



Supporting informed choice for women with a breech-presenting baby at term: Challenges and opportunities for NHS maternity services

AIMS Journal, 2026, Vol 38, No 3



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Introduction

This article uses the terms “women” and “mothers” in relation to biological sex and reproductive roles. We recognise that not all people who are pregnant or give birth identify with these terms. Their use does not intend to exclude or invalidate the experiences of any person who is pregnant or gives birth.

Breech presentation refers to an in-utero position where the baby's buttocks, feet, or both, are in position to be born first, rather than the head. The term "breech presentation" in this article includes all variations of breech presentation. In this article, physiological breech birth refers to a vaginal breech birth in which care is guided by the normal physiology of birth, with intervention used when indicated, rather than routinely.¹

Every pregnancy is unique, and all women should be supported to make informed decisions about their birth through informed decision-making that considers the best available evidence as well as their

individual circumstances, values and preferences. For women with a breech-presenting baby who meet certain clinical criteria, planned breech birth can achieve favourable maternal and neonatal outcomes when supported by skilled clinicians. For some women, planning a breech birth may be associated with additional risk in certain circumstances. Despite this, all women should be supported to make an informed decision that is right for them, and their choices respected regardless of the options they choose.²

Although informed choice is central to care, access to support for planned vaginal breech birth is limited, as caesarean birth has become the recommended mode of birth for breech presentation. The caesarean section rate in the United Kingdom has risen substantially in recent years and breech presentation remains a common indication for planned caesarean birth.^{3, 4} Although caesarean birth can be lifesaving when clinically indicated, it is associated with immediate and long-term risks for mothers and babies, including implications for future pregnancies.⁵

Despite this, physiological breech birth is uncommon in the UK, accounting for approximately 0.3% of births.⁶ As opportunities to support physiological breech birth have declined, access to skilled care has become increasingly difficult across NHS maternity services.⁷ Women wishing to consider a planned breech birth may encounter considerable variation in the information, expertise and support available to them, depending on where they live.^{8, 9}

This article explores the challenges NHS maternity services face in supporting informed choice for women with a breech-presenting baby at term. It examines how changes in breech care have led to variation in service provision, fewer opportunities to maintain clinical expertise, and inequitable access to support for planned breech birth. It also considers how training and development and service organisation could strengthen woman-centred breech care and improve meaningful birth choices.

The Current Landscape of Breech Care within the NHS

Care for women with a breech-presenting baby has changed significantly over the past two decades. Physiological breech birth was once a routine part of midwifery and obstetric practice, but since publication of the *Term Breech Trial* in 2000, many maternity services began recommending planned caesarean birth for term breech presentation.^{10, 11, 12} Although later research has shown that physiological breech birth can achieve favourable outcomes within certain clinical parameters when supported by skilled clinicians,^{13, 14} the shift towards planned caesarean birth has had a lasting impact on breech care, including within NHS maternity services.¹⁵

As the number of planned caesarean births for breech presentation increased, opportunities to support physiological breech birth declined.¹⁶ Over time, expertise has become concentrated within a relatively small number of clinicians and specialist services, with many maternity units seeing little or no exposure to physiological breech birth in practice.¹⁷ This change has contributed to considerable variation in the availability of supportive care for women with a breech presentation across the NHS.⁸

Some NHS trusts have established dedicated breech teams or specialists, such as breech specialist

midwives, with the knowledge, skills and experience to support physiological breech birth, while others offer limited or no access to specialist support.^{8, 18} As a result, access to up to date, evidence-based information and genuine birth choice is often shaped by variation in specialist breech care. Women living in areas without access to specialist breech services may have fewer opportunities to discuss physiological breech birth as a realistic option, despite national guidance supporting informed choice.²

These variations raise important equity concerns. Women with financial resources, transport and social support may be better able to transfer care to another maternity unit, while women experiencing socioeconomic disadvantage may face additional barriers, including travel costs, caring responsibilities, language barriers and reduced [health literacy](#), making it harder to access options outside their local maternity service.^{19,20, 21} Meaningful choice may therefore not be equally available to all women.

