

# Midwifery care for Induction of Labour



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# Introduction

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This document comprises a summary of the evidence and recommendations for the midwifery care of women for induction of labour (IOL). There are very important reasons why women may be offered an IOL, including underlying medical reasons, pathologies of pregnancy, multiple pregnancies and post-maturity. Induction is one of the most common interventions offered to pregnant women in the UK, with almost a third of all women reported to have their labours induced in 2018<sup>1</sup>. There is wide variation in IOL rates between maternity units<sup>2,3</sup> and the number of inductions has risen by 60% in the past ten years<sup>1</sup>.

This document provides a summarised version of systematically produced evidence for aspects of midwifery care related to IOL. The methods used to derive the summaries are outlined below. Full information detailing the scientific methods and processes utilised in the production of this guidance will be reported in publications arising from this work. A companion version to this document is available for women and families.

The belief underlying this work is that midwifery care makes a significant difference to the experiences of and clinical outcomes for women and their families<sup>4</sup>. This guidance seeks to support midwives in the aspects of induction where midwives can make a real difference. A recent systematic review commissioned by the World Health Organisation highlighted important aspects of women's experiences: an environment that feels clinically and psychologically safe; support from their companions and kindness and competence from those providing care; and active involvement in decision-making<sup>5</sup>.

This guidance should be viewed as complementing other high quality sources of evidence-based information. This includes that produced by the National Institute for Health and Care Excellence<sup>6</sup>, the Scottish Intercollegiate Guidelines Network<sup>7</sup> and local guidance supporting the provision of safe, high quality care that achieves optimal clinical and psychosocial outcomes. Recommendations for midwifery care apply to all women for whom induction is being considered but specific reasons for induction are not covered by this guidance. In addition, adaptation may be needed according to the health, social or other needs of individual women. In all situations, midwives should work in partnership with women and exercise their professional judgement in utilising the guidance. As with all guidance, recommendations derived from the evidence should form the basis of discussion between healthcare providers, pregnant women and their families when negotiating care. Women's own views, preferences and choices should always be taken into account; women should always be treated as individuals and with respect to ensure that informed consent is gained for all procedures.

Following an initial mapping of areas to be included, research questions were framed and scoping searches conducted to identify aspects of care for which high quality, systematic review evidence existed. The final topic areas were chosen during a period of user and professional consultation to identify priorities for IOL care. The evidence was identified and analysed in a systematic way using Joanna Briggs Institute (JBI) tools for evidence synthesis. The products of these searches were developed into evidence summaries. New systematic reviews were completed for areas where pre-existing, recent reviews were not available and where work in progress was not identified. The date range for inclusion of primary studies in new reviews was 2000-2019 and existing systematic reviews were included if published between 2014-April 2019.

This document includes contextual information, a short evidence summary for five broad aspects of care, Recommendations for Practice and Good Practice Points based on professional perspectives and individualised care.

**All recommendations are drawn from existing or new systematic reviews and we have used the following phrases to signal the strength of the recommendations:**

Recommendations starting **"There is good evidence to recommend..."** are based on strong evidence, and sentences starting with **"There is some evidence to suggest..."** are based on limited evidence, or evidence which may be of low or moderate quality.

In developing the guidance, we have drawn on research from settings beyond the UK where there appears similarities of care provision, availability of maternity care and the health of the childbearing population. In the context of a rising induction rate, it would appear important that future research related to induction includes women's experiences at all stages of the process, in addition to those related to achieving optimal clinical outcomes.

We acknowledge the significant support and contributions throughout of the members of our multi-disciplinary and cross-sectoral Expert Advisory Group, the Nottingham Maternity Research Network and the Royal College of Midwives (RCM) who funded this work. The RCM did not influence the guidance development process or individual recommendations. The guidance development group recommend review and updating within three years of publication.

