Babies Are Born Where They Are Born:

A Conversation with a Midwife about Not Handing Babies to Their Mothers

by Mary Esther Malloy

As a doula, one of the questions I ask my pregnant clients is, "How do you envision the moment of birth?" Women respond differently, but something I hear over and over is the clear expectation and hope that doctors or midwives will deliver their babies to their chests for that first, long-awaited hello. With my first two children, I didn't give it a second thought—I assumed my babies would be handed to me as they were born and, following two hardworking but straightforward labors, this is what happened. When I gave birth to my third child, however, this first hello with my baby went quite differently.

It turns out that some midwives are exploring other ways of facilitating the moment of birth. They are doing less and leaving more to the mothers. Valeriana Pasqua-Masback, a midwife with a thriving homebirth practice in the New York City metropolitan area, is one such midwife. Instead of placing my daughter on my chest as the midwives had done at the births of my sons, Valeriana simply guided my baby down where she emerged and left her there for me to explore on my own time.

On a recent autumn morning, I dropped my sons off at school, wrestled my almost-2-year-old daughter into the car and drove to Valeriana's home in Rockland County, New York, to chat with her about why she is doing things differently at births these days.

"Let's talk in the cottage," she said as we pulled into her driveway. "My little guy is just waking up. I'll be right out." Valeriana, a fit, 60-year-old midwife, equestrian and self-described mad gardener, was on babysitting duty for her 6-month-old grandson. She hurried into the house while my daughter and I turned toward her impressive vegetable gardens and the cottage where she sees her midwifery clients.

I settled on her sheepskin-covered couch and my daughter began exploring the room. When I was pregnant with my daughter, I wrote about the simple practice of guiding a baby down at birth. It seemed to allow for a slowing of the moment of birth, a kind of pause where, as a doula, I had observed women catch a breath from the work of labor and then turn their attention to the child resting below or before them, touching, exploring and then gathering in their babies (Malloy 2011). When my daughter was born, I had the pleasure of meeting a baby of my own in this way. After a labor that had lasted just shy of forever, I gave birth on my bed on all fours. Valeriana placed the baby down between my knees and I sat back on my heels, relieved beyond words to be done and suddenly hungry beyond imagining to discover my child. I touched her strong little arms, took in her wet reddish hair standing on end, watched her first breaths, caressed her sweet belly, felt her cord pulsing with life and finally, when I felt I had *really seen her*, I picked her up—the experience was nothing less than euphoric. I had been moved each time I had witnessed this moment as a doula, but I had no idea that being upright for this precious first meeting with my daughter and being able to really see my child would feel so powerful.

As I waited for Valeriana, I thought about how the midwives at my sons' births had given me a different gift—they had given me my babies. Each labor was completed with what I've come to think of as a victory pass of baby to mom, something I mean with great respect for the triumph this move represents in our recent history of childbirth. In the twentieth century, we conducted a bold experiment surely not seen on this scale in the history of humans: we separated mothers and babies at the moment of birth. Reclaiming this connection has been hugely important and handing women their babies as they are born was the obvious and necessary correction. But with that victory at least partially under our belts, perhaps we can trust birth even further and *do less*. Slow down for a breath, a pause, leaving this moment to the women who have grown and birthed these babies so beautifully, leaving them to find and welcome their babies even as they are born.

Valeriana walked through the doors of the cottage with her grandson on her hip. "He is almost sitting up," she said with a note of pride as she propped him up in the center of the room with a few pillows. My daughter and I scooted in for a closer hello to this new member of the family.

Valeriana's career spans decades. She spent 15 years as a nurse in the hospitals of New York City as twilight sleep gave way to Demerol and Demerol gave way to the epidural. She was active in the early, passionate years of the natural childbirth movement and finally left nursing to become a midwife. After apprenticing for five years with a homebirth midwife who had learned the art of midwifery from her own grandmother, a "granny" midwife, Valeriana went back to school. She returned to the hospitals of New York City for 3 years as a certified nurse midwife, before stepping out 17 years ago to open her own homebirth practice.

My daughter got to work rearranging the birth art on the oversized windowsill and I thought I would ask Valeriana about when and why she started doing things differently at births.

"Well," Valeriana said, jiggling a doll in front of her grandson, "five years ago I attended a workshop with Karen Strange." Karen Strange is a midwife from Colorado who travels the country leading an expanded course on neonatal resuscitation and transitional physiology with a focus on the baby's experience of birth. "Karen kept challenging us to consider birth from the perspective of what hap-

pens when no one is there to tell a woman what to do." Valeriana said she was intrigued by a "rest" Strange described in the middle of what she referred to as a "natural sequence of birth." As Strange explained it, this sequence consists of a series of phases we are likely to see when birth is undisturbed: mother and baby are connected in pregnancy; they experience a separation at the moment of birth; this is followed by a rest with the baby below the mother, the mother recovering herself and then examining her child who is also integrating this major moment of transition; and, finally, a repair occurs where the mother gathers the baby in and allows her child to find the breast, a gesture that completes the sequence.