For many women seeking a planned physiological breech birth, navigating maternity services can be emotionally and practically difficult. Some report feeling unsupported, dismissed or unable to access balanced information about their options.^{22,23,24} When their preferred option appears unavailable locally, they may feel forced to accept a planned caesarean birth or transfer their care elsewhere. Alternatively, they may consider alternative birth settings, such as home birth due to fear they will not be supported in hospital.^{25, 26} While planned home breech birth does not increase the chance of complications, which can be unpredictable with breech births, the delay in emergency intervention if complications arise may increase the risk of serious adverse outcomes.²⁷ Some may choose to birth without assistance entirely. Evidence suggests that neonatal outcomes improve when planned breech births are attended by clinicians with expertise.^{28, 29, 30} Although the presence of an experienced clinician does not prevent complications from occurring, it enables timely recognition and management of complications which may reduce the risk of serious adverse outcomes.

Access to specialist support and accurate information influences not only women's birth choices but also the development and sustainability of clinical skills in physiological breech birth within maternity services.

Breech Skills: Training, Competence and Experience

Reduced exposure to physiological breech birth has created a cycle in which fewer clinicians develop the knowledge, skills and confidence to support it, which further limits future learning opportunities.^{18, 31} Many clinicians today, especially midwives, complete their training never having attended a physiological breech birth.¹⁸ Limited exposure can understandably contribute to anxiety when caring for women planning a physiological breech birth, particularly within a maternity system under increasing scrutiny regarding safety, governance and litigation.^{32, 33} Concerns about rare but serious adverse outcomes may influence both individual clinicians and institutional policy, reinforcing a cautious approach to breech care even when women are deemed suitable for a planned physiological breech birth.^{34, 35, 36}

Maintaining competence in breech care is therefore a significant challenge for NHS maternity services.³⁷ NHS England's Core Competency Framework sets out training and competency requirements for maternity staff in key areas of clinical safety.³⁸ However, there is no national requirement for all

midwives to achieve competence in physiological breech birth. Training therefore varies between organisations and is often shaped by local expertise, funding and service priorities.³⁹ As a result, maintaining competence requires approaches that extend beyond mandatory training alone.

Simulation-based training is an essential component of physiological breech birth education, enabling clinicians to practise assessment, communication, teamwork and manoeuvres within a safe learning environment. However, simulation alone is insufficient. It cannot fully replicate the clinical judgement, situational awareness and decision-making developed through supporting women during real births.^{40, 41} Where opportunities to attend physiological breech births are limited, shared learning through case discussion, reflection and observation of breech birth videos with clinicians who support breech births can improve knowledge, develop clinical reasoning and build confidence.^{38, 42} These approaches highlight that competence in physiological breech birth is best viewed as an ongoing process of education, reflection and opportunities to apply knowledge in practice rather than a one-off achievement.⁴³

One example of an educational model that reflects this continuum of learning is the Breech Birth Network CIC approach. It combines evidence-based theory, hands-on simulation, observation of breech birth videos and case reflection.⁴¹ Rather than relying on simulation on its own, the model uses complementary learning methods, recognising that expertise also develops through shared learning. It also emphasises investment in specialist breech teams that can support women, mentor colleagues and help maintain expertise within maternity services.^{7, 42}

Importantly, experienced support does not necessarily depend on a clinician having personally attended large numbers of physiological breech births. Competence involves understanding the physiology of breech birth, recognising normal progress, identifying complications promptly and knowing when intervention is required, and may be developed through training, supervised practice, research involvement, case reflection and shared learning.^{30, 42, 44} Sustaining this expertise within maternity services is essential to ensure women have equitable access to safe, evidence-based breech care and achieve favourable outcomes.⁴⁵

