Induction of Labour (Induction): Information Brochure and Decision Aid

What is this Document?

This document is designed to help **you decide** what to do if you need some help to start the birth of your baby. This is called induction of labour (Induction). This leaflet has been created to help you, and your family understand:

1. what induction is
2. why you are offered induction
3. what your choices are
4. what are the potential benefits and risks
5. what to expect during the induction process.

This will be helpful to read earlier on in your pregnancy in case you need to make a choice about induction in the future. **It is IMPORTANT to share and discuss this information with your birthing partners so that they are aware of what to expect.**

What is Induction?

Generally, labour will start spontaneously between 37- 42 weeks 'gestation (Appendix 1). However, sometimes labour may need to be started artificially, this is known as Induction.

Induction is a process where a drug or procedure is used to artificially start your labour. This is a medical intervention aimed to soften and dilate your cervix.

There are different ways that labour can be induce and you may need to try more than one method. This leaflet provides information on the different methods of induction that may be offered to you in Swansea Bay.

It is usually best for your labour to start naturally but for some people induction is recommended when the risks of the pregnancy continuing, may be greater than the risks of you remaining pregnant.

In the UK approximately 33% of women and birthing people will have their pregnancies induced (NHS Digital, 2023).

Why is Induction offered?

There are various reasons why induction may be offered to you. Some of the most common reasons are:

1. For prolonged pregnancy
2. If your waters break and your labour does not start spontaneously within 24 hours. Most people labour spontaneously within 24 hours however, if they don't then induction is recommended due to the slight increase in the chance of infection, which increases from 0.5% to around 1%.
3. You have a medical complication such as diabetes, high blood pressure or intrahepatic cholestasis of pregnancy
4. There are concerns for your baby, such as problems with growth
5. If your baby's pattern of movements has changed
6. Maternal age
7. Multiple pregnancy
8. Raised Body Mass Index (BMI)
9. Other concerns such as bleeding, severe infection, Group B Streptococcus (GBS) or meconium-stained liquor

This list is not exhaustive, and induction may be offered for other clinical reasons that would be discussed with your obstetrician.

Your health and your baby's wellbeing are always our top priorities. The decision to induce labour will only be made after a thorough discussion between you and your obstetrician, and only with your informed consent.

If you decide not to be induced, you may require closer monitoring for the remainder of your pregnancy. More information on this is provided in this leaflet.

You may have a slightly higher chance of stillbirth if they remain pregnant past a certain gestation. Your doctor and midwives will discuss this with you based on an assessment of your stage of pregnancy, ethnicity, history, health and lifestyle choices. (NICE, 2021) (Appendix 3).

You do not have to accept any procedure if you don't want to. It is ALWAYS your decision. You can also change your mind about the options you choose at any point. You can still discuss your options once the induction has started.

When you are thinking about planning your pregnancy, labour and birth, you may find it helpful to use this 'BRAIN' acronym to talk with your midwife or doctor.

They will be happy to give you information to help you make choices that are right for you.

#useyourBRAIN

Benefits	What are the benefits of doing this?
Risks	What are the risks involved?
Alternatives	Are there any alternatives?
Intuition	What is my gut feeling?
Nothing	What if we did nothing or waited a while?

