

How do social discourses of risk impact on women's choices for vaginal breech birth? A qualitative study of women's experiences

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Short title Social discourses of risk impact and women's choices for vaginal breech birth

Abstract

In this article, we aim to explore the impact of social discourses of risk around childbirth on the decisions made for birth by women who planned to have a breech baby late in pregnancy. This article uses data from a qualitative descriptive study in New South Wales, Australia in 2013. In the study we talked to 22 women about their decision making process for planned a vaginal breech birth and the impact of social discourses of risk on this decision. Twelve of these women had a vaginal birth and the other 10 had a caesarean section. In this article we note that the mothers' talked about their option in a social setting in which the dominant discourse focussed on the riskiness of breech birth and the vulnerability of female bodies that required medical surveillance, supervision and intervention to ensure a safe delivery. Thus for these mothers their pregnancy was seen through the societal lens of risk and medicalisation with surgical intervention through a caesarean section, the optimum outcome. Women could resist this dominant discourse but such resistance required both justification and action, for example the women who wanted a vaginal birth often had to resist the pressure for their families to have a Caesarean section. We identified four related strands in women's talk about resisting the dominate discourse: acknowledgment that they would be considered irrational for wanting a vagina birth; having confidence in and believing that their body could give birth vaginally,

convincing significant others that a vaginal birth was possible and desirable and looking for sources of support, for example from new on-line social networks

Keywords: risk, social discourse; risk discourse; childbirth; vaginal breech birth; decision making.

Introduction

In this article, we examine the experiences of women who seek the option of vaginal breech birth over elective caesarean section for the birth of their breech presenting baby. We start our analysis by exploring how society seeks to manage risk in natural process such as childbirth to obtain a predictable outcome and how this manifests itself in approaches to childbirth. In clinical settings, increasingly medicalised practices and technological intervention have restricted opportunities for natural birth. We explore this in the context breech birth, where the dominant medical and social discourses favour the option of caesarean section for breech presentation. In this article we explore women's experiences in seeking a vaginal breech birth and how social discourses of risk for this birth option impact on this process.

Childbirth and discourses of risk

The concept of a risk society has been developed by Beck (1992), who argued that the inevitable dangers of life have been selectively amplified and translated into risks that inform day to day life and decision making (Scamell, 2014). Taylor-Gooby (2000) called this the 'paradox of timid prosperity' (p. 236), where collective anxiety about dangers such as illness and crime appears to be increasing despite reducing incidence of disease and crime (Coxon, Homer, Bisits, Sandall, & Bick, 2016; Taylor-Gooby, 2000). In childbirth the likelihood that a mother or her baby in a high income will be harmed during childbirth has fallen over the past 150 years while awareness of the dangers appear to have risen. Cartwright and Thomas (2001) argued that this reflects a changing response to the dangers of childbirth, while these were seen as essentially

unmanageable before the 20th century, the development of various technologies and groups claiming to be able to identify and deal with the dangers have meant that such dangers have been converted into medically constructed and sanctioned risk managed by experts (Cartwright & Thomas, 2001). In principal all harmful outcomes can and should be prevented.

Childbirth as a risky process

In modern society, the need to 'risk manage' birth stems from society's view of birth as a fateful moment, where the future welfare and potential of the baby are decided (Alaszewski & Coxon, 2008; Coxon, Scamell, & Alaszewski, 2012; Scamell & Alaszewski, 2012). Alaszewski (2016) suggested that the medicalisation of birth stems from the view that the female body is both vulnerable and dangerous, thereby requiring increased surveillance. This is underpinned by medical discourses relating to the need to protect the welfare of the vulnerable foetus and child as a priority over the mother's welfare (Coxon, Homer, Bisits, Sandall, & Bick, 2016). As Alaszewski (2016) noted the foetus is increasingly visible through constant surveillance via medical imaging 'so that it acquires the status of a quasi-person and the pregnant woman acquires responsibility for minimising risk to the foetus.' (p.237).

These developments have fostered an increased reliance on medical technology in the management of childbirth. Skinner (2003) argued that current practices in maternity care are symptomatic of a wider risk society, where the loss of faith in birth as a natural process, coupled with an intense dependency upon expert

knowledge and technology, manifests as professional anxiety and amplifies risk sensitivity (Skinner, 2003). It creates a challenge in clinical setting, where clinicians have become accustomed to continual surveillance of women giving birth and the identification and management of risk as a measure of best practice, thereby obscuring the possibility of normality (Scamell, 2014). It also impacts on clinicians whose original philosophy may have been to minimise interventions in the birth process but whose approach of birth is altered by their organisation's risk governance agenda and the use of risk management technologies and interventions (Scamell & Alaszewski, 2012). The increased medicalisation of birth has therefore created difficulty in ascertaining the need for interventions deemed as necessary as opposed to supporting the normal physiological process of birth to unfold of its own accord (Coxon, Sandall, & Fulop, 2014).

Davis-Floyd (2003) suggested the social discourses of childbirth as a high risk process in need of medical intervention are perpetuated by society, including the medical system, family, friends or the media (Davis-Floyd, 2003). The meanings these groups ascribe to childbirth create a form of ritualised behaviour- a 'patterned, repetitive, and symbolic enactment of a cultural belief or value' (page 8). The ritual of medicalisation of pregnancy and birth, Davis-Floyd argued, serve to provide a sense of stability and predictability in what is perceived to be a risky and stressful event.