Supporting Choice in Practice

For a small but significant group of women, maintaining physiological breech birth as a supported option is an important aspect of their care.^{46, 47} While planned caesarean birth may be the preferred option for many women with a breech-presenting baby, access to support for both planned caesarean and planned physiological breech birth supports women's autonomy by enabling them to make decisions that align with their values, preferences and individual circumstances.^{44, 48}

A planned physiological breech birth, if successful, offers benefits associated with avoiding major abdominal surgery. Recovery is often quicker, with fewer risks in the immediate postnatal period.⁴⁹ For women planning future pregnancies, avoiding a primary caesarean birth also reduces the cumulative risks associated with multiple caesarean births.⁵⁰ On the other hand, a planned caesarean birth may be the option that best aligns with the woman's priorities, values or perception of risk.^{51, 52} The role of

maternity professionals is not to promote one mode of birth over another, but to support women in making decisions that are informed and appropriate for their individual circumstances.

Supporting informed choice does not mean presenting each option as equivalent. Careful assessment of individual clinical circumstances remains essential.^{53, 54, 55} Women should receive balanced, evidence-based information about both modes of birth, with honest discussion of the potential benefits, risks and uncertainties associated with each option, taking into account their individual circumstances.² While clinicians may discuss both planned caesarean birth and planned physiological breech birth as options, meaningful choice depends on whether services can provide the expertise, pathways and support needed to make each option realistically accessible.

Breech specialist midwives have a vital role in helping women explore their options, understand uncertainty and consider how the evidence relates to their own circumstances.⁵⁶ Counselling conversations should be individualised, consistent and meaningful, and include discussions about both the immediate and longer-term implications of different birth options. Discussion should also recognise that women place different values on particular outcomes and perceive risk differently.⁵⁷ Understanding what is most important to each woman is essential to providing genuinely personalised care.

Women should feel listened to, respected and supported regardless of the decisions they make. The breech specialist midwife's role is not to direct women towards a particular mode of birth, but to act as an advocate, facilitator and trusted professional. By providing balanced information, supporting informed decision-making and respecting women's choices, the specialist midwife helps ensure that breech care remains safe, respectful and genuinely woman centred.

Moving Forward: Developing Services that Support Informed Choice for Breech Presentation

Developing services that support informed choice for breech presentation does not require every clinician to become an expert in physiological breech birth. Instead, maternity services should ensure that women with a breech-presenting baby have access to appropriate expertise, clear clinical pathways and timely referral when required.² As interest in physiological breech birth grows and training becomes more available, there is an opportunity to build sustainable models of breech care that improve both access and equity.^{15, 42}

The benefits of developing services that support informed choice for breech presentation go beyond maintaining physiological breech birth as an option. For women, access to skilled and supportive care can improve equity and promote genuinely informed decision-making about mode of birth.⁴⁶ Trusting relationships with care providers may also reduce the likelihood that women feel they need to avoid aspects of maternity care or seek care outside the maternity system to achieve their preferred birth experience. This highlights the importance of maternity services creating environments where women's autonomy is respected and they feel able to make informed decisions about the care that is right for them and their baby.^{58, 59} While some women will make an informed decision to plan a homebirth, others may disengage from some or all aspects of maternity care because they do not expect their choices to be

supported. Maternity service should therefore seek to provide personalised, respectful care that supports informed choice and optimises safety in all birth settings.

A practical starting point is identifying clinicians with an interest in breech care who can lead service development within their organisation. Sometimes referred to as breech champions, these clinicians can be midwives or obstetricians. They can support colleagues, facilitate training, contribute to guideline development and help establish consistent approaches to breech care.^{19, 60} Breech care should not be viewed as the responsibility of a single profession; safe services depend on effective multidisciplinary collaboration between midwives, obstetricians, sonographers, anaesthetists and neonatal teams.¹⁹

A key role of breech champions is to foster a culture of continuous learning. Education and training should form part of an ongoing programme of service development as competence in physiological breech birth develops through continued learning, reflection and clinical experience rather than one-off training events.^{8, 19} Opportunities are increasingly available through online training packages and multidisciplinary workshops, including those provided by the Breech Birth Network CIC, which combine evidence-based theory with practical skill development and are frequently updated as more evidence emerges from ongoing research.⁴¹

