

(introductory music)

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MARYN: Welcome to Indie Birth's series of podcasts here on iTunes, *Taking Back Birth*. Hi, everyone. Maryn here to talk about the fascinating topic of newborn transition at birth. So I love to say that babies come earth side when they're born. That just resonates with me. It just seems to make so much sense on a physical level, on an emotional level and spiritual level. They're here in this place at birth and after birth where they just haven't been before. Their bodies literally are functioning differently. And in a way, I wish I could remember what that was like. Kind of being in a whole different world in utero and then remembering the experience of that transition. I don't remember. Perhaps you do. But I think this is something that everybody is interested in probably for that reason. We've all done it. And we may or may not remember it, but something in us probably does. So it's fascinating to think of a baby being born and learning to breathe and just function, again, on this side of the uterus.

So whether you're a parent, a mom or a dad, or a midwife, or a student midwife, I think this is a topic that's really worth talking about and really fun talking about. So for me, I feel like it's taken years—and by that, I mean 11 years—to really understand this and to get really comfortable with how this transition looks and feels at a home birth. And the home birth part is, of course, key because I think this can look and feel and be analyzed in almost a completely different way when babies are born in a hospital setting. So really babies that are born in a hospital are not given the time and space to transition to acclimate. There are rules and protocol, and we'll go through some of that with the neonatal resuscitation program information. I'll at least touch on that. But it makes sense, in a way. That's a business and institution. And when babies are born, they want to ensure, of course, that they're breathing. And so there are very, very strict protocols and numbers and this kind of thing.

And gratefully, at home birth, that's just usually not the way things are done. But, again, as a student especially early as a student—again, 10, 11 years ago, I found it kind of challenging to watch this transition. Growing up, who doesn't see pictures or movies of babies being born and hung upside down or spanked to cry? I mean kind of this awful visual comes to mind when most of the general population thinks about a baby being born. And the word transition doesn't even really enter anybody's picture or vocabulary. I don't know that most people have ever even thought about this transition. It's simply birth and a baby breathes. Hopefully, everybody kind of holds their breath about that. But very different experience at home, hopefully.

So in my 11 years in birth thus far, I think it has been a gift that I have seen most babies—almost all—make this transition and adaptation really successfully, really seamlessly. Some more gradually than others. And I think it takes that experience seeing lots of babies being born. Of course, knowledge and studying. And I think patience as well. That has really been something that's helped me. And I wouldn't consider myself a person that's really high on patience in my normal life setting but somehow in birth I do find patience. Patience is a really big part of a baby transitioning.

There's also a lot of grace involved. I mean let's be real. There's whatever higher power, whatever bigger picture you have in your head or that you believe. I do think that that is a very real part of birth and, again, of a baby transitioning to this side. It's not just our knowledge or the fact that most babies do just naturally do it. I think there is also a lot of grace as there is in pregnancy and birth in general. So there's just so many ways I kind of want to go with this today. Hopefully, you'll keep up or make sense of what I'm saying. But so few babies really need to be prompted or made to transition. Again, especially at a home birth. We're talking low risk, normal, healthy moms and babies. And they don't need us to do anything. Most of them. And when we do do anything, and we're going to talk about what those things might be, I think it's rushing them.

And maybe for me, it's even really personal. I was born as a preemie 38 years ago. And I'm sure—that long ago especially—everybody was super concerned about my lung development and if I was breathing. And if I could consciously remember, I have a feeling that what I would remember is being sort of forced into extra uterine life and not really given the time to come into my body and figure out what was next. Now, of course, there are scenarios, and we're going to talk about that too where we don't wait. There are babies that do need our help. It's just so rare. And, again, if we're prompting them, if we're doing anything at all when they don't need us then we're rushing them. So, again, I think we need to talk about this today, so that we're really aware of the things that we are doing or aren't doing and how to possibly gain more respect for a baby as it makes this huge adjustment.

I would say that it's probably the biggest adjustment a person makes in their life. It's just so enormous. So it's huge on a physical level, and it's huge on a spiritual level. And that is why we are talking about this today. So what comes to mind when I think about a baby being born especially at home is excitement. And for me, my favorite part of the birth process whether I'm the one giving birth or whether I'm the one witnessing it. But I remember the midwife I apprentice with years and years ago had asked me pretty early in my apprenticeship what my favorite part of birth was. And that was my answer. When the baby is emerging, when the baby is out. And it still is. Now after seeing hundreds of babies being born, it's not always the tearful, emotional experience that it is as someone witnessing as it is for the parents. But it's still really special. It's still really

mysterious and amazing. And so that's my take on it. But, again, I think of the years having gained patience and respect definitely someone that steps away at that time, again, unless a baby really needs something.

