Choices about episiotomy:
A decision aid for women having a vaginal birth
This decision aid has been written to support women who are planning a vaginal birth to know what to expect and to have a say in making decisions about episiotomy (when a care provider uses scissors to make a cut to increase the size of the opening of the vagina).

This decision aid provides information about two options:
1. Choosing not to have an episiotomy
2. Choosing to have an episiotomy

This decision aid will answer the following questions:
- What happens during vaginal birth?
- What can affect my chance of having a tear during vaginal birth?
- What is an episiotomy?
- What are my options?
- What happens if I choose not to have an episiotomy?
- What happens if I choose to have an episiotomy?
- Will I always be able to choose?
- How might I choose between not having and having an episiotomy?
- What are the differences between selective use of episiotomy and routine use of episiotomy?
- How can I make the decision that is best for me?
- How can I ask questions to get more information?

If you have any concerns about yourself or your baby/babies and want to talk to someone, please call:
- your family doctor
- 13 HEALTH telephone line (13 432 584)
- Lifeline counselling service (131 114)
- Stillbirth and Neonatal Death Support (SANDS) helpline (1800 228 655)
- Pregnancy, Birth & Baby Helpline (1800 882 436)

The research and development of this decision aid was conducted by Rachel Thompson, a health psychology researcher at the Queensland Centre for Mothers & Babies. The Centre is an independent research centre based at The University of Queensland and funded by the Queensland Government. The Centre does not stand to gain or lose anything by the choices you make after reading this decision aid. This decision aid has been developed to be consistent with International Patient Decision Aid Standards criteria for quality decision aids wherever possible.

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What do the symbols mean?

The information in this decision aid has come from the best scientific studies available to us. Numbers in brackets [1] indicate a reference to a study that is listed at the back of the decision aid.

We use this symbol 🍎 when there is something you might like to ask your care provider about.
During a vaginal birth, the baby usually moves head first down from the uterus (womb), through the cervix (the opening between the uterus and vagina) and out of the vagina. Before coming out of the vagina, the baby’s head pushes on the woman’s perineum, which makes the perineum bulge and stretch. The perineum is the area between the vagina and the anus (the opening to the back passage).

Sometimes during a vaginal birth, the pressure of the baby’s head can cause a woman to have a tear in the skin or muscles around her vagina, in her labia (the flaps of skin around her vagina), or in her perineum. If a tear happens, it usually happens around the time that the baby’s head passes through the opening to the vagina.

There are different types of tears, with some tears more serious than others. More serious tears are usually stitched up after birth. Less serious tears often heal by themselves without stitches. The most common types of tears are described below.

- **Graze** — A graze is a scratch to the surface level of the skin. Very few women who have a graze have stitches to repair the graze [1].

- **1st degree tear** — A 1st degree tear is a tear involving skin only. About half the women who have a 1st degree tear have stitches to repair the tear [1].

- **2nd degree tear** — A 2nd degree tear is a tear involving both skin and muscles, but not involving the anus. Most women who have a 2nd degree tear have stitches to repair the tear [1].

- **3rd or 4th degree tear** — A 3rd or 4th degree tear is a tear that involves the skin, muscles and anus. All women who have a 3rd or 4th degree tear have stitches to repair the tear [1]. A 3rd or 4th degree tear is also called a severe tear.

Different care providers have different opinions about when it is useful to stitch up a tear and when a tear is better left to heal by itself. You might like to ask your care provider about when he or she usually offers to do stitches after a perineal tear and why. 📦
Some things can increase your chance of having a tear.

For example, a tear can be more likely if your baby’s head is in an unusual position, such as an occipito-posterior position (or OP position) during birth [2]. An occipito-posterior position is when the baby is in a head down position, but is facing the front of the woman, rather than facing the back.

The chance of tearing can also be higher for women having their first birth than for women who have had a baby before [3].

There are also some things that can reduce a woman’s chance of having a tear.

