**Breech Birth Research Paper**

**What is ‘breech’ position?**
Breech position refers to the position a baby has adopted in the womb, whereby their bottom is down and their head is up. Up until the 30th week this is the case for about 25% of babies, but at term only 3% of babies are in this position. It is often referred to as the baby being ‘upside down’ as the most common position is for a baby to have its’ head down and its’ bottoms and legs up.

**Types of Breech Presentation**
There are three main types of breech position;
**Frank Breech** (sometimes called incomplete breech); where the hips are flexed but the knees are straight, so the feet are up by the baby’s ears.
This type of breech is quite common, especially to first time mothers, and is also considered the most well-suited to vaginal delivery.

**Complete Breech**: where the hips and the knees are flexed (i.e. bent), so the baby looks as though it is sitting in the pelvis. This too, is deemed to be a good presentation for considering a vaginal birth.

**Footling Breech**: when a foot, or both feet are fully extended below the body. This is a much rarer position for a baby to adopt, and can sometimes make vaginal delivery more difficult.
Why does Breech occur?
In many cases there is no answer to this question. However, there are a range of possible reasons which are listed below:

1) Prematurity – This is one of the most common causes of breech. Many babies are in breech position until 30 weeks or so (because they have more room to move around) and if labour happens to start, then the birth is a breech birth. Because of their less well-developed lungs and their softer skulls, babies that are premature and breech are often better better delivered abdominally.¹

2) Placenta Previa; this is when the placenta is low lying and can mean the baby only has room by turning into a breech position.
Obstruction of Pelvis e.g. fibroids, ovarian cysts etc - Mary Cronk argues that scans at this stage are important to eliminate these as causes of breech before a vaginal delivery is considered.

3) Shape of Uterus- there is the possibility that the shape of a woman’s uterus has an impact on the position taken up by her baby, though studies have suggested that it is genetics that is a more substantial contributing cause.

4) Multiple Pregnancies- approximately 40% of twin pregnancies have one baby lying in breech- their lying head to feet makes sense in terms of the room available.

5) Excessive amniotic fluid- can give the baby too much room to move around and get itself into breech- by the same token a baby who is in breech for this reason also has room to change.

6) Foetal Anomalies; In very rare cases a baby is in breech because there is something wrong with it….it must be emphasised that this is very rare, but it is a factor and therefore needs addressed. (One statistic I came across said that congenital abnormality of the baby occurs in 6.3% of breech births as compared to 2.4% of non-breech births)
The reasons for babies’ who are suffering from a birth defect moving into breech may be due to the baby’s diminished muscle tone reducing their ability to move themselves around, malformation of the skull, reduced amniotic fluid volume etc)

7) Subsequent Pregnancies; this argument is mixed. Statistics show that the incidence of breech is higher in first pregnancies; presumably because there is less space for a baby to turn once it has got itself into the breech position. Having said that, the incidence of breech seems to rise again after three previous births, suggesting that too much space enables the baby to move freely right up until birth. The risk though is lower than in first births.

8) Emotional Factors; this is obviously not scientific but it has been argued, often quite convincingly, that a baby goes into breech position as a result of some emotional factors (stress, fear etc) on the part of the mother. That hypnosis has been shown to have a positive impact on the incidence and turning of breech babies lends credence to this idea. Having said that, having a baby diagnosed as breech can be emotionally trying for a woman, especially if it is her first baby and as such exacerbating the stress by implying she is the cause is something that should only be explored with caution and sensitivity.

¹ ‘Midwifery Skills needed for Breech’ Mary Cronk Midwifery Matters Issue No 78, Autumn 1998
The Emotional Impact of Breech

The emotional impact of breech should not be underestimated. As only three percent of all babies are in this position at term, the experience is rare, making the mother often feel extremely isolated. The notion that the baby is the ‘wrong way up’ compounds a mother’s fear and often gives rise to a sense of inadequacy, making a mother believe she may have done something wrong or is in some way ‘abnormal’. Michel Odent talks of the diagnosis of breech as having the ‘nocebo’ effect; whereby health professionals cause more harm than good by interfering in and over-medicalising a natural process.

These emotions are then compounded by the difficulties parents face in accessing unbiased opinions on the subject; since the Hanah trial health professionals are reluctant to discuss anything other than the risks involved in breech births and offer no choice but to have a caesarean.

I am of the belief that it is in this area that a yoga or active birth teacher can play the most prominent role. Firstly, we can be a sounding board for an anxious mother, willing to listen when perhaps her more ‘medical’ carers do not seem to. Equally, it is important to have contacts and sources at our fingertips i.e. telephone numbers for Aims & the NCT, the contact details of alternative therapists, book titles and website links on the subject.

