Induction of labour

Information for pregnant women
This booklet provides information about induction of labour, which is based on national guidelines.

What is induction of labour?

Labour is a natural process which usually starts on its own, but sometimes labour needs to be started artificially; this is called induction of labour or ‘induced labour’.

Why you might be offered an induction

Most women will have a normal pregnancy, but sometimes it can be best to induce labour rather than let it start naturally. The reasons for this are:

• To avoid your pregnancy lasting longer than 42 weeks (known as a prolonged pregnancy).

• If your waters have broken but labour does not start.

• If it is safer for you or your baby.

• For other reasons recommended by your obstetrician, which they will explain to you at your appointment.

The most common reason for induction is to avoid a prolonged pregnancy. Allowing a pregnancy to continue for more than 42 weeks is slightly more risky for the baby. Your midwife or obstetrician should offer to discuss this with you at your 38 week antenatal appointment.

You may be offered an induction if you are more than 34 weeks pregnant and your waters break but labour has not started on its own after 24 hours.
If you are offered an induction

Your midwife or obstetrician should explain why you are being offered an induction. They should also talk with you about the risks and benefits, explain the alternatives, and encourage you to look at sources of information such as the NICE guidelines: www.nice.org.uk/guidance/cg70

They should talk to you about when, where and how labour can be induced and about how pain relief options may vary depending on how you are induced. You should be told what your options will be if inducing your labour doesn’t work. These might include the option of a caesarean section.

You should be given plenty of time to discuss the induction with your partner or family before making a decision. Your healthcare professionals should support you in whatever decision you make. If you choose not to go ahead with an induction, your midwife or obstetrician will discuss your care options with you.

Before you are offered an induction

Before you are offered an induction, you should be offered a membrane sweep (sometimes called a ‘stretch and sweep’) to help you go into labour before 42 weeks. This involves your obstetrician or midwife doing an internal examination and placing a finger into the neck of your womb (called the cervix). They will make a circular, sweeping movement to separate the membranes that surround the baby, or will massage the cervix if this is not possible. This may cause some discomfort, pain or bleeding, but makes it more likely that you will go into labour naturally.

You should be offered a membrane sweep at your 40 and 41 week antenatal appointments during your first pregnancy, or your 41 week antenatal appointment if you have had a baby before. If labour does not start after this you can ask for additional membrane sweeps. If you go into labour after a
stretch and sweep, and wish to do so, you may be able to give birth at home or in a midwife-led unit.

If you are planning to breastfeed your baby, we also recommend that you start hand expressing colostrum 3 to 4 times per day, from 37 weeks of pregnancy. This helps prepare your body for labour and encourages the production of milk, ready for when your baby is delivered.

Hand expressing stimulates your milk production and makes it easier for you to feed after your baby is born. It can also stimulate the hormones which start labour, but not usually enough to mean you won’t need to be induced.

Colostrum is the first milk produced. It contains higher levels of antibodies, to help protect your baby from infection. Any colostrum collected can be frozen for use after your baby is born. To find out more about this please speak with your midwife.

Before you are induced

If you and your midwife/obstetrician decide your labour should be started artificially, the midwife will check your baby’s heartbeat beforehand using a cardiotocograph (CTG). This involves two sensors being attached to your tummy with elastic straps. The doctor or the midwife will also carry out an internal examination to check your cervix.
**What happens during the induction?**

**Prostaglandins**

During an induction, you will be given drugs which act like the natural hormones (prostaglandins) that kick-start labour. A gel or tablet containing these prostaglandins will be inserted into your vagina during an internal examination. Your cervix should then be re-examined again 6 hours later, to see if it has softened, shortened and opened. As the cervix changes, your womb may start to contract. This may start your labour off without further intervention.

If there are no changes, you may either be given another application of gel/tablet or have your waters broken. This is called amniotomy (see next section).

Your baby’s heartbeat will be checked again when contractions begin. Your midwife may then switch to using a small handheld device (Sonicaid) to check your baby’s heartbeat at regular intervals or your baby’s heart rate will be continuously monitored using the cardiotocograph (CTG).

If your pregnancy is otherwise low risk and you go into labour following just one dose of prostaglandin gel/tablet, you may be able to use the birthing pool and/or give birth in the Spires Midwifery Unit.

**Amniotomy** (breaking the waters)

This is a method of induction in which a healthcare professional artificially breaks your waters during an internal examination. It is carried out if either you haven’t gone into labour within 6 hours of the first prostaglandin gel/tablet and your cervix is soft and starting to dilate (open), or by the morning after the second application of prostaglandin gel/tablet. The timing of this will depend on how busy the delivery suite is.

If your obstetrician thinks there may be specific problems with using prostaglandins, such as very frequent or very long
contractions, you may be offered an amniotomy without prostaglandins. If your pregnancy is otherwise low risk and you have only had one dose of prostaglandin you may be able to use the birthing pool following an amniotomy.

**Syntocinon (oxytocine) drip**

If you are not in labour 1-2 hours after the amniotomy, this drug will be given to you as a continuous intravenous infusion drip. It is a synthetic hormone designed to cause contractions. The midwife will increase the dose slowly until you are contracting regularly and strongly. Your baby’s heartbeat will need to be continually monitored on a CTG if you are given Syntocinon and you won’t be able to use the birthing pool. Your midwife will help you to keep moving around and to be as comfortable as possible.

**Pain relief**

Induced labours are often more painful than spontaneous labours. You should be encouraged to use your own coping strategies and your midwife will support you. They will offer you whatever pain relief is appropriate to you, in the same way as if your labour had started naturally.

Labouring in a birthing pool can be helpful if your pregnancy is otherwise low risk and you go into labour following just one dose of prostaglandin gel/tablet or an amniotomy. Some women opt for an epidural. Your obstetrician or midwife will be able to give you more detailed advice on the pain relief options available to you.
If the induction doesn’t work

If you don’t go into labour after an induction, your midwife or obstetrician will discuss this with you and check on you and your baby thoroughly. If your waters are still intact it may be possible to stop the induction process and allow you to go home after a period of monitoring. Alternatively, they may offer you a further dose of prostaglandin.

In some circumstances (particularly if your waters have been broken and you have had a Syntocinon drip) a caesarean section may be recommended if the induction process has failed.

What happens if I choose not to be induced?

If you decide you would prefer to continue your pregnancy beyond 42 weeks we will discuss a plan of care with you. This plan will include:

• an explanation of the risks
• a request that you should continually monitor your baby’s movement pattern
• an arrangement to meet an Obstetric Consultant, who will help to develop your plan of care
• an appointment at the Day Assessment Unit for monitoring.

Your appointment at the Day Assessment Unit will involve:

• measurement of blood flow in the baby’s cord (umbilical artery Doppler study)
• heartbeat monitoring (CTG).
Further information

For further information or advice, please telephone:
John Radcliffe Maternity Assessment Unit: 01865 220 221
John Radcliffe Delivery Suite: 01865 221 988

If you have a specific requirement, need an interpreter, a document in Easy Read, another language, large print, Braille or audio version, please call 01865 221 473 or email PALS@ouh.nhs.uk