Potential benefits and risks of induction

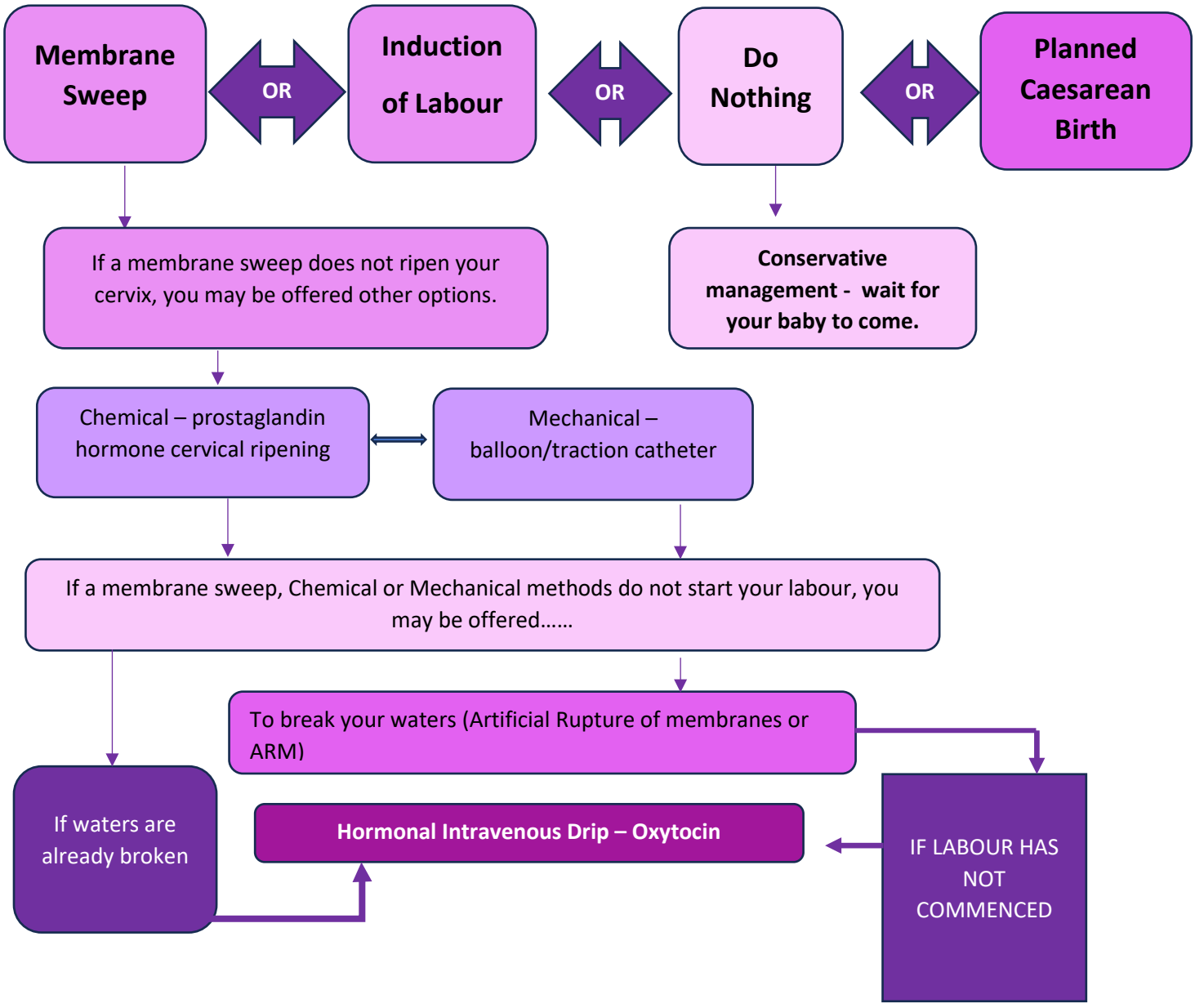
The risks of induction, watching and waiting, or a planned caesarean birth will depend on the reason you're being offered induction and your own personal circumstances.

- Induction may prevent infection when your waters have ruptured but you haven't gone into spontaneous labour.
- It may prevent stillbirth.
- It may prevent further complications with existing obstetric or medical conditions.
- It may prevent the risk associated with increased risk of caesarean birth.

However, an induction of labour is a medical intervention that will affect your birth options and your experience of the birthing process. This could include:

- If your pregnancy has been straightforward, your chance of a vaginal birth with no interventions is highest if your labour starts spontaneously and you plan to birth in a midwifery led care setting.
- Your choice of birthplace will be limited as you may be recommended interventions such as oxytocin infusion or continuous monitoring of the baby's heart rate in labour.
- You may be less likely to use the birthing pool.
- You may be more likely to need an assisted vaginal birth (using forceps or ventouse), which has an increased risk of severe vaginal tear (obstetric anal sphincter injury)
- Induced labour may be more painful that spontaneous labour.
- You may require stronger analgesia such as an epidural.
- You may need to stay in hospital for a longer period.

What are your choices?



Alternative and complementary options

There are some alternative and complementary options when labour does not start spontaneously. However, the evidence and literature around these tend to be low grade and more research is needed to conclude if these are effective options:

Keeping active – Keeping mobile and active can help to encourage labour to start, as it encourages your baby's head into the pelvis, placing pressure onto the cervix which encourages oxytocin (a natural hormone which helps to stimulate contractions) to release and aids cervical dilation.

Biomechanics – biomechanics is the practice of supporting physiological birth by relaxing and releasing muscle tension, which helps to create more space in the pelvis, encouraging your baby into an optimal position for birth. Speak to your midwife or health care assistant for more information.

Sexual Intercourse - when your waters are yet to break, sexual activity may help release oxytocin. Prostaglandins are also present in semen.

Nipple stimulation – Nipple stimulation from 36 weeks onwards, or hand expressing can help to release oxytocin. Ask your midwife or health care assistant for any advice or support.

Membrane Sweep – Before being induced you may be offered or could request a membrane sweep. This in an internal examination that may encourage your labour to start naturally and reduce the need for induction. Research suggests that women and birthing people who have membrane sweeps are less likely to need induction.

A midwife or doctor will place a finger inside your cervix and make a circular or sweeping motion, sweeping the membranes to separate them from the cervix. This stretches the cervix and releases a natural hormone called prostaglandin which increases the chance of labour starting spontaneously. As part of routine care, you may be offered a membrane sweep from 39 weeks depending on your individual situation. If your labour does not start within 48 hours another sweep can be offered.

This procedure can be uncomfortable, and you may notice a small amount of blood or a show following the sweep. This is a mucoid discharge that is sometimes bloodstained. This show or plug is what seals the opening of the cervix and can be lost several days before labour starts. This is normal and nothing to be concerned about.