Now those are my personal feelings and take on that part of birth. But I'd say if we're going to generalize there is a ton of fear around that part of birth for most people. And, again, back to the cultural beliefs that we might have. It's a scary time. Is the baby breathing? Is the baby screaming? Did the baby cry? Even at home births, there can be what I call fearful chaos meaning that the energy in the room really changes once the baby is out. And, again, with most babies, there is just no need for it. The fear is almost palpable or not even almost. You can feel the fear in the room. Everybody tenses up. And generally speaking, it's not the parents. They are into their baby. They're staring at their baby. They're touching this baby. They're in the moment. It might be other people, other family members, sometimes even the midwives or doulas or whoever is observing feeling uncomfortable with this part of birth and having all of those thoughts run through their heads. So is the baby breathing? Is the baby okay? They might try and kind of get in there listening to the baby with a stethoscope, rubbing the baby with towels, handing the parents a hat, lots of activity. Lots of action.

And this, I think, is the most common set of reasons why the third stage or the delivery of the placenta and the attachment and bonding between mom and baby are so disrupted. It is an enormous disruption to have this fear in the room. Again, to be getting involved, to check—to be checking, to be making sure, to be in the middle of this family center when nothing is wrong. And, again, it's because a lot of people don't understand this transition. They don't know what to look for. And it creates fear. So it's really hard sometimes just to observe, to back away, to become part of the wallpaper really at moments like this. We all know, hopefully, that the highest oxytocin release happens at the moment of birth. So I think that's just—I don't need to say any more about it. This mom is completely bathed in hormones and so is her baby and so is her partner or whoever is right there in this moment.

So to disrupt this moment, again, with unnecessary fear or prompting or over stimulating the baby to breathe is just unnecessary. And it's creating problems because then, of course, the mom is disrupted and maybe the baby is disrupted. And we may be creating the problems we're seeking to avoid. So my advice really whether you're the mom birthing or somebody in the room during the birth is to take a deep breath. To just stop and allow time to really slow down like it does when a baby is coming earth side. Anybody that's been at a birth whether it's one or hundreds knows that time slows down. That if we're looking at our watch to assess a baby we are kind of transported. Time isn't what it was a couple minutes ago. And I think it's because when a baby is born, we are just completely in that moment. We're not really thinking about five minutes from now. We're not really going too far in our heads. We're just right there

watching that baby, watching him or her make this really gradual transition. And, of course, in the back of our minds, we're always thinking, "Right. Does this baby need anything?"

But it's pretty simple most of the time, right? We take a deep breath. We're just observing. Our calm, confident energy, again, whether we're the mom or the caregiver or the grandmother—our calm energy is really valuable to the room. And, again, with most normal, healthy babies that are being born, we're respecting this transition. We're taking this breath kind of with them, for them as they take their first breath even if it's not absolutely immediately. So a little divergence here. A little bit about neonatal resuscitation or as it's affectionately known in our world, NRP, which is the neonatal resuscitation program. And this is a course that, as midwives, we must be up to date on, so we recertify every couple of years. And truly, it's a great reminder to just revisit these skills because we use them so very rarely. There's lots of good stuff in this program. It is put on, for lack of a better word, by the American Academy of Pediatrics. So that tells you a lot right there just what the perspective is. And, again, as I always say, it's not that it's bad or good. It's just that's what the perspective is. Group of pediatricians. So we're going to go through more of how to interpret what we might learn in the NRP program for home birth just because I think it's so helpful and so valuable. And, again, whether you are a mom or a student midwife, we really need to simplify this, so that we understand it and can actually use it if we need to.

So anybody, I believe, can take this NRP program. Parents may take it. And, again, as midwives we're required to take it. But, again, I thin—I just completed my recertification, so I think this is why it's definitely on my brain is just how do I translate this information for home births. Now I've been taking this course every couple years for the last ten years and have been surprised over the years how the information has kind of changed. Maybe as far as use of oxygen or this number or that number. But the basic principles do remain the same. And I'm really thrilled to report that the basic principles of any kind of helping a baby to breathe, they're really physiological. So yay. When we're having home births, whether we have a midwife there or it's unassisted, we really have so many of the criteria down already. And that is really, really cool.

So the NRP has a couple of stats, and this is just something they always talk about in the class. And I think they're good to discuss. And I want to discuss them in a just a slightly different way unique to home birth. But their stats are, according to them, that 10% of babies at birth need some kind of assistance breathing. Now even that's kind of vague because we'll talk more about a baby being stimulated. That can help a baby breathe. And, again, at home births, there is a lot of ways that that looks. But there it is. 10% of babies, according to them, need some kind of help breathing. And 1% need serious help. So chest compressions. Now it's just such an interesting thing to think about. On one hand I feel like 10% is kind of high. But, again, this is a medical setting.

