Choosing vaginal breech birth:

Discourses of breech birth in contemporary society

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Certificate of Original Authorship

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as part of the collaborative doctoral degree and/or fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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Date:

This research is supported by an Australian Government Research Training Program Scholarship.

Dedication

I dedicate this thesis to my late father, Velko Petrovski, and my mother, Cena Petrovska, who were brave enough to come to Australia empty handed, and barely into adulthood, from their Macedonian homeland in the hope of starting a better life for themselves and gaining better access to education for their children. I know it was not easy and I will forever be in awe on your strength and courage. I hope I have made you proud.

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In 2012, when I was pregnant with my second daughter, I was told at 36 weeks gestation that she was breech and unlikely to turn. Never in my wildest dreams did I think that moment would result in me taking the most enthralling, liberating and challenging ride that has led me to complete a PhD thesis. I would like to thank the following people for supporting me through this incredible experience.

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second daughter Eden. Thank you for everything you do for women seeking a vaginal breech birth and thank you also for facilitating access to the women willing to be interviewed about their own experiences of trying for a vaginal breech birth. These interviews formed a significant part of my study and acted as a springboard to additional research that is also included in this thesis. I am forever grateful to you for all that you have done.

I co-interviewed women who had sought a vaginal breech birth with midwife Nicki Watts (my partner-in-crime!). Nicki, conducting these interviews with you was such a fun, interesting and moving time. Unexpectedly, you and I also developed a friendship which I am sure will outlast the duration of this work. Christine Catling, I am also very grateful to you for reviewing the products of this research - thank you for being so generous with your advice and time (and for being so nice!).

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And finally, thank you to the women who were interviewed for this research, to the women who participated in the survey and to all other women seeking autonomy in their birth choices. I stand with you.

Peer-Reviewed Publications and Conference Presentations

This study is part of a larger project, “Breeching in the System”. The aims of this larger project are to explore the decision-making process for women seeking a vaginal breech birth and to explore the experience of the clinicians who counsel and attend these women.

As part of the Breeching in the System Team, I have co-authored a number of papers and given presentations on behalf of the Team.

Breeching in the System Research Team

Peer-Reviewed Publications from the overall project

Watts, N.P., **Petrovska, K.**, Bisits, A., Catling, C. & Homer, C.S. 2016, 'This baby is not for turning: Women's experiences of attempted external cephalic version', *BMC Pregnancy Childbirth*, vol. 16, p. 248.

Catling, C., **Petrovska, K.**, Watts, N., Bisits, A. & Homer, C.S.E. 2016a, 'Barriers and facilitators for vaginal breech births in Australia: Clinician's experiences', *Women and Birth*, vol. 29, pp. 138-43.

Catling, C., **Petrovska, K.**, Watts, N.P., Bisits, A. & Homer, C.S.E. 2016b, 'Care during the decision-making phase for women who want a vaginal breech birth: Experiences from the field', *Midwifery*, vol. 34, pp. 111-6.

Homer, C.S.E., Watts, N., **Petrovska, K.**, Sjostedt, C. & Bisits, A. 2015, 'Women's experiences of planning a vaginal breech birth in Australia', *BMC Pregnancy and Childbirth*, vol. 15, no. 1, p. 89.

Poster Publications

Petrovska K., Watts N., Catling C., Bisits A., Homer C.S.E., 2015. Breeching in the system: Expectations and experiences surrounding a planned vaginal breech birth. RCOG /RANZCOG World Congress, 12-15 April, 2015, Brisbane, Australia.

Conference Presentations

Petrovska, K., Watts, N., Bisits, A., Homer, C.S.E. Breeching in the system: Expectations and experiences surrounding a planned vaginal breech birth. ACM NSW Branch Annual State Conference & AGM 2014. 24th-25th October 2014 at Novotel Sydney Brighton Beach.

My PhD Thesis and the publications

This thesis includes five papers, Chapters 4 to 8. Chapters 4 to 7 are papers that have been published during my PhD candidature. Permission to reproduce the publications in this thesis has been provided by each of the journals. Chapter 8 is currently under review.

Publication details for each chapter are outlined below, together with a statement of contribution and percentage contribution for each author.

Incorporated as Chapter 4

Petrovska, K., Watts, N.P., Sheehan, A., Bisits, A. & Homer, C.S.E. 2016, How do social discourses of risk impact on women's choices for vaginal breech birth? A qualitative study of women's experiences. *Health, Risk and Society* (early view). http://dx.doi.org/10.1080/13698575.2016.1256378

Statement of contribution	**Perecentage of contribution**
Concept and design of study	KP 30%, NW 30%, CH 30%, AB 10%
Supervision and conduct of field research	KP 45%, NW 45%, CH 10%
Data analysis and interpretation	KP 80%, NW 20%
Writing of initial manuscript	KP 100%
Manuscript revisions through provision of detailed commentary	KP 80%, CH 10%, AS 10%

Incorporated as Chapter 5

Petrovska, K., Watts, N.P., Catling, C., Bisits, A. & Homer, C.S.E. 2016, 'Supporting Women Planning a Vaginal Breech Birth: An International Survey', *Birth*, vol. 43, no. 4, pp. 353-7.

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Data analysis and interpretation	KP 90%, CH 10%
Writing of initial manuscript	KP 100%
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Incorporated as Chapter 6

Petrovska, K., Watts N.P., Catling, C., Bisits, A., Homer C.S.E. 2016, 'Stress, anger, fear and injustice: An international survey of women's experiences planning a vaginal breech birth'. *Midwifery* (early view). http://dx.doi.org/10.1016/j.midw.2016.11.005

Statement of contribution	**Perecentage of contribution**
Concept and design of study	KP 80%, CH 10%, NW AB 10%
Supervision and conduct of field research	KP 90%, CH 10%
Data analysis and interpretation	KP 80%, NW 20%
Writing of initial manuscript	KP 100%
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Concept and design of study	KP 90%, CH 10%
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Concept and design of study	KP 90%, CH 10%
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Data analysis and interpretation	KP 100%
Writing of initial manuscript	KP 100%
Manuscript revisions through provision of detailed commentary	KP 80%, CH 10%, AS 10%

Poster Publications

Petrovska, K., Sheehan, A., Homer, C.S.E. Death, risk and danger: A prospective analysis of web-based news reports on breech birth. Normal Labour and Birth Conference 10 - 13 October 2016, Sydney, Australia.

Conference Presentations

Petrovska, K. How does social discourse impact on women's choices for vaginal breech birth? Normal Labour and Birth Conference 15 - 17 June 2015 University of Central Lancashire, United Kingdom.

Petrovska, K. An international survey of women's expectations and experiences surrounding planned vaginal breech birth. Normal Labour and Birth Conference 10 - 13 October 2016, Sydney, Australia.

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List of Abbreviations

ACM	Australian College of Midwives
ACOG	American College Obstetricians and Gynecologists
CNM	Certified Nurse Midwife
CS	Caesarean Section
ECV	External Cephalic Version
HREC	Human Research Ethics Committee
NHMRC	National Health and Medical Research Council
NICE	National Institute of Clinical Excellence
NSW	New South Wales
OB	Obstetrician
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCOG	Royal College of Obstetricians and Gynaecologists
SCBU	Special Care Baby Unit
TOLAC	Trial of Labour After Caesarean
UTS	University of Technology Sydney
VBAC	Vaginal Birth After Caesarean Section

Prologue

“Never again,” I said to my husband. “This is it as far as more children are concerned, I can’t go through this stress again.”

I was sitting up in bed with my hands resting on my very pregnant belly, late at night and unable to sleep. We had found out that afternoon our baby was well and truly breech and, at 36 weeks, the likelihood of her turning to a cephalic presentation was small.

Earlier that afternoon, during the antenatal appointment, I felt my face grow hot with panic when the lovely midwife, with whom I had carefully cultivated a relationship with from 14 weeks gestation, informed me that the facility we were in did not offer the option of vaginal breech birth. I worked in maternity services policy development at the NSW Department of Health, so this was not news to me. I understood the maternity service landscape across the state - it was my job. Hearing someone say it to me, though, made it all too real and utterly destabilising. It wasn’t a statistic or situation that I was detached from, as was usually the case. Now it was about me, about my world. Gone were nesting and excitement of the final few weeks of pregnancy. Instead it was replaced by decisions about external cephalic version, the potential for Caesarean section, exploring vaginal breech birth, and the logistics of getting to a hospital further away from our home that supports this birth option. The potential of getting stuck in Sydney’s eye watering peak hour traffic and my genetic predisposition to labour and birth quickly led to many a dream about a roadside birth in those final few weeks of pregnancy.

I remember the panic…of getting phone numbers to the ‘right’ obstetrician, organising an ECV, of changing facilities late in pregnancy so I could try for a vaginal birth after the baby remained

breech, of squeezing in appointments with midwives at the new facility so at least I had met them once before they would see me in full flight during birth.

I remember feeling fortunate… I knew how to navigate the system. What would other women have done? I knew who to call, I knew where to go. How would other women have known what to do? I could only imagine how impossible it all would have seemed for them.

I remember cursing myself…I had been smug about the birth of our second child, I shouldn't have been. The birth of our first child was quick and straight forward. My husband and I took bets on how much quicker the second would be. I should have known better, anything can happen and nothing is guaranteed.

I remember forcing myself to change my mindset…a Caesarean section could be on the cards. If it was needed, then of course I would have one. But was it definitely needed? We had seen the obstetrician at the new hospital, he was encouraging and advised that I was a favourable candidate for vaginal breech birth.

I remember wrestling with feelings of selfishness…despite our decision to try for a vaginal breech birth, the unknown was scary. Was I 'making it about the birth not the baby'? Was that what I was doing?

I remember looking for information…I was desperate for some sort of recognition that vaginal breech birth was *ok to explore as an option.* I didn't find much.

I remember the judgement…of people's eyes widening and conversations falling silent. I knew what they were thinking…that I was crazy. My husband and I decided to keep it a secret from our

families. What a great shame that what should have been a time of excitement was instead replaced with secrecy and anxiety.

And finally, I remember packing my bag a few days before I went into labour… I realised I was going to be OK. I had changed care providers, they listened to me and instead of the system putting itself at the centre of MY pregnancy, I was at the centre and I was being supported in trying for a vaginal breech birth with skilled clinicians. If I needed an emergency Caesarean section, then so be it. At least I had the chance to try for a vaginal birth. I would not have to spend the rest of my life feeling like not trying was a wasted opportunity. I also remember feeling lucky. And then I remember feeling sad and angry for other women, because finding clinicians that support you in your options for birth should not have anything to do with luck.

Abstract

Aim

Most breech presenting babies are born by elective Caesarean section. Very few are born vaginally, with even fewer accounting for planned, rather than unplanned, vaginal birth. Despite maternity services in middle and high income countries offering limited support for planned vaginal breech birth, some women continue to seek this option for birth. Little is known about these women and how socio-cultural views impact on their decision-making for birth. The aims of this research were to understand how social discourse in contemporary society impact on women's decisions for vaginal breech birth; explore how and why women make decisions for this birth option; and identify strategies for clinicians to support women considering vaginal breech birth.

Methods

A multi-methods study was undertaken in which four different approaches were employed to gather data for this project. The approaches were taken in four parts: 1) semi-structured interviews with 22 women who opted for a vaginal breech birth in Australia; 2) an international online survey of 204 women between April 2014 - January 2015 who sought a vaginal breech birth; 3) an analysis of internet forum discussions; and 4) a content analysis of online news media to explore how breech presentation and birth are portrayed.

Findings

Social discourse in contemporary society holds a strong belief that Caesarean section is the safe way to manage the birth of a breech baby. Planned vaginal breech birth has a limited profile in

society and is seen as a high risk option. These views may be the result of limited clinical support for this birth option. Despite this resulting in anxiety for women when decision-making for this mode of birth, women seeking a vaginal breech birth feel strongly about bodily autonomy and their ability to give birth. They are able to transcend negative views of others and display a determination in finding supportive care for birth. These findings are presented in Chapters 4-8, which outline the results and conclusions arising from this study.

Conclusion and implications

Clinical recognition of vaginal breech birth as a legitimate option for women may address socio-cultural perceptions of risk relating to this birth option. Strategies to increase the profile of vaginal breech birth in clinical settings include the development of high level policy supporting this birth option, increasing availability of vaginal breech birth services and targeted training programs for clinicians. This in turn may normalise the option of vaginal breech birth in socio-cultural contexts and facilitate a more positive experience for women seeking this mode of birth.

Chapter 1 Introduction

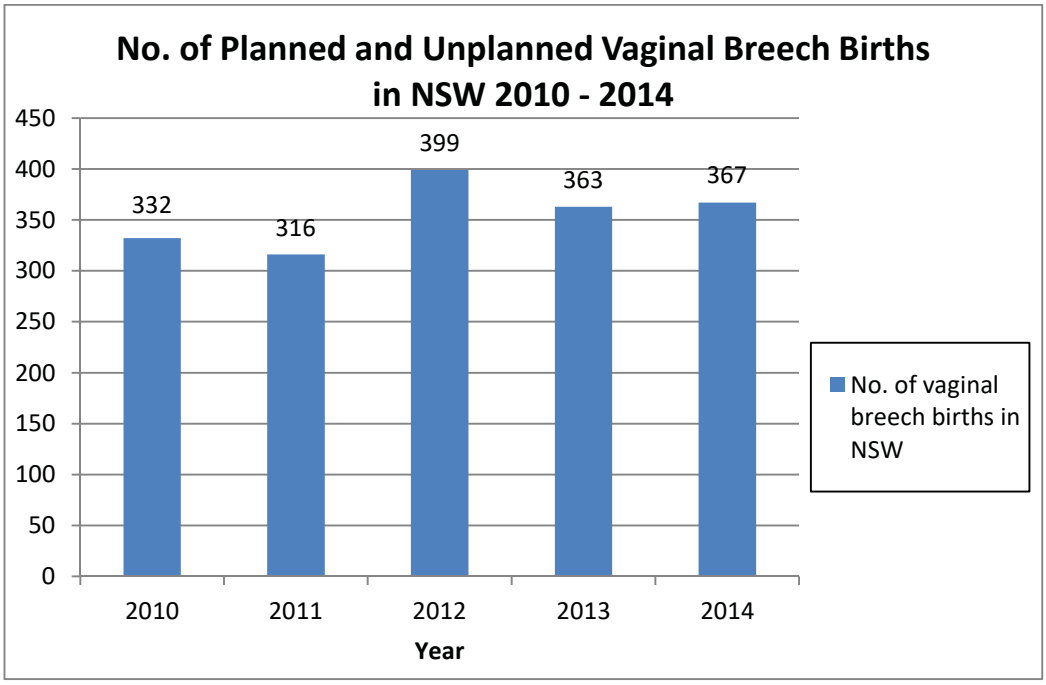
1.1 Background

It is estimated that breech presentations (where the baby's bottom is coming first) occur in 3-5% of pregnant women at the end of their pregnancy (Guittier et al. 2011). Data on the percentage of women with breech babies who seek planned vaginal birth is limited. The American Congress of Obstetrics and Gynecologists notes in its committee opinion *"During the past decade, there has been an increasing trend in the United States to perform Caesarean delivery for term singleton fetuses in a breech presentation"* (ACOG 2006). A 2016 analysis of a nationally representative cohort of US women suggested Caesarean section for breech presentation was as high as 94.9%, an increase from 86.9% in 2003 (Martin, Hamilton & Sutton 2003; Weiniger et al. 2016). The remaining 5.1% of vaginal breech births from the 2016 analysis included both planned and unplanned vaginal breech births, suggesting the figures for planned vaginal breech births are much fewer. The United Kingdom has no recent national data available on the incidence of planned vaginal breech birth.

In Australia in 2013, of the 13,617 babies who were diagnosed breech at term (4.4% of all babies born), 88% were born by Caesarean section (AIHW 2015). The remaining 12% of vaginal breech births included both planned and unplanned vaginal breech births. In New South Wales (NSW) alone approximately 97,000 babies are born each year (Ministry of Health 2016), with potentially up to almost 5,000 of these babies presenting breech. The most recent figures available for NSW births show that approximately 7% of these breech babies were born vaginally with the remainder being born by Caesarean section, mostly electively before the onset of labour. The number of breech babies born vaginally has remained small for many years (Figure 1). In NSW in 2014, 97,325

babies were born. Of these, 367 babies in the breech position were born vaginally with the remainder being born by Caesarean section (Ministry of Health 2016). This trend is echoed across a number of high income countries (Berhan & Haileamlak 2016; Sharoni, Lyell & Weiniger 2015; van Roosmalen & Meguid 2014). Data that separates planned and unplanned vaginal breech birth for NSW is not available, nor is it distinguishable in any other Australian states and territories.

Figure 1 Planned and unplanned vaginal breech births in NSW



The small number of vaginal breech births is largely attributed to a large international randomised control trial conducted in 2000, known as the Term Breech Trial, which concluded that Caesarean section is the safest mode of birth for babies in the breech position (Hannah et al. 2000). As a result, the immediate response in maternity units around the world was a significant increase in Caesarean section operations for breech birth and the decline in clinicians with the skills and confidence in attending vaginal breech birth (Lawson 2012). Subsequent research and systematic reviews have also been released since the Term Breech Trial reinforcing the Trial's results (Bin,

Roberts, et al. 2016; Hofmeyr, Hannah & Lawrie 2015; Vlemmix et al. 2014), with one study noting that vaginal breech birth carries a two to five fold greater relative risk of short term morbidity and mortality than Caesarean section (Berhan & Haileamlak 2016).

Since the Term Breech Trial was published, subsequent research has cited significant flaws in the design and recommendations of this study (Glezerman 2006; Hauth & Cunningham 2002; Kotaska 2004; Lawson 2012). Concerns relating to trial results focused on trial standards of care, violations of inclusion criteria, erroneous attribution of adverse outcomes to mode of delivery and lack of difference in two year outcomes for infants (Borbolla Foster et al. 2014). Additionally, obstetric units who continue to offer vaginal breech birth as an option have demonstrated acceptable safety using term breech trial comparable outcomes, where stringent selection criteria and management are maintained. This selection criteria for planned vaginal breech birth includes normal pelvimetry, no hyperextension of fetal head (checked with ultrasonography), fetal weight estimated between 2500 and 3800 g (with clinical and ultrasound examinations) and a Frank breech presentation (Goffinet et al. 2006).

Current support for the option of vaginal breech birth is based on other research demonstrating the safety of vaginal breech birth for carefully selected women, as outlined above, with the appropriate care and expertise (Berhan & Haileamlak 2016; Glezerman 2012; Goffinet et al. 2006; Kotaska et al. 2009b; Lawson 2012). Additionally, long term outcomes of babies born via vaginal breech birth or Caesarean section have been shown to be similar (Hofmeyr, Hannah & Lawrie 2015), and a recent meta-analysis has demonstrated that the absolute risks of vaginal breech birth is lower than previously indicated (Berhan & Haileamlak 2016). The existence of guidelines and recent research that supports vaginal breech birth in selected instances also indicates that there is

some potential for women to explore this birth option in facilities that have staff with the relevant clinical expertise (Catling et al. 2016a, 2016b; RANZCOG 2013; RCOG 2006).

Despite evidence demonstrating the safety of vaginal breech birth in selected women, many maternity services across the world have been reluctant to respond to this evidence, with the number of clinicians skilled in vaginal breech birth decreasing to almost non-existent levels (Lawson 2012; Walker, Scamell & Parker 2016). This current clinical climate limits the birth options available to pregnant women with breech presenting babies. The paucity of clinicians available who are skilled in vaginal breech birth leads most women in high to middle income countries to opt for a Caesarean section for the birth of their child (Kotaska et al. 2009b).

Vaginal breech birth, both planned and unplanned, still occurs albeit in small numbers. Little is known about the decision-making process for women planning a vaginal breech birth and what factors may influence their choices for birth. Women who seek this birth option are probably highly motivated and, after having done their own research, choose to navigate the health system to find a clinician who is willing to assist them to give birth vaginally (Ecker 2009; Homer 2015; Lawson 2012).

In the context of decision-making for birth, many researchers have concluded that social discourse, including social media and information found online, has an impact on pregnant women when considering their birth options (Dahlen & Homer 2011; Lagan, Sinclair & Kernohan 2011; Munro, Kornelsen & Hutton 2009; Romano, Gerber & Andrews 2010). Social discourse has been defined as the 'study of human meaning-making' and increases understanding of social interaction and how knowledge is constructed across societies and cultures (Wetherell, Taylor & Yates 2001). For women making decisions about birth in general, social discourse can influence both attitudes

to birth and choices made during pregnancy and childbirth (Dahlen & Homer 2011; Lagan, Sinclair & George Kernohan 2010; Lagan, Sinclair & Kernohan 2011; Munro, Kornelsen & Hutton 2009; Peddie et al. 2015; Romano, Gerber & Andrews 2010; Song, West, Lundy & Smith Dahmen 2012).

I became interested in learning about the experiences of other women in their decision-making for vaginal breech birth, and how social discourse may impact on them during this time, after having a planned vaginal breech birth myself in early 2012. As I explained in the Prologue to this thesis, my own decision-making process was impacted upon significantly by information and videos I found online and discussions I had with friends and family about the possibility of attempting a vaginal breech birth. I will discuss how my own experience impacts on this study later in this chapter.

I did my own preliminary research and found, perhaps due to the rarity of vaginal breech birth, there is limited understanding about the decision-making processes women engage in when deciding on their preferred way of giving birth to a breech baby and how social discourse may impacts upon that process. The gap in the literature led me to the question that prompted the research question for this thesis: **How do discourses of breech birth in contemporary society impact on women choosing vaginal breech birth?**

1.2 Aims of this study

This study is part of a larger project, "Breeching in the System" that is examining women's decision-making for planned vaginal breech birth. The aims of this larger project were to explore the decision-making process for women seeking a vaginal breech birth and to explore the experience of the clinicians who counsel and attend these women. My component of the project focused on gaining a deeper understanding of how women's decision-making around vaginal breech birth is influenced by social discourse, which includes friends, family and the media and

how women manage attitudes around vaginal breech birth that may differ from their own. Therefore the aims of this research were to understand how social discourse in contemporary society impact on women's decisions for vaginal breech birth; explore how and why women make decisions for this birth option; and identify strategies for clinicians to support women considering vaginal breech birth.

This specific study examining the impact of social discourse on breech birth choices was undertaken to assist in understanding how knowledge of breech birth is constructed and how meanings around breech birth develop for childbearing women. Further, it was anticipated that research into how social narratives may guide women's decision-making for breech birth may also assist maternity service clinicians in providing more appropriate counselling to women to promote women's full inclusion in the decision-making process for breech birth. This study may also guide the development of available information, including resources online and in social media, for women seeking further information on vaginal breech birth.

1.3 Original inspirations

The original inspiration for the design of this research project came from the findings of Robbie Davis-Floyd and her anthropological exploration of the symbols associated with birth in the United States. In her book, "Birth as an American Rite of Passage", Davis-Floyd concluded that the culture surrounding pregnancy and birth, both within maternity facilities and socio-cultural contexts outside of these facilities, had moved away from seeing birth as a normal physiological event and had become increasingly medicalised (Davis-Floyd 2003). One of the leading questions Davis-Floyd stated was the impetus for her research was:

"What is the significance, for the individual who can choose how and where to give birth, of the standard American hospital birth, and what are the cultural factors that underlie that standardization?" (p.4)

Davis-Floyd's research examined how birth in the United States, and the meanings surrounding it, were represented through symbols that demonstrate the shift away from birth as a woman-centred process and further towards a relationship between care provider and woman where the power to guide the outcome rested firmly with the medical establishment.

This resonated strongly with me and my own experiences of how others reacted to my decision to explore vaginal breech birth when pregnant with my second child. When I first read Davis-Floyd's theory, I felt it was a sound explanation for the reason behind the discourse I encountered around vaginal breech birth both in social situations and in online forums and web pages. It made me wonder about the experiences of other women whose baby was identified as breech late in pregnancy and what their journey in deciding on mode of birth may have been like in the last few weeks of their pregnancy.

To address the questions Davis-Floyd had about the ritualisation of birth, both in hospitals and in wider society, she applied a model derived from symbolic interactionism. Using this approach, Davis-Floyd aimed to *"decode the symbolic messages conveyed to birthing women by the rituals of hospital birth"* (p.4). These messages, Davis-Floyd argued, influence women's choices as they are *"embedded in the hegemonic cultural model of reality that most of us to some degree embrace, in part because that model is consistently presented to us though our most basic rituals."* (p.5)

As I developed the ideas and approaches for my own research, I realised that I too would be decoding messages, rituals and symbols conveyed to birthing women in society, but my project

would be concentrating on breech birth. In particular, I would be examining the impact of discourses in contemporary society relating to breech presentation and how this impacted on women choosing the option of vaginal breech birth. I undertook four interlinked studies consisting of interviews with women who sought a vaginal birth for their baby; and international online survey that yielded both qualitative and quantitative data; an analysis of internet forum discussions and a content analysis of online news media to explore how breech presentation and birth are portrayed.

1.4 Organisation of the thesis

1.4.1 Choosing vaginal breech birth: Discourses of breech birth in contemporary society

The overall thesis contains 10 chapters. This introductory chapter (Chapter 1) has outlined the background, rationale and my own personal motivations and original inspirations for engaging in this research as a researcher. This chapter has also highlighted the current status of vaginal breech birth and provided data to demonstrate the low incidence of vaginal breech birth in local contexts within NSW and Australia and the perceived rationale behind these low rates.

1.4.2 Literature review

In Chapter 2 I have presented a review of the existing literature on women's decision-making for vaginal breech birth. Exploration of the literature yielded limited existing research in this area. As a result, I investigated related areas of research that included general attitudes to breech presentation, the impact of social discourse on other birth choices and the influence of other factors that may impact on women's decision-making for birth, such as the internet and the views of family and friends. From this literature review, it was evident that my research would

contribute a unique perspective to knowledge on women's decision-making for planned vaginal breech birth and provided justification for this research project going forward.

1.4.3 Methods

The methods chapter (Chapter 3) I provide a discussion on the theoretical framework and the rationale for this study as well as outlining the four part approach taken when undertaking this research project. This four part approach included using semi structured interviews with women, an online survey seeking data on women's experiences in planning a vaginal breech birth, a content analysis of internet discussion forums discussing decision-making for vaginal breech birth and an analysis of news media reporting on the topic of breech presentation and birth. A summary of how the four part approach to this research corresponds with the papers in Chapters 4-8 is found in Table 1 (below). Four of the five papers have been accepted for publication in peer reviewed journals, as explained at the outset of the thesis, and one is currently under peer review. They will be discussed in the next section of this chapter.

Table 1 Summary table of methodologies and corresponding chapters

Methodology	**Corresponding chapter and paper title**
Part 1 - Semi-structured interviews	Chapter 4: *How do social discourses of risk impact on women's choices for vaginal breech birth? A qualitative study of women's experiences*
Part 2 - Survey: Quantitative data	Chapter 5: *Supporting women planning a vaginal breech birth: An international survey*
Survey: Qualitative data	Chapter 6: *"Stress, anger, fear and injustice": An international survey of women's experiences planning a vaginal breech birth*
Part 3 - Thematic analysis of internet forum discussions	Chapter 7: *The Fact and the Fiction: A prospective study of internet forum discussions on vaginal breech birth*
Part 4 – Media content analysis	Chapter 8: *The Fact and the Fiction: A prospective study of internet forum discussions on vaginal breech birth*

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

In Chapter 4 I explore the impact of social discourses of risk on women's choices for vaginal breech birth through semi structured interviews with 22 women who planned a vaginal breech birth. The interviews were undertaken in 2013 with women who volunteered to be a part of the study from NSW, Australia.

1.4.5 Supporting women planning a vaginal breech birth: An international survey

Chapter 5 is the first of two chapters where I present the results of an online survey distributed via Facebook pages with a consumer focus on vaginal breech birth between April 2014 - January 2015. There were 204 unique responses to the survey, which included both qualitative and quantitative data. In this paper I explore the results from the quantitative data elicited from the survey, with the qualitative data being explored in a separate study due to the significant volume of responses.

1.4.6 "Stress, anger, fear and injustice": An international survey of women's experiences planning a vaginal breech birth

In Chapter 6 I present the qualitative data from the online survey. Written responses to the open ended questions were extensive and were analysed thematically.

1.4.7 The Fact and the Fiction: A prospective study of internet forum discussions on vaginal breech birth

Chapter 7 I examine how women use English language internet discussion forums to find out information about vaginal breech birth. In this paper I also aim to increase understanding of how the option of vaginal breech birth is perceived among women. The methodology for this paper

involved creating Google alerts with the search terms “breech birth” and “breech”. Data were collected from January 2013 to December 2013 and analysed using thematic analysis.

1.4.8 Death, risk and danger: A prospective analysis of web-based news reports on breech birth

In Chapter 8 I aim to explore the content and tone of media or news reports relating to breech presentation and birth and that women who had a breech baby late in pregnancy may be exposed to. Google alerts were created to search for the term “breech” and “breech birth” in online English-language news sites over a three year period from 1/1/2013 to 31/12/2015. The data were analysed to generate concepts and themes. The data collected came from a variety of media such as newspapers, television and magazines. A total of 84 web-based news reports were gathered over the course of the study.

1.4.9 Discussion

In Chapter 9 I draw together the findings of the five studies conducted for this thesis, synthesise the findings as a whole and reflect on interpretations and commonalities in the findings.

1.4.10 Conclusion

In the final chapter of the thesis (Chapter 10), I reflect on the research journey, and the findings of the study, to draw conclusions that it is hoped will increase understanding as to how social discourse in contemporary society impacts on women’s decisions for vaginal breech birth.

1.5 Summary

This chapter I have provided an overview of current and historical contexts for the management of breech presentation. The aims and objectives of this thesis, the research question and the original

inspirations for this work were also described. The rationale for undertaking this study and the description of the structure of the thesis were presented in the last section of this chapter.

In the next chapter I review the literature to explore current evidence on women's decision-making for vaginal breech birth, social attitudes towards breech presentation and how social networks, including the internet, social media and family and friends, may impact on women's choices for birth.

Chapter 2 Literature Review

2.1 Introduction

This chapter consists of a review of the literature related to women's decision-making for breech birth. In this section, I briefly outline the method used for the literature review and then expand on the findings of my literature search. Existing evidence on women's decision-making for breech birth will be explored as well as general social attitudes toward breech presentation. I will then discuss existing literature relating to the impact of social discourse on women's decision-making for birth in general and the role the internet and family and friends may have on women's birth choices. Gaps in the current evidence are identified throughout the chapter.

2.2 Method

A search of available databases was undertaken from September 2013 to December 2016 to review the available evidence for women's decision-making for vaginal breech birth. Literature from peer reviewed journal publications was included only. Databases responded differently to various search terms (see Table 2, following page). Search terms were kept broad and included only 'breech presentation' and 'decision-making' as there were zero results with the additional inclusion of the terms 'woman's choice', 'social' or 'media'. While the results yielded many articles that concerned the clinical rather than the woman's decision-making process, this was thought to still be useful as some of the data did mention maternal choice as an aspect to be considered for choice of mode of birth.

Only ProQuest Health and Medicine yielded high results for the terms 'breech presentation' and 'decision-making' (1177). This was narrowed down to 412 by adding the terms 'woman's choice', 'social' and 'media'.

The Maternity and Infant Health Care database did not respond to 'breech presentation' and 'decision-making', and only the terms 'breech birth' were used.

2.3 Synopsis of literature reviewed

There were no studies found that specifically examined in detail how social discourse impacts on women's choices for breech birth. Very few studies exist that examine in general women's decision-making processes around breech birth-this is confirmed by the literature search and also the larger study that this project is attached to. Those that do exist were examined in this literature review.

Other studies were found that examine how media and society view birth in general. Influences on women's decision-making for birth in other scenarios, such as vaginal birth after Caesarean section were also explored. These studies are also discussed in this literature review.

Table 2 Literature search results

Search terms	Source	Results	Useful results
Breech presentation, breech birth, patient, decision-making.	MEDLINE	48 articles located	12
	CINAHL	68 articles located	19
	PUBMED	91 articles located	33
Breech birth	Maternity and Infant Health Care	135 articles located	36
Breech presentation, breech birth,	ProQuest Health and Medicine	412 articles located	49

woman's choice, patient, decision-making, social, media.			

2.4 Women's decision-making for breech birth

There were only two studies found that solely focused on women's decision-making processes for breech birth, one from Europe and the other from the Caribbean.

The first was a qualitative study undertaken in Switzerland that interviewed 12 pregnant women with breech presenting babies. This study found that decision-making processes related to mode of birth, were influenced by intra- and extra-personal factors (Guittier et al. 2011). The study demonstrated that the women interviewed experienced decisional conflict regarding the birth options available to them. The major factors influencing this conflict were lack of support, social pressures and lack of information. The study concluded that improved support from clinicians was required and more accurate information should be made available so that women felt more supported during the decision-making process.

Weaknesses of this study included the small sample size and the question of the study's applicability outside of Europe or in a country like Australia. While social pressure was noted as having an impact on birth choices, no detail was given regarding the form this social pressure came in. The degree of impact that social discourse had on the final choice for birth mode was also not discussed and information regarding the option the women eventually chose in response to these pressures was not identified.

The second paper was a qualitative study that interviewed nine women in rural Jamaica in order to detail their decision-making for breech birth choices (Founds 2007). Interviews with these women

revealed that the majority relied partly on their social networks for information. These social networks generally regarded breech birth as high risk, with the baby having either many complications or being stillborn. The cultural view of breech babies represented them as being difficult babies that cried a lot. The women responded to these views with fear and worry that their baby would be born with 'problems', with these concerns also having a subsequent impact on future reproductive choices.

Limitations of this study include the small sample size and its context, as it is unclear as to how applicable findings from Jamaica would be to women in other countries, including Australia. It was clear that the women were not presented with a choice for mode of birth and it was not indicated how they felt about this. Given social discourse was identified as influencing attitudes towards breech presentation, it would have been useful for the study to examine the women's feelings regarding birth choices rather than just attitudes towards breech presentations.

The call for accurate clinical information for women with breech babies to enable choices about giving birth is also supported in other literature. A discussion paper by Azria et al (2009) recommended that pregnant women with a breech baby should have access to accurate clinical information so that maternal autonomy is reached in the decision-making process (Azria et al. 2009). This paper concludes that maternal autonomy and medical responsibility can only coexist when there is an understanding of all information exchanged between the caregiver and the pregnant woman. While social discourse was not always identified as having an impact in women's decision-making in this study, strong emphasis was placed on the importance of evidence-based clinical information that supports autonomous decision-making.

2.5 General attitudes regarding breech presentation

While only very few papers were identified that investigated women's decision-making for breech birth and the potential impact of social discourse, more studies examined general attitudes around management of breech presentation. These are useful to explore as they provide some insight into factors that may influence women's decision-making for vaginal breech birth.

One English study investigated attitudes of women and clinicians towards external cephalic version (ECV), a procedure where a clinician attempts to turn a breech baby to a head down position late in pregnancy by placing gentle pressure on the mother's abdomen (Say et al. 2013). Examining attitudes around ECV may be useful given this procedure and decision-making for breech birth are intertwined, hence potential similarities may be found in the two scenarios.

In Say et al's study, semi structured interviews were conducted with 11 pregnant women with breech babies and 11 health professionals who cared for women with breech presentations. The study concluded that women's attitudes to breech presentation were derived from misinformation obtained in social and cultural contexts such as friends and family. The study also concluded there was very limited evidence-based information regarding breech presentation and the options available to women for birth options.

The lead researcher of this study was a trainee obstetrician who was known to the clinicians interviewed. This could be viewed as a limitation of this study as established relationships may have impacted upon interactions during the interviews. The women interviewed were also permitted to ask clinical questions, which were addressed, and this may have also impacted on the type of information or experiences provided by the women. Additionally, given the study was conducted in the United Kingdom (UK), it may not be transferable to other international settings.

An Australian study examining decision-making by women for ECV more than a decade ago also highlighted the need for evidence-based and accurate information from care providers (Raynes-Greenow et al. 2004). Data were collected from 174 women through a self-administered questionnaire during visits to the women's antenatal care appointments. Findings from the study suggested that women's decisions regarding management of breech presentations was impacted upon by sources, such as lay beliefs and misconceptions, other than the information provided to them by their care provider. A strength of this study was that its findings may be generalisable given its Australian context although given it was only four years after the Term Breech Trial was published (Hannah et al, 2000), the findings may not now be so directly relevant.

While social discourse is not always identified as having an impact on women's decision-making in these studies, strong emphasis is placed on the importance of evidence-based clinical information that addresses misconceptions and fears and that ultimately supports autonomous decision-making by women. A description of the most useful information sources during the antenatal period would also be helpful to provide a deeper understanding of women's decision-making processes for breech birth and the degree of impact social discourse may have. When reviewing these studies, in conjunction with the two papers explored in the previous section of this literature review, there appears to be a clearly defined need to undertake such investigations in an Australian context so that the findings are applicable to women seeking breech birth options in maternity services at a local level.

2.6 The impact of social discourse on other birth choices

The limited amount of research into the impact of social discourse on decision-making for vaginal breech birth is itself a good reason to justify further exploration in this area. To add support to this

argument, a broader literature search was undertaken by using the search terms 'birth' and 'decision-making'. This search captured further literature that confirms the impact of social discourse on birth choices in general, including birth options such as vaginal birth after Caesarean section (VBAC).

A number of the studies focus on the impact of the media by examining the use of the internet on women's decision-making processes during pregnancy, while others investigate how conversations with friends and family may have an effect on birth choices. They will be explored further as the findings demonstrate social discourse exerts significant influence in these contexts.

