



**OBSTETRICS AND GYNAECOLOGY
 CLINICAL PRACTICE GUIDELINE**

Labour and birth: Planned birth timing (indications and gestations for booking inductions and caesareans)

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH and OPH

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Contents

Introduction	2
Indications for planned birth	2
Planning: Induction of labour	2
Consent	2
Contraindications	3
Assessment	3
Methods	3
Delayed induction: Management	4
Planning: Caesarean birth	4
References	4
Appendix: Safe timing of birth	7



Introduction

Initiatives to reduce unnecessary elective early births: Birth before 39 weeks may have serious outcomes for the child.¹ The statement by the Australian Preterm Birth Prevention Alliance draws attention to recent research suggesting that “birth before 39 weeks of pregnancy may have important consequences in later life, including behavioural and learning problems in school aged children”.¹

Recommendations [2023]:

- The timing of planned birth should be delayed to 39 weeks or later, in women without additional risks.^{1,2}
- Individualise decisions through partnership between the pregnant woman and health care providers, considering risk of stillbirth against risk of harm in childhood.¹

Induction of labour (IOL) or Caesarean birth may be indicated when the available evidence suggests benefits of birth to the mother or fetus outweigh the potential risks of continuing the pregnancy. There remains no one point in time that suits every woman, and decisions around optimal timing of births are multifactorial.

Indications for planned birth

- For recommendations and considerations for gestations of planned birth, refer to [Appendix: Safe timing of birth](#)
- Timing of elective birth may be altered to meet the anticipated postnatal medical needs of the neonate, in the context of availability of paediatric specialist expertise.

Planning: IOL

Consent

A shared decision-making approach should be used to inform the consent discussion with the woman. Discuss and document:

- Indication
- Maternal and/or fetal benefit and risk
- Individual circumstances
- Method(s) of IOL
- Recommended fetal monitoring
- Pain relief options
- Options if IOL is unsuccessful, declined or if expectant management is preferred

Contraindications

- Placenta praevia (including if distance of <20mm from the internal cervical os on transvaginal assessment in third trimester)
- Vasa praevia
- Malpresentation including transverse lie, compound presentation, and oblique lie
- Known cephalopelvic disproportion
- Acute fetal compromise
- Cord presentation or prolapse
- Active [genital herpes](#)
- [HIV positive women](#)
- Maternal refusal

Assessment

1. Review maternal history. Confirm gestation and check for contraindications for IOL.
2. Perform abdominal palpation (confirm presentation, lie, position and engagement)
3. Assess fetal wellbeing
4. Assess cervix and document the Bishop score

Assessment of the cervix - Bishop score

The Bishop score is used to determine method for IOL at commencement of IOL.

Score	0	1	2
Station	-3cm	-2cm	-1/-0cm
Dilation	0 cm	1 -2 cm	3-4 cm
Length	3 cm	2 cm	1 cm
Consistency	Firm	Medium	Soft
Position	Posterior	Mid	Anterior

Generally, a score of 8 or more indicates a cervix is ready to dilate, and is associated with a high chance of spontaneous labour and responsiveness to induction interventions.³

Methods of IOL

Bishop score ≤ 6	Bishops score ≥ 7
<ol style="list-style-type: none"> 1. Transcervical catheter 2. Prostaglandins (PG) including: <ol style="list-style-type: none"> a. PG- E₂ gel b. Cervidil 	<ol style="list-style-type: none"> 1. Artificial rupture of membranes (ARM) 2. Oxytocin infusion

Refer to [IOL: Methods guideline](#) (available to WA Health staff through HealthPoint).

Delayed induction: Management

- An updated medical management plan is to be documented in the clinical file, including any need for fetal (or maternal) assessment.

Planning: Caesarean birth

When planning of birth indicates that Caesarean birth is medically recommended, follow the elective caesarean, pre-admission and preparation sections within the [Caesarean Birth guideline](#).

At OPH, see also [Osborne Park Hospital WNS: Caesarean Section- Elective \(OPH\)](#)