This is the numbers that they have gathered from hospital births and, obviously, labors and births that are interfered with, intervened with. There are no other statistics associated with these numbers. So it's not the most solid information. But it gives us a clue.

And I think what they are trying to say is resuscitation is an important skill. They say you should always have someone there that's knowledgeable. But I think they're trying to say it's not that many babies that really need anything. And if we're thinking of 1% of babies in the hospital—and, again, these are including high risk situations and, again, interference and interventions in birth then 1% is pretty darn low. And if we are thinking of home births, it has to be less than 1%. Now we don't have that data on home births and the percentage of babies that need serious help like chest compressions. But I think it's a pretty safe assumption to say definitely less than 1% at home births. And knock on wood in the 11 years I have not had or seen a baby at a home birth need chest compressions. And really I may never, and that's a great thing.

So we need to know what normal is. Again, I say this in so many podcasts. But because we're not attending births with our friends and our family, we're not routinely watching our nephews and nieces come into the world. Most women, most people, have no idea what birth looks like. And, again, it can be a really scary thing for a lot people because we have this cultural thing around is the baby breathing. So we need to know what's normal. And we need to know what to do if a baby does need something. And I'll say it one more time. Most babies just don't need anything. And we'll never know. But as somebody that sees lots of home births, I'm always curious to imagine even the babies that we think need something. Now, of course, we're not going to neglect them. But let's just say there was nobody there. There was no midwife. There was no attendant. This baby that we allegedly think needs something may not get it if no one is there and, truthfully, will probably be just fine.

So, again, no research on that. Just sort of thinking and observation and believing and knowing that normal newborns, which is always everybody are pretty darn resilient. So, again, I think take it all with a grain of salt. What we do, what we don't do, and the fact that most babies will really be fine regardless. So I think there is some confusion for people if they're thinking about taking the NRP course, or if you're just maybe watching birth videos and you're thinking, "Is that baby okay? How do I know if my baby is going to be okay?" Because it kind of overlaps with the whole APGAR score thing. Now I'm not going to go into great detail about that because really APGAR scores were created when babies were needing to be assessed in the hospital, and this is decades ago. Virginia Apgar was the doctor to name this criteria. And these babies were being looked at more closely because their mothers were drugged during labor. So it was truly an assessment of the baby but in that situation.

So to this day, we still assign APGARs. Most people do anyway. Most midwives, doctors for sure. But when we're looking at a baby that's just emerged from his mother's body, from the water in the birth tub, we're not thinking APGARs at that particular moment. We're more just knowing what normal is and watching for signs that the baby is going to begin breathing or is breathing. So NRP has one assess a baby at 30 seconds. Now all of this, again, is with a grain of salt. So if the APGAR assesses a baby at 1 minute and NRP is saying 30 seconds it's all—I think it all needs to flow a little more which I guess is my point with this. That we don't need too—I don't think—be super impatient. We don't need to descend on a baby at 30 seconds that's obviously making a transition. Maybe a little bit more slowly because they were born in the water or whatever.

So I understand these guidelines. And I understand why they need to be in place. But, again, I think at home birth when everything is expected to be fine and a baby is showing signs of just doing what a normal baby does that we don't need to rush it. So 30 seconds—huh. Maybe. And on the flip side, if a baby is born completely compromised and limp and white and almost dead looking, then we don't wait 30 seconds at all, right? We are on that baby. We are helping as much as we can from the moment of. So there definitely some, I guess, intuition involved or maybe experience. And as usual, we just don't—I don't think—we don't use numbers as the be all and end all.

So this baby emerges. Maybe it's your baby. Maybe it's somebody else's baby. Is the baby breathing? And they don't do that right away. So NRP teaches you to ask that question and have it answered. But the truth is a baby gradually has to dispel fluid from the sacs in the lungs. And really they kind of exhale to do that along with the positive pressure just of the air. It's no positive pressure from anyone at all. And only then are these little sacs in the lungs—the alveoli—able to fill up with air. So, again, a baby doesn't come out and just open its mouth and start breathing. There are very finely tuned physiological changes that are happening. So that's all to say that you're not going to probably notice a baby breathing, as in chest rise, seconds after birth. They have to clear the fluid. They have to exhale. And in the meantime, you'll notice the color probably changing, and the muscle tone becoming more pronounced. The baby may even look around or whatever before he's actually breathing on his own.