It would be inadvisable for yoga teachers to offer opinions on particular courses of action, but there is no harm in helping point a woman in the direction of information so that she might feel in more control of her situation and come to an informed choice. In the face of medical expertise and apparently authoritative information, a woman is easily disarmed. That we might help her to tap into her instincts and regain a sense of conviction could be invaluable.
Delivery of Breech- Caesarean v Vaginal

Options when faced with a Breech presenting baby

1) Attempting to turn the baby
2) Planned vaginal Birth
3) Planned caesarean section

Turning the baby

ECV

ECV stands for ‘External Cephalic Version’. It is a medical means to turn a baby from breech position to vertex (i.e. head-down) while the baby is still in the uterus. This practice of turning a baby went inexplicably out of fashion several years ago though there are very convincing arguments to suggest that it should be an option for all women faced with a breech presenting baby. (That it reduces the need for caesarean sections by up to 50% is one such argument). The advice from a MIDIRS leaflet on the topic of breech is unequivocal in its opinion of ECV- ‘ECV has been the subject of rigorous scientific appraisal in 6 randomised controlled trials involving over 600 women. The results are consistent and clear. ECV should be offered to all women with an uncomplicated breech presentation at term.’

The procedure is undertaken in a hospital by a trained doctor who manually manipulates the baby within the womb, attempting to guide the baby through a forward somersault. Sometimes a drug is used to help the womb relax – women have spoken of this making them feel drowsy and occasionally a little nausea but generally it has few other side-effects.

ECV is undertaken at about 37 weeks and success rates vary widely but range from 35-86% (average 58%). Success depends on a variety of factors including proximity to due date, amount of amniotic fluid around the baby, weight of the baby, number of pregnancies and the sheer will and determination of the baby to remain in breech if it so wishes!!! The skill of the person carrying out the manoeuvre is also important, emphasising the need for adequate training in the practice.

It is deemed to be a safe procedure for the baby and the mother, though on the very rare occasion a baby might become distressed and a caesarean delivery will be necessary. It is for this reason that a scan is used and the procedure is undertaken in hospital where facilities for surgery are close by if necessary.

Contra-Indications for ECV are as follows:

1) vaginal bleeding
2) a low-lying placenta
3) an abnormally small baby
4) a low level of amniotic fluid
5) an abnormal foetal heart-rate
6) twins or other multiple pregnancies
7) premature rupture of the membranes

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2 MIDIRS and the NHS Centre for Reviews and Dissemination ‘(((&) Breech Baby- Options for Care.
Midirs. Bristol
There is always a chance that the baby might turn back after a successful ECV, and this is said to occur in approximately of 2.5% cases.

The evidence shows that ECV should at minimum be considered by the mother. As a survey on options for care has shown that only 55% of consultants are offering or referring women for ECV so the mother might have to insist.

**Other ways to turn a baby.**

There are a host of alternative therapies that have been known to turn babies from breech position. Thorough studies in the field of alternative medicine are rare however, and so the science is not available to ‘prove’ their effectiveness. Regardless, stories of mother’s who have had the experience of breech babies can speak volumes and so it is always worth considering. That the procedures are more natural and so less invasive or subject to side-effects lead many to argue ‘why not try, it can’t hurt’.

**Acupuncture**

Acupuncture has been known to be very successful at turning breech babies. The acupuncture point known as Zhiyin (or Bladder 67), which is located on the little toe, on the outside corner of the nail is treated using a moxa stick. The moxa stick is lit in exactly the same way as if it were a cigarette. When the tip is smoldering nicely, it is held near the Zhiyin point on the left foot for a few seconds, and then the procedure is repeated on the right foot. This is continued, alternating between the left and right foot for a total of ten to fifteen minutes. The whole procedure then needs repeated twice a day for maximum of five days – it is said that most babies turn within 3 days.

Unless you are trained in the art of acupuncture and Chinese medicine it would not be advisable to attempt this, but good acupuncturists are now widely available. See crib sheet for contacts.

The treatment is not suitable after 36 weeks so there is an argument to say that this should be tried first. High blood pressure and twins are further contra-indications. And if the treatment itself gives rise to any unusual side-effects such as difficulty sleeping or uterine cramps then the treatment should be stopped.

**Homeopathy**

Homeopathy has also been widely used to turn breech babies. Pulsatilla is the remedy most commonly prescribed. Pulsatilla is supposed to encourage the muscle fibres of the uterus to relax and even out (homeopathically), thereby providing space and encouraging the baby to turn.

Patty Brennan, a qualified homeopath, suggests trying 1 pulsatilla 200c. If there is no response after a few days then another dose should be taken. It is inadvisable to take the remedy more than twice and you should stop taking it if and once the baby has turned.

