

Chapter 20

Childbirth

By Judy Luce and Jane Pincus, with
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WITH SPECIAL THANKS TO Carol Sakala*

We bring to childbirth our histories, our relationships, our rituals, our needs and values that relate to intimacy, our sexuality, the quality and style of family life and community, and our deepest beliefs about life, birth, and death.¹

CLIMATE OF CONFIDENCE

When we are taught to listen to our bodies and trust in our abilities to give birth; when we are attended by practitioners who affirm the naturalness of birth and both teach and guide us through the birthing process; when the people who surround us provide love and affirmation, we are in a *climate of confidence* that

allows us to have a voice in and to shape our unique birthing experiences.

We begin this chapter with the stories of women who have given birth—at home, in birth centers, and in hospitals—with the support they need to have confidence in their own birthing powers.

I had a long, drawn-out labor. Each person there got a chance to rest. They switched on and off being with me. I could do what I wanted. I was standing most of the time and walking around. I was so pleased not to be in bed. They encouraged me to eat; I did drink some tea. Finally they convinced me to lie down and I got a little sleep.

Labor was painful. Pain isn't an adequate word. I was bowled over by the intensity of the physical experience. I remember thinking as labor got heavy, women are fantastic, they get pregnant over and over again and are strong enough; people go through this all the time. Nobody could have prepared me for it in words.

I could imagine myself understanding how I'd take drugs if someone urged them on me in a hospital.

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But here, because everyone was saying, "Everything is fine," it was easy to keep going.

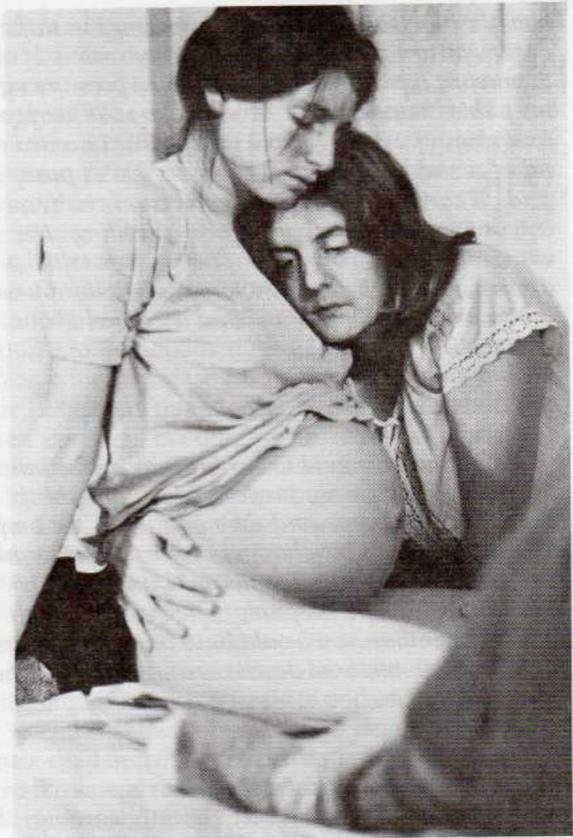
Laura called Peter [the doctor]. He came over, sat in a corner reading a magazine, saying, "This could take up to two hours. Don't worry. You have plenty of time."

Then came the best time of all. Pushing wasn't at all painful. Mary was holding the mirror; each time I pushed I could see the effects. Laura: "Try breathing—blow out from really deep inside you. Let your cheeks puff out." It worked. I started squatting, then sitting up with Lewis behind me. My final delivery position was on my side, one leg up on Laura's shoulder. With every single push I could see Emma coming out, bigger and bigger. After every push Laura would massage my perineum. The little—no, the big—head came out. She was cooing. It was the sweetest thing I ever heard. Laura said to Lewis and me, "Reach down and pull out your baby." It was a big surprise to us! We did! We pulled her out! I brought her to my breast. We were enthralled. The afterbirth came out with no problem. Laura showed it to us.

The whole experience changed my life. It taught me how deeply physical life is, and connected me much more with my body. I'd learned a refined kind of Catholicism where nothing was earthy, nothing was said aloud. But there's nothing subtle about being pregnant and having a baby!

A new lesbian mother tells this story about labor at home and then in the hospital.