But like any guidelines, I think they all need to be interpreted as best we can in a situation and understand that the guidelines are there just because guidelines are needed. At least according to somebody. So I'll say it again. I think we need to be patient with babies that are showing signs of transitioning. Are we looking at our watches for 30 seconds and then exactly on 30 seconds after birth jumping in there to rub and touch and stimulate a baby that's obviously doing it? I think not. And I think it's disrespectful to be that impatient, frankly, to the baby unless—there is always the

unless, right? And we already talked about that. If there is a baby that's clearly not doing well, then we don't wait 30 seconds at all.

So I know there's always question about water birth and the slower transition. And I'd agree for the most part although not every water birth I've seen—and I have seen hundreds probably. Most of those babies are just fine. And whether they transition more slowly than a land birth baby it's almost hard to tell. The color might change more gradually in a water birth baby. But their reaction to life on the outside once they hit the air seems to be sort of at the same pace. But, again, I think it's more that we're stuck in our little time warp as we watch this. But according to experts, I know Cornelia Enning, who is a water birth expert midwife, has actually set a different set of APGAR scores for the water born baby. And you can look them up. They're just a tiny bit different. Just water birth babies don't usually get screaming and crying perhaps as often as a land birth baby. But they're still responding. So they're not out of it. I mean they're not limp and not breathing or not present. They're just not often as vocal. But, again, they are responding, so they might grab the mom or dad's finger. They're looking around.

It can, in general, be a quieter experience it seems to watch a baby transition from a water birth. But, again, not always. There's certainly babies that are taken out of the water and are screaming. So just something to keep in mind. But really, I think it reminds us that every situation is a little bit different. So back to the NRP thing for a minute. The neonatal resuscitation program is a physical assessment. It's all physical. That's really all we're talking about. And as I mentioned, I don't think that's all that's going on. Now that is important. But there is this emotional transition for a baby. There are certainly a very real spiritual transition of a soul coming a body. And everybody has their beliefs about that. Mine is that a soul chooses to come into the body when it chooses to come. It's not just at conception. Or it's not just at birth. It may be any time in the pregnancy. And there really are babies that are born where you can see—or I can see—I have seen—that the soul of the baby isn't present in the body yet. And sometimes those babies are the ones that seem to be slower to breathe, or maybe they do need a little help. And other times, they're not. The baby is doing just fine physically, but you could see in their eyes almost that they're just not here yet. So, again, not something NRP is going to talk about.

But if we're talking about the physical assessment of a baby, we really need to understand what happens before birth and what happens after birth on a physical level. So before birth, the baby's lungs are compressed. They're pretty tight. And they can contain fluid. Amniotic fluid. And the blood running through the baby's body bypasses the lungs or almost completely bypasses the lungs. The lungs get a tiny bit of blood, but they're not perfused. They're not working the way lungs work on this side or as an adult. So the blood kind of bypasses the lungs and is shunted away from the lungs through the ductus arteriosus. So even if you don't remember all that, just understand

that the circulation is different. That's the most important thing to understand, and that the lungs have never breathed oxygen. They have never done that.

So once the baby is born, as I said earlier, the lungs must first disperse the amniotic fluid. They can't fill up with oxygen when they're filled with liquid. So the liquid needs to get pressed out and, again, the positive pressure of just normal room air will do that plus the baby being stimulated and maybe crying. And these little alveoli in the lungs will start to absorb oxygen. Excuse me. And there is 21% oxygen in room air. It's not 100% oxygen. What else happens is that the little alveoli that were so constricted, so tight, in utero need to learn how to relax, so that the blood flow can be carried through the body. And the ductus arteriosus, of course, begins to close. And the blood is redirected through the lungs which, again, is a whole new thing. And when I said this was the biggest transition that a person will make in their lifetime, I really think I'm right because that's enormous. Our bodies just work completely differently when we're in utero to when we are out here.

So that's the basic way things work and change and also pretty basic that when a baby isn't transitioning well most of the time one of those things or maybe all of those things are not happening. Now, of course, there is the rare baby that maybe has a congenital issue, and it's not a matter of time or NRP or anything like that. This baby has an issue and may need medical help. But for babies—all the rest of the babies that are healthy, if they are experiencing any kind of trouble breathing at birth, again, it's due to one of these things. So maybe their little alveoli are just staying really constricted. Maybe they're early. Maybe they're not strong enough to kind of inflate those enough to begin the breathing process. Yeah. But usually, again, it all happens perfectly and normally, and it's still great to have an understanding, I think, of what's happening because it's like you can almost see it. The next time you see a birth, if you didn't know this already, think about what I just said. And it's like you can almost see it happening. I mean you watch the color change gradually. You watch the baby exhale first and get rid of that fluid. Then you watch them start to take their first breath, and you imagine all those changes that are going on inside that just enable them to do something so amazing.

