WHO recommendation on outpatient induction of labour

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Recommendation

Outpatient induction of labour is not recommended for improving birth outcomes.

(Low-quality evidence, Weak recommendation)

Publication history

First published: February 2011

Updated: No update planned

Assessed as up-to-date: February 2011

Remarks

- The participants in the consultation noted that research is ongoing on this issue. They placed a high value on safety issues and choose to recommend against the practice of outpatient induction of labour until new information becomes available.

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) During induction of labour, the woman has restricted mobility and the procedure itself can cause discomfort to her. To avoid potential risks associated with the procedure, the woman and her baby need to be monitored closely. This can strain the limited health-care resources in under-resourced settings. In addition, the intervention affects the natural process of pregnancy and labour and may be associated with increased risks of complications, especially bleeding, caesarean section, uterine hyperstimulation and rupture and other adverse outcomes. (2, 7)

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 comparing outpatient with inpatient induction of labour was conducted. (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 during induction of labour (P), outpatient care (I), compared to inpatient care, (C), improves maternal and perinatal outcomes (O)?

Evidence Summary

Three small trials that had compared outpatient with inpatient induction of labour have been included in a systematic review (10) and comprise randomized-controlled-trial-based evidence related to the choice of setting for induction of labour. Each of these trials had used a different method for induction of labour: vaginal prostaglandin E2 (201 participants), controlled-release vaginal prostaglandin E2 (299) and Foley catheter (111 participants).
None of the trials found any statistically significant differences between inpatient and outpatient induction of labour with regard to the priority outcomes. However, with the use of vaginal prostaglandin E2 (without the controlled-release function), there was a non-statistically significant increased risk for all priority outcomes. The available evidence is still too sparse to issue a recommendation regarding outpatient induction of labour for improving birth outcomes (EB Tables 3.1.1 and 3.1.2).

**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:

- In under-resourced settings with weak health systems and staff shortages, how can effective monitoring of women be ensured during induction of labour?

**Related Links**


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:


**References**


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Citation


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