At this workshop, Strange showed the film, *Birth in the Squatting Position*, and Valeriana watched the 1979 classic for the upteenth time. "How many times had I seen these Brazilian women give birth?" she exclaimed. "I had watched it over and over and I had watched it for the upright squatting births. Now, I suddenly saw what was going on: the babies were born where they were born. They landed below their mothers and no one told anyone what to do."

The film features a series of women giving birth in the squatting position. As each baby emerges, the obstetrician guides the baby down onto pads. Each woman in her own way turns her attention from the effort of birth to her baby below her. Each woman reaches for, explores and then slowly gathers in her child. "I saw that it was the woman's decision when to engage with her baby, when to touch and when to bring the baby up. I loved how it was all about the women during the birth and all about the women and their babies after the birth. It made sense to me immediately." She laughed and described how sobering it was to realize that it had never occurred to her to really look at this aspect of the film. "It makes me wonder," she mused, "how many other things in my life, not just in midwifery, I am missing out on because of my own ideas of what is. I think about all the places I am not looking outside the box and simply can't see other options."

Valeriana knew she wanted to do this. "As a homebirth midwife, I always look to keep interventions minimal. We are champions of women's autonomy. This was one extra step that had never occurred to me before. Suddenly, I didn't want to put the baby on the chest as I had always done. It was a big shift for me."

Valeriana described how she most often catches babies now. She explained how if a woman gives birth in a squatting position, she gently guides the baby onto pads below the mother. If she gives birth on all fours, Valeriana directs the baby slightly forward so that when the mother sits back on her heels, she can easily see her baby. If a woman gives birth in a reclining or semi-sitting position, she places the baby down between the mother's legs and the mother sits up (sometimes with help) to see and discover her child. If a woman births lying on her side, Valeriana guides the baby slightly forward towards the mother's belly and rests the baby on the bed before her. In this position, the mother will often prop herself up on her elbow to meet and then gather in her baby. In water, Valeriana (or the mother) will bring the baby up to the surface and then rest the baby in the mother's slightly extended arms, so that the mother is more or less face to face with her baby.

Photo by Michele Anderson—www.pinkletoes.com

For the first 10 or 15 births following the workshop with Karen Strange, Valeriana explored this practice without "preempting a response from women," as she put it. She wanted to see what they would do. "I wouldn't say anything beforehand. I would just observe and then reflect afterwards with the moms." She recalled that it was with the second- and third-timers where she found the conversations so eye-opening. "For first-timers," she remarked, "it was the only thing they knew, but everyone else had their first births as a point of comparison. They loved being face to face with their babies," she said, her eyes bright. "They loved the eye contact and touch. I noticed how they looked at their babies with their husbands. They loved that. They loved being able to pick up their babies and say, 'Hi.'"

Valeriana continued, "Little by little we are chipping away at a process where we are stewards. We are there for safety, not to control this process. It is not about the midwife or obstetrician making the decision not to put the baby on the mother." Again, she paused. "She [the mother] might gather the baby up right away or she might want to take her time, savor the moment of seeing and touching the

baby before she picks up her child. It is not our decision. It is the mother's. In a way, it is the mother's initiation making that decision.

"This idea of the baby going to the mother immediately," Valeriana said, "is in one sense an emotional reaction to babies being taken away. It said, 'We have the right to have our babies. Nobody has the right to take my baby.' We needed that. Now, maybe we can to take it one step further."

Because of the widespread expectation that a midwife will deliver a baby directly to the mother, Valeriana now discusses the moment of birth with her clients during prenatal meetings. She reminds the expectant mother and father that it is *their* moment to welcome their child, and they can feel free to do as they like. She can place the baby onto the mother's chest if that is their preference. Or, if they like, she or the mother or father can guide the baby down where the baby is born and leave it up to them when to pick up their child. Because this idea is unfamiliar to most, she often describes the range of responses she has seen, such as a birth she attended where the mother, a visual artist, took an exceptionally long time touching and talking to her baby, but mostly just looking at her child. "It was absolutely what she needed to do," Valeriana says. Or, she might describe someone who felt a strong need to pick up and hold her baby almost immediately, such as a woman whose first baby had been born by caesarean. "She had mourned being separated from her son," Valeriana explains, "and this was exactly what she needed to do when she met her daughter." Most of the time, however, she says she sees people taking a minute or two, looking at, touching and talking to their just-born babies before picking them up. "Interestingly," she added, "I have seen some women ask for permission to pick up their babies, so now I always remind women ahead of time that they do not need permission from anyone."