These approaches can impact on women's choices for birth (Coxon, Sandall, & Fulop, 2014; Dahlen & Homer, 2011; Davis-Floyd, 2003; Fenwick, Gamble, & Hauck, 2007; Lagan, Sinclair, & Kernohan, 2011; Munro, Kornelsen, & Hutton, 2009; Romano, Gerber, & Andrews, 2010). Social endorsements of childbirth intervention have become prevalent, where moral terms are used to characterise interventions as 'good' and 'necessary', while giving women the choice to challenge this status quo by optimising opportunities for normal birth are often viewed negatively (Coxon et al., 2012).

The societal pressure to view child birth through the lens of risk, without giving consideration to maternal request to minimise intervention and to support the normality in birth, is demonstrated in birth contexts perceived to be at an ever higher level of risk, such as a vaginal birth after caesarean section or vaginal breech birth. (Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Homer et al., 2015; MacKenzie Bryers & van Teijlingen, 2010; Malacrida & Boulton, 2014; Munro et al., 2009). The challenges women may experience in seeking to 'go against the flow' of medical intervention and opt for vaginal breech birth remains relatively unexplored particularly in social contexts that view this birth option as dangerous (Homer et al., 2015) and forms the focus of this article.

The implications of having a breech baby: A risky choice?

Breech presentation in pregnancy occurs when a baby is positioned buttocks or feet first rather than head first. It is estimated that 3-5% of pregnant women are carrying a breech presenting baby at the end of their pregnancy (Guittier et al., 2011). The most recent figures available for births in the largest Australian state (New South Wales) show that approximately 367 (0.4%) breech babies were born vaginally (N.S.WHealth, 2016), with even fewer accounting for planned (rather than unplanned) vaginal breech birth. These figures show how uncommon planned vaginal breech birth is, a trend reflected in many regions in the world (Kotaska et al., 2009).

The small number of babies who are breech born vaginally is largely attributed to an international randomised control trial published in 2000, known as the Term Breech Trial. This trial concluded that caesarean section was the safest mode of birth for babies in the breech position (Hannah et al., 2000){Hannah, 2002 #93}. Many maternity units in high and middle income countries responded to the report by moving towards caesarean sections for all breech presentations (Glezerman, 2012; Kotaska, 2007; Lawson, 2012). Subsequent research and systematic reviews have tended to confirm the results of the Term Breech (Bin, Roberts, Ford, & Nicholl, 2016; Hofmeyr, Hannah, & Lawrie, 2015; Vlemmix et al., 2014). For example one study (Berhan & Haileamlak, 2016) noted that vaginal breech birth carried a two to five fold greater relative risk of short term morbidity and mortality than caesarean section.

Since the publication of the Term Breech Trial there have been criticisms of its design and recommendations (Berhan & Haileamlak, 2016; Borbolla Foster, Bagust, Bisits, Holland, & Welsh, 2014; Glezerman, 2006; Hauth & Cunningham, 2002; Kotaska, 2004; Lawson, 2012). One of the major concerns was that the trial did not explore the outcome for different categories of women. Since the publication of the Term Breech Trial researchers have found that if women with breech presentation are suitably selected and received appropriate care and expertise then they can safely give vaginal birth (Berhan & Haileamlak, 2016; Borbolla Foster et al., 2014; Glezerman, 2012; Goffinet et al., 2006; Kotaska et al., 2009; Lawson, 2012). A recent meta-analysis demonstrates that the absolute risks of vaginal breech birth is lower than previously indicated (Berhan & Haileamlak, 2016). Researchers have found that the long term outcomes of babies born via vaginal breech birth or caesarean section are broadly the same (Hofmeyr et al., 2015). This research recent is beginning to feed into practice guidelines which have started to acknowledge that in selected cases mothers should be offered the option of delivering a breech presentation baby, vaginally (Homer, Watts, Petrovska, Sjostedt, & Bisits, 2015; RANZCOG, 2013; RCOG, 2006).

Despite the existence of research and guidelines that indicate that for selected women vaginal breech birth is a safe option, many maternity services in high income countries are reluctant to offer this option. Part of the problem lies with declining skills, as vaginal breech birth became increasingly uncommon so the number of doctors and midwives who had the skill and confidence to support this birth option declined

and in many high income countries, is non-existent meaning that many women who would have opted for a vaginal delivery had to have a caesarean section (Glezerman, 2012; Kotaska et al., 2009; Lawson, 2012; Robson, Ramsay, & Chandler, 1999). This decline in vaginal breech birth is reflected in the training curriculum, in many high income countries there are no formal education and standards of practice enabling professionals to develop skill and expertise in vaginal breech birth (Walker, Scamell, & Parker, 2016). Until further acceptance of vaginal breech birth is achieved, the current clinical climate limits the birth options available to women with breech presentations, with both clinicians and socio-cultural views seeing vaginal breech birth as risky and outside the obstetric norm (Homer et al., 2015).

