Reviewer’s report

Title: Perceptions, careseeking, and experiences pertaining to non-cephalic births in rural Sarlahi District, Nepal: a qualitative study

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Reviewer: Shawn Walker

Reviewer’s report:

Thank you for asking me to review this fascinating study. The data presented certainly made me want to know more about breech presentation within this rural Nepalese culture. However, I had some concerns about the assumptions and recommendations which surrounded the qualitative data.

My biggest concern with this article is the underlying assumption that motivating care-seeking based on risk perception is likely to enhance this population's well-being. p. 15, lines 24-27, "While perceived risk often appeared to motivate care-seeking, it rarely was sufficient to overcome the barriers for care-seeking beyond the first facility point-of-contact." What is the evidence that fear-based motivations will do this? It seems to me that up-skilling, empowering and resourcing health care providers across settings to collaboratively provide culturally sensitive care is the main intervention needed in the context your data describes. Scaring women into compliance with a policy of referring all breech presentations to tertiary-based facilities does not appear to be culturally and economically sensitive, especially if you cannot provide evidence that this approach will significantly improve outcomes for mothers and babies. I would be reluctant to import into this culture the almost irrational fear that has arisen around breech in Western settings, leading to a situation in which even well-resourced families cannot access a vaginal birth for a breech-presenting fetus; a higher caesarean section rate in rural Nepal would have serious consequences for the maternal population. I also do not understand the rationale for placing the onus on families to understand the risks around breech presentation, when those providing their health care do not share this understanding and facilities cannot necessarily provide safer care for breech births.

In the introduction, you seem to be arguing that a focus on intrapartum care for breech presentation, by which they mean referral to a large facility where women can receive continuous monitoring and access to a caesarean section if needed, would improve neonatal and maternal outcomes. However, your recommendation is for an antenatal educational intervention - informing women and decision-makers about the risks associated with breech presentation in order to influence their care-seeking behaviours, so that more women with a breech-presenting fetus attend these large facilities for their births. This logic has two problems. The first is that you have not presented any proof that automatic referral to a large facility will improve outcomes for women and their breech-presenting infants. This may be an assumption based upon the way the western world has approached breech in recent years. Second, the data itself suggests that for numerous reasons, this strategy would not be acceptable to a large portion of this population. Some of the data indicated that they facility-based care the authors would like
the women to access is still very sub-optimal. Convincing people they are at risk and need such care is unethical without evidence that it will offer a significant benefit.

There is little evidence that obstetric intrapartum interventions improve outcomes in low-resource settings, and they may introduce additional risks. (Hofmeyr et al 2009) Understanding the cultural knowledge and barriers to care in this setting is useful and this research contributes to such understanding, but does not lead to the recommendations you are making.

The other problem with studying breech presentation in this retrospective, qualitative way is that breech is often associated with preterm birth and growth restriction. Some of the authors have already studied these factors in this population, which carries a higher burden for these complications (Kozuki et al, 2015). If you are recommending that women have universal ultrasounds to determine if their baby is breech - when will these occur? And are you certain that the majority of adverse outcomes these women experienced were due to breech, or were these babies also premature, with asymmetrical growth. I don't feel this data warrants the recommendations you are providing, although it is interesting for other reasons.

From the abstract: "Some participants were acutely aware of the dangers, and that the potential consequences were as severe as death of the mother and/or the child …" This is highly sensationalist. Any birth's potential consequences are as severe as death of the mother and/or the child. None of the research around breech presentation indicates a higher risk to the mother of breech presentation per se, except in subsequent pregnancies when a caesarean section has been planned for the first. Higher risk of obstructed labour, perhaps. In which case the educational intervention is around recognizing obstructed labour, not breech presentation.

"Many interviewees said that the position in which a pregnant woman sleeps could impact the position of the baby. Several participants had either taken or heard of medication that will rotate the fetus into the correct position." Western cultures also abound with folk medicine (positional interventions, homeopathy) aiming to 'correct' baby's position. It is interesting that such folk interventions co-exist with what the authors perceive to be little awareness of the risks associated with breech presentation. Perhaps there is awareness, but also fear of facilities-based care which is perceived as expensive, not necessarily effective and potentially harmful in other ways? This certainly drives Western demand for folk remedies, and in some cases out-of-hospital and/or births without a professional attendant.

"Conclusions: Given the risk of complications associated with non-cephalic birth, our findings underscore the need to incorporate risk communication regarding the condition into antenatal care materials. A myriad of other barriers to care-seeking exists beyond identification of risk, but the knowledge may better inspire decisionmakers to take actions that will reduce mortality and morbidities associated with noncephalic birth." If the you have not presented evidence that seeking care from facilities will improve outcomes, this is not a logical conclusion. This paper's data is qualitative. It provides insight into the beliefs, motivations and behaviours related to breech presentation in this population, and can potentially be used to inform culturally sensitive interventions with both providers and consumers of health care in this setting. But it does not present evidence which supports the interventions you are recommending. I am also confused as to why, given the descriptions of caregivers you have presented, you feel that mothers and
decisionmakers' actions will reduce mortality and morbidities associated with noncephalic birth. Surely, care providers' education needs improving first?

[Challenging to provide feedback because no page numbers are given and line numbers are individual to pages.]

Background, lines 41-44 Founds' 2007 study of women's and provider's experiences in Jamaica had some findings which resonate with this study. Her study also indicates that women's worries about presentation in this setting are minimal compared to the co-morbidities usually associated with breech, such as prematurity. She also found that although women were frightened about the risks associated with breech presentation, they avoided or delayed accessing facility-based care.

The methods seem reasonable. Very good description of quality controls.