An alternative way of taking it is 1 dose of 30c every two hours, up to six doses. As the information differs across homeopathic practitioners, it would be advisable to call the homeopathic helpline for advice or to see a qualified homeopath.

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3 Moxa Stick is a tight roll of powdered herbs which burns like a large cigarette. The moxa stick is placed an inch away from the relevant acupuncture point.
Bach Flower Essences
Bougainvillea flower essence has been known to be effective in turning breech babies- a Belgian doctor in a maternity hospital was said to have been used it with high levels of success and anecdotal evidence from women has been largely positive. Most health food stores stock Bach Flower remedies.

Hypnosis
A small study was undertaken in 1994 to assess the effectiveness of hypnosis to covert a breech presentation to a vertex presentation, the results of which were positive. Of 100 cases studied, 81% of the foetuses in the group who undertook hypnosis turned as compared to 48% who had received standard obstetric care.\(^4\)

The conclusion of the study was that ‘Motivated subjects can be influenced by a skilled hypnotherapist in such a manner that their fetuses have a higher incidence of conversion from breech to vertex presentation.’

In support of this, Debra Sequoia, a qualified practitioner of self-hypnosis, says the key to success in turning a baby in this way is the extent to which the mother is reflective and open to suggestion that she may for some unconscious or conscious reason be holding on. She also said that those who have a regular program of hypnotherapy or self-hypnosis don’t often have breech presenting babies.

Yoga Positions
The rationale behind all these positions is to maximize the space in the uterus and to free up the baby’s possible movement, as well as preventing engagement prior to the baby’s turning. Once the baby has turned the emphasis should shift to encourage the baby into the Optimal Fetal Position- see next section.

Positions to help baby turn;
1) **Downward Dog**; this takes the weight of the baby away from the pelvis, reducing the tendency for the baby to engage and increases the space available for the baby to turn.

2) **Shoulder Stand**- alternative is hand stand in a pool. Again this is designed to disencourage engagement.

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\(^4\) ‘Hypnosis and Conversion of the bBreech to Vertex Presentation’ Arch Fam MEd
3) **Knee chest position** - this is known more formally as the Elkins knee-chest position and is purported to have a high rate of success. Elkins conducted a study of 71 women with persistent breech babies after 37 weeks. After using the knee-chest position for fifteen minutes for every two hours of waking time, over the course of 5 days, 91% of the babies turned. Though some remain skeptical, it can not hurt to encourage a woman to do this. Furthermore, if a woman with a breech baby suddenly goes into labour, this position is a good one to adopt in order to slow things down until suitable care has arrived or the woman is in hospital- it is perfectly possible to adopt this position on the back seat of the car on the way to hospital if necessary!!

4) **Tilting pelvis up** - this is another inverted position, though a little less strenuous than head stands or downward dog. The mother should lie on her back with her knees bent and feet flat on the floor. Alternatively, she can have her legs raised against a wall. The pelvis should be tilted upwards and back using several cushions. This should be done for a minimum of ten minutes twice a day. Caution must be exercised in the position though, as lying on one’s back should be limited in late pregnancy due to the excessive weight on the main arteries that run along the spine bringing oxygen to the baby.

What to avoid-
Deep squats or any other positions that might encourage the active engagement of the baby.

**Optimal Foetal Position**

Optimal Foetal Position is a term coined by childbirth educator Pauline Scott after learning about Jean Sutton’s pioneering approach to aligning unborn baby’s in the mother’s pelvis prior to labour. Although the bulk of her advice is designed to counter a baby’s positioning itself in the posterior position i.e. baby’s spine to mother’s spine, and when the time comes, to engaging well in the pelvis, Jean also postulates that a baby can find itself in breech and then be unable to move back because of a lock of room in the pelvis. Though there have been no ‘scientific’ tests to prove it, engaging gravity as a means to help the baby into an optimal position is advisable. To do this, a mother must be shown how to sit correctly (upright, with the pelvis tilted slightly forward), to walk a lot and to use upright and squatting postures throughout the day. More specifically, advice on optimal fetal position will be of particular benefit after a baby has successfully turned, either spontaneously, or by means of an ECV or another alternative treatment
Regular use of the upright and forward leaning position increases the chance that a baby will engage well i.e. head down, spine to the mother’s belly and on the left side. When sitting the mother should be conscious that her knees are well below her hips and her pelvis slightly tilted forward- so rather than slumping into a sofa she should sit cross-legged on the floor, on a birthing ball or a hard chair. Additionally, long trips in cars with bucket type seats should be avoided, or when unavoidable, cushions should be used to tilt pelvis forward. Finally, sitting with one leg crossed over the other should be avoided as this reduces the space in the front part of the pelvis, effectively forcing a baby around to the back.

