companion who is present exclusively to provide continuous support throughout labor is associated with substantially decreased use of pain medication and increased satisfaction with the childbirth experience in comparison with usual care, and has no known adverse effects (Hodnett et al. 2007; Simkin and O'Hara 2002). [page 40]

Using hands-to-belly maneuvers to try to turn babies to a head-first position (external version) at the end of pregnancy succeeds in doing so in many instances and reduces the likelihood of cesarean section (Hofmeyer and Kulier 1996). [page 53]

A classic study to understand factors that are associated with women's experience of labor found that women's degree of confidence in their ability to handle labor was most important and had a bigger impact than such matters as their childbirth preparation, fear of pain, cervical dilation, and frequency of uterine contractions (Lowe 1989). [page 40]

Physiologic Birth

With appropriate support and protection from external interference, childbearing women and their fetuses/newborns experience innate, mutually regulating, hormonally driven processes that have developed during human evolution. [page 25]

Examples of steps along this path include the following (Buckley 2004a; Winberg 2005):

- the mother's elevated levels of beta-endorphin, an endogenous opiate that relieves pain and facilitates an altered state of consciousness, similar to experiences of endurance athletes
- the mother's rhythmic involuntary expulsion efforts shortly before birth (Ferguson's reflex)
- the unmedicated and undisturbed infant's drive to crawl on its mother's chest, self-attach to the breast, and begin suckling shortly after birth
- the mother's surge of oxytocin at the time of birth, which stimulates loving feelings and inhibits hemorrhage by contracting the uterus
- the continuing oxytocic effects with breastfeeding [page 25]

When facilitated, these naturally occurring processes overwhelmingly succeed in conferring a cascade of physical, psychological, and social benefits for the mother-baby dyad (Buckley 2004a; Odent 2001; Winberg 2005). [page 25]

By mobilizing these capacities, caregivers also humanize childbirth, show respect to women and fetuses/newborns as agents of these processes, enable all involved parties to experience the remarkable competence of birthing women and newborns, strengthen mother-baby bonds, and foster a uniquely fulfilling and empowering experience (Wagner 2001). [pages 25-26]

In contrast with unmedicated babies, babies whose mothers received epidurals and/or systemic opioids during labor exhibited reduced breast-seeking and breastfeeding behaviors, were less likely to breastfeed within 150 minutes of birth, and cried more; from 90 percent to 100 percent of the unmedicated newborns exhibited all six measured breastfeeding behaviors (Ransjo-Arvidson et al. 2001) [page 32]

The following information is taken from *Breastfeeding Decreases Infant Mortality*, May 2, 2004 Press Release – NIH News <http://www.nih.gov/news/pr/may2004/niehs-02.htm>

Data analyzed by scientists at the National Institute of Environmental Health Sciences suggest that breastfeeding can reduce the risk of death for infants in their first year of life...Children who were breastfed had 20% lower risk of dying between 28 days and one year than children who weren't breastfed. Longer breastfeeding was associated with lower risk. The effect was the same in both black and white children." (Breastfeeding Decreases Infant Mortality, May 2, 2004 Press Release – NIH News.)

Closing Words (Our Own)

In a country with our level of wealth and technology it is unconscionable that so many babies die unnecessarily. In order for changes to be made it is imperative that more people become aware of this pressing issue. According to the National Campaign to Prevent Teen and Unplanned Pregnancy, more than half of all pregnancies in the US are unplanned. Programs need to be offered in every high school so young people know how to prevent unwanted pregnancies, as well as how to care for themselves in preparation for having healthy babies when they are ready to become parents. Every expectant mother and infant must have quality medical care available and accessible which includes the entirety of pregnancy and beyond. Pregnant women and their loved ones need to have information made readily available to them about the hazards of unnecessary medical procedures as well as safer, more natural alternatives in childbirth.

Help us spread the word that naturalizing birth is not only safer, but also saves lots of money. Refer your friends and associates to our website. Donations of any amount are gratefully received (see "DONATE" on our home page), and please visit "TAKE ACTION" on our home page for more ideas about what you can do to help. Babies can't speak up for themselves. They need our help. Please join us in supporting these most precious and vulnerable members of our community to become healthy, fulfilled individuals that they may grow to support future generations in becoming the same.