I had been waiting for Yancey for a long time at a restaurant. Finally she arrived. Her shirt was on backward. She said: "My waters broke! I'm in labor!" We dashed home and called Elaine, our labor support, a nurse-midwife (for her) and Melanie, a good friend who is also a midwife, a lesbian with three children (for both of us). They said, "Relax, eat, drink." The house became calm. Yancey called from her room, "Come! My back is killing me!" Then she said "Leave!" An hour later, through the door, "This is getting hard. Call Melanie." She wanted to be in the bathroom so we set up a little nest there. Melanie stayed with her for five hours; I tossed and turned in bed. Then I heard, "Get up! We have to go right now! She wants to push!" I had the presence of mind to hang a diaper out the window, our prearranged sign to our neighbors that we'd need their car. I drove faster and faster, with Yancey on all fours on the backseat. In the hospital Yancey knew what she wanted. She'd say, "Touch me here" or "Stay awhile." Finally we encouraged Yancey to push. She said, "I'm afraid I'll hurt myself," and then, "OK, let's do it." She pushed hard, popped the baby's head out, looked at his face, said, "It's a boy," and reached down to pull him out herself. I was weeping, she was laughing, she was feeling so exultant. I cut the cord, intensely moved. Then Yancey had to get stitched up because she had torn a bit. I spent a sweet hour with our beautiful son.



Suzanne Arms

Another woman and her husband created their own climate of confidence when they had their second baby in a large, busy city hospital where they were more or less left to themselves.

Labor really began at 12:30 A.M., on Monday. At 2 A.M. we went to the hospital. At 2 P.M. the next day I was working harder but still 4 centimeters dilated. The obstetrician wanted to give me morphine, saying, "This has gone on too long for a second labor. I'll put you to sleep for five hours and you'll wake up in active labor." Jack and I looked at each other and said, "This guy's really hot to trot." But we knew that when the baby's ready to be born, it would be born. We said we'd decide at 3 P.M. At 3 P.M. I was 5 centimeters dilated. Nurses were changing shifts. Though they were wonderful, there were never many of them around. I was sitting up. Jack and I used a lot of imagery. He helped me to breathe into the pain. We imagined wind and waves. I made sure the sensation would go down and through my cervix, and pictured my cervix opening, pictured myself being born. That helped a lot. Looking at Jack was best, or burying my face in his neck, or closing my eyes and going inside. If he hadn't been there, forget it. We were so concentrated on what we were doing. We knew it was our experience. He knew exactly what to do. He never left me.

At 3:30 they said they were thinking of breaking my

bag of waters, but because of the change in shifts, they never got around to do it. Then my waters broke by themselves and labor got harder. I felt pressure against my pubic bone, which was relieved by counterpressure and singing. Singing was exactly what I needed to do. All of a sudden I needed to push. "Don't push," they said. "I can't not," I said. I delivered my baby quickly. It was intense. I did my share of yelling. Her head came through while the doctor was still getting dressed, so I had no episiotomy. My baby nursed in the recovery room, just as I had dreamed about it last summer.

A midwife states:

All efforts are made to see birth as a continuum. I tell women who have prepared for home birth, who begin labor at home and then end up at the hospital, "Who you are never changes. Your planning, ideals, values, beliefs, principles never change just because you end up in the hospital, or with a cesarean. You are stronger than you would have been because you've gone through all those decisions and made the choices you did."

These women show us that giving birth can be richer than we ever imagined. They speak of excitement, doubt, determination, effort, learning about themselves; of momentary lapses and pulling themselves together; of hard work and giving in; of contentment, amazement, ecstasy, and exaltation. They listen to their bodies and remain open to their attendants' encouragement to relax and renew themselves. Their experiences make it vividly clear what birth can be and contrast sharply with the purely medical view of birth that focuses primarily on fear: fear of pain, fear that something will go wrong, fear that our bodies don't work.

CLIMATE OF DOUBT

The *climate of doubt*, with its overwhelming focus on worry and fear, has been in the making ever since obstetrics began in the U.S.

Brief History

*More drugs and technologies are now used in "normal" births in America than anywhere else in the world. This reflects in part the desire to master, conquer, and control nature that was present among the colonists from the beginning.*²

*The present system was born in and shaped by the competition between male and female healers.*³

In colonial America and the preindustrial U.S., midwives and community women attended child-bearing women, usually with excellent results. Sometimes, in extremely complicated situations, they called upon barber-surgeons, called "man-midwives." These men

used forceps and hooks, as few women did. Small wonder that the men regarded birth as deadly and dangerous, for they lacked the midwives' experience of hundreds of routine births that required no assistance.⁴ Obstetrics became the first surgical specialty to be taught and practiced by male doctors in U.S. medical schools in the 18th century.