When sleeping a mother is also advised to take care of her position- she should lie on her left side with a pillow behind her back and her top leg resting forwards over the lower leg. This again pushes the abdomen forward, creating a ‘hammock’ for the baby to swing into.\footnote{p 25 ‘Understanding and Teaching Optimal Foetal Position’ Jean Sutton and Pauline Scott}
The Breech Birth Debate

The topic of breech birth is a highly controversial one, with opinions and research postulating vastly differing conclusions- it is this controversy that makes it so difficult for parents to make any sort of ordered decisions when faced, late on in pregnancy, with a possible breech birth. Following the publication of the Hanah paper (the outcome and implications of which will be explored later) it has become policy in most hospitals to conduct caesarean sections at 38 weeks when a baby is discovered to be in breech position.

It is interesting (horrifying?) to note the rate of caesarean delivery for breech presentation in the United States was 14% in 1970 and 86% in 1986. It currently is 90-95%. Breeches account for 10-15% of all caesarean deliveries.

Such policy-making and statistics belies, however, the vast amount of research on the subject of breech that argues that under the right conditions and with the attendance of experienced midwives or obstetricians, vaginal delivery can be as safe and even preferable to a caesarean section. It also ignores that the labelling of breech as ‘abnormal’ and therefore ‘high risk’ is a relatively recent occurrence. As the AIMS chair Beverly Beech said in a report of the meeting of the Royal College of Obstetricians


at one time breech was considered a normal birth, just an alternative presentation, and every midwife would have felt confident in helping a woman having a breech presentation vaginally.’

Likewise, an extract from Spiritual Midwifery implies a similar attitude ‘There is a slightly higher risk for the baby in breech presentation than in the vertex, but this is not so great as to rule out delivery at home- provided that the midwife is knowledgeable and experienced, with a doctor backing her up and that the mother is extremely well prepared for natural childbirth.’ Finally, an article published in the Lancet has this to say ‘To a midwife a breech delivery is a variation of the normal; to a doctor it is a pathological condition.’

By the same token, the proponents of the ‘caesarian is best’ argument can be equally passionate. An investigator who served on the now landmark ‘Term Breech Trial’ (or Hanah trial as it is often known) stated

‘The Term Breech Trial clearly shows that planned caesarian section is much safer than planned vaginal delivery. I have completely changed my practice as a result of this trial’

8 Lancet 356[9239]:1375-83, 2000

The assumption is that the poorer outcomes that tend to follow a breech delivery as compared to a cephalic presenting baby are the result of the mode of delivery i.e. the ‘more complicated’ vaginal delivery itself, rather than factors which may have been the cause of the breech position in the first place e.g. abnormalities, prematurity etc. In fact research has shown that the greatest risk to a baby, regardless of position or delivery, is prematurity. As the main cause of breech is prematurity, it seems unwise to assume that there is no link between the outcome of the breech birth and the reason for it in the first place. Additionally, the second most common cause of problems following birth is from congenital malformation, which can also be a cause of breech. That the cause of the breech might also be the cause of a negative outcome has not phased the adamance of some, however, in their desire to see all breech babies born by caesarian.
**Advocates of Caesarean**

The Term Breech Trial has been described by Michel Odent as ‘the most typical example of the impact one published study can have overnight all over the world.’ He says ‘Without being simplistic we can claim that the turning point in the history of breech birth came on October 21, 2000.’ It was then that the findings of the Hanah trial were published in the Lancet. The trial, involving 2088 women with a complete frank or breech presentation and an estimated foetal weight of no less than 4000g in a singleton pregnancy, at least 37 weeks, was randomised into either planned caesarean or planned vaginal delivery. The results of the trial at the time seemed to suggest unequivocally that caesarean section was safer for the babies, with no difference in outcome for the mothers. The results led the authors to conclude that ‘a policy of planned caesarean is substantially better for the singleton foetus in the breech presentation at term.’ Analysis of the trial itself and the outcomes of trials conducted subsequently have led to different advice emanating from different quarters, but the overall effect of the trial has remained within most obstetric circles. The result is that vaginal delivery of breech birth is a far less common occurrence- which is arguably a cause for some concern for those minority of undiagnosed breeches that go to term.

Those who advocate caesareans point to the medical concerns surrounding breech. These are as follows:

- **The possibility of a prolapsed cord** during delivery. A prolapsed cord is when the loop of the umbilical cord is below the baby’s head and can become compressed, restricting oxygen flow to the baby. The risk of this when the baby is head down is minimal, because the head is in the way, but increases slightly with a breech baby as the legs and bottom leave more space for the cord to be washed through. It occurs in approximately 3.7 to 7% of breech labours as compared to 0.3% of head down labours. It is rare however, that the outcome of cord prolapse is negative – it seems that the very thing that causes the higher incidence of cord prolapse in breech i.e. space for cord to wash down, is what ensures that the cord is not compressed.

