DC Birth Doulas

INDUCTION GUIDE

To induce or not to induce? That is the question. Whether your provider has recommended a medical induction of labor, or if you are considering an elective induction, we are here to support your decision making and induction of labor preparation.

CONTENTS

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CHAPTER 1

CHOICES

TO INDUCE OR NOT?
CHATTING WITH YOUR PROVIDER

An induction uses medications to start and continue the labor process. In most cases, you will be in the hospital for the duration of the induction process and have continuous fetal monitoring throughout.

The medical community can agree on one thing: Expectant parents should be fully informed about the benefits and risks and potential adverse aspects of an induction before agreeing to it.

Your provider may offer an induction as on option (rather than a medical recommendation) or there may be compelling medical reasons to plan for an induction.

Some situations are backed with strong medical evidence and professional guidelines. In other cases, the evidence is inconclusive; thus there is great variation on how providers may manage your care.

TO INDUCE OR NOT?
CHATTING WITH YOUR PROVIDER

Can I wait for labor to start on its own?

Are there risks in my situation that prohibit waiting for spontaneous labor? What can we do to mitigate those risks? (additional monitoring)

As I wait for labor to start, are there things I can do to help stimulate labor? In your experience, what methods are most effective?

- Membrane sweep
- Nipple stimulation
- Acupuncture

I hear you suggesting an induction, given my _____ (age, health status, activity level, baby's situation), can you tell me more about the medical reasons and evidence informing your recommendation?

- What is the difference in the 'risks' based on gestational age?
- What is the earliest you suggest the induction take place?
- What is the latest gestational age you would like labor to start?

In general, what are the benefits & risks of induction to me or to baby? Such as

- Postpartum hemorrhage
- Cesarean rates based on gestational age
- likelihood of NICU stays or neonatal assistance based on gestational age
- Use and timing of pain medications
- impact on birth satisfaction

To explore more about your choices, values, preference, and answers to some questions posed on this page, check out this **interactive Induction Decision Aid by Partner to Decide.**

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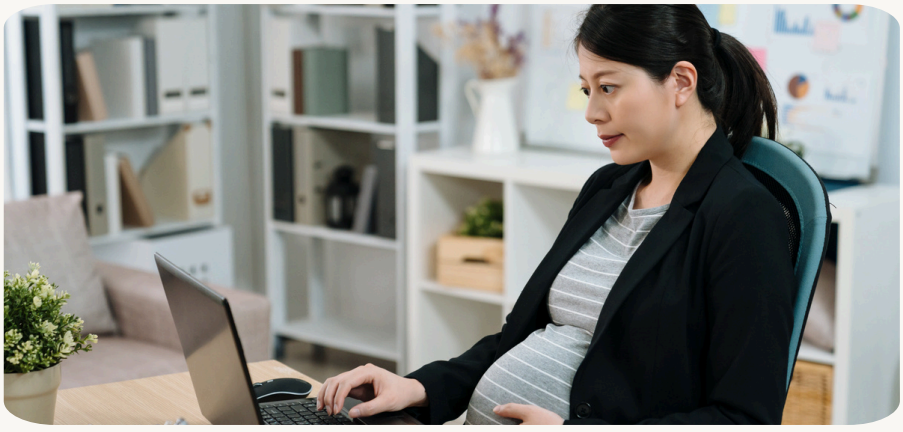
CHAPTER 2

REASONS

REASONS
MEDICAL RECOMMENDATIONS

Reducing the risk of medical complications is the primary reason to proceed with an induction. The American College of Obstetricians and Gynecologists (ACOG) defines the following as complications where the risk of an induction outweighs the risk of proceeding with a pregnancy:

High blood pressure and/or Preeclampsia
Cholestasis
Infection in the uterus
Growth issues with baby
High/Low amniotic fluid
Diabetes
PROM: Breaking of the amniotic sac without the onset of contractions within a ‘reasonable’ amount of time (Prelabor Rupture of Membranes)



REASONS
INDUCTION GREY AREAS

There are also ‘grey’ reasons for inductions which you and your provider may take into consideration, such as:

- Advanced Maternal Age (AMA)
- Use of reproductive technology
- Suspected larger size of your baby

Advanced Maternal Age (AMA)

ACOG defines advanced maternal age (AMA) as 35 years or older. Keep in mind this is in reference to the “age of your eggs” and is not an evaluation of your personal health. Currently, there is no agreed-upon professional guidance on the best care for pregnant persons 35+ years old as they approach their due date (i.e. induction, timing of induction, or wait for spontaneous labor until x gestational weeks). This is an individual decision based on conversations with your provider.