In the 1830s and 1840s, a strong grassroots popular health movement campaigned against a growing medical elitism, and many kinds of healing sects flourished. The medical "regulars"—upper-class and middle-class men—had nothing more to offer than lay practitioners; "they still couldn't claim to have any uniquely effective methods or special body of knowledge."⁵ Nevertheless, they won out through political influence, and went on to found the American Medical Association in 1848.

About the same time, the profession of gynecology began to thrive. Some doctors performed cruel experimental surgery on many women, especially enslaved black women and poor women, in the name of science⁶ (an experimentation that continues, in a milder form, in gynecology and obstetrics to this day).⁷ Out of these devastating efforts grew "cures" for gynecological conditions, many of which were actually created by barbarous childbirth practices, although this connection was not recognized at the time. These procedures increased gynecologists' powers enormously, since the promise of cures and even of prevention lay with them.

The second half of the 19th century saw gynecologists and obstetricians gain even more control over women. This control represented political and economic triumph rather than scientific necessity. Admiring education and science, middle-class and upper-class women were able to afford doctors' fees. They continued to change their allegiance from midwives to "scientifically" trained doctors, who, as men of their own class, advised them in personal matters and judged their moral conduct—a role that continues today. Many upper-class and middle-class women wore tight corsets and were physically inactive. Some stayed in bed all day. Meanwhile, working-class women worked long hours in factories, fields, and upper-class households, attended by local midwives. Physicians looked upon these midwives as both economic threats and threats to the masculine medical order they were establishing. They waged a virulent campaign against them, stereotyping them as ignorant, dirty, and irresponsible. They deliberately lied about midwifery outcomes to convince legislators that states should outlaw them, when in fact midwives' safety records were often superior to those of physicians.⁸ In addition, obstetricians campaigned to reverse the belief that birth was a healthy, natural process: "They set out to make mothers 'fear' the dangers of pregnancy and childbirth and think of 'no precaution as excessive,'"⁹ all the while telling women of their right to be cared for by the only qualified providers: the obstetricians themselves. Doctors also deliberately excluded women from medical training,¹⁰ fearing that

if women were admitted to the profession, women patients would prefer physicians of their own sex, especially for childbirth.¹¹

As medical boards and state legislators systematically suppressed midwifery, women had to move out of their homes into hospitals to give birth, which did not prove to be safer or better for them and their babies.¹² In 1900, 5% of babies in the U.S. were born in hospitals; by 1935, 75%;¹³ and presently 98 to 99% are born in hospitals or birth centers. With the myth of safety grew other myths tied to obstetrical practices and technology (that only doctors can deliver babies; that labor is a process that needs to be "managed") that had no scientific basis. By giving birth in hospitals, women took the last step toward total dependence on the man-made, male-dominated obstetrical system. To this day, we struggle to change this de facto monopoly.

Institutions Contribute to the Climate of Doubt

Women experience the influence of the hospital setting long before labor begins. With the increasing routine use of pregnancy screening procedures, we are visiting hospitals earlier and earlier. When we enter these places for sick people, it is difficult not to view pregnancy, birth, and our bodies as unhealthy. From the very first ultrasound, hospital procedures bypass our maternal bodies, as family, technicians, and practitioners focus beyond ourselves on the blurry image of a fetus on a screen several feet away. Already, months before it is really born, the baby growing within seems to be outside our body. A process of continuous monitoring and surveillance has begun.

As we become "patients" and our experience is defined in medical terms, we become part of an impersonal production process. Upon entering the hospital in labor, we are often placed in wheelchairs. Our personal effects are removed. We are among strangers. We become anonymous. We are immobilized, hooked up to fetal monitors and IVs. Each "stage" of labor is allotted a certain amount of time, and no more.

During the 1950s and 1960s, operations research techniques used to expedite the manufacture of various forms of weaponry in WWII were applied to developing more effective obstetrical suites. Priorities were formulated to facilitate the efficient processing of as many women as possible rather than to allow for an adjustable tempo for each individual birth. The factory approach was soon incorporated into textbooks on hospital design: "The conveyor belt concept . . . emphasizes the repeated transference of a mother (as in motor-car assembly) from place to place, and also that unequal time periods at any station can render the process uneconomical."¹⁴

Such hospital routines debilitate us. We become passive, dependent. Until recently, routine enemas and shaving of the pubic area desexualized and in-

fantilized us. Even now, many hospitals do not allow food or liquids during labor, so that we become hungry, weak, our contractions slowed and our health endangered. The sterile hospital atmosphere caused one nurse-midwife to say regretfully, "The most natural aspects of birth—sexuality, blood, sweat, shit, movement, and sounds—have no place here."