- **The time lag** between the bottom or legs being born and the head being born- there is some concern about the head getting trapped in delivery because the cervix has not dilated properly. What might occur is that the feet slipping down prematurely gives the mother the urge to push prior to full dilation. Careful guidance on the part of the carers is therefore needed at this stage and under such circumstances.

- **Head decompression.** Breech presentation causes the head to come through the pelvis relatively rapidly which produces more rapid compression of the skull. In babies at term this is of little significance but is a risk to a premature baby whose skull bones are softer. It is for this reason that it is often deemed inadvisable to opt for a vaginal birth if the baby is premature.

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9 Michel Odent, Extract of Ch 13 ‘The Caesarean’.
10 Hannah, M et al, Planned Caesarean section vs planned vaginal birth for breech presentation at term; a randomized multicentre trail, Lancet 2000
- **Suboptimal care given in labour**: due to obstetrically managed deliveries becoming the norm there has been a deskilling of doctors and midwives and it might be argued that it is this rather than any inherent physiological risks that is the greatest risk regarding breech babies. An extract from the British Medical Journal argues as much when it states ‘The single and most avoidable factor in causing stillbirths and deaths among breech babies is suboptimal care given in labour, according to the seventh annual Confidential Enquiry into Still births and Deaths in Infancy (CESDI)’.  

Furthermore, there are certain contra-indications for vaginal birth that are more agreed upon. These are as follows:

- **Hyperextension of the head**: where the baby’s head is upright or stretched back rather than tucked in to its chest. This can be determined by a scan. It is almost unanimously agreed that a caesarean section would be the best mode of delivery, as the risk of spinal cord injury to the baby is extremely high. Luckily, this is considered to be a very rare occurrence with many experienced midwives and obstetricians having never come across a single case of head hyperextension.
- **Size and Maturity of Baby**: the prevailing view seems to be that for premature babies a caesarean section is preferable.
- **Difficult first stage labour**: see section on vaginal births.

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11 British Medical Journal June 24,2000
Advocates of Vaginal Birth

There has been much debate in response to the Hannah Trial, much of which questions its reliability as completely conclusive. Taking these limitations into account, as well as the problems deemed to be associated with caesareans has led many not to rule out vaginal births as the preferable option for some mothers, circumstances obviously dependent.

Problems with the Hannah trial

1) As the trial was held across countries, no account was taken of differences in medical procedures and training between countries. In fact, the study itself showed that there was a reduced benefit of caesarean section in countries that have a higher perinatal mortality rate i.e. developing countries. It might be postulated that this is because those countries, where medical facilities are more limited, have carers who are more experienced in vaginal breech births.

2) The trial was a randomised controlled trial. Though this is positive because it is the only scientific means to remove bias, in this case it necessarily ‘selected’ women who were indifferent to the mode of their delivery and as such did not include those who were perhaps more insistent on and therefore better suited to a natural, vaginal delivery.

3) The results of this study were analysed by “intention to treat”. This meant that the data on the 43.3% of women who were randomised into the vaginal birth group but who actually had a caesarean (a statistic which, in itself, might tell you something about the “keen-to-intervene” philosophy held by those involved in the trial) was analysed as if those women had given birth vaginally. Though there is some justification for analysing the results this way, it would have been very useful if the researchers had also included an analysis of the results by actual mode of birth.

4) Though the authors required an ‘experienced clinician’ to be present at delivery, a delve beneath the label showed vastly different levels of experience were deemed acceptable for the study. Furthermore, reminders were published about the need for expertise when it became clear there were no experienced clinicians available at some births. That ‘handy hints’ were published and posted throughout the course of the trial explaining things as basic as the difference between complete and footling breech presentations, how to deal with the baby’s arms if they were above the head and the nature of physiological second stage of labour is indicative of a low level of expertise by some of the medical practitioners in the study. When the authors correlated degree of experience and outcomes, there was a significant positive correlation between more experience and a better outcome. Additionally when the figures for the sub-group of women attended by a more experienced clinician were compared with caesarean outcomes, the difference between the two groups became much less significant.

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12 Breech Birth Beyond the ‘Term Breech Trial’ by Maggie Banks
5) The trial necessarily involved only medically managed vaginal births and therefore conclusions are arguably limited to such births, and do not reflect the possible outcome of genuinely physiological births. By medically managed it is meant that the women are likely to have laboured on their backs, will have been given routine epidurals and had contractions sped up with syntocinon or some equivalent augmentation drug. [Note- a table presenting information about the babies who died shows that 9 out of the 14 labours were subject to induction or augmentation]. Furthermore, time limits were applied to the vaginal birth group – a classic example of the confounding variable of the clock as technology. More babies in the vaginal birth group acquired infections - but then prophylactic antibiotics were given to the caesarean group, so the infection rates of babies not given this advantage were bound to be higher by comparison.