Planned caesarean birth – Planned caesarean birth will need to be discussed with your medical team as this may increase the chance of complications during your birth and in future pregnancies. Your clinician can discuss these complications in more depth

Wait for your baby to come naturally, do nothing – If you decide against induction, you will be offered additional monitoring and tests. These tests will not be able to predict stillbirth but will help to identify any changes that might increase the risk of stillbirth.

Some risks associated with prolonged pregnancy may increase over time. These include the need for a caesarean birth, the likelihood of the neonate requiring admission to the neonatal unit and the chance of stillbirth and neonatal death. Scan QR code for more information.

You can contact your midwife or doctor if you change your mind at any point or have any concerns you wish to discuss.

Induction methods

There are various ways in which your labour can be induced, and this will depend on various factors. When considering which method will be used your medical history, current pregnancy history, previous pregnancy and mode of delivery and the findings from your vaginal examinations will all be considered. Advice regarding the best option for you provided by your care provider. Some of these methods can be uncomfortable and can cause a small amount of bleeding. This is normal and nothing to be concerned about. Analgesia options are available if required. Please speak to your midwife or obstetrician.

Membrane Sweeping can be offered prior to Induction of Labour. However, if membrane sweeping does not start your labour, you may be offered alternative options.

Chemical – Prostaglandin hormonal cervical ripening

Prostaglandin helps to prepare your cervix. The two forms of prostaglandin used are a Propess pessary or a Prostin gel. Propess looks like a small, flattened tampon attached to a ribbon that is inserted into your vagina behind the cervix. It slowly releases prostaglandin over 24 hours and during this time you may experience some pain and contractions. Prostin gel is also inserted into the vagina behind the cervix. You may need more than one dose of this gel, and it can be given 6 hrs apart. The midwife will need to monitor your baby's heart rate more frequently during hormonal methods of induction.

Mechanical

Mechanical method of induction can be offered. Our hospital uses a balloon catheter for this method. The catheter is inserted through the cervix which has a small balloon at the top. The balloon is filled with water once inserted through the cervix. The catheter is taped to the thigh to add some tension. This encourages the cervix to open by putting pressure on the internal opening of the cervix. When your cervix has dilated enough the balloon will fall out or removed after 24 hours. This procedure can be discussed with your clinician.

Breaking your Waters – Artificial Release of Membranes (ARM)

Occasionally women are suitable to have their waters broken on admission and will not require any induction methods. Once your cervix is open enough, a vaginal examination is performed, and a small hole is made in the membranes to break the waters around your baby. The process may be uncomfortable but will not harm your baby. You may feel a gush of fluid following this. You will be given time to mobilise, to encourage prostaglandin release and contractions. An ARM needs to be performed on labour ward, we aim to transfer you to labour ward in a timely manner, however, when it is busy it can take longer. Please be reassured that we will get you to labour ward for ARM as soon as it is safe to do so.

If membrane sweeping, prostaglandins or mechanical methods do not start to prime the neck of the cervix, you may be offered another option

Other options:

A second round of vaginal Prostaglandins

Mechanical method if not already attempted

A rest day

Hormonal Intravenous Drip

Once your waters are broken the hormone Syntocinon (synthetic oxytocin) is given through a drip into your vein, to start or maintain contractions. You will be offered continuous monitoring of your baby's heart rate, to check your baby is coping with this form of induction. This also monitors your contractions to ensure they are not too long or frequent, which can happen during Induction of Labour in comparison to spontaneous contractions.

Home Induction – Home induction may be offered for some women. If you are suitable, a risk assessment will be completed to ensure the criteria are met. If the risk changes, then you may not be suitable for this method of induction. The criteria for outpatients' induction are:

- Meets criteria for midwifery led care, therefore healthy woman and birthing person and uncomplicated pregnancy requiring induction for prolonged pregnancy
- Consultant led care where there is a clear care plan documented for outpatients' induction e.g. for predicted large for gestational age fetus or raised BMI
- Maternal request induction for social reasons after 39 weeks
- Three previous births or less with no history of precipitate birth
- Lives within 30 minutes of the maternity unit and has transport available
- Access to a telephone
- No language barrier or disability that might impair your ability to access care.
- Bishop score of less than 7 on vaginal examination (a system used to assess the ripeness of the cervix)
- Reassuring fetal heart rate monitoring pre prostaglandin administration
- Uncomplicated previous obstetric history

How long will it take?

The length of time induction takes will vary. The aim of induction is to soften and dilate your cervix enough to enable the clinician to break your waters, you will need time to respond to the medication before we can do this. This may mean having more than one induction method. Occasionally, the induction process may need to be repeated, particularly if you are an earlier gestation induction. It is important to consider that this can sometimes mean a prolonged stay in hospital.