2.7 The impact of the internet and social media on birth choices

One global study that collected information from 613 women over a 12 week period through a web-based survey demonstrated that most women used the internet to seek information about their pregnancy (Lagan, Sinclair & George Kernohan 2010). Almost 94% of the women in the study used the internet to supplement the information already provided to them by their health care providers, with 83% of the women stating the information found online influenced their decision-making. Almost half of the women in the study reported unsatisfactory or inadequate information provided to them by clinicians.

Another study examined the use of English language internet blogs by pregnant women to discuss vaginal birth after a previous Caesarean section and how this information influenced birth choices for their next child (Dahlen & Homer 2011). Data were collected from online blogs over a period of 12 months and the results demonstrated that women seek support for their birth choices through the use of online blogs. This method of seeking information, according to the authors of the study, was potentially important and requires further exploration.

In their review of existing research regarding the ways social media can shape health care choices, Romano et al (2010) concluded that women use social media to inform their birth choices. Social media may assist women in gaining new perspectives on birth choices for VBAC through sharing stories with women who have similar concerns, priorities and past experiences (Romano, Gerber & Andrews 2010). Romano et al (2010) stated that the United States (US) maternity care system was unable to provide information regarding locations of VBAC clinical providers and this in turn created online communities that were seen to 'fill in the gaps' by exchanging this information in these forums. The conclusions from this review paper provided strong justification for further investigation into the internet's influence on women's choices for vaginal breech birth.

There were several identified limitations to these studies which are useful to observe. In particular, women who 'blog' were mostly well educated professionals, which makes it difficult to generalise the results of the study to all women (Dahlen & Homer 2011). The data were also sourced from English speaking sites only, mostly from the US in both the Dahlen and Homer study and the Romano study. Given VBAC is difficult to access in the US, this is may have influenced the tone of the discussion.

Decision-making for breech birth has not been explored using this kind of research and further investigation into the influence of the internet and its impact on women's choices for breech birth is warranted. It may assist in gaining a deeper understanding of women's use of online information regarding breech presentations, mode of birth and the impact the internet may have had during this process. It may also assist in guiding clinicians to educate women to seek reliable sources of information online, if they indeed exist. A study into the impact of the internet on breech birth choices may inform local health authorities of the need to provide more accurate consumer

information in the local context that allows women to make decisions based on appropriate facts and information.

2.8 The impact of family and friends on choices for mode of birth

Women do not only receive information and advice from health providers; they also receive it from family, friends and social networks. Research has been undertaken that explored the impact of conversations with friends and family on birth choices. A qualitative study of 17 women in Canada demonstrated that women drew heavily from social and cultural knowledge in forming their decision to give birth by elective Caesarean section, although not specifically for breech birth (Munro, Kornelsen & Hutton 2009). Social narratives were identified as portraying vaginal births as "horror stories" and Caesarean sections as positive experiences. Popular media was seen to guide cultural narratives around birth that reinforced these existing social narratives.

Another study of a group of 107 Western Australian women who were interviewed by telephone, demonstrates how positive social stories around vaginal birth and support from family encouraged women to attempt a VBAC (Fenwick, Gamble & Hauck 2007). Thematic analysis was used to analyse the interview data collected from women who attempted a vaginal birth (n=24), or stated they would choose this option, in a subsequent pregnancy (n=11).The study concluded subsequent research for decision-making around birth choices should take into consideration the pregnant woman's psychosocial influences, including discourse from family and friends, as this has a notable impact during the antenatal period.

2.9 Conclusion

The findings of the studies discussed in this review support the need for research into the impact of social discourse on women's decision-making for breech birth given very little research exists in

this area. Additionally, no recent Australian studies specifically around breech birth exist. There is evidence to suggest that social discourse does have an impact on birth choices, yet its impact on decision-making for breech birth remains relatively unexplored.

From the literature reviewed, it became apparent that there were two central concepts explored regarding social and cultural influences on birth in general. These two concepts were, firstly, the impact of the internet and social media and, secondly, the impact of family and friends. Decision-making for vaginal breech birth by women has not been explored in depth using these central concepts and it was thought appropriate that they form the basis for investigation for my research project.

2.10 Summary

In this chapter I have reviewed the literature discussing women's decision-making for vaginal breech birth and the impact of social discourses in contemporary society on women's general choices for birth. Gaps in the literature concerning the impact of contemporary discourses in society on women's decision-making for breech birth were identified. These knowledge gaps point to the value of and the need for further research on the experiences of women's decision-making when exploring the option of vaginal breech birth and how socio-cultural attitudes and beliefs impact on that process. The last section of this chapter identified two concepts that form the basis of this research - the impact of the internet and social media and, secondly, the impact of family and friends.

In the next chapter I provide an overview of the theoretical framework for this research, the methods as well as the rationale for the four different approaches taken for this research. More

detailed and specific descriptions of the data analysis process are also provided. I will also discuss how I plan to link the findings of my study to the theoretical framework.

Chapter 3 Methods

3.1 Introduction

This chapter outlines the methodology used in the research, including the theoretical underpinnings and the justification for my choice of theoretical framework to support this study. The methodology and methods section will outline the approaches for the four parts of this study that includes: the interviews, the survey, the media content analysis and the analysis of internet forum discussions. For each of these the methodology, data collection methods and data analysis techniques are explained. All parts of this study aimed to answer the research question of how discourses of breech birth in contemporary society impact on women who choose the option of vaginal breech birth. Later in this chapter I describe how the findings from this research and the theoretical framework are linked. Following this I discuss the ethical approval processes and the resources used to support the research conducted for this study.

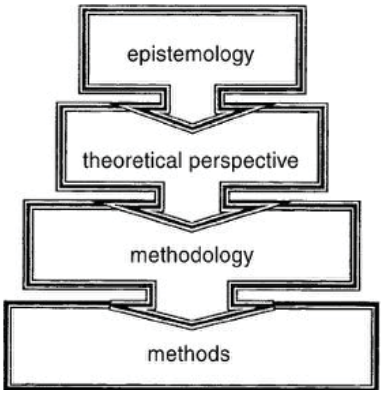
3.2 Theoretical frameworks in social research

A theoretical framework underpins all aspects of an investigation and *"has implications for every decision made in the research process"* (p.3) (Mertens 1998). According to Crotty (1986), a research project commences with the identification of the methodologies and method, and those choices are then required to be justified by a theoretical framework (Crotty 1998). Consideration for the choice of methodologies is key in the pursuit of answers to the question(s) posed in the research. However, the justification for choosing the method and methodologies is a part of a bigger picture and relates to the underlying assumptions of a *theoretical perspective* that underpins the choice in methodology. This perspective brings with it the underlying philosophical

assumptions about the researcher's view of the human world and the social life within that world (Crotty 1998).

Lying beneath the theoretical perspective is the final layer of the framework, the *epistemology,* which *"is concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate" (p.8)* (Crotty 1998). The following diagram (Figure 2) demonstrates this schema:

Figure 2 Formulating a theoretical framework (Crotty 1998)



Formulation of modern theoretical frameworks in social theory occurred in the latter half of the 20th Century among scholars who challenged the assumption that social and educational research was to be governed by dominant, empirical, analytical methodologies which characterised the so-called 'hard' or 'natural sciences'(Candy 1989; McCann 2006). Increasing recognition of more appropriate, alternative approaches to social research saw the formation of epistemologies, theoretical perspectives, methodologies and methods to underpin such research (Jacob 1988; Manis & Meltzer 1972; Torbert 1981; Wiersma 1991). Crotty (1989) refers to the epistemologies as objectivism, constructionism and subjectivism. It should be noted that there is not always a perfect fit for a research study to sit neatly within one paradigm (Candy 1989), however there

should be a dominant perspective which informs the final choice of the theoretical framework for a research project.

3.3 The Theoretical Framework for this study

Table 3 Schema outlining the theoretical framework of this study (Crotty 1998)

Epistemology	**Theoretical Perspective**	**Methodology**	**Methods**
Constructionism	Interpretivism ➢ Symbolic Interactionism	➢ Descriptive exploratory analysis ➢ Survey research ➢ Media Content Analysis	➢ Semi-structured interviews ➢ Questionnaire ➢ Media content analysis ➢ Statistical Analysis ➢ Theme identification

The purpose of this study is to explore how discourses of breech birth impact on women's choices for birth of their breech baby. The theoretical framework shown in Table 3 above shows the elements of the theoretical framework for this study. The following section will explore the reasons for the choice of the epistemology of constructionism and the theoretical perspective of symbolic interactionism for this research project.

3.3.1 Epistemologies

As noted previously, Crotty (1998) outlines three epistemological constructs that can be applied in a conceptual framework for social research - objectivism, subjectivism and constructionism (Crotty 1998). Evaluating the position of all three approaches will provide an overview of the philosophical

basis, nature and limits of human knowledge and will provide justification for the preference on constructionism for this study.

Objectivism

Crotty (1998) describes objectivism as *"meaning, therefore meaningful reality, exists as such, apart from the operation of any consciousness"(p.8)* (Crotty 1998). Objects have inherent meaning that can be measured, quantified and deciphered by the researcher (Guba & Lincoln 1994). These measurements or quantities, in the objectivist's view, can discover the objective truth. Applying objectivism in social research suggests that the *"social world can be studied in the same way as the natural world, that there is a method for studying the social world that is value free" (p.7)* (Mertens 1998).

Research through an objectivist lens, lends itself to experimental and quantitative research and is commonly used in the natural and physical sciences (Crotty 1998). Candy (1989) states objectivism involves the dispassionate pursuit of 'scientific truth' and consists of variables that are identified and defined (Candy 1989). The relationship between these variables can be expressed in mathematically precise ways through testing of hypothetical propositions.

Given this research project is largely based on gathering qualitative data, objectivism per se is not the most appropriate fit for this project as an epistemology. Although there is an element of quantitative analysis in the data to be gathered though the survey element of this project (see section 3.4.2), this data is being gathered to further construct and support the findings of the qualitative data. As previously stated, research does not necessarily have a 'perfect fit' paradigm - the way this project is designed is a good illustration of that point.

Subjectivism

The epistemology of subjectivism suggests meaning is imposed on the object by the subject (researcher) rather than a result of the interplay between object and subject. In subjectivism, the subject does not make a contribution to the generation of meaning (Crotty 1998). The limitation of applying subjectivism to social research is that the subject, in their generation of meaning, can import meaning from other sources unrelated to the object or event at hand. Another limitation of subjectivism in a social-cultural context is that the relationships between the subject and the object, and the accompanying interpretations, influences and actions, are neglected (McCann 2006).

For this research project, subjectivism is not an appropriate epistemology to underpin a theoretical framework given generation of meaning through the analysis of the data will involve both the subjects and objects view of reality.

Constructionism

Constructionism provides a comfortable fit to the social cultural world as it is based on the tenet that reality is socially constructed (Mertens 1998). Crotty (1998) states the focus of constructionism is:

> *"Truth, or meaning, comes into existence in and out of engagement with the realities in one's world….Meaning is not discovered, but constructed…In this understanding of knowledge it is clear that different people may construct meaning in different ways, even in relation to the same phenomenon."* (p. 8, 9) (Crotty 1998)

One of the assumptions underlying constructionism is that meaning is not generated in one's social world until they experience an event - meaning is then constructed in the subject's

interactions with objects encountered. The reality that is built through this generation of meaning includes individual perspectives, perceptions and experiences (Blumer 1962). Therefore, one's concept of events can be attributed to how the subject engages with objects and events, and how they subsequently relate to them (Charon 2001; Guba & Lincoln 1994). Crotty (1998) adds that the social construction of meaning is linked to symbols that have a social origin within various cultures, and this meaning is linked to symbols that guide human behaviour (Crotty 1998).

The focus of a researcher working from a constructionist epistemology is to gain an understanding of a subject's interpretations of reality derived from social interaction and interpersonal relationships (Mertens 1998). A main characteristic of this research is to discover a subject's interpretation of reality within particular social/cultural contexts by exploring details of the backgrounds of the participants and the contexts in which they are being studied.

Methodologies and methods used in constructionist based research are often biased towards qualitative research, however Mertens (1998) states that a triangulated approach, where multiple methods and multiple data sources can be used to support interpretations and conclusions, (Mertens 1998). Additionally, when presenting findings from constructionist based research, it is common for researchers to provide direct quotes from participants who took part in the research to support conclusions drawn from the data (Wiersma 1991).

After considering the different epistemologies, as well as the approach taken by Davis-Floyd (2003) in her research, constructionism was considered the best epistemological basis for this research. To construct meaning, a triangulated approach using different methods was used to collect data. This will be discussed further in this chapter.

3.3.2 Theoretical perspective

The second column in Table 3 shows the second component of the schema outlining the theoretical framework of this study - the theoretical perspective. The theoretical perspective can be described as *"the philosophical stance informing the methodology and thus providing a context for the process and grounding its logic and criteria"* (p.3) (Crotty 1998). Given this research project is based on a constructionist epistemology, and the purpose of the question posed, the theoretical perspective underlying this study aligns itself to interpretivism under the subset of symbolic interactionism, which can be seen as a stream of interpretivism.

An interpretivist approach attempts to explain human social cultural reality (Crotty 1998). Interpretivism is often cited as originating from the sociological studies of Weber, who studied society in the context of human beings acting and interacting (McCann 2006). When taking this explanation of how reality is formed, the outcomes of this 'acting' and 'interacting' are seen to develop the fabric of society, the cultural world in which individuals live and how they identify as individuals within this society (Blumer 1962; Congalton & Daniel 1976; McCann 2006).

Symbolic Interactionism

Symbolic interactionism is a prominent interpretive approach that is used to examine society and individuals' actions and behavior within their socio-cultural context (Crotty 1998).The origins of symbolic interactionism can be attributed to the work of George Herber Mead, whose work aimed to increase understanding of how human behavior is influenced by culture. Mead explored the role of the individual as a creator and shaper of society (Charon 2001; McCann 2006). Mead's work has been further developed by other social psychologists including Herbert Blumer, who describes symbolic interactionism as:

> *"the peculiar and distinctive character of interaction as it takes place between human beings. This human interaction is mediated by the use of symbols, by interpretations, or by ascertaining the meaning of one another's actions."* (p.139) (Blumer 1962)

In symbolic interactionism, the socialisation process and social cultural journey is based on symbols within human society. These symbols are the basis of ongoing communication and allow human beings to pass down knowledge from one generation to the next (Charon 2001). Language also plays a significant role in symbolic interactionism by allowing individuals to develop perspectives of the world and to understand events within each individual's environment (Berger & Luckmann 1966; Hertzler 1965).

Crotty (1998) cites three basic assumptions of symbolic interactionism:

- that human beings act toward things on the basis of the meanings that these things have for them;
- that the meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows; and
- that these meanings are handled and modified through, an interpretive process used by the person in dealing with the things he (or she) encounters.

In conclusion, an individual develops an understanding of the world through interactions with others within their own sub-cultural units, such as families or peer groups. These units exist within wider society, which is also an influencing factor on sub-cultures within the individual's sphere (McCann 2006). Sub-cultural units and wider society bring with it norms, rules and conventions that have developed over time as well as definitions of what is socially and culturally acceptable. An individual's response and subsequent actions to any given situation is informed by these

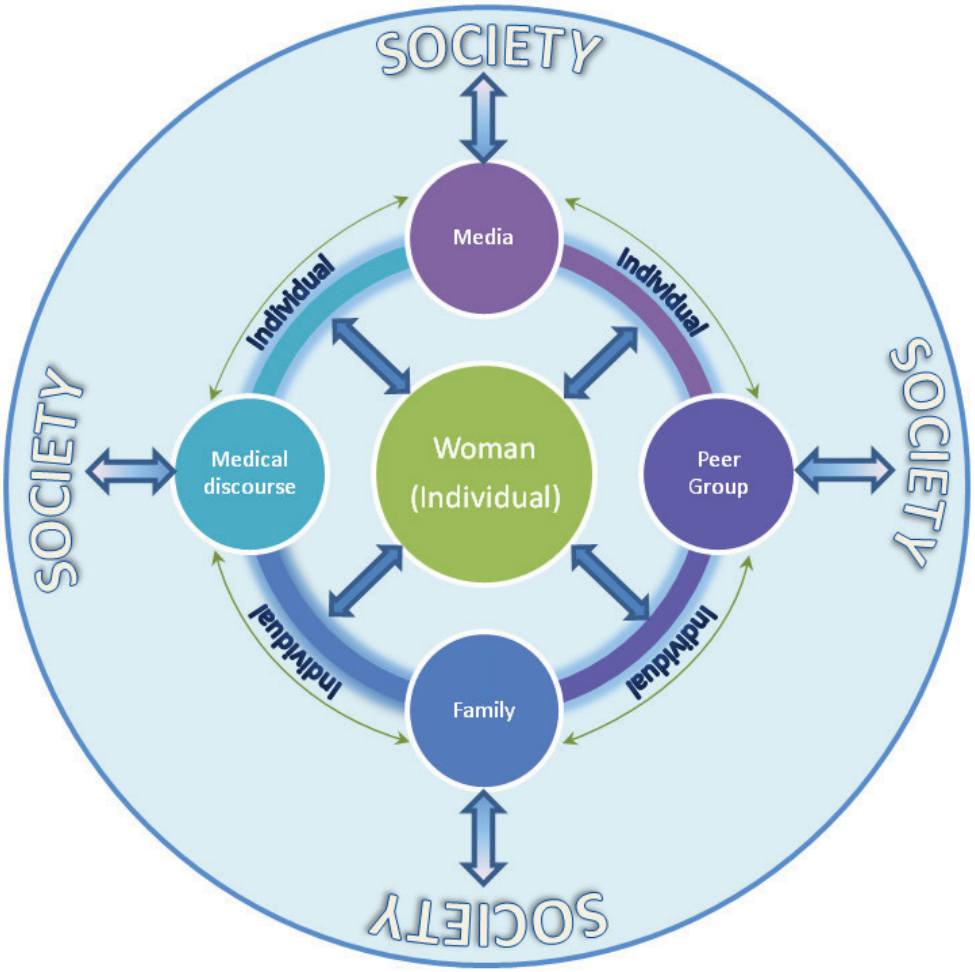
definitions that have developed over time. Additionally, this process is not static - it is one of continual engagement and development as individuals construct, reconstruct and renew their place in society and how their identity to self within this sphere.

3.3.3 Alignment of this study with Constructionism and Symbolic Interactionism

As demonstrated by the descriptions of theoretical perspectives in this section of this chapter, this study aligns itself with the ideologies of the epistemology of constructionism and the theoretical perspective of symbolic interactionism. Given this study aimed to explore the impact of social discourse on women's decision-making for vaginal breech birth, it sought to understand how the responses of these women to the meaning society has developed regarding the options of vaginal breech birth may influence their decisions.

Figure 3 illustrates an individual's journey through the sub-cultures that may exist in their life for this particular study. For this diagram, these sub-cultures include (but may not necessarily be limited to): media, family, peer groups and other associations (community groups, employment interactions). The bi-directional arrows between the individual and these sub-cultures and larger society demonstrate their dynamic inter-relationship. During the decision-making process for birth, women with a breech baby interact with society through these inter-relationships (i.e. the 'reality'). The socially constructed meanings around birth that women encounter through these inter-relationships may impact upon them during their experience of decision-making for birth.

Figure 3 An individual's journey through sub-cultures



In this section I have discussed how I formulated a theoretical framework for this study. In choosing symbolic interactionism as the 'best fit' for this thesis, I demonstrated how I expect the research in this thesis to align with the chosen theoretical framework. This was done in Figure 3 (above) where I illustrated how women interacting with sub-sets in their social network, or 'sub-cultures', may encounter 'meanings' or 'symbols' relating to breech presentation and vaginal breech birth that may impact on their experiences in decision-making or choosing vaginal breech birth as an option during their pregnancy. The next part of this chapter will outline the methodologies and methods for the four elements of this study. As previously identified, these

elements are semi-structured interviews, an online survey, a media content analysis exploring how breech presentation and birth is represented in the media and an analysis of internet forum discussions.

3.4 Methodology and methods

There are no set methodologies or methods prescribed by a constructionist approach to research, however, certain methodologies or methods fit more comfortably with certain theoretical approaches. Constructionist based research often employs the concept of *triangulation* which involves the *"use of multiple methods and data sources to support the strength of interpretations and conclusions"* (p.429) (Mertens 1998) . Triangulation has been identified as a major contributor to a research study's credibility (Lincoln & Guba 1985). Triangulation should not merely be aimed at strengthening the validity of a study, but to also deepen understanding of the data and analysis gathered and to corroborate data across different sources (Olsen 2004).

Moving from left to right across Table 3 to the methodology column, this study will consist of four methods to gather the data for this research project. They are:

- Semi-structured interviews
- Women's views through an internet survey
- Analysis of internet forum discussions
- Media Content Analysis

In the next section of this chapter I will describe each study in detail. Some methods are repeated in the individual papers in **Chapters 4 – 8** but are included here to explain the complete approaches, with more detail available here than could be included in the published papers.

3.4.1 Part 1 - Semi-structured Interviews: Women's views through interviews

The published paper for Part 1 of this study, the semi-structured interviews with women who chose to try for a vaginal breech birth, is incorporated as **Chapter 4** of this thesis.

Methodology

Part 1 of this study was a qualitative study using a descriptive exploratory methodology. This methodology has been identified as aligning well with interpretivism and symbolic interactionism (Sandelowski 2000; Thorne, Kirkham & O'Flynn-Magee 2004). Qualitative descriptive research entails a commitment to studying a phenomenon in its natural state, or as it is, within the scope of the research project.

Researchers conducting such qualitative studies seek an accurate accounting of events from the participants of the study, known as descriptive validity, that most people observing the same event would agree is accurate. In this case, the participants are the women making decisions about the option of vaginal breech birth and while their stories are described and explored, the findings seek to interpret meanings and actions from those stories.

Method

For this part of the research project, purposive sampling was used as the study was designed to elicit views from individuals who have experienced the event being studied (Sandelowski 2000). Women who were planning to have a vaginal breech birth in the past seven years were recruited - regardless of the actual final outcome (vaginal or Caesarean birth). It was a requirement of the study for the women to be able to read and speak English.

Data were collected using in-depth semi-structured interviews. These women were interviewed to explore how social discourse, amongst other factors, impacted on their decision-making process for birth. A series of trigger questions for the semi-structured interview were used.

The recruitment process involved sending a letter inviting women who were known to have planned a vaginal breech birth in the last seven years asking them to participate in a face to face interview. The majority of these women were identified by the lead researcher of the larger "Breeching in the System" project who was an attending clinician for the women when they attempted a planned vaginal breech birth. One woman was identified through my professional contacts. Human research ethical approval to interview the women for this study was provided through the South East Sydney Local Health District Human Research Ethics (HREC) Committee and the UTS HREC.

The letter sent to the women included an information sheet about the study and a consent form. The information sheet explained that participation in the study was voluntary and women were assured that they did not have to take part and that they were free to withdraw at any stage. Participation in the study included granting permission for the interview to be video and/or audio-taped. Women interested in being interviewed for the study were invited to contact the researchers and discuss an appropriate time for the interviews to take place.

The interviews were undertaken in conjunction with a midwife who was also working on the "Breeching in the System" project. Theoretical saturation was reached after 22 interviews. Of the 22 women, 12 had a vaginal breech birth and 10 had a Caesarean section.

Data Analysis

Data were transcribed verbatim using a professional transcription service for each interview. The questions I used in the interviews relating to social discourse were isolated in the transcripts for the analysis that I conducted for this study. In keeping with a qualitative descriptive methodology, thematic analysis was used to analyse the data (Taylor et al., 2006). Thematic analysis is an iterative process where concepts, categories or themes and relationships are constantly refined through multiple readings (Dahlen & Homer 2011).

The process of thematic analysis was done on the entire content of the interviews in conjunction with the midwife who was also working on this project and who conducted the interviews with me. As in previous qualitative studies (Dahlen & Homer 2011; Liamputtong & Ezzy 2005), the process to analyse the interview data was undertaken in three main steps

1. Immersion in data
2. Identification of preliminary concepts
3. Developing and refining themes

Immersion in data

Becoming immersed in the data is key in familiarising oneself with this first step in thematic data analysis. The interview transcripts were read and re-read a number of times. Myself and another researcher (Nicole Watts) undertook this step for the reading of transcripts of all the interviews.

Identification of preliminary concepts

The second step involves identification and judgement

labelling of the concepts in the data (Taylor, Kermode & Roberts 2006). A total of six concepts were developed and colour coded, five of which are associated with the "Breeching in the System" study (Blue, Pink, Yellow, Green, Purple) and one of which will be used for this thesis (Orange). Upon reading and re-reading the transcripts each concept was coloured as shown:

ORANGE: The influence of friends, family, other peers and the media

BLUE: Finding out baby was breech

PINK: Why the women wanted to try for a vaginal breech birth

YELLOW: Information given by clinicians (both helpful and not helpful)

GREEN: The experience of labour

PURPLE: How the women felt after the birth

Once these concepts were coloured, they were grouped together in preliminary categories (Fenwick et al. 2010). Both researchers moved back and forth between the processes of induction and deduction, and as the data analysis progressed, subthemes and/or themes evolved. These preliminary themes were developed using appropriate phrases or, where suitable, the language of the participant.

To conduct my own work in developing and writing Chapter 4, I isolated the preliminary themes developed from the orange highlighted text. I then undertook further refinement of the themes based on the ideas illustrated in the diagram in Figure 3. The themes developed from the remaining colours were used to inform the findings of the larger "Breeching in the System" study (Homer et al. 2015).

Developing and refining themes

The third step involved further refining of the preliminary themes and identifying linkages and relationships between themes (Liamputtong 2005; Speziale & Carpenter 2003). These findings informed key conclusions drawn from this study. As the subthemes/themes emerged, audit trails were used to document the rationale for decisions (Speziale & Carpenter 2003).

3.4.2 Part 2 - Survey: Women's views through an internet survey

Part 2 of this study, the online survey exploring women's experiences in choosing vaginal breech birth, is divided into two parts and presented in **Chapters 5 and 6.** Findings from the on-line component of the study were divided into two papers due to the significant volume of qualitative data gathered from the survey. The published paper describing the quantitative data is at **Chapter 5** and the published paper describing the qualitative data is at **Chapter 6.**

Methodology

In order to further investigate the degree of influence that social discourse has had on women's decision-making for vaginal breech birth, a survey was developed to gather qualitative data from further afield, both nationally and internationally, and to also add quantitative data to support the qualitative data gathered during Part 1 of this research project.

As a methodology, survey research gathers data from a number of people at any given point in time in various settings (McCann 2006). Open ended questions in a survey provide valuable insights into the individual's experience by gathering data to elaborate on the issues relating to the study question(s). From a quantitative perspective, the demographics gathered on individuals can provide valuable information on the participants. Other quantitative data gathered during a survey

can support, or refute, conclusions drawn from data gathered in other elements of a study (McCann 2006).

Method

For this study, an electronic survey was developed with the research team for distribution to both the women interviewed for this study, and women online via social media. The survey can be viewed at **Appendix 9** on page 257.

The survey was comprised of Likert scales (five and ten point response scales ranging from 'strongly agree' to 'strongly disagree' or from 1 to 10), and open-ended style questions. It was self-administered and took approximately 30 minutes to complete. The development of the survey questions were informed by the theories underpinning a symbolic interactionist approach as the questions asked were similar to those asked of the women in the semi-structured interviews. However, in the survey, the potential for degrees of impact of social discourse could be demonstrated by the participants via 5 and 10 point scales as well as the open ended questions.

The survey was piloted with two of the participants from the semi-structured interviews conducted in Part 1 of this study. To gain different perspectives one of the women had a planned vaginal breech birth, the other a Caesarean section following an attempted planned vaginal breech birth.

The survey was granted HREC approval by South Eastern Sydney Local Health District HREC (see Appendix 4, age 260) and was uploaded onto 'Survey Monkey', a website that allows uploading and distribution of research surveys for a nominal fee.

The survey was distributed online via closed membership consumer Facebook groups that had a focus on vaginal breech birth.

Data Analysis

The data obtained from the Likert Scales in the questionnaire were analysed using descriptive statistics including percentage, mean, standard deviation, frequency, and cross-tabulations (see Chapter 5). Thematic analysis was used to analyse the qualitative data (see Chapter 6) sourced from the open ended questions in the study using a similar approach to Dahlen & Homer (2011) and Fenwick et al. (2010) (Dahlen & Homer 2011; Fenwick et al. 2010).

3.4.3 Part 3 - Thematic analysis of internet forum discussions

The published paper for Part 3 of this study, an analysis of internet forum discussions on breech presentation and breech birth, is presented in **Chapter 7** of this thesis.

Methodology

Given the widespread use of the internet for gathering information, and the lack of options around vaginal breech birth, it is likely that women finding themselves with a breech baby will turn to the internet for support and information. No studies have been found that explore the ways in which women discuss vaginal breech birth online. Therefore, the aim of this part of my study was to examine how women use English language internet chat forums to discuss the option of vaginal breech birth and to increase understanding in how vaginal breech birth is perceived in these online communities.

A qualitative study using Internet discussion forums as the source of data was undertaken. A qualitative method was considered an appropriate choice for this study as it is a technique used to collect and analyse data in areas where there is little knowledge (Dahlen and Homer 2001; Grbich, 2007; Schneider et al., 2007).

Method

Data were gathered over a 12 month period to explore freely available Australian and international internet forums discussing breech birth. Google alerts were created to search for the term “breech” and “breech birth” on the internet from 1 January 2013 to 31 December 2013. I received the alerts on a daily basis and these were filed for analysis at the end of the data gathering period. Each of the blogs received during the one-year period were accessed, read and saved according to the month.

Google was used for this study as it enabled gathering data that can be tailored to the specific needs of the researcher. Google allows the option to gather data using this method by entering the desired search terms into an ‘alerts’ option, whereby emails are forwarded to a selected email address containing websites that have mentioned the selected search terms. Additional information can also be requested, such as the type of information required (e.g. news, web or groups), how often it is required (e.g. once a day, as-it-happens) and language (English). Once the ‘alert’ was created, an email was sent to the named contact for confirmation. Emails are subsequently sent to the nominated email address at the requested time intervals containing hyperlinks to articles that have been identified as containing the requested term.

Based on the experience of similar research, ethical approval was not sought as the data from the internet discussion forums being studied are in the public domain and fully accessible and no human participants were directly contacted (Betts, Dahlen & Smith 2014; Dahlen & Homer 2011; Peddie et al. 2015).

Data analysis

Thematic analysis was used to analyse the data (Taylor et al., 2006). Thematic analysis involves repeated reading of text, facilitating identification of main concepts, categories or themes that reveal themselves in the data. This method has been used previously in similar research. (Betts, Dahlen & Smith 2014; Dahlen & Homer 2011). This style of qualitative analysis resembles that described by Burnard (1991) and termed 'editing analysis style' (Fenwick et al. 2010). This process involves immersion in the data to gain an understanding of the 'feel' of what forum participants were saying and to identify meaningful statements. The statements were edited to form preliminary concepts, with common and contrasting views identified in the data. These concepts were coded and eventually named as the themes and reported in the results of this analysis (Liamputtong and Douglas 2005; Taylor, Kermode and Douglas 2006; Boyatzis, 1998; Green and Thorogood, 2005).

3.4.4 Part 4 - Media Content Analysis

The paper for Part 4 of this study is an analysis of news media and its representation of breech presentation and birth. This paper is currently under review and is presented in **Chapter 8** of this thesis.

Methodology

Part 4 of this study is an analysis of information from the internet as the source of data - otherwise known as a media content analysis. Media content analysis takes a systematic approach to studying mass media (Lasswell, Lerner & Pool 1952). It is informed by the theoretical perspective taken by the researcher and by the key messages the researcher chooses to focus on in the form of media to be studied (Roth, Homer & Fenwick 2012). Contemporary researchers in this field support an interpretive approach to media content analysis as they attempt to analyse how media

content reveals 'truths' about society, essentially seeing media as a reflection of society and culture (Roth, Homer & Fenwick 2012). This approach seeks to interrogate the content to uncover deeper meaning of texts to audiences in an attempt to understand the likely interpretations of the audience and to see how language and visual imagery combine to create meaning.

Method- Media Content Analysis and thematic identification

The approach to gathering data for this study was similar to that of Part 3 of this study, the analysis of internet forum discussions. Data were gathered over a 36 month period to explore freely available social and broadcast media representations of breech positioning and breech birth. Google alerts were created to search for the term "breech" and "breech birth" on the internet from 1 January 2013 to 31 December 2015. Alerts were filed during this time for analysis at the end of this period.

Data Analysis

The media content analysis took a qualitative approach. Inductive category development was used to interrogate the language and images, in an attempt to develop themes and better understand how social language constructs messages about breech positioning and breech birth. Inductive analysis involves working from specific observations of categories and patterns (e.g. issues or messages) to a broad theory or conclusion (Macnamara 2005). Initially each piece of text and/or image was examined to ascertain the messages portrayed through the language and images used. This aimed at finding out how the reader is potentially persuaded by the language and/or images used to create meaning. This approach to media content analysis brought a systematic approach to qualitative text analysis by matching a pre-existing category to a text, rather than matching the text to a category (Macnamara 2005).

With this in mind, the pre-existing categories used were based on work done by Jeffries (2007) in her analysis of how the female body is portrayed in the media. Jeffries uses a number of defined analytical techniques to analyse media content (Jeffries 2007). Categories drawn from Jeffries' work for use in this study included the following:

- Naming
- Describing
- Contrasting
- Enumerating and Exemplifying
- Assuming and Implying

Key text elements for review of the language in the media samples gathered included the following:

- Identification of pronouns as key signifiers of meaning in text
- Adjectives used in descriptions (positive and negative) which give strong indications of a speaker's and writer's attitude (e.g. it was 'disgusting');
- Metaphors and similes used (e.g. labelling a car a 'lemon' or a person a 'rat');
- Whether verbs are active or passive voice;
- Viewpoint of the narrator (i.e. first person, second person, third person);
- Tonal qualities such as aggressiveness, sarcasm, flippancy, emotional language; and
- Binaries established in texts and how these are positioned and used.

3.5 Linking the findings to the theory

Once the analyses of all parts of this research project were complete, I undertook further exploration of the results as a whole through the lens of my chosen theoretical framework (see Table 3). The theoretical perspective of symbolic interactionism was used to examine the outcomes of the studies as I sought to investigate the presence of a socially constructed 'reality' relating to vaginal breech birth, created through the women's sub-culture, that I hypothesised may have an impact on their decision-making.

To apply this model of analysis, I returned to the text that originally inspired me to undertake this project, Robbie Davis-Floyd's 'Birth as an American Rite of Passage' (Davis-Floyd 2003). In this book, Davis-Floyd states she analysed her findings as follows:

> *"I have therefore tried in this book….to move to a perspective that views [such] choices as embedded in the hegemonic cultural model of reality that most of us to some degree embrace, in part because that model is consistently presented to us though our most basic cultural rituals."* (p.5)

In her work, Davis-Floyd applied a model derived from symbolic anthropology to the pregnancy and childbirth process. This model decodes symbolic messages conveyed to birthing women by the rituals of hospital birth, and from detailed consideration of the responses of individual women to these birth messages. Davis-Floyd proposed that the symbols of childbirth that are created by society to develop meaning, and therefore a constructed reality, are a form of ritual behavior. A ritual, Davis-Floyd states, is a *"patterned, repetitive, and symbolic enactment of a cultural belief or value"* (p.8). Rituals emerge from a belief system, and are enforced within society through rhythmic repetition. They serve to provide cognitive stabilisation for an individual in times of

stress, and to add a sense of order and inevitability for these individuals during these times of anxiety.

Davis-Floyd argues that messages conveyed through ritual are *felt* and received by an individual on an unconscious level that *"map changed or adjusted perceptions of the possibilities inherent in a situation onto the actor's orientation to it"* and serve to *"regulate and affirm a coherent symmetrical relationship between individual subjectivity and the objective social order"* (p.10). In this way, the rituals developed from symbolic actions reinforce the belief system of an individual with that of the social group conducting the ritual.

In the context of decision-making for vaginal breech birth, I applied Davis-Floyd's model of analysis to explore the presence of these symbols and how they inform the rituals that create a woman's perceived reality for her breech birth choices. This approach to analysis was also discussed in one of the two papers existing on women's decision-making for vaginal breech birth (Founds 2007) (see Chapter 2). Although symbolic interactionism and ritual formation was not used as a framework for analysis, the author suggests that the women interviewed were socialised into forming a 'reality' regarding vaginal breech birth.

Both Davis-Floyd (2003) and Founds (2007) note the strength of the medical system in informing social discourse around birth practices, which features in much of the literature studying birth in general, as well as choices for other modes of birth such as VBAC (Fenwick et al. 2010; MacKenzie Bryers & van Teijlingen 2010; Malacrida & Boulton 2014; Munro, Kornelsen & Hutton 2009). Given these conclusions, this may also be the case for decision-making for vaginal breech birth in Australia, particularly in light of the established management practices for vaginal breech birth in

NSW (Ministry of Health 2012, 2016). This theory however, is something I anticipate the findings of this research project will shed further light on.

Exploring the tensions between medical and social discourse

In her book, Davis-Floyd discusses a 'technocratic model' of medical discourse that informs socio-cultural views on birth (Davis-Floyd 2003). Davis-Floyd noted there is a tension that exists for women during the decision-making process between the 'technocratic model' and the 'nature based' model which is a more woman-centred approach. These oppositional paradigms are reflected in the following illustration.

For pregnancy and birth, the 'technocratic model' represents medical technology as a superior option for managing birth. The philosophy of the 'nature based' is in direct conflict with the technocratic model and, as Davis-Floyd argues, many women find themselves caught between these two philosophies when faced with making birth related decisions.