References

1. Australian Preterm Birth Prevention Alliance. Statement by the Australian Preterm Birth Prevention Alliance n.d. Available from: <https://www.pretermalliance.com.au/Alliance-News/Latest-News/Statement-by-the-Alliance>
2. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Timing of planned caesarean section at term. 2022. Available from: <https://ranzcof.edu.au/wp-content/uploads/2022/05/Timing-of-elective-caesarean-section-at-term.pdf>
3. National Institute for Clinical Excellence [NICE]. Inducing labour: NG207. 2021. Available from: <https://www.nice.org.uk/guidance/ng207>
4. Gordon A, Raynes-Greenow C, et al., (2013). Risk factors for antepartum stillbirth and the influence of maternal age in New South Wales Australia: a population based study. BMC Pregnancy Childbirth 13:12.
5. Cleary-Goldman J, Malone FD, et al., (2005) Impact of Maternal Age on Obstetric Outcome. Obstet Gynecol 105:983-90.
6. Walker KF, Thornton JG. (2021) Timing and mode of delivery with advancing maternal age. Best Pract Res Clin Obstet Gynaecol. 70:101-111.
7. Green-top Guideline No. 65: The Management of Women with Red Cell Antibodies during Pregnancy. Obstet Gynecol. (2014) 16: 224. www.rcog.org.uk/media/oykp1rtq/rbc_gtg65.pdf
8. Ovadia C, Seed PT, Sklavounos A, et al. (2019) Association of adverse perinatal outcomes of intrahepatic cholestasis of pregnancy with biochemical markers: results of aggregate and individual patient data meta-analyses. Lancet 393:899-909. .
9. Eidem I, Vangen S, et al., (2011) Perinatal and infant mortality in term and preterm births among women with type 1 diabetes. Diabetologia 54:2771-2778.
10. American College of Obstetricians and Gynecologists. Gestational diabetes: Practice Bulletin No. 190. Obstetrics and Gynecology (2018) 131:406-8.
11. Kazemier BM, Voskamp BJ, et al., (2015) Optimal timing of delivery in small for gestational age fetuses near term: a national cohort study. Am J Perinatol 30:177-186. .
12. Boers K E, Vijgen S M C, Bijlenga D, van der Post J A M, Bekedam D J, Kwee A et al. (2010) Induction versus expectant monitoring for intrauterine growth restriction at term: randomised equivalence trial (DIGITAT). BMJ 341:c7087
13. Boers KE, van Wyk L, et al. (2012) Neonatal morbidity after induction vs expectant monitoring in intrauterine growth restriction at term: a subanalysis of the DIGITAT RCT. Am J Obstet Gynecol 206:344.e1-344.e3447.
14. Lausman A, Kingdom J; Maternal Fetal Medicine Committee. (2013) Intrauterine growth restriction: screening, diagnosis, and management. J Obstet Gynaecol Can. 35:741-748. .

15. Boulvain M, Irion O, Thornton JG. (2016) Induction of labour at or near term for suspected fetal macrosomia. Cochrane Database of Systematic Reviews Issue 5. Art. No.: CD000938.
16. Magro-Malosso ER, Saccone G, et al., (2017) Induction of labour for suspected macrosomia at term in non-diabetic women: a systematic review and meta-analysis of randomized controlled trials. BJOG. 2017 124:414-421.
17. Koopmans CM, Bijlenga D, et al. (2007) Induction of labour versus expectant monitoring in women with pregnancy induced hypertension or mild preeclampsia at term: the HYPITAT trial. BMC Pregnancy Childbirth. 7:14.
18. Broekhuijsen K, van Baaren GJ, et al. (2015) Immediate delivery versus expectant monitoring for hypertensive disorders of pregnancy between 34 and 37 weeks of gestation (HYPITAT-II): an open-label, randomised controlled trial. Lancet 385:2492-2501.
19. Society for Maternal-Fetal Medicine SMFM (2022) Consult Series #60: Management of pregnancies resulting from in vitro fertilization. Am J Obstet Gynecol 226:B2-B12.
20. Yao R, Ananth CV, Park BY, Pereira L, Plante LA, Perinatal Research Consortium. (2014) Obesity and the risk of stillbirth: a population-based cohort study. Am J Obstet Gynecol. 210:457.e1-9.
21. Balayla J, Wo B & Bédard M (2015) A late-preterm, early-term stratified analysis of neonatal outcomes by gestational age in placenta previa: defining the optimal timing for delivery, The Journal of Maternal-Fetal & Neonatal Medicine, 28:1756-1761.
22. Allen L, Jauniaux E, et al., (2018), FIGO consensus guidelines on placenta accreta spectrum disorders: Nonconservative surgical management. Int J Gynecol Obstet. 140: 281-290. .
23. Bowman ZS, Manuck TA, et al., (2014) Risk factors for unscheduled delivery in patients with placenta accreta. Am J Obstet Gynecol. 210:241.e1-241.e2416. .
24. Mitchell SJ, Ngo G, et al., (2022). Timing of birth and adverse pregnancy outcomes in cases of prenatally diagnosed vasa previa: a systematic review and meta-analysis. Am J Obstet Gynecol. 227:173-181.e24.
25. Morris JM, Roberts CL, Bowen JR, et al. (2016) Immediate delivery compared with expectant management after preterm pre-labour rupture of the membranes close to term (PPROMT trial): a randomised controlled trial. Lancet. 387:444-452.