For example, doing perineal massage in pregnancy can reduce the chance of having stitches in the vagina or perineum after birth for women having their first vaginal birth [3]. Perineal massage is when you use your fingers or thumbs, inserted into your vagina, to massage and stretch your perineum. Perineal massage can also reduce the chance of having an episiotomy for women having their first vaginal birth [3]. More information about episiotomy is provided below.

You might like to ask your care provider more about perineal massage (eg how and when to do it) and other things that can reduce or increase your chance of having a tear during vaginal birth.
What is an episiotomy?

Sometimes during a vaginal birth, a care provider might offer to do an episiotomy. An episiotomy is when a care provider uses scissors to make a cut in the woman’s perineum to increase the size of the opening of the vagina. The cut is usually between 2cm and 4cm long. An episiotomy is about the same in size as having a 2nd degree tear.

There are different reasons that a care provider might offer to do an episiotomy. Some common reasons for offering to do an episiotomy are explained below.

To try to prevent a severe tear

Your care provider might offer to do an episiotomy if he or she thinks you might have a severe tear (a 3rd or 4th degree tear). It used to be thought that episiotomies prevented severe tears. Studies now show that severe tears are more common when episiotomies are done routinely (all the time) than when episiotomies are done selectively (only in certain circumstances). More information about this is provided later in this decision aid.

Because you have had a severe tear in a previous birth

Your care provider might offer to do an episiotomy if you have had a severe tear in a previous birth. Women who have had a severe tear in a previous birth have the same chance of having a severe tear as women having their first baby.

To help the baby to be born quickly

Your care provider might offer to do an episiotomy if your baby’s head is on your perineum and your care provider thinks he or she is becoming distressed and needs to be born quickly. Increasing the size of the opening of the vagina means there is more room for the baby’s head and that the baby can be born more quickly.

To allow forceps or a vacuum cap to be used

Your care provider might offer to do an episiotomy if forceps (metal tongs) or a vacuum cap (suction cap) are going to be used to help pull your baby out. Increasing the size of the opening of your vagina means there is more room to insert the forceps or vacuum cap. Increasing the size of the opening of your vagina means there is also more room to birth the baby’s head with the forceps or vacuum cap around it. Without an episiotomy, care providers may not be able to use the forceps or vacuum cap effectively to help pull the baby out.

To make more room to rotate or move the baby during birth

Your care provider might offer to do an episiotomy if you choose to have your baby moved or rotated manually (when your care provider uses his or her hands) during birth. Reasons for moving or rotating your baby might include your baby having shoulder dystocia (when the baby’s shoulder gets stuck while travelling down through the vagina). Increasing the size of the opening of the vagina means there is more room for the care provider to move or rotate the baby.

Some care providers do an episiotomy more often than other care providers. Some care providers also do an episiotomy for different reasons than other care providers. You might like to ask your care provider when he or she would usually offer to do an episiotomy and why.
What are my options?

If you are having a vaginal birth, there are two options:

Option 1
Choose not to have an episiotomy

Option 2
Choose to have an episiotomy
If you choose not to have an episiotomy, you will birth your baby without having a cut to enlarge your vagina. If you choose not to have an episiotomy, you may have a tear during your birth.

For every 100 women in Queensland who did not have an episiotomy [1]:

After birth, your care provider will usually do an examination of your vagina, labia and surrounding areas to see whether you had a tear during birth. Before the examination, your care provider should explain what he or she plans to do and why, and ask your permission. You may also be offered gas and air (drugs you breathe through a mask or mouthpiece) to manage pain or discomfort during the examination.

**What if I don’t have a tear?**

If you don’t have a tear, no stitches will need to be done after birth. However, you may still have some soreness or pain around your vagina and perineum after birth.

**Option 1**

What happens if I choose not to have an episiotomy?

If you choose not to have an episiotomy, you will birth your baby without having a cut to enlarge your vagina. If you choose not to have an episiotomy, you may have a tear during your birth.

For every 100 women in Queensland who did not have an episiotomy [1]:

- No tear (39)
- Graze or 1st degree tear (33)
- 2nd degree tear (26)
- 3rd or 4th degree tear (2)

**What if I have a tear?**

If you have a tear, a more detailed examination may be done. This may include a rectal examination. A rectal examination is when a care provider does an internal examination of your back passage with his or her finger. Again, before the detailed examination, your care provider should explain what he or she plans to do and why and ask your permission.