After the initial analysis of the socially constructed 'reality' for women's decision-making regarding planned vaginal breech birth, I delved further into the presence of this 'tension' that may exist for women. Women are making these decisions in the midst of complex socio-cultural views on birth and the rituals perceived as necessary to enact to guarantee a "safe" birth. Davis-Floyd suggests that by grasping the inner workings of how ritual becomes a powerful didactic and socialising tool, one can overcome its power and recognise there is choice in how an individual can respond to rituals that permeate our lives. In Chapter 9, I return to these issues by exploring how women grasped the inner workings of the socially reinforced rituals surrounding vaginal breech birth and how they came to a position where they recognised their right to choose an option against that which is reinforced by these current rituals.

3.6 Reflexivity

When I committed to this research, I had concerns that my own personal experience may interfere with the data gathering for this project. I was also concerned that I may have been 'too close' to the topic being studied and this would somehow bias or influence the findings and conclusions drawn from the study.

When I was advised by one of my supervisors to examine the concept of reflexivity, I became aware of the potential for my own experiences with vaginal breech birth to be a positive factor in my role as a researcher, provided that certain techniques were employed to overcome any potential problems.

Reflexivity is defined as *"an effort to reflect on how the researcher is located in a particular social, political, cultural and linguistic context"* (p.179) (Alvesson & Sköldberg 2009). The researcher with assumptions and values about the subject being studied can subconsciously allow this to colour the research process, leading to biased results. A researcher who engages in reflexivity ensures that data gathering and interpretation of findings is qualified by this knowledge (Alvesson & Sköldberg 2009). Rigour in data gathering methods is key to managing this situation. Additionally, employing adequate supervision and review of interview transcripts to identify interview techniques, that allow identification of techniques that may need modifying, is also useful (McNair, Taft & Hegarty 2008).

Personal experience with the subject being studied can allow for positive effects on the research process (McNair, Taft & Hegarty 2008). Reflecting on the identities a researcher can bring to an interview can encourage the use of these identities in a positive way, such as how their own

experiences can support the research process so that it has transferability across a variety of contexts.

The discovery that my own experience with vaginal breech birth could assist this research process, rather than hinder it, was a relief and it allowed me to commit fully to this project without concern around my own experiences. Any anxiety I had regarding this issue was alleviated by working closely with supervisors to employ the techniques mentioned below to ensure reflexivity was applied in this research. In the context of this study, they are as follows:

- My PhD was part of a larger study looking into decision-making for vaginal breech birth by women and how clinicians counsel these women. One of the midwives working as a part of the research team was a co-interviewer for the interviews with the women recruited to the study (Nicole Watts). A second interviewer present at the interviews assisted in ensuring the interviews were undertaken in an unbiased manner;
- The interview questions were devised with the assistance of my supervisors before the interviews commenced to ensure questions were not leading in any way; and
- It was agreed that I would not advise the women before the interview of my own experience.

After each interview, my research colleague and I recorded a reflective discussion to explore how the interview had gone. Reflecting on the self-perceived positives and negatives during this process also assisted in honing and refining my skill and approach to subsequent interviews. I was careful to focus on the interviewee experience, rather than my own, and draw as much information as possible from the interviews. The interviews were a rewarding process that allowed me to develop strong experience in conducting research interviews. In particular, the reflective

discussions with my research colleague were extremely useful and I felt these skills were transferrable to other elements of my PhD journey as I constantly checked myself to ensure I maintained researcher reflexivity throughout the work I conducted for this thesis.

3.7 Data Management and Storage

The Australian Code for the Responsible Conduct of Research (NHMRC 2007) identifies four important aspects data management in a research project: storage, retention, disposal, and access.

This PhD project collected two kinds of data: soft files (in the form of computer and audio-taped files), printed documents (interview transcriptions) and handwritten notes collected during interviews. All data related to participants were de-identified in order to ensure their confidentiality. Soft files data were entered and stored on a computer with a password protected directory. All printed sources of information were kept in a locked and secure filing cabinet. To prevent data loss, data backups were regularly completed.

In order to remain consistent with the guidelines from the Australian Code for the Responsible Conduct of Research (NHMRC 2007), all research data will be stored for a minimum of five years after the study is completed. After five years, the primary data will be disposed of to prevent data from being retrieved by unauthorised persons.

3.8 Ethical approval and resources

3.8.1 Ethics application

This study is part of a larger project, “Breeching in the system”, that obtained HREC approval in 2012 prior to the study commencing in 2013.

HREC ratification for my involvement in the project was granted in February 2013. Update reports were provided annually to the Royal Hospital for Women Ethics Committee and the UTS Human Research Ethics Committee.

3.8.2 Potential ethical Issues

An ethical issue that arose during the interviews with women we interviewed (Chapter 4) was the potential for the interviews to elicit strong, and perhaps upsetting, feelings for the women particularly if their birthing experience was not a positive one. Early in the interview phase of this research study, a protocol was developed for managing these situations, should they arise, that recommended subsequent contact with any of the women that the interviewers may be concerned about and ensuring information was provided for referral to appropriate counseling and support. There was one instance where this occurred and follow up phone calls were made to the woman by one of the researchers and information and support were provided.

3.8.3 Confidentiality and Anonymity

All transcripts were de-identified to ensure confidentiality of the interviewees. Completion of the questionnaires was anonymous.

3.8.4 Consent and Information Sheets

Interviews

Prior to the interviews commencing, an information sheet was provided to each woman to ensure they fully understood their research involvement. The participants voluntarily took part in the research after providing written consent.

Questionnaire

Participants were advised at the beginning of the questionnaire that completing and returning the questionnaire to the researchers implied consent for participant data to be included in the study for analysis.

3.8.5 Facilities and Resources

I have used hardware and software facilities provided by the University of Technology, Sydney as well as personal resources required for the completion of this project. Hardware included computer, printer, photocopy machine, and digital recorder, while the software includes SPSS (a statistics software package used for statistical analysis) and other Microsoft office tools. The University of Technology Sydney provided training for developing skills in using this software.

3.8.6 Resources

This project is a part of a larger study, “Breeching in the System”, which had a small amount of funding attached to it. This funding was used for transcription of the interviews with the women. Travel to and from the interviews was covered by personal finances. Any other aspects of the research project were also self-funded.

3.8.7 Summary

This chapter has provided an overview of the methodology used in this research including the theoretical framework for this study; and how the research in this thesis aligns with the chosen theoretical framework. I also provided an outline of the approaches for the four parts of this study, with the methodology, data collection methods and data analysis techniques provided for each of the four parts.

In the four following chapters (4-7), I present the findings of this study in the form of papers that have been accepted for publication and/or published. In these papers I provide a succinct summation of the results of the research I have undertaken and are in accordance with the scholarly conventions of peer-reviewed articles. The papers have not been rewritten from their published form. As a result, there is some repetition in the introduction, literature review and method sections from that described in this chapter. Chapter 8 has not been accepted for publication at the time of writing this thesis and is currently under review.

The next chapter presents the results from the semi-structured interviews with women who sought a vaginal breech birth in the form of paper that has been published in the Health, Risk and Society journal.

Chapter 4 How do social discourses of risk impact on women's choices for vaginal breech birth? A qualitative study of women's experiences *(Publication 1)*

Reference:

Petrovska, K., Watts, N.P., Sheehan, A., Bisits, A. & Homer, C.S.E. 2016, How do social discourses of risk impact on women's choices for vaginal breech birth? A qualitative study of women's experiences. *Health, Risk and Society* (early view)

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Permission to reproduce this publication in this thesis has been received by Health, Risk and Society.

4.1 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. In total, 12 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 for birth in a social setting in which the dominant discourse focused on the riskiness of breech birth and the vulnerability of female bodies that required medical

surveillance, supervision and intervention to ensure a safe birth. Thus for these mothers their pregnancy was seen through the societal lens of risk and medicalisation, with surgical intervention through a Caesarean section seen by society as the optimum choice. 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 from their families to have a Caesarean section. We identified four related strands in women's talk about resisting the dominant discourse: acknowledgment that they would be considered irrational for wanting a vaginal 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.

4.2 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 processes 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 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 et al. 2016; Taylor-Gooby 2000). In childbirth the likelihood that a mother or her baby in high income countries will be harmed during childbirth has fallen over the past 150 years, while awareness of the dangers appears 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 (Alaszewski 2016). This is underpinned by medical discourses relating to the need to protect the welfare of the vulnerable fetus and child as a priority over the mother's welfare (Coxon et al. 2016). As Alaszewski (2016) noted the fetus 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 settings, 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 to 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"* (p. 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 & George Kernohan 2010; 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, Scamell & Alaszewski 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 et al. 2010; Homer et al. 2015; MacKenzie Bryers & van Teijlingen 2010; Malacrida & Boulton 2012, 2014; Munro, Kornelsen & Hutton 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 form 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 most populated Australian state (New South Wales) show that approximately 367 (0.4%) breech babies were born vaginally (Ministry of Health 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. 2009a).

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). Many maternity units in high and middle-income countries responded to the findings of this study 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, et al. 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 et al. 2014; Glezerman 2006; Hauth & Cunningham 2002; Kotaska 2004; Lawson 2012). One of the major concerns was that the trial was not designed to explore outcomes from different categories of women. Since the publication of the Term Breech Trial researchers have also found that if women with breech presentation are suitably selected and received appropriate care and expertise then they can safely give vaginal birth (Borbolla Foster et al. 2014; Glezerman 2012; Goffinet et al. 2006; Kotaska et al. 2009b; Lawson 2012). A recent meta-analysis demonstrates that the absolute risk of vaginal breech birth is lower than previously indicated (Berhan & Haileamlak 2016). Researchers have also found that the long-term outcomes of babies born via vaginal breech birth or Caesarean section are broadly the same (Hofmeyr, Hannah & Lawrie 2015). This recent research 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 et al. 2015; RANZCOG 2013; RCOG 2006).

Despite the existence of research and guidelines that indicate, 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, the number of doctors and midwives who had the skill and confidence to support this birth option declined. In many high-income countries this option is non-existent, meaning that many women who would have otherwise opted for a vaginal delivery have to undergo a Caesarean section (Glezerman 2012; Kotaska et al. 2009b; Lawson 2012; Robson, Ramsay & Chandler 1999). This decline in vaginal breech birth is reflected in clinical training curriculums - 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 determined 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.

4.3 Methods

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

Design

In this article we draw on data from a qualitative descriptive study (Sandelowski 2000) of women in the state of New South Wales (N.S.W), 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 2000). We use an interview schedule to structure our conversation with these women which 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 - developing 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 2010; Sandelowski 2002).

Sample

We accessed the sample of women interviewed for this study through a clinician who cared for the women who planned vaginal breech birth at a large metropolitan hospital in N.S.W, 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 who conducted the interviews, Karolina Petrovska and Nicole Watts, travelled to a location convenient to the woman, usually her home. Both interviewers have worked in the NSW health system, although 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 and 35 years of age. All had given birth to their breech baby between the years 2009 and 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 we 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 article are pseudonyms.

Analysis

We used thematic analysis to analyse the data (Taylor, Kermode & Roberts 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 & Ezzy 2005; Taylor, Kermode & Roberts 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

Potential sampling bias may have influenced the results as these women were able to find hospitals that supported vaginal breech birth and agreed to be interviewed for this study. Women who had a breech baby in pregnancy that were less concerned about achieving a vaginal birth may have been less likely to agree to be interviewed. During their pregnancy, the women in this study 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. As vaginal breech birth is rare, we initially decided on a 7-year retrospective period to recruit an adequate number of participants; however all of the women consenting to be interviewed had given birth to their breech babies in the last 2-years, thereby decreasing the potential for recall bias.

4.4 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 this section how they dealt with others' lack of faith in their bodies.

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 [the 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 [from family and friends] 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 in which family and friends accepted the dominant social discourse that childbirth was a 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 procedure. It's 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 professionals who worked in maternity services contribute to the problem and that the general sense of fear around childbirth plus the threat of litigation restricted professionals' willingness to support vaginal breech birth. 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 <u>they</u> decided that was best or because <u>they</u> didn't have enough staff. And because <u>they</u> 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 a 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. 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 discussions relating to responses from family and friends, 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 fetus. 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 are 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 to recognise that they were the best judge of their own well-being and that of their unborn fetus.

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 patronising tone which friends 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 friends 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 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 <u>your</u> body and <u>your</u> baby?" (emphasis in the original)

Dealing with medical expertise and 'Doctor knows best'

The women in our study talked about the ways in which their interactions with professionals, especially doctors, appeared to be based on the assumption that the doctor has superior expertise and was therefore in a better position to judge the best interests of the mother and her unborn fetus. These assumptions, therefore, concluded that Doctors could and should veto a bad decision, such as mother trying to have a vaginal breech birth.

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 was no room in these discussions for talk of the benefits and risks of Caesarean section versus those of vaginal breech birth and therefore no room to discuss the evidence that for many women vaginal birth was a viable option. Phillippa agreed that if women went against medical advice and current practice then they were very much on their own:

"To try 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 a woman gives 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 did not result in a vaginal birth and who had to have a 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 the standard practice of Caesarean section for breech presentation. It was important that they retained control of decision-making, retained a sense of personal choice 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 birth 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 fetus 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 she 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 described her sister's 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 been 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 fetus. 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 women could not resist family pressure. For example Carly 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 judgements and commentary trying to convince me otherwise."

Christine told us that she felt frustrated when her family kept commenting on 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 isolation 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. 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.

4.5 Discussion

In this study we focused on women 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 it 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 it is more surprising that there is a general assumption that this intimate circle will provide emotional support, especially when individuals are experiencing a unique and important moment 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 friends and seeking alternative, sympathetic 'friends' online.

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, et al. 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 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). In 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 manage all the risks through a Caesarean section. If women accept this offer then they participate in the ritual of medical technology which reinforces the sense of control that technology brings that both society and clinicians appear to find comfort in (Coxon, Sandall & Fulop 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 their body through a Caesarean section with the risks of a 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 fetus. In their talk, women were sensitive to the accusation that they were being selfish by prioritising their own birthing experience over the safety of their baby, but stressed they were seeking a balance. As Dahlen and Homer (2011) have noted in many high-income countries there is a tension between 'childbirth' and 'motherbirth' (Dahlen & Homer 2011). Women who accept the 'childbirth' approach claim to be good mothers because they minimise 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 to them 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 often (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 online 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 a woman and her health care provider (Centola 2013; Centola & van de Rijt 2015). Of key importance, however, is the need for information shared via social media to be accurate and evidence-based, as propagation of misinformation can lead to inappropriate dilution or distortion of information, potentially impacting on consumer's choices in healthcare (Griffiths et al. 2012).

For the women in our study, using the media was a way of resisting the negative pressure from their existing social networks and creative 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 online. Romano et al made similar conclusion in their study of women's use of social media and vaginal birth after Caesarean section (Romano, Gerber & Andrews 2010). Engaging with 'like minds' on online 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 online 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 women (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, Scamell & Alaszewski 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, Scamell & Parker 2016). Coxon et al argue that high-level policy may not be sufficient in changing socio-cultural attitudes around the 'riskiness of birth' (Coxon, Sandall & Fulop 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*" (p.65). In our research there is evidence that vaginal breech birth as 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 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, Scamell & Parker 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.

4.6 Conclusion

In this article we have focused 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 breech births, that these 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' online.

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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Chapter 5 Supporting women planning a vaginal breech birth: An international survey *(Publication 2)*

Reference: Petrovska, K., Watts, N.P., Catling, C., Bisits, A. & Homer, C.S.E. 2016, 'Supporting Women Planning a Vaginal Breech Birth: An International Survey', *Birth*, vol.43, no.4, pp.353-7.

5.1 Abstract

Objective

The aim of this study was to explore the experiences of women who planned a vaginal breech birth.

Method

An online survey was developed consisting of questions regarding women's experiences surrounding planned vaginal breech birth. The survey was distributed between April 2014 - January 2015 to closed membership Facebook groups that had a consumer focus on vaginal breech birth.

Results

There were 204 unique responses to the survey from women who had sought the option of a vaginal breech birth in a previous pregnancy. Most women (80.8%) stated they were happy with the birth choices they made and a significant proportion (89.4%) would attempt a vaginal breech

birth in subsequent pregnancies. Less than half of women were formally referred to a clinician skilled in vaginal breech birth when their baby was diagnosed breech (41.8%), while the remainder sourced a clinician themselves. Half of the women felt supported by their care provider (56.7%) and less than half (42.3%) felt supported by family and friends.

Conclusion

The women who responded to this international survey sought the option of a vaginal breech birth, were subsequently happy with this decision and would attempt a vaginal breech birth in their next pregnancy. Access to vaginal breech birth is important for some women, however this choice may be challenging to achieve. Consistent information and support from clinicians is important to assist decision-making.

Key words: decision-making, information, support, vaginal breech birth.

5.2 Background and Objective

Breech presentation is estimated to occur in 3-5% of pregnant women at, or close to, term (Guittier et al. 2011). Most breech presenting babies are now born by elective Caesarean section. Data on the percentage of women with breech babies who seek planned vaginal birth is limited, however in Australia, 2013 data shows that of the 13, 617 babies who were diagnosed breech at term (4% of all babies born), 88% were born by Caesarean section(AIHW 2015). The remaining 12% of vaginal breech births in Australia in 2013 included both planned and unplanned births, suggesting that figures for planned vaginal breech birth are much fewer. This trend is echoed across a number of high income countries (Berhan & Haileamlak 2016; van Roosmalen & Meguid 2014). The low number of vaginal breech births is largely attributed to an international randomised control trial published in 2000, known as the Term Breech Trial, which concluded that Caesarean section was the safest mode of birth for babies in the breech position (Hannah et al. 2000). Subsequent research and systematic reviews have also been released reinforcing the Trial's results (Hofmeyr, Hannah & Lawrie 2015; Vlemmix et al. 2014), with one study noting that vaginal breech birth carries a two to five fold greater relative risk of short term morbidity and mortality than Caesarean section (Berhan & Haileamlak 2016).

Since the Term Breech Trial was published, many have challenged the methods and findings of this research (Glezerman 2006; Hauth & Cunningham 2002; Kotaska 2004; Lawson 2012). Subsequent research has also concluded that vaginal breech birth can be a safe option with the appropriate care and expertise for carefully selected women (Glezerman 2012; Goffinet et al. 2006; Kotaska et al. 2009b; Lawson 2012). However, many maternity services across the world have been reluctant to respond to this evidence, with the number of clinicians skilled in vaginal breech birth decreasing

to almost non-existent levels (Lawson 2012). This limits the birth options available to pregnant women with breech presenting babies and results in most women, in many regions across the world, having a planned Caesarean section (Kotaska et al. 2009b).

Despite the limited support for vaginal breech birth in maternity facilities, some women continue to request it as an option (Homer 2015). Women who plan a vaginal breech birth are often highly motivated and value autonomy in their decision-making for birth. Previous studies have indicated that these women undertake their own research and choose to navigate the health system to find a clinician who is willing to assist them to give birth vaginally (Ecker 2009; Homer et al. 2015; Lawson 2012).

The limited amount of quality information about vaginal breech birth and the importance of responding to consumer demand for access to vaginal breech birth was recently highlighted in The Lancet (van Roosmalen & Meguid 2014). Therefore, this study was undertaken to explore the experiences of women who reported choosing a vaginal breech birth and were motivated to seek supportive care and information that assisted them to access this option for birth. This study also aimed to increase understanding in how to best support these women and provide quality information.

5.3 Methods

This study was initially prompted by a qualitative research project that interviewed women on their decision-making for vaginal breech birth (Homer et al. 2015). In order to further investigate women's decision-making, a survey was developed to explore experiences nationally and internationally.

The electronic survey was developed by the research team for distribution to women online via social media. The survey focussed on women's expectations and experiences surrounding planned vaginal breech birth, including methods used by the woman to source a clinician skilled in vaginal breech birth and the level of support and quality of information provided from clinicians. The survey consisted of five and ten point Likert scale questions as well as open ended questions for participants to add further information if desired. Ethical approval for distribution of the survey was granted by the relevant local Human Research Ethics Committee.

The survey was piloted with two volunteers who had planned a vaginal breech birth; one had a vaginal birth, the other a Caesarean section in labour. The survey was modified following feedback that focused on the need to ensure instructions were clear and unambiguous. As a result, some questions were split to distinguish between clinician 'helpfulness' and clinician 'influence'.

The survey was uploaded onto SurveyMonkey®, an online platform that allows the distribution of research surveys for a nominal fee. Once uploaded, the survey was distributed via closed membership Facebook groups from the United States, United Kingdom and Australia that had a focus on vaginal breech birth. The survey was posted online from April 2014 to January 2015. Two reminders were posted during that period to reach women who may not have seen previous posts about the survey.

Women who were interviewed for the original research conducted on their decision-making experiences for vaginal breech birth (Homer et al. 2015) were also given the opportunity to complete the survey. It is unclear as to how many of these women responded given the anonymity of the survey submissions.

All potential respondents were provided with clear information about the nature of the data being collected and the identity of the organisation holding the data. They were also advised of the purpose for which the data were going to be used and advised that all responses were anonymous. The survey took approximately 30 minutes to complete.

Data from the Likert Scales were analysed using descriptive statistics. Responses to questions were optional and the number of respondents for each question varied. Therefore, the denominator varied depending on the number of responses. The Likert scale questions were grouped into 3 categories (Agree, Neutral and Disagree) for analysis and reporting purposes. Data from the open ended questions included in the survey was significant in volume and will be analysed using thematic analysis that will be reported elsewhere.

5.4 Results

In total 204 women who had previously planned a vaginal breech birth responded to the survey. A significant proportion was from the United States (36.2%) or Australia (29.7%). Most of the participants (53.1%) were between 31–35 years of age. More than three-quarters of the women had tertiary education (76.3%). Over one third of those who responded to the question relating to parity (62.9%) had given birth more than once (Table 4).

Table 4 Women's experiences planning a vaginal breech birth April 2014 - January 2015: Women's demographic characteristics

Variable	**n (%)**
Country of origin	**n= 185**
United States	67 (36.2)
Australia	55 (29.7)

United Kingdom	22 (11.9)
Canada	17 (9.1)
New Zealand	14 (7.5)
South Africa	3 (1.6)
Germany	2 (1.0)
Other	5 (2.7)
Age (years)	**n=203**
18-25	9 (4.4)
26-30	47 (23.2)
31-35	90 (44.3)
36-40	38 (19.7)
>41	13 (9.4)
No. of children (including index pregnancy)	**n=197**
1	73 (37.1)
2	64 (32.5)
3	28 (14.2)
4	19 (9.6)
5	13 (6.6)
Education	**n=190**
High School	31 (16.3)
University	145 (76.3)

Apprentice/Technical	16 (8.4)
Mode of birth	**n=164**
Vaginal	104 (63.4)
Emergency CS	60 (36.6)

When asked about referral to a clinician skilled in vaginal breech birth, less than half of women who responded to this question (41.8%) were referred to, and subsequently saw, a clinician who was skilled in vaginal breech birth when their baby was noted to be in the breech presentation. Women not referred to a skilled clinician sourced one independently. About half (54.2%) of the women who saw a skilled clinician received information at the first meeting to assist them in their decision-making. Of these women, almost half (49.4%) were satisfied with the information they received while a third (33.8%) were dissatisfied. Of the 164 women who disclosed their mode of birth, 104 women had a vaginal breech birth (63.4%).

Women were asked about the usefulness of being provided with detailed statistics on the safety and risk of vaginal breech birth in helping them make a decision regarding mode of birth. Over half (53.9%) agreed that the statistics were useful, while one quarter (24.4%) felt undecided.

The helpfulness of the information from clinicians was explored. Two-thirds (66.7%) of the women agreed that information received from a midwife was helpful in choosing the way they wanted to give birth while one fifth (20.3%) were unsure. About one-third (32.9%) of these women agreed that information received from a doctor was helpful in choosing the way they wanted to give birth, while almost half (49.3%) disagreed.

Access to the internet for information on vaginal breech birth was investigated. Three quarters of respondents (74.5%) felt that the information they found on the internet was helpful for choosing the way they wanted to give birth. Less than half of these women (43.1%) felt the information they found online was from reliable sources, and a third (33.3%) felt that information online had an influence on their birth choices.

Women were asked about the major external influences on their decision-making in the survey. Among those that responded, almost half (49.7%) agreed that their midwife had influenced their decision-making regarding mode of birth, while almost a third (30.5%) indicated that their doctor had an influence. Family and friends had the least influence, with less than a quarter of these women (21.3%) agreeing that family and friends had an impact on their birth choices. Almost half (42.0%) felt that family and friends held no influence over their decisions regarding their birth.

Women were asked about the support they received during decision-making for birth. Just over half (56.7%) felt supported by their care provider while one-quarter (22.7%) remained unsure. Less than half of these women (42.3%) agreed that they felt supported by family and friends. Almost all (85.8%) agreed that they would have liked to have spoken to other women who had been through the same experience.

Despite varying levels of satisfaction with information and support from care providers and family and friends, most women (89.4%) stated that they would attempt a vaginal breech birth in a subsequent pregnancy if their baby presented in the breech position and most (80.8%) were happy with the decision made for the birth of their baby.

5.5 Discussion

Our study aimed to explore women's experiences of planning a vaginal breech birth. The findings of this survey showed that levels of satisfaction with care and support varied, however many of the women who responded indicated that they were happy with the choice they made and would attempt a vaginal breech birth in a subsequent pregnancy. Our study suggests that access to vaginal breech birth was important for these women.

In our previous qualitative study, we found that the women interviewed wanted the option for a vaginal breech birth as it was considered essential to have a choice in their mode of birth (Homer 2015). They saw 'having a go' at vaginal birth as a 'rite of passage' and a primal test of womanhood. The results of the quantitative data in this study support the notion that access to skilled clinicians to explore the opportunity to give birth to their baby vaginally is important.

This is demonstrated in the findings related to the impact of external influences on the decision-making process, with a significant proportion of women either disagreeing or remaining neutral regarding external factors influencing their choices. Although midwives were noted to have a stronger influence than doctors in the decision to try for a vaginal breech birth , these findings note that overall, many of the respondents found that the clinicians they came into contact with did not have a strong influence on their decision to pursue a vaginal breech birth. Similarly, the internet and family influences were not seen as major influences.

Most women would have liked to have spoken to other women during this period, indicating that they felt a sense of isolation during this time. This is supported in our qualitative study of women's decision-making for vaginal breech birth (Homer 2015), as well as other research (Guittier et al.

2011), that suggests women feel alone in the process of making decisions about mode of birth for breech presentation.

Gaining access to helpful information was a common challenge for women who participated in this study. The challenge for clinicians is to provide this information using an unbiased, non-judgemental approach, which may be difficult given that many maternity clinicians today are heavily influenced by current practices and medico-legal contexts relating to the option of vaginal breech birth (Glezerman 2012; Homer 2015). Communicating management options for breech presentations may be related to local attitudes regarding vaginal breech birth and historical contexts following the findings of the Term Breech Trial and other studies. The Term Breech Trial changed practice in many clinical settings across the world, effectively reducing or removing the option for vaginal breech birth for many women (Berhan & Haileamlak 2016). Countries that continued to offer the option of vaginal breech birth, despite the findings of the Term Breech Trial retained clinician skill and have higher numbers of vaginal breech births than those that were significantly more affected by the Trial's findings (Glasø, Sandstad & Vanky 2013; Glezerman 2006; Homer 2015; Lawson 2012). Maintenance of clinician skill and general acceptance of vaginal breech birth as a viable option for birth may therefore account for increased satisfaction from women regarding clinician support for their options (Homer 2015).

Despite reporting dissatisfaction with information received from clinicians and the limited influence on their decision-making, two thirds of the women felt supported by their care providers. It was unclear if the care providers referred to in this question were the same as those in previous questions where they reported dissatisfaction with information and levels of influence. It may suggest that, for some women, a change in care provider to a clinician who was more supportive of vaginal breech birth occurred. This was consistent with results from our previous

qualitative study of women seeking a vaginal breech birth in New South Wales, Australia (Homer 2015). Most women in that study had to fight against the health system for the option of vaginal birth and were met with clinicians who they felt used 'scare tactics' to highlight negative consequences of vaginal breech birth as a means to dissuade them. The majority of these women were initially not in a hospital supportive of vaginal breech birth which meant finding a skilled clinician and transferring to another hospital (one that supported vaginal breech birth) or to another clinician within the same facility.

Less than half of women in the survey felt supported by family and friends, suggesting that most women's immediate social circle had negative attitudes towards vaginal breech birth. The lack of trust from broader society in the birthing process is not a new concept in the literature (Davis-Floyd 2003; Fisher, Hauck & Fenwick 2006; Murphy 2010; Reiger & Dempsey 2006; West 2011) including studies that focus on women's decision-making processes for breech birth. Findings from a Swiss study demonstrated that the women experienced decisional conflict regarding their birth options (Guittier et al. 2011). The major factors influencing this conflict were lack of support, social pressures and lack of information. Improved support from clinicians was required and more accurate information should be made available so that women felt more supported during the decision-making process. It also demonstrates the importance of clinicians engaging with women's families and/or significant others when sharing information and discussing the options available.

Our survey was available online and in English only. It may have been useful to have elicited views from non-English speaking countries that may have a more liberal policy toward vaginal breech birth. The potential for sampling bias may have impacted on the results, as only women motivated for a vaginal breech birth and who were members of closed Facebook groups were likely to have responded. This self-selected convenience sample were also women likely to have been

passionate about birth choices, which is reflected in the results indicating that many of the women would attempt a vaginal birth for a breech baby in a subsequent pregnancy. Therefore, this sample may not be representative of all women who have a breech baby or choose the option of vaginal breech birth. Responses to questions were optional and the number of respondents for each question varied, which may have impacted on the conclusions drawn from the findings. Despite these considerations, this is the first international study to explore women's experiences of vaginal breech birth and the support they received in deciding on mode of birth. The findings support the need for larger studies that explore women's experiences when choosing vaginal breech birth.

5.6 Conclusion

The women who responded to this international survey sought the option of a vaginal breech birth, were subsequently happy with this decision and would attempt a vaginal breech birth in a subsequent pregnancy. Many of the women in this study appeared to receive varying degrees of information and support for the option of vaginal breech birth. This highlights that access to vaginal breech birth is important for some women, however this choice may be challenging to achieve. Consistent information and support from clinicians is important to assist decision-making and planning care in the antenatal period.

Chapter 6 "Stress, anger, fear and injustice": An international survey of women's experiences planning a vaginal breech birth *(Publication 3)*

Reference:

Petrovska, K., Watts, N.P., Catling, C., Bisits, A., Homer, C.S.E. 2016, Stress, anger, fear and injustice": An international survey of women's experiences planning a vaginal breech birth. *Midwifery* (early view). http://dx.doi.org/10.1016/j.midw.2016.11.005

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6.1 Abstract

Objective

The outcomes of the Term Breech Trial had a profound impact on women's options for breech birth, with Caesarean section now seen as the default method for managing breech birth by many clinicians. Despite this, the demand for planned vaginal breech birth from women does exist. This study aimed to examine the experiences of women who sought a vaginal breech birth to increase understanding as to how to care for women seeking this birth option.

Design

An electronic survey was distributed to women online via social media. The survey consisted of qualitative and quantitative questions, with the qualitative data being the focus of this paper. Open ended questions sought information on the ways in which woman sourced a clinician skilled in vaginal breech birth and the level of support and quality of information provided from clinicians

regarding vaginal breech birth. Thematic analysis was used to analyse and code the qualitative data into major themes.

Findings

In total, 204 women from over seven countries responded to the survey. Written responses to the open ended questions were categorised into seven themes: *Seeking the chance to try for a vaginal breech birth; Encountering coercion and fear; Putting the birth before the baby?; Dealing with emotional wounds; Searching for information and support; Traveling across boundaries ; Overcoming obstacles in the system.*

Key Conclusions

For women seeking vaginal breech birth, limited system and clinical support can impede access to balanced information and options for care. Recognition of existing evidence on the safety of vaginal breech birth, as well as the presence of clinical guidelines that support it, may assist in promoting vaginal breech birth as a legitimate option that should be available to women.

Keywords: Vaginal breech birth, support, decision-making, women's experiences

6.2 Introduction

The outcomes of the Term Breech Trial had a profound impact on women's choices for birth of their breech presenting baby, with the findings of the Trial concluding that Caesarean section (CS) was the safest mode of birth for babies in the breech position (Glezerman 2006; Hannah et al. 2000; Kotaska et al. 2009b; Lawson 2012). The swift response from maternity facilities across the world was to virtually abandon planned vaginal breech birth (vaginal breech birth) in favour of elective CS for management of breech presentation at term (Berhan & Haileamlak 2016). The design and recommendations of the Term Breech Trial have since been the subject of significant critique (Catling et al. 2016a; Glezerman 2006, 2012; Lawson 2012). Additionally, subsequent research has also shown that vaginal breech birth can be a safe option for carefully selected women with the appropriate care and expertise (Borbolla Foster et al. 2014; Glezerman 2012; Goffinet et al. 2006; Kotaska et al. 2009b; Lawson 2012).

For the 3-5% of women who have a breech presentation at the end of their pregnancy, the options for birth in many high income countries have largely diminished with CS now seen by many facilities as the default method for managing breech birth (Borbolla Foster et al. 2014; Guittier et al. 2011; Kotaska et al. 2009b). This has contributed to the rise in CS (and its associated morbidity), a lack of support for women who may seek a vaginal breech birth, and a lack of clinicians who have the skills to provide that care (Berhan & Haileamlak 2016; Catling et al. 2016a; Homer et al. 2015; Petrovska, Watts, Catling, et al. 2016; Walker, Scamell & Parker 2016).

Clinician skill in supporting vaginal breech birth, once an integral part of obstetric and midwifery training, virtually disappeared, with the number of clinicians skilled in facilitating vaginal breech births decreasing to almost non-existent levels in many institutions (Borbolla Foster et al. 2014;

Glezerman 2012; Lawson 2012; Walker, Scamell & Parker 2016). Recent research has suggested that in order to address the shortage of skilled clinicians, structured training programs may contribute to increasing professional competence and confidence in physiological vaginal breech birth as a normal practice (Walker, Scamell & Parker 2016). These programs may facilitate maternity services to address the lack of options many women currently face when seeking the opportunity to birth their breech baby vaginally. Without the availability of skilled clinicians, women considering planned vaginal breech birth face numerous obstacles in seeking information for this birth option as facilities that support vaginal breech birth continue to be largely unavailable (Catling et al. 2016a; Glezerman 2012; Hogle et al. 2003; Homer et al. 2015; Kotaska et al. 2009b; Phipps et al. 2003).

Few studies exist on the experience of women who are seeking information to assist them in their decision-making for vaginal breech birth. The limited research that does exist suggests that accessing support for vaginal breech birth can be challenging for women seeking this option for birth (Guittier et al. 2011; Homer et al. 2015). Given a demand for vaginal breech birth does exist, and there is continuing support in the literature about the need to increase the availability of this option for birth, it is important to examine the experiences of women to increase understanding as to how care for planned vaginal breech birth can be optimised (Glezerman 2012; Kotaska et al. 2009b; Lawson 2012; van Roosmalen & Meguid 2014). Little is known about the global experiences of women from high income countries and the similarities and differences in their experiences in seeking the option of vaginal breech birth. Therefore, the aim of this study was to examine the views and experiences of women from a number of high income countries who sought a vaginal breech birth, with a view to increase understanding as to how these women can be best supported should they choose this option for care.

6.3 Methods

An electronic survey was developed by the research team for distribution to women online via social media. The aim of the survey was to gather data on women's expectations and experiences surrounding planned vaginal breech birth. The survey was targeted at women who have planned a vaginal breech birth at or close to full term in the past 7 years, regardless of whether the final outcome was a vaginal breech birth or a Caesarean section. The survey was designed to gather both qualitative and quantitative data. Data from the open ended questions included in the survey were analysed for this paper. The open ended questions focused on the methods used by the woman to source a clinician skilled in vaginal breech birth; use of the internet to source information on vaginal breech birth; the level of support from family and friends; and the level of support and quality of information provided from clinicians regarding vaginal breech birth. Survey questions were developed and informed by the data gathering methods used in previous qualitative research that involved semi- structured interviews with women who planned a vaginal breech birth (Homer et al. 2015). The survey was piloted with two women who had planned a vaginal breech birth; one had a vaginal breech birth, the other a CS in labour. Following feedback, the survey was modified to ensure survey questions were accessible and unambiguous.

Data Collection

Previous research shows that women access social media to gather information and interact with other women who have had or are planning a vaginal breech birth (Homer et al. 2015). This method of information gathering is frequently used by pregnant women for decision-making about birth (Dahlen & Homer 2011; Lagan, Sinclair & Kernohan 2011; Munro, Kornelsen & Hutton 2009; Romano, Gerber & Andrews 2010). It was therefore decided to use social media to

distribute this survey. In order to facilitate sharing of the survey, it was first uploaded onto SurveyMonkey®, an online platform that allows the distribution of research surveys for a nominal fee. Once uploaded, a link to the survey was distributed via closed membership Facebook groups from the United States, United Kingdom and Australia that had a focus on vaginal breech birth and whose membership to these groups is not limited to women from each of these countries. Ethical approval for distribution of the survey was granted by both the Local Health District and the University's Human Research Ethics Committee.

The survey was posted from April 2014 to January 2015. This extended period of data collection was implemented to maximise the sample size of respondents, given planned vaginal breech birth is a relatively rare occurrence. During this period, one researcher was responsible for providing two reminders to ensure as many women as possible viewed the link to the survey. Women who were involved in previous research on women's experiences in planning vaginal breech birth (Homer et al. 2015) were also invited by email to complete the survey anonymously via SurveyMonkey®.