Maintaining competence is only one aspect of providing safe breech care. Even in units where skilled clinicians are available, supporting planned physiological breech birth presents logistical challenges. As spontaneous labour is unpredictable, women planning a physiological breech birth have to rely on skilled clinicians being available when labour begins.⁴⁶ If no confident clinician is available at the time, she may feel she should proceed with caesarean birth despite having planned a physiological breech birth.⁶¹ Unless services have arrangements for specialist clinicians to provide on-call support, access to experienced care during labour cannot always be guaranteed.⁶²

Clinicians with expertise in physiological breech birth may also face barriers to providing care, such as limited opportunities to offer on-call support, organisational constraints, local governance and differing professional attitudes towards physiological breech birth among their colleagues. In some maternity units, clinicians who support women planning physiological breech birth provide informal or additional on-call care beyond standard service arrangements, particularly where formal pathways have yet to be developed.^{7, 61} Reliance on informal or unfunded arrangements is unlikely to be sustainable or able to provide a fair service to all women. In some maternity units, concerns regarding litigation and risk management reduce institutional support for maintaining breech skills and developing specialist services.^{63, 64} These challenges affect not only clinicians, but also women's ability to access the care required to support their planned mode of birth.

These service-level challenges highlight the need for coordinated regional referral pathways. Not every maternity unit has the expertise or workforce capacity to support planned physiological breech birth. Regional networks can help ensure that women who wish to consider a planned physiological breech birth have timely access to centres able to provide expertise, while enabling specialist teams to maintain competence through more frequent exposure to planned breech birth.⁹ Transparent communication

about local expertise, referral options and the services available enables women to make informed decisions and plan their care with realistic expectations.⁶⁵ Where no maternity unit within a Local Maternity and Neonatal System offers support for planned breech birth, service development and formal referral pathways should be established to ensure women can access appropriate care.

Conclusion

The decline in the incidence of physiological breech birth has led to reduced clinical experience, variation in the availability of expertise and inconsistent service provision across the NHS. This has created barriers to evidence-based, personalised breech care. Meaningful choice cannot exist when physiological breech birth is discussed in principle, but the expertise, referral pathways or service arrangements needed to support it are unavailable in practice, or if a woman's informed choices are not respected.

Addressing these challenges requires investment in multidisciplinary collaboration, training and workforce development, specialist breech teams and/or clinicians, and regional referral pathways that enable women with a term breech-presenting baby to access skilled, evidence-based care. Women with a breech-presenting baby should be provided with evidence-based information, balanced counselling and appropriately skilled care, regardless of where they live.

Although not every maternity unit will be able to support planned physiological breech birth locally, every service should provide clear referral pathways, transparent communication and evidence-based information so that women can make informed decisions about their care. Local Maternity and Neonatal Systems should ensure that appropriate support is available for women with a breech presenting baby at term. By strengthening sustainable models of care, maternity services can provide a more equitable, sustainable and responsive service for women with a breech-presenting baby, while developing and maintaining clinical expertise and ensuring that women and their families receive safe, respectful and personalised care.

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¹ Walker, S., *What is 'physiological breech birth?'*. 2021.

² Impey, L., et al., *Management of breech presentation*. BJOG, 2017. **124**(7): p. E152-E177.

³ Ambia, J., et al., *International comparison of caesarean birth rates, 2020–2025*. 2026.

⁴ Lafitte, A.-S., et al., *Rate of caesarean sections according to the Robson classification: Analysis in a French perinatal network–Interest and limitations of the French medico-administrative data (PMSI)*. Journal of Gynecology Obstetrics and Human Reproduction, 2018. **47**

(2): p. 39-44.

5 Sandall, J., et al., *Short-term and long-term effects of caesarean section on the health of women and children*. The Lancet, 2018. **392**(10155): p. 1349-1357.