Continuity of care, one of medicine's own standards for quality care, does not usually exist. Sometimes we are left completely alone for long periods of time—in no other culture are laboring women left so alone. Isolation and immobility during labor increase tension and fear, which increase pain, which causes more fear, which brings on more pain. In such surroundings, women end up "needing" pain relief, and obstetricians, anesthesiologists, researchers, and drug companies hasten to provide it in abundant variety. Those nurses who want to help us are overburdened with paperwork and have too many women to attend to at once.

At the other extreme, particularly in teaching hospitals, too many strangers—nurses, nursing and medical students, residents, lab technicians, and anesthesiologists—walk freely in and out of our room. The doctor—someone we may never have seen before—may appear briefly from time to time, or just before birth. After the baby is born, we meet a new set of nurses and a pediatrician. In large hospitals, a specialist in newborns (a neonatologist) may appear as well.

Medical Training Reinforces the Climate of Doubt

Nursing and medical students rarely, if ever, see a normal spontaneous labor and birth. To most of them, labor consists of a woman lying on her back, hooked up to a monitor and IV, her bag of waters broken artificially, her cervix ripened with prostaglandin gel, contractions "accelerated" with Pitocin, and her body immobilized by an epidural. The hierarchical nature of medical training, and the status our culture accords physicians, means that most of them never learn how to deal with a fully conscious, unanesthetized woman in labor. They don't sit through labor from beginning to end as midwives do, to find out how and what a woman feels, and to become acquainted with the unique rhythm of each labor.

Nor do medical students learn the midwifery skills of massage, physical assistance, and emotional support—those techniques providing comfort and facilitating labor that are so important to laboring women. Instead of "mastering the art of inactivity," most find it undramatic and boring to sit through labor (one obstetrician has a sign over his desk reading, "Birth is 95% boredom and 5% disaster"). Even if they want to, they don't have enough time. Instead, they learn to use technological interventions routinely to speed up labor. In addition, since obstetrics is a surgical specialty, students must meet a quota for procedures performed; in order to obtain experience, they have to

practice on women whether procedures are indicated or not. They learn too that unless they have every available tool and instrument close at hand, they may be sued for malpractice at any moment.

Women trained as caregivers and practitioners within the medical system often adopt these practices and internalize the values inherent in the medical/technocratic approach to birth. Women obstetricians intervene in labor and utilize technology just as their male counterparts do. Even certified nurse-midwives working within large medical centers often use technology.

After such an education, it is no wonder that physicians genuinely believe we cannot and should not give birth without medical interventions.

Physicians' Attitudes Create and Sustain a Climate of Doubt*

Trained in a system where male bodies are the norm, most doctors believe women's bodies and the birth process to be abnormal and dysfunctional. Among the most influential 20th-century obstetricians' writings, we find appalling descriptions of labor and birth—Joseph B. DeLee's, for example, who in 1920 compared labor to a crushing door, and birth to falling on a pitchfork, its handle driven through the perineum.

In both cases, the cause of the damage, the fall on the pitchfork and the crushing of the door, is pathogenic, that is, disease provoking, and anything pathogenic is pathologic and abnormal.¹⁵

The well-known author of *Birth Without Violence*, Dr. Frederick Leboyer, says:

One day, the baby finds itself a prisoner . . . the prison comes to life . . . begins, like some octopus, to bug and crush . . . stifle . . . assault . . . the prison has gone berserk with its heart bursting, the infant sinks into this hell . . . the mother . . . she is driving the baby out. At the same time she is holding it in, preventing its passage. It is she who is the enemy. She who stands between the child and life. Only one of them can prevail. It is mortal combat not satisfied with crushing, the monster . . . twists it in a refinement of cruelty.¹⁶

Women Internalize the Medical Model of Birth†

Childbirth has always involved perfectly natural fears of something going wrong, of the unknown, of pain, and of the risk of death. Birth is as safe as life

* Obstetric myths without scientific basis continue to influence practice in modern obstetrics. See Henci Goer, *Obstetric Myths vs. Research Realities: A Guide to the Medical Literature*, as well as Enkin et al., *A Guide to Effective Care in Pregnancy*.