So, again, that's the NRP very physical explanation as to what is happening. I will say, again, just because I think it's so important that babies do enter spiritually at their own time. And, of course, we want them really to enter as soon as possible. I've talked a little bit here and there about my fourth baby, who came out of the water at birth as I described earlier. It was very frightening. He was white and limp and as close to dead as is probably possible to see. So in his case, there was basic resuscitation done. Honestly, he wasn't even the 1% that needed chest compressions. And as his mother, I can confidently say that it wasn't a physical issue, I don't believe. He just wasn't quite ready to be in that body. Now that didn't make it any less scary. That didn't make it any less necessary to know the basics of NRP or to how a baby transitions. But, again,

just my personal take on it. That sometimes it's a combination of things. And we do the best we can with what we know and, again, these physical criteria are really important. But if it's your baby or even if it's a baby where you're the midwife, there is something to be said for calling the baby's soul into their body in such a situation. And it's not even something that has to be done out loud. But, again, that can be a very real part of why a baby is taking time to transition or not transitioning well.

So let's see. NRP does talk about risk factors. And I think that's important to note. I know, as midwives, we certainly have those things in our brains too. And there are risk factors that are associated with more resuscitation scenarios then, of course, there are scenarios where we would never expect a baby to need help. And like I just told you, with my son, he really didn't have risk factors. Neither did I. It was just one of those things. So it certainly can happen without risk factors. But preterm babies more risky in the sense of maybe needing help to get started for the reasons we talked about. The mom may have some kind of health condition. The baby could unknowingly most likely have some kind of infection, and then there are things like breech presentations, which we, textbook wise, associate with resuscitation. Things like shoulder dystocia or really tight cords.

And what I think goes along with those kind of scenarios is just that once in awhile—just like only once in awhile—does a baby need help breathing. Only once in awhile does a baby need help being born. And I say that as a very strong supporter of unassisted births. But I will say that in the rare, rare, rare occasion where a baby needs to be born and there is no one there to help with that those situations can create a more intense need for resuscitation because, again, very rarely a baby is born or the head is coming or the head is out and it's very clear, from the midwife end of things, that this baby needs to be born now and not wait another contraction or two. And in those situations, that baby may still need help breathing. But, of course, I'm thinking, "Well, geez. I'm glad the baby was born immediately even with a little help because waiting three more minutes may have really increased the need for a serious resuscitation."

And I say that because I watch lots of birth videos. Excuse me. Many of them unassisted births. And, of course, birth works. Most of them are just fine. But just a couple I saw recently that kind of sparked this topic in my head even was a baby really looking like it needed to be born. So not the greatest scalp color. And just kind of mouth gaping open. Looking like the baby could use some help coming out. And, of course, unassisted birth there was no one there. Just whoever was holding the camera. And this baby is coming out and being more compromised than they probably needed to be. So risk factors like that are kind of hard to identify because it's not something that you're going to know before labor or maybe even in labor. But as the baby is coming, again, really rare but some babies do need help coming out. And the time is of the

essence. And when we don't have that, then we're looking at a more severe resuscitation.

So as midwives or as anyone really that's planning a home birth or an unassisted birth, we are thinking about and we are taking into account so many other criteria besides what I just mentioned. So we're not just thinking is the baby full term? Is the baby breech? Because most of the time, they're not. But there are other things going on. So we're thinking about the temperature of the room. So with NRP, it's all about warm the baby. Bring the baby to a warmer. Well, we don't have those at home births. And even though some midwives do carry around heating pads and cookie sheets, we don't really need those things most of the time because, again, the physiological process is set up that a baby is going to be warm on its mother. We can help by having a warmer room, making sure the fans aren't on, reducing the lighting. Of course, we may need the light or think we need the light more to assess color. But in other words a really welcoming place for this baby to transition. And, again, I think most of us were born into really abusive, aggressive situations. So hospitals, freezing cold, a bright light. Again, being handled intensely. Those are our really deep memories of birth for a lot of us.