Your care provider will sometimes offer to do stitches to repair the tear. If you like, you can use a mirror to look at the tear yourself before you choose whether to have stitches or not. Usually, stitches can be done straight away or later (eg after you have had some time with your baby). You might like to ask your care provider when he or she usually does stitches to repair a tear.

If you choose to have stitches, the stitches usually dissolve by themselves within about 6 weeks and do not need to be removed. Your care provider will usually give you local anaesthetic before doing the stitches. A local anaesthetic is a drug given in a needle that makes a specific part of the body numb. If you have had a more serious tear, you may be asked to be taken to theatre (the operating room), where repairs might be done after giving you a local anaesthetic or a general anaesthetic (when you are put to sleep).

If you have a tear, you might have soreness or pain around your vagina and perineum after birth. You might like to ask your care provider about your options for pain relief after birth. Your care provider will also give you information about things like eating and drinking, going to the toilet, hygiene and pelvic floor exercises (exercises you can do to strengthen the muscles in and around your vagina).
If you choose to have an episiotomy, the episiotomy can be done by either a midwife or a doctor in the room where you are birthing your baby. Your care provider will usually give you a local anaesthetic before doing the episiotomy. The episiotomy is usually done during the last part of the second stage of labour. The last part of the second stage of labour is when you push your baby down and out through your vagina.

There are two main ways an episiotomy can be done. The first way is called a midline episiotomy. A midline episiotomy is when the episiotomy is cut in a straight line from the vagina towards the anus. The second way is called a mediolateral episiotomy. A mediolateral episiotomy is when the episiotomy is cut on an angle away from the anus, towards the left or right hand side. Studies are not clear about whether there is any difference between midline episiotomy and mediolateral episiotomy in terms of the outcomes for women or for babies. You might like to ask your care provider whether he or she usually does a midline episiotomy or a mediolateral episiotomy.

Some women who have an episiotomy also have a tear. This tear can happen before the episiotomy is done. The tear can also happen after the episiotomy is done, when the cut that has been made tears further.

For every 100 women in Queensland who have an episiotomy:

- Do not have a tear (86)
- Have a tear as well (14)

Your care provider will usually do a detailed examination of your vagina, labia and surrounding areas after your birth to check on your episiotomy and to see whether you also had a tear during birth. This may also include a rectal examination. Before the examination, your care provider should explain what he or she plans to do and why, and ask your permission. You may also be offered gas and air to manage pain or discomfort during the examination.

After an examination, your care provider will usually offer to do stitches to repair the episiotomy and any additional tearing. If you like, you can use a mirror to look at the episiotomy yourself before you choose whether or not to have stitches. Usually, stitches can be done straight away or later (eg after you have had some time with your baby). You might like to ask your care provider when he or she usually does stitches to repair an episiotomy and any additional tearing.

If you choose to have stitches, the stitches usually dissolve by themselves within about 6 weeks and do not need to be removed. Your care provider will usually give you some more local anaesthetic before doing the stitches. If you have had a serious tear as well as an episiotomy, you may be asked to be taken to theatre where repairs might be done after giving you a local anaesthetic or a general anaesthetic.

If you have an episiotomy, you might have soreness or pain around your vagina and perineum after birth. You might like to ask your care provider about your options for pain relief after birth. Your care provider will also give you information about things like eating and drinking, going to the toilet, hygiene and pelvic floor exercises.
A number of studies have looked at what happens when episiotomies are done selectively (only in certain circumstances) compared to when episiotomies are done routinely (all the time). We have included some of the results of these studies in the next few pages. Only high quality studies have been included in this decision aid.

Studies can’t say for sure what would happen if you choose one option over another. However, the results of studies might give you an idea of the possible outcomes of each option. The studies we use in this decision aid give you the best possible estimates of how likely different things are to happen.

