Induction of labour in women at or beyond term

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Summary

Induction of labour (artificially initiated labour) is becoming more common worldwide. Up to 25% of women in developed countries undergo induction, while in developing countries these are generally rates are generally lower, but increasing. Induction of labour is not risk-free and many women find it to be uncomfortable. These guidelines were developed in order to promote evidence-based practice in inducing labour to improve maternal and newborn outcomes worldwide.

The WHO recommendations for Induction of Labour (2011) contain recommendations on the timing and methods of induction and management of adverse events related to induction of labour.

WHO 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.)

- The above recommendation does not apply to settings where the gestational age cannot be estimated reliably.
- There is insufficient evidence to recommend induction of labour for uncomplicated pregnancies before 41 weeks of pregnancy.

- WHO recommendations for induction of labour
- Evidence base and GRADE tables

Evidence for this WHO recommendation was extracted from the Cochrane reviews below:


Abstract

As a pregnancy continues beyond term the risks of babies dying inside the womb or in the immediate newborn period increase. Whether a policy of labour induction at a predetermined gestational age can reduce this increased risk is the subject of this review.

To evaluate the benefits and harms of a policy of labour induction at term or post-term compared with
awaiting spontaneous labour or later induction of labour.

We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (31 March 2012).

Randomised controlled trials conducted in women at or beyond term. The eligible trials were those comparing a policy of labour induction with a policy of awaiting spontaneous onset of labour. Cluster-randomised trials and cross-over trials are not included. Quasi-random allocation schemes such as alternation, case record numbers or open random-number lists were not eligible.

Two review authors independently assessed trials for inclusion. Two review authors independently assessed trial quality and extracted data. Data were checked for accuracy. Outcomes are analysed in two main categories: gestational age and cervix status.

We included 22 trials reporting on 9383 women. The trials were generally at moderate risk of bias.

Compared with a policy of expectant management, a policy of labour induction was associated with fewer (all-cause) perinatal deaths: risk ratio (RR) 0.31, 95% confidence interval (CI) 0.12 to 0.88; 17 trials, 7407 women. There was one perinatal death in the labour induction policy group compared with 13 perinatal deaths in the expectant management group. The number needed to treat to benefit (NNTB) with induction of labour in order to prevent one perinatal death was 410 (95% CI 322 to 1492).

For the primary outcome of perinatal death and most other outcomes, no differences between timing of induction subgroups were seen; the majority of trials adopted a policy of induction at 41 completed weeks (287 days) or more.

Fewer babies in the labour induction group had meconium aspiration syndrome (RR 0.50, 95% CI 0.34 to 0.73; eight trials, 2371 infants) compared with a policy of expectant management. There was no statistically significant difference between the rates of neonatal intensive care unit (NICU) admission for induction compared with expectant management (RR 0.90, 95% CI 0.78 to 1.04; 10 trials, 6161 infants). For women in the policy of induction arms of trials, there were significantly fewer caesarean sections compared with expectant management in 21 trials of 8749 women (RR 0.89, 95% CI 0.81 to 0.97).

A policy of labour induction compared with expectant management is associated with fewer perinatal deaths and fewer caesarean sections. Some infant morbidities such as meconium aspiration syndrome were also reduced with a policy of post-term labour induction although no significant differences in the rate of NICU admission were seen.

However, the absolute risk of perinatal death is small. Women should be appropriately counselled in order to make an informed choice between scheduled induction for a post-term pregnancy or monitoring without induction (or delayed induction).

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