Related policies

[Medicines and Poisons Act 2014](#)

Related WNHS policies, procedures and guidelines

WNHS Clinical Guidelines:

[Obstetrics and Gynaecology](#) (see also links to specific guideline conditions within appendix):

- [Caesarean Birth](#)
- Labour and Birth guidelines

[Osborne Park Hospital WNS: Caesarean Section- Elective \(OPH\)](#)

[Perioperative Services](#) (available to WA Health staff through HealthPoint):

- [Complex Surgical Care in Perioperative Patients](#)
- [Elective Surgery](#)









WNHS policy: [Elective Surgery List Management](#)

Useful resources and related forms

The University of Sydney:

- Consumer information: [Every Week Counts \(external website\)](#)
- Healthcare professionals: [Every Week Counts: Healthcare professionals \(external website\)](#)

[The Safer Baby Bundle](#) (external website): Timing of Birth

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Version history

Version number	Date	Summary
1	July 2023	<ul style="list-style-type: none"> • New guideline created with content relating to booking an induction moved to this guideline from the IOL guideline. • Statements and recommendations relating to prevention of preterm birth added. The timing of planned birth should be delayed to 39 weeks or later, in women without additional risks. Added appendix with table of indications for planned birth with suggested gestations. • Individualise decisions through partnership between the pregnant woman and health care providers, considering risk of stillbirth against risk of harm in childhood. • New considerations for earlier birth in women of South Asian ethnicity
2	Dec 2023	<ul style="list-style-type: none"> • Minor amendment- hyperlink changed to AMA guideline in appendix

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Appendix: Safe timing of birth

Indications that commonly prompt birth before 39 weeks

Note- This is not an exhaustive list. The Australian Preterm Birth Prevention Alliance recommends decisions on timing of birth should be made with consideration for the overall individual clinical scenario and available evidence, through shared decision making with pregnant women and their support persons.¹

Condition	Consensus	Evidence
Age (advanced maternal) - see also guideline for general management	In light of the increased risk of late stillbirth in women aged 40 or over, initiate shared decision-making regarding birth from 39+0 weeks in the absence of an indication for an earlier birth.	4-6
Alloimmunisation - see related Blood Group and Antibody guideline for general screening and management	If titres of an antibody known to cause haemolytic disease of the fetus and newborn (HDFN) other than Kell are stable at < 1:32, initiate shared decision-making regarding birth from 38+0 weeks . This recommendation does not apply if the fetus is believed to be negative for the antigen in question on the basis of cfDNA or paternal testing. If the titre of an antibody known to cause HDFN is 1:32 or greater, or anti-Kell antibodies are present, management decisions including timing of birth should be made by a fetal medicine service.	7
Cholestasis - see also guideline for general management	If total bile acids <100 µmol/L, initiate shared decision-making regarding birth from 38+0 weeks based on bile acid concentration, other risk factors, and discussion with the patient. Given the higher stillbirth risk with total bile acids >100 µmol/L, very close surveillance and birth from 37+0 weeks should be discussed, with a low threshold for preterm delivery for stillbirth prevention. Plan for early delivery with maternal morbidity (jaundice and/or severely deranged transaminases), or in the setting of suspected fetal compromise.	8
Diabetes – see also guideline for general management		
Pre-existing diabetes	Initiate shared decision-making regarding birth from 38+0 weeks if well controlled. Discuss birth from 37+0 weeks only in select cases (e.g. significantly unstable BSLs or fetal growth restriction). Counselling needed regarding risks/benefits of vaginal birth if high risk of shoulder dystocia. Avoid preterm delivery for diabetes alone.	9
Gestational diabetes mellitus (GDM)	If diet controlled and no other perinatal concerns, management should be in accordance with usual maternity care for women without diabetes. If insulin is required but control of blood sugar levels is good and fetal growth is within the normal range, initiate shared decision-making regarding birth from 39+0 weeks . Management for women with suboptimal glycaemic control or other complications needs to be individualised, with the aim to achieve 38+0 weeks where safe to do so.	10