At prenatal meetings Valeriana also discusses the benefits for a baby born below the mother. She tells clients that when she places the baby down, she will often see the moro reflex that she believes helps expand the baby's lungs for those important first breaths. She feels comfortable with those first few moments of cooling, she explains, because this temperature change may very well be an important part of start-up. Karen Strange suggests that because the body's internal temperature is 101°F, the baby actually needs to cool down at birth and that this temperature change may be part of what "ignites" a baby as it is born (Strange, personal communication). In addition, Valeriana tells expectant parents how much she appreciates what she considers an added safety value in her ability to see and study the newborn so clearly in those first moments as she assesses how the baby is doing.

Valeriana's clients also learn of the significance of the placental transfusion and how it is aided by gravity as the baby rests below the mother. She tells parents that at the time of birth, approximately one-third of the baby's blood volume is still circulating in the cord and placenta. In the minutes following the birth, this blood is pumped back by way of the cord into the baby and is rich with iron, oxygen and stem cells. This transfusion increases the baby's iron levels which can aid cognitive and motor development, fortifies the baby in ways we are only beginning to understand with all those valuable stem cells and helps the placenta make a timely, uncomplicated exit (Chapparo 2011; Tolosa et al. 2010; Soltani, Dickinson and Symonds 2005). Allowing the placental transfusion also provides for a secondary source of oxygen for those delicate first minutes, she explains.

On this point of when to clamp and cut the cord, I mentioned to Valeriana an interesting parallel I have noted. Researchers whose studies are highlighting the benefits associated with optimal delayed cord clamping are employing an intervention where the baby is placed between 10 and 40 cm below the mother at birth. To facilitate the placental transfusion, the baby is kept below the mother for a period of time that ranges from 30 seconds to 3 minutes (Andersson et al. 2011; Yao and Lind 1969). "This certainly looks something like what you and your clients are doing," I commented. "Interesting," she said, and added, "It would be fascinating to see a study that looks at the degree to which the placental transfusion is more effective or efficient when a baby is below the mother for the first few minutes. I mean, really, how much of a factor is gravity?" For a few moments we pondered some corollary questions: When a baby is delivered "up" directly to the mother's chest, how might this impact the timing or quantity of the flow of blood? When a baby is born in water, how does the pressure of water on the cord and the need to bring the baby up quickly affect the placental transfusion, if at all? If indeed gravity is a meaningful factor and the transfusion is more efficient when a baby is below the mother for the first few minutes, how might our hospitals accommodate this in ways that facilitate the mother's access to her baby during this time?

In a study published in 1969, Yao and Lind found that the rate and volume of placental blood transfer is indeed affected by gravity. They state that the transfusion was largely unaffected when babies were held approximately 10 cm above or below the mother's introitus. However, hydrostatic pressure either hastened or impeded the transfusion when a baby was placed + or – 20 cm above or below the mother, with the most obvious impact in the 50 cm + range. If the baby was held in the range of 20 cm or more above mother, "the effect of the hydrostatic pressure created by having the infant held above the level of the mother's introitus lessened or prevented the placental transfusion by partially or completely obliterating the pressure created by uterine contractions" (Yao and Lind 1969, 505). They found that lowering a baby 40 cm below the mother completed the bulk of the transfusion in about 30 seconds, with no significant increase happening beyond that point.

Just as we started imagining these projects, Valeriana's 20-something daughter, dressed in horseback riding gear, appeared in the doorway to collect her son who seemed both hungry and tired by this point. My daughter was fatiguing as well. As Valeriana and I packed it in, she turned to me and said, "Really, this is about autonomy. It is about giving the mother the right to be the mother rather than somebody telling her that the baby must be down for 3 minutes or 30 seconds or that she has to gather her baby in immediately. What does she want to do with her baby in that moment? We have to remember who is in charge here. This is not about doing it a new right way. We just need to be able to whittle away at how we can get out of the woman's way to be the mother."

I loaded my sleepy girl into the car for the ride home and thought again about meeting my children. My boys were born to the comfort and warmth of my body; surely, a good place to land. My daughter was also born to the comfort and warmth of my body. She just paused for a few moments on the way, resting below me. I was able to really see her and this tapped something deep within: I touched and massaged her with my hands, drank her in with my eyes and I welcomed this child with every fiber of my being, exactly as I needed to.

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Mary Esther Malloy, MA, is a New York City-based doula, Bradley childbirth educator and lactation counselor. She facilitates "Inspiring Birth Stories" nights for Choices in Childbirth and runs moms' talk groups. With the help of her trusty assistants, ages 2, 8 and 10, she is something of a mad gardener herself. For more about Mary Esther, visit www.mindfulbirthny.com. You can read her daughter's birth story at www.thebirthpause.com.

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