When you are at the point your waters can be broken, we will transfer you to labour ward at the earliest opportunity. When the maternity department is busy, your induction may be placed on hold, which could result in delays. On very rare occasions, you may be waiting up to 7 days from admission until you are transferred to labour ward to have your waters broken (this is uncommon but could happen when labour ward is busy). Monitoring of you and your baby would continue until you are transferred to labour ward to have your waters broken.

On rare occasions the maternity unit can be extremely busy, and this could result in the start of your induction being delayed until later that day, or sometimes by 24-48 hours later. We may also look to other nearby maternity units to continue your induction when the unit is busy, and we are unable to proceed. We understand delays or postponement in the induction process can be frustrating and upsetting for you, but this is to ensure yours and your baby's safety.

What pain relief is available?

Pain Relief Options on Ward 19 during Induction	
Paracetamol and **Codeine**	For most, the usual options of **Paracetamol** and **Codeine** will help to manage pain.
Water immersion	Sitting in the warm water is known to aid relaxation and may help you to cope better with the induction process. We have several baths available on ward 19 for this reason. A warm shower can also be of benefit.
TENS machine	Can be brought into hospital use during their induction. These use electrical impulses to stimulate nerves during a contraction and work by blocking messages of pain to the brain.
Pethidine	This is an injection that is given into your thigh. It is an opioid analgesia which also crosses the placenta into your baby's blood stream. Pethidine can make you feel drowsy and can also have a temporary effect on your baby too. It can also make you nauseous and sometimes vomit. We can offer you anti-sickness medication at the same time to help with this. If you have Pethidine, you will not be able to use the pool for two hours following administration (because of drowsiness) or have Remifentanyl patient-controlled analgesia in labour. Remifentanyl is also an opioid, so cannot be given within 4 hours of Pethidine. There are other pain relief choices available on labour ward.

For more information on pain relief options see below QR codes:

Tens Machine

Pethidine

Staff are available to support you through the induction process, and you should use whatever pain relief is appropriate for you. There are other relaxation methods that will help you manage your pain, for example, breathing techniques and mobilisation.

Induction may impact on your choices of pain relief, and/or your choice of place of birth. You are more likely to request an epidural following induction compared to those who labour spontaneously. For this reason, you may wish to consider some changes to your birth plan regarding pain relief during induction.

Frequently asked questions of labour

Please take time to review these questions

What are my options if the induction process does not work?

If your cervix does not dilate enough to break your waters, or you do not go into labour, your midwife and obstetrician will discuss your options with you, based on factors such as medical history and pregnancy details. Depending on your history your options can include:

- 24hrs rest then a further round of prostaglandin medication
- Delay induction for a few days longer
- Planned caesarean birth

How long will my induction take? Will I give birth the same day?
It may take around three to five days for your induction to be effective, people react differently to the induction process. Occasionally the maternity department becomes very busy, and your induction may be delayed to keep you and your baby safe. On these occasions, the induction process can take up to seven days. It is not usual to labour and birth on the same day that their induction is started.

Do the hormones/ Induction establish labour?

No, the purpose of mechanical and chemical induction is to soften your cervix to allow it to open enough for us to be able to break your waters. However, for a small number of people it can result in you going into labour.

Hormone medication induction - When should the Propess be removed?
The Propess should remain in place even after contractions start, unless you are found to be in active labour. It is common to have tightenings which feel like contractions. These can be painful and you may require pain relief. Sometimes the prostaglandins cause your uterus to contract too frequently, which causes changes to the fetal heart rate on the CTG (a monitor to record your baby's heart rate and any uterine contractions). If this happens, the Propess will be removed. It is really important to keep the midwife caring for you informed of changes during the induction process, especially when your contractions start so a complete assessment can be undertaken. After 24hrs you will be asked to remove the Propess as it will not release any further prostaglandin after this time. If your waters break spontaneously while the propess is in place, you should notify your midwife and the propess will be removed.

What happens if the propess falls out?
On occasions, the Propess can fall out. When this happens, (if you are aware it's fallen out) please keep the Propess in tissue for the midwife to observe. If the Propess falls into the toilet, please inform the midwife. To help prevent the Propess falling out when using the toilet, please pat dry rather than wiping. Prior to reinsertion the midwife may need to monitor your baby's heartrate on a CTG. The medication may also need to be re prescribed by the doctors before insertion. When the maternity unit is busy there could be delays in having the medication re prescribed.

Why am I being offered induction when I go overdue?
There can be some additional risks should your pregnancy continue over 42 weeks' gestation.

- There is a small increased chance of caesarean birth.
- Your baby may be more likely need admission to a special care baby unit for care and treatment.
- The placenta may not function as effectively which may reduce the oxygen supply to your baby which can lead to fetal distress
- The chance of stillbirth or neonatal death shortly after birth increases very slightly (see appendix 2)

Although these risks do increase slightly in pregnancies which continue past 42 weeks, the overall risk remains low.

What, if any, is the increased risk of needing a c-section after having an induction?

The research from Randomised Controlled Trials (RCT) suggests there is no increased risk of caesarean section following induction after 37 weeks.