Women who are thinking of opting for a planned vaginal breech birth are 'going against the tide' of current practice and professional advice and this can create major challenges for themselves, their family and their care providers (Homer et al., 2015). However there is little evidence on precise nature of these challenges and how those deterred to try a vaginal birth deal with them. Therefore in this article we explore the ways in which these women talked about their choice and decisions and how they addressed the dominant discourses of risk and danger relating to vaginal breech birth, and childbirth in general, may impact upon that process.

Although there are challenges surrounding the choice of vaginal breech birth, some women still make the deliberate choice for this birth option. This choice is made against a backdrop of social discourses of risk surrounding childbirth and the perception that medical interventions, such as caesarean section, are favoured for

perceived better outcomes for the baby. In this article we aim to create a deeper understanding of how women's experiences are impacted upon by these discourses and the ways in which these women seek to overcome the resistance to their desire to have a vaginal breech birth.

Methods: Using qualitative descriptive methods to elicit the experiences of women seek a vaginal breech birth in pregnancy

Design

In this article we draw on data from a qualitative descriptive study (Sandelowski, 2000a) of women in the state of New South Wales (NSW), Australia who wanted to have a vaginal breech birth. We use purposive sampling to identify such women and then we talked to these women about their experiences exploring why they wanted a vaginal birth, the type of resistance they met and how they sought to overcome this resistance (Sandelowski, 2000a). We used an interview schedule to structure our conversation with these women, this enabled us to guide the conversation to the topics we were interested in while enabling the women to talk about these topics in their own way. As such, we considered this method to be the most effective for achieving our desired objective - seeking a deeper understanding of the impacts of social discourse on women seeking to explore the option of vaginal breech birth.

While the experiences of the women interviewed for this study are described and explored, we seek to interpret meanings and actions from their stories in the discussion section of this article (Homer et al., 2015; Sandelowski, 2000b)

Sample

We accessed the sample of women interviewed for this study through a clinician who cares for the women who planned vaginal breech birth at a large metropolitan hospital in NSW, Australia. Women were eligible to be interviewed if they planned a vaginal breech birth for a singleton pregnancy in the previous 7 years regardless of their eventual model of birth, were more than 37 completed weeks gestation (full-term) at the end of their pregnancy, could read and speak English and were available for a face to face interview after the birth. We obtained written consent from the women prior to conducting the interview. In total, 32 women were invited and 22 agreed to participate.

Interviews

We undertook the interviews between March and December 2013 and recorded them using a digital voice recorder. The two members of the research team conducted the interviews travelled to a location convenient to the woman, usually her home. Both interviewers are experienced health care providers and neither worked at the hospital where the women interviewed gave birth. Data were transcribed verbatim using a professional transcription service.

Of the 22 women interviewed, 12 had a vaginal breech birth and 10 had a caesarean section. For three quarters it was their first pregnancy ($n = 16$; 73%), and the women were generally older when they gave birth, between 31-35 years of age. All had given birth to their breech baby between the years 2009- 2012. All women were of European descent and the majority were educated to tertiary level. Many of the

women transferred care late in their pregnancy on finding out their baby was breech as the facility they had originally been receiving antenatal care from was a facility that did not support vaginal breech birth, with some travelling significant distances from their home for their birth option.

The interviews lasted about 60 minutes each and stopped when had asked all trigger questions and the women had no further information to add. We used a series of trigger questions to assist in eliciting responses from the women to address the aims of the study. Examples of the trigger questions are as follows:

- Can you explain how you felt when you were told your baby was in the breech position?
- How did you make the decision to have the birth you felt you wanted? What helped you make this decision? What did not help in the decision making process?
- When you found out you were having a breech birth, did you seek out any information?
- Did you share your choices for the birth of your child with family and or/friends?
- If you did share with others, what was their response?

Prior to commencement of the interviews, we sought approval from the Human Research Ethics Committee-Northern sector, South Eastern Sydney Local Health

District, New South Wales Health. Reference: HREC 12/072 (HREC/ 12/POWH/163) (date of approval: 5 July 2012). All names used in the paper are pseudonyms.

Analysis

We used thematic analysis to analyse the data (Taylor et al., 2006). This is an iterative process where concepts, categories or themes and relationships are constantly refined through multiple readings. The process we undertook to analyse the interview data involved immersion in data, identification of preliminary concepts and developing and refining themes (Liamputtong and Douglas 2005; Taylor, Kermode and Douglas 2006). To improve the credibility of the findings, we implemented investigator triangulation and undertook peer debriefing (Denzin, 2006). We read the transcriptions multiple times and three members of the research team analysed the data. This process involved colour coding of transcripts by hand. We then identified potential themes and reviewed them in relation to the codes and the entire data set. We returned to the transcripts to check the themes against the women's narratives, with consideration being given to counter examples or opposing views to the potential themes to ensure that the full range of the women's experiences were captured. We asked a fourth researcher to look at and comment on the initial findings and themes, which allows for further refinements of the results. Themes generated from the interviews are named using women's exact words. Direct quotes are referenced by pseudonyms to protect participant identity.