There are many who would argue that such medically managed births are by no means the safest way to give birth vaginally regardless of the baby’s position. Michel Odent goes as far to assert that until the physiology of birth is properly understood and respected, then caesareans might well be the better way to deliver breech babies. This should be seen as a condemnation of obstetrically managed vaginal births, and not vaginal births for breech babies per se. Midwives who feel confident delivering breech babies generally adhere to the mantra ‘hands off the breech’ until the nape of the neck is seen, unless complications call for earlier intervention. That during the study itself the guidelines for intervention were changed and ended up as simply ‘check that total breech extraction was not done’ contrary to much advice, indicated that there was a high degree of intervention in the majority of the vaginal births within the study.

Unfortunately, no studies have been undertaken using the midwifery model of vaginal birth as a source of comparison to caesareans for breech positioned babies. The midwifery model- where care is continuous, the physiological process of birth is respected, the woman is encouraged to follow her instincts and the use of intervention is kept to an absolute minimum- improves the outcome of vaginal births as compared to obstetrically managed ones. It would therefore be more interesting and more worthwhile to be able to compare a truly natural breech vaginal birth with a caesarean breech delivery.
Concerns Regarding Caesareans

In addition to the questionable conclusive nature of any trial’s results, including the most apparently influential, that caesareans carry their own risks is another reason why many would argue that vaginal birth for breech presenting babies should at least be considered. Contrary to what many obstetricians like to imply, caesareans are far from risk free.

- **Prematurity**- One of the major concerns is the common-place practice of delivering babies in this way at 38 weeks gestation. This means that babies are born prematurely by choice. As prematurity is one of the main causes of perinatal mortality, such a policy should by necessity be called into question. If babies were ready to be born at 38 weeks then average gestation time would be 38 weeks!! Thus the timing of caesareans increases the chances of a child suffering from respiratory difficulties—many paediatricians emphasise that such difficulties are found to be lower after ‘in-labour’ caesareans which is an argument for allowing births to at least begin naturally. However the risk is not eliminated entirely, as the natural process of labour is believed to clear the lungs, as well as change the child’s physiological characteristics to promote natural breathing.

- **Bonding**- Michel Odent also talks of the bonding experience that comes out of a natural birth due to the peak levels of oxytocin that are involved in the process. He believes that whilst we are rational animals equipped with an ability to play catch-up and thus bond with our children, inevitably something is lost in not being able to rely on the instinctive and biologically driven bonding experience that comes from natural labours and an uninterrupted first hour after birth.

- **Health of the Mother** – It is widely agreed that the recovery rate following a caesarean is much longer than after a natural birth. But the health risks from a caesarean are far greater than simply recovery time- a trial carried out in 1989, studying 208 frank breech babies after 36 weeks pregnancy were marked by ‘the striking and concerning degree to which women undergoing caesarean sections suffered from infection, haemorrhage and unintentional injury (49.3% of the caesarean group vs. 6.7% of vaginal group).

Having a caesarean can also then affect the mother’s health and ability to have children in the longer term—there are limits to the number of children that a woman who has caesareans should safely have—its is generally agreed to be three. Furthermore, there is an increased chance of miscarriage and ectopic pregnancy, premature separation of the placenta in subsequent. Equally, the chances of the need for a hysterectomy are increased fourfold by caesarean sections.

- **A policy of mandatory Caesarian section** is problematic for a number of reasons—

There will always be those babies (approximately a quarter of all breech presentations) who remain undiagnosed until labour and many will be born vaginally before Caesarian section can be organized. Within the Hanah Trial, 9.6% of women experienced vaginal birth despite their allocation to the planned Caesarian section group. Of these 100 women, the reason given in 59 cases was that vaginal birth was
imminent. This is unlikely to change therefore vaginal breech births will continue to occur.

The fear evident with medicalised practitioners will only increase. It is likely that birth injuries will increase as practitioners, guided by fear, perform panicked interventions when faced with breech presenting babies, first diagnosed in labour, which go on to rapidly be born.

Experience shows that when women have had the opportunity to consider the findings of the Term Breech Trial, some will continue with their plans to give birth vaginally to their breech babies.

A study by the Royal College of Obstetricians and Gynecologists found, on reviewing trainee logbooks from one busy district general hospital (1987 and 1997), that there had been a ten-fold reduction in vaginal breech delivery experience for UK registrars. This will have fallen further following the Term Breech trial. They advised that it was imperative that alternative methods of training urgently need to be introduced (e.g. videos, models and scenario teaching) to cope with, if nothing else, the scenarios outlined above where vaginal birth was unavoidable.