6 Digital, N., *NHS Maternity Statistics, 2018-2019*. 2019.

7 Walker, S., et al., *The feasibility of team care for women seeking to plan a vaginal breech birth (OptiBreech 1): an observational implementation feasibility study in preparation for a pilot trial*. Pilot and Feasibility Studies, 2023. **9**(1): p. 80.

8 Dasgupta, T., et al., *Breech specialist midwives and clinics in the OptiBreech Trial feasibility study: An implementation process evaluation*. Birth, 2023. **50**(3): p. 596-605.

9 Walker, S., et al., *The OptiBreech Care Pathway: evaluating the feasibility and acceptability of team care for women seeking to plan a vaginal breech birth (OptiBreech 1)–a mixed methods implementation feasibility study*. 2022.

10 Hannah, M.E., et al., *Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial*. The Lancet, 2000. **356**(9239): p. 1375-1383.

11 Glezerman, M., *Five years to the term breech trial: the rise and fall of a randomized controlled trial*. American journal of obstetrics and gynecology, 2006. **194**(1): p. 20-25.

12 Vidaeff, A.C., *Breech delivery before and after the term breech trial*. Clinical obstetrics and gynecology, 2006. **49**(1): p. 198-210.

13 Goffinet, F., et al., *Is planned vaginal delivery for breech presentation at term still an option? Results of an observational prospective survey in France and Belgium*. American journal of obstetrics and gynecology, 2006. **194**(4): p. 1002-1011.

14 Walker, S., et al., *How safe is it to plan a vaginal breech birth with OptiBreech collaborative care?: analysis of cumulative data within the OptiBreech Multiple Trials Cohort*. NIHR Open Research, 2023. **3**: p. 61.

15 Daviss, B.-A. and A. Bisits, *Bringing Back Breech: Dismantling hierarchies and reskilling practitioners*. Birthing Models on the Human Rights Frontier, 2020: p. 145-183.

16 Stone, H., et al., *Retention of vaginal breech delivery skills taught in simulation*. Journal of Obstetrics and

Gynaecology Canada, 2018. **40**(2): p. 205-210.

[17](#) Walker, S., M. Scamell, and P. Parker, *Deliberate acquisition of competence in physiological breech birth: A grounded theory study*. Women and Birth, 2018. **31**(3): p. e170-e177.

[18](#) Davies, S.M., et al., *The OptiBreech Trial Feasibility Study: A Qualitative Inventory of the Roles and Responsibilities of Breech Specialist Midwives*. Journal of Midwifery & Women's Health, 2025. **70**(2): p. 270-278.

[19](#) McLeish, J. and M. Redshaw, *Maternity experiences of mothers with multiple disadvantages in England: a qualitative study*. Women and Birth, 2019. **32**(2): p. 178-184.

[20](#) Ebert, L., et al., *Socially disadvantaged women's views of barriers to feeling safe to engage in decision-making in maternity care*. Women and Birth, 2014. **27**(2): p. 132-137.

[21](#) Darling, E.K., et al., *Access to midwifery care for people of low socio-economic status: a qualitative descriptive study*. BMC pregnancy and childbirth, 2019. **19**(1): p. 416.

[22](#) Coates, D., et al., *Women's experiences of decision-making and beliefs in relation to planned caesarean section: A survey study*. Australian and New Zealand Journal of Obstetrics and Gynaecology, 2021. **61**(1): p. 106-115.

[23](#) Kotaska, A., *In the literature: combating coercion: breech birth, parturient choice, and the evolution of evidence-based maternity care*. Birth, 2007. **34**(2): p. 176-180.

[24](#) Schafer, R., et al., *"I had no choice": A mixed-methods study on access to care for vaginal breech birth*. Birth, 2024. **51**(2): p. 413-423.

[25](#) Hollander, M., et al., *Women's motivations for choosing a high risk birth setting against medical advice in the Netherlands: a qualitative analysis*. BMC pregnancy and childbirth, 2017. **17**(1): p. 423.