Study strengths and limitations

All women were from one area in Australia, were of European descent and the majority (73%) were educated to tertiary level. During their pregnancy they were able to use digital technology to access information and social media, which may not be representative of all women in this age group. The results may be influenced by this and the findings may be different for women from diverse ethno-cultural demographics. None of the women wanted an elective caesarean section which may not reflect the wider population of women with a breech presentation.

Findings

Confidence in the birthing body and challenges to this confidence

In their discussions about their choice to opt for vaginal birth, the women in our study talked about their confidence in their body and their conviction that they could give birth without medical intervention. However the women also noted that this belief was not necessarily shared by others and we will explore in a later section how they dealt with this lack of faith in their bodies.

Confidence in the birthing process The women we talked to mostly told us that they felt a strong urge to 'have a go' at a vaginal breech birth and that if they did not try to have a vaginal birth they would see it as a wasted opportunity. For example Mary noted that caesarean section was always an option if her labour did not progress as expected, but her desire to attempt a vaginal birth was strong and informed by her confidence in her body's ability to birth:

I've never been someone who was busting to have children but now that I was pregnant and having one it was like 'well no damn it I want to do this how I was designed to do it or at least try to'. It was very upsetting [what was? pressure to have a caesarean]....caesarean should be a lifesaving thing or something that you do when there's no other option.

While some women said that negative views from members of their social network tended to undermine their confidence, others said that they were able to distance themselves from such views during their pregnancy. For example Susie felt that her confidence helped her overcome the potential negative effects of the doubts which others expressed:

The negativity [of whom?] did niggle a bit but in the end you have to believe your body is capable of doing what it is created to do. I switched off to it because I was confident with my decision.

Despite their confidence in their own bodies and their ability to give birth vaginally, the women in our study spoke of encountering challenging views from family and friends.

Society's medicalised view of birth Many of the women in this study spoke of having conversations with family and friends in which family and friends accepted the

dominant social discourse that child birth was an dangerous medical event that needed medical intervention to ensure a safe outcome. During her pregnancy, Denise found the tendency for society to medicalise birth troubling:

Our [society's] attitudes around it [birth] need a serious look, we have become so detached from it and we frighten women. We've moved away from birth being natural and births being something that people do every day, to some sort of medical....like it's a sickness you've got to cure yourself of, so it's easier, painless.

Most of the women in our study talked about the ways in which professional who worked in maternity services contribute to the problem and that the general sense of fear around child birth plus the threat of litigation restricted professionals' willingness to support vaginal breech birth as this highlighted there risks. Marlene spoke of feeling angry that perceived risks and clinician fears relating to vaginal breech birth take priority over her right to choose a vaginal birth:

I don't know if this counts as disempowering but it was a huge deal to me. The threat of being disempowered after the birth, in having a caesarean. The threat of being in a recovery room without the baby....because *they* decided that was best or because *they* didn't have enough staff. And because they didn't want to be sued...it was the

threat of that disempowering situation for such a bad reason. That really infuriated me. (emphasis in the original)

When they talked about vaginal birth, most of the women in our study noted that many of those in their intimate social network drew on belief that birth was intrinsically dangerous and the outcome was likely to be poor if there was not appropriate expert input.

The 'horror' of birth In their conversations with us, the women spoke of constantly being told 'horror stories' about vaginal breech births that went wrong and commented that they found this very upsetting. Mary talked about the lack of positive birth stories in general and felt that it was product of the medicalisation of birth:

There's such negativity around birth. You really get the sense that we've moved away from the fact that it's not natural and it's just sort of this horrific thing. You always hear the terrible stories; you never hear the good ones.

While women the women in our study talked about the confidence they had in their bodies, they identified many factors which threatened this confidence including horror stories. Some suggested that positive vaginal breech birth stories could potentially have a role in raising awareness of the option of vaginal breech birth as an

alternative to planned caesarean section as the default management option for breech presentation.

Dealing with imputed irrationality

One of the challenges the women in our study talked about was being seen as irrational by those round them and being referred to as ‘mad’ or ‘selfish’ because they rejected medical advice and wanted to have a vaginal breech birth. They talked about being especially upset when family and friends accused them of being selfish and ‘putting the birth before the baby’.

Accusations of ‘selfishness’ The women in our study talked about being labelled as selfish for considering the option of giving birth to a breech baby vaginally as they said those in their intimate social network did not see this a ‘normal’ or legitimate course of action. Fiona discussed the accusations of selfishness but rejected them arguing that exploring the option of vaginal birth was an act of selflessness not one of selfishness :

I was really looking forward to that whole experience of childbirth and everything else. And all of my friends are like ‘you’re mad to want to do it naturally’. People said I was being selfish, but I was being selfless.

The women in our study talked about the reaction of their friends and family indicating that virtually all those in their intimate network argued that a responsible mother should opt for the (medically) accepted standard of best practice for breech birth, caesarean section. Jade talked about a discussion she had had with her father in the following way:

Dad said I just needed to do what's best for the baby and I was furious, and he meant having a caesarean section. It just made me really angry that I was looking like I was putting the baby at risk for my own satisfaction of a birth experience.