All potential respondents were provided with clear information about the nature of the data being collected and the identity of the organisation holding the data where the research team was based. They were also advised of the purpose for which the data were going to be used and informed that all responses were anonymous. The survey took approximately 30 minutes to complete. A research team member checked social media pages regularly to respond to any further questions that may have arisen from potential respondents.

Data Analysis

Two members of the research team used inductive thematic analysis to analyse and code the data (Liamputtong 2005). Thematic analysis was used as it has been cited as a process that identifies patterns that uncover true meanings in the data (Betts, Dahlen & Smith 2014; Boyatzis 1998; Grbich 2007).

The qualitative components of the survey were read and re-read by two members of the research team with the intention of gaining familiarity with the text. Following this process, initial identification of codes and potential themes occurred through colour coding of transcripts by hand. The accuracy of how to sort codes with similar content into sub-themes was confirmed in discussions between the two researchers.

Major themes were generated from the sub themes and then compared with the entire data set to confirm authenticity and to ensure the experience of the respondents were captured (Taylor, Kermode & Roberts 2006). Where there was divergence of opinion the data was re-examined, themes revisited and refinements or changes were made (Dahlen & Homer 2011). Themes have been generated using the women's exact words as they provided compelling examples of the responses included in the survey and were representative of the themes (Betts, Dahlen & Smith 2014; Homer et al. 2015). A third and fourth researcher then critiqued these findings and themes, which allowed for further refinement of the results.

6.4 Results

In total 204 women responded to the survey. Table 5 (following page) outlines the demographic characteristics of survey respondents. Most of the participants (44.3%) were between 31–35 years

of age and were from the United States of America or Australia. More than three-quarters of the women had tertiary education (76.3%). Over one third of those who responded to the question relating to parity (62.9%) had given birth more than once. Of the 164 who disclosed their mode of birth, 104 women had a vaginal breech birth (63.4%).

Table 5 Women's demographic characteristics

Variable	**n (%)**
Country of origin	**n= 185**
United States	67 (36.2)
Australia	55 (29.7)
United Kingdom	22 (11.9)
Canada	17 (9.1)
New Zealand	14 (7.5)
South Africa	3 (1.6)
Germany	2 (1.0)
Other	5 (2.7)
Age (years)	**n=203**
18-25	9 (4.4)
26-30	47 (23.2)
31-35	90 (44.3)
36-40	38 (19.7)
>41	13 (9.4)
No. of children (including index	**n=197**

pregnancy)	
1	73 (37.1)
2	64 (32.5)
3	28 (14.2)
4	19 (9.6)
5	13 (6.6)
Education	**n=190**
High School	31 (16.3)
University	145 (76.3)
Apprentice/Technical	16 (8.4)
Mode of birth	**n=164**
Vaginal	104 (63.4)
Emergency CS	60 (36.6)

Written responses to the open ended questions in the survey ranged widely from a few words to longer, more detailed answers. Seven themes were generated from these responses: *Seeking the chance to try for a vaginal breech birth; Encountering coercion and fear; Putting the birth before the baby?; Dealing with emotional wounds; Searching for information and support; Traveling across boundaries ; Overcoming obstacles in the system.*

These are presented below with quotes to illustrate the key concepts. Direct quotes are referenced by participant number (for example: Participant 1-P1)

Seeking the chance to try for a vaginal breech birth

Women expressed the desire to labour and give their bodies a chance to attempt to give birth to their babies vaginally. While there was disappointment that for some, a CS was required, there was satisfaction in knowing that they had tried their best. It seemed to be important for them to know they had done everything they could to maximise the chance of vaginal birth. Rather than seeing a CS as a failure, women instead felt it would be a failure to not explore the opportunity to give themselves a chance for vaginal birth, for example, one woman wrote:

"It didn't work as a vaginal birth which was disappointing as my first birth was natural and lovely, but I'm ok with it because I tried everything to turn it and deliver it. A c section was my last option but that is ok. Baby is here now and I have no regrets because at least I tried. I would have felt completely cheated if my only option had been a Caesar and I would have felt like I had failed."(P 35)

Women regretted not having access to this care or feeling like they had a voice in order to express their wishes for birth of their baby. For those women who were not given the opportunity to try, the sense of loss was significant, for example:

"It was the most disempowering experience of my life." (P36)

While the experience of meeting their baby for the first time was an exciting and moving experience, women felt that the disempowerment they experienced had left a mark that was long lasting. Women seemed to want or need the chance to try for a vaginal birth and were regretful if this could not happen.

Encountering coercion and fear

Respondents wanted to be able to make a choice for their birth option and when they expressed this desire, they felt further disempowered when they experienced 'scare tactics' and judgemental attitudes from care providers. Women felt this was a direct cause of the stress they experienced in the final weeks of their pregnancy. The presence of supportive partners and clinicians did not preclude them from experiencing negative sentiments and threats from other staff present that were not supportive of vaginal breech birth. One woman wrote:

"I was not happy with the threats and bullying which continued into labour - in the complete absence of any medical problems whatsoever I should add, it was a textbook breech/vertex twin birth. [They said] 'You have to get on the bed for a VE (vaginal examination)-*you don't have a choice, your babies are going to die, you are going to die, why did you come here if you don't want us to help you, your kids will be left without a mother….' " (P 23)*

Lack of clinician engagement was also cited by women as an element of care that was unsupportive of their choices. Women who sought the opportunity to have informed discussions with their care provider and engage in shared decision-making did not feel they were given this opportunity. Instead, they were treated as an inconvenience, with their decision-making process for birth being treated as unimportant. One woman explained this:

"It was either: planned Caesarean section or not. 'Have you made up your mind yet? I am busy, go outside and see me if I have a spare minute to let me know what you want. If you don't go for a planned Caesarean section and you end up with an emergency Caesarean section you are at the bottom of our list. That was the info I got. It was bullying, and giving me options as if I could choose between a cappuccino or an Americano." (P 56)

Women felt their views and wishes about the birth of their baby were not listened to and this caused a sense of isolation and vulnerability.

Putting the birth before the baby?

Pressure and judgement from family members also featured strongly during the decision-making process for women who responded to the survey. The resulting stress and anxiety had the potential to impact on the birth experience, for example:

"I feel like breech is a highly politicised area – and the weight of negativity is against you. People feel free to tell you that the thought of a breech baby was "their worst nightmare" during their pregnancy; people are quick to label the baby stubborn or difficult; you have to answer to everyone about why you are potentially risking the baby's life in order to deliver it naturally. I didn't feel supported from diagnosis of breech to day of birth. It was a very difficult time between myself and my partner and our families. The birth ended up being very, very difficult in terms of what was going on in my relationship and with family members." (P 18)

Accusations of women 'putting the birth before the baby' were also common. Women felt that society's view was that seeking a vaginal breech birth was selfish. Women were driven to find support online, where social media connected them with other women who sought vaginal breech birth. This was explained by this example:

"Friends and family were terrified and uninformed. I was told I was putting the safety of my baby at risk because of my own desires to have a natural birth. The reality is that I wanted a natural birth for the benefit of my baby! Most friends told me that I was being selfish and that it was way too dangerous." (P 18)

Fielding negative views and judgements of others was a common theme from many of the respondents in this survey. While some were able to remain confident about their choices, other felt it had a profound impact and caused significant anxiety in the lead up to the birth of their baby.

Dealing with emotional wounds

Women spoke of experiencing stress and anxiety during the decision-making process for vaginal breech birth. Additionally, for some, the day of their baby's birth was recalled as a mostly negative experience, with the only positive aspects being a sense of satisfaction that they had fought as hard as they could to optimise the chance of vaginal breech birth, for example:

"My baby's birth day was filled with stress, anger, fear and injustice. The only part that felt good was that I did my very best to advocate for myself." (P 63)

Women also discussed the longer term impacts of how this stress manifested itself and the effects it had on their immediate relationships. This was explained:

"It was a very difficult experience for my partner and I, who weren't 100% reconciled on the decision I made to try and deliver. The effects of this continued after the birth, too. It's taken two years and another baby (head down, born naturally) to heal some of those emotional wounds." (P 18)

Women felt there was a lack of recognition of the potential for negative long term impacts when experiencing stressful negotiations around birth late in pregnancy. One woman identified as having developed significant mental health problems during the postnatal period that she linked

directly to the challenges she experienced when making the decision to try for a vaginal breech birth and negotiating her desired birth plan. She explained:

"I had PND (postnatal depression) *and honestly believe it started in pregnancy as a result of the stress and unhappiness I felt whilst fighting everyone to get the birth I wanted." (P 3)*

These responses indicate there is potential for considerable psychological impact on those that felt it was a significant struggle to search for supportive care.

Searching for information and support

Women who were unable to access clinicians supportive of vaginal breech birth found obtaining information to assist them in making an informed decision challenging. The lack of available counseling drove them to do their own research, which they feel had a profound impact on their birth choices and final outcome. One woman explained:

"My antenatal care was disjointed and challenging, was laughed at by Doctors and had no proper counseling, and was given no proper options other than an elective Caesarean. I was never given any detailed statistics, all I was given was threats of dead babies if I didn't comply. It was very much a "pull" system for information. Had we not done our own research, we would've had a Caesarean." (P 34)

It was difficult for women to feel like they had comprehensive information from clinicians to make an informed decision. As a result, women turned to the internet to seek information, both through websites and by sharing information with other women on social media. Approximately 50% of respondents used social media websites to connect with other women and seek information

through those channels. Reading other women's birth stories was comforting and provided a sense of relief from the isolation they were experiencing, for example:

"It [social media] was hugely helpful and motivating when making our decision. It was very useful to read birth stories and get good support online from breech moms across the globe." (P 18)

The internet was used as a tool for information sharing and helped women build confidence in their decision-making processes. For those who had the means to travel late in the pregnancy, it was also used to seek information on the location of clinicians skilled in vaginal breech birth outside of their local area.

Traveling across boundaries

It was common for women to change care providers later in pregnancy to access care providers that were supportive of vaginal breech birth. Most women spoke of doing their own research to find these care providers after feeling unsupported by the care provider they had accessed for most of their pregnancy. For some, this meant travelling long distances to access this care. This woman said:

"There were zero providers in my area so I contacted a doctor interstate in – 8 hours north. He was both skilled, confident and relaxed so we traveled to his hospital. My water broke as we arrived and, 24 hours later, I had my beautiful breech baby, vaginally." (P 29)

Transferring facilities to access vaginal breech birth was not always a positive experience. Women resented being forced to make choices to avoid personal conflicts and the need to feel grateful to clinicians for being 'saved' from intervention that was potentially unnecessary to begin with. One woman explained:

"I sometimes regret having transferred care and not sticking up for myself and demanding my rights in the public system. My husband was against anything that might involve conflict and that was a big part of my decision. If I'd had the support of somebody who was not scared to advocate for me, I may have made different choices. I would have preferred to work with the system rather than leave the system so I have regrets about that. I also really hate the fact that I am expected to be 'grateful' to the Obstetrician who 'saved me' from a Caesarean that I didn't need." (P 55)

For the women in this survey, accessing supportive care was challenging and often required significant effort and anxiety to travel across service boundaries or state lines to access supportive care.

Overcoming obstacles in the system

The women who responded in this survey found themselves negotiating a system of care in conflict over vaginal breech birth. Women who felt they had established support for vaginal breech birth found that this was not always sufficient and that there were additional obstacles to overcome at a system wide level. They stated that their clinician's 'hands were tied' by system attitudes towards vaginal breech birth that sought to prevent the option being available to women seeking it, for example:

"I was already being attended by a group of hospital midwives skilled in vaginal breech birth, which I confirmed several times in the second half (of pregnancy)*. At 37 weeks they finally disclosed that although they were skilled and experienced, hospital policy did not allow for them to attend a primip vaginal breech birth even with informed consent and informed refusal of a Caesarean." (P 19)*

Respondents expressed concern that the lack of system wide support for vaginal breech birth was limiting the opportunity for supportive clinicians to observe vaginal breech birth. They feared that the limited, or non-existent, chances for clinicians to develop skills would impact on the availability of choice for women seeking a vaginal breech birth in the future. This was explained:

"I feel it's a shame there is not more education and support for new doctors coming through. They can't support us mums of breechlings if they aren't supported themselves. I'm genuinely fearful that the option of breech vaginal births will die out as the skills are being lost as CS has become the norm." (P 11)

The women recognised the importance of clinician skill in maintaining the availability of vaginal breech birth and recognised that lack of wider system support for vaginal breech birth had a significant impact on opportunities for clinicians to gain and maintain these skills.

6.5 Discussion

This study sought the views of women from a number of countries about their expectations and experiences surrounding planned vaginal breech birth. In summary, women found it challenging to find supportive care as many clinicians and health facilities they encountered were not supportive of this option for birth. Women were faced with negativity from both unsupportive clinicians and social circles about the option of vaginal breech birth. Those who were unable to obtain information to support their decision-making for vaginal breech birth turned to social media and the internet and used this forum as a means to find supportive clinical care, with some having to travel long distances to access this care.

System-centred care vs woman-centred care

Women seeking a vaginal breech birth in this study found themselves negotiating a system where they no longer felt at the centre of the pregnancy and birth process. Clinician and facility concern over risks associated with vaginal breech birth created a 'system-centred' approach where health facilities were led by perceptions of risk around vaginal breech birth. This resulted in women being denied the opportunity to explore their desired birth option.

Similar results were reported in a qualitative study of 22 women that explored their decision-making process for vaginal breech birth (Homer et al. 2015). The women cited a lack of autonomy and control in their decision-making and attributed this to entrenched clinician and system views regarding the risks associated vaginal breech birth. These views are difficult for health systems to shift. When faced with a woman seeking to explore this birth option, health systems seek to manage the woman by dictating her options to her rather than maintaining her as the focus of the pregnancy and birth process.

System attitudes to vaginal breech birth may be a result of it being viewed as outside the parameters of normal birth, thereby requiring increased surveillance and risk management (Homer et al. 2015; Murphy 2010). The decline in clinicians skilled in vaginal breech birth further reinforces the current perceptions of the need to medically manage breech presentation by engaging CS as default practice of the birth of a breech baby (Berhan & Haileamlak 2016; Glezerman 2012). The preference for medicalisation and control of birth for perceived guarantee of safe outcomes directly opposes the woman-centred focus in favour of the technocratic approach whereby medical management of birth is seen as the superior option to vaginal birth (Coxon, Scamell & Alaszewski 2012; Davis-Floyd 2001, 2003; Scamell 2014; Scamell & Alaszewski

2012, 2016). Women seeking vaginal breech birth may often pose a challenge to obstetric maternity care that is characterised by paternalistic authority and decision-making for the woman, rather than in collaboration with the woman (Cheyney, Everson & Burcher 2014; Homer et al. 2015). These current norms are seen as an attempt to control power and preserve authority in obstetric care which relies on the ritualised medicalisation of birth. Women seeking vaginal breech birth are a threat to this authority and challenge the ritualised behaviour of CS for management of the breech presenting baby. Ritualised medical norms have also been cited to inform social discourse, which, for vaginal breech birth, may reinforce CS as the safest option for breech birth (Coxon, Sandall & Fulop 2014; Coxon, Scamell & Alaszewski 2012; Davis-Floyd 2003; Homer et al. 2015).

The impact of anxiety and the need for support

Pressure from the women's social circles, in addition to negative clinician views regarding vaginal breech birth, created anxiety for many of the women in this study during their last weeks of pregnancy. Stress and anxiety during the antenatal period has been shown to increase the potential for childbirth interventions, emergency and elective CS, postnatal depression, post-traumatic stress disorder and depression (Buist et al. 2008; Donnellan-Fernandez 2011; Fisher, Hauck & Fenwick 2006; Söderquist et al. 2009). Current evidence also suggests that maternal anxiety during the antenatal period can also have poor long term health implications not only for the mother but also for the baby postnatally (Ding et al. 2014; Hector, LeFevre & Williamson 1989; Leigh & Milgrom 2008).

Existing research on decision-making for breech birth suggests that women feel a sense of isolation in their decision-making for vaginal breech birth (Guittier et al. 2011; Homer et al. 2015).

Therefore healthcare providers should give close attention to anxiety in pregnant women and make all attempts address any concerns from the woman that may arise. For women with breech babies, the time from diagnosis of breech to birth can be intensely stressful, as evidenced by the women's stories in the findings of this study. It is important for clinicans to ensure women with a breech baby feel supported in the final weeks of their pregnancy to prevent anxiety from escalating.

The challenge of shared decision-making for vaginal breech birth

The women in this study reported feeling stress and anxiety because they were not able to access care that was supportive of vaginal breech birth. The women who encountered resistance to vaginal breech birth found the traditional process of provider-led decision-making failed to prioritise their medical, social and psychological factors that may have played a role in the decision to seek a vaginal breech birth. This has previously been identified as an obstacle to shared decision-making between the care provider and the woman (Cox 2014). Those who felt they had maintained autonomy through shared decision-making with their treating clinicians reported feeling more positive about their experience, regardless of the eventual mode of birth. They spoke of preserving a sense of control and feeling a sense of satisfaction at having 'exhausted all the options' to try for vaginal breech birth.

Shared decision-making can be seen as a midpoint between "paternalistic" and "informed choice" models of decision-making and is characterised by a patient and health care provider relationship where information is shared and management decisions are agreed upon (Elwyn, Edwards & Kinnersley 1999; Müller-Engelmann et al. 2011). Shared decision-making has been shown in the literature to have a number of benefits for women's decision-making in birth scenarios that may

be considered challenging for clinicians (Cox 2014; Nieuwenhuijze et al. 2014; Shorten et al. 2004). It has also been cited as encouraging evidence-based practice and incorporation of women's values and preferences and it has also been suggested that it may reduce the likelihood of malpractice liability (Bryant et al. 2007; Cox 2014; Kaimal & Kuppermann 2010). The importance of clinicians providing information to women to make informed choices has recently been emphasised by the Supreme Court of the UK in Montgomery v Lanarkshire Health Board (Powell, Walker & Barrett 2015). The outcomes of this case emphasised the need for those receiving medical care to be made fully aware of risks and benefits of all options for care. In the context of breech birth, therefore, clinicians also have legal and professional duties to support the process of shared decision-making by providing full and unbiased information to women diagnosed with a breech baby during pregnancy.

The challenge of incorporating shared decision-making for vaginal breech birth may include a lack of system support for clinician training and upskilling to support vaginal breech birth, thereby creating an entrenched bias in favour of CS as the preferred management option (Glezerman 2012; Lawson 2012). Challenging limited system and clinical support for vaginal breech birth requires recognition of existing evidence on the safety of vaginal breech birth and recognition of the need to provide unbiased information on vaginal breech birth in an accessible manner as well as increasing access to clinicians skilled in supporting vaginal breech birth through structured and targeted education (Azria et al. 2009; Goffinet et al. 2006; Lawson 2012; Walker, Scamell & Parker 2016).

By combining evidence-based practice and shared decision-making, women's views will be valued and their preferences will be prioritised (Cox 2014). A useful model that may assist in supporting this process entails five steps of evidence-based inquiry: 1) finding out what is important to the

woman and her family 2) using the information from the clinical examination 3) seeking and assessing the evidence to inform decisions 4) talking it through 5) reflecting on outcomes, feelings and consequences (Page & McCandlish 2006).

Maternity services should also acknowledge that women are likely to continue to choose vaginal breech birth as an option for birth and that shared decision-making should be recommended in clinical guidelines that are developed for guidance on the management of breech presentation. This approach is supported in existing research (Homer et al. 2015; Kotaska 2007) as well as clinical guidelines for management of breech presentation from the UK and Canada (Kotaska et al. 2009b; RCOG 2006). These documents contain clear statements about the need to respect a woman's decision and that information on risks and benefits for all option for birth should be provided. There is also some evidence emerging of specialist multidisciplinary teams to support planned vaginal breech births wherever possible, along with some other services who support formal referral processes and counseling of women prior to decision-making for vaginal breech birth (Borbolla Foster et al. 2014; Maier et al. 2011; Marko et al. 2015; Walker, Scamell & Parker 2016). Increasing the existence of such services may raise the profile of vaginal breech birth as a valid option and, given the influence medical discourse has on social discourse (Coxon, Sandall & Fulop 2014; Coxon, Scamell & Alaszewski 2012), may also impact on the acceptability of vaginal breech birth in socio-cultural contexts as a normative practice.

One limitation of this survey is that it was provided in English only and excluded women who do not speak English and could access the internet and social media. The sample size was relatively small given the membership of each of the Facebook groups from the United States, United Kingdom and Australia had over 1,000 members in each group. Distribution of the survey was also limited to these social media sites, making it inaccessible to women who may not use social media.

Survey responses were not identified or analysed by country. A large proportion of respondents were from the United States, where access to vaginal breech birth is limited in many states and this may have influenced the results. Additionally, the differences in the provision of maternity care and the training and skill of clinicians may have also influenced the findings. However, this survey is the first of its kind to examine this issue. The views of this group of women and the results should be considered in obstetric and midwifery practice.

6.6 Conclusion

Women with a breech presentation diagnosed late in pregnancy may choose to explore the option of vaginal breech birth. Limited system and clinical support for vaginal breech birth can impede women's access to balanced information for decision-making and sourcing care that is supportive of vaginal breech birth. This potentially increases maternal anxiety and, from a service provision perspective, diminishes woman-centred approaches to care. Recognition of existing evidence on the safety of vaginal breech birth, as well as the presence of clinical guidelines that includes support for vaginal breech birth, may assist in shared decision-making for vaginal breech birth and promoting vaginal breech birth as a legitimate option for birth that should be available to women for birth of their breech baby.

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Chapter 7 The Fact and the Fiction: A prospective study of internet forum discussions on vaginal breech birth *(Publication 4)*

Reference:

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7.1 Abstract

Background

Women with a breech baby late in pregnancy may use the internet to gather information to assist in decision-making for birth. The aim of this study was to examine how women use English language internet discussion forums to find out information about vaginal breech birth and to increase understanding of how vaginal breech birth is perceived among women.

Method

A descriptive qualitative study of internet discussion forums was undertaken. Google alerts were created with the search terms "breech birth" and "breech". Alerts were collected for a one-year period (January 2013 to December 2013). The content of forum discussions was analysed using thematic analysis.

Results

A total of 50 forum discussions containing 382 comments were collected. Themes that arose from the data were: Testing the waters-which way should I go?; Losing hope for the chance of a normal birth; Seeking support for options-who will listen to me?; Considering vaginal breech birth-a risky choice?; Staying on the 'safe side'- Caesarean section as a guarantee; Exploring the positive potential for vaginal breech birth.

Conclusion

Women search online for information about vaginal breech birth in an attempt to come to a place in their decision-making where they feel comfortable with their birth plan. This study highlights the need for clinicians to provide comprehensive, unbiased information on the risks and benefits of all options for breech birth to facilitate informed decision-making for the woman. This will contribute to improving the woman's confidence in distinguishing between "the fact and the fiction" of breech birth discussions online.

Keywords: vaginal breech birth; decision-making; information; internet

7.2 Introduction

Problem
Vaginal breech birth remains a rare option for birth. It can be difficult for women to find information to assist them with their decision-making when exploring the potential for a vaginal breech birth.
What is Already Known
Pregnant women turn to online communities to seek information about birth in general. These interactions can have a significant impact on pregnant women in their decision-making around birth.
What this Paper Adds
Women are searching for information online about vaginal breech birth. There is a need for clinicians to provide comprehensive, non-judgemental information on the risks and benefits of all birth options for women with a breech presentation.

Breech presentation occurs in 3-5% of pregnant women at the end of their pregnancy (Guittier et al. 2011). Caesarean sections (CSs) are widely regarded as the default option for birth of a breech baby, with worldwide trends showing only a small number of breech babies being born vaginally (Kotaska et al. 2009b). Data on the percentage of women with breech babies who seek planned vaginal birth is limited, however in Australia, 2013 data shows that of the 13, 617 babies who were diagnosed breech at term (4.4% of all babies born), 88% were delivered by CS (AIHW 2015). This trend is echoed across a number of developed countries (Berhan & Haileamlak 2016; Sharoni, Lyell & Weiniger 2015; van Roosmalen & Meguid 2014). The small number of vaginal breech births can most likely be attributed to a large international randomised control trial conducted in 2000,

known as the Term Breech Trial, which concluded that planned CS is the safest mode of birth for babies in the breech position (Hannah et al. 2000). Following this Trial, CSs increased significantly and the number of clinicians skilled in facilitating vaginal breech births decreased to almost non-existent levels in many countries (Berhan & Haileamlak 2016; Lawson 2012; Sullivan, Moran & Chapman 2009). Subsequent research and systematic reviews have also been released since the TBT reinforcing the Trial's results (Hofmeyr, Hannah & Lawrie 2015; Vlemmix et al. 2014), with one study noting that vaginal breech birth carries a two to five fold greater relative risk of short term morbidity and mortality than CS (Berhan & Haileamlak 2016).

Support for the option of vaginal breech birth is based on significant research demonstrating the safety of vaginal breech birth for carefully selected women with the appropriate care and expertise (Berhan & Haileamlak 2016; Glezerman 2012; Goffinet et al. 2006; Kotaska et al. 2009b; Lawson 2012). Additionally, long term outcomes of babies born via vaginal breech birth or CS have been shown to be similar(Hofmeyr, Hannah & Lawrie 2015), and a recent meta-analysis has demonstrated that the absolute risks of vaginal breech birth is lower than previously indicated (Berhan & Haileamlak 2016). The existence of guidelines and recent research that supports vaginal breech birth in selected cases also indicates that there is some potential for women to explore this birth option in facilities that have staff with the relevant clinical expertise (Catling et al. 2016a, 2016b; RANZCOG 2013; RCOG 2006).

Despite this recent evidence and clinical guidelines supporting planned vaginal breech birth in selected cases, this option for birth remains rare with lack of clinician skill being cited as a major factor for the limited opportunity to birth a breech baby vaginally (Glezerman 2006, 2012; Lawson 2012; Walker, Scamell & Parker 2016). As a result, most women with a known breech baby have a planned CS (Kotaska et al. 2009b)' (Sullivan, Moran & Chapman 2009), however there are a small

number of women who seek out the potential for vaginal breech birth (Homer et al. 2015; Sullivan, Moran & Chapman 2009). Given the limited number of clinicians skilled in vaginal breech birth, it can be difficult for women to find information to assist them with their decision-making (Catling et al. 2016a; Homer et al. 2015).

Several researchers have observed that some pregnant women turn to online communities to network with other pregnant women, seek information on their pregnancy and share their experiences (Dahlen & Homer 2011; Lagan, Sinclair & Kernohan 2011; Munro, Kornelsen & Hutton 2009; Romano, Gerber & Andrews 2010). The information found in these online communities can have a significant impact on pregnant women in their decision-making around birth. This study adds to the growing body of research on health information seeking on the internet and the way in which this informs patient decision-making on personal health matters (Backman et al. 2011; Centola & van de Rijt 2015; Griffiths et al. 2012; Lagan, Sinclair & Kernohan 2011; Lee & Kvasny 2013; Stewart Loane & D'Alessandro 2014). While existing research has demonstrated discussion with communities online can be positive tool for women's decision-making during pregnancy, this method of information gathering has also been criticised for "scare mongering" due to misrepresentation of information or misinformation (Griffiths et al. 2012; Lagan, Sinclair & George Kernohan 2010).

Given the widespread use of the internet for gathering information, and the lack of options around vaginal breech birth, it is likely that women finding themselves with a breech baby may turn to the internet for support and information. No studies exist that explore the ways in which women discuss vaginal breech birth online. Therefore, the aim of this study was to examine how women use English language internet chat forums to discuss the option of vaginal breech birth and to increase understanding in how vaginal breech birth is perceived in these online communities. It is

hoped the findings will support clinicians to adequately address women's concerns and tailor evidence-based information that supports women's decision-making for planned vaginal breech birth.

7.3 Methods

A qualitative descriptive study using internet discussion forums as the source of data was undertaken. This method was considered an appropriate choice for this study as it is a technique used to collect and analyse data in areas where there is little knowledge (Dahlen & Homer 2011; Grbich 2007). It is the preferred approach when a description of phenomena is required to capture experiences and breadth of knowledge on any given topic prior to subsequent theoretical development and testing of the data (Sandelowski 2000). The data gathered in this study were likely to provide a rich source of discourse amenable to this analysis approach.

Data collection

Data were gathered over a 12 month period to explore freely available Australian and international internet forums discussing breech birth. Google was used for this study as it enabled gathering data that could be tailored to the specific needs of the researcher. Google allowed the option to gather data by permitting the entry of the desired search terms into an "alerts" option, whereby emails could be forwarded to a selected email address containing websites that mentioned the selected search terms. Alerts were created to search for the term "breech" and "breech birth" on the internet from 1/1/2013 to 31/12/13. For this study, additional information was also requested, such as the type of information required (e.g. news, web or groups), how often it was required (e.g. once a day, as-it-happens) and language (English).

Once the “alert” was created, an email was sent to the named contact that confirmed the request. Emails were subsequently sent to the nominated email address at the requested time intervals containing hyperlinks to articles that were identified as containing the requested terms. For this study, the alerts were received on a daily basis by the first author and filed for analysis at the end of the data gathering period. Each of the discussion forum links received during the one-year period were accessed, read and saved according to the month received.

Based on the experience of similar research, ethical approval was not sought as the data from the internet discussion forums being studied are in the public domain and fully accessible and no human participants were directly contacted (Betts, Dahlen & Smith 2014; Dahlen & Homer 2011; Peddie et al. 2015). All internet forums used as data for this research were open for all to comment and were not password protected. Internet forums can facilitate intimate discussion, yet they are publically available. This can be challenging for the researcher when designing such studies, as it should be ensured the data gathered contain appropriate protections for human subjects (Eastham 2011). For the purposes of anonymity, website details in this study have been removed and no names have been provided. Eastham (2011) describes online discussions forums located via a search engines as public information which is open to the response of others, while password protected or member sites are seen as less open forums that are more restricted and private in nature. This study avoided password protected sites as the researchers felt this would be misrepresenting our intentions and invading the privacy of group members (Dahlen & Homer 2011).

Data analysis

Thematic analysis was used to analyse the data (Taylor, Kermode & Roberts 2006). Thematic analysis involves repeated reading of text, facilitating identification of main concepts, categories or themes that reveal themselves in the data. This method has been used previously in similar research on internet forum discussions (Betts, Dahlen & Smith 2014; Dahlen & Homer 2011) and involves immersion in the data to gain an understanding of the "feel" of what forum participants were saying and to identify meaningful statements. The lead author grouped statements to form preliminary concepts, with common and contrasting views identified in the data. These concepts were coded and eventually named as the themes that are reported as the results of this analysis (Boyatzis 1998; Green 2002; Liamputtong 2005; Taylor, Kermode & Roberts 2006).

A second and third researcher critiqued the initial findings and themes, which allowed for further refinement of the results. This process supported researcher reflexivity by facilitating reflection and acknowledgement of any bias or personal beliefs (Steen & Roberts 2011). Involving other researchers was considered to increase the face validity of the findings (Dahlen & Homer 2011).

7.4 Results

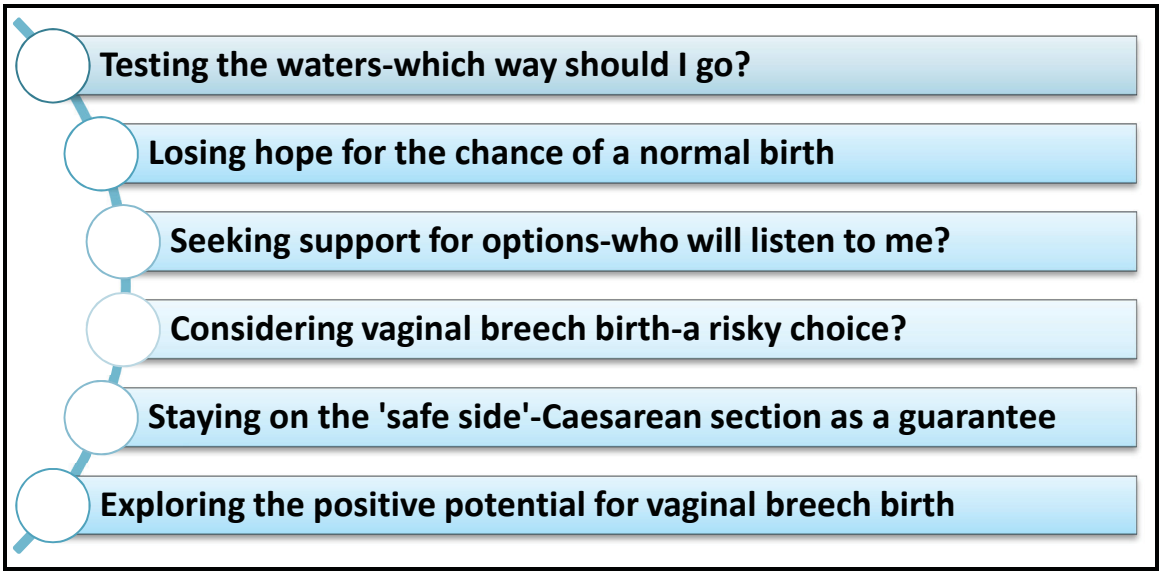
A total of 50 "discussion threads" were collected from 1/1/2013 to 31/12/13 which consisted of 382 separate comments. Approximately 10% (n=31) of comments were from women who provided multiple comments with the remainder of women providing one comment only. The forums did not always allow for identification of the woman's country of origin, therefore it was not possible to analyse by country, however website addresses were based in the UK, USA, Canada and Australia. This may have been due to the fact that the data search was limited to English sites

only. While many of those who commented were pregnant women seeking advice, clinicians identified themselves on two occasions and provided advice and information.

The forums were all public web pages with a focus on childbirth and parenting related content. Some were run independently while others contained sponsored content. The discussion threads led with a question from one woman seeking information and others' views on vaginal breech birth. Women making the initial approach to forum discussions with a leading question made up approximately 20% (n=70) of all comments gathered. An initial question on a forum denoted the commencement of a "discussion thread" for that particular question. Some of the threads were brief, with only 2 or 3 respondents to the initial question, while others contained a higher number of responses that created ongoing discussion between participants (i.e. longer threads). Facebook pages did not feature strongly in the data gathered (23 comments only). It is likely that this is due to many of these pages belonging to "closed groups", where permission is required to join and the content is therefore not freely available to the public.

Six themes that arose out of the data were: *Testing the waters-which way should I go?; Losing hope for the chance of a normal birth; Seeking support for options-who will listen to me?; Considering vaginal breech birth-a risky choice?; Staying on the 'safe side'- Caesarean section as a guarantee; Exploring the positive potential for vaginal breech birth (Figure 4).*

Figure 4 Key themes: The Fact and the Fiction: Internet forum discussions on vaginal breech birth



Testing the waters-which way should I go?

Women turned to online forums to hear the stories of other women's experience of their baby presenting as breech late in pregnancy. Women initiating online discussions seemed to have many unanswered questions and doubts about the possibility of having a vaginal breech birth, despite some having support from their care provider. Conflicting emotions were common, for example:

"I spoke to my consultant [doctor] yesterday who says I have proven hips and he'd be happy for me to try a vaginal breech birth….I have so many worries and questions right now. [I'm] Struggling between feeling like a coward one minute and then feeling like I have complete faith in my body. I'm trying to think things through because I have some big decisions to make."

Others were advised that CS was the only option should the baby persist in the breech position following an external cephalic version:

"I have an ECV scheduled for a week from today that if it is not successful the doctor wants to immediately follow with a C-section. I have had all my other kids natural and do not want to go this route if at all possible. I know her safety is number one concern. Has anyone had a successful birth of a butt first baby vaginally?"

Many of the forum posts were initiated by women seeking information from others who had experienced a vaginal breech birth, with some saying they were fearful of a CS. Women struggled with the idea of placing the baby at a perceived risk of harm if choosing a vaginal breech birth compared with the challenges of recovery from a CS, for example:

"He [the clinician] also said that babies born vaginally who are breech are often in shock and need help to breath which can mean going to the SCBU (Special Care Babies Unit), of course this might not necessarily happen but I hate the thought of my baby being in the SCBU just because I don't want a section! So what would you do? Try for the vaginal birth which might not be so pleasant for the baby or go for the section with the longer recovery period? I am torn. I just wish they would tell me what to do!"

The search for connections with other women online showed that women felt conflicted in their decision-making process and that there was a need to find comfort in hearing stories from other women.

Losing hope for the chance of a normal birth

Women who did not have access to services that supported vaginal breech birth seemed to report a sense of loss of control and mourned the loss of opportunity to give birth to their baby vaginally.

CS was spoken of as an inevitable outcome and women were resigned to the fact that they would have no choice but to undergo a surgical procedure for birth, for example:

"…what has me down is the thought of missing out on the whole natural experience and have it feel so surgical. I know if it's safer for baby and myself I will do whatever is necessary..."

A change in birth plan for some was a source of great disappointment:

"I was planning on having a home delivery and to say I'm devastated is an understatement."

Many hoped that their baby would turn to a cephalic (head down) position before labour, as this was the only way they could hope to experience vaginal birth:

"…they told me our baby boy is breech at 36 weeks. Thus, a scheduled CS should take place in the next 2.5 weeks. I want to feel hopeful that he will turn on his own and I will get to experience vaginal delivery."

A major factor in women's disappointment seemed to be a sense of losing control and fear of what a CS operation entails and how this affects their ability to bond with their baby:

"I'm not sure how I feel about the sudden loss of control I feel and the sense of feeling a bit robbed of a much more natural, positive labour. I am concerned that I am not going to enjoy holding and feeding my baby because I am going to be in pain? Is this an over the top worry? I am also just generally worried about how I am going to feel emotionally…this sense of loss of the labour I had dreamt of seems like a lot to take in right now. I considered a vaginal birth still but it wasn't really presented to me as a possible option anyway."

