WHO recommendation on induction of labour for women beyond 41 weeks of gestation

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Recommendation

Induction of labour is recommended for women who are known with certainty to have reached 41 weeks (>40 weeks + 7 days) of gestation.

(low-quality evidence, weak recommendation)

Publication history

First published: February 2011

Updated: prioritized for updating in 2018

Assessed as up-to-date: February 2011

Remarks

- This recommendation does not apply to settings where the gestational age cannot be estimated reliably.

Background

Induction of labour is defined as the process of artificially stimulating the uterus to start labour (1). It is usually performed by administering oxytocin or prostaglandins to the pregnant woman or by manually rupturing the amniotic membranes. Over the past several decades, the incidence of labour induction for shortening the duration of pregnancy has continued to rise. In developed countries, the proportion of infants delivered at term following induction of labour can be as high as one in four deliveries (2-4).

Over the years, various professional societies have recommended the use of induction of labour in circumstances in which the risks of waiting for the onset of spontaneous labour are judged by clinicians to be greater than the risks associated with shortening the duration of pregnancy by induction. These circumstances generally include gestational age of 41 completed weeks or more prelabour rupture of amniotic membranes, hypertensive disorders, maternal medical complications, fetal death, fetal growth restriction, chorioamnionitis, multiple pregnancy, vaginal bleeding and other complications.
Although currently available guidelines do not recommend this, induction of labour is increasingly being used at the request of pregnant women to shorten the duration of pregnancy or to time the birth of the baby according to the convenience of the mother and/or health-care workers (5, 6).

Methods

The recommendation was developed using standardized operating procedures in accordance with the process described in the “WHO handbook for guideline development”, guided by the GRADE approach (7, 8). Outcomes used for this recommendation were aligned with the prioritized outcomes from the WHO recommendations on induction of labour (2011). (9)

A Cochrane systematic review was conducted, on induction of labour at or beyond term. (10) In the review, randomized controlled trials relevant to the key question were screened by review authors, and data on relevant outcomes and comparisons were extracted. Evidence profiles (in the form of GRADE tables) were prepared for comparisons of interest, including the assessment and judgments for each outcome, and the estimated risks.

WHO convened a Guideline Development Group (GDG) meeting on recommendations induction of labour in April 2010, where this recommendation was developed. The GDG comprised of a group of independent experts, who used the evidence profiles to assess evidence on effects on the pre-specified outcomes. GDG members discussed the balance between desirable and undesirable effects, overall quality of supporting evidence, values and preferences of stakeholders, resource requirements, cost-effectiveness, acceptability, feasibility and equity, to formulate the recommendation. Remarks were added to clarify the recommendation, and aid implementation.

Recommendation question

For this recommendation, we aimed to answer the following question:

- in pregnant women at or beyond term (P), does induction of labour (I), compared to no intervention, (C), improve maternal and perinatal outcomes (O)?

Evidence Summary

Evidence related to induction of labour at term and beyond term was extracted from one Cochrane systematic review of 22 randomized controlled trials. (10) Most of the trials were judged by the Cochrane review authors to likely have a moderate risk of bias, largely due to unclear concealment of allocation and generation of the sequence of randomization. The trials had evaluated the effect of inducing labour at 37–40 weeks, 41 completed weeks, and 42 completed weeks of gestation, and the intervention was compared with expectant management with fetal monitoring at varying intervals.
There were no statistical and clinical differences in the priority comparisons and outcomes, except for a reduction in perinatal deaths when labour was induced at 41 completed weeks. A total of 12 studies had compared the incidence of perinatal deaths at 41 weeks. The total number of women included in this comparison (labour induction versus expectant management with fetal monitoring at 41 completed weeks) was 6274. Only eight perinatal deaths occurred in the 12 trials, all in the expectant management group. The resulting relative risk (RR) was 0.27, with the 95% confidence interval (CI) being 0.08–0.98 (EB Table 1.1.1).

Implementation considerations

- The successful introduction of this recommendation into national programmes and health-care services depends on well-planned and participatory consensus-driven processes of adaptation and implementation. The adaptation and implementation processes may include the development or revision of existing national guidelines or protocols based on this recommendation.
- The recommendation should be adapted into a locally appropriate document that can meet the specific needs of each country and health service. Any changes should be made in an explicit and transparent manner.
- A set of interventions should be established to ensure that an enabling environment is created for the use of the recommendations (including, for example, the availability of induction agents and monitoring capacity), and that the behaviour of the healthcare practitioner changes towards the use of this evidence-based practice.
- In this process, the role of local professional societies is important and an all-inclusive and participatory process should be encouraged.

Research implications

The GDG identified that further research on the following high-priority questions is needed:

- What risks (for both the mother and the fetus) are associated with induction of labour and, in terms of those risks, how does induction of labour compare with elective caesarean section? What is the role of caesarean section in the management of women in whom induction of labour has failed?
- In settings where reliable gestational age determination is problematic, what should be the policy for labour induction at term and post-term?

Related Links

- [WHO recommendations on induction of labour](#) (2011) – full document and evidence tables
- [Pregnancy, Childbirth, Postpartum and Newborn Care: A guide for essential practice](#)
- [Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors (2nd ed)](#)
- **Supporting systematic review/s:**
  - [Gulmezoglu AM, Crowther CA, Middleton P. Induction of labour for improving birth outcomes for women at or beyond term. Cochrane Database Syst Rev. 2006;4.](#)
References


Citation