In some situations, your care provider might suggest that you have an episiotomy. If this happens, you can ask your care provider about the reasons for their suggestion and make decisions as a team. You can choose to follow their suggestion or you can choose to say no.

You may not always be able to choose to have an episiotomy. Usually episiotomy is only offered to a woman in labour when it is believed that not having an episiotomy might cause problems for a woman and/or her baby. You might like to ask your care provider for more information about when an episiotomy might be offered.

Some care providers choose not to offer, or are not comfortable offering, all options to women. If you are not offered all options, or the option you prefer, you can ask to have another care provider.

Will the results of these studies apply to me?

The studies we’ve included are mostly studies of women who were described as low risk (women who were not thought to have any complications with their pregnancy or labour). However, every woman’s pregnancy is different, so the possible consequences of each option might be different for you. Your care provider can give you extra information that is suited to your unique pregnancy.

In the next few pages we talk a lot about the chance of different things happening. If you would like help understanding what this means, please visit www.havingababy.org.au/chance
What are the differences between selective use of episiotomy and routine use of episiotomy?

Studies have found there is a difference between selective use of episiotomy and routine use of episiotomy in:

**Selective use of episiotomy (only in certain circumstances)**

The chance of having **posterior perineal trauma** (damage from a tear or cut to the back of the vagina, the perineum or the anus) [5]

- Women who had posterior perineal trauma
- Women who did not have posterior perineal trauma

- 72 out of every 100 women had posterior perineal trauma
- 82 out of every 100 women had posterior perineal trauma

The chance of having **anterior trauma** (damage from a tear or cut to the labia, the front of the vagina, the urethra or the clitoris) [5]

- Women who had anterior trauma
- Women who did not have anterior trauma

- 21 out of every 100 women had anterior trauma
- 11 out of every 100 women had anterior trauma

The chance of having **severe perineal trauma** (a 3rd and/or 4th degree tear) [5]

- Women who had severe perineal trauma
- Women who did not have severe perineal trauma

- 3 out of every 100 women had severe perineal trauma
- 4 out of every 100 women had severe perineal trauma

**Routine use of episiotomy (all the time)**

The chance of having anterior trauma

- Women who had anterior trauma
- Women who did not have anterior trauma

- 21 out of every 100 women had anterior trauma
- 11 out of every 100 women had anterior trauma

The chance of having severe perineal trauma

- Women who had severe perineal trauma
- Women who did not have severe perineal trauma

- 3 out of every 100 women had severe perineal trauma
- 4 out of every 100 women had severe perineal trauma
What are the differences between selective use of episiotomy and routine use of episiotomy?

Studies have found there is a difference between selective use of episiotomy and routine use of episiotomy in:

<table>
<thead>
<tr>
<th>Difference</th>
<th>Selective use of episiotomy (only in certain circumstances)</th>
<th>Routine use of episiotomy (all the time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The chance of having healing complications (when a tear or cut does not heal as well as expected 7 days after birth)</td>
<td>21 out of every 100 women had healing complications</td>
<td>30 out of every 100 women had healing complications</td>
</tr>
<tr>
<td>Women who had healing complications</td>
<td>Women who did not have healing complications</td>
<td></td>
</tr>
<tr>
<td>The chance of having perineal wound dehiscence (when a tear or cut has opened back up 7 days after birth)</td>
<td>4 out of every 100 women had wound dehiscence</td>
<td>9 out of every 100 women had wound dehiscence</td>
</tr>
<tr>
<td>Women who had wound dehiscence</td>
<td>Women who did not have wound dehiscence</td>
<td></td>
</tr>
<tr>
<td>The chance of still having perineal pain when leaving one’s place of birth</td>
<td>31 out of every 100 women had perineal pain when leaving one’s place of birth</td>
<td>42 out of every 100 women had perineal pain when leaving one’s place of birth</td>
</tr>
<tr>
<td>Women who had perineal pain at discharge</td>
<td>Women who did not have perineal pain at discharge</td>
<td></td>
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</tbody>
</table>

Studies have found there is a difference between selective use of episiotomy and routine use of episiotomy in:

- The chance of having healing complications (when a tear or cut does not heal as well as expected 7 days after birth)
- The chance of having perineal wound dehiscence (when a tear or cut has opened back up 7 days after birth)
- The chance of still having perineal pain when leaving one’s place of birth

Women who had healing complications: 21 out of every 100 women
Women who did not have healing complications: 42 out of every 100 women

Women who had perineal wound dehiscence: 4 out of every 100 women
Women who did not have perineal wound dehiscence: 21 out of every 100 women

Women who had perineal pain at discharge: 31 out of every 100 women
Women who did not have perineal pain at discharge: 62 out of every 100 women
What are the differences between selective use episiotomy and routine use of episiotomy?

Studies have found there is a difference between selective use of episiotomy and routine use of episiotomy in:

**Selective use of episiotomy** (only in certain circumstances)

- **The chance of having stitches after birth** (3 out of 100 women had stitches)
  - Women who had stitches
  - Women who did not have stitches

- **The amount of blood a woman loses during birth**
  - On average, women lost 214ml of blood during birth

**Routine use of episiotomy** (all the time)

- **The chance of having stitches after birth** (6 out of 100 women had stitches)
  - Women who had stitches
  - Women who did not have stitches

- **The amount of blood a woman loses during birth**
  - On average, women lost 272ml of blood during birth

Studies have found no difference between selective use of episiotomy and routine use of episiotomy in:

- **The chance of having a perineal infection**
- **The chance of having a perineal haematoma** (a collection of blood, like a bruise, in the area between the vagina and the anus) at discharge
- **The chance of having moderate or severe perineal pain up to 3 months after birth**
- **The chance of having sex, or trying to, during the first three months after birth**
- **The chance of having dyspareunia** (pain during sex) during the first three months after birth
- **The chance of having urinary incontinence** (losing control of your bladder) within 3 to 7 months
- **The chance of the baby having a low APGAR score** (being slow to breathe and respond) one minute after birth
- **The chance of the baby going into the special care baby unit** (unit in the hospital for babies who need special medical care)
How can I make the decision that’s best for me?

At the Queensland Centre for Mothers & Babies, we understand that the right decision for you may not be the right decision for others.

When making decisions about their maternity care, some women prefer to get the information and make decisions by themselves or with their families. Other women like to make decisions as a team with their care providers and some women like their care providers to make decisions for them. This decision is yours to make. You might change your mind about previous decisions if you get more information, if your circumstances change or your preferences change. For all decisions before, during and after your birth, you are entitled to know your different options, know what happens if you choose different options and choose the option that is best for you.

Following these steps might help you to make the decisions that are best for you:

Think about the reasons for choosing each option

When making a decision about which option is best for you, it can be helpful to think about the reasons that you personally might choose each option. We have included a table in this decision aid where you can write down both the reasons you might choose not to have an episiotomy and/or the reasons you might choose to have an episiotomy. You might have come up with your own ideas or have found information somewhere else.

Think about which reasons matter to you the most

Some reasons might matter more to you than others and you might want to give these reasons extra thought when making a decision. There is room in this decision aid for you to mark how much each reason matters to you in a box. Doing this can also help you talk to other people about what matters to you. You might like to use a simple star rating like this to mark how important each reason is:

★ | Matters to me a little ★★ | Matters to me quite a bit ★★★ | Matters to me a lot

Think about whether you’re leaning towards one option or the other

Once you’ve thought about the reasons for choosing each option and how much each reason matters to you, you might feel that one option is better for you. Or, you might still be unsure and want to think about it some more or ask questions. There is a place to mark what you feel about your options within this decision aid. You can also show this table to your care provider to help you make decisions as a team.
How can I make the decision that’s best for me?

Reasons I might choose to not have an episiotomy...

Reasons I might choose to have an episiotomy...

At the moment, I am leaning towards...

Not having an episiotomy

I’m unsure

Having an episiotomy
How can I ask questions to get more information?

Asking your care provider questions can help you get the information you want and need. Below are some questions you might want to ask your care provider to get more information during your pregnancy.