Fetal		
<p>Fetal growth restriction (EFW / AC <10%)</p> <p>-see guideline for general management</p> <p>[EFW- estimated fetal weight; AC- Abdominal circumference]</p>	<p>In FGR suspected on ultrasound at or near term, close biophysical monitoring and shared decision-making for birth from 38+0 weeks should be initiated. Consider that accurate biometric measurements are difficult to achieve at late gestations, and that UA PI and MCA PI are often poor guides of pathology at term. The evidence to support cerebroplacental ratio(CPR) for decision-making remains unclear.</p> <p>In FGR suspected preterm on serial biometry with persistently normal UA PI, MCA PI, AFI and fetal movements, initiate shared decision-making regarding birth from 38+0 weeks with close monitoring (ultrasound, CTG).</p> <p>If UA PI is increased but positive end-diastolic flow is present, initiate shared decision-making regarding birth from 37+0 weeks. Earlier birth based on other Doppler abnormalities needs to be individualised, ideally with input from a fetal medicine service.</p>	11-14
<p>Fetal macrosomia (suspected) *</p> <p>(ultrasound EFW +/- AC ≥95th centile for gestation)</p>	<p>IOL for suspected fetal macrosomia may reduce the risk of shoulder dystocia and neonatal fractures. The evidence base is limited and heterogeneous, however, and the accuracy of antenatal ultrasound in predicting neonatal macrosomia is poor. For this reason, management needs to be individualised, using shared decision-making that incorporates other risk factors for macrosomia (e.g. clinically large fetus, increased maternal BMI).</p> <p>In the absence of diabetes, it is reasonable to consider birth in women with suspected fetal macrosomia from 39+0 weeks.</p> <p>See also RANZCOG Macrosomia guideline (external website)</p> <p>*Note- EFW not taken as a single predictor and other factors including previous birth weight and maternal factors are considered.</p>	15, 16
Hypertensive disorders- see 'H' medical and midwifery guidelines for general management		
<p>Pre-eclampsia</p>	<p>Expectant management where safe before 34+0 weeks.</p> <p>From 34+0 to 37+6 weeks, close surveillance with plan for early birth if evidence of maternal or fetal compromise (severe disease).</p> <p>In asymptomatic well women with good blood pressure control and no features of severe disease, initiate shared decision-making regarding birth from 38+0 weeks.</p>	17, 18
<p>Isolated hypertension (pre-existing or gestational)</p>	<p>For women with well controlled, stable, uncomplicated hypertension, initiate shared decision-making regarding birth from 39+0 weeks to avoid worsening of disease.</p> <p>Earlier birth should be considered on an individualised basis in the context of suboptimal control of blood pressure or other complications.</p>	
<p>In-vitro fertilisation (IVF)- (pregnancies resulting from)</p>	<p>There are no good data to guide the timing of birth for women with otherwise uncomplicated pregnancies conceived through in-vitro fertilisation. A proportion of women with IVF pregnancies will develop one of the conditions listed above, and should receive care appropriate to that condition. In the absence of an indication for an earlier birth, the earliest gestation at which elective birth should be considered is 39+0 weeks.</p>	19

Obesity (maternal)- see guideline for general management	<p>The risk of stillbirth in women with a body mass index (BMI) of ≥ 50 kg/m² is significantly increased after 38 weeks. Shared decision-making should be initiated for such women regarding birth from 38+0 weeks.</p> <p>Lesser degrees of obesity are associated with a less pronounced increase in the risk of stillbirth. There is a lack of high-level evidence to guide the care of women with BMIs of 30 – 49 kg/m², and management needs to be individualised. Birth from 39+0 weeks may be considered in this population following counselling.</p>	20
Placental: site disorders or adherence (see guideline for general care)	<p>Elective CS for asymptomatic placenta praevia from 38+0 weeks.</p> <p>Elective CS for asymptomatic placenta accreta spectrum from 35+0 weeks.</p> <p>Elective CS for asymptomatic women with vasa praevia from 36+0 weeks.</p>	21-24
Preterm prelabour rupture of membranes - see guideline for general management	<p>Before 34 weeks, expectant management with antibiotic therapy. Deliver with any signs of maternal or fetal compromise.</p> <p>Between 34+0 and 36+6 weeks with no signs of chorioamnionitis, discuss risks with woman but aim cautious expectant management with antibiotic coverage regardless of GBS status. Close monitoring and low threshold to deliver if evidence of chorioamnionitis or fetal compromise.</p> <p>Initiate shared decision-making regarding birth from 37+0 weeks if no concerns prior.</p>	25

Acknowledgment of source: Australian Preterm Birth Prevention Alliance (2022). Promoting safe timing of birth through prevention or delay of iatrogenic preterm and early term birth.

Prolonged pregnancy

Prolonged pregnancy - see guideline for general management	<p>Low risk women should be offered IOL from 41+0 weeks and have their IOL booked to occur by 41+3 weeks.</p> <p>Low risk women of South Asian ethnicity- from 40+0 weeks</p>	<p>Australian Government Department of Health and Aged Care. Part J: Clinical assessments in late pregnancy: Prolonged pregnancy. 2022. In: Pregnancy care guidelines [Internet].</p> <p>The average length of pregnancy may be earlier (39 weeks) in women of South Asian ethnicity (e.g. Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan, Sri Lanka), compared to women born in Australia and New Zealand (40 weeks), and this has implications for late pregnancy monitoring and birth planning.</p>
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Maternal request

Maternal request for early birth, without medical indication, is not recommended at WNHS as it does not align with the Australian Preterm Prevention Alliance principles for 'Promoting safe timing of birth through prevention or delay or iatrogenic preterm and early term birth'.