How does the medication used during induction affect the newborn baby. i.e. Does it make my baby sleepy and less likely to feed?

The prostaglandins used to induce labour do not make the baby sleepy or affect feeding. However, medications taken for pain relief during the induction process such as Codeine, Pethidine and Remifentanyl analgesia do cross the placenta and can make your baby sleepy after birth.

Can I go home during induction of labour?

If you are suitable for home induction you can go home for 24 hours, however this is not recommended for everyone. For most people who are being induced, it is not advisable for you to go home during the induction process. If your induction is prolonged, you may be offered the option to go home for a rest day. This will depend on your risk factors and reasons for induction

How can an induced Labour differ from a non-induced spontaneous labour?

Induction can be more painful than spontaneous labour because it can cause your uterus to contract more frequently. Sometimes if you are contracting too frequently you will need closer monitoring of your baby's heart rate. There are pain relief options available to support you during this time.

What happens if I have too many contractions?

On occasions the induction may cause your uterus to contract too frequently. If this happens let your midwife know as you will need to be monitored on the CTG to observe your baby's heart rate. If there are any concerns with the heart rate then the propess will be removed. You may be offered an injection into your arm to reduce the frequency of contractions and you may need to be transferred to labour ward for closer monitoring and observation. Prior to restarting your induction a plan will be made following a discussion with you and the obstetric team.

What do I need to bring into hospital to prepare for an Induction?

To make your stay more comfortable you may wish to bring some of the following items:

- iPad
- Books/magazines/colouring
- Extra pillows
- Earplugs
- Headphones
- TENS machine

  Please be mindful we do not advise you bring anything valuable into hospital with you as we do not have facilities to store these securely.

What if I decide that induction is not for me?

If you decide you do not wish to have your labour induced, you will be offered a discussion with an obstetrician to discuss this and to make a plan of care to meet your needs. We will

offer you increased surveillance monitoring your baby's heartrate, an ultrasound scan to check the blood flow through the placenta, and amount of amniotic fluid around your baby. This will only provide a snapshot of what is happening at that precise moment. It will not predict how your placenta will continue to function nor predict stillbirth. You can discuss this further with your obstetrician should you accept the further monitoring as part of your ongoing care plan.

Can I birth at home or in a midwife led unit?

Induced labour with medication (chemical) can affect your options for place of birth. Induction would prevent you from choosing to birth at home. If you are midwife led care throughout your pregnancy and meet the criteria for home induction, you may have the option to birth in the alongside midwife led unit (Bay Birth Unit, Singelton Hospital). If you require the hormone drip you will require continuous fetal heart rate monitoring which will need to be on an obstetric unit on the labour ward.

C**an my birth partner stay with me during the induction process?**

Yes your birth partner will be able to stay if you wish them to. Unfortunately, due to space constraints, there is only a chair for them to use during their stay and we would therefore recommend they go home to rest when they can. We do not provide refreshments or meals for your partner and recommend they bring snacks with them.

Visiting policy on ward 19 Antenatal Ward

Please visit our Swansea Bay University Hospital intranet page for the most up to date Maternity visiting policy

Can I move around freely in labour?

If you are given a hormone drip your baby's heart rate will need to be continuously monitored. We have wireless monitors available which can help you to remain mobile during labour. We also have peanut balls and birthing balls to support you with positional changes during induction, labour and birth.

Can I bring items in to make the birth environment more relaxing?

We always endeavor to help make your birth environment as calm and relaxing as possible. We are very happy for you to play your own music, bring battery operated candles, your own bedding and pillows etc. Please feel free to personalise your space.

Can I use the birthing pool during my labour and birth?

We have 3 pools within the maternity department. Two are situated in the Bay Birth Unit and one on the labour ward. Please be mindful that some reasons for induction or methods of induction may mean that the pool is not recommended. You can discuss this with your midwife or doctor.

When can't labour be induced?

Induction may not be an option for you if:

- Your baby is in the breech position.
- Placenta previa (where your placenta is covering your cervix).
- Active genital herpes
- Transverse fetal lie (where your baby is lying across rather than head down)
- In some cases of Intrauterine growth restriction (IUGR), (where your baby's growth has been affected by your pregnancy).

Appendices

Appendix 1 - Gestational age at which labour started, as a proportion of labours which started spontaneously.

Gestational age (weeks)	Proportion of spontaneous labours' that started at this gestational age	Cumulative proportion of spontaneous labours' that started by this gestational age.
31 weeks and under	2.4%	2.4%
32+ to 36+6 weeks	5.3%	7.7%
37+0 to 37+6 weeks	5.1%	12.8%
38+0 to 38+6 weeks	12.1%	24.9%
39+0 to 39+6 weeks	25.4%	50.3%
40+0 to 40+6 weeks	32.5%	82.8%
41+0 to 41+6 weeks	16.2%	99.0%
42+0 weeks and over	0.9%	100%

Data from Recommendations | Inducing labour | Guidance | NICE (NICE, 2021)

Appendix 2. Stillbirth rates in England and Wales by gestational age (measured in complete weeks)

Gestational age	Stillbirth rate per 1000 births
37 weeks	2.8
38 weeks	1.3
39 weeks	0.9
40 weeks	0.9
41 weeks	1.0
42 weeks and over	1.2

Postdates Induction of labour decision aid

This decision aid is part of a series of information leaflets on common reasons that an induction may be recommended for you, with the best available evidence, to help you make an informed decision about what feels right for you and your baby at this time. Please use this leaflet when discussing your birth plans during your antenatal appointments.