Why might I be offered an induction for AMA? For those over 35 years, the relative risk for stillbirth increases after 39 gestational weeks. However, the overall absolute risk remains very low, around 1 in 1,000.

REASONS
INDUCTION GREY AREAS

Assisted Reproduction Pregnancies

There are very few clinical practice guidelines when it comes to "best care" for Assisted Reproduction (AR) pregnancies. The bottom line is that an AR pregnancy automatically puts the birther in a high-risk category and has increased complications. However, research shows that a majority of AR pregnancies will be uncomplicated.

Increased risk associated with AR pregnancies is often due to the rate of multiples and other risk factors of the pregnant person (older than average, fertility/cycle irregularities, and uterine anomalies). Due to this, offering induction of labor is extremely common for AR patients (systematic review).

REASONS
INDUCTION GREY AREAS

Suspected Big Babies

Estimating a baby's weight in the womb is not easy and often inaccurate. By the end of pregnancy, estimates can be 15% above or below the actual baby's weight (a margin of error that could be one pound!). Your provider is looking at your baby's growth trend and may do their due-diligence by discussing your baby's size and subsequent risks with you. The primary risk (assuming baby's size is not due to gestational diabetes) for vaginally born "big" babies is shoulder dystocia, or when the baby's head is born, but the anterior shoulder does not deliver freely and remains behind the pubic bone. Shoulder dystocia occurs in 0.6% to 1.4% of all vaginal births. While bigger babies have a higher rate of shoulder dystocia, half of cases occur in babies that are not "big." Importantly, most shoulder dystocia that occurs does not equate to harm (to birther or baby) and is resolved effectively by a trained and skilled provider. See: Evidence-Based Birth article on "suspected big babies."

The goal is to keep you and your baby content, comfortable, and happy leading up to your birth! **Please reach out to us**, as we have curated information on various situations (don't go down the induction Google rabbit hole!). We are always available to talk with you - to provide a sounding board and answer questions you may have.

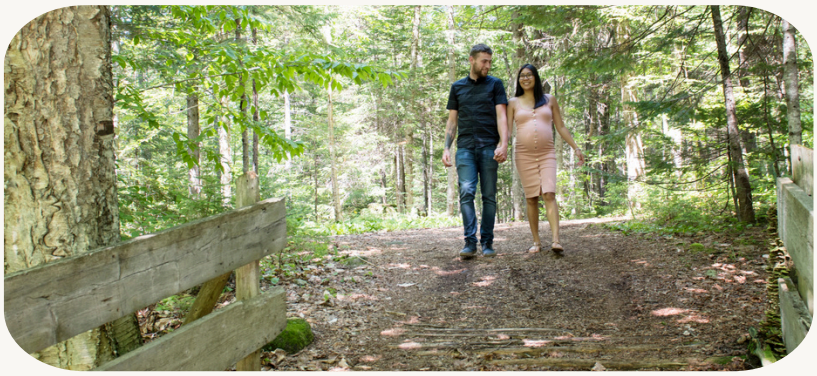
Call your Birth Doula Team to discuss
202-505-4468

REASONS
FURTHER READING ON INDUCTIONS

Research and Professional Guidelines for Low-Risk Singleton Pregnancies

Induction at 39 Weeks:

- ACOG and the Society for Maternal-Fetal Medicine **(Guidelines)**
  - It is reasonable to **offer induction** to low-risk women at 39 gestational weeks, but should **not be routine care**, contingent on:
    - Individual preferences
    - Provider IOL protocols
    - Hospital setting
- ARRIVE Trial **(Research looking at routine IOL at 39 weeks)**:
  - **Key Results:** Lower cesarean in IOL group (18.6%) compared to spontaneous labor group (22.2%), but not better outcomes for the baby.
  - **Challenges:** The study did not include many people 35+ years old. There is disagreement on whether this one trial should be adopted as obstetric practice.
- 35/39 Trial **(Research looking at routine IOL at 39 weeks for AMA)**
  - **Key Results:**
    - no significant difference between rates of cesarean birth
    - no adverse short-term effects on neonatal or maternal outcomes.



REASONS
FURTHER READING ON INDUCTIONS

Induction at 40 plus Weeks

Guideline: The World Health Organization Generally does not support IOL prior to 42 weeks.

Guideline: UK National Institute for Health Suggests IOL between 41 and 42 weeks.

Research: Cochrane Systematic Review (updated July 2020)

The majority of the study participants in these trials were induced at 41 or more weeks. Results:

- Fewer cesarean births and NICU admissions
- About the same assisted vaginal births
- Fewer admission to intensive care nursery with induction compared to waiting for labor to start on its own at 41+ weeks.
- Conclusion: “The best timing of when to offer induction of labour to women at or beyond 37 weeks' gestation warrants further investigation, as does further exploration of risk profiles of women and their values and preferences.”