<table>
<thead>
<tr>
<th>Question</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>When would you normally offer a woman an episiotomy?</td>
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<tr>
<td>How often do you do an episiotomy?</td>
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<tr>
<td>Are there guidelines at my planned place of birth about episiotomy?</td>
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<tr>
<td>Would you do an episiotomy if I asked for one?</td>
<td></td>
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<tr>
<td>How would you feel if I refused an episiotomy if it was offered to me?</td>
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</tr>
<tr>
<td>Are there things I can do during my pregnancy to reduce my chance of having a perineal tear?</td>
<td></td>
</tr>
<tr>
<td>Are there things I can do during my pregnancy to reduce my chance of having an episiotomy?</td>
<td></td>
</tr>
<tr>
<td>Are there things I can do during my labour to reduce my chance of having a perineal tear?</td>
<td></td>
</tr>
<tr>
<td>Are there things I can do during my labour to reduce my chance of having an episiotomy?</td>
<td></td>
</tr>
<tr>
<td>Under what circumstances do you usually offer a woman stitches to repair an episiotomy or tear?</td>
<td></td>
</tr>
<tr>
<td>How long after birth do you usually do stitches to repair an episiotomy or tear?</td>
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</tbody>
</table>

Below are some questions you might ask your care provider to get more information if you are offered an episiotomy.

<table>
<thead>
<tr>
<th>Question</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long do I have to think about this decision?</td>
<td></td>
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<tr>
<td>What are the possible outcomes in my unique pregnancy if I do not have an episiotomy?</td>
<td></td>
</tr>
<tr>
<td>What are the possible outcomes in my unique pregnancy if I have an episiotomy?</td>
<td></td>
</tr>
<tr>
<td>Are there any alternatives?</td>
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</tbody>
</table>
Where did this information come from?

The information in this decision aid has come from the best scientific studies available to us. A list of these studies is included below:


In time, the technical report for the development of this decision aid will be available online. Technical reports are a record of the decisions the researchers made when considering which studies to include and exclude in each of the decision aids.
Acknowledgements

The Queensland Centre for Mothers & Babies would also like to acknowledge the families in Queensland for their generosity in contributing many of the beautiful photos contained in this book. We would also like to thank the following organisations and individuals for their contribution to the development of this decision aid, or other decision aids we’ve developed.

Organisations

- Australian College of Midwives (ACM)
- Caboolture Hospital
- Central Maternity & Neonatal Clinical Network
- Ethnic Communities Council of Queensland
- Friends of the Birth Centre Queensland Association Inc
- General Practice Queensland
- Griffith University
- Herston Multimedia Unit
- Mater Mothers’ Hospital
- Maternity Coalition
- Maternity Unit, Primary, Community and Extended Care Branch, Queensland Health
- Midwives Information & Resource Service (MIDIRS), UK
- Midwifery Advisory Committee, Office of the Chief Nursing Officer, Queensland Health
- Midwifery Advisor, Queensland Health
- Northern Queensland Maternity & Neonatal Clinical Network
- Preventative Health, Queensland Health
- Queensland Maternal and Perinatal Quality Council
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- Redland Hospital
- Sexual Health and HIV Service
- Southern Queensland Maternity & Neonatal Clinical Network
- Statewide Maternity & Neonatal Clinical Network
- Stillbirth and Neonatal Death Support (SANDS) Network
- The University of Queensland

Individuals

- Lana Bell
- Dr Wendy Brodribb
- Deirdrie Cullen
- Rachel Ford
- Dr Glenn Gardener
- Professor Geoffrey Mitchell
- Rosalie Potter
- Dr Camille Raynes-Greenow
- Assoc. Professor Allison Shorten
- Hayley Thompson
- Assoc. Professor Lyndal Trevena

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Other decision aids

- Choosing your model of care
- Choices about first semester ultrasound scans
- Choosing how to birth your baby: for women without a previous caesarean section
- Choosing how to birth your baby: for women with a previous caesarean section
- Choosing how you labour will start
- Monitoring your baby during labour
- Choosing your positions during labour and birth
- Choices about epidural
- Birthing your placenta