The women in our study tended to talk about their decision in terms of women having the right to self-determination and this included the right to decide how to give birth. They talked about the support which women should receive in exercising this choice and argued that society should support their right to make such choices. Marlene spoke about her feeling of being misunderstood in her wishes to explore the option of vaginal breech birth:

There's an emotional reckoning that I think happens through the passage of [normal] birth and I didn't want to miss out on that part. And the fact that I thought I was going to miss out on that part, I was already grieving it. So the grief—nobody really understood the grief apart from my partner.

In their discussion of family and friends response, many women indicated that there was a clash of values. The women in our study argued that their own mental and physical health was and should be the basis of decision making while they said their family and friends tended to prioritise the safety and wellbeing of the unborn foetus. Rebecca talked about the potential for feelings of disempowerment to have adverse effects on a woman's ability to parent their baby after birth:

This [labour and birth] isn't a small part of your life that you get over, this affects your health individually, it can affect your relationship with your child, it affects your child's health, it affects your psychology deeply and it's really huge and it's really important. I think there's a lot of people—dare I say it, men—who don't get it.

Women in our study talked about the lack of recognition for their ability to take part in decision making for birth and the failure of those who they felt should be supporting their decision making, family, friends as well as professionals, to recognise that they were the best judge of their own well being and that of their unborn foetus.

Dealing with criticism of their competence to make decision Women in our study talked about the ways in which they had to deal with criticism from their intimate social network that was condescending and/or challenged their competence to make

decisions about child birth. Tina recalled the patronizing tone which some people adopted when she sought to gain more information so she could make an informed decision on how to have her breech baby:

I was spoken to by people in a patronising tone whenever I tried to inform or educate myself. Several times people said ‘you’ve been on the internet haven’t you?’, you know, as if to say ‘aren’t you cute!’ and ‘you still don’t know what you are talking about!’

Debbie told us that, she felt that women seeking vaginal breech birth were judged as incapable of autonomous decision making and could be trusted to make a ‘good’ decision :

There’s so much fear operating around birth...[there is a view] that you’re the mother of this child but you’re not capable of making the right decision.... well, why wouldn’t you be capable of making your own decision about *your* body and *your* baby? (emphasis in the original)

Dealing with medical expertise and ‘Doctor knows best’

The women in our talked about the ways in which their interactions with professionals, especially doctors, appeared to be based on the assumption that the doctor has supers expertise and was therefore in a better position to judge the best

interests of the mother and her unborn foetus and therefore could and should veto a bad decision, such as mother trying to have a vaginal breech delivery.

The women expressed concern about the 'Doctor knows best' attitudes they encountered in their discussion of how to deliver their baby. They felt that there had been with no room in these discussions for a discussion of the benefits and risk of caesarean section versus those of vaginal breech birth and herefor no room to discuss the evidence that for many women vaginal birth was as safe as caesarean section. Phillipa agreed that if women went against medical advice and current practice then they were very much on their own:

To try a for a natural breech birth and go against the status quo...that's a really hard thing to do...[the view is] that the medical profession needs to make the decision [of how I give birth.

If things don't go to plan, a trial of vaginal labour fails and the baby is delivered by caesarean section, then, mothers have to deal with the accusation that they were irresponsible and should have followed medical advice. For example Claudia whose trial of labour for vaginal breech birth did not work and who had to have a that caesarean section commented that: 'Afterwards they said 'You should never have done it, the doctor was right all along.'

The women in our study spoke about their need to resist the claims that ‘doctor knows best’ and the pressure to accept standard practice. the caesarean section. It was important that they retained control of decision making, retained a sense of personal option and retained the option of having a vaginal birth.

Trying to convince the unconvinced

The women in our study talked about having numerous discussions with family, friends and others to try convince them that the option of vaginal was a reasonable alternative for them to explore. However they also said they had not been that successful as those they were trying to convince shared the widespread assumptions that a caesarean section was the safest way of giving birth of the foetus was in breech position.

Challenging the belief that a caesarean section is the safest and best option

The women in our study spoke about the ways in which those in their intimate social network viewed a caesarean section as a ‘no-risk’ option, with vaginal breech birth being considered an unsafe alternative. Dana recalled experiencing negative reactions from family members once she told them that her and her partner were thinking about a vaginal breech birth. She said ‘People around me were terrified [when they heard] and they thought I was being some weird hippy mother.’

The women in our study told us that the 'caesarean is best' view as difficult to challenge as those who held it were unwilling to acknowledge that there were any risks associated with a caesarean section. Mary describe her sisters reaction when she told her she was thinking of having a vaginal birth:

My sister was saying 'don't do it, why would you risk it? There's nothing wrong with a caesarean section. She thought it [the option of vaginal breech birth] was absolutely absurd.

The women said they felt frustrated by these views and attributed them to collective failure to understand the benefits of vaginal delivery and of the risks of caesarean sections that had developed because vaginal breech births were so rare.

Trying to address the misconceptions about vaginal breech birth

Again the women in our study told us that they tried to discuss vaginal breech birth with their family and friends but they were not willing to listen. Some of the women told us that those they talked with often responded with 'worst case scenarios', events that could happen but were highly improbable. For example, Julie who had been herself a breech baby born by caesarean section, told us that her mother responded by 'shroud waving', suggesting that an inevitable outcome of vaginal breech birth was the death of the foetus. Julie said that her mother told her that:

Vaginal breech birth is basically impossible because the [baby's] head comes out last and the umbilical cord is compressed and that's a real life threat. [her mother said] 'If it wasn't for caesarean section, you [Julie] might not be here'.

