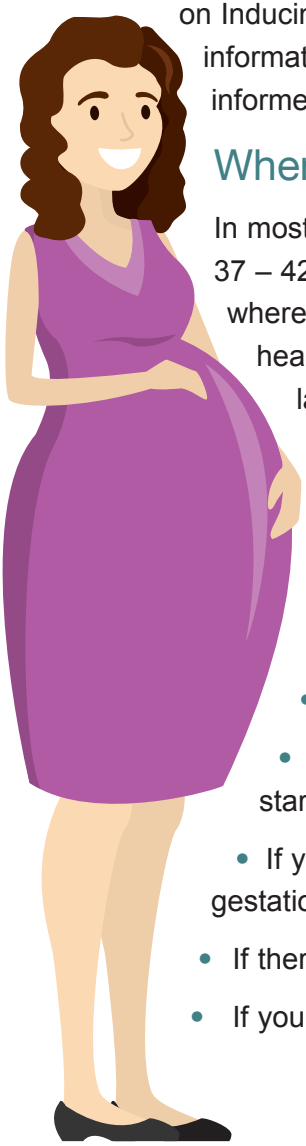
Belfast Health and Social Care Trust

caring supporting improving together

Induction of Labour (IOL)

– what you need to know

Induction of labour is a process that is used to start labour artificially. There are different methods that can be used which stimulate the cervix (neck of the womb) to soften and open and the womb (uterus) to contract. This leaflet is informed by the National Institute for Health and Care Excellence (NICE) Guidelines on Inducing Labour (2021) and provides you with the information that you should have so that you are fully informed and supported in your decision making.



When is induction of labour advised?

In most pregnancies, labour starts on its own between 37 – 42 weeks. However, there are some situations where it may be beneficial for you and your baby's health for labour to be started by induction of labour.

There are a number of reasons when induction would be offered or advised. These may include:

- If you have pre-eclampsia or high blood pressure
- If you have diabetes
- If your waters break and contractions do not start on their own
- If your baby is thought to be small for its gestational age or there is a slowing of baby's growth
- If there are concerns around your baby's movements
- If you are overdue (40 weeks + 7 days).

The NICE Guidelines state that women should be informed that induction is a medical intervention that can affect their birth options and experience of the birth process.

Anyone who is being advised about induction should be informed that:

- Vaginal examinations are needed before and during induction to determine the best method of induction and to monitor progress
- Choice of place of birth will be limited as some recommended interventions are not available for home birth or in midwife-led birth units
- There may be a need for forceps or vacuum birth, which can, in turn, lead to increased risk of more severe tearing
- Some medicines used for induction can cause the womb to contract too frequently or contractions to last too long which can lead to changes in the baby's heart rate and increased risk for the baby
- An induced labour may be more painful than a spontaneous labour
- It could take hours or days for labour to start and baby to be born once the process has started
- Your hospital stay may be longer than with a spontaneous labour.

Discussions should also include:

- The reason induction is being offered
- The process of induction, and the risks and benefits of induction of labour
- Options for support and pain relief

- The alternative options if you decide not to have induction of labour, or decide at a later stage that you no longer wish to proceed with the induction process
- That induction may not be successful and what steps would be considered next.

You should have the opportunity to discuss the reason(s) that induction is being recommended or offered, the benefits and risks of induction for you and your baby as well as any alternatives with your midwife or obstetrician. You should then have the time to ask questions and consider your options so that you can make an informed decision about the right path for you.

Membrane sweep

A membrane sweep can be done at home, at an antenatal clinic appointment or in hospital; you may be offered this before other methods are used, although it is not recommended if your membranes have ruptured (waters have broken). Membrane sweeping involves your midwife or obstetrician placing a finger just inside your cervix and making a circular, sweeping movement to separate the membranes from the cervix. The sweep may cause discomfort and slight bleeding but will not cause any harm to you or your baby.

A membrane sweep has been shown to increase the chances of labour starting naturally and can reduce the need for other methods of induction of labour.

How is labour induced?

Each stage and method of the induction process should be discussed with you, including how it is done and the risks and benefits, and you are able to accept or decline any method or accept or decline at any point in the process.

There are different ways of inducing labour, and the process is individualised to each woman. Some women may need all steps and some only one. The methods are briefly explained below, but all should be fully explained by your midwife or obstetrician.

3 steps to inducing labour:

1. Ripening (softening and opening) the cervix (neck of the womb)
2. Artificial Rupture of Membranes (ARM) – manually breaking your waters
3. Syntocinon (artificial oxytocin) infusion (given via a drip in your arm or hand).

1. Ripening (softening and opening) the cervix

Mechanical

Foley catheter (balloon) is used as a mechanical ripening device. It is placed by performing a vaginal examination and inserting the tube housing the balloon of the catheter above the cervix. The balloon is then inflated with sterile water and is positioned to sit on top of the cervix.

This encourages the cervix to dilate and when it is open enough, the balloon will drop out of the cervical opening and into the vagina. There is no time limit on how long this will take to happen; however, the balloon will normally have worked within 24 hours.

It may cause you to experience lower abdominal cramps. These can be managed by mobilising, changing position or taking a warm bath.

Outpatient IOL

Some women who have a Foley catheter inserted will be suitable for outpatient care. These women can return home after the Foley catheter is inserted and asked to return when the Foley catheter has come out; this means the cervix has dilated (opened) enough to allow an ARM to be performed. They will be able to contact the IOL team via a mobile at any time for advice.

Pharmaceutical

If the cervix is completely closed or having a Foley catheter inserted is not advised, Dinoprostone 10mg (Propess) in the form of a pessary can be used to soften the cervix. It is inserted behind the opening of the cervix by a vaginal examination, and contains hormones (prostaglandins) that stimulate the cervix to soften and open.

The pessary is attached to tape which can be felt on the outside of the vagina. The pessary should be left in place for 24 hours.

Women having pharmaceutical induction will not be suitable for outpatient care, as it is recommended that they have extra monitoring.

2. Artificial Rupture of Membranes (ARM) – manually breaking the waters

When the cervix is soft and dilated, artificially breaking the membranes to release the waters around baby can be performed. This is done during a vaginal examination using a sterile plastic hook called an amnihook.

3. Syntocinon (artificial oxytocin) Intravenous (IV) Infusion

Syntocinon is given through an IV drip (released directly into your bloodstream through a small tube placed in your arm or hand) in the delivery suite. It is artificial oxytocin that causes the uterus to contract. The dose is started at the lowest level and is increased slowly at intervals until a strong and regular contraction pattern happens. The rate of the drip can be adjusted or turned off if either your body takes over labour on its own or the drip is causing the uterus to contract too much. While you are being given the syntocinon, it will be recommended that your baby's heartbeat is monitored continuously via Cardiotocography (CTG) this is done by wearing a monitor on the abdomen which is secured by an elastic belt; this monitor is connected to a machine that will give a continuous reading of baby's heart rate.

Women who wish to labour and birth in a pool while having a syntocinon drip should be supported to do so with the use of telemetry monitoring (wireless CTG – continuous monitoring of your baby's heartrate).

Occasionally, the process of induction does not work and labour fails to start. If this happens, your midwife or obstetrician will discuss your options with you to support your decision on how to proceed.

BT22-2846
November 2022 Review date 2025