The women who were grieving a missed opportunity to birth vaginally did not appear to be able to access services that supported vaginal breech birth as a legitimate option.

Seeking support for options-who will listen to me?

Women used the internet chat forums to seek advice on facilities that would support vaginal breech birth as the hospitals they had originally planned to give birth in did not support this birth option. Facilities that supported vaginal breech birth were often further away from home, for example:

"I am thinking of changing [hospitals], but as I'll be 36 weeks when I know for sure if bub is breech I wonder if that's too late? I chose the local hospital because its 15 mins away not 35 mins."

Although this woman appeared happy to have a CS, her comment indicated it would be challenging for women seeking vaginal breech birth at her chosen facility:

"My little dude is breech and I'll be scheduled for a c section on Wednesday. Personally I wouldn't deliver him vaginally…my hospital don't even consider vaginal breech delivery! So couldn't have one if I wanted to."

Other women seeking a vaginal breech birth described positive interactions with the health system they were accessing. They described supportive care where they felt confidence in the clinicians skilled in vaginal breech birth and expressed excitement about their impending labour and birth experience:

"My appointment with the specialist went so well today! I'm healthy, bub is perfect size and position. It's all systems go for an active breech birth! Woohoo! He didn't even question my

decision. He just spoke to me like it was a done deal and made me feel so confident that it won't be too difficult since my first basically 'fell out'. I'm so relieved!"

There was a clear difference in tone in forum comments from women who felt supported in their choice for vaginal breech birth by their care provider compared with those who were accessing a facility that did not support vaginal breech birth. Those who were supported used excited, joyous language, while those who felt unsupported spoke of lost hopes and opportunities as their care providers saw vaginal breech birth as a dangerous option.

Considering vaginal breech birth-a risky choice?

Respondents to those initiating the discussion threads were divided on the safety of vaginal breech birth, with many mentioning anecdotal stories of what could go wrong. There appeared to be limited knowledge, or acknowledgement, of services, evidence and guidelines that support the option for planned vaginal breech birth from the women commenting on the forums and clinicians or friends they interacted with during their pregnancy. The possibility of vaginal breech birth was not thought by some to be a viable birth option:

"…I'm amazed they're even considering a vaginal breech birth, I didn't realise they were still willing to try, I thought they always had to be [Caesarean] sections due to the risks involved."

The risk of vaginal breech birth was also considered by some women to be significantly higher than for other birth scenarios. This discussion was usually not framed in the context of risk of vaginal breech birth compared with the risks associated with other modes of birth but rather as a choice that would bring heightened anxiety and was associated with an assumption by their care providers that it would end in a poor outcome, for example:

"I looked into it before my daughter turned at 35 wks. I personally wouldn't. The risks to mother a baby are HUGE and if something happened I would never forgive myself. And to be honest my hospital would do everything to persuade me not to do it."

System attitudes to vaginal breech birth also showed an assumption that vaginal breech birth would end in poor outcomes. Vaginal breech birth was described as not being supported as it was associated with an increased medico-legal risk:

"I also have a girlfriend who works as a midwife in another hospital and when I asked her about breech births she said her hospital didn't do them because of the court costs??"

"My doctor said my [medical/health] insurance would not cover a vaginal birth with a breech presentation, and that was that."

Women spoke of clinicians describing vaginal breech birth as a dangerous option. Some used graphic descriptions of the mechanism of breech birth, including physiological reasoning as to how vaginal breech birth can be unsafe for the baby:

"My doctor explained the danger of breech to me. Aside from the fact the bottom or foot can come out first and cause a variety of complications for mom, the vagina can tighten around baby's neck and basically refuse to open back up to allow baby's head to pass. This is horribly graphic but literally the baby is strangled by the birth canal and their head is stuck inside mom and the doctor is forced to try and yank baby out, potentially causing severe damage."

Similarly, the use of negative language and warnings were issued by some women to those interested in hearing about the experiences of women having had a vaginal breech birth. The potential for poor outcomes associated with CS were not mentioned:

"Even if you labour at home and go in late, they will section you. Believe me, you don't want most current health care providers trying to catch your breech baby. They no longer train breech births in most places and it should never be done with an inexperienced health care provider. Breech births require special skills which are different from normal head-first births. An inexperienced clinician can damage your baby, sometimes fatally, and it poses additional risks for you as well."

CS was spoken of in as the inevitable outcome for women with a breech presenting baby as it provided a sense of predictability, whereas vaginal breech birth outcomes were seen as unpredictable by commenters, despite the existence of supporting guidelines and evidence for planned vaginal breech birth.

Staying on the 'safe side'- Caesarean section as a guarantee

Many women recounted their experience of discussions with their care provider where CS was discussed as the safer option, without mention of any associated risks, and they contrasted this with a detailed list of the risks and potential negative outcomes associated with vaginal breech birth. Labouring with a breech baby was also discouraged in most of the forums as it was seen to be associated with emergency scenarios and higher risk of poor outcomes for the baby. For example:

"The registrar came down and she explained that if I wanted to attempt a vaginal delivery they would support me but there is a slightly higher chance of cord prolapse, cord compression and placental abruption in a breech delivery. There is also a chance that the feet/leg can deliver and then the shoulders/head become stuck. All of which would result in a crash Caesarean and some of which (e.g. prolapse or abruption) carried a high risk of still birth. She also told me that breech babies delivered vaginally have a chance of slight developmental delay (I don't have stats on it).

The pros of a Caesarean were given as higher chance of a favourable outcome, safer for me as well as baby."

Questioning the "status quo" of CS for breech presentation was also met with incredulousness from some forum participants in response to women seeking information on the option of vaginal breech birth, for example:

"I can't see why you would want to purposefully go against doctor's orders. It's quite possible you would get to the hospital in a terrible state and then need a very scary emergency c section. Hopefully you will realize you need help before it is too late and something terrible happens."

When comparing the risk of vaginal breech birth with CS, the latter was spoken of favourably in terms of limiting physical damage to the baby as it is born:

"His hip joints would be put under a huge amount of pressure during the birth, which could cause problems. But during a c/section, the entire baby is lifted out safely, with no pressure on any part of its body. That is why doctors do c/sections for breech babies – it's the best and safest way of delivering them. Don't worry about the hip problems as those are caused when the baby is delivered vaginally, not via Caesarean."

Those women considering a vaginal breech birth also described a lack of support from their social circles when they discussed exploring the potential for vaginal breech birth, indicating that lack of support for vaginal breech birth encountered by some women in clinical settings was mirrored in socio-cultural attitudes towards vaginal breech birth. Women felt pressure from family and friends to opt for a CS as it was viewed as a guaranteed safe outcome, whereas vaginal breech birth was

not supported. They described these experiences as upsetting and found it increased their anxiety levels. Clinicians who supported vaginal breech birth were helpful in allaying these fears:

"I'm finding it harder to get support from people around me than medical people! There have been a few very insensitive comments said. My SIL (sister in law) had two previous c sections and was having her third a few months after me so my partner and I were faced with the "why wouldn't you just have one". My partner's parents were quite shocked we would even consider a natural birth. There comments and reactions actually made me nervous, but speaking to my OB evened everything out [i.e. allayed any fears the woman may have had]."

Other women who commented provided a more balanced view and compared risks of both vaginal breech birth and CS and also addressed the view of others who commented regarding CS as guaranteeing a safe outcome:

"I'm not sure I agree that having a C-section is ensuring your baby is safe. I did a huge amount of reading while my baby was breech (including the Term Breech Trial) and from memory, the risks of vaginal delivery were not that much greater (if particular conditions were in place and your care provider was confident in breech delivery), and decreased significantly when compared to the risk to subsequent pregnancies following Caesarean. But, we all make our own choices based on perceived risk and in discussion with our care providers."

Health system and social attitudes appeared to be dictated by the prevalence of CS as the most common management for breech presentations. Very few forum comments (about 10%) were positive about the option of vaginal breech birth.

Exploring the positive potential for vaginal breech birth

While approximately 90% of the responses about vaginal breech birth were negative, there were some women who spoke positively about the option of breech birth. These women wrote of CS as a choice rather than an inevitable outcome for women with a breech baby. CS was also noted by some as coming with its own set of risks, for example:

"Breech doesn't have to mean c-section! My breech baby was born naturally and many care providers are retraining in the skills of how to deliver a breech baby. Other complications aside, c-section is not necessarily safest option for breech anyway. Of course, if that is what you feel safest with then that is your choice to make. But don't feel railroaded into a c-section if you don't want it just because of breech."

Some discussed the Term Breech Trial (Hannah et al. 2000) and how that has affected the availability of vaginal breech birth as a birth option. Clinicians also contributed to these discussions online and cited increasing care providers' skill in vaginal breech birth as challenging:

"It's [the Term Breech Trial] been shown to be a deeply flawed piece of research that has unfortunately had a huge effect on how we manage breech births.

"…the simple fact is that as mws (midwives) and drs (doctors) we have become deskilled at delivering breech babies. We are working hard to train and change this but it is hard to change attitudes."

A number of contributors also discussed how attitudes to vaginal breech birth in other countries than their own influenced clinician attitude to supporting this birth option. Women also supported

the idea of increasing skills locally by agreeing to their birth being observed by more junior doctors:

"2 of my 3 OBs did their major training outside Australia where it's more common to do vaginal breech births….OB #3 (who will deliver bub now) said it was normal when and where he trained but it's a bit 'out of fashion' here so he's asked me if I would allow a registrar or 2 to watch and get some experience. I didn't hesitate to say yes to that if it means that more women will be supported to birth naturally in the future!"

Forum entries that were supportive of the option of vaginal breech birth appeared to have a more in depth understanding of historical contexts and the impact of the Term Breech Trial on the availability of vaginal breech birth. These who commented wrote more openly about women being able to choose between vaginal breech birth and CS rather than CS as being inevitable.

7.5 Discussion

This study explored how women use English language internet discussion forums to seek information on the option of vaginal breech birth to support their decision-making for birth. It also aimed to increase understanding of how the option of vaginal breech birth is perceived among women. Forum users were divided on the issue of safety and risks associated with vaginal breech birth and the option of CS for birth of a breech baby. Online discussions included content that was either evidence-based information (fact) or misinformation (fiction).

The leading comment on each of the forums was usually from women seeking more information to assist her in her decision-making for birth of her breech baby (approximately 20% of all comments). These women sought information on vaginal breech birth and the opinions and

experiences of other women who were diagnosed with having a breech presenting baby in pregnancy. They also displayed conflicted feelings on the options for birth of their breech baby and sought support and reassurance from other women who had been in similar situations to their own to help with their decision-making for mode of birth. Some of these women felt CS was inevitable and mourned the lost opportunity of having a vaginal birth. Those who responded conveyed attitudes that were generally negative towards vaginal breech birth. CS was seen as a guaranteed safe option that provided a predictable outcome. While some others commented more positively about the potential of vaginal breech birth as a legitimate alternative option, these were in the minority.

There was also evidence of a tension in the decision-making process for those women who considered vaginal birth as their preferred option and wanted to avoid a CS. While they were keen to explore the option of vaginal breech birth, these women were also anxious about the associated risks of vaginal breech birth and of the potential for their baby to require intensive care if they chose this option for birth *"all because I didn't want a CS*." Responses to these posts were largely negative about vaginal breech birth, with respondents implying that the most important outcome was a healthy baby and that, for breech presentation, the mother's wishes to explore vaginal breech birth are secondary to the baby's welfare. This view has also been echoed in other studies (Bryant et al. 2007). For the women posting the initial questions, the tension appeared to bring with it anxiety and a sense of urgency in hoping their baby will turn "in time" so that they did not have to make the choice between vaginal breech birth and CS.

Many of those responding to the lead comment seeking information on vaginal breech birth used alarming language and misinformation when discussing vaginal breech birth. For example, one respondent spoke of the baby being "strangled by the birth canal" during vaginal breech birth

while another spoke of the high risk of stillbirth associated with vaginal breech birth. Another stated that hip problems in breech babies are caused when the baby is delivered vaginally, not via CS. These comments are not supported by evidence (Bitar & Panagiotopoulou 2011) and served to reinforce vaginal breech birth as a high risk option. The lasting impact of the Term Breech Trial (Hannah et al. 2000) and the small number of women who have a vaginal breech birth appears to have created a dominant perception by both women and healthcare providers that vaginal breech birth is an unsafe option for mode of birth and that it carries significantly more risk than CS, despite evidence supporting the safety of vaginal breech birth in selected cases(Berhan & Haileamlak 2016; Glezerman 2012; Goffinet et al. 2006; Kotaska et al. 2009b; Lawson 2012).While it is acknowledged that vaginal breech birth carries a two to five fold greater relative risk of short term morbidity and mortality than CS(Berhan & Haileamlak 2016), the absolute risk remains low. The findings of this study indicated there is a distorted perception of risk associated with vaginal breech birth in the internet discussion forums examined.

The conflicting information online about the option of vaginal breech birth may contribute to women's anxieties and levels of stress when diagnosed with a breech baby towards the end of their pregnancy and potentially, should a woman choose the option of vaginal breech birth, during labour. Many comments in the data collected for this study viewed vaginal breech birth as a "fatal" choice and felt their views had been reaffirmed by interactions with clinicians during their own experiences. These negative attitudes have the potential to impact on women's confidence when seeking information in discussion forums online to support her decision-making for birth.

The findings in our study support the need for provision of balanced, evidence-based information, found in relevant research and existing clinical guidelines, from clinicians supporting women with a breech presenting baby late in pregnancy. This information should include the risks and benefits

for all birth options for the woman's current pregnancy, as well as the consequences of a woman's choices in her current pregnancy for future pregnancies(Powell, Walker & Barrett 2015). Providing accessible information to support women in decision-making for birth options is particularly important given previous research has shown propagation of misinformation online between consumers can lead to inappropriate dilution or distortion of information (Griffiths et al. 2012).

The findings of our study also suggest that women's decision-making is also informed by discussions outside of clinical consultations, including friends and family. Socio-cultural interactions have been identified as one factor that may impact on women's decision-making for childbirth (Dahlen & Homer 2011; Davis-Floyd 2003; Fenwick, Gamble & Hauck 2007; Lagan, Sinclair & Kernohan 2011; Munro, Kornelsen & Hutton 2009; Romano, Gerber & Andrews 2010). Our study support this view with regard to the option of vaginal breech birth and adds further emphasis to the need for women to feel informed during their decision-making for birth.

The discussions in the internet forums studied also reveal a need for increased clinician support for women with a breech presenting baby. 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 CS. Clinician reference to guidance documents for supporting women in their decision-making for breech birth is essential to ensure all option for care are discussed with the woman. Recent research on clinician experiences in caring for women choosing a vaginal breech birth has also called for further education and upskilling of clinicians to increase their abilities and confidence in supporting women considering a vaginal breech birth (Catling et al. 2016a).

A number of limitations exist in this study that may impact on generalisability. The authenticity of the data may be questioned given it is difficult to confirm quality assurance given the method used to collect the data (Betts, Dahlen & Smith 2014). Possible selection bias may have also been present given only open-access forums were used when gathering data from discussion forums. Online groups that require members to join and use a password before posting may express different experiences, information and opinions.

Women who choose the make comments on public forums could be those at the extreme of either end of normality versus medicalisation of birth and hence the middle ground may have been missed. Additionally, the only forums accessed were in the English language. However, given there is limited information on the use of the internet for decision-making for breech presentation in the literature, the findings in this study offers perspectives from women that may differ from direct questioning through surveys or interviews and may therefore be useful for clinicians to consider when this issue arises for women with a breech presentation (Betts, Dahlen & Smith 2014).

7.6 Conclusion

This study shows that women are searching for information online about breech birth in an attempt to come to a place in their decision-making where they feel comfortable with their plan for birth. The large volume of conflicting content found in the data collected for this study, both for and against vaginal breech birth, highlights the need for clinicians to provide comprehensive, non-judgemental information on the risks and benefits of all birth options to facilitate informed decision-making that is free from the distorted views of vaginal breech birth that may be encountered online. Provision of accurate and unbiased information by clinicians may contribute

to improving the woman's confidence in distinguishing between "the fact and the fiction" of discussions online. This approach to care for women with breech presentation will ensure that woman and baby centred care is maintained and that the woman is supported in making informed choices for birth.

Disclosure statement

The authors declare that they have no competing interests, financial interest or benefit arising from this research.

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Chapter 8 Media representations of breech birth: A prospective analysis of Web based news reports

Reference:

Petrovska, K., Sheehan, A. & Homer, C.S.E. 2017, Media representations of breech birth: A prospective analysis of web-based news reports, *Journal of Midwifery & Women's Health* (in print).

8.1 Abstract

Introduction

Recent research has demonstrated that the media presentation of childbirth is highly medicalised, often portraying birth as risky and dramatic. Media representation of breech presentation and birth is unexplored in this context. This study aimed to explore the content and tone of news media reports relating to breech presentation and breech birth.

Methods

Google alerts were created using the terms “breech” and “breech birth” in online English-language news sites over a 3year period from 1/1/2013 to 31/12/2015. Alerts were received daily and filed for analysis and data were analysed to generate themes.

Results

A total of 138 Web based news reports were gathered from 9 countries. 5 themes that arose from the data included: The problem of breech presentation; The high drama of vaginal breech birth; The safe option of Caesarean birth versus dangers of vaginal breech birth; The defiant mother versus the saintly mother; and Vaginal breech birth and medical misadventure.

Discussion

Media reports in this study predominantly demonstrated negative views towards breech presentation and vaginal breech birth. Caesarean birth was portrayed as the safe option for breech birth, while vaginal breech birth was associated with poor outcomes. Media presentations may impact decision-making about mode of birth for pregnant women with a breech fetus. Health care providers can play an important role in balancing the media depiction of planned vaginal breech birth by providing non-judgemental, evidence-based information to such women to facilitate informed decision-making for birth.

Key words: Breech birth, media, content analysis, women's decision-making.

8.2 Introduction

The media plays a significant role in both creating and influencing cultural norms and social discourse (Ferguson & Kasper 2002; Macnamara 2005; Seale 2003). The media's ability to shape public opinion by setting health agendas has also been shown to create accepted truths, irrespective of evidence that may exist to the contrary, which members of society may use to inform their own narratives and decision-making (Dahlen & Homer 2011; Seale 2003). The internet, a relatively new form of media, enables the public to have instant access to information that has been shown to shape social views and consumer health choices,(Seale 2003) with "Dr Google" being a term commonly heard in health care lexicon today.

Researchers have used media content analysis as a systematic approach to explore how the media reports and represents childbirth (Dahlen & Homer 2012; Morris & McInerney 2010; Shaw & Giles 2009). This approach seeks to interrogate media content to uncover deeper meaning of texts to audiences, to understand the likely interpretations of the audience and to see how language and visual imagery combine to create meaning around childbirth. Results from recent research show the media perpetuates the medicalisation of childbirth, often portraying it as risky and dramatic, with portrayals of normal birth often being under-represented (Luce et al. 2016; Morris & McInerney 2010).

An unexplored area in this field is media portrayal of breech presentation and breech birth. Breech presentations occur in 3-5% of pregnancies, with most of these babies in high income countries being currently born by elective Caesarean birth (Berhan & Haileamlak 2016; Guittier et al. 2011; Kotaska et al. 2009b). Data on the percentage of women with a breech fetus who seek planned vaginal breech birth is limited, however the American College of Obstetrics and Gynecologists

notes in its committee opinion *"During the past decade, there has been an increasing trend in the United States to perform Caesarean delivery for term singleton fetuses in a breech presentation"* (ACOG 2006).

A 2016 analysis of a nationally representative cohort of US women suggested Caesarean section for breech presentation was as high as 94.9%, an increase from 86.9% in 2003 (Martin, Hamilton & Sutton 2003; Weiniger et al. 2016). The remaining 5.1% of vaginal breech births from the 2016 analysis included both planned and unplanned vaginal breech births, suggesting the figures for planned vaginal breech births are much fewer.

In Australia in 2013, of the 13,617 babies who were diagnosed breech at term (4.4% of all babies born), 88% were born by Caesarean birth (AIHW 2015). The remaining 12% of vaginal breech births included both planned and unplanned vaginal breech births. In New South Wales (NSW) alone approximately 97,000 babies are born each year (Ministry of Health 2016), with potentially up to almost 5,000 of these babies presenting breech. The most recent figures available for NSW births show that approximately 7% of these breech babies were born vaginally with the remainder being born by Caesarean birth, mostly electively before the onset of labour. The United Kingdom, which was also a source country for data collected in this study, also has no recent national data available on the incidence of planned vaginal breech birth.

The small number of breech fetuses born vaginally can be partially attributed to a large international trial published in 2000, known as the Term Breech Trial (Hannah et al. 2000) which concluded that Caesarean birth was the safest way for fetuses in the breech position to be born. The results of the study showed that perinatal mortality, neonatal mortality, or serious neonatal morbidity was significantly lower for the planned Caesarean birth group than for the planned

vaginal birth group (17 of 1039 [1·6%] vs 52 of 1039 [5·0%]). The Trial's findings also demonstrated that for women with a singleton fetus in breech presentation at term, maternal morbidity was lowest following vaginal birth and highest following Caesarean birth during active labour (41 of 1041 [3·9%] vs 33 of 1042 [3·2%]) (Hannah et al. 2000; Su et al. 2007). More recent research and systematic reviews reinforcing the Trial's results have since been released (Hofmeyr, Hannah & Lawrie 2015; Vlemmix et al. 2014) with one study noting that vaginal breech birth carries a 2 to 5 fold greater relative risk of short term morbidity and mortality than Caesarean birth (Berhan & Haileamlak 2016).

Following the Term Breech Trial, studies of maternal and neonatal outcomes of Trial participants were conducted to gauge the longer term impact of mode of delivery. The findings demonstrated planned Caesarean birth was not associated with a reduction in risk of death or neurodevelopmental delay in children at 2 years of age (14 children [3.1%] vs 13 children [2.8%]) (Whyte et al. 2004). There was no also no difference in maternal outcomes at 2 years postpartum for planned Caesarean birth and planned vaginal birth for the singleton breech fetus at term (Hannah et al. 2004). Despite this, the Trial's findings have been enthusiastically embraced maternity facilities in the Western world (Lawson 2012). Caesarean births for breech fetuses have increased since 2000 and the number of clinicians skilled in facilitating vaginal breech births has decreased significantly (Berhan & Haileamlak 2016; Kotaska et al. 2009b).

Evidence supporting vaginal breech birth is based on a number of studies demonstrating safety of vaginal breech birth for carefully selected women who have appropriate care and obstetric provider expertise (Berhan & Haileamlak 2016; Borbolla Foster et al. 2014; Glezerman 2012; Goffinet et al. 2006; Kotaska et al. 2009b; Lawson 2012). A recent meta-analysis indicated that the absolute risk of vaginal breech birth is lower than previously thought. In this study, Berhan et al

concluded that the absolute risks of perinatal mortality, fetal neurologic morbidity, birth trauma, 5-minute Apgar score <7 and neonatal asphyxia in the planned vaginal delivery group were 0.3, 0.7, 0.7, 2.4 and 3.3%, respectively (Berhan & Haileamlak 2016). Long-term childhood outcomes of breech presentation by intended mode of delivery have also demonstrated that planned vaginal breech birth confers no additional risks for child health, development, or educational achievement compared to planned Caesarean birth (Bin, Ford, et al. 2016).

Despite significant bodies of research and clinical guidelines from professional colleges supporting the option of vaginal breech birth for carefully selected women, such as those from Canada, Australia and the United States, vaginal breech birth continues to remain rare across the world (ACOG 2006; Berhan & Haileamlak 2016; Glezerman 2012; Goffinet et al. 2006; Kotaska et al. 2009b; Lawson 2012; RANZCOG 2013; RCOG 2006). The option of vaginal breech birth also remains controversial due to research conducted since the Term Breech Trial citing significant flaws in the design and recommendations of the Trial (Glezerman 2006; Kotaska 2004; Lawson 2012).

A small number of facilities internationally continue to offer the option of planned vaginal breech birth, supported by skilled clinicians working in specialised services (Borbolla Foster et al. 2014; Catling et al. 2016a; Goffinet et al. 2006; Kotaska et al. 2009b). However, these services are in the minority and, as a result, women who are diagnosed with a breech fetus late in pregnancy have very few options but to have a Caesarean birth. Some women continue to seek the option of planned vaginal breech birth and source care providers to support them in their birth choices, however this has proven to be challenging (Homer et al. 2015; Petrovska, Watts, Sheehan, et al. 2016; Petrovska et al. 2017).

Socio-cultural attitudes towards breech birth have been shown to impact on women's decision-making for vaginal breech birth (Petrovska, Watts, Sheehan, et al. 2016). Given the media plays a role in influencing these attitudes (Ferguson & Kasper 2002; Macnamara 2005; Seale 2003) we were interested in the media exposure that women who have a breech fetus late in pregnancy might be subjected to and the content and tone of any media or news reports relating to breech presentation and birth, as no studies exist that have explored this issue.

8.3 Methods

Design

A qualitative descriptive study using media content analysis was undertaken. Media content analysis takes a systematic approach to studying media by objectively identifying specified characteristics within text (Macnamara 2005). Data were sourced from information on the Internet that took the form of news reports.

Google alerts were created to search for the term "breech" and "breech birth" on the internet over a 3 year period from 1 January 2013 to 31 December 2015. Alerts were received on a daily basis by the first author and filed throughout this period for analysis at the end of the data gathering period. Google was used as it facilitates gathering data that can be tailored to the specific needs of the researcher. Each of the news reports received during the 3 year period were accessed, read and saved. Sampling was limited to reports from media outlets reporting on all aspects relating to breech presentation and breech birth. Internet chat forums and personal blogs were excluded. Reports that discussed the same news story were counted for the purposes of gathering information from different journalists and countries. Reports were checked to ensure

they were written by different authors and not a republication of the same story using similar language. Those that reports that had the same author were only counted once.

While Google permits collection of data on a daily basis to a nominated email address, which in this study was the first author, cross-checking also took place. Another search engine, Yahoo, was used to cross check data collected to ensure a comprehensive collection of data was undertaken, as has been undertaken in similar research (Dahlen & Homer 2011, 2012).

Data Analysis

The media content analysis used inductive category development to interrogate the language to develop themes and better understand how social language constructs messages about breech presentation and breech birth. Inductive analysis involves working from specific observations of categories and patterns (e.g. issues or messages) to a broad theory or conclusion (Macnamara 2005). Immersion in the data involved reading and re-reading each news story multiple times to ascertain messages portrayed through the language and images used. This method aimed to uncover how the reader could potentially be persuaded by the language and/or images used to create meaning. This approach to media content analysis is said to bring a systematic approach to qualitative text analysis by matching pre-existing category to a text, rather than matching the text to a category (Macnamara 2005).

The pre-existing categories were based on work done by Jeffries (2007) in her analysis of how the female body is portrayed in the media. Jeffries suggests that language in the media plays a significant role in the construction of socio-cultural views (Jeffries 2007). Jeffries uses a number of defined analytical techniques to analyse media content, which have been adapted for use in this study (Table 6).

To further support this analysis, key text elements for review of the language in the media were also used to explore the tone or tenor of the reports, such as the use of adjectives that give an indication of a writer's attitude, tonal qualities such as aggressiveness or emotional language and identification of pronouns as key signifiers of meaning in text (Macnamara 2005). Research ethical approval was not sought as the data from the Internet being studied are in the public domain and fully accessible (Betts, Dahlen & Smith 2014; Dahlen & Homer 2011; Peddie et al. 2015).

A second and third researcher critiqued the first researcher's findings and themes to reduce the potential for bias and increase the credibility of the research (Dahlen & Homer 2011). This process facilitates lead researcher reflexivity by permitting reflection and acknowledgement of any bias or personal beliefs (Steen & Roberts 2011).

Table 6 Analysis techniques

Category	**Description**
Naming	Initially, the language in the text was scrutinised to assess the presence of a word or words that were used as a label to describe breech presentation in a negative or positive light. Jeffries (Jeffries 2007) notes the highly repetitive nature of 'naming' terms sends strong ideological messages and thus has the potential to influence readers' perceptions.
Describing	'Describing' examined how the presence of a breech baby, or the event of a breech birth, was portrayed and how the news story was constructed based on depictions of breech presentation and birth.
Contrasting	'Contrasting' focused on identifying the construction of opposites and the language used when the writer of the news story created opposing

	scenarios of 'good' versus 'bad'.
Enumerating and Exemplifying	'Enumerating' and 'exemplifying' is the next technique aiming at identifying generic categories through the constructions of 'lists' of descriptions that exemplified breech presentation or birth in either a positive or negative light.
Assuming and Implying	The final technique seeks to uncover hidden meanings in the text that implies a message to the reader at a subconscious level. Previous research has suggested that when similar messages are repeatedly delivered, they act as a reinforcement of ideological assumptions and conceptual influences that the reader is vulnerable to (Jeffries 2007; Roth, Homer & Fenwick 2012).

8.4 Results

A total of 138 Web based news reports were gathered over a 3 year period from 1/1/13 to 31/12/15 and analysed. Reports came from a variety of countries, including the United States (60%), United Kingdom (17%), Australia (14%), Canada (4%), New Zealand (3%), Germany (3%), India (1%), Singapore (1%) and Kenya (1%).

The alerts were sourced from a variety of media, such as online newspapers, videos from televised news reports and online magazines. All categories that appeared in the 'news' portion of the Google alert were included. This covered a wide variety of news sources, such as local and national newspapers as well as 'lighter' news sources for more targeted audiences such as entertainment

news sites. Terminology that was used in the analysis of the reports is highlighted in bold to demonstrate the data used to generate each theme.

Of the 138 news reports that were collected, 17 (12%) were reported the option of vaginal breech birth as a legitimate choice for women. The remainder portrayed breech presentation and breech birth negatively. The data were analysed to generate themes, with a total of 5 themes generated. Table 7 describes how themes were generated from each analysis technique by providing example quotes from the sample source (Table 7).

Table 7 Audit trail of analysis techniques used

Analysis technique category	**Theme**	**Example from sample source**
Naming	The 'problem' of breech presentation	*Their fetus was facing the wrong way* *Just last week she announced her son was incorrectly positioned in her womb, but with the help of doctors, her fears of subjecting the child to a breech birth have been alleviated.*
Describing	The 'high drama' and 'rarity' of vaginal breech birth	*The clock is ticking once birth begins"* *It was a natural breech-so rare, even some of the medical staff had not seen one before.*

Contrasting; Enumerating and exemplifying	The safe option of Caesarean birth vs the dangers of vaginal breech birth	*C-section is still the best choice for a breech baby, since vaginal delivery could kill the infant.* *C-section is still the best choice for a breech baby, since vaginal delivery could kill the infant. Caesarean section is the safest mode of delivery for the breech presenting baby at term and that should be discussed with the mother.*
Contrasting	The defiant mother vs the saintly mother	*She will defy doctor's advice that her breech baby should be delivered by Caesarean section.*
Assuming and implying	Vaginal breech birth and medical misadventure	*$25.6 million malpractice lawsuit over vaginal delivery of breech baby*

The 'Problem' Of Breech Presentation

Diagnosis of breech presentation in pregnancy was portrayed as a problem in the news reports collected for this study, with descriptions in the majority of the data (69%) of the fetus being the "wrong way" and "upside down" and "in a dangerous position".

A total of 55 headlines (39%) described breech as a pregnancy complication for high profile celebrity Kim Kardashian, who discovered her fetus was breech late in her second pregnancy. All reports were investigated for this study as they were sourced from different media outlets that may have treated the reporting of this story differently. One report was noted to use language

that implied breech presentation is to be feared. An external cephalic version eventually turned the fetus to a cephalic position, with the "problem" of breech presentation being corrected and turned the fetus to the "right position": *the star said 'it feels so good to not have the stress of thinking I need a C-section.*

Another celebrity, Amber Rose, also had a fetus in the presentation late in pregnancy. Entertainment news sites spoke of her plans for a homebirth "unravelling", with Rose frantically trying to encourage the fetus to turn: *…her efforts were futile and Rose eventually accepted the reality that she would have to undergo a c-section.*

By contrast, planned vaginal breech birth was mentioned less often (12% of all news reports), with the accepted view being that a fetus does not turn antenatally, Caesarean birth is inevitable.

The 'High Drama' And 'Rarity' Of Vaginal Breech Birth

Breech birth was most often reported as being unplanned and dramatic. Descriptions of panic and danger during an unplanned breech birth occurred in 19% of reports, with alarming language such a "chaotic" and "horrific" being used to illustrate the scene of a vaginal breech birth.

7(5%) of the news reports gathered described the involvement of emergency personal, either via telephone or in person, which added to the drama of newborns making a "dramatic debut". The outcomes of these births were portrayed as "beating the odds" with the portrayal that luck was involved in avoiding imminent death of the newborn:

> *"…it was the second baby that would prove more difficult for Adam [a paramedic] to deliver. The second born was breech...when the baby came out he was blue and not breathing regularly…it required a lot of tactile stimulation to get him breathing again.*

After the job you start to think about what could've gone wrong and you start to go 'that was a close one.' "

Vaginal breech birth was also spoken of in miraculous tones, with medical staff being noted as rarely witnessing vaginal breech birth and women gaining "superhero powers" and achieving the impossible when giving birth to a breech newborn vaginally.

The Safe Option Of Caesarean Birth Versus The Dangers Of Vaginal Breech Birth

Caesarean birth was viewed by the majority of the reports (69%) as the superior and lifesaving option for management of breech birth. News reports that viewed vaginal breech birth as negative did not discuss the risks associated with Caesarean birth or evidence supporting the safety of vaginal breech birth. In 17 (12%) of the reports, quotes that were included from doctors appeared to add weight and professional authority to the opinions reflected in the reports, with one doctor stating that Caesarean birth was the best choice for breech birth as vaginal delivery could "kill the infant."

Descriptions of the potential complications relating to vaginal breech birth were listed extensively, without mention of the risk of Caesarean birth. Emotive language was also used, for example:

"The dangers of breech birth are numerous, including taking a longer time, exerting too much strain on the pelvis and injury to the birth canal which can lead to severe bleeding and painful urination. The greater threat is on the baby who can be distressed as a result of deprivation of oxygen leading to brain damage or cerebral palsy. An injury can also occur to any of their tiny limbs."

News reports supportive of vaginal breech birth were limited (12%). These articles provided a balanced view of risks and benefits for both vaginal breech birth and Caesarean birth, noting that Caesarean birth does not necessarily provide a safe or predictable outcome and that women should understand all options for care before making an informed decision. These reports were more equivocal about the risks and benefits of all options available, and discussed the need for individualised decision-making for women so they can choose the best plan for themselves and their newborn.

Woman's choice was discussed in only 9 out of the 138 articles (7%) and the prevailing view was that medical opinion should lead the decision-making process for birth. The dominant tone was one of medical authority and a "doctor knows best" approach.

The defiant mother versus the saintly mother

The number of news reports describing women seeking the option of vaginal breech birth were limited (8% of all data gathered), however the language in these reports portrayed these women as difficult and demanding. They were described as defiant and resistant to medical advice. By contrast, women who changed their original birth plan (vaginal birth) and agreed to a Caesarean birth were seen as self-sacrificing and "doing the right thing" for the perceived safety of their newborn. One report provided a more nuanced approach between the selfish and the saintly mother. This report expressed was more neutral in relation to the option of vaginal breech birth:

> *"Morena's [an American actress] decision to have a vaginal breech birth has prompted both praise and criticism, with some charging that she put her ideal "birth experience" above what was best for the baby, while others have applauded her for following her instincts and pursuing the birth she wanted."*

This theme demonstrates that the negative perceptions around the safety of planned vaginal breech birth impacted on how the mother was perceived with regard to her choices for birth.

Vaginal Breech Birth and Medical Misadventure

Out of the 138 news reports collected, a proportion (16%) reported lawsuits against health services and medical practitioners who were involved in vaginal breech births that resulted in adverse outcomes. Vaginal breech birth was described as an uncommon practice, with 2 of these births being planned vaginal breech births, while the remainder were unplanned births. All reports noted the inexperience of the clinician involved in the birth. For example, one report headlined "Fatal Breech Birth" noted:

"The registrar [doctor training as a specialist] responsible for the delivery had only delivered 2 breech babies previously and the latter moments of the delivery had been 'panicked' and a 'mad fumble'".

Headlines such as "*$25.6 million malpractice lawsuit over vaginal delivery of breech baby* imply that vaginal breech birth is associated with poor outcomes that bring high financial cost to the health facility or death of the neonate. Reports of misadventure associated with the alternative (Caesarean birth) were not present in the data gathered.

3 news items reporting about lawsuits against health services and medical practitioners who were involved in vaginal breech births discussed the skill of the clinician attending the birth being a key factor in minimising risks and poor outcomes for vaginal breech birth and that it may be a safe option for women who fulfill selected criteria. Despite this, the dominant view in the data gathered perceived the option of vaginal breech birth as increasing the likelihood of poor

outcomes and increasing subsequent vulnerability to litigation for health services and medical practitioners.

8.5 Discussion

This study observed that 3 years of Web-based news reports presented a largely negative view of vaginal breech birth. Breech presentation was viewed as a problem in the news reports, with stories predominantly covering unplanned breech birth with a focus on the urgency and drama of the birth. Caesarean birth was seen as a safe, predictable option for breech birth in the data gathered.