Claire told us about her encounter with her General Medical Practitioner, who told her that: 'Oh, it [vaginal breech birth] will be excruciating [painful] compared to normal birth.'

Some meohr could not resist family pressure. For example Caroline told us that she engaged in long conversations with her family and that they had persuaded her not to have a vaginal delivery. She said that:

On a scale of 1 to 10, the impact on my decision [to have a caesarean section after initially planning a vaginal breech birth] from my family was 10/10 [where 10 is the maximum level of impact].

Seeking information for better understanding Some of the women talked about getting more and better information to deal with what they considered to be the lack of understanding of the real benefits of vaginal birth and the real risks of caesarean sections. However they said that they often found it difficult to get this information. The women talked about how this lack of information tended to reinforce the

perception of vaginal breech birth as an unsafe option that should only be chosen by women who were to 'take risks'. For example, Melinda, who had a university education and had the skill to undertake literature searches, found it difficult to find evidence based information that was specifically targeted to supporting women in their decision making. She noted that 'Apart from the Canadian stuff [evidence] everywhere says don't do it because you will risk injuring the baby.'

Women talked about many of sites they found online as 'scare mongering', filled with negative reports about vaginal breech birth that had poor outcomes for the baby. Jenny spoke of restricting herself from searching the internet after the first few attempts as she found herself becoming increasingly anxious about what she was finding:

I banned myself from reading [the internet] after the first week...the more I read the more anxious and worried I got about what was wrong with the baby and why it didn't turn.

Women talked about wanting to justify their birth choice to birth family and friends who were unconvinced, but found it difficult to do this as they found it difficult to access material that provided clear evidence.

Seeking support from new social networks

Many of the women in this study told us that as they made their decision to have a vaginal delivery, they began to distance themselves from family and friends and instead sought out new contacts, often via the social media, of women who were supportive and had positive experience of vaginal breech deliveries.

Staying mum and keeping secrets Some of the women in our study talked about moving out of their existing social network during pregnancy to avoid causing worry for their family, and friends or from receiving harsh judgements that were difficult to manage. Rebecca talked about not sharing her decision. She said she felt she had made a sound decision to try for a vaginal breech birth but agreed with her partner to limit the sharing of their decision:

I purposefully didn't share because they would think I was mad for trying. There would have been judgments and commentary trying to convince me otherwise.

Christine told us that she felt frustrated when her family kept commenting on the was the 'stubbornness' of her baby for remaining in the breech position. She told us that she did not value the opinions of her family and friends they were based on 'old wives tales:

I noticed everyone started making judgemental comments about her [her baby]. Like, 'Oh! She'll be stubborn' and 'Oh! She's a stubborn little

thing.’ And so suddenly, your pregnancy’s abnormal and your child’s a little upstart [she is uncooperative]. And in fact you think, ‘She’s not stubborn. She is just doing what she feels she needs to do.’ There’s nothing negative about it [so] I didn’t share it with the wider circle because I didn’t feel there was anything they could offer me in terms of evidence; it would be anecdotal old wives tales.

Managing the family’s anxiety

During their pregnancy, those women who chose to share their birth choice with their family spoke of feeling the need to manage their family’s anxieties, which they said was an additional burden for them in the final weeks of their pregnancy. Michelle, who chose to share her plans for a vaginal breech birth told us that she noticed that her mother’s behaviour changed and this caused her concern:

She [Michelle’s mother] grew quiet when talk of the birth arose. I could tell that she felt a little bit reserved about it. She was worried about it.

Alex spoke of telling her mother-in-law and subsequently regretting it for the rest of the pregnancy, as she felt her mother-in-law’s stress impacted on her ability to stay calm about trying for a vaginal breech birth , saying: *‘I overshared and I wish I hadn’t.’*

Social media as social support

A number of the women in our study talked about their during their pregnancy. Some sought alternative sources of support, and talked about how they used the social media to find sympathetic women who had gone through a similar experience and who could offer support. They talked about how they found connecting with other previously unknown women through social media extremely helpful even. Those women who accessed this support said it made them feel less isolated as they could communicate with others who shared their experiences. Jane, who said she travelled long distances to be close to the obstetrician who would support her during labour and birth, said she found the on-line community very helpful:

The [breech-specific] Facebook group was so supportive to me when I was in Sydney and I was overdue [past the due date for delivery] and I didn't have any of my friends around. To be able to connect...I remember someone just saying [online], 'Checking in, how are you doing?' Just that kind of support was really useful.

Some women talked about the ways in which social media gave them an opportunity to find positive birth stories and videos and photographs that other women had posted. These women stated they had struggled to find such support elsewhere. They said that the women's online stories and images gave them confidence and enabled them to see themselves going through the same process. Mandy felt that hearing

stories from women who ultimately had a caesarean section after trying for a vaginal breech birth was also helpful in her managing her expectations:

There were [also] plenty of birth stories [on-line] that did end up in caesarean section even though they had planned a vaginal birth. And I remember thinking, 'Oh yeah, that's right. This is kind of quite realistic that it could end like that.