† Ann Oakley's *Subject Women* (New York: Schocken Books, 1980) has an excellent discussion of women's attitudes about themselves and professionals' attitudes toward them. Diana Scully's *Men Who*

LABOR

Embracing Your Labor: Creating a Nurturing Birth Environment Wherever You Give Birth

For many women, labor is the most powerful experience of their lives and the hardest, most intense work they've ever done. There are many ways you can prepare to meet this challenge.

Surroundings and People

Familiar people help you feel comfortable. Some women give birth at home, where they feel most free to be themselves. Freestanding birth centers are home-like; you can cook, use the living room, spend time with children and friends. In a hospital, you can bring "home" along with you—clothes, personal objects, tapes for music. The reassuring touch of loved ones provides comfort and strength and adds to your confidence. Even if you want to labor alone at times, nearby support is reassuring.

The pain was like a hurricane shaking me apart. I yelled a lot and walked around and took showers. I remember looking at Paul and thinking, What are you so happy about? This is terrible. Yet I know that the grin on his face sustained me. I needed his touch and his joy, and I needed—very differently—the midwife's words and knowledge and reassurance.

Choose people who understand your wishes, who focus on your needs, and who won't be hurt if you are irritable or demanding or if you ask them to leave.

gets, yet we can never be completely certain of the outcome wherever and however we give birth. We are assaulted by assumptions about our inability to give birth without interventions. We are presumed unable and unwilling to handle the pain and intensity of labor. Inevitably, most of us internalize these powerful negative attitudes. Medical practice thrives on our fears. One mother says:

Control Women's Health describes obstetrical residents' attitudes toward the women they see in hospitals. Gayle Peterson, in *Birthing Normally*, details some of the ways in which our beliefs and attitudes can affect pregnancy and labor, and Robbie Davis-Floyd, in *Birth as an American Rite of Passage*, chronicles the deep cultural and historical roots underlying the medical model of birth, physician's attitudes and practices, and the way women adopt them. She describes the belief in technological progress that is central to our society and analyzes the many ways in which hospital birth expresses this ideology.



Ann McQueen/Stock, Boston

It is as if our confidence is a large, bright piece of fabric. When little pinprick holes of fear and doubt appear, the medical mentality makes them larger and larger until the once-beautiful cloth is nothing but gaping holes.

When we do not have experienced, empathetic women by our side during labor, listening, encouraging, providing information, and enhancing our confi-



Suzanne Arms

SIMPLE AND EFFECTIVE WAYS TO HELP WITH THE PAIN AND INTENSITY OF LABOR

Activity

Stay home as long as you can during early labor. If you are still in early labor (less than 5 centimeters dilated) when you go to the birthing facility, walk around or return home instead of being admitted. Move around and change positions. Being upright, as when you are walking or rocking, can help you relax, can alleviate pain, and can make contractions work more effectively. Being on hands and knees also helps, especially with back labor. You can rock back and forth, dance slowly and rhythmically, and move in ways you'd never dream possible.

Nourishment

Drink and eat light foods. If you don't feel like eating you can sip juices, tea with honey, or soup. (Warm beverages tend to relax you and help you open.) This helps strengthen you, prevents dehydration, facilitates labor, and makes you better able to handle contractions. It keeps your baby vigorous. Labor requires great energy, equal to that required for running a marathon or long-distance swimming.

Breathing

You know how to breathe—don't stop! Deep breathing relaxes you, dissipates tension, helps you focus and get inside your labor. Imagine your breath carrying oxygen to every part of your body. Open your mouth and throat. Relax into any tenseness. Smile, laugh, sing, chant.

Some women who have practiced special techniques may become too tense.

I was with a woman doing rigid strong labor breathing she had learned in a childbirth class. She was tight, exhausted. I said, "You don't have to do that." "What will I do?" "Just see what happens." She began to relax. When she let go trying to keep her control, her energy started to flow. Over the next few hours she started doing little sighs which became moans at the end. On the floor, kneeling, she breathed into her husband's lap and rocked her pelvis. He started to breathe and rock with her.

continued on next page



Dana Sib

Endorphins

When you relax, your body produces its own substances for pain relief, called *endorphins*. They actually block pain reception.¹⁷ They help you feel exhilarated during labor, and mellow and peaceful between contractions. Fear, on the other hand, causes you to secrete adrenaline into your bloodstream, which tenses you up, slows your labor, makes it more painful, and inhibits the secretion of endorphins. By relaxing, you enable endorphins to flow again. Endorphins won't make labor painless, but they make it bearable, particularly if you are surrounded by empathetic and supportive attendants.

