



*The Royal College of*  
**Midwives**

# Evidence Based Guidelines *for* *Midwifery-Led Care in Labour*

Persistent Lateral and  
Posterior Fetal Positions  
at the Onset of Labour



## *Practice Points*

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Some women will begin their labour with their baby in an occipito-posterior or occipito-lateral position (Simkin 2010). Internal rotation to anterior positions can be expected in the majority of cases. Midwives should discuss this with women at late pregnancy and in early labour to ensure they understand what may happen and the activities that may help. Midwives should have a sound knowledge of the mechanism of labour when the baby is in this position and use positive actions to support women through this type of labour.

Women should be encouraged to adopt postures of comfort, to remain mobile if they wish, and should be supported in using coping methods to deal with their particular pattern of labour (Simkin 2010).

Midwives should also be alert to the potential for women to experience anxiety if interventions are followed and rotation does not occur (Walmsley 2000).

There is no current evidence of effectiveness of women adopting hands and knees positions with the aim of rotating a baby in a posterior position during late pregnancy or during labour (Hunter et al. 2007).

The use of this strategy during labour is associated with a reduction in persistent back pain (Stremmer et al. 2005). Women should be encouraged to use this position for comfort in labour.

Midwifery care should be supportive, encouraging and provide continuity where possible.

## *Persistent Lateral and Posterior Fetal Positions at the Onset of Labour*

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Between 15-32% of women experience a baby in an occipito-posterior or occipito-lateral position at the onset of labour (Simkin 2010 ); this occurs more frequently among nulliparous than multiparous women. Whilst internal rotation to anterior positions can be expected in the majority of cases, between 5 and 8 % of babies will remain posterior at birth (Simkin 2010; Gardberg and Tupperainen 1994). This indicates the need for facilitating discussion with women in late pregnancy and early labour to ensure that women understand what may happen and address issues in their care plan.

Simkin (2010) has reviewed the evidence supporting prevailing concepts which underpin care in this context. Her findings suggest that current techniques used to diagnose the fetal position such as the location of fetal heart tones, Leopold's manoeuvre, presence of back pain and vaginal examinations are unreliable. This failure to identify the position accurately can impact on the ability of midwives to offer appropriate care as it can result in wrong interventions being offered (eg. augmentation) or the withholding of potentially useful interventions. Ultrasound appears to be the most reliable way to accurately to detect the fetal position; however, the potential risks of multiple brief exposures to ultrasound are yet unknown, and it maybe unacceptable to many women. As Simkin concludes, more research studies are needed to examine the efficacy of midwifery developed skills in diagnosing this problem and non-technological approaches to improving the outcome.

For women with babies in posterior or lateral positions, labour can be experienced as longer and more tiring and with more backache than when the baby is positioned anteriorly (Simkin 2010; Pearl et al. 1993). Persistent posterior or lateral positions are generally associated with a higher incidence of interventions in labour and instrumental birth.

Early studies of postural interventions aimed at achieving rotation during labour appeared promising. A small trial, published in 1983, reported rotation of the baby from posterior and lateral positions when hands and knees positioning was used during late pregnancy (Andrews and Andrews 1983). This trial did not, however, include objective or repeated observations of position (Coates 2002). The Cochrane review by Hunter et al. (2007) included two further trials. One of these, Kariminia et al.'s (2004) randomised controlled trial involving 2547 women in six hospitals in Australia, investigated the effect on incidence of occipito-posterior positions at birth of hands and knees position used twice each day for ten minutes with pelvic rocking exercises from 37 weeks' pregnancy until labour onset. Outcomes reported also included use of epidural, length of labour, type of birth, use of episiotomy and baby's condition at birth as assessed by Apgar scores. No difference in the primary outcome of persistent fetal occipito-posterior position was detected. No negative effects were reported from the intervention for women or their babies. The trial by Stremmer et al. (2005) investigated the use of hands and knees position in labour for at least 30 minutes and involved 147 labouring women at 37 or more weeks gestation. Occipito-posterior position of the baby was confirmed by ultrasound. There was a significant reduction in back pain but no difference detected in positions at birth or operative deliveries.

The reviewers recommended that, in the absence of further evidence, use of hands/knees posture for 10 minutes twice daily in late pregnancy should not be recommended as an intervention. They also comment that this should not mean that women should not use this position if they find it comfortable.

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In a discussion of an earlier review, Anderson (1999) offered a different opinion, suggesting that in the absence of reports of harm to the woman or her baby, these approaches could be incorporated by midwives. However, one group of midwives reported discontinued use of these approaches due to concerns about women experiencing anxiety if they accidentally adopted an “incorrect” posture, and voicing feelings of failure if rotation of their baby did not occur (Walmsley 2000).

At this stage, therefore, there is no evidence that hands and knees positioning during pregnancy or labour rotates a malpositioned baby.

Consensus opinion from midwives identified a range of midwifery care practices considered helpful and unhelpful for women experiencing persistent posterior or lateral positions. Aspects of practice considered helpful include:

- Midwives should have a thorough knowledge of physiology and the mechanism of labour when malposition is a feature;
- Midwifery care should aim to provide explanation of the likely course and timescale of labour, encouragement, use of positioning that achieves comfort and avoiding exhaustion and dehydration;
- Advice on interventions either during pregnancy or labour should be offered in such a way that acknowledge the extent of the evidence base and should not increase women’s feelings of anxiety or predispose to feelings of failure;
- Mobility, change of position during labour and use of birthing pool or bath, if wished;
- Continuity of carer;
- Use of coping strategies to deal with a long labour, backache and pain in labour.

Practices considered unhelpful include:

- Immobility and labouring on a bed;
- Setting arbitrary time limits on the various stages of labour;
- Early epidural.

## References

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This updated guideline was authored by:

Jane Munro, Quality and Audit Development Advisor, RCM, Mervi Jokinen,  
Practice and Standards Development Advisor, RCM

And peer reviewed by:

Dr Tracey Cooper, Consultant Midwife – Normal Midwifery, Lancashire Teaching  
Hospitals NHS Foundation Trust.

Dr Fiona Fairlie, Consultant Obstetrician and Gynaecologist, Sheffield Teaching  
Hospitals NHS Foundation Trust.

Anne-Marie Henshaw, Lecturer (Midwifery and Women's Health)/ Supervisor of  
Midwives, University of Leeds

Helen Shallow, Consultant Midwife & Head of Midwifery, Calderdale & Huddersfield  
NHS Foundation Trust.

The guidelines have been developed under the auspices of the RCM Guideline  
Advisory Group with final approval by the Director of Learning Research and Practice  
Development, Professional Midwifery Lead.

The guideline review process will commence in 2016 unless evidence requires  
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### Sources

The following electronic databases were searched: The Cochrane Database of Systematic Reviews, MEDLINE, Embase and MIDIRS. As this document is an update of research previously carried out, the publication time period was restricted to 2008 to March 2011. The search was undertaken by Mary Dharmachandran, Project Librarian (RCM Collection), The Royal College of Obstetricians and Gynaecologists.

### Search Terms

Separate search strategies were developed for each section of the review. Initial search terms for each discrete area were identified by the authors. For each search, a combination of MeSH and keyword (free text) terms was used.

### Journals hand-searched by the authors were as follows:

- Birth
- British Journal of Midwifery
- Midwifery
- Practising Midwife
- Evidence-based Midwifery