Women discussed social media and new online connections as an alternative support system that alleviated the anxiety they encountered elsewhere in their social network regarding their choices for mode of birth.

Discussion

In this study we focussed on women who had who had decided to resist accepted 'best practice' and opted instead to have a vaginal breech birth. We found that in their talk about choosing vaginal breech birth, they described how they had to resist and overcome opposition from professionals with their 'doctor knows best' assumptions. Given the development of modern medical practice with its scientific-evidence based ideology such opposition is hardly surprising. However the women also talked about the strong opposition of their intimate circle, their family and friends and this is more surprising the general assumption that this intimate circle will provide emotional support especially when individuals are experiencing fateful

moments such as childbirth. From the women's accounts it appears that the medical ideology is so dominant that it has become embedded within 'common sense'. The women in our study told us that their family and friends accepted the dominate medical narrative that caesarean section was the best and safest option for breech presentation and vaginal breech birth was seen as a rare occurrence, aberrant and an unknown, risk-laden choice. These narratives create challenges for women during their social interactions but did not stop most of them from seeking a vaginal birth for their breech baby. Indeed the women talked about the strategies they used to deal with criticism of their decisions, including restricting communication with some family and fiends and seeking alternative, sympathetic 'friends' on-line.

Control of the birthing body-challenging current discourses of risk in childbirth

In previous studies we have found that women who plan a vaginal breech birth value autonomy and are highly motivated to find a clinician that supports them in their choices for birth(Homer et al., 2015; Petrovska, Watts, Catling, Bisits, & Homer, 2016). The women in this study also talked about the ways in which choosing vaginal birth provided them with a sense of agency. They talked about the negativity they experienced but stressed how their t belief in their body's ability to give birth gave them the confidence to resist this negativity. The women in this study were willing and able to resist the passive role which is often ascribed to women in childbirth and to resist the paternalistic and authoritative status of biomedical thinking (Coxon, Scamell, & Alaszewski, 2012; Viisainen, 2001). The particular context of this study,

giving birth with a baby in breech position highlighted the ways in which childbirth is viewed through the lens of risk and the pressure placed on women to accept this framing of their pregnancy (Homer et al., 2015). Doctors and midwives offer a 'safe' solution for breech presentation. They offer to deal with all the anxiety by creating a safe and predictable outcome that will deal with all the risks through a caesarean section. If women accept this offer then they participate in the ritual of medical technology which reinforced the sense of control that technology brings that both society and clinicians appear to find comfort in (Coxon et al., 2014; Scamell, 2014; Scamell & Alaszewski, 2016).

Women who opt for a vaginal breech birth challenge this dominant ideology, they claim to view the risks through their own personal lens and through their confidence in their own body not medical technology. In their talk, the women in our study gave equal weight to the risk of being disempowered and losing control of body through a caesarean section with the risks of harmful outcome to themselves and their baby. They sought to develop a more holistic account of the risks in which their physical and mental wellbeing did not take second place to that of their unborn foetus. In their talk, women were sensitive to the accusation that they were being selfish, prioritising their own birthing experience over the safety of their baby but stressed they were seeking a balance. As Dahlen and Homer (2010) have noted in many high income countries there is a tension between 'childbirth' and 'motherbirth'. Women who accept the 'childbirth' approach claim to be good mothers because they minimize all risk to their baby even if this means placing their own wellbeing at risk.

IN contrast women who accept the ‘motherbirth’ approach feel giving birth matters for the woman and that a happy, healthy mother means a happy healthy baby. The women interviewed in our study operated in the ‘motherbirth’ framework but were largely surrounded by members of their social network who operated in the ‘childbirth’ framework, leading many women to withdraw from those known totem and to seek solace from new social networks.

The power of social media

Social media, also known as the ‘participative internet’, consists of a broad set of Internet-based communications, tools, and aids such as Facebook, that women in our study talked about heavily (Korda & Itani, 2013). Social media has become an indelible part of the health landscape, creating a new forum for people from a wide range of geographical locations to share information that would perhaps otherwise be unavailable to them and that is free from the constraints of traditional healthcare (Centola, 2013; Griffiths et al., 2012). The networks and groups created on-line form communities that are seen to ‘fill in the gaps’ that may exist in conventional care by exchanging this information in these forums. The personal and empathetic interaction that occurs in peer to peer interaction in the virtual world adds significant value to these social networks being an alternative support system to the traditional relationship between woman and health care provider (Centola, 2013; Centola & van de Rijt, 2015).

For the womb in our study, using the media was a way of resisting the negative pressure from their existing social networks and creating a new supportive one. It was a way in which they could maintain power and control. As social media strategist Zandt noted:

In traditional power systems, those with more influence or power... are dependent on our being passive consumers of information. We're freed significantly from that dependency when we're given easy tools with which to share our stories' (Zandt, 2010, p. 55).