So just think how important it really is, conversely, to have comfortable situations where babies can come into. So comfortable temperature, comfortable lighting. Other things that we take into account, again, not NRP but sort of the more holistic view of when a baby might need help or not is the length of the labor. Of course, not all babies in long labors need help. But it's always something to keep in the back of your mind especially if the baby is in the birth canal, so to speak, for awhile. Maybe there is a really long pushing phase. The emotional state of the mother is really, really important. And if I only had enough money and time and ways of conducting research like that, I would love to just because it's not something we ever see. So how is the mother feeling? Did she kind of disassociate towards the end of the birth? Is she—I don't know. Is she nervous about having another baby? Was it a boy and she expected a girl? Is she just exhausted? Does she need food to eat? These are all the things that are running through my head when I think, "Will this baby need help?" If the baby is slower, then sometimes there are just reasons like this. And, again, it doesn't mean we ignore a baby that needs some serious physical help. But we take into account the whole situation.

The emotional state of others in the room. That's pretty huge as we talked about before. So if people are really fearful and it all of a sudden gets chaotic and crazy because the baby is transitioning slowly or does need help, I really think this only adds to this fear that the baby is probably feeling. Again, I don't remember consciously, but my imagination wants to tell me that it might be a little bit scary. It might be a little bit overwhelming to be that baby and to have to transition or figure that out. And babies feel. I mean we all know that. Babies feel in utero. So for this baby to be laying there

and surrounded by fear or chaos or people doing things or kind of over touching or over stimulating the baby when it's not really needed, I think that can really contribute to the amount of time it might take for a baby to come around. Wow. That's a lot, huh?

So I think I went through what normal really looks like. What can we do to help? Now that's kind of a loaded question because, of course, I said most of the time we don't need to do anything at all. So, again, more than 90% of babies—more than 90% need absolutely nothing from us as the caregiver. What they do get just because and which is part of their adjustment—what they do get is stimulation. And that is a crucial part of the neonatal resuscitation process. But, again, it's physiologically based because where do babies get stimulation from? Their parents. their mom. Whoever is holding them, which is, of course, almost always the mom. So how is the baby getting stimulated? The mom is talking to the baby, rubbing the baby's head. the dad is there. He is rubbing the baby's back. All of those things are actually stimulatory, if that's a word.

The baby is skin to skin. That's also a wonderful thing. That's what we would want is to provide warmth anyway. So so much of the checklist is already there with a normal, physiological birth. Now what else can we do to help or not? We do want to create an airway if the baby is struggling. So just imagine being a brand new baby and your head and your neck are kind of unstable and floppy and if you just got brought onto your mother's chest out of the birth pool and your head is kind of like folded and your neck is folded and kind of burrowed into her chest, you might have a little bit of trouble getting that transition going because you don't have a good airway. You can't get air down there. So, again, it's pretty rare at home births because somehow babies take of it, right? Somehow they know how to adjust and adapt, and babies in a physiological situation and for millions of years were not born and placed on a flat, rigid table just to create an airway. We know that a normal, healthy newborn can create its own airway.

But occasionally—again, if a baby is struggling or looks like they need some help, all you have to do is correct the airway. So just kind of straighten the baby out on yourself or move the baby around. It's really not hard. So what is unnecessary? Hmm. So much. So in the NRP program—again, and this isn't a home birth thing but yet we're taught this anyway when we take the course because the course is just the course. That we dry baby off immediately after birth. We replace the wet linens, and we get the baby warm and dry. Now, again, in a hospital setting when the baby has already been taken from the mom, perhaps that is the best idea. But in a home birth, we already have that going. We already have the warmth. We already have the stimulation, which is what the towel rubbing would provide. I don't think—and I think we've been shown over all of these years that babies don't need to be dried. It's okay for them to be wet when the room is warm, and they're placed on their mother. We don't need to go crazy drying babies.

Unnecessary, routine suctioning of any kind, and this is definitely something that has changed within NRP over the years. They've recommended suctioning at various points for just normal babies or meconium stained babies. At this moment, it's a pretty physiological recommendation. They're not recommending any suctioning at all even with a meconium baby that is vigorous. So a baby that had meconium in the waters and is born pink and crying and with a good heart rate, we don't suction those babies either. So I think that's probably news to some people. I know tons of midwives that still use the bulb syringe routinely. I've seen unassisted birth videos where people think they need a bulb syringe and are doing that to their baby. It's really a dangerous practice especially when not needed. Can stimulate a vagal response and just be really, really offensive to a baby that doesn't need it.

And, again, if a baby does need suctioning to remove secretions because they're really unresponsive, then a mom can do that mouth to mouth just by sucking it out. So a bulb syringe is really the last resort and really, really, really, really, really rarely. So, again, unnecessary, I think, to create an artificial heat source. Again, an exception would be a baby that does, in fact, need chest compressions. And you really want that baby—you want to be able to work on that baby, as we say. One of the only situations that a baby would probably need to, in my opinion, be a little bit away from mom and have that kind of intense stuff going on. And in that case, yes. Having a firm surface would probably be a good idea and creating that heat artificially may be a good idea as well because the baby wouldn't be on the mom.