The overall tone of the reports identified for this study was negative and alarming. The limited number of news reports supporting planned vaginal breech birth reinforces current perspectives that exist in dominant medical discourse that view vaginal breech birth unfavorably (Homer et al. 2015). Both Davis-Floyd and Founds note the strength of the medical system in informing social discourse around birth practices, which includes the popular media (Davis-Floyd 2003; Founds 2007; Roth, Homer & Fenwick 2012). The medical system's influence on social discourse is demonstrated in much of the literature studying media's treatment of birth in general, as well as choices for other modes of birth such as vaginal birth after Caesarean birth (Fenwick et al. 2010; MacKenzie Bryers & van Teijlingen 2010; Malacrida & Boulton 2014; Munro, Kornelsen & Hutton 2009). It appears the news reports investigated in this study have been influenced by the medical system's uptake of the findings of the Term Breech Trial, where Caesarean births are largely seen as the default management for breech presenting fetuses and the risks associated with vaginal breech birth are perceived to be higher than current evidence suggest (Berhan & Haileamlak 2016).

The lack of detail regarding medical malpractice suits associated with vaginal breech birth demonstrate that the news reports examined in this study tended to focus on poor outcomes related to vaginal breech birth without deeper investigation of the possible causes of the adverse events. For example, there was little information regarding the presence, or absence, of skilled clinicians at these births, which is a key factor in maximising safe outcomes for relating to vaginal breech birth (Borbolla Foster et al. 2014; Glezerman 2012; Kotaska et al. 2009b). The exclusion of discussion regarding poor outcomes relating to Caesarean birth and evidence supporting the safety of planned vaginal breech birth under specific conditions in the data collected reinforces a biased view in favor of Caesarean birth (Alcorn et al. 2010; Berhan & Haileamlak 2016; Glezerman 2012; Goffinet et al. 2006; Kotaska et al. 2009b). Additionally, the data collected included reports on unplanned vaginal breech births that involved the attendance of emergency personnel. This is likely to add to the perception of vaginal breech birth as an emergency and that breech presentation itself is therefore problematic.

The predominance of focus on negative outcomes in the reports in this study may be explained by media theory which suggests that the media's role is to satisfy the audience's need to seek health-promoting information as a part of risk profiling at fateful moments and to assist the audience in warning of potential dangers by focusing on "things that can go wrong" (Seale 2003). Audiences may also seek emotional stimulation through dramatisation that has an entertaining effect-fear and anxiety, for example, may be heightened so that the audience is experiencing these feelings as a contrast to security and pleasure. In this study, vaginal breech birth and the risks and dangers associated with it contrasted with the perceived safety and security of Caesarean birth.

Medical technology, and its ability to provide a "predictable outcome", can be seen to reinforce cultural rituals and an acceptance that medical intervention is superior to nature (Coxon, Scamell

& Alaszewski 2012; Davis-Floyd 2003; Tully & Ball 2013). Media text analysed in this study portrayed the need for intervention (i.e. Caesarean birth) to overcome the perceived danger associated with vaginal breech birth (Luce et al. 2016; Morris & McInerney 2010). This has the potential to lead the audience to believe that Caesarean births are the only option to "manage" or avert the risks for mother and her breech neonate.

The inter-relationship between the media and medical discourse has also contributed to the socially accepted perception that women's reproduction is intimately intertwined with medical technology (Coxon, Scamell & Alaszewski 2012; Morris & McInerney 2010). This has created a normalisation of technology, thereby creating pressure on women to accept the status quo of Caesarean birth for management of breech birth (Petrovska, Watts, Sheehan, et al. 2016). Rather than demonstrate a balanced view of the risks and benefits of all options for birth, portrayal of planned vaginal breech birth in the reports collected for this study can be seen as a way of controlling the bodies of women during birth to guarantee a perceived good outcome (Luce et al. 2016).

Women who seek or who have had a vaginal breech birth were depicted as difficult and defiant in the reports examined for this study. These women display a trust in the birthing process that challenges the idea that birth is an imperfect and untrustworthy process that should be managed with technology (Leao et al. 2013). The dominant norm portrayed in the data collected was that a mother's wish for a natural birth was secondary to her newborn's safety, and that "good mothers" are self-sacrificing and women who challenge the norm are vilified by the media (Charles & Shivas 2002; Coxon, Scamell & Alaszewski 2012; Johnston & Swanson 2003; Morris & McInerney 2010; Weaver, Statham & Richards 2007). This study reinforces this view - women who insisted on trying

for a vaginal breech birth were seen less favorably than those women who sacrificed their desired birth plan for the “safety” of their newborn.

The majority of the reports collected for this analysis did not clearly articulate evidence for all options for breech birth. The treatment of this option for birth in the data collected provides an example of how media reporting may demonstrate a bias towards Caesarean birth for breech presentation and this may have an impact on women’s decision-making for breech birth. The role of the clinicians is crucial in providing balanced and non-judgemental information that is essential for women to support informed decisions about their options for birth when diagnosed with a breech fetus (Guittier et al. 2011; Homer et al. 2015; Kotaska 2007; Petrovska, Sheehan & Homer ; Powell, Walker & Barrett 2015). This may be challenging in the current climate where Caesarean birth is seen by many maternity facilities across the world as the safer, default option for birth of a breech fetus. However, the value of woman-centred care should be a fundamental element of maternity care and for this to truly be achieved, the woman should be supported in her decision-making for birth (Dahlen 2016). The provision of evidence-based information for all birth options plays a significant role in this process.

This study had several limitations. The inclusion of English language Web sites may have excluded data from countries that have increased support for the option of vaginal breech birth, such as Scandinavian countries or the Netherlands. The dominance of data from the United States may have also impacted on conclusions drawn from the analysis. This study was limited to written text only and did not include radio interviews or television video clips as these mediums are not comprehensively available on the internet. The use of Google as the sole search engine may have also created limitations, of which the authors are unaware, in the level of comprehensiveness of the data gathered.

8.6 Conclusion

Media reports in this study predominantly demonstrated negative views towards breech presentation and vaginal breech birth. Perceptions of vaginal breech birth in the news reports collected for this study reinforced dominant medical views regarding current practices for management of breech presentations. Caesarean birth was portrayed as the safe option for birth, while vaginal breech birth is viewed was a risk laden choice that inevitably ended in poor outcomes. This portrayal may impact on women's decision-making for birth when diagnosed with a breech fetus during pregnancy. A significant role a health care provider can play in balancing the media depiction of vaginal breech birth is to provide non-judgemental, evidence-based information to women to facilitate informed decision-making for birth.

Chapter 9 Discussion

9.1 Introduction

In this discussion chapter I will draw together the findings of the five studies conducted for this thesis, synthesise the findings as a whole and reflect on interpretations and commonalities in the findings. While there has been some analysis of the findings in Chapters 4 – 8, this discussion chapter provides more in-depth analysis than can be undertaken in the individual papers accepted for publication.

The first section of this chapter (9.2) analyses the findings of this study through the lens of symbolic interactionism, followed by Section 9.3 which discusses the socially constructed "reality" for managing vaginal breech birth. Section 9.4 explores notions of control - control of "defective" women's bodies and control of birth and how medical technology is seen as the superior option for managing birth, particularly in scenarios where the level of risk is perceived to be high such as breech presentation. Following this, Section 9.5 examines how women seeking a vaginal breech birth are viewed by society, and the methods these women recruit to transcend the "status quo" for management of vaginal breech birth, including the use of social media. This chapter concludes with promoting changes in social discourse around vaginal breech birth and how increasing the incidence of vaginal breech birth in maternity services may support this change.

9.2 Review of the research aims and subsequent findings

This study has examined contemporary discourses of breech birth and how these discourses impact on women choosing vaginal breech birth through a four individual approaches to data collection and analysis that included semi-structured interviews, a web based survey, a thematic

analysis of internet forum discussions and a media content analyses. At the commencement of my studies, my aims were to understand how social discourse in contemporary society impact on women's decisions for vaginal breech birth; explore how and why women make decisions for this birth option; and identify strategies for clinicians to support women considering vaginal breech birth. This PhD thesis achieves those aims.

The overarching finding is that social discourses of risk and danger can impact on women's decision-making processes for vaginal breech birth, with many feeling significant pressure to have a Caesarean section for the birth of their breech baby, as I have shown from women's own experiences discussed in Chapters 4 to 6. Their views threatened to interrupt the continuing ritual of medical technology as the superior option for breech birth, and the notion that women's bodies, and the process of birth, should be controlled in order to minimise the perceived high level of risk for vaginal breech birth. Women seeking a vaginal breech birth experience negativity and resistance from members of their sub-cultural units, as I have demonstrated in Chapters 4 and 6. Despite this, in Chapters 4 to 6 I have shown that women seeking a vaginal breech birth are determined to find support, both from other women and from facilities that will support them in their birth option. In doing so, these women displayed a tenacity that transcends socially constructed and entrenched views about Caesarean section for breech presentation as the best option for birth, as noted in Chapters 4 to 6. These women trusted the birthing process and found confidence in their right to self-determination and bodily autonomy. In depth examination of these findings will be explored in this chapter.

9.3 A socially constructed reality for managing breech birth

9.3.1 Symbolism and ritual for breech birth

Chapter 3 defined symbolic interactionism as a process of social conditioning, where an individual develops an understanding of the world through interactions with symbols and ritual that inform a socially constructed concept of reality. Symbolic interactionism is described as the socialisation process and socio-cultural journey of an individual through the through norms, rules and conventions that have developed over time (Crotty 1998). These conventions become rituals that are symbolic in nature and loaded with cultural meaning.

As described in Chapter 3, Davis-Floyd in her book, *Birth as an American Right of Passage,* has proposed that the symbolisms of childbirth that are created by society to develop meaning, and therefore a constructed reality, are a form of ritual behavior (Davis-Floyd 2003). This reliance on ritual, which acts to provide a normalisation of an event such as childbirth, provides powerful reassurance to society and provides a sense of order and predictability (Luce et al. 2016). In this way, the rituals developed from symbolic actions reinforce the belief system of an individual within the social group conducting the ritual.

As noted in Chapter 3, I proposed in this study to apply Davis-Floyd's lens of childbirth to the context of decision-making for vaginal breech birth. The findings in Chapters 4 through to 8 suggest the presence of a socially accepted ritual for vaginal breech birth in high income countries - that is the default management for breech presentation should be a planned Caesarean section. Through this socially accepted ritual, members of society have been socialised into forming their own perceived reality regarding vaginal breech birth.

This perceived reality has a close relationship with medical technology and the rituals established in that domain. Both Davis-Floyd (2003) and Founds (2007) suggested that the medical system has a strong influence in informing social discourse around birth practices. This also features in much of the literature studying birth in general, as well as choices for other modes of birth such as VBAC (Fenwick et al. 2010; MacKenzie Bryers & van Teijlingen 2010; Malacrida & Boulton 2014; Munro, Kornelsen & Hutton 2009). The negativity surrounding women's choices for planned vaginal breech birth from women's sub-cultural units (see Chapters 4 to 7) and from the media (Chapter 8) suggest that the default option for management of breech presentation, that is, Caesarean section, has been ritualised by medical technology. This in turn has informed a socially constructed "reality" that normalises Caesarean section for the management of breech birth, creating a sense of stability and a sense of order and predictability for the birth of a breech baby.

9.3.2 Mass media, social discourse and the legitimisation of obstetric power

In Chapter 8, I examined web based news reports on breech presentation and birth and explored how the media perpetuated health and sociocultural views on the perceived danger of breech presentation and birth. I concluded perceptions of vaginal breech birth in the media demonstrated negative views towards breech presentation and vaginal breech birth. Caesarean section is portrayed as the safe option for birth, while vaginal breech birth is viewed as a risk-laden choice that inevitably ends in poor outcomes. These findings suggest that web-based new reports may have a significant impact on women's decision-making for birth options relating to breech presentation.

Mass media's influence in the topic of childbirth has been identified by researchers as having a significant influence on socio-cultural views (Luce et al. 2016; Morris & McInerney 2010).

Representations of an event through mass media are one way that meanings are produced in a culture. Society's interpretation and consumption of the images and narratives produced in these representations creates a discourse that dictates society's version of "normal" where social practices and behaviours are constructed and maintained (Nall 2014; West 2011). Dominant groups in society, such as doctors of medicine, exert and maintain the power of enforcing these "norms" and reinforce a social hegemony that acts as the dominant discourse on any given issue.

For childbirth, the dominant social group that enforces these "norms" has been identified as the obstetric profession (Davis-Floyd 2003; Mander et al. 2014). Media and the institution of obstetric medicine are observed to shape one another, working together to form an ingrained "cultural logic" that legitimises the obstetric profession, and their connection to medical technology, as the perceived exclusive producers of health and safety in the event of childbirth (West 2011). In this context, the model of maternity care is typified by the birthing woman needing to acquiesce to the male-dominated obstetric profession within powerful medical institutions (hospitals) (Nall 2014). Sociologists have labelled obstetrics the "success story of modern medicine" with the claim that the power of being able to dictate social hegemony for childbirth has resulted in a system where birth "routinely require(s) the arts of medicine to overcome the processes of nature." (Wertz & Wertz 1989).

The power of the obstetric profession in dictating socio-cultural narratives for breech presentation was demonstrated in Chapters 4 though to 8. In a socio-cultural context, the "blanket" approach of Caesarean section for breech presentation was seen as the "right" approach for management of breech presentation. The lack of support for vaginal breech birth, therefore, reinforced the views that vaginal breech birth is impossible and/or dangerous.

The media platforms examined in Chapter 8 support the existing obstetric-dictated paradigm that breech presentation and birth is a problematic and difficult birth scenario to manage. The lack of in depth analysis on media reports discussing medical malpractice suits associated with vaginal breech birth also show that it is the media's preference to focus on poor outcomes relating to vaginal breech birth, once again reinforcing dominant obstetric views and fear surrounding this option for birth. Additionally, the exclusion of discussion regarding poor outcomes relating to Caesarean section and evidence supporting the safety of planned vaginal breech birth under specific conditions (Glezerman 2012; Goffinet et al. 2006; Kotaska et al. 2009b) reinforced this view.

Media text analysed in the study findings presented in Chapter 8 also portrayed the need for intervention (Caesarean section) to overcome the perceived danger associated with vaginal breech birth. This has the potential to further reinforce the belief that Caesarean sections are the only option to 'manage' or avert the risks for mother and her breech baby. This has created a normalisation of technology in breech birth scenarios, thereby creating pressure on women to accept the status quo of Caesarean section operation for management of breech birth. Rather than demonstrate a balanced view of the risks and benefits of all options for birth, it seems apparent that there is a preference for the media/socio-cultural/obstetric triad to portray vaginal breech birth as an unsafe option that legitimises the control of women's bodies through technology during birth to "guarantee" a perceived good outcome (Luce et al. 2016).

Adding further to the current contexts of the 'status quo' for the management of breech presentation is the obstetric profession's apparent reluctance to respond to evidence that supports the safety of vaginal breech birth. Following the release of the Term Breech Trial's findings (Hannah et al. 2000), its recommendations were immediately and comprehensively

accepted by the medical community (Glezerman 2006). At the time, the randomised design of the trial was considered to be the highest quality evidence available (Keirse 2011; Lawson 2012). It has also been suggested that the outcomes of the Term Breech Trial were also *"almost gratefully accepted"* by obstetricians, mainly in Western countries, as it absolved them of the responsibility of supporting this birth option due to perceived increased risks and fear of litigation (Glezerman 2006). Since that time, the literature has recognised that maternity service providers have been slow to respond to contemporary evidence regarding safety of vaginal breech birth, as this evidence continues to be overshadowed by the strong and lasting impact of the Trial (Glezerman 2012; Lawson 2012). The Trial's findings changed practice across the world so profoundly that, as a result, vaginal breech birth is now a rarity, as are clinicians skilled in the practice of vaginal breech birth. Management practices continue to favour Caesarean section operations and a reluctance to shift away from this as the perceived 'optimal' mode of birth for breech babies remains (Glezerman 2012). The increasing focus on medico-legal concerns in obstetric practice is often quoted as an explanation for this reluctance (Burke 2006; Glezerman 2012), along with lack of clinicians skilled in the facilitation of vaginal breech birth. The findings of this research project support the suggestion that the obstetric profession's own dominant narratives around vaginal breech birth remain a significant obstacle for women who may seek this birth option.

9.4 Control of the birthing body

9.4.1 The "defective" female body and the "abnormality" of breech

In Chapter 4, the findings demonstrate that the women interviewed expressed a motivation to achieve control of the birthing process as an expression of resistance to their perceived supervisory role society appeared to exert over pregnant women in general and, in particular, the

authoritative status of biomedical thinking (Viisainen 2001). The lack of trust from broader society in the birthing process, and the need for medical technology to "manage" birth is not a new concept in the literature (Davis-Floyd 2003; Fisher, Hauck & Fenwick 2006; Murphy 2010; Reiger & Dempsey 2006; West 2011) and was strongly expressed by the women interviewed in Chapter 4. The need for medical technology during birth was also evident in the news media analysis in Chapter 8 and the analysis of internet chat forums in Chapter 7.

The notion that medical technology must control a natural process such as birth is rooted in the idea that birth is a flawed process that requires medical management in order to optimise outcomes for the women and babies. Feminist studies extrapolate further by suggesting that over time, fundamental assumptions have been formed regarding the superiority of the male body, with the female body regarded as *"abnormal, inherently defective and dangerously under the influence of nature."* (p.51) (Davis-Floyd 2003). This idea is embedded in historical text as far back as Aristotle, who defined women as mutilated males and *"a defect or an imperfection of nature*" (Nall 2014). Feminist philosopher Carolyn Merchant also suggests Western civilisation's assumptions about the inferiority of women dates back to the stories of Adam and Eve (Merchant 2004). Eve's connection to nature and identification with fertility, and subsequent expulsion from the Garden of Eden for ingesting forbidden fruit, is representative of women's weaknesses and faults.

The view that women's bodies were flawed remained prevalent throughout history. A witch hunting manual published in the 1400s, used widely throughout European witch trials, used the Bible as the basis for the idea that women's bodies are defective:

> *"…they are feebler both in mind and body, it is not surprising that they should come under the spell of witchcraft….it should be noted that there was a defect in the formation of the first woman, since she was formed from a bent rib…which is bent as it were in contrary direction to a man. And since through this defect she is an imperfect animal, she always deceives."* (p.120-121) (cited in Nall 2014)

The idea that the defective women's body required transformation through male rationality arose in the 17th and 18th Century. The Industrial Revolution reinforced this idea by applying a mechanical metaphor to the human body (Davis-Floyd 2003; Nall 2014). This approach, supported by developing scientific and medical discoveries, was amenable to the idea that human bodies could be taken apart, studied and "fixed" with the newly developed scientific knowledge supported. The idea that the female body was inferior in this context was perpetuated by labelling it deviant due to its closer relationship with nature, through pregnancy and birth, and its tendency to be unpredictable. By contrast, the male body was seen to have a more distant relationship with nature and this resulted in a predictability that was more easily controlled and therefore more acceptable (Merchant 1990; Nall 2014; Reynolds 1991).

The early 20th century rise of the male-attended mechanically manipulated birth, and the subsequent shift away from the social model of birth care practised by midwives, is a significant driver for the philosophical foundation of modern obstetrics (Davis-Floyd 2003). A wider cultural acceptance grew from this movement, reducing the female body to an inferior status, with childbirth seen as something that was "performed on a woman" rather than "something women performed" (Bak 2004; Kline 1997; Luce et al. 2016; Morris & McInerney 2010; Song, West, Lundy & Dahmen 2012; VandeVusse 2008). While it is difficult to argue that many medical advances of the 20th Century made birth safer for some women and have saved the lives of mothers and babies

who would have otherwise not survived, it can also be said that the move towards the medicalisation of birth has altered some socio-cultural views of birth. The wider acceptance of the technological management of the birth process has impacted women in less beneficial ways that did not necessarily become obvious until well into the 20th Century (West 2011).

The impact of the medicalisation of birth has resulted in contemporary society developing a firmly entrenched view that birth is an imperfect process that requires medical technology as an "essential rescue" from the uncertainties of birth (Coxon, Sandall & Fulop 2014). My research found that breech presentation brings with it an additional layer of perceived complexity or "abnormality" and this further reinforces the cultural belief that medical intervention is necessary for a safe outcome for breech birth. The dependence of modern obstetrics on technology, and the dynamic relationships medicine has with society in informing socially constructed "realities" for management of breech birth, reinforces the ritual management of Caesarean section for management of breech birth. The lack of trust in the female body to give birth to a breech baby and the trust and security that stable institutions such as hospitals provide through protocol and ritual, act to entrench the idea that Caesarean section for breech presentation is not only normal but safest (Coxon, Sandall & Fulop 2014; Zinn 2008). Therefore, it is suggested that the default management approach of Caesarean section for breech presentation by medical institutions is seen as the "right" approach. The findings of my study support this view.

By contrast, vaginal breech birth, with its emphatic departure from technology, embraces nature. Women seeking a vaginal breech birth threaten the validity of an entrenched belief system rooted in a technocratic medical framework and as a result are generally met with great resistance. The women's trust in the birthing process is in direct conflict with the idea that birth is an imperfect

and untrustworthy process that should be managed in an orderly, controlled fashion with the superiority of medical technology (Bryant et al. 2007; Leao et al. 2013). Vaginal breech birth is therefore seen as impossible and/or dangerous. The findings of the research I have conducted for this PhD thesis shows that these entrenched views impact significantly on pregnant women who choose vaginal breech birth for their baby and, in some cases, may act as a primary factor in those who choose Caesarean section, a finding that has been confirmed in other research (Centola 2013).

9.4.2 The risk society and the prioritisation of fetal welfare

This thesis has demonstrated that social views on management of breech birth implied that, for breech presentation, it is the mother's moral obligation to have a Caesarean section to protect her baby. Women seeking a vaginal breech birth in this study were viewed with suspicion and hostility as they were perceived to be more interested in the kind of birth they wanted over the welfare of their baby. Dahlen and Homer (2011) identified this as the "childbirth vs. motherbirth" dichotomy, where those who operate in the "childbirth" framework were identified as a good parent as they sacrifice themselves for the health of their baby and take no apparent risks. Those who operate in the "motherbirth" framework feel giving birth matters for the woman and that a happy, healthy mother means a happy healthy baby. Dahlen and Homer's study showed that these women are often viewed as selfish by society. Women seeking a vaginal breech birth in my research appeared to operate in the "motherbirth" framework but were largely surrounded by members of their sub-culture who operated in the "childbirth" framework.

In recent years, there has been an increasing predominance of society reinforcing the "childbirth" framework. Pregnant women are under an intense social gaze that expects them to engage in

"reproductive asceticism"- that is to bear full responsibility for the health of their unborn child by stringently monitoring and controlling their bodies and choices for birth (Lupton 2012). The power of this social focus on pregnant women is thought to be the result of what has been termed by Beck (1992) as a "risk society", 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). In contemporary society, discourses surrounding pregnancy and birth are underpinned by a preoccupation of risk. Close monitoring and a fixation on risk is thought to be an approach used to create a perceived sense of security and a way to avoid potentially unfavorable outcomes.

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). Clinical discussions around risk have expanded to now include the possible, as well as the improbable, and are also informed by an increased vigilance and anxiety around the need to protect the welfare of the fetus and child (Bisits 2016; Coxon et al. 2016). This has impacted on social constructions of risks relating to childbirth, where birth is increasingly cited as a period of danger that requires heightened surveillance and expert guidance. As a result, it has become difficult to ascertain the necessity of interventions currently deemed appropriate in managing the perceived dangers of childbirth. It has also led to social endorsements of childbirth intervention, where moral terms are used to characterise interventions as "good" and "necessary", while consumer choice that challenges this status quo in favour of optimising opportunities for normal birth are viewed as "risky" and "bad mothering" (Coxon, Scamell & Alaszewski 2012).

Increasing scientific knowledge over the last century has increased medicine's ability to manage risk in childbirth (Scamell & Alaszewski 2012). While this is often done under the guise of

optimising safety, the realities of focusing on risk management, is for the avoidance of litigation by clinicians and to manage clinician fear. It is this approach to managing uncertainty that has permitted social and state sanctioned surveillance and intervention of childbirth to ensure that the welfare of the fetus remains paramount (Healy, Humphreys & Kennedy 2016; Possamai-Inesedy 2006). Ritualised intervention in childbirth is seen as necessary to avoid adverse outcomes, so much so that birth attendants themselves may find the concept of normal birth challenging to support in practice (Coxon, Scamell & Alaszewski 2012; Scamell & Alaszewski 2012). For breech presentation, the psychological reassurance of a predictable outcome via Caesarean section can be seen as a way of preserving the ritual of medical technology and reinforces a belief system that both society and clinicians seem to find comfort in (Scamell 2014; Scamell & Alaszewski 2016).

Technology used in maternity care in modern hospital settings ”manages” pregnancies that are increasingly defined in terms of risk, with the focus being on the fetal body rather than the pregnant body (Helen 2004; Weir 2006). It also perpetuates a view that pregnant women should be carefully controlled rather than empowered. The current culture of risk aversion contributes to social perception that sees pregnant woman as public property whose voice is silenced and whose interests are discounted (Ballantyne et al. 2016).

Society’s perceived ‘ownership’ of women’s bodies is a notion discussed at length in Minkoff and Marshall’s paper “Fetal risks, relative risk and relatives’ risk” (2016). Minkoff and Marshall suggest that fetal welfare takes precedence over women’s autonomy, giving society permission to exert control over the pregnant body. They also cite the misuse of relative risk as a tool for informing women and society’s views about risks relating to birth (which for many women are voiced by the sub-cultural units of family and relatives) arguing that relative risk as a tool can be open to misinterpretation and confusion (Minkoff & Marshall 2016). Minkoff and Marshall contend that

society's approach is explained by how the fetus is viewed as *"uniquely pure…even more vulnerable and dependent on ascribed "virtuous" parental behavior..."* (p.8). The authors suggest that the notion of the 'purity' of the fetus prompts different approaches to medical management by doctors as opposed to other medical scenarios. They use the example of a survey of obstetricians who were given a choice of intervening in one of two hypothetical scenarios, both under a hypothetical court order. The first scenario concerned a pregnant woman with a prolapsed cord who refused surgery, the second a mother of a two week old baby who refused to donate her bone marrow to her baby that, without the marrow, would die within 24 hours. The results showed that 66% of obstetricians would perform a Caesarean section on the woman with a prolapsed cord while 38% would perform a marrow aspiration in the second scenario. This is a clear demonstration of removal of autonomy based on the notion of prioritising fetal welfare over a woman's self-determination. For breech presentation, the lack of options for vaginal breech birth can also be seen as a way of controlling women's bodies by limiting the birth options available to them, despite evidence supporting this birth choice. Debruin extrapolates further and provides an additional interpretation of the results of this survey (DeBruin 2016). The intensity in which pregnant and birthing women are monitored for the sake of the preservation of the "pure fetus" implies that pregnant women's bodies, their connection to nature and their ability to birth pose as threats to the fetus that are best managed by removing the connection to nature and replacing it with medical technology (Davis-Floyd 2003; DeBruin 2016). Kukla (2005) also described how the views of the "unruly mother" have influenced the perception of pregnant women as the primary source of harm and damage to the "innocent fetus" (Kukla 2005). Rather than solely focusing on the medicalisation of childbirth as a way transcending the "imperfect female body", Debruin also points to the socio-cultural views on women's lack of trustworthiness in the context

of reproduction. The conflicts that arise between women's autonomy in pregnancy and birth, and socio-cultural views about control for the sake of the "pure fetus", could be remedied, Debruin argues, if women's trustworthiness in the context of reproduction was respected and valued.

Obstetric literature also demonstrates these notions of control and ownership of the fetus over the mother. In a discussion paper about the perceived medicalisation of childbirth, de Costa and Robson (2004) mention the notion of maternal satisfaction as being worthy of consideration in the decision-making process. While their paper purports to commit to the notion of a woman's bodily autonomy, it tellingly ends with the following warning when ascribing value to maternal choice where increased risk to the fetus is perceived:

"It should not be a heresy to ask whether an increase in maternal satisfaction is a fair and reasonable trade for a decrease, however slight, in safety for the baby. After all, ***our*** *babies will have to live with the consequences." (bolded font added for emphasis)* (p.439) (de Costa & Robson 2004)

There are obstetric voices that demonstrate a contrary narrative that supports the model of woman-centred care rather than fetus-centred care as demonstrated in the following quote from American Obstetrician Mark Landon when discussing women's choices for vaginal birth after Caesarean:

"A shared decision-making process should be adopted, and whenever possible, the patient's preference should be respected …. One thing I've learned from my clinical practice and research on this issue is that the desire to undergo a vaginal delivery is powerful for some women." (p.3) (Landon 2015)

The notion of choice and control around the option of vaginal breech birth in obstetrics also demonstrates opposing narratives on maternal choice and fetal risk. Support for vaginal breech birth is present in the literature, with the right for women to have this option for birth being clearly articulated (Catling et al. 2016a; Glezerman 2012; Kotaska 2007; Lawson 2012; van Roosmalen & Meguid 2014). However, the profile of vaginal breech birth continues to be low and women face the challenge of negotiating entrenched clinician and system views regarding the risks associated vaginal breech birth. Homer et al (2015), in our recent study of women's decision-making for vaginal breech birth, noted that the a lack of autonomy and control in women's decision-making was the result of a health system that sought to manage the woman by dictating her options for the sake of "fetal safety" rather than maintaining the woman as the focus of the pregnancy and birth process (Homer et al. 2015).

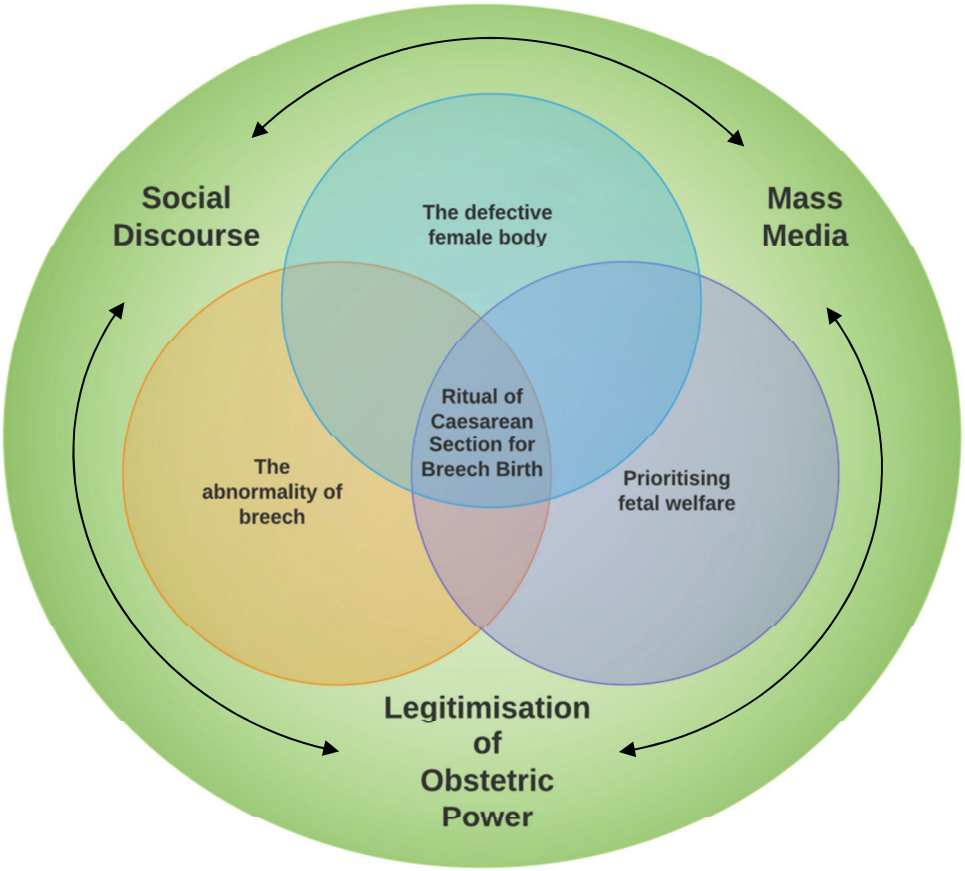
Women seeking vaginal breech birth may pose a challenge to obstetric maternity care which is characterised by paternalistic authority, control of the birthing body and decision-making for the woman, rather than in collaboration with the woman (Cheyney, Everson & Burcher 2014; Homer et al. 2015). These current norms are seen as an attempt to exert control and power and preserve authority in obstetric care over the birthing body. My research demonstrates that current obstetric approaches and attitudes to management of breech birth have informed social discourses surrounding management of breech birth and these discourses act as a barrier during women's decision-making for vaginal breech birth.

9.5 The challenges of seeking vaginal breech birth

9.5.1 Threatening a sanctioned ritual

My research has found that a number of components inform a socially and medically sanctioned ritual for managing breech presentation that endorses Caesarean section as the default option for birth. Figure 5 uses the findings of my research that have been discussed previously in this chapter to illustrate the how the currently entrenched ritual of managing breech birth is a closed system that brings a sense of predictability and order.

Figure 5 Factors endorsing the ritual of managing breech birth by Caesarean section



The findings of my research also demonstrated that women seeking vaginal breech birth are a threat to the stability of the breech birth ritual of elective Caesarean section. The women's motivation to achieve a sense of choice and control of the birthing process was an expression of resistance to the "status quo" for managing breech birth. Challenging the norm upsets the sense of order that has been established over time by the management of breech birth through Caesarean section.

As a result of challenging the ritualised behaviour of Caesarean section for management of the breech birth, women seeking vaginal breech birth were depicted as difficult and defiant. This is supported in the findings in Chapter 4 (interviews with women), Chapter 6 (internet survey-qualitative analysis) and Chapter 8 (analysis of web based news reports), where women were labelled as selfish, difficult or defiant due the mother's perceived prioritisation of the wish for a natural birth over the baby's safety. As discussed in section 9.3.2 in this chapter, this is echoed in birth literature outside the breech birth context where 'good mothers' are seen as self-sacrificing and women who challenge the norm are vilified (Charles & Shivas 2002; Johnston & Swanson 2003; Morris & McInerney 2010; Weaver, Statham & Richards 2007).

The charge of selfishness towards women who opt for a vaginal breech birth can be seen as a way of society responding to the 'threat' of the pregnant and birthing body to the 'pure fetus'. A woman's choices around the options she takes during both pregnancy and birth has been suggested as a signal for society that is the focus of social attention and is interpreted as an "emblematic summation" of her mothering abilities (Kukla 2008). A woman who upsets the status quo and refuses to subscribe to hegemonic views about how she should birth is viewed with hostility that is strong and explicit in society and popular culture. Society's way of managing this is

to draw the conclusion that this bad behavior reflects poorly on her potential to be a 'good' mother.

The findings from my research have found that women who upset the status quo for management of breech birth are susceptible to isolation and anxiety, which is also supported in other studies on decision-making for vaginal breech birth (Guittier et al. 2011; Homer et al. 2015). The qualitative element of the research undertaken for this thesis (Chapters 4, 6 - 8) showed that reactions from women's sub-cultural units implied the women seeking a vaginal breech birth were potentially 'bad' mothers. This led to women removing themselves from their social circle to avoid receiving harsh judgements or negative comments. While they felt they had made a sound decision in trying for a vaginal breech birth, they felt that their conviction could waiver if they experienced a significant amount of disapproval and pressure from members of their sub-cultures. This approach to self-protection is not unique to vaginal breech birth contexts and has also been demonstrated in other studies for contexts such as homebirth (Keedle et al. 2015).

Many elements of my research also demonstrated heightened anxiety for many of the women in this study during their last weeks of pregnancy as a result of having to search for support for their birth choices, as demonstrated in Chapters 4 (interviews with women), Chapter 6 (qualitative data analysis from an internet survey) and Chapter 7 (analysis of internet chat forums). Stress and anxiety during the antenatal period has been shown to increase the potential for childbirth interventions, emergency and elective Caesarean section, postnatal depression, post-traumatic stress disorder and depression (Buist et al. 2008; Donnellan-Fernandez 2011; Fisher, Hauck & Fenwick 2006; Söderquist et al. 2009). Current evidence also suggests that maternal anxiety during the antenatal period can also have poor long term health implications not only for the mother but also for the baby postnatally (Ding et al. 2014; Hector, LeFevre & Williamson 1989; Leigh &

Milgrom 2008). Healthcare providers should give close attention to the potential for increasing anxiety in pregnant women and make all attempts to address any concerns from the woman that may arise. For women with breech babies, the time from diagnosis of breech to birth can be intensely stressful, as evidenced by the women's stories in the findings of this study.

9.5.2 Social Media - A Safe Haven?

This section explores how women seeking a vaginal breech birth, thereby threatening the ritual of elective Caesarean section for breech presentation, are using new forms of media as a source of support and comfort from groups who offer the acceptance that these women are not finding in their sub-cultural units and social circles. Chapter 8 demonstrated that perceptions of vaginal breech birth in the media exhibit negative views towards breech presentation and vaginal breech birth. While news media may not be a space where support for vaginal breech birth is demonstrated, the advent of the internet, and access to social media, has created a shift in the landscape in how media is used. Social media creates a platform from which women can generate stories based on their own narratives rather than narratives dictated by dominant views from the medical/social dyad. Social media provides an unprecedented source of new communities and new communication across spectrums that are united by common experiences. Women are using these new resources to find ways of connecting with other women and giving shape to narratives that previously have not been discussed in forums open to the public (Dahlen & Homer 2011; Hardy & Kukla 2015; Stadtman Tucker 2009).

The findings presented in Chapters 4 (interviews with women), Chapters 5 and 6 (qualitative and quantitative data from an internet survey) and Chapter 7 (analysis of internet chat forums) demonstrate that social media can act as a 'safe haven' for women who feel abandoned by the

health care system by going against the 'status quo' (Lagan, Sinclair & George Kernohan 2010; Romano, Gerber & Andrews 2010). They may also seek the support of other women online in an attempt to make sense of what they are experiencing where society or health care providers are not providing the support they need to assist in their decision-making (Betts, Dahlen & Smith 2014; Hardy & Kukla 2015). Bainbridge (2002) also suggests online communities provide a space where women can find acknowledgment from like-minded peers who feel that the actual birth is a significant psychological experience, not simply as a process that sees the creation of a new mother (Bainbridge 2002).