Traditional power systems in maternity care tend to make women passive recipients of care, however there is evidence that women can use social media to become more active participants in their care (Romano, Gerber, & Andrews, 2010). Women in our study talked about how they used social media to combat their sense of isolation created by their decision to opt for a vaginal breech birth. They talked of feeling strengthened by the connections they made on-line. Romano et al made similar conclusion in their study of women's use of social media and vaginal birth after caesarean section (Romano et al., 2010). Engaging with 'like minds' on on-line social networks may enhance women's opportunities to achieve autonomy, empowerment, and self-efficacy in supporting them to make health care decisions that align with their personal priorities and individual concepts of risks and reward.

Vaginal breech birth and risk: A public relations challenge

Despite the support women receive from on-line communities, it was clear from their talk that women in our study found it difficult to find support for having a vaginal breech birth in both clinical and social settings. Part of the problem lies in the rarity of vaginal breech birth. The women in our study talked of feeling let down by the maternity care system they had accessed as they felt it was a clinician's responsibility to gain and maintain skill for vaginal breech birth in order to ensure this option for birth was available. Many had to move hospitals to access what they felt should be a readily available option.

The lasting impact of the Term Breech Trial (Glezerman, 2012; Kotaska, 2007; Lawson, 2012) and the rarity of vaginal breech birth has created a challenging image problem for vaginal breech birth as an option for mode of birth. Clinicians rarely see breech babies born vaginally, creating the perception that the procedure carries significantly more risk than caesarean section, despite evidence supporting the safety of vaginal breech birth in selected cases (Berhan & Haileamlak, 2016; Glezerman, 2012; Lawson, 2012). The power and influence held by medical technology, and its ability to provide a 'predictable outcome', can be seen to underpin the development of cultural rituals and an acceptance that mechanical intervention is superior to natural physiological processes (Coxon et al., 2012; Davis-Floyd, 2003; Tully & Ball, 2013). Findings from this study suggests that the 'blanket' approach of caesarean section for breech presentation by medical institutions has informed cultural and societal beliefs that caesarean section is the 'right' approach for management of

breech presentation and that vaginal breech birth is impossible and/or dangerous (Centola, 2013).

To address this requires an acknowledgment from medical institutions, through high level policy that promotes the establishment of vaginal breech birth services and increased opportunities for clinical education, that vaginal breech birth is a legitimate option for women with a breech presenting baby (Homer et al., 2015; Walker et al., 2016). Coxon et al argue that high level policy may not be sufficient in changing socio-cultural attitudes around the 'riskiness of birth' (Coxon et al., 2014). Reflecting on their research on women's choices for place of birth they suggested that alternative birth settings, such as birth centres and birth at home, will only be considered as culturally acceptable when birth itself is viewed as a normal process in socio-cultural contexts. They concluded that any changes to discourses of risk around birth are 'unlikely to be rapid or even to occur within a generation'. In our research there is evidence that vaginal breech birth is generally considered to be a 'high risk' requiring special treatment so Coxon et al's findings suggest that achieving social acceptance of vaginal breech birth may be an even greater obstacle.

However, we argue that that social discourses of risk and childbirth are significantly influenced by medical discourses. Developing high level policy that not only recites current evidence, but also support establishing services that offer vaginal breech birth with structured opportunities for clinicians to develop their skills is key to positively informing medical discourses around the option of vaginal breech birth (Powell, Walker, & Barrett, 2015; Walker et al., 2016). Increasing the availability of consumer information may also be a key factor in driving demand for vaginal

breech birth (Guittier et al., 2011). Normalising vaginal breech birth in medical discourses may engender acceptability of vaginal breech birth in socio-cultural contexts and increase support for women to exercise choice and control making decisions for breech birth.

Conclusion

In this article we have focussed on 22 women who opted to have a vaginal breech birth. Twelve of these women succeeded in having a vaginal breech delivery. It is clear from their talk that these women encountered considerable resistance, not only from health care professional but also from their friend and family. They were challenging the dominant framing of the breech births, that they are intrinsically risky and can only be safely managed using the expertise and technology of medicine through a caesarean section. The women talked about the strategies which they used to resist this including restricting information to their friend and families and seeking alternative, supportive 'friends' on-line.

Normalising the option of vaginal breech birth in maternity services may influence social perceptions of risk regarding this choice for birth. This, however, is challenging given current practices in maternity care are symptomatic of the wider risk society, where the loss of faith in birth as a natural process, coupled with an intense dependency on technology, amplify perceptions of risk. The development of high level policy that supports vaginal breech birth could positively impact on medical

discourses and options for clinician training to support this birth option and may engender acceptability in socio-cultural contexts.

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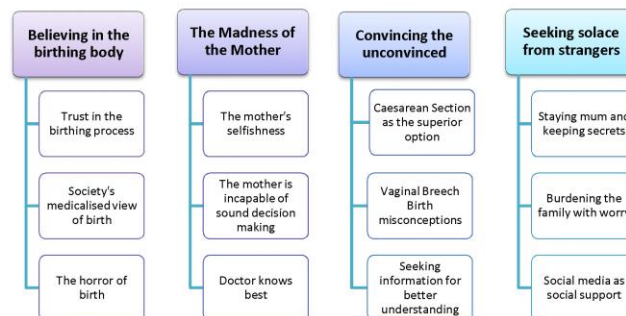
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1.

Figure 1: Themes and sub themes: Social discourses of risk in childbirth: Impact on women's choices for vaginal birth



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choices
planned
breech