Expressing Emotions

In labor you may run the gamut of emotions; so much is happening in your body. Birth is a time of transition and transcendence. Some women need to retreat. Others express anger, exaltation, fear, and pain; and some of us need encouragement to do so. Do what feels best for you; it may change from hour to hour.

Rocking, breathing, groaning, mouthing circles of distress, laughing, whistling, pounding, waving, digging, pulling, pushing—labor is the most involuntary work we do. My body gallops

to these rhythms . . . labor is a drama in which the body stars . . .¹⁸

Enjoying Water

Baths and showers are relaxing. Some women stay in the shower for hours. One midwife says, "It's better than Pitocin for getting contractions going!" Deep water lifts your uterus up and away from your spine, which can reduce the intensity of contractions, especially back labor.

Receiving Supportive Assistance

Many women appreciate physical support, touch, and massage. Ask others to help you when you squat, stand, or kneel; to lean against you; to hold you under your arms; to let you hang from their shoulders; to hold you however you want to be held. "Drink in" touch. Companionship and contact can make you feel at ease, sustained, and loved. Or you may not want to be touched at all; this is all right. You may simply want the presence of others. Your support people may know exactly what to do without being asked. Or they may not. If it doesn't feel right, speak up.

I asked my two friends to massage deeply and hard, putting a lot of pressure on my lower back muscles to counter all that force. I liked feeling their hands supporting my belly at the same time.

Imagining

In south India, birth attendants place a flower near the laboring woman; as its petals unfold, her cervix opens, and when the flower is in full bloom, they know it is time to push. Opening is a ceremony, a celebration. Imagine being in a place you love the best, where you are most happy. Open your mind to images. Imagine your baby hugged by your uterus, pushing down, opening you, ready to be born. Imagine your muscles letting go; your cervix stretching, opening, open . . . open . . . OPEN. Imagine you are a flower opening, a light exploding. Think ever-widening circles, ripples formed by raindrops on a pond. A woman, in labor after two previous cesareans, dreamed of a doughnut hole getting larger and larger. When she awoke, her baby was moving through her pelvis and she was pushing.

These ideas and activities can help you cope with the sensations and pain of labor.

A Word to Family and Friends

Be present. Be quiet. Be in tune. Focus your attention on the woman in labor. Be joyful, en-

couraging, positive, uplifting. Be calm. Don't communicate anxiety or fear. Don't focus on time. Leave the room if you feel uncomfortable. Don't expect a laboring woman to be stoic or polite or patient with you. She may not want you to touch her at all or she may not want you to stop, even for a second. If she tells you to go away, don't take it personally. Allow her space to be alone, if that is what she needs. Don't feel sorry for her; show your belief in her strength. If she says, "I can't stand this anymore," encourage her, affirm her, tell her she can. She is doing it. Suggest a walk, a shower, a bath, a change of position. Help her concentrate and keep focused on the present. Hold her, sing, chant, laugh, moan, rock with her. Breathe along with her, if this helps. Provide hot compresses, cool cloths or a hand fan, liquids, and light nourishment. Let her lean against or on you. Help her be free to go deep inside herself and be in touch with her body and follow its rhythms. (Special thanks to Becky Sarah.)

dence; when we put our faith only in people who don't believe in our ability to give birth; when we depend, as they do, on their medical tools and techniques, then we reinforce their belief that we can't do without them.

MAKING A BIRTH CARE PLAN

You can envision your labor and birth, imagine it, prepare for it—but you can't plan it, nor plan when it will happen. However, you can plan the kind of care you want. We encourage you to draw up a birth care plan well before you go into labor, laying out clearly where you plan to give birth, who will attend you, whom you want for labor support, and what kind of care you want. Make informed, reflective choices about interventions, drugs, and anesthesia. Negotiate ahead of time with your hospital or birth center and your practitioner, and visit the birth site to familiarize yourself with the routines and be better able to state your preferences. Plan to have your partner and/or advocate with you at all times during the birth. Such planning will prepare you to deal with any onslaught of institutional routines and medical procedures.

You will want to prepare your children for birth and make plans for their care whether you birth at home or in an institution. Children, even very young children, often do well at birth. For many women it is important that their children be part of the experience, or at least be present for the actual birth.

Laboring in water and giving birth in water are possible at home and in some hospital settings. You may want to research this and make certain your caregiver is comfortable with this choice and that the institution you choose is equipped with birth tubs.