While the literature suggests that online communities can act as a formidable social tool for women to articulate their experience of birth in different contexts, they can also be spaces for misinformation that can subsequently lead to inappropriate dilution or distortion of fact (Griffiths et al. 2012). This was demonstrated in Chapter 7 which discussed internet forums and discussions regarding vaginal breech births. While there were some comments in the forums supportive of vaginal breech birth, many used alarming language and misinformation. The conflicting information online regarding the option of vaginal breech birth may contribute to women's anxieties and levels of stress when diagnosed with a breech baby towards the end of their pregnancy.

An example of this can be found in Hardy and Kukla's (2015) study of discussions about miscarriage online that identified differences in how discussions were conducted in online communities, depending where they were situated (Hardy & Kukla 2015). Hardy and Kukla suggest that discussion boards contain *"a conversational bottom-up structure, with no one participant having any special authority or power more than the direction of the discourse"* (p.122). Facebook, by contrast allows for more civility as groups are formed via private membership and consist of

engaged members that seek detailed narratives that permit member identities to be formed through the sharing of their birth stories.

The findings from Chapter 7 reinforce this. Women who sought to interrupt the ritual of Caesarean section for breech birth by exploring the option of vaginal breech birth on discussion forums were met with warnings and strong language associated with the risk of vaginal breech birth. Respondents suggested that vaginal breech birth was a selfish choice given the perceived high level of risk associated with vaginal breech birth. Generally, the view on these forums was that, for breech presentation, the mother's wishes to explore vaginal breech birth are secondary to the baby's welfare, a view that has been echoed in other studies (Bryant et al. 2007) and discussed in section 9.3.2 of this chapter.

By contrast, the women interviewed for the study in Chapter 4 found connecting with other women previously unknown to them through Facebook proved to be extremely beneficial and inspiring for those who accessed this social media platform. This may be due to the fact that *all* had sought to break the ritual of Caesarean section for vaginal breech birth. This instant acceptance supported new members, such as those interviewed in Chapter 4, in feeling less isolated as they were connecting with others in the same situation. Facebook was also used as an opportunity to find positive birth stories and videos and photographs that other women had posted, support which many women had struggled to find elsewhere. Women's stories and images appeared to give women confidence that vaginal breech birth was possible and it enabled them to see themselves going through the same process. Hearing stories from women who ultimately had a Caesarean section was helpful in their planning.

For women feeling isolated as a result of challenging dominant rituals around birth choices, being able to share stories with women, such as those that are found online, may be of benefit (Callister 2004). Not only do women connect and find common ground with other women in this process, it also creates the opportunity to 'make sense' of a major life event for the mother and to integrate the birthing experience into the framework of her life (Blainey & Slade 2015). For women seeking to distance themselves from a traumatic or negative experience, writing birth stories allows women to process feelings of inadequacy or disappointment that can act as a way of filling in 'missing pieces' of emotions that she may not yet have identified about her birth. In my research I found that birth stories were also seen as a chance to reflect, and for women to gain an understanding of their strengths.

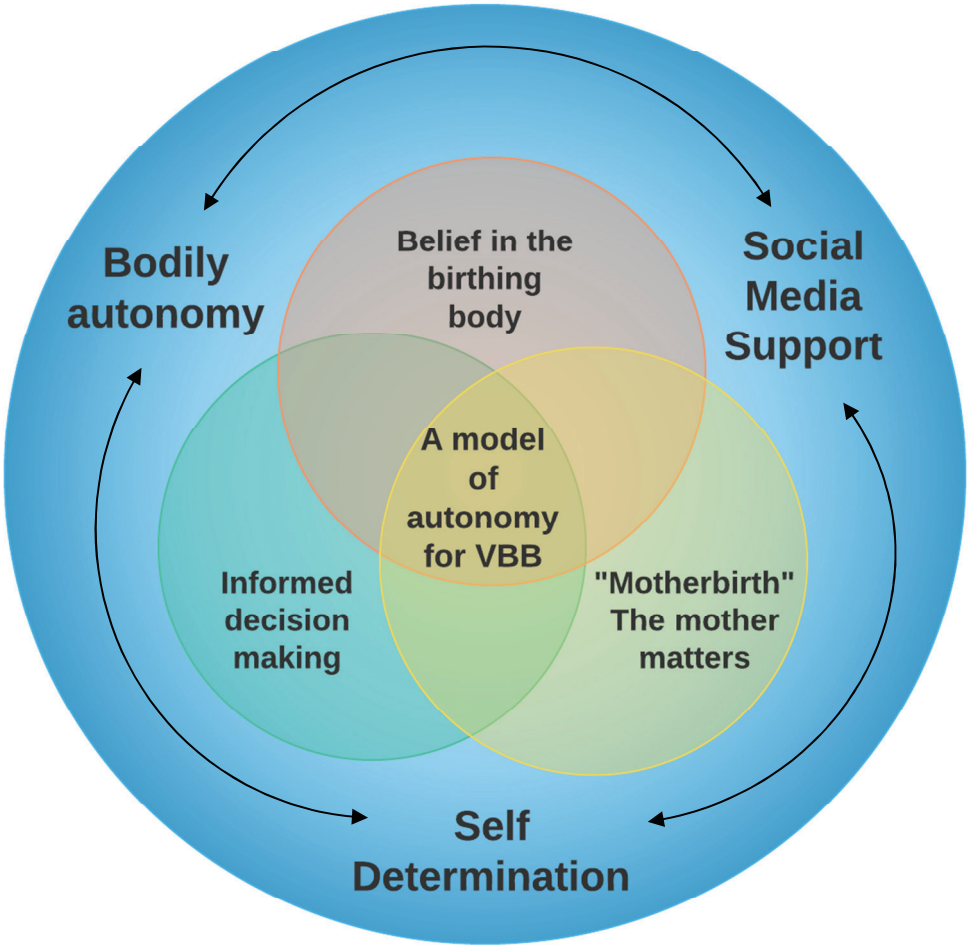
9.5.3 Self-determination: A model of autonomy for choosing vaginal breech birth

Findings from Chapters 4 through to 8 showed that women create their own model of autonomy, rather than succumbing to ritual, when going through the process of seeking a vaginal breech birth, as demonstrated in Figure 6 (following page). Despite the social/obstetric dyad that acts to heavily influence management of breech birth via Caesarean section, women seeking a vaginal breech birth determinedly balance and contextualise the risks and benefits of vaginal breech birth to come to a decision that supports their autonomy. Figure 6 illustrates the elements of this process.

The women who were interviewed in Chapter 4 and those who participated in the survey (Chapters 5 and 6) had a strong belief in the birthing body and appeared to fall under the "motherbirth framework", where they recognised that choice in how a woman gives birth matters. These women sought balanced, unbiased information to assist them in making informed decisions

about the birth of their breech baby. They also recognised that the concept of risk is value laden and holds different truths for different people, and for these women their "truth" is their belief in the birthing body, self-determination and the need for bodily autonomy (Kukla et al. 2009). Social media also plays a significant role in supporting women though their decision-making.

Figure 6 A model of autonomy for choosing vaginal breech birth



Finding autonomy for vaginal breech birth enables women to be primary agents of their own birthing process that incorporates safe access to birth that incorporates personal and social circumstances and preserves their values and their sense of integrity and dignity.

9.6 Promoting change in social discourse: A way forward for supporting women choosing vaginal breech birth through policy, clinician education and consumer information

Despite the rarity of vaginal breech birth, women will continue to seek this option to give birth. Understanding this will assist clinicians in acknowledging the need for autonomy and support for the woman in this process. For clinicians, enhancing women's autonomy should be negotiated *"by a rich understanding of women's agency and its placement within a complicated set of cultural meanings and pressures surrounding birth"* (p.8) (Kukla et al. 2009). Bioethicists suggest trust in both the care provider and the woman's own judgement and capacities are key drivers to achieve autonomy in birth. The results of my research support this notion for the contexts of vaginal breech birth. By valuing the women's autonomy in decision-making for vaginal breech birth as a priority, further consideration can then be given to guidelines, practices, and conversations that will best promote and protect women's full inclusion in a safe and positive vaginal breech birth process.

The challenge for clinicians in this context is the lack of system exposure, training and skill in supporting vaginal breech birth, thereby creating an entrenched bias in favour of Caesarean section as the preferred management option (Glezerman 2012; Lawson 2012). Challenging entrenched system bias that exists around vaginal breech birth requires recognition of existing evidence on the safety of vaginal breech birth and recognition of the need to provide unbiased information on vaginal breech birth in an accessible manner (Azria et al. 2009; Goffinet et al. 2006; Lawson 2012). By combining evidence-based practice and developing trust in a shared decision-making framework, women's views will be valued and their preferences will be prioritised (Cox

2014). A useful model that may assist in supporting this process entails five steps of evidence-based inquiry redeveloped for midwifery practice: 1) finding out what is important to the woman and her family 2) using the information from the clinical examination 3) seeking and assessing the evidence to inform decisions 4) talking it through 5) reflecting on outcomes, feelings and consequences (Page & McCandlish 2006).

Shared decision-making can be seen as a midpoint between 'paternalistic' and 'informed choice' models of decision-making and is characterised by a patient and health care provider relationship where information is shared and management decisions are agreed upon (Elwyn, Edwards & Kinnersley 1999; Müller-Engelmann et al. 2011). Shared decision-making has been shown in the literature to have a number of benefits for women's decision-making in birth scenarios that may be considered challenging for clinicians (Cox 2014; Nieuwenhuijze et al. 2014; Shorten et al. 2004). It has also been cited as encouraging evidence-based practice and incorporation of women's values and preferences and that it may reduce the likelihood of malpractice liability (Bryant et al. 2007; Cox 2014; Kaimal & Kuppermann 2010).

Providing accurate, accessible clinical information plays a significant role in a shared decision-making framework, as was demonstrated in the findings from the internet survey discussed in Chapters 5 and 6, as well as the discussions analysis in the internet chat forums in Chapter 7. My findings are further supported in the literature (Azria et al. 2009). Azria et al conclude that maternal autonomy and medical responsibility can only coexist when there is an understanding of all information exchanged between the caregiver and the pregnant woman. Similarly, in our study of women's decision-making for vaginal breech birth (Homer et al. 2015), we found that women with a breech presentation placed a high value on clear, consistent and relevant information in deciding about mode of birth for their breech baby.

Kaimal and Kuppermann (2010) suggest a range of strategies are available to facilitate this to be a more positive process, such as presenting risk using a number of presentation styles, for example, using graphs rather than complex statistics and incorporating this into a model of shared decision-making.

The Royal College of Obstetricians and Gynaecologists (RCOG) and the National Institute of Clinical Excellence (NICE) Guidelines have also produced documents that discuss optimal ways to communicate risk, with the RCOG document providing obstetric-specific examples of how to present risk to women in maternity care (NICE 2012; RCOG 2008). These documents support the notion of tailoring risk with a careful approach to framing concepts and also discuss the notion of understanding the woman's perception of risk. RCOG notes that:

"People's assessment of the importance of risk for themselves can vary even if the actual risk does not….a number of known factors or 'risk attributes' influence the perception of risk. People place different weights on different risks according to these risk attributes even where the numerical magnitude of the frequency of a bad outcome from those risks is the same."(p.4) (RCOG 2008)

Maternity services should also acknowledge that women are likely to continue to choose vaginal breech birth as an option for birth and that a shared decision-making framework should be recommended in clinical guidelines that are developed for the management of breech presentation. This approach can be seen in existing research as well as clinical guidelines for management of breech presentation from the UK and Canada (Homer et al. 2015; Kotaska 2007; Kotaska et al. 2009b; RCOG 2006). These documents contain clear statements about the need to respect a woman's decision and that information on risks and benefits for all options for birth should be provided.

Coxon et al also argue that high level policy may not be sufficient in changing socio-cultural attitudes around the "riskiness of birth", which could also be applied to the vaginal breech birth context (Coxon, Sandall & Fulop 2014). Their research on women's choices for place of birth suggests 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 conclude that any changes to discourses of risk around birth are *"unlikely to be rapid or even to occur within a generation."* (p.65). In light of the findings in my research that concludes that society views vaginal breech birth as a 'high risk', Coxon et al's findings suggest that achieving social acceptance of vaginal breech birth may be an even greater obstacle.

I argue that maternity services should go a step further in providing guidance to clinicians. Services should develop high level policy that not only recites current evidence and best practice recommendations, as is currently the case, but also support establishing services that offer vaginal breech birth with structured opportunities for clinicians to develop their skills. This is the key to positively informing medical discourses around the option of vaginal breech birth (Powell, Walker & Barrett 2015; Walker, Scamell & Parker 2016). Increasing the availability of consumer information may also be a key factor in driving demand for vaginal breech birth (Guittier et al. 2011). Given the relationship that has been established between medical and social discourses in my research, this will be a positive step in promoting changes in social discourse surrounding choices for breech birth. Normalising vaginal breech birth in medical discourses will engender acceptability of vaginal breech birth in socio-cultural contexts as a normative practice and increase opportunities for women to exercise choice and control making decisions for breech birth.

> *"It is the pregnant woman whose personal, fetal, and family interests hang in the balance when issues of home births, TOLAC, or Caesarean sections are raised, and it is the*

decisionally capable pregnant woman, not third parties with false claims to objective decision-making, who is best situated to speak on these matters. After all, physical risks might be minimized by life in a bubble, but no one would suggest that a caring mother should choose that life for her child." (p.9) (Minkoff & Marshall 2016).

9.7 Summary

This chapter reviewed the purpose of the study and presented an in depth analysis and discussion of the findings. The discussion in this chapter was underpinned by the theoretical framework for this PhD thesis, symbolic interactionism. This chapter also made recommendations as to how change can be promoted for the option of vaginal breech birth that may positively influence contemporary social discourses for this birth option.

In the next chapter, I will formulate conclusions relating to the research I conducted for this thesis, discuss the limitations of the studies conducted for this PhD thesis and make some final observations regarding the characteristics of women who choose vaginal breech birth and how they overcome entrenched views in contemporary society relating to the management of breech birth.

Chapter 10 Conclusion

10.1 Introduction

In this final chapter, I will make conclusions that draw on observations I made in Chapter 3 of this PhD thesis and how these observations link to the findings of the research I conducted. I will also discuss the characteristics of women seeking a vaginal breech birth and how they are able to overcome opposition they encounter during their experiences in choosing this option for birth. The limitations of the research conducted for this PhD thesis are also outlined in section 10.3.

10.2 Study conclusions

The research in this thesis sought to explore how social discourse impacted on women's choices for vaginal breech birth. This study aligns itself with the ideologies of the epistemology of constructionism and the theoretical perspective of symbolic interactionism. Through this theoretical lens, this study sought to understand how women responded to the meaning society has developed regarding the options of vaginal breech birth and how this may influence their decision making for birth.

Figure 3 on page 33 in Chapter 3 aimed to illustrate the individual's journey through the sub-cultures that may exist in their life when choosing vaginal breech birth. These sub-cultures included (but were not necessarily limited to): media, family, peer groups and other associations (community groups, employment interactions). During the decision-making process, Chapter 3 proposed that for the woman with a breech baby, the meaning constructed by society through these inter-relationships (i.e. the 'reality') had an impact upon the individual during this process.

This study found that these elements of society are significant forces that can potentially impact on women's decision-making for vaginal breech birth. However, women who seek vaginal breech display the ability to transcend hegemonic beliefs regarding vaginal breech birth, which are heavily laden with rhetoric of risk, control around childbirth in general, and demonstrate a drive to come to a place of self-determination and bodily autonomy.

While Figure 3 on page 33 proposed to illustrate a woman's individual journey through the sub-cultures that may exist in their life for this particular study, this study found that women seeking a vaginal breech birth are able to overcome existing rituals and symbols surrounding management of breech birth by Caesarean section. They identified that that the ritual of Caesarean section for breech presentation had become a powerful didactic and socialising tool and sought an alternative option. By doing this, these women were able to overcome the power of ritual and recognise that there is choice in how an individual can respond to entrenched rituals.

Despite this, women seeking a vaginal breech birth find themselves navigating a health system that is largely unsupportive of this birth option, which creates a time of high stress for women with a breech baby late in their pregnancy. Health systems seek to 'manage' breech presentations by a pre-determined elective Caesarean section, and as such, place system needs at the centre of care rather than the woman's needs. To achieve woman-centred care, and to preserve the woman's bodily autonomy, a balance of trust in both the care provider and the woman's own judgement should be central to pregnancy care. Valuing this relationship and acknowledging that there will be a continuing demand for breech birth will permit exposure to the option of vaginal breech birth in health care systems where there is more opportunity for it to be considered in policy and practice. Increasing exposure to vaginal breech birth will potentially foster more social acceptance of this

birth option given the influence of medical discourse on social discourse, as demonstrated in this study.

10.3 Study limitations

This study has a number of limitations. Chapter 3 identified my own experience in having a vaginal breech birth in 2012. Throughout the work of my thesis, I exercised researcher reflexivity to avoid as much as possible my own experiences and views impacting on the study outcomes. Regular review of my work by my supervisors and research team members limited the influence of my personal experience influencing the findings of this study.

While the international survey conducted for this study yielded a relatively small sample size, gathered from English speaking women only, it is the first of its kind to examine this issue. The interviews with women studied in Chapter 4 were a part of a small sample size who were well educated. 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.

A number of limitations exist in the analysis of internet forums study that may impact on generalisability. Studies have shown that women who “blog” tend to be well educated, professional women, therefore the findings in this study may not be applicable to other socio-economic populations. Women who choose the make comments on public blogs could be those at the extreme of either end of normality versus medicalisation and hence the middle ground may have been missed. Additionally, the only blogs accessed were in the English language.

Analysis of news media articles included English language websites only and as a result may have excluded data from countries that have increased support for the option of vaginal breech birth, such as Scandinavian countries or the Netherlands. The dominance of data from the United States may have also impacted on conclusions drawn from the analysis.

Despite these limitations, this is the first study of its kind. The views of women seeking a vaginal breech birth and the social ramifications for doing so should be considered in obstetric and midwifery practice in order to fully support women's choices for vaginal breech birth. Given the limited information on this issue, this study has also demonstrated there is an opportunity for further research in this area which will aide in the promotion of vaginal breech birth as a legitimate option for women.

10.4 Summary

This conclusion chapter made final summations regarding the findings of my research and made recommendations as to how increasing exposure to vaginal breech birth will potentially foster more social acceptance of the option of vaginal breech birth. Acknowledgment of the study limitations of this research is provided in this chapter. Despite these limitations, the research and its findings are unique and add new knowledge relating to women's experiences in choosing vaginal breech birth, how contemporary discourses of breech birth may impact on women's decision-making and how women choosing vaginal breech birth transcend negative attitudes towards vaginal breech birth to achieve choice and autonomy for birth. The remainder of this thesis includes an epilogue, a list of references and appendices.

Epilogue

The vaginal birth of our daughter went smoothly and was a very moving experience, as all births are. At 40 weeks and 2 days gestation I had an antenatal appointment and, after a vaginal examination, the midwife announced I was 3 cm dilated (but she could stretch me to 5cm!).

We decided it was best to stay in the vicinity of the hospital and made childcare arrangements for our 2 year old daughter so we could relax and allow the labour to progress. We walked on the beach, marched up and down stairs, had fish and chips and then went to the movies. I lasted an hour before I could no longer keep quiet (I didn't want to scare the cinema patrons either). We made it to the hospital in plenty of time and shortly afterwards I gave birth to a healthy baby girl.

I took 12 months away from work to be with my children. On my return, I knew there was something I could do, however small, to support women with a breech baby. I lobbied for state wide guidance for both ECV and vaginal breech birth. I knew there were clinicians who supported vaginal breech birth in our jurisdiction and after almost 3 years, the hard work of a group of exceptional midwives, obstetricians and consumers paid off. I led the process of developing these guidelines and also worked on the production of the consumer brochures for women.

Deciding on a way forward for the development of the breech guideline was challenging for the advisory group developing the guideline. Originally, I had hoped it would be a comprehensive guideline that included both the evidence for the safety of vaginal breech birth and how to support women in their decision-making. The Chair of the advisory group, a senior obstetrician who is very supportive of vaginal breech birth and normal birth in general, suggested that the document may be more successful in gaining traction in the system if it focused on supporting women to gain access to services that provide the option of vaginal breech birth, rather than

'going in all guns blazing' into the safety vs risks debate and mandating that higher level services provide this option for care. Rather than recite evidence that may inflame tensions with those clinicians who have a strong stance on the risks of vaginal breech birth, it was decided that the document would focus on three things:

- Acknowledging some women may choose this birth option and outlining methods for using referral networks for women to gain access to vaginal breech birth if a service does not have this option for care
- Outlining a process for services wishing to establish a vaginal breech birth service, including necessary staffing configurations and quality and safety considerations
- Consumer information to assist women in their decision-making

Initially, I was disappointed. However, I understood that it was a strategic and ultimately, wise move. Changing deeply ingrained attitudes takes years, and perhaps generations – inflaming long standing debates through one document was not going to change that. I realised though, that for the NSW Ministry of Health to have such a positive, supportive stance on vaginal breech birth in the first instance was powerful and to have that stance represented in clinical guidance for the state was an important step forward that could influence further thinking and practice in years to come.

The guidelines and brochures have now been signed off for release, although this was not a straight forward process. They layers of bureaucracy that exist in the NSW Health system dictate that there are a number of sign off points before a document is considered approved for distribution across the state. Often, the final sign of point is a very experienced senior bureaucrat who has an immense responsibility to ensure that anything approved is of high quality and, just as

importantly, will not 'create waves' and cause a media storm that will impact on politicians in charge of the NSW health system. The sign off and subsequent approval of the vaginal breech birth guideline stalled on a number of occasions as amendments were required to ensure that, in the currently devolved system of NSW Health, the document was not seen to be dictating services to offer vaginal breech birth, but rather supporting access for women to facilities already providing this option (of which there are very few) and supporting facilities that were interested in establishing this service.

This concern was informed by the response to another guideline released by the NSW Ministry of Health that I had also been involved in a few years prior, *Towards Normal Birth in NSW* (Ministry of Health 2010). This document gained significant support and significant criticism in equal measure, particularly from media and clinicians that felt it was 'forcing' women to have a vaginal birth and placing pressure on clinicians to minimise interventions in all cases, irrespective of whether they were necessary or not. The response to this document created nervousness around provisions of guidance for maternity care, and the guideline for vaginal breech birth was no exception.

Despite these obstacles, the vaginal breech birth guideline was eventually signed off for release after some minor amendments to language were made. These changes did not change the general thrust of the guideline's focus and overcoming that last hurdle and seeing the approval signature on the guideline's cover brief was a very satisfying experience indeed.

It remains to be seen how effective the guideline will be in influencing attitudes to vaginal breech birth in NSW. My hope is that the existence of these documents raises the profile of vaginal breech birth and that they contribute to destigmatising it. I also hope that it helps women realise

that vaginal breech birth is a legitimate birth option. Rather that it being a matter of luck, finding a clinician skilled in vaginal breech birth should be a process supported and facilitated by clinicians in maternity services so that woman-centred care and self-determination for birth choices is preserved.

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List of Appendices

Appendix 1 Table of Evidence – Literature Review

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
1. Alvesson, M. & Sköldberg, K.,	2009	USA	Social psychology	Textbook	This book is a guide to this central aspect of research methodology. The authors review the major intellectual streams; discuss the development of a reflexive methodology; and show how culture, language, selective perception, and ideology all, in complicated ways, permeate scientific activity.
2. Azria, E., Schmitz, T., Bourgeois-Moine, A., Goffinet, F., Tsatsaris, V. & Mahieu-Caputo, D.	2009	France	Obstetrics	Discussion Paper	This article is discussion paper reflecting on the process of information exchange between the obstetrician and the mother and the need for the mother to feel autonomous in her decision-making.

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
3. Berelson, B.	1952	USA	Behavioural science	Textbook	This book outlines the foundations of content analysis and techniques for researchers choosing this methodology
4. Berger, P.L. & Luckmann, T	1966	USA		Textbook	The work introduced the term *social construction* into the social sciences. The central concept of this text is that knowledge and people's conception (and belief) of what reality is becomes embedded in the institutional fabric of society. Reality is therefore said to be socially constructed.
5. Blumer, H.	1962	USA	Social sciences	Textbook	This seminal text puts forward an summary of the perspective that people act toward things based on the meaning those things have for them; and these meanings are derived from social interaction and modified through interpretation.
6. Candy, P.C.	1989	Australia	Educational research	Discussion paper	This paper discusses research methodology and the underlying philosophical assumptions that a researcher may take about the phenomena to be studied and how it can be analysed and understood.

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
7. Charon, R.,	2001	USA	Medicine	Discussion paper	This article discusses the way in which medicine practiced with narrative competence, or narrative medicine, and it proposes a model for humane and effective medical practice. Adopting methods such as close reading of literature and reflective writing allows narrative medicine to examine and illuminate 4 of medicine's central narrative situations: physician and patient, physician and self, physician and colleagues, and physicians and society.
8. Congalton, A.A. & Daniel, A.E.	1976	Australia	Sociology	Textbook	This book describes broad sociological concepts and definitions. It provides a foundation for understanding the discipline of sociology.
9. Crotty, M.	1998	Australia	Sociology	Textbook	This book links methodology and theory and demonstrates how to navigate the maze of conflicting terminology to produce a theoretical framework for a research project. The major epistemological stances and theoretical perspectives are detailed. Crotty reveals the philosophical origins of these schools of inquiry and shows how various disciplines contribute to the practice of social research as it is known today.
10. Dahlen, H.G. & Homer, C.S.E.	2011	Australia	Midwifery	Qualitative, internet blogs	This study examines the use of English language internet blogs by pregnant women to discuss vaginal

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
				used as data source n=311	birth after previously having a Caesarean section and how this information influenced birth choices for their next child. Data was collected from online blogs over a period of 12 months and the results demonstrated that women seek support for their birth choices through the use of online blogs. This method of seeking information, according to the authors of the study, is potentially important and requires further exploration.
11. Davis-Floyd, R.,	2003	USA	Anthropology	Book	Davis-Floyd's research examines how birth in the United States, and the meanings surrounding it, is represented through symbols that demonstrate the shifts away from birth as a woman-centred process and further towards a relationship between care provider and woman where the power to guide the outcome rests firmly with the medical establishment.
12. Ecker, K.	2009	Australia	Consumer opinion	Documentary Film	The film features a story of a woman, who wants to give birth to her breech baby in a hospital, whose staff advise her she has to have a Caesarean section. This documentary is about her to attempt to birth naturally.
13. Fenwick, J., Gamble, J. & Hauck, Y.	2007	Australia	Midwifery	Qualitative, interviews n^1=24	This study explored how positive social stories around vaginal birth and support from family encouraged women to attempt a VBAC. Thematic analysis was used to analyse telephone interview data collected from women in Western Australia who attempted a vaginal

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
				n^2=11	birth or stated they would choose this option, in a subsequent pregnancy. The study concluded subsequent research for decision-making around birth choices should take into consideration the pregnant woman's psychosocial influences. It also stressed the importance of considering social context and relationships.
14. Fenwick, J, Staff, L., Gamble, J., Creedy, D. & Bayes, S.	2010	Australia	Midwifery	Qualitative, interviews N=14	This study's aim was to describe Australian women's request for Caesarean section in the absence of medical indicators in their first pregnancy. Interviews conducted with 14 women who requested a Caesarean section during their first pregnancy in the absence of a known medical indication. Childbirth fear, issues of control and safety, and a devaluing of the female body and birth process were the main themes underpinning women's requests for a non-medically-indicated Caesarean section. Women perceived that medical discourses supported and reinforced their decision as a 'safe' and 'responsible' choice.
15. Founds, S.A.	2007	Jamaica	Midwifery	Qualitative, interviews n=9	This study detailed women's decision-making for breech birth choices. Interviews with these women revealed that the majority, in part, on their social networks for information. These social networks generally regarded breech birth as high risk, with the

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					baby having either many complications or being born dead. The cultural view of breech babies represented them as being difficult babies that cried a lot. The women responded to these views with fear and worry that their baby would be born with 'problems', with these concerns also having a subsequent impact on future reproductive choices.
16. Glezerman, M.	2006	Israel	Obstetrics	Discussion paper	This paper gives an analysis of the original data from the Term Breech Trial and new data that has become available since. The data is examined and gives rise to serious concerns as far as study design, methods, and conclusions are concerned. The author indicates most cases of neonatal death and morbidity in the term breech trial cannot be attributed to the mode of delivery. Moreover, analysis of outcome after 2 years has shown no difference between vaginal and abdominal deliveries of breech babies. The author concludes the original term breech trial recommendations should be withdrawn.
17. Glezerman, G.	2012	Israel	Obstetrics	Discussion paper	This discussion paper reviews current evidence surrounding vaginal breech delivery and recommends women who are candidates for planned vaginal delivery, or those for whom CS is not an option, should

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					be given an opportunity to choose between the two delivery modes. The author states this requires the establishment of 'supra-regional' centers that specialise in breech delivery, and for other hospitals the provision of basic training with birthing simulators for all residents in obstetrics. In addition, a system of 'supra-institutional' standby teams of experienced obstetricians should be established to provide expertise in planned vaginal delivery.
18. Goffinet, F., Carayol, M., Foidart, J.M., Alexander, S., Uzan, S., Subtil, D. & Bréart, G.	2006	France	Obstetrics	Observational prospective study n=8105	The cases of pregnant women delivering singleton fetuses in breech presentation at term in 138 French and 36 Belgian maternity units were reviewed. Caesarean delivery was planned for 5579 women (68.8%) and vaginal delivery for 2526 (31.2%). Of the women with planned vaginal deliveries, 1796 delivered vaginally (71.0%). The rate of the combined neonatal outcome measure did not differ significantly between the planned vaginal and Caesarean delivery groups (unadjusted). The study concludes that in facilities where planned vaginal delivery is a common practice and when strict criteria are met before and during labor, planned vaginal delivery of singleton fetuses in breech presentation at term remains a safe option that can be offered to women.

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
19. Guba, E.G. & Lincoln Y. S.	1981	UK	Sociology	Textbook	This book explores naturalistic approaches to evaluation. The authors have developed a model of evaluation based on theory. This book provides advice to evaluators and consumers of evaluation information.
20. Guba, E.G. & Lincoln, Y.S.	1994	UK	Sociology	Textbook (Chapter)	This book chapter analyses four research paradigms: positivism, post positivism, critical theory, and constructivism. The emphasis of this chapter is on the paradigms, their assumptions, and the implications of those assumptions for research. The authors use comparison charts to show the differences between the paradigms. The authors discuss the implications of each paradigm on selected practical issues.
21. Guittier, M.-J., Bonnet, J., Jarabo, G., Boulvain, M., Irion, O. & Hudelson, P.	2011	Switzerland	Midwifery	Qualitative study, semi-structured interviews n^1=7 n^2=5	Women experiencing a singleton breech presentation for childbirth were interviewed to explore perceptions of their experience of the diagnosis of breech presentation and decision-making processes regarding the choice of mode of childbirth. The study concludes the role of caregivers needs to go beyond information on the risks and benefits of both modes of childbirth. Emphasis should be placed on listening to the expectations of pregnant women for childbirth, creating spaces for dialogue, and allowing additional time for reflection. Useful information material should be provided to give the women a feeling of shared

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					decision-making.
22. Hannah, M.E., Hannah, W.J., Hewson, S.A., Hodnett, E.D., Saigal, S. & Willan, A.R.	2000	Canada	Obstetrics	Randomised Control Trial n=2083	At 121 centres in 26 countries, women with a singleton fetus in a frank or complete breech presentation were randomly assigned planned Caesarean section or planned vaginal birth. Of the 1041 women assigned planned Caesarean section, 941 (90·4%) were delivered by Caesarean section. Of the 1042 women assigned planned vaginal birth, 591 (56·7%) delivered vaginally. Perinatal mortality, neonatal mortality, or serious neonatal morbidity was significantly lower for the planned Caesarean section group than for the planned vaginal birth group. There were no differences between groups in terms of maternal mortality or serious maternal morbidity. The authors conclude planned Caesarean section is better than planned vaginal birth for the term fetus in the breech presentation; serious maternal complications are similar between the groups.
23. Hauth, J.C. & Cunningham, F.G.	2002	USA	Obstetrics	Discussion paper	This paper is a critique of the Term Breech Trial (Hannah et al. 2000). It questions the recommendations of the Trial and notes a number of methodological weaknesses in how the Trial was conducted. The paper questions the applicability of the Trial's findings to

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					contemporary maternity care in the United States and does not accept the conclusion of the Trial's findings.
24. Hertzler, J.O.	1965	USA	Sociology	Textbook	This book studies society in relation to language, in that language reflects, amongst several other things, attitudes that speakers want to exchange. A 'sociology of language' seeks to understand the way that social dynamics are affected by individual and group language use.
25. Jacob, E.	1998	USA	Educational Research	Discussion paper	This paper describes and compares six traditions of qualitative research approaches from the fields of psychology, anthropology, sociology, cognitive anthropology, ethnography and symbolic interactionism.
26. Jeffries, L.,	2007	UK	Language and communication	Textbook	This book takes a critical discourse approach to the ways in which texts from women's magazines contribute to the social construction of particular kinds of female body. By looking at a wide range of texts and studying the language used to describe female forms, this book provides an insight into the experience of the female reader of such texts, and the likely impact upon her own self-image.
27. Kotaska, A.	2004	Canada	Obstetrics	Discussion paper	This paper notes that while the Term Breech Trial's methodological flaws have been examined and noted by a number of clinicians and researchers, little attention has been given to the limitations of applying a

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					large scale randomised control trial to complex phenomena such as vaginal breech birth. The author notes that one trial has dictated a new standard of care for breech deliveries worldwide without regard for the limitations that the trial may have had in its approach.
28. Kotaska, A., Menticoglou, S., Gagnon, R., Farine, D., Basso, M., Bos, H., Delisle, M.F., Grabowska, K., Hudon, L., Mundle, W., Murphy-Kaulbeck, L., Ouellet, A., Pressey, T. & Roggensack, A.	2009	Canada	Obstetrics	Clinical guideline	These clinical guidelines note that vaginal breech birth can be associated with a higher risk of perinatal mortality and short-term neonatal morbidity than elective Caesarean section. However, with careful case selection and labour management in a modern obstetrical setting, vaginal breech birth may achieve a level of safety similar to elective Caesarean section.
29. Kress, G. & van Leeuwen, T	2006	UK	Language and communication	Textbook	This textbook is a systematic and comprehensive account of the grammar of visual design. Drawing on a range of examples from children's drawings to textbook

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					illustrations, photo-journalism to fine art, as well as three-dimensional forms such as sculpture and toys, the authors examine the ways in which images communicate meaning.
30. Kukla, R., Kuppermann, M., Little, M., Lyerly, A.D., Mitchell, L.M., Armstrong, E.M. & Harris, L.	2009	USA	Obstetrics	Discussion paper	This paper discusses the need to give value of women's autonomy in decision-making around birth, and outlines what sorts of guidelines, practices, and social conditions will best promote and protect women's full inclusion in a safe and positive birth process.
31. Lagan, B.M., Sinclair, M. & George Kernohan, W.	2010	UK	Midwifery	Qualitative, explanatory and descriptive n=613	The aim of this study was to investigate why and how pregnant women use the Internet as a health information source, and how it influenced their decision-making. Data were collected from 24 countries over a 12 week period using a valid and reliable web-based questionnaire. The results showed that most women (97%) used search engines such as Google to identify online web pages to access a large variety of pregnancy-related information and to use the Internet for pregnancy-related social networking, support, and electronic commerce. Almost 94 percent of women used the Internet to supplement information already

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					provided by health professionals and 83 percent used it to influence their pregnancy decision-making. The authors concluded the Internet played a significant part in the respondents' health information seeking and decision-making in pregnancy. Health professionals need to be ready to support pregnant women in online data retrieval, interpretation, and application.
32. Lagan, B.M., Sinclair, M. & Kernohan, W.G.	2011	UK	Midwifery	Qualitative, descriptive n=92	This global study aimed to understand Internet use in pregnancy and its role in relation to decision-making. Thirteen online focus groups across five countries were conducted women who had accessed the Internet for pregnancy-related information over a 3-month period. Analysis of the data indicated that the Internet is having a visible impact on women's decision-making in regards to all aspects of their pregnancy. The key emergent theme was the great need for information. The authors concluded that health professionals must work in partnership with women to guide them toward evidence-based websites and be prepared to discuss the ensuing information.
33. Lasswell, H., Lerner, D. & Pool, I.	1952	USA	Social psychology	Textbook	This book uses content analysis to identify how symbols in society are laden with positive or negative connotations and calculated to evoke certain emotional responses among the populace.