An induced labour is one that's started artificially. Around 3 out of 10 women are induced in the UK.

It's your choice whether to have your labour induced or not.

Why an induction might be recommended to you

- To reduce the likelihood of stillbirth if your pregnancy is longer than 41 weeks (called overdue or 'post-dates'). This is because of a concern that problems might develop or some risks to you or your baby (including stillbirth) might increase if the pregnancy were to continue beyond a certain number of weeks.
- If your baby doesn't seem to be moving
- to prevent infection if your waters have broken but you haven't gone into labour.
- If there's any risk to you or your baby's health. This risk could be if you have a health condition such as high blood pressure, for example, or your baby is not growing.

Induction of labour when your baby is overdue or 'post-dates'

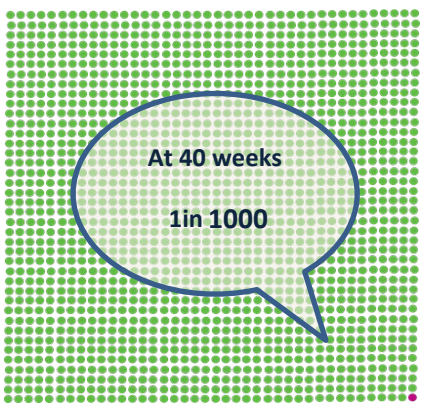
You have been provided with this leaflet to help you decide if a *post-dates* induction of labour is the right decision for you and your baby.

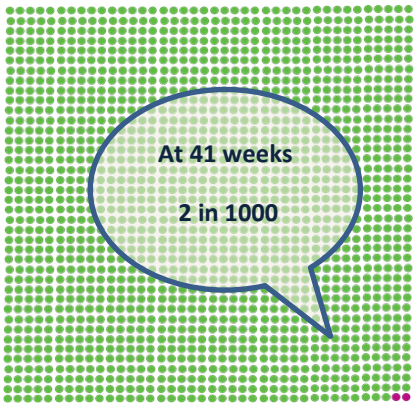
If your pregnancy has been straightforward, induction will be offered if you do not go into labour naturally by 41-42 weeks, as the risk of a stillbirth (when a baby dies before it is born) increases over time and having an induction ***from*** 41 weeks may reduce this risk.

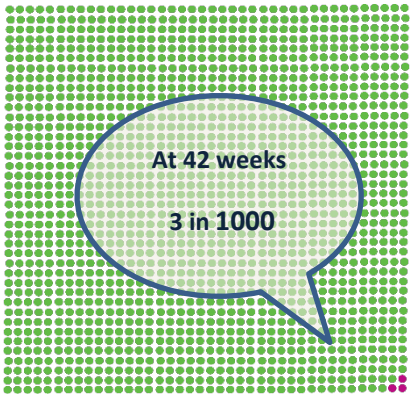
The quality of the evidence about whether there really is an increased risk in these situations, and if so whether induction would reduce it can vary, but the information in a recent (2019) UK review of stillbirth rates from 15 million births is the one most commonly used as a guide. This shows that the overall risk of stillbirth in every 1000 births is:

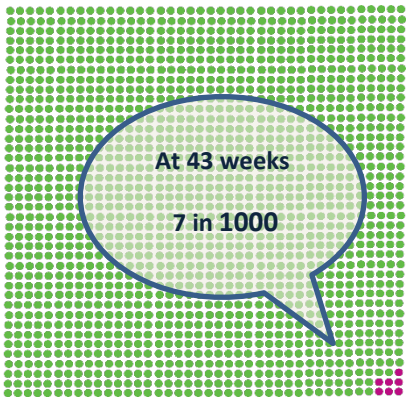
At 40 weeks 1 per 1000 or a 0.1% chance
At 41 weeks 1.8 per 1000 or a 0.2% chance
At 42 weeks 3.0 per 1000 or a 0.3% chance
At 43 weeks 6.5 per 1000 or a 0.7% chance

You may find it easier to look at these figures as pictograms:

