WHAT ARE MY OPTIONS?

WAITING FOR LABOUR TO START ON ITS OWN

Choosing to wait for labour to start on its own is called expectant management. If your pregnancy lasts beyond 40 weeks, you may feel pressure or concern from friends or family who are anxious for your baby's arrival. Not all pregnancies are the same length, and it is perfectly normal for some to last longer. Many pregnant people prefer to wait for labour to start on its own. You may feel that labour will begin when both the baby and your body are ready. You may also wish to avoid unnecessary medical intervention.

If you decide to wait for labour to start on its own, your midwife will offer to monitor your baby's health, usually with an ultrasound. If they have concerns, they may recommend an induction.

NON-MEDICAL METHODS TO ENCOURAGE LABOUR

Many midwives will offer non-medical methods to encourage labour. It is important to remember that these approaches do not guarantee that labour will start. One method that midwives frequently offer is called a stretch and sweep, or sweeping the membranes. Your midwife will use their fingers to assess your cervix (the opening to the womb). Depending on the degree of change to your cervix, they will stretch your cervix open (stretch) and pass their finger between the inside of your cervix and the bag of waters that holds your baby (sweep). This can be uncomfortable; you may even find it painful. Research shows that a stretch and sweep between 38 and 40 weeks can shorten the time before the baby's birth by about a day. Your midwife may offer multiple stretch and sweeps.

HOW CAN I DECIDE WHAT'S BEST FOR ME?

There are many things to think about when you decide whether to have a medical induction or wait for labour to start on its own.

For example, you may want to consider these questions:

- How do you feel about the risks and benefits of medical induction compared to waiting for labour to start?
- Where do you want to labour? Where do you want to have your baby?
- How comfortable are you with having birth interventions?
- Are there any other factors that might affect your options (e.g., presence of other medical conditions, previous labour history)?

Other non-medical methods used to encourage labour include castor oil, acupuncture, acupressure, homeopathy, and naturopathic and herbal remedies. Little research has been done to establish how well these approaches work or to test the ideal circumstances for their use. Please check with your midwife if you are interested in these methods of starting labour so you can discuss the benefits and possible risks of each.

INDUCTION OF LABOUR

Sometime between 41 and 42 weeks your midwife will offer an induction of labour. You may feel impatient, anxious or uncomfortable waiting for your baby's arrival. If you choose an induction, your labour will be started by one or more of the methods below, depending on how ready your body is to go into labour and other factors. The induction process may take multiple days.

- Gel or a tablet (like a tampon) can be inserted into your vagina, or birth canal. It contains a hormone called prostaglandin that softens the cervix so it can dilate more easily. In some cases, prostaglandin will also cause the uterus to contract. This method is administered in a hospital setting.
- A needle can be inserted in your arm (an intravenous drip, or IV) to give you a synthetic version of oxytocin, another hormone that stimulates the uterus to contract. IV oxytocin for induction of labour is only provided in a hospital setting. Because IV oxytocin can cause strong contractions, your baby's heart rate will be watched carefully with an electronic fetal monitor (EFM). It can be hard to move around with an EFM, though, because you are attached to a machine. You can ask if wireless EFM, called telemetry, is available at your hospital.
- A small hole in the amniotic sac can be made to break the water surrounding your baby. This will often encourage the uterus to contract. If your midwife recommends breaking the amniotic sac as a method of induction, this may be done at home, in a clinic or in the hospital. Your midwife will discuss this with you.

  In some hospitals, induction is managed by midwives, and in others your care will need to be transferred to a doctor. Talk to your midwife about what to expect at your local hospital.