Guideline: American College of Nurse Midwives Recommends induction at 2 weeks past due date and prior to that only for medical indications.

Research: UK AIMS Journal, 2019 Suggests continuing beyond 42 weeks does not increase the risk of stillbirth.

REASONS
DECISION MAKING FATIGUE?
LET'S TAKE A BREAK

GENTLE MOVEMENT

- Sometimes reflection happens best alongside movement (DCBD YouTube playlist)
- Take moment in nature, go for a walk, stretch, swim, or receive a massage.
- What is your body and your baby telling you?

REST AND DIGEST

- Stop and take a deep, diaphragmatic, slow breath (to activate the parasympathetic nervous system 'rest and digest')
- Take a moment to ground yourself (a long shower, warm/cool drink, nice meal).
- Create space for calm and peace to connect to your inner wisdom and instinct.

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CHAPTER 3

PATHS

INDUCTION PATHS

A medical induction of labor may not have been what you originally planned, however, it may be the option that you choose (after careful consideration) as part of your birth story. The process looks different for each person. Your provider has a variety of medications and tools at their disposal and depending on your circumstances, will work with you to determine which ones will be most effective.

All of these methods either introduce synthetic forms of your body's labor hormones (**Prostaglandin** and **Oxytocin**) or encourage your body to stimulate its own production of these hormones. Prostaglandin and Oxytocin both help soften the cervix. The increasing levels of Oxytocin also stimulate contractions that will eventually open your cervix and bring your baby down in your pelvis!

The following is an overview of all of the tools available to your provider. Your induction path will be unique to you. Please reach out to your doula team to talk through the risks, benefits, and questions to ask as you prepare for this conversation with your provider.

INDUCTION PATHS

The most common induction path that we see

1. Cervical ripener (Cervidil or Cytotec) *often given overnight
2. Evaluation of the cervix:
    a. if cervix is responsive, move to Pitocin
    b. if cervix has not responded yet:
        i. more cervical ripening
        ii. and/or the introduction of the Balloon, with or without medication such as cytotec or pitocin
3. Re-Evaluation of the cervix:
    a. once cervix is responsive and/or Balloon has fallen out, move to Pitocin and increase Pitocin slowly until contractions are longer, stronger, closer together and resulting in dilation of the cervix
4. Re-evaluation of the cervix and position of the baby, increase Pitocin and if needed, the breaking of waters

Average length of inductions for DCBD clients: 30.5 hours (trending higher for clients 35yr+)

INDUCTION PATHS

Overview of Medications & Tools Used

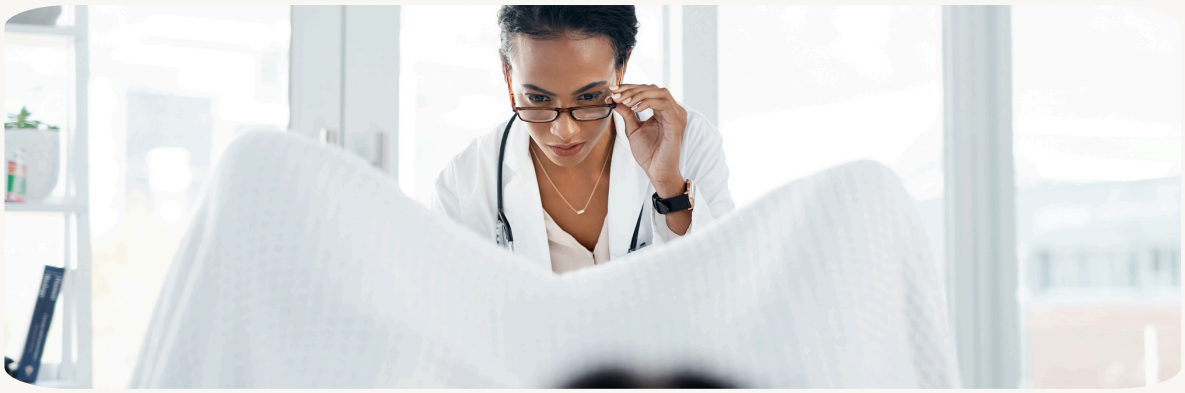
Membrane Sweep (Procedure)

Membrane sweeping is a hands-on technique where your provider, usually in clinic prior to your hospital induction, would insert one or two fingers into the slightly opened cervix and attempt to manually create space between your amniotic sac and uterus using a continuous circular sweeping motion. This “irritation” of the membranes can stimulate contractions and the production of labor hormones. This deeper vaginal exam can vary in its level of discomfort.