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
34. Lawson, G.W. 2012,	2012	Australia	Obstetrics	Discussion paper	This discussion paper revisits the initial criticisms of the Term Breech Trial and provides an in depth analysis of the limitations of the Trial. Reports are now surfacing of maternal deaths as a result of the conclusions that the Trial had promoted. The author calls for an increase in obstetric training so that clinicians can regain skills in the management of breech birth. Additionally, protocols from the very few units that offer vaginal breech birth should be reviewed so that further lessons may be learned.
35. Liamputtong, P. & Ezzy, D.	2005	Australia	Anthropology	Textbook	This book is a practical guide to conducting qualitative research. It explains methodological issues and presents a step-by-step guide to qualitative research techniques. It contains general chapters on sampling and rigour, the use of theory, data analysis, and writing research proposals and reports. It reviews established methods such as interviewing, focus groups and ethnography, as well as more innovative and complex methods such as narrative method, memory-work and participatory-action research.
36. Lincoln, Y.S. & Guba, E.G.	1985	UK	Sociology	Textbook	This book provides social scientists with a basic but comprehensive rationale for non-positivistic approaches to research. It confronts the basic premise underlying the scientific tradition that all questions can

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					be answered by employing empirical, testable, replicable research techniques. The authors maintain that there are scientific facts that existing paradigms cannot explain, and argue against traditional positivistic inquiry. They suggest an alternative approach supporting the use of the naturalistic paradigm.
37. Lothian, J.A.	2009	USA	Nursing	Discussion paper	This piece discusses the relationship between persuasion and choice and how it may change women's ideas about safe, healthy birth. The differences between presenting information and persuading women that natural birth is the safest and healthiest way to give birth are also explored.
38. Mackenzie, H. & van Teijlingen, E.	2010	UK	Midwifery	Discussion paper	This study aims to provide a critical analysis of the risk concept, its development in modern society in general and UK maternity services in particular. The researchers explore the origins of the current preoccupation with risk and the way maternity services changed from a social to a medical model over the twentieth century and suggests that the risk agenda was part of this process. They conclude that although current policy advocates a return to this more social model, policy implementation is slow in practice which the authors suggest is linked to

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					perceptions of risk.
39. Malcrida, C. & Boulton, T.	2012	Canada/UK	Sociology	Qualitative, descriptive n=21	The researchers in this study interviewed 21 childless women and 22 new mothers to explore their perceptions of choice and birthing. The women's interviews indicated that their birthing choices are reflective of tensions embedded in normative femininity; conflicting ideas relating to purity, dignity, and the messiness of birth; and contradictions about women's bodies as heteronormative sites of pleasure and sexuality on one hand and of asexual, selfless sources of maternal nurturance on the other. Finally, the women's views reflected understandings of moral and normative constructs about selflessness as a core attribute of femininity and motherhood, particularly in terms of enduring pain as the "proper" means of accomplishing the rite of passage to motherhood.
40. Manis, J.G. & Meltzer, B.N.	1972	USA	Social psychology	Textbook	This book attempts to trace the theory of symbolic interactionism and points to phenomenology, evolutionary theory and existentialism among some of the sources for the genesis of symbolic interaction as a theoretical perspective.
41. McCann, P. 2006,	2006	Australia	Educational Psychology	PhD Thesis	This thesis seeks to explore Principals' understandings of aspects of the law impacting on the administration

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					of Catholic schools and how this impacts on leadership roles within the catholic education system.
42. McNair, R., Taft, A. & Hegarty, K.,	2008	Australia	Medicine	Discussion paper	This paper recommends recognising the multiple identities that a researcher brings to interview. This involves acknowledging the clinician interviewer as a potential insider in relation to interviewees and negotiating shared understanding to avoid insider assumptions. Other essential requirements are having an experienced research supervisor, arranging pilot interviews that include active feedback on interviewing style from interviewees, and being reflexive during interviews.
43. Mertens, D.M.,	1998	USA	Educational Research	Textbook	This book provides foundational knowledge for combining qualitative and quantitative research. It focuses on discussing what is considered to be “good” research, incorporating the viewpoints of various research paradigms into the descriptions of mixed methods studies.
44. Minichiello, V., Aroni, R. & Hays, T.N.	2008	Australia	Health Research	Textbook	This book aims is a guide for designing qualitative research and provides guidance for developing skills in conducting qualitative research interviews.
45. Munro, S., Kornelsen, J. & Hutton, E.	2009	Canada	Midwifery	Qualitative, interviews	This paper aims to examine the role of birth stories in general social contexts and how they impact on women’s decision-making for patient initiated

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
				n=17	Caesarean section without a medical indication. Primiparous women were interviewed who had a patient initiated Caesarean section within a 24 month period prior to the commencement of the study. The results showed that women were influenced significantly by birth stories though both social and cultural narratives. This study concluded that although women had received evidence-based information from their care provider regarding modes of birth, there was a resoluteness as to their choice to have a Caesarean section that had been created and reinforced though social and cultural narratives. It was recommended that clinicians consider the social and cultural contexts of individual women when providing antenatal care.
46. *New South Wales Mothers and Babies 2010*	2012	Australia	Epidemiology	Data report	This is the most recent annual report from the NSW Ministry of Health that details birth trends in NSW for the 2010 year.
47. Olsen, W.	2004	UK	Sociology	Textbook	This chapter supports the notion of triangulation as an approach to social research. It states that not only does triangulation allow for improved validity in a study, it also allows the analysis to produce a deeper understanding of the study findings.

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
48. Paltridge, B.	2006	Australia	Educational research	Textbook	This book provides an introduction to discourse analysis by examining different approaches to discourse, looking at discourse and society, discourse and pragmatics, discourse and genre, discourse and conversation, discourse grammar, corpus-based approaches to discourse and critical discourse analysis. The final chapter presents a practical approach to doing discourse analysis.
49. Raynes-Greenow, C.H., Roberts, C.L., Barratt, A., Brodrick, B. & Peat, B. 2004	2004	Australia	Obstetrics	Mixed methods n=174	This study aimed to assess women's familiarity with breech presentation and external cephalic version (ECV), and to identify women's preferences and attitudes regarding breech management. A cross sectional survey was administered that included Likert scale responses as well as open ended questions. The results showed 85% could correctly identify breech presentation, and 66% had heard of ECV. For 87% this information was from books, and family or friends, and not their midwife/doctor. The authors concluded although the majority of the women had a preference for vaginal birth, their knowledge of ECV appeared insufficient to enable them to make informed decisions about attempting ECV. These findings suggest that care-providers should offer women information on ECV, in a shared-decision-making environment.

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
50. Romano, A.M., Gerber, H. & Andrews, D.	2010	USA	Midwifery	Discussion paper	This paper is a review of current evidence around how social media can inform women about VBAC and how this can influence positive change in the United States (US) maternity health care system to create more options for birthing women. The authors conclude that social media informs women and enables to them to gain new perspectives through shared stories from women with similar priorities, concerns and experiences. Online groups are also seen to 'fill in the gaps' where information regarding locations of VBAC clinical providers is shared, something that the maternity care system is unable to provide.
51. Roth, H., Homer, C. & Fenwick, J.	2012	Australia	Midwifery	Thesis	This thesis examines how the changing pregnant, birthing and early postpartum 'body' is portrayed through the use of 'celebrity' media images and text. The study aimed to lend insight into socially constructed factors that might influence women's body image expectations in pregnancy, birth and the early parenting period.
52. Sandelowski, M.	2000	USA	Nursing	Discussion paper	This paper describes the role of qualitative descriptive studies as a comprehensive summary of an event in the everyday terms of that event. Researchers conducting such studies stay close to the words used in the data.

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					Qualitative descriptive is identified as the best method of choice when straight descriptions of phenomena are required.
53. Say, R., Thomson, R., Robson, S. & Exley, C.	2013	UK	Obstetrics	Qualitative, semi-structured interviews n^1=11 n^2=11	This study is the first to explore attitudes of women and clinicians towards external cephalic version (ECV). Interviews were conducted with pregnant women with breech babies and health professionals who manage breech presentations. Major themes regarding ECV from the women interviewed included viewing ECV as a pathway to birth naturally, concerns about ECV, professional and social attitudes regarding ECV and breech presentation as an indicator for Caesarean birth. This study concluded that women have a generally negative view of ECVs and this was largely based on lay accounts. It was recommended that clinicians consider further education to obtain competencies in communication of birthing options and risk perspective, to recognise the cultural and social contexts of women's attitudes and how to address women's concerns with appropriate sensitivity and evidence-based information.
54. Shoemaker, P. & Reese, S.	1996	USA	Communications/	Textbook	The authors of this book focus on the individual as existing in a paradigm of media and how the content of

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
			Journalism		media influences individuals through a hierarchy of interactions within the individual's sphere of existence.
55. Speziale H. J. & Carpenter, D. R.	2003	USA	Nursing	Textbook	This textbook provides a foundation for understanding a wide range of qualitative research methodologies. It includes emphasis of ethical considerations and methodological triangulation, instrument development and software usage; critiquing guidelines and questions to ask when evaluating aspects of published research; and tables of public research that offer resources for further reading.
56. Taylor, B., Kermode, S., Roberts, K. (Eds.)	2006	Australia	Nursing	Textbook	This book is written by experienced nurse-researchers and provides a comprehensive outline of the research process from conception and planning to design and application. It includes both quantitative and qualitative methodologies, post-modernist approaches and practical examples of nursing and health based research.
57. Taylor, S.	2013	UK	Social Science	Textbook	This book explores the idea of how meaning is socially constructed and how 'talk' and text can be interpreted. The challenges of discourse analysis are outlined as well as ways to process and interpret data.
58. Thorne, S., Kirkham, S.R. & O'Flynn-Magee, K.	2004	USA	Nursing	Discussion paper	This article examines interpretive description as an inductive analytic approach designed to create ways of understanding clinical phenomena. In this article, further understanding is provided of this methodology

Authors	Year	Country	Profession	Study Design and size (where relevant)	Abstract
					by elaborating on the objective and mechanisms of its analytic processes and by expanding consideration of its interpretive products.
59. Torbert, W.R.	1981	USA	Social psychology	Textbook (chapter)	This chapter explores a collaborative, experimental approach to research in which inquiry is firmly rooted in subjects' experience of their lives. It covers the philosophy, methodology, practice and prospects of how to do research *with* people rather than *on* people.
60. Wetherell, M., Taylor, S. & Yates, S.J.	2001	UK	Social psychology	Textbook	The aim of this book is to provide understanding of the key epistemological and methodological issues of discourse theory, practice and analysis.
61. Wiersma, W.,	1991	USA	Psychology	Textbook	This book explains the research process with emphasis on the formulation of a research question, referencing current literature in the field, using appropriate research designs, and writing and evaluating research reports. Both quantitative and qualitative research designs are described. Measurement, sampling, and statistics are presented as essential research tools.
62. Yin, R..	1994	USA	Social Science	Textbook	This text covers the design and use of the case study method as a valid research tool. The book provides a clear definition of the case study method as well as discussion of design and analysis techniques.

Appendix 2 Ethics Approval from the University of Technology Sydney

Racheal Laugery

From: Research.Ethics@uts.edu.au
Sent: Wednesday, 6 February 2013 1:53 PM
To: Chauncey Sjostedt; Caroline Homer; andrew.carlin@hnehealth.nsw.gov.au; IEC RIO; Post Award Grants; Research Ethics
Subject: HREC Approval Granted
Categories: Print and Save

Dear Applicant

[External Ratification: South Eastern Sydney Local Health District (Northern Sector) Human Research Ethics Committee HREC approval - HREC ref no 12/072 - 05/07/12 to 05/07/17]

The UTS Human Research Ethics Expedited Review Committee reviewed your application titled, "Breeching in the system: Maternal expectations and experiences surrounding a planned vaginal breech birth", and agreed that the application meets the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that your external ethics approval has been ratified. Any conditions of approval as stipulated in the Committee's comments will be noted on our files.

Your approval number is UTS HREC REF NO. 2012000565

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Research Involving Humans requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

You should consider this your official letter of approval. If you require a hardcopy please contact Research.Ethics@uts.edu.au.

To access this application, please follow the URLs below:
* if accessing within the UTS network: http://rmprod.itd.uts.edu.au/RMENet/HOM001N.aspx
* if accessing outside of UTS network: https://remote.uts.edu.au , and click on "RMENet - ResearchMaster Enterprise" after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: http://surveys.uts.edu.au/surveys/onlineethics/index.cfm
If you have any queries about your ethics approval, or require any amendments to your research in the future, please do not hesitate to contact Research.Ethics@uts.edu.au.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office University of Technology, Sydney T: (02) 9514 9645
F: (02) 9514 1244
E: Research.Ethics@uts.edu.au
I: http://www.research.uts.edu.au/policies/restricted/ethics.html
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[Level 14, Building 1, Broadway Campus]
CB01.14.08.04

Appendix 3 Ethics Approval from South Eastern Sydney Local Health District

HUMAN RESEARCH ETHICS COMMITTEE - NORTHERN SECTOR
Room G71 East Wing
Edmund Blacket Building
Prince of Wales Hospital
RANDWICK NSW 2031
Tel: 02 9382 3587 Fax: 02 9382 2813
www.sesiahs.health.nsw.gov.au/Research Support/NHN/

5 July 2012

Professor Caroline Homer
Centre for Midwifery, Child and Family Health
University of Technology Sydney
PO Box 123
SYDNEY NSW 2007

Dear Professor Homer

HREC ref no: 12/072 (HREC/12/POWH/163)
Project title: Breeching in the system: Expectations and experiences of planning and having a vaginal breech birth

Thank you for your letter dated 14 June 2012 and response document dated 16 June 2012 to the Human Research Ethics Committee (HREC) addressing questions raised by the Committee. The application was first considered by the HREC on 29 May 2012

I am pleased to advise that the Executive Committee on 3 July 2012 agreed that satisfactory responses had been provided. The Committee granted ethical approval for the project to be conducted at the following sites:

- Royal Hospital for Women
- John Hunter Hospital

The following documentation has been approved:

- Response Letter version 1, dated 16 June 2012
- Protocol version 2, dated 16 June 2012
- NEAF submission code AU/1/FE1D08, dated 27 April 2012

- Information sheet and consent form - Women, version 2, dated 16 June 2012
- Information sheet and consent form - Clinicians, version 2, dated 16 June 2012
- Letters of Invitations (Letter to be sent to Women inviting them to participate & Letter to be sent to senior medical officer inviting them to participate) version 2, dated 16 June 2012

Conditions of approval

1. This approval is valid for 5 years from the date of this letter.
2. Annual reports must be provided on the anniversary of approval.
3. A final report must be provided at the completion of the project.
4. Proposed changes to the research protocol, conduct of the research, or length of approval will be provided to the Committee.
5. The Principal Investigator will immediately report matters which might warrant review of ethical approval, including unforeseen events which might affect the ethical acceptability of the project and any complaints made by study participants.

For NSW Public Health sites only: You are reminded that this letter constitutes ethical approval only. You must not commence this research project until you have submitted your Site Specific Assessment to the Research Governance Officer of the appropriate institution and have received a letter of authorisation from the General Manager or Chief Executive of that institution.

Should you have any queries, please contact the Research Support Office on (02) 9382 3587. The HREC Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Research Support Office website: http://www.sesiahs.health.nsw.gov.au/Research Support/NHN/.

Please quote **HREC ref no 12/072** in all correspondence.

We wish you every success in your research.

Yours sincerely

for **Deborah Adrian**
Executive Officer, Human Research Ethics Committee

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007),* NHMRC and Universities Australia *Australian Code for the Responsible Conduct of Research (2007)* and the *CPMP/ICH Note for Guidance on Good Clinical Practice.*

Appendix 4 Amended Ethics Approval from South Eastern Sydney Local Health District (including amendment request for inclusion of survey)

HUMAN RESEARCH ETHICS COMMITTEE
Room G71 East Wing
Edmund Blacket Building
Prince of Wales Hospital
RANDWICK NSW 2031
Tel: 02 9382 3587 Fax: 02 9382 2813
RSOSESLHD@SESIAHS.HEALTH.NSW.GOV.AU
http://www.seslhd.health.nsw.gov.au/POWH/researchsupport/default.asp

20 March 2014

Professor Caroline Homer
Centre for Midwifery, Child and Family Health
University of Technology Sydney
PO Box 123
SYDNEY NSW 2007

Dear Professor Homer

HREC ref no: 12/072 (HREC/12/POWH/163)
Project title: Breeching in the system: Expectations and experiences of planning and having a vaginal breech birth

Thank you for your amendment request dated 3 March 2014 to the Human Research Ethics Committee (HREC). The Executive Committee reviewed your request on 18 March 2014.

Ethical approval has been given for the following:

- Amendment Form, dated 3 March 2014

- Protocol, version 3, dated 8 March 2014
- Participant Information Sheet, version 1, dated 3 March 2014
- Survey, version 1, dated 3 March 2014

Ethical approval is valid for the following site(s):

- Royal Hospital for Women
- John Hunter Hospital

This amendment has also been reviewed by the Research Governance Officer at SESLHD. Further authorisation of the above approved documents is not required for any site that has the Research Governance conducted by the SESLHD Research Support Office. Implementation of this amendment can now proceed.

For multi-site projects reviewed by the HREC after 1 January 2011 a copy of this letter must be forwarded to all Principal Investigators at every site approved by the SESLHD HREC for submission to the relevant Research Governance Officer along with a copy of the approved documents.

Should you have any queries, please contact the Research Support Office on (02) 9382 3587. The HREC Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Research Support Office website:
http://www.seslhd.health.nsw.gov.au/POWH/researchsupport/default.asp

Please quote **HREC ref no 12/072** in all correspondence.

Yours sincerely

Deborah Adrian
Executive Officer, Human Research Ethics Committee

This HREC is constituted and operates in accordance with the National Health and Medical Research Council's (NHMRC) *National Statement on Ethical Conduct in Human Research (2007),* NHMRC and Universities Australia *Australian Code for the Responsible Conduct of Research (2007)* and the *CPMP/ICH Note for Guidance on Good Clinical Practice.*

Appendix 5 Consent form

The Royal Hospital for Women

CONSENT FORM: WOMEN

Breeching in the system: Maternal expectations and experiences surrounding a planned vaginal breech birth

1. I,.....

   of.....
   agree to participate in the study described in the participant information statement set out above.
2. I acknowledge that I have read the participant information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.
3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.
4. I understand that I can withdraw from the study at any time without prejudice to my relationship to the University of Technology Sydney, the Royal Hospital for Women or the John Hunter Hospital.
5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified. The only exception is the video which will be made into a DVD that will be used for the next 10 years in teaching and training.
6. I understand that if I have any questions relating to my participation in this research, I may contact Professor Caroline Homer on telephone 02 9514 4886 who will be happy to answer them.
7. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

Complaints may be directed to the Research Ethics Secretariat, South Eastern Sydney Local Health District - Northern Sector, Prince of Wales Hospital, Randwick NSW 2031 Australia (phone 02-9382 3587, fax 02-9382 2813, email ethicsnhn@sesiahs.health.nsw.gov.au.

Signature of participant	**Please PRINT name**	**Date**
_____	_____	_____

Signature of witness	Please PRINT name	Date
_____	_____	_____
Signature of investigator	**Please PRINT name**	**Date**
_____	_____	_____

Appendix 6 Revocation of Consent

The Royal Hospital for Women

REVOCATION OF CONSENT

Breeching in the system: Maternal expectations and experiences surrounding a planned vaginal breech birth

I hereby wish to **WITHDRAW** my consent to participate in the study described above and understand that such withdrawal **WILL NOT** jeopardise any relationship with the University of Technology Sydney, the Royal Hospital for Women or the John Hunter Hospital.

Signature of participant	**Please PRINT name**	**Date**
_____	_____	_____

The section for Revocation of Consent should be forwarded to:

Professor Caroline Homer
University of Technology Sydney
PO Box 123
Broadway NSW 2007
Email: caroline.homer@uts.edu.au

Appendix 7 Information sheet-Interviews

The Royal Hospital for Women

PARTICIPANT INFORMATION SHEET AND CONSENT FORM
Women

Breeching in the system: Maternal expectations and experiences surrounding a planned vaginal breech birth

Invitation
You are invited to participate in a research study into the experience of women who planned a vaginal breech for the birth of their baby.

We are interested in interviewing women who planned to have a vaginal breech birth in the past 7 years. We are interested in interviewing women who had a vaginal birth as well as those who had a Caesarean.

The study is being conducted by Professor Caroline Homer (University of Technology Sydney), Associate Professor Andrew Bisits (Royal Hospital for Women) and Dr Andrew Carlin (John Hunter Hospital).

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. **What is the purpose of this study?**
   The purpose is to investigate the experiences surrounding your decision to have a vaginal breech birth and your actual experience of the birth, regardless of whether you had a vaginal breech or a Caesarean section.

   The study is being undertaken to better understand the experiences of women who had a breech baby and decided to try and have a vaginal birth. We will use the findings of the study to better inform other women who have a breech baby and also to help in the education of doctors and midwives about women's decision-making and how best to support women who choose to have a vaginal breech.

2. **Why have I been invited to participate in this study?**
   You are eligible to participate in this study because the hospital records indicate that you planned to have a vaginal breech birth in the last 7years either at the John Hunter Hospital or the Royal Hospital for Women. .

3. **What if I don't want to take part in this study, or if I want to withdraw later?**
   Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect the treatment you receive now or in the future.

Whatever your decision, it will not affect your relationship with the staff caring for you.

If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason.

If you choose to withdraw, the video and tape recording of your interview will be destroyed and will not be included in the analysis.

4. What does this study involve?

If you agree to participate in this study, you will be asked to sign the Participant Consent Form.

Being part of this study will mean having a one to one interview with an experienced midwife researcher. This will take about an hour and will be in time and place that is convenient to you. With your permission, the interview will be tape recorded.

We will ask for your additional consent to video the interview. This is an optional component and will involve a video camera being placed in a stationary position in the room. The camera will just film your face. Footage from the video will be edited into a DVD that will be used for training and teaching purposes only.

In the interview we are interested in asking these questions:

- Can you explain how you felt when you realised that your baby was in the breech position?
- How was information about breech birth presented to you? What was the most useful information and why? What information did you feel was missing?
- How did you make the decision to plan to have a vaginal breech birth? What helped you make this decision? What did not help in the decision-making process?
- Can you tell us about your labour and birth?
- How did you feel about being in labour?
- What aspects of care during labour helped or hindered your progress?
- How did you feel about the birth of your baby?

5. How is this study being paid for?

The study does not have any additional funding. The University of Technology and the hospitals are supporting its conduct.

6. Are there risks to me in taking part in this study?

We do not expect that there are risks associated with this study. It may be that you find discussing the care you received or the way you make decisions might be distressing to you. If this happens, we can arrange counselling and support through the hospital or through outside organisations.

7. What happens if I suffer injury or complications as a result of the study?

We do not expect that there will be any injury or complications associated with this study. .

8. Will I benefit from the study?

We cannot guarantee or promise that you will personally receive any benefits from this project. In our previous work however, women have experienced benefits from having an opportunity to participate in interviews about their experiences.

9. Will taking part in this study cost me anything, and will I be paid?

Participation in this study will not cost you anything. You will not be paid for your participation.

10. What will happen to my interview after the study?

After the interview is completed, it will be transcribed (written down) into a document. This will be done by a trained research transcribe. Transcription is necessary so that your interview can be analysed using qualitative methods which looks for common themes. Once the interview is transcribed, the audiotape will be destroyed.

The video of the interview will be edited by a professional video editor. A number of the interviews will form a DVD that we will use only for teaching purposes.

11. How will my confidentiality be protected?

Any information obtained in connection with this project and that can identify you will remain confidential. Only the research team will have access to your personal details. We will use a false name or code number to identify you. All records containing personal information will remain confidential and no information that could lead to your identification will be made public. It will only be disclosed with your permission as required by law.

In any publication, information will be provided in such a way that you cannot be identified. Original materials will be stored in a password protected computer and in locked filing cabinets. No one other than the researchers listed on this project will have access to the data. Each one of these researchers on this study fully understands the obligation to adhere to full confidentiality. All data and personal information will be stored, accessed and used in accordance with Commonwealth Privacy Laws and the NSW Health records and Information Act 2002, as well as in accordance with the University of Technology, Sydney standards.

The only exception to the identification is if you agree to have your interview videoed. You can choose to be identified with a pseudonym in any videos of the interview.

12. What happens with the results?

If you give us your permission by signing the consent document, we plan to discuss/publish the results in medical and midwifery journals and also presenting the findings at conferences. You will not be individually identified in either the papers or presentations.

In any publication, information will be provided in such a way that you cannot be identified. You will receive a copy of the first publication that details the findings of the study.

We also plan to make a DVD about women's experiences. The DVD will identify the women who provide this optional additional consent. This DVD will be used for the next 10 years only for teaching purposes.

13. What should I do if I want to discuss this study further before I decide?

When you have read this information, the researcher [Professor Caroline Homer] will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact her on 02 9514 4886 or 0418 466 974.

14. Who should I contact if I have concerns about the conduct of this study?

This study has been approved by the South Eastern Sydney Local Health District - Northern Sector Human Research Ethics Committee. Any person with concerns or complaints about the conduct of this study should contact the Research Support Office which is nominated to receive complaints from research participants. You should contact them on 02 9382 3587, or email ethicsnhn@sesiahs.health.nsw.gov.au and quote [HREC 12/0721.

The conduct of this study at the Royal Hospital for Women has been authorised by the South Eastern Sydney Local Health District .Any person with concerns or complaints about the conduct of this study may also contact the Research Governance Officer of the health district on 02 9382 3587.

Thank you for taking the time to consider this study.
If you wish to take part in it, please sign the attached consent form.
This information sheet is for you to keep.

Appendix 8 Interview questions (Chapter 4)

Questions for breech interviews:

1. Tell me about your pregnancy before you found out your baby was in the breech position

   (Possible prompts: How did you feel about the thought of giving birth to your baby? When did you find out your baby was breech)

2. Can you tell me what you knew/ thought about breech birth prior to finding out your baby was breech?

   (Possible prompts: Where did you hear about that?)

3. How did you feel when you were told your baby was breech?

4. Did you ever hear your friends or family talk about breech birth?

   (Possible prompt:
   - What did they say?
   - How did that make you feel?)

5. When you found out you were having a breech birth, did you seek out any information?

   (Possible Prompts:
   - Where did you seek the information and what sent you there?
   - How did you feel about the information provided?
   - If the internet comes up, explore this further (if not, bring it up at end of interview)
     - Do you use the internet often for information?
     - What was your view about the information found on the internet?
     - What was the experience like? Was it helpful/not helpful? Please explain.
     - Have you ever used an on-line chat room or Facebook for gathering information about breech birth? Tell me what that was like?)

6. How was information about breech presented to you by your midwife or doctor?

   (Possible prompts:
   - How did you feel about what you were told?
   - Did you feel the information received this way was different to what you gathered for yourself? How?)

7. What do you feel was the most useful information of all the information sources?

   (Possible prompts:

- From whom did it come from and why was it useful to you?
- What wasn't useful and why? Where did that come from?)

8. What information did you feel was missing?

9. How did you make the decision to have the birth you felt you wanted?

   (Possible prompts:
   - What helped you make this decision?
   - What did you find unhelpful?)

10. What helped you make this decision?

11. What didn't help in making your decision?

12. Did you share your choices for the birth of your child with family and or/friends?

    (Possible prompts:
    - How you feel about this?
    - If you did share with others, what was their response?)

13. Did you go into labour? If so, how did you feel about being in labour? (planned VB only)

14. What aspects of the care you received during labour helped?(planned VB only)

15. What aspects of your care hindered your progress?(planned VB only)

16. How did you feel about having a c/s after labour started? (c/s once in labour women only)

17. What aspects of care during your Caesarean were most helpful to you? (planned C/S only)

18. What aspects of your care hindered your Caesarean? (planned C/S only)

19. How did you feel about the birth of your baby?

20. How would you discuss the option of breech birth with others in the future?

Appendix 9 Survey

Survey-Women's decision-making for planned vaginal breech birth

Breeching in the system: Women's expectations and experiences surrounding a planned vaginal breech birth

Thank you for taking the time to complete this survey for the Breeching in the System study being conducted by the University of Technology, Sydney, NSW, Australia. This study aims to explore experiences of women who have been diagnosed with a breech presentation late in pregnancy and plan for a vaginal breech birth.

This survey is aimed at women who have planned a vaginal breech birth at or close to full term in the past 7 years. We are interested in your experiences regardless of whether the final outcome was a vaginal breech birth or a Caesarean section. Sharing your experience with us is greatly valued and your views will contribute to improving care provided to pregnant women with a breech baby.

This survey is requesting information about your decision-making process for planning a vaginal breech birth. It should take approximately 20 minutes of your time to complete. Your answers will be completely anonymous. By filling out this survey it is implied that you are giving consent for this information to be used in the Breeching in the System study.

Participation in this study is voluntary. It is completely up to you whether or not you participate. Any information obtained in connection with this project and that can identify you will remain confidential.

Only the research team will have access to your personal details. All records containing personal information will remain confidential and no information that could lead to your identification will be made public. It will only be disclosed with your permission as required by law. In any publication, information will be provided in such a way that you cannot be identified.

If you have any questions about the survey, please contact Professor Caroline Homer, Professor of Midwifery, Faculty of Health, University of Technology at Caroline.Homer@uts.edu.au.

****

**

Please tell us about yourself: (please highlight your answer in a colour)

Age range

☐ 18-25 ☐ 26-30 ☐ 31-35 ☐ 36-40 ☐ greater than 41

How many children have you given birth to?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

If you are from Australia, in what state do you reside?

☐ New South Wales ☐ Victoria ☐ Queensland ☐ South Australia

☐ Western Australia ☐ Tasmania ☐ Northern Territory ☐ ACT

If you do not live in Australia, please provide the name of the city and the country in which you live.

_____

Relationship status

☐ Single ☐ In a relationship

Which ethnicity do you most identify with?

☐ Australian ☐ European ☐ Asian ☐ Other

If other, please tell us where you are from:

_____

What is your highest level of education achieved?

☐ High school ☐ University ☐ Apprenticeship/Technical Diploma

Employment status

Are you currently:

☐ Employed ☐ Self-employed ☐ Not currently employed outside home

☐ A student ☐ Unable to work

If you are working, please let us know what work you do

_____

Was your breech baby your first baby?

_____

What year was your breech baby born?

_____

What type of birth did you have for your breech baby?

Survey-Decision-making for a planned vaginal breech birth

1. **I was referred to, and subsequently saw, a clinician who was skilled in vaginal breech birth when my baby was diagnosed breech?**

   ☐ Yes ☐ No (Please go to question 3)

2. **I did my own research and sourced a clinician who was skilled in vaginal breech birth when my baby was diagnosed breech?**

   ☐ Yes ☐ No

3. I received information at my first meeting with the clinician who was skilled in vaginal breech birth when my baby was diagnosed breech?

   ☐ Yes ☐ No (Please go to question 5)

4. I was satisfied with the information I received at my first meeting with the clinician who was skilled in vaginal breech birth (please choose one answer only by highlighting the number you choose)

   1 2 3 4 5 6 7 8 9 10

   Not at all ***Some degree*** ***Very much***

   If you would like to provide more detail, please do so:

   _____

   _____

5. Detailed statistics on the safety and risks of vaginal breech birth from a skilled clinician were helpful to me in deciding upon the way to give birth (please choose one answer only by placing an 'x' in the box)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

If you would like to provide more detail, please do so:

_____

_____

6. Information and/or advice that I received from my friends was helpful to me in choosing the way I wanted to give birth (please choose one answer only by placing an 'x' in the box)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

If you would like to provide more detail, please do so:

_____

_____

7. Information that I received from a midwife was helpful to me in choosing the way I wanted to give birth (please choose one answer only by placing an 'x' in the box)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

If you would like to provide more detail, please do so:

_____

_____

8. Information that I received from a doctor was helpful to me in choosing the way I wanted to give birth (please choose one answer only by placing an 'x' in the box)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

If you would like to provide more detail, please do so:

_____

_____

9. Please indicate the degree of influence your midwife (if you had one)had on your birth choices (please choose one answer only by highlighting the number you choose-if you did not see a midwife, please go to the next question)

1 2 3 4 5 6 7 8 9 10

Not at all ***Some degree*** ***Very much***

If you would like to provide more detail, please do so:

_____

10. Please indicate the degree of influence a doctor had on your birth choices (please choose one answer only by highlighting the number you choose)

1 2 3 4 5 6 7 8 9 10

Not at all ***Some degree*** ***Very much***

If you would like to provide more detail, please do so:

_____

_____

11. Please indicate the degree of influence your family or friends had on your birth choices (please choose one answer only by highlighting the number you choose)

1 2 3 4 5 6 7 8 9 10

Not at all ***Some degree*** ***Very much***

If you would like to provide more detail, please do so:

_____

_____

12. Information I found on the internet was helpful for choosing the way I wanted to give birth (please choose one answer only by placing an 'x' in the box)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

If you would like to provide more detail, please do so:

_____

13. Please indicate the degree of influence the internet or social media had on your birth choice (please choose one answer only by highlighting the number you choose)

1 2 3 4 5 6 7 8 9 10

None at all ***Some degree*** ***Very much***

If you would like to provide more detail, please do so:

_____

_____

14. I felt most of the information I found online was from reliable sources (please choose one answer only by highlighting the number you choose)

1 2 3 4 5 6 7 8 9 10

None at all ***Some degree*** ***Very much***

If you would like to provide more detail, please do so:

_____

_____

15. If you used the internet, which websites did you find helpful when looking for information about vaginal breech birth?

_____

_____

_____

16. I felt supported by family and friends during the decision-making process (please choose one answer only by highlighting the number you choose)

1 2 3 4 5 6 7 8 9 10

None at all ***Some degree*** ***Very much***

If you would like to provide more detail, please do so:

_____

_____

17. I felt supported by my care providers in my decision-making process (please choose one answer only by highlighting the number you choose)

1 2 3 4 5 6 7 8 9 10

None at all ***Some degree*** ***Very much***

If you would like to provide more detail, please do so:

_____

_____

18. I would have liked to have spoken to other women who had been through this experience (please choose one answer only by placing an 'x' in the box)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

If you would like to provide more detail, please do so:

_____

_____

19. I would attempt a vaginal breech birth in a subsequent pregnancy if my baby was breech (please choose one answer only by placing an 'x' in the box)

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

If you would like to provide more detail, please do so:

_____

_____

20. I feel happy with the choices that I made for the birth of my baby (please choose one answer only by highlighting the number you choose)

1 2 3 4 5 6 7 8 9 10

None at all ***Some degree*** ***Very Much***

If you would like to provide more detail, please do so:

_____

_____

21. If you are not happy, can you explain the choices you were unhappy with?

_____

_____

_____

22. Looking back, I feel happy with my birth experience (please choose one answer only by highlighting the number you choose)

1 2 3 4 5 6 7 8 9 10

None at all ***Some degree*** ***Very Much***

If you would like to provide more detail, please do so:

_____

_____

23. Are there any further comments you would like to share with us?

_____

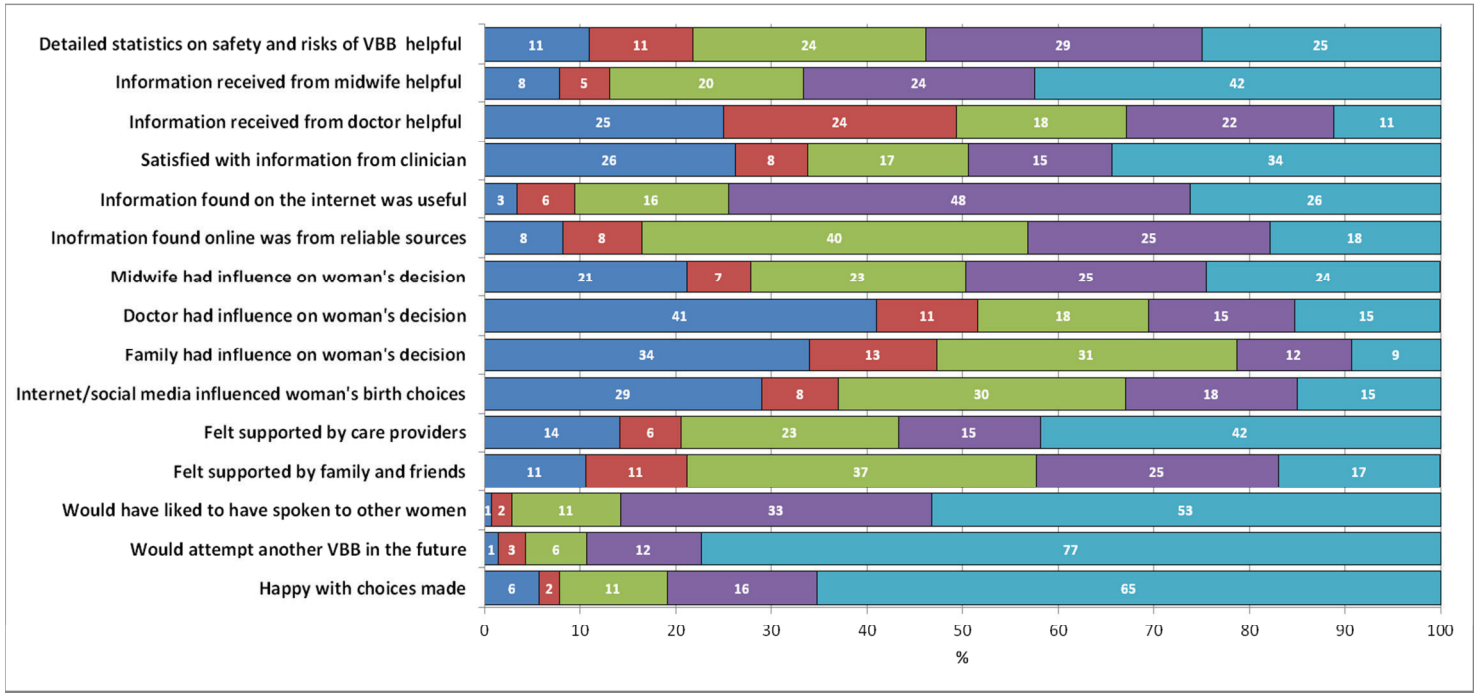
_____

_____

Thank you for taking the time to complete this survey, your contribution is greatly appreciated.

Appendix 10

Results: Quantitative data from a survey of women's experiences planning a vaginal breech birth (Chapter 5)



Legend

Strongly Disagree **Neutral** **Disagree** **Agree** **Strongly Agree**