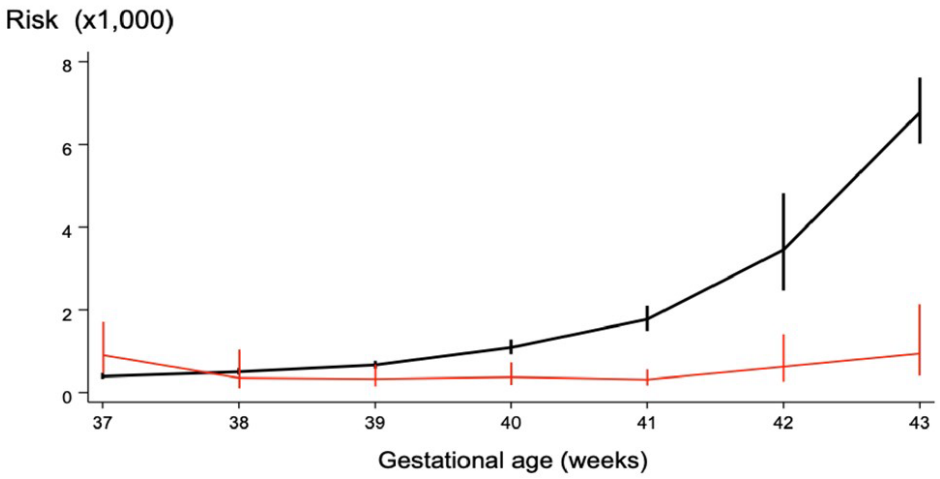








This graph below shows the overall risk of stillbirth (black line) and neonatal death (red line) per 1000 births by stage of pregnancy after 37 weeks.



Although the stillbirth rate increases significantly from 40 to 43 weeks, the actual risk is still very low. The risk of a baby dying after birth (neonatal death) also remains very low.

As there is no way of telling whether YOUR baby is at risk, the recommendation is to consider an induction by 42 weeks is to reduce the number of stillbirths that happen with prolonged pregnancies.

Your own risk may be different due to several factors such as being overweight (BMI over 30), underlying medical problems, your age, IVF conception, your ethnic background or clinical concerns that arise in your pregnancy. In these situations, your midwife and doctor will discuss an individualised plan with you.

What are the potential benefits and risks of having an induction?

The risks of induction, watching and waiting, or a planned caesarean will depend on the reason you're being offered induction and your own personal circumstances.

- An induction of labour around 41 weeks may have the best chance of you achieving a vaginal birth and is not usually associated with an increased likelihood of caesarean birth. It may prevent a stillbirth occurring

However, an induction of labour is a medical intervention that will affect your birth options and your experience of the birth process. This could include that:

- If your pregnancy has been straightforward, your chance of a natural (vaginal) birth is highest if your labour starts spontaneously (by itself) and you plan to labour and birth on a midwife-led Birth Centre near to a Labour Ward
- Your choice of place of birth will be limited, as you may be recommended interventions (for example, oxytocin infusion, continuous baby (fetal) heart rate monitoring and epidurals) that are not available for a home birth or in a midwife-led Birth Centre
- You may be less likely to be able to use a birthing pool
- You may be more likely to need an assisted vaginal birth (using forceps or ventouse), which has an increased risk of a severe perineal tear (obstetric anal sphincter injury)
- An induced labour may be more painful than a spontaneous labour. Your hospital stay may be longer than with a spontaneous labour

Timing of induction and birth outcomes

- Over 95% of labours will start spontaneously by 42 weeks so delaying an induction until then may reduce the need for this intervention at all
- But delaying it until after 42 weeks is associated with a higher likelihood of having a caesarean birth although these rates will be affected by the reason for the induction
- Where you plan to give birth (home, a hospital birth centre or a hospital labour ward) will also affect the chance of achieving a vaginal birth
- You may want to consider an informal method of induction known as a 'membrane sweep' at 40 and 41 weeks
- Evidence suggests that a sweep makes it about 20% more likely that you will go into labour without further interventions, but you are no more likely to avoid a caesarean or assisted birth.

Membrane sweep

To carry out a membrane sweep, your midwife or doctor sweeps their finger around your cervix during an internal examination. This action should separate the membranes of the amniotic sac surrounding your baby from your cervix. This separation releases hormones (prostaglandins), which may start your labour. Having a membrane sweep does not hurt, but expect some discomfort or slight bleeding afterwards.

What happens if I decline an induction?

If you prefer to not have an induction, you can **watch and wait** instead – wait for your baby to come on its own and your natural labour to start, while keeping an eye on how you and your baby are feeling.

If you choose to wait for your baby to come on its own, your midwife or doctor should explain about your situation and how this affects your personal risks and benefits.

You may be offered closer monitoring of you and your baby and this may include some extra appointments at the hospital including an ultrasound scan and monitoring your baby's heartbeat. This is often called **'expectant management'**.

Monitoring and using scans do not help predict or avoid problems that might happen suddenly and none of these tests can accurately predict whether your baby is more or less likely to have a stillbirth in the future, but can help to tell you how your baby is at the time of the scan or test.

You will be supported if possible to give birth where you had planned (Birth Centre, home or Labour Ward). If your baby doesn't come on its own you will have the opportunity to revisit your options with your birth team.

You will be offered an appointment with your obstetric consultant and / or a consultant midwife to make an individualised plan for you.