Results, p 10, lines 24-46 The indiscriminate use of 'injections' in homes and facilities is an interesting finding, and an example of why this sort of qualitative research with the recipients of health care is an important adjunct to quantitative reports of outcomes. However, again it weakens your argument that antenatal risk-based education of women and families will improve outcomes. It is strong evidence of the to explore how clinical practices differ from recommended care, in order to improve training and education of health care providers.

P 10-11, lines 49-27: The description of 'possibly harmful practices' is interesting. However, very important to check your assumptions here. According to Hofmeyr et al 2009, fundal pressure is still in widespread use, even in high-resource settings. While it would be considered inappropriate in the US or UK, it is used frequently by very experienced breech attendants in Germany, where it is known as the Kristellar manoeuvre. Similarly with sticking hands into the vagina to pull the head out. Depending on how it is done, this could be a fairly standard and necessary manoeuvre. I wouldn't want to assume traditional birth attendants don't have knowledge of it just because they are not trained obstetricians, although clearly leaving this up to the mother-in-law is not good enough. Again, especially given the similar issues with facilities-based care, up-skilling health care providers, in whatever settings they work in, seems to be needed before instructing women and families to seek them out.

p. 11, lines 29-46. Again, these descriptions of the very significant practical and economic difficulties women and families face trying to access care in tertiary facilities undermine your argument that they should be educated about the significant risks to themselves and their babies if they do not access such care. Surely, up-skilling regional centres and traditional birth attendants (to provide skilled midwifery care, which has been shown in research to significantly improve outcomes, including prematurity) is the logical first step? If these front-line professionals have more knowledge, they are better able to make referrals and facilitate communication and transportation to tertiary referral centres.

p. 11-12, Antepartum diagnosis. Here we have both traditional birth attendants sometimes failing to diagnose breech presentation, sometimes getting it right and making the referral to a facility, where the trained professionals get it wrong and send the woman back where she came from. Meanwhile, Grandmother points out that ultrasound is expensive for the family to access, and
she isn't convinced the benefits outweigh the risks associated with the expense. Again, I am not sure how this scenario fits with your argument that women and families should be educated about risks and encouraged to seek out facilities-based care, including ultrasound. Later in the paper, you point out that ultrasound is becoming cheaper and more readily available, so why has this not led to the recommendation that regional centres and community health workers be up-skilled and resourced to provide such care in the settings women are more likely to access? Placing the burden on individuals, through fear for their safety, to seek out care that is expensive, difficult to access and unreliable does not seem logical.

Also, to put this in perspective, 15-25% of breech presentations in the UK are not diagnosed before labour, and in the last audit I completed in a university trust hospital in the UK, 30% of those that were undiagnosed at the start of labour received multiple vaginal examinations until they were diagnosed as breech. This is a common feature of the breech experience globally, and not a product of unskilled health professionals. Providers in high resource settings also struggle with the feeling that diagnosing all breech babies antenatally with ultrasound will improve outcomes, but actual evidence that routine ultrasound in late pregnancy improves perinatal outcomes for mothers or babies is lacking, at least according to the latest Cochrane Review (Bricker et al 2015).

p. 13, line 29-32: Clearly, for some women and families, breech presentation does result in fear. I am not convinced introducing more fear around breech presentation, without providing the sound solution of more highly skilled health care workers across all settings, will be helpful to the population you are describing.

p. 13, lines 46-56: You have presented evidence that some women are not even aware that breech presentation exists. As they have discovered this at a focus group, the subsequent insistence that they would have accessed facility-based care if they knew the baby was upside-down is likely to be influenced by the fact that they are participating in this focus group, especially as it appears to be divergent from what others have done when actually confronted with a similar discovery.

p. 14 lines 12-19: The 'pervasive theme' that they would have sought care before delivery if they knew about the condition conflicts with lines 29-32 on the previous page, where they all agreed that the delivery could be done at home until a complication occurred.

p. 18, lines 1-3 "A few women did not seek facility care because interventionist actions of facilities would interfere with god's timing and will." The beliefs held by older and younger women in this population are really important. In a culture where just under half of the population has experienced a stillbirth or neonatal death, strong faith probably contributes to resilience in the face of such hardship. Understanding the role of such beliefs in people's lives can help to develop services which work in harmony with their beliefs, so that health care workers can be welcomed as part of 'god's timing and will,' rather than a disruption to it.

p. 19, 17-34: The recommendation here that ultrasound be more available in the communities where these women are most inclined to seek care seems in line with the data presented in the results, although still lacking in evidence that universal use of it will improve outcomes. Here, the need for research about whether such measures will actually improve outcomes is
acknowledged. The speculative nature of the interventions being recommended needs to be more emphasized.

p. 20, line 2-17: I feel this discussion is becoming more balanced, and would benefit from a greater shift in this direction. Instead of maintaining the a priori idea that 'seeking facility care is important,' identifying the need for skills and collaborative care across settings, including skills shifting and effective referral networks, seems a more balanced and culturally appropriate approach.

p. 20, lines 36-49. However, we've returned to this idea that, although there is ample evidence facilities are not managing breech births well, all breech births should be referred to them. This is not a logical conclusion. And the authors seem to be suggesting that planned caesarean section for breech presentation may be the solution to reducing the stillbirth rate. Now, maternal risk becomes salient, especially in a country where women begin their childbearing careers at a very young age and give birth mostly at home. Primary caesarean section for breech has significant implications for maternal and neonatal mortality and morbidity in future pregnancies, even if it does reduce short-term adverse outcomes for the baby. (van Roosmalen and Meguid, 2014)

p. 21, lines 2-15. The finding that women associate uterotonics with a positive effect on their births is interesting, and suggests that their aversion to interference with god's will is very complex, with some interference being more acceptable than others. This finding should be reported in findings rather than for the first time in discussion. Good awareness and discussion of some potential weaknesses of the study.

References:


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