Foley Bulb/Cook’s Catheter Balloon (Device/Procedure)

A *Foley Bulb/Cook’s Catheter* are silicone catheter balloons inserted into the cervix. Once in place, saline inflates the balloon. One (Foley Bulb rests on top of the cervix) or two (Cook’s one on top of the cervix and one underneath) balloons may be filled. Depending on how cervical exams feel in your body, your provider may suggest some pain medication prior to insertion.

The pressure of the saline filled balloon(s) on the cervix stimulates the production of the labor hormone prostaglandin that softens and dilates your cervix. The balloon falls out on its own (around 3-4cm dilation) or your provider may ‘tug’ on the tubing to see if it is ready to come out. We’ve seen this tool used from anywhere between 3-12 hours.



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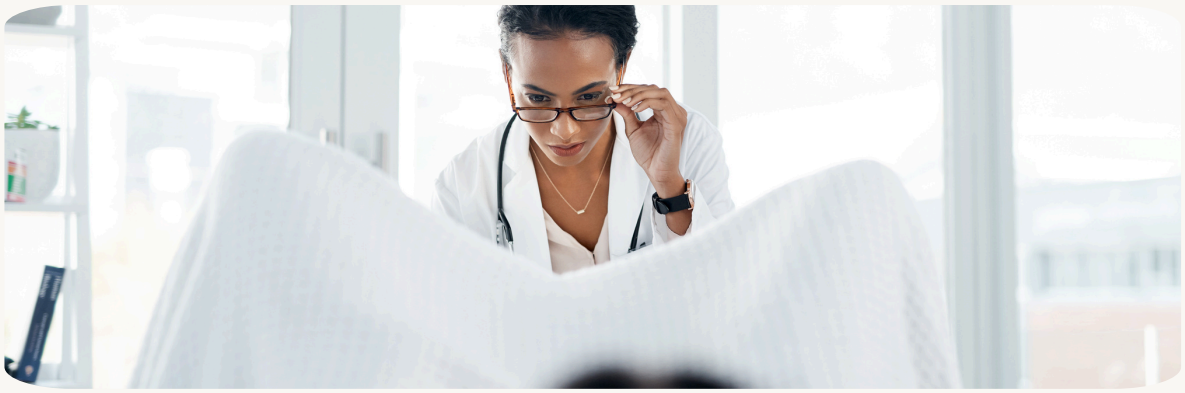

INDUCTION PATHS

Overview of Medications & Tools Used

Cytotec/Misoprostol (Medication)

Cytotec is also a synthetic prostaglandin (hormone that soften and ripen the cervix). This medication can be given orally, dissolved in your cheek, administered every 2-4 hours, depending on the dosage. It also can be administered as a suppository vaginally. Six doses in 24 hours is the maximum of this medication we've seen used, but more typically 2-3 doses. You will be connected to an external fetal monitor during this time.

Cervidil (Medication)

Cervidil is a synthetic prostaglandin (hormone that softens and ripens the cervix). This medication is administered as a suppository (vaginally) and is about half as big as your pinky with a very long string, similar to a tampon. It is inserted to rest against your cervix. Some clients report that Cervidil feels itchy. Cervidil can stay inserted for up to 12 hours. Often you can sleep as your cervix starts to soften. You will be connected to an external fetal monitor during this time. This process may also take some time before there are regular contractions and is an opportunity for some distraction and movement.

INDUCTION PATHS

Overview of Medications & Tools Used

Pitocin (IV Medication)

Pitocin is a synthetic form of the hormone Oxytocin (hormone that softens the cervix and stimulates contractions). Pitocin is administered intravenously. A nurse will start an IV line connected to a bag of IV fluid and a bag of Pitocin. IV fluid is administered along with the Pitocin to enable the small drips of Pitocin to actually reach your vein. In the same way that your body releases oxytocin in waves, Pitocin will be titrated in small but increasing doses in order to create contractions that will eventually help birth your baby. Pitocin simulates what the body would do on its own - increasing so that contractions become longer, stronger and closer together.

There is no way to tell exactly what amount of Pitocin your body will need to create contractions that are strong enough and frequent enough to help you meet your baby. Your nurse and provider will work with you to adjust the medication as needed. You will be connected to an external fetal monitor during this time.

Artificially Rupturing of Membranes/AROM (Procedure)

AROM is the manual breaking of your amniotic sack (also referred to as waters or membranes). To do this, your provider would use a small plastic tool with a tiny hook on the end to “snag” and rupture your membranes. Hormones in your amniotic fluid may help stimulate contractions. Also, the baby descending lower and putting pressure on the cervix can help the cervix dilate.