You also have the option of having a planned caesarean birth rather than an induction if this is your choice.

Where can I go for more information?

If all is well with you and the baby, there is no rush in making a decision about whether to have an induction during an antenatal appointment. You can go home and think about it, read more or talk to your midwife or doctor again.

Glossary of Terms

Spontaneous Labour	Vaginal delivery that happens on its own, without requiring doctors to use tools to help pull the baby out.
Gestation	The period of developing inside the womb between conception and birth
Body Mass Index (BMI)	A numerical value of your weight in relation to your height
Obstetrician	A doctor who specializes in pregnancy, childbirth, and a woman's reproductive system
Cervix	Lowest region of the uterus; it attaches the uterus to the vagina and provides a passage between the vaginal cavity and the uterine cavity.
CTG	A monitor to record your baby's heart rate and any uterine contractions
Membranes	Membranes are the layers of tissue called the amniotic sac. These hold the fluid that surrounds the baby in the womb
Oxytocin	Is a hormone that is produced naturally in your body, often called the love hormone. This hormone stimulates the muscles of the uterus to contract and boosts the production of naturally occurring prostaglandins, which increase uterine contractions. During induction, synthetic oxytocin is often administered to increase uterine contractions.
Post Dates	Is a term used to describe when your pregnancy has extended over the due date, in Swansea Bay we use 12 days over your due date, but this varies in different hospitals depending on their protocols
Propess	A pessary, inserted into the vagina, containing the naturally occurring female hormone called Prostaglandin.
Analgesia	Medication that acts to relieve or block pain

Epidural	An injection in your back to stop you feeling pain in part of your body
Forceps	Used to encircle a baby's head and assist in birth
Ventouse	A cup-shaped suction device applied to the baby's head in childbirth, to assist the birth
Ruptured	Breaking open or bursting
Stillbirth	When a baby is born dead after 24 Completed weeks of pregnancy
Breech	When the baby is presenting with the buttocks down to the cervix instead of head down to the cervix.
Post Maturity (Term +12 days)	12 days over your due date
SGA (growth under 10th centile)	baby's weight is smaller than expected on scan
Growth Restriction	There are concerns around the baby's growth
Polyhydramnios >50mm	The amniotic fluid around your baby (your waters) are measured by ultrasound scan and are higher than the normal expected level.
Oligohydramnios <50mm	The amniotic fluid around your baby (your waters) are measured by ultrasound scan and are lower than the normal expected level.
LGA (above 95th centile)	Baby measure larger than expected for gestational age
GDM diet	Developed diabetes in pregnancy, and managed by changes to your diet
GDM Medicated/ Pre-existing Diabetes (Type 1 or Type 2 or other rarer forms of Diabetes)	Diabetes; either pre-existing or developed in pregnancy, and requires medication, usually with either metformin or insulin injections
PET (Raised Blood pressure and proteinuria), also known as Pre-Eclampsia.	Pre-eclampsia, this is raised blood pressure and protein in the urine, or symptoms of pre-eclampsia
PIH (Raised BP only) – Pregnancy Induced Hypertension.	Raised blood pressure developed in pregnancy, with no protein in the urine,

	again requires closer monitoring and treatment
Chronic Hypertension (↑BP before 20/40)	This is pre-existing high blood pressure, that is there even before your pregnancy, again this also needs closer monitoring and treatment
Obstetric Cholestasis	Is a disorder that affects your liver during pregnancy. Common symptoms are persistent itching of the body.
Research trial	These are research projects that are happening in the department where you are having your baby, and would have had a discussion with a research midwife beforehand to be involved.

Other useful sources of information on Induction

1. NHS website: Inducing labour - NHS (www.nhs.uk)
2. National Institute for Health and Care Excellence: Overview | Inducing labour | Guidance | NICE
3. Royal College of Obstetricians and Gynaecologists: www.rcog.or.uk
4. Royal College of Midwives: www.rcm.org.uk/media/5460/midwifery-care-for-induction-of-labour-a4-2019-16pp_2v2.pdf
5. Sara Wickham (2018) "Inducing Labour, making informed decisions".

Source data

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2. www.nice.org.uk/guidance/ng207/evidence/c-induction-of-labour-for-prevention-of- prolonged-pregnancy-pdf-9266825056
3. Maternity and birth statistics: 2021 | GOV.WALES
4. Induction of labour at or near the end of pregnancy for babies suspected of being very large (macrosomia) | Cochrane
5. induction and caesareans | AIMS
6. Predictive model for risk of cesarean section in pregnant women after induction of labor (springer.com)
7. The Birthplace cohort study: key findings | NPEU > Birthplace (ox.ac.uk)
8. www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/childmortalitystatisticschildhoodinfantandperinatalchildhoodinfantandperinatalmortalityinenglandandwales

This document has been co-created with Swansea Bay Maternity Voices Partnership

SWANSEA BAY Maternity Voices

Working in partnership to improve maternity services

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