[26](#) Holten, L., M. Hollander, and E. de Miranda, *When the Hospital Is No Longer an Option: A Multiple Case Study of Defining Moments for Women Choosing Home Birth in High-Risk Pregnancies in The Netherlands*. Qual Health Res, 2018. **28**(12): p. 1883-1896.

[27](#) Spillane, E., S. Walker, and C. McCourt, *Optimal time intervals for vaginal breech births: a case-control study*. NIHR open research, 2022. **2**: p. 45.

- [28](#) Impey, L., et al., Management of breech presentation. BJOG, 2017. 124(7): p. E152-E177
- [29](#) Walker, S., P. Parker, and M. Scamell, Expertise in physiological breech birth: a mixed-methods study. Birth, 2018. 45(2): p. 202-209.
- [30](#) Su M, McLeod L, Ross S, Willan A, Hannah WJ, Hutton E, Hewson S, Hannah ME; Term Breech Trial Collaborative Group. Factors associated with adverse perinatal outcome in the Term Breech Trial. Am J Obstet Gynecol. 2003 Sep;189(3):740-5. doi: 10.1067/s0002-9378(03)00822-6. PMID: 14526305.
- [31](#) Walker, S., P. Parker, and M. Scamell, Expertise in physiological breech birth: a mixed-methods study Birth, 2018. 45(2): p. 202-209.
- [32](#) Catling, C., et al., Barriers and facilitators for vaginal breech births in Australia: clinician's experiences. Women and Birth, 2016. 29(2): p. 138-143.
- [33](#) Scamell, M., The fear factor of risk-clinical governance and midwifery talk and practice in the UK. Midwifery, 2016. 38: p. 14-20.
- [34](#) Sloman, R., et al., Midwives' views, experiences and feelings of confidence surrounding vaginal breech birth: A qualitative study. Midwifery, 2016. 41: p. 61-67.
- [35](#) Betran, A.P., et al., Interventions to reduce unnecessary caesarean sections in healthy women and babies. The Lancet, 2018. 392(10155): p. 1358-1368.
- [36](#) Petrovska, K., et al., How do social discourses of risk impact on women's choices for vaginal breech birth? A qualitative study of women's experiences. Health, Risk & Society, 2017. 19(1-2): p. 19-37.
- [37](#) Vincent, H., et al., Barriers and facilitators for implementation of OptiBreech collaborative care: A qualitative study as part of an implementation process evaluation. Women and Birth, 2024. 37(5): p. 101656.
- [38](#) England, N., Core competency framework v2: Minimum standards and stretch targets 2023.
- [39](#) Walker, S., et al., Effectiveness of vaginal breech birth training strategies: An integrative review of the literature. Birth, 2017. 44(2): p. 101-109.
- [40](#) Farin, A., et al., Training for breech deliveries with the mother in an upright position: An innovative adaptation of a simulation model. European Journal of Obstetrics & Gynecology and Reproductive Biology, 2023. 280

: p. 108-111.

[41](#) Walker, S., M. Scamell, and P. Parker, *Principles of physiological breech birth practice: a Delphi study*. Midwifery, 2016. **43**: p. 1-6.

[42](#) Network., B.B. *Breech Birth Network CIC*. 2026; Available from: <https://breechbirth.org.uk>.

[43](#) Walker, S., et al., *Physiological breech birth: evaluation of a training programme for birth professionals*. Pract Midwife, 2017. **20**(2): p. 25-28.

[44](#) Walker, S., M. Scamell, and P. Parker, *Standards for maternity care professionals attending planned upright breech births: a Delphi study*. Midwifery, 2016. **34**: p. 7-14.

[45](#) Walker, S., P. Parker, and M. Scamell, Expertise in physiological breech birth: a mixed-methods study. Birth, 2018. **45**(2): p. 202-209.

