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Ready or not here comes your induction!

A policy to delay induction of labour in low risk women to reduce caesarean section rates.

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What is induction of labour?

Induction of labour (IOL) is a cost effective interventional procedure used to stimulate the onset of labour and is usually offered to pregnant women with diagnosed morbidities, women carrying a twin or multiple pregnancy or from 41 weeks gestation. IOL can reduce fetal compromise, stillbirth and promote better birth outcomes.


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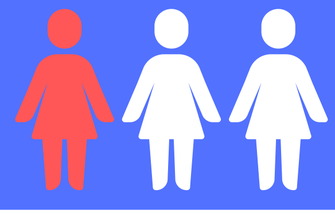
Most common induction methods:

- Prostaglandins for cervical ripening.
- Artificial rupture of membranes (ARM).
- Continuous infusion of artificial oxytocin delivered intravenously.

1 in 3 women are induced each year in Australia



Suggested amendments to current IOL guidelines to reduce CS rates.

- Induction is not to be offered prior to 41+3 weeks gestation for low risk women.
- The MBS of 6 is to be increased to 8 with particular focus on cervical "ripeness".
- Women have the right to decline any intervention, these rights are to be supported with no room for clinician bias and preference related to IOL.
- Clinicians are required to seek a second opinion with full disclosure of the woman's current circumstances prior to booking IOL.
- Women are to be provided with access to comprehensive, evidence-based information on **ALL** risks and benefits and time for discussion and questions with a clinician.
- In respecting women's autonomy, clinicians are not to make decisions for women but rather make them with women when developing or altering a birthing care plan.

Risks associated with induction

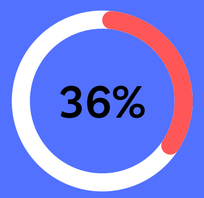
- Cord prolapse.
- Increased stay in hospital.
- Repeated induction if failure occurs.
- Increased frequency of vaginal examinations.
- Uterine hyperstimulation.
- Caesarean section.

The ARRIVE trial

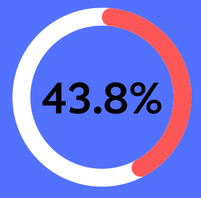
The ARRIVE trial was a randomised trial completed in 2018 by researchers in the US and was designed to determine whether induction from 39 weeks gestation would result in lower rates of death or fetal compromise in the newborn compared with expectant management of labour; and whether induction at this gestation influenced caesarean section rates. Only women agreed to participate in the trial with 3,062 women assigned to induction at 39 weeks gestation and 3,044 women assigned to expectant management.

The results of the trial found that IOL performed on women at 39 to 40 weeks gestation (over expectant management), reduced the rates of caesarean section (18.6% vs 22.2%; relative risk (RR) 0.84; 95% CI 0.76–0.93). These findings had a substantial global impact on when obstetric clinicians in high income countries should routinely offer IOL to women, including those who were deemed low risk.

Australian Caesarean Section Rates



ACT Induction rates



ACT caesarean section rates

Background and research

Research has found that offering IOL too early or without medical indication increases the likelihood of associated risks, fetal compromise and of caesarean section (CS) being the birth outcome. Offering IOL to women who are deemed low risk (in that their pregnancies are uncomplicated with no existing or diagnosed complexities) is not recommended as it exposes them to unnecessary and avoidable interventions. IOL should be delayed and spontaneous labour supported for these women to promote the best possible birth outcomes.

Studies have found that following IOL, women were at more risk of fetal compromise and having a CS than those going into spontaneous labour (26.5 and 12.5 % respectively (OR 2.54, 95 % CI 2.4, 2.7, $p < 0.001$). However, studies on IOL are divided with some finding no increase in CS rates following IOL, while some found CS rates increased significantly. The studies all mentioned the ARRIVE trial in 2018, with some drawing on its results to determine their findings, and all studies included nulliparous and multiparous women as participants. Parity can affect IOL success dramatically with multiparous women more likely to complete a vaginal birth following IOL. One study by Mahomed et al (2016), found that 42% of nulliparous women birthed via a CS following unsuccessful IOL compared to 14% for multiparous women.

Ways to promote a successful IOL and avoid births by CS are to delay IOL to a gestational age of 41+3 weeks (unless medically indicated) and to ensure the woman's cervix is appropriately ripe and well positioned.

Current guidelines require a cervical assessment using a Modified Bishop's Score (MBS) to determine the cervical viability (dilation, softness, length and position), prior to attempting the IOL. The minimum MBS required is 6 but a higher score increases the safety and success of the IOL. An unfavourable (low) MBS at the commencement of IOL was found to be primarily related to increased risk of CS (Mahomed, Pungsornruk, & Gibbons, 2016).

Overall women who received an IOL reported poorer birth experiences, and many felt that decisions regarding their IOL were made for them and not with them, making them feel as though they were forced to accept the offer of the IOL. One study reported that women also felt confused by the conflicting and varied information they were provided with by each clinician they spoke to. This issue must be addressed if we are to support women's autonomy.

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