**A Vaginal Breech Birth**

**Observing the Birth**

Almost all advocates would agree with Michel Odent’s idea that during a vaginal breech birth the first stage of labour is a trial; if birth proceeds spontaneously and is straightforward, without having been made too artificially easy i.e. with the use of an epidural or augmentation or even water immersion, then a vaginal birth is possible for the second stage. If however, the first stage is long and difficult then a caesarean should be ‘decided without delay’. Mary Kronk supports this view stating quite emphatically that a baby in breech position can be born easily and spontaneously if the labour proceeds easily and spontaneously. It follows from these arguments that amongst experienced breech birth carers and those who contend that vaginal birth is appropriate under particular circumstances, that there is no place for intervention in the natural birth process when faced with a breech delivery. If a labour is not progressing then the baby should be delivered by caesarean-section. This philosophy rules out induction, but also pulling a baby through the pelvis i.e. ventouse or forceps. Mary Kronk and Jane Evans have gone so far as to stipulate, quite categorically certain principles for a breech birth that they contend must be adhered to if such a birth is to have a positive outcome. These I quote directly-

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- The labour starts spontaneously at term i.e. between the 38th and 42nd week gestation.
- The labour progresses well, i.e. contractions come more regularly, last longer, come more regularly, last even longer….
- The cervix effaces and dilates, and the presenting part descends into the birth canal. As the second stage develops the contractions become expulsive and the woman pushes spontaneously.
- External signs of active second stage become apparent; perineal bulging, and dilation and the presenting part becomes visible at the vulva.
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13 Michel Odent. Extract of chapter 13 (A thousand and one reasons to be offered a caesarean) in ‘The Caesarean’. Free association Books. April 2004
In the first stage of labour, if progress is not apparent with a fully established labour then a caesarean section is advisable.

If intervention is deemed necessary then a c-section is immediately advisable. There is no place for either trying to push breeches through the pelvis with oxytocic drugs or pull them through with actively managed breech extractions.”

It is believed by many that intervention in a breech birth is the product of anxiety on the part of the carer and thus a mark of inexperience, or simply a sign that the birth should not proceed vaginally. The little evidence that there is available suggests that a less interventionist approach leads to better outcomes.

However, as with so many areas of the breech debate, there are some arguments to counter the ‘non-interventionist’ approach. Some obstetricians argue that epidurals should be routinely given as a means of managing any premature urge to push, so that second stage is not falsely entered into prior to the complete dilation of the cervix. Adequate communication with the mother and good management of the birth should, however, be able to do the same job without having risking the labour’s slowing as a result of the epidural.

Creating the Optimum Conditions for Birth

As the aim is to have a spontaneous and straightforward birth the conditions for birth are paramount. Odent argues that ‘Creating the conditions for a powerful ‘foetus ejection reflex’ are paramount’. These are privacy, low-level lighting, warmth, no or at worst minimal interference with the mother and no stimulation of her intellect with questions or rational language, as few attendants as possible. The true role of a midwife or partner is to protect the environment and provide for the optimal conditions for birth- and this is never more imperative than in a breech birth where a spontaneous and easy delivery is necessary.

Positions for Vaginal Delivery

There is some debate regarding the optimum position for a mother to adopt during the second stage of labour. Lying down has been shown to increase the length of vaginal labours and reduce the incidence of normal births. It has also been associated with more abnormal foetal heart rate patterns as well as reducing the dimensions of the pelvic cavity. Thus, lying down would be inadvisable for any birth, and especially breech. It is only those who agree with intervening in the second stage of a breech birth that might advocate this position, but this is to make it easier to intervene, not to make it easier for the mother.

Alternative positions are standing or all fours or supported squat. The advantage of standing is that it engages the full force of gravity to help the baby descend, but there has been some concerns voiced over the possibility of premature separation of the placenta in this position. The hands and knees position still enables the woman to come onto her knees and so engage gravity of necessary but also avoids the problem of placental separation. As a result Mary Kronk advises this as being preferable. She also says that left to her own devices a mother with a breech positioned baby tends to instinctively adopt the all fours position. Michel Odent strongly advocates the supported squat for breech births, with the argument that it is mechanically the most efficient.14

The Experience of Carers

This is arguably one of the most important components of a vaginal breech birth, and should be the primary concern of anyone faced with a decision regarding mode of delivery. Lack of experience on the part of carers has been shown to be one of the primary reasons for negative outcomes of vaginal birth. It is a fact that breech birth with inexperienced carers can be dangerous. It is for this reason that perhaps surprisingly, Yehudi Gordon, a champion of natural birthing techniques argues that the anxiety alone surrounding a breech birth makes caesareans the preferable means of delivery.