[46](#) Roy, R., et al., *What are women's experiences of seeking to plan a vaginal breech birth? A systematic review and qualitative meta-synthesis*. NIHR Open Research, 2023. **3**: p. 4.

[47](#) Petrovska, K., et al., 'Stress, anger, fear and injustice': An international qualitative survey of women's experiences planning a vaginal breech birth. Midwifery, 2017. **44**: p. 41-47.

[48](#) Morris, S.E., D. Sundin, and S. Geraghty, *Women's experiences of breech birth decision making: An integrated review*. European Journal of Midwifery, 2022. **6**: p. 2.

[49](#) Torkan, B., et al., *Postnatal quality of life in women after normal vaginal delivery and caesarean section*. BMC pregnancy and childbirth, 2009. **9**(1): p. 4.

[50](#) Silver, R.M. *Implications of the first cesarean: perinatal and future reproductive health and subsequent cesareans, placentation issues, uterine rupture risk, morbidity, and mortality* in *Seminars in perinatology*. 2012. Elsevier.

[51](#) Guittier, M.-J., et al., *Breech presentation and choice of mode of childbirth: A qualitative study of women's experiences*. Midwifery, 2011. **27**(6): p. e208-e213.

[52](#) Thompson, E., J. Brett, and E. Burns, *What if something goes wrong? A grounded theory study of parents' decision-making processes around mode of breech birth at term gestation*. Midwifery, 2019. **78**: p. 114-122.

- [53](#) Kotaska, A., et al., *Vaginal delivery of breech presentation: No. 226, June 2009*. 2009, Elsevier.
- [54](#) Parissenti, T.K., et al., *Risk factors for emergency caesarean section in planned vaginal breech delivery*. Archives of Gynecology and Obstetrics, 2017. **295**(1): p. 51-58.
- [55](#) Carbillon, L., et al., *Revisiting the management of term breech presentation: a proposal for overcoming some of the controversies*. BMC Pregnancy and Childbirth, 2020. **20**(1): p. 263.
- [56](#) Dasgupta, T., et al., Breech specialist midwives and clinics in the OptiBreech Trial feasibility study: An implementation process evaluation. Birth, 2023. 50(3): p. 596-605.
- [57](#) Dixon, L., et al., *Singleton breech presentation at term: Review of the evidence and international guidelines for application to the New Zealand context*. New Zealand College of Midwives Journal, 2018. **54**: p. 5-14.
- [58](#) O'Brien, D., M.M. Butler, and M. Casey, *The importance of nurturing trusting relationships to embed shared decision-making during pregnancy and childbirth*. Midwifery, 2021. **98**: p. 102987.
- [59](#) Ganisia, A. and M.K. A'zdom, *Effective communication in midwifery practice strengthening patient trust and maternal health outcomes*. Journal of Nutrition and Health Care, 2025: p. 65-73.
- [60](#) Furtado, V. and E. Kitson-Reynolds, *Changing the tide: influencing factors for midwives on vaginal breech birth skill acquisition*. British Journal of Midwifery, 2021. **29**(8): p. 454-462.
- [61](#) Morris, S., S. Geraghty, and D. Sundin, *Women's experiences of breech birth and disciplinary power*. Journal of Advanced Nursing, 2021. **77**(7): p. 3116-3131.
- [62](#) Derisbourg, S., et al., *Impact of implementation of a breech clinic in a tertiary hospital*. BMC pregnancy and childbirth, 2020. **20**(1): p. 435.
- [63](#) Law, S.A., *Childbirth: An opportunity for choice that should be supported*. NYU rEv. I. & sOC. CHaNgE, 2007. **32**: p. 345.
- [64](#) Lazar-Shoef, T., N.J. Efron, and N. Davidovitch, *Collective Forgetting of American Vaginal Breech Delivery*. Journal of the History of Medicine and Allied Sciences, 2026. **81**(3): p. 322-343.
- [65](#) Organization, W.H., *WHO recommendations on intrapartum care for a positive childbirth experience* 2018: World Health Organization.