We do not want to cut the cord at all ever. It's kind of like hard for me to get those words because it's so obvious to me. And NRP is not that way, right? It's all about drying and stimulating the baby because you've cut the cord or are just about to. So this is a completely different paradigm. We're not cutting cords even for babies that might need help. We're able to stimulate the baby. We're able to give positive pressure ventilations on the mom without taking, without cutting the cord. Now, again, I'm just hypothesizing here that if you really did have a baby that needed serious, serious, serious help then it might be risk benefit to cut the cord at a certain point to enable yourself and whoever is with you to do chest compressions. Now, again, that is super, super, super, super rare. And cord cutting is not something we really ever want to do for obvious reasons because that's where the baby is getting what it needs before it's able to breathe on its own.

But it is worth saying, I guess just because it's factual, that cutting the cord does raise the blood pressure. So just sort of worst case scenario with all of those factors that I mentioned that it may be something that happens even at a home birth. But, again, really rare and generally speaking we never want to do that. And we really never want to take the baby away from the mom that—I—yeah. You would need some really good reasons and really need to feel like you had to create this airway that wasn't possible on

mom. And, again, I think not in the moment but, at other times, considering what kind of damage that does to a baby to take it away from its mom at birth.

So what might we truly need to do at a home birth whether we're the midwife, whether we're the doula that unexpectedly is there without anyone else or having an unassisted birth and trying to give our partner some information on what we might truly need to do if this baby needed any kind of help? So back to the basics. Stimulation. Remember that the baby is going to get warmth and stimulation just by being brought up on mom's chest. Just by being talked to. Just by being touched. So it's kind of like we got that covered without even thinking. And if a baby is not responding—and, again, this is really hard and a hypothetical situation. It's like you want to say, "It's not responding in a couple of minutes," but then, of course, there's the baby that needs help way sooner. And there's the baby that can wait a little bit, and you can see the progress.

If you're in a situation where you're all alone and you're not really sure if a baby is responding to stimulation, then the next step would be to give a breath. And you kind of can't go wrong with that especially if it's your own baby and you're going to put your mouth on your baby's and give your baby a breath. Not too much that can go wrong there. So if you're in doubt, that's the next step. And if you are attending a birth the, of course, you can have the mom give a breath, if the baby is not responding to stimulation. So I think NRP guidelines are heart rate at 100 or below. The baby is not pinkening up. Just kind of has its mouth gaping open. And to me and the couple that I've seen literally look like they're asking for help. They're not trying, and that's a sign to me that that baby probably needs a breath. And the stimulation is not enough.

So what NRP says that I think is really cool to remember is that stimulation can only go so far. So if a baby isn't improving with stimulation, don't keep stimulating with the hopes of having that do anything. A baby that is more compromised—and they call this secondary apnea—a baby that's in secondary apnea must get an inflation breath to improve. All the stimulation in the world will not help this baby that is in secondary apnea. So to make that really simple, just what I said, baby is not responding to being stimulated or talking or touched and is just mouth gaping open, heart rate if you can feel the pulse of the cord even is 100 or below, then this baby needs a rescue breath. And that's one of the highlights of the NRP program that I think is great, and we should all remember. That the most important part of resuscitating a baby is inflating the lungs. That's the most important part. And that's a completely different physiological concept than CPR because, as adults, that's not our problem when we're needing help breathing.

So for, again, for a newborn, that's the most important thing to do. Really anything more serious that would come after that can only come after that. The lungs must be inflated. And, again, the way to do that is mouth to mouth especially if it's your baby.

Just breathe in. And you will feel it happen. You will feel their lungs fill up. You will feel their little chest rise. Most parents don't have a bag and mask although you could, I guess. Really better to use your own body especially if it's your own baby. But a bag and mask. And then that's the NRP training is to learn how to use a bag and to use the right resistance and to get the correct seal of the mask. So, again, I do think it's a really worthy program for people that are attending births or just want to know more because getting that inflation breath into the baby will correct almost every situation.

And I heard this just yesterday from the woman I took the NRP class from who is actually a nurse here at a hospital. So not a homebirth midwife. And so her perspective was really cool because she has a completely different perspective or experience than I do, but yet she was reiterating these very simple basics even for her setting. So that's what we want to do is get the lungs inflated. And the couple over the years that I've seen, honestly—again, knock on wood—I've had the moms do. So just put your mouth on your baby's and breathe into the baby. And one breath and the baby is kicking and screaming. So if the baby needs more than that, then, of course, you need more than that. But, again, for most babies, that's absolutely enough.