Having said that, there are still a number of independent midwives available who have much experience with breech birth, and thus for whom vaginal breech birth under the right conditions is seen as a viable and often better option. Caroline Flint, founder of the Birth centre in Tooting, South London argues that midwives are preferable to obstetricians as attendants when it comes to breech birth – her argument is that the obstetrician is trained to think of what might go wrong, whereas an experienced midwife can just sit quietly and allow birth to proceed naturally. Alice Coyle reiterates this view with the argument that doctors are ‘specialists in the abnormal’ and are increasingly less experienced in the art of vaginal births, used instead to coming in at the end when things need done.

Obstetrician or midwife debate aside, what is needed, above all else is carer who is experienced in natural vaginal births in general, as well as breech births in particular and for whom the importance of the environment and the process of birth is deeply understood.

**Help with Coming to a Decision**

As has, I think, been highlighted by the fierce debate surrounding the topic, coming to a decision regarding a breech birth is by no means easy. In all likelihood a mother faced with a breech presenting baby will be under serious pressure to opt for an elective caesarean at 38 weeks, and there will be some mothers who find this an infinitely preferable option and a way to alleviate their concern.

There will however, be others for whom at least an ‘in-labour caesarean’ is preferable, as a way of ensuring that the baby is ready to come out, whilst for others still a vaginal birth is what they would prefer. For those who are interested in the latter, they must recognise that decisions have to be made on a case-by-case basis and that as ‘emergency caesarean’ is still never ruled out, an open mind should be kept up until the last.

There is however much evidence to show that if performed with an experienced practitioner, with a respect for the physiology of natural labour and provided there were no contra-indications in the first place a vaginal birth can proceed just as smoothly for a breech positioned baby as for a cephalic presenting one. The key for parents who have decided upon a vaginal birth is to find an experienced carer to whose advice they then remain open.

As I have already alluded to, as yoga teachers we are not medically trained, thus our as a player within this heated topic is not to advise on any one course of action. Instead we can be invaluable and often much needed sounding boards for a woman’s anxieties and a source of information – I have listed good books and organisations as well as the names of several practitioners who might be called upon for advice or treatment.

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15 Benna Waites. ‘Breech Birth’ p 175
16 Benna Waites. ‘Breech Birth’ p 175
Ultimately a woman is best to arm herself with as much information as possible, and then based on her specific circumstances make a decision that is in line with her own instincts. In pregnancy our instincts are often more acute and thus should be listened to. That yoga gives the woman the ability to simply sit and be with herself, and thus tap into her instinctive side, makes yoga itself an invaluable aid to decision-making.
Sources of Information

AIMS Journal Special Issue on Breech Birth Volume 10 1998 Autumn
Midirs Leaflets Breech Babies - Options for Care
Breech Birth. By Benna Waites (Can be ordered on www.amazon.co.uk)

Useful Contacts

AIMS Association for Improvement in Maternity Services
08707 651 433

National Childbirth Trust
0870 444 8707

Independent Midwives Association
01483 821104
www.independentmidwives.org.uk
email: info@independentmidwives.org.uk

Association of Radical Midwives
01695 572776
www.midwifery.or.uk
email: arm@midwifery.org.uk

Practitioners

British Acupuncture Council
02087350400
Provides a list of qualified acupuncturists and those who specialise in pregnancy and birth.

Homeopathic Helpline
www.homeopathyhelpline.com
0906 534 3404

Homeopaths-
Caroline Gaskin
carolinegaskin@blueyonder.co.uk
Tel- 02077046900 or 02077277003

Julia Linfoot
juliahomeopath@hotmail.com
0207 732 1417
Bibliography

Articles/Leaflets
‘Midwifery Skills needed for Breech’ Mary Cronk Midwifery Matters Issue No 78, Autumn 1998


Midirs and the NHS Centre for Reviews and Dissemination (1997) Breech Baby- Options for Care

Hannah, M et al, Planned caesarian section versus planned vaginal birth for breech presentation at term: a randomized multicentre trial, Lancet, 2000; 356: 1375-1383


Beverly Beech- Aims Chair- Report from Meeting of Royal College of Obstetricians and Gynecologists 19th January 2004

Maggie Banks ‘Commentary on the Term Breech Trial’

Books


Jean Sutton & Pauline Scott Understanding and Teaching Optimal Foetal Position. Birth concepts, New Zealand, Birth Concepts

Gordon, Yehudi Birth And Beyond. Random House 2002


Balaskas, Janet & Gordon, Yehudi ‘ The Encyclopaedia of Pregnancy and Birth’ MacDonald & Co 1987