INDUCTION PATHS

What is your path?

Your Unique Induction Path

In order to determine which tools will be most effective for your particular circumstances, your provider will consider the following:

- What are the reasons for considering an induction of labor? Are there time considerations associated?
- To what degree is the health of you or your baby a concern? Are there health related limitations to consider?
- To what degree is your body showing signs of being ready for labor? (e.g. position of the baby, position, effacement and dilation of the cervix)

Your body is unique and may respond more or less to different methods. At each step along the way, your provider will check the status of your cervix, as well as you and your baby's well being, and have a conversation about what next tool to propose from the toolbox. A small fraction of people will respond effectively to one medication alone, but most of our clients use a combination of several of these tools to meet their babies. No matter what path you take to get to birth - we've got you!

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CHAPTER 4

PREPARATION & TIPS

PREPARATION
FOOD & REST

During the days leading up to your induction, we recommend you focus on healthy foods, rest, and hydration.

Make sure you enjoy a nutritious meal before checking into the hospital. We recommend something filling, yet light: fish or a very small portion of lentils, lean beef or chicken, vegetables, a simple carbohydrate, or anything from a brunch-type menu.

Try to avoid acidic foods like oranges or orange juice, slow-to-digest foods (red meats or fries), or high sugar foods (doughnuts, cakes, pastries) that may exacerbate nausea and would cause pain if you vomit during labor.

Many, but not all inductions, start at night. We encourage you to take things that will help you sleep (ex: white noise machine, eye mask, pillow, robe). As the early part of the induction often goes into the next day, also pack items for distraction and entertainment.

If you are having difficulty sleeping during the first part of your induction, you may want to talk to your provider about taking a pharmaceutical sleep aid like Benadryl or Ambien. It is helpful in the long run to be rested - so you have energy for the hard work of active labor and the demands of caring for a newborn.

PREPARATION
CONNECTING WITH YOUR DOULA

The induction medications have differing levels efficacy for each person. For some, it may take a good amount of time before the meds take effect, which makes the early labor induction process unpredictable. For our clients having their first baby through an induction, the average duration is **30.5 hours** (trended slightly longer for those over 35 years old) - and a good chunk of this time is early labor.

Once you start medications, we stay in touch with phone and text support and will have multiple conversations with you in this early labor phase. Once you are progressing into more active labor and/or you need reassuring in-person support, a doula will physically join you.

Please keep in mind inductions can sometimes take 1 - 3 days and we like to ensure you are matched with a well-rested doula; thus, one doula may provide phone support and another support your birth in person.

If labor doesn't start spontaneously, please call us during business hours a day or two prior to your induction check-in time. We will address any concerns you may have and discuss communication expectations.

PREPARATION
SETTING EXPECTATIONS

Cervical softeners may cause strong cramps or minor contractions. We urge you to think of these like menstrual cramps that you can manage by ignoring them, distracting yourself, using some movement, a heating pad, or resting.

- Stay flexible about your needs during labor.
- Talk with your provider about sleep aids and other pharmaceutical pain management options, if you are open to this. Nubain, Stadol, Nitrous Oxide may be options, as is an Epidural.
- It is possible to labor without pain meds/epidural during an induction, utilizing the same comfort measures tools as if labor started spontaneously.

Ensure you pack a home pillow, items for entertainment and distraction, and patience - as your induction experience will progress one step at a time.

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CHAPTER 5

SECOND(+) TIMERS

SECOND(+) BABY
INDUCTIONS ARE DIFFERENT

Many people having their second+ baby (called Multiparous) find their cervix is softening and opening in late pregnancy. They start their labors (whether spontaneous or induced) already 1-4cm dilated or with an extremely soft/effaced cervix.

Due to this pre-labor cervical change, many inductions for multiparous clients begin the morning instead of at night.

Here's what we see:
Among a small sample of 35 DCBD multiparous clients being induced, the average length of labor - from first intervention to meeting their baby - is **15 hours.** In this sample we found:

- average dilation at the start of the induction was 3cm
- 50% used a dose of Cytotec prior to Pitocin
- 79% used Pitocin
- 71% had their amniotic sac ruptured by their provider

Once contractions fall into a regular pattern or the amniotic sac breaks, we find Multip labors really take off!

DC Birth Doulas

WE ARE HERE TO SUPPORT YOU EVERY STEP OF THE WAY -

from helping you curate questions for your provider, to guiding you into helpful positions and grounding techniques during labor, we are here for you!

BIRTH@DCBIRTHDOULAS.COM