So if that's not working, you can kind of go through the motions again. Stimulating although we've already said that that's not really going to get you anywhere. But clearing the mouth and nose with a bulb syringe. Not ideally but that is an option. Just getting the secretions out so that the airway is clear. make sure that the baby is positioned so that air can actually get down. And talk the mom through breathing into the baby's mouth again. And honestly, I think this can be approached in the prenatal period without a whole lot of fear. Just kind of like this is the way newborn transition looks. If your baby doesn't seem to be responding to you after rubbing the baby, then you can put your mouth on your baby and breathe into the baby. It makes it a lot less scary than bringing out the bag and mask and making this big giant deal when really it's just an inflation of the lungs.

So, of course, the obvious is if that doesn't do it especially after a couple of inflation breaths, this baby is still unresponsive, not breathing, no tone, no color then that is serious. And that's when—well, maybe even before then, that's when you need to call for help. Chest compressions can only be done by two people because somebody has to be giving the inflation breaths, and somebody has to be doing the chest compressions. So even as a midwife—heaven forbid I ever was in that situation—9-1-1 would be called immediately because it's just not something you want to handle at home, and you can only keep up for a certain amount of time. So you may even have to keep it up—meaning chest compressions on the way to the hospital but definitely not ideal.

So a little bit more about the NRP program just because I think it's worth talking about is the new guidelines are based on using a pulse—excuse me—oximeter. And wow. That was new to me a couple years ago when I took the class. And what does this mean? It means there's a little expensive tool that we can get onto a baby after birth, if we're concerned about how much oxygen is running through their bodies. And if it's not ideal because, of course, oxygen concentration is going to increase in a baby over minutes of life, right? So when they're one minute old, they're not going to be as concentrated as normal healthy baby at a couple hours old. But even NRP—excuse me—program says that it can take 10 minutes. And I'd say it can take even more for a baby to be fully oxygenated. So 90% or more on the pulse oximeter.

So I understand that this is part of the new guidelines. New technology is always going to come into play. I don't feel like it's that helpful at home, to be honest with you. And I had this conversation yesterday, again, with this nurse. This perinatal nurse that taught our class. And it was very insightful because she agreed. She said it didn't make sense to her either to have a pulse oximeter at home. If you're that concerned about a baby, then the baby needs to get medical help, and I completely agree with that. And midwives are using pulse oximeters now at home because of these recommendations. They may be accurate. They may not be. The truth is we don't have that much experience as midwives. We may put a pulse oximeter on—I don't know. 1 in 100 babies. And then if the oxygen saturation isn't what we think it should be—so say we think it should be 60 and the baby is at 40, then what are we going to do? So I think the obvious answer is that baby needs some help especially if that baby is older than a couple minutes.

And I don't think home is the place for that because to increase the oxygen saturation you need oxygen. And that's a whole other podcast. But oxygen is not benign. So to go oxygenating babies based on this little tool that you really don't have that much experience with, I think is pretty darn dangerous. And, again, if a baby is exhibiting respiratory distress, perhaps there is something else going on. So I don't think that part of the NRP program really translates to home births, to be honest with you. I just don't. I don't think those things belong at a home birth. Because if we're paying attention, there are signs that this baby is exhibiting that it needs help. We're not waiting for some piece of machinery to tell us that.

Hmm. Let's see. Oh, I guess just a couple things that—a couple other criteria where we would want to call for help. And last time I'll say it but super, super, super, super rare but because people ask and it is good to know. I think I already said no response from the baby despite the stimulation and positive pressure ventilation even with our own mouths or the bag and mask. A heart rate below 60 according to NRP is meaning you need chest compressions for this baby. So 9-1-1 for sure. Super thick meconium with an unresponsive baby. So this isn't the baby I referred to earlier that's born

through meconium stained waters and is vigorous and pink and screaming. This is a baby that's unresponsive and had thick meconium. This baby probably needs some pretty serious help. Deep suctioning, to say the least, which we can't really do at home even when we have basic tools. And then, of course, intubation, which no midwife would ever attempt to do at home which is essentially getting medications like epinephrine into a really unresponsive baby.

So these are truly the situations where you want medical help. You want their expertise. You want their experts at the NRP program. You want that. Again, just so nice that it's really, really rare. So hoping that helped today just talking through basics about new born transition, what that looks like, what to look for, how to kind of channel your inner patience along with your knowledge and skill so that these babies can come earth side as gently as possible.

Thanks so much for listening. Have a great day.

(closing music)