## June 2019

### References:

1. NHS Digital (2018) <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-maternity-statistics/2017-18>
2. NMPA Project Team. (2018) National Maternity and Perinatal Audit: Clinical Report 2017. RCOG London, <http://www.maternityaudit.org.uk/downloads/NMPA%20Clinical%20Report%202018.pdf>
3. RCOG (2016) Patterns of maternity care in English NHS trusts. RCOG London. [https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/maternity-indicators-2013-14\\_report2.pdf](https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/maternity-indicators-2013-14_report2.pdf)
4. Renfrew MJ, McFadden A, Bastos M H et al. (2014) Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *Lancet* 384: 1129-1145.
5. Downe S, Finlayson K, Oladapo O, Bonet M, Gulmezoglu M (2018) What matters to women during childbirth: A systematic qualitative review *PLOS ONE* 13(4): e0194906. <https://doi.org/10.1371/journal.pone.0194906>
6. NICE (2008) Inducing labour: Clinical guideline CG70. <https://www.nice.org.uk/guidance/cg70/chapter/guidance#setting-and-timing>
7. Scottish Government (2017). *The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care in Scotland*. Edinburgh. The Scottish Government.

# Supporting women to make decisions about induction of labour

## Context to the guidance

*The decision to undergo an IOL is an important one for many women. It is essential to support women prior to them deciding about this intervention by discussion of current, high quality evidence to facilitate women to weigh up risks and benefits and make an informed choice. Estimated due dates (EDD) should be discussed with women and families, indicating that it is normal for a woman to have her baby up to about two weeks on either side of the EDD. Having conversations about IOL during the antenatal period may be useful to give the woman and her family time to consider all the options. All information should be tailored to a woman's specific clinical and psychosocial circumstances. Midwives should discuss care plans with women and the wider maternity team where appropriate. Specific evidence-based guidance for women with more complex medical and pregnancy needs can be accessed through national (e.g. NICE) and local guidelines.*

## Evidence summary

Women can feel pressured into accepting an induction and therefore detailed discussion is essential to support women to make the choices that are right for them<sup>1</sup>. Some women do not understand the process of IOL and do not feel involved in the decision-making process<sup>1,2</sup>. This can negatively impact on their experience<sup>1</sup>. There is some evidence that an information brochure, explaining the induction process in plain language, including the actions and side effects of prostaglandin and the time involved in the process can support women's decision-making and improve understanding<sup>3</sup>. This is important to enable women to make their own choices.

Concerns about their baby are a major influence in women's decision-making about IOL<sup>1</sup>. After 42 weeks of pregnancy, the risks of stillbirth or perinatal death are increased but still low<sup>4</sup>.

IOL at or beyond term (37-43 weeks<sup>4</sup>) is associated with fewer perinatal deaths in comparison to expectant management policies (1 per 1,000 compared with expectant management 3 per 1,000)<sup>4</sup>.

Although the optimal timing of offering IOL in low-risk pregnancies is still not clear, sub-group analysis comparing IOL at less than 41 weeks and IOL at or above 41 weeks revealed no clear differences in neonatal outcomes<sup>4</sup>.

However there are other considerations to discuss with women and their families as women may be concerned about the likelihood of further intervention if they choose induction<sup>1</sup>. There is low quality evidence which reported no clear differences in perineal trauma and post-partum haemorrhage between induction and expectant management groups<sup>4</sup> (awaiting labour onset with varying levels of monitoring). Women may also experience increased pain from induction<sup>1</sup>. Outcomes for women and their babies which are measured beyond the early postnatal period (i.e. breastfeeding, postnatal depression, child development) have not been reported<sup>1</sup>.

A policy of IOL at or beyond term is associated with a slightly higher risk of operative vaginal birth compared to expectant management policies (20.6% compared to 19.3%)<sup>4</sup>. Furthermore, operative

vaginal birth is more common among women having IOL at less than 41 weeks compared with inductions at later gestational ages<sup>4</sup>.

Fewer caesarean sections have been reported for IOL compared to expectant management groups<sup>4,5</sup> (16.3% compared to 18.4%<sup>4</sup>). However, another review utilising lower grade evidence presents conflicting data<sup>6</sup>.

There are different options in the process of induction and there is good evidence that it is important for women to consider each intervention offered as a choice, with clear informed consent for each separate intervention<sup>1</sup>. There is good evidence that it is important to discuss the implications of each intervention on the family's plans for birth, infant feeding and the postnatal period, as well as in terms of potential effects and experiences<sup>1</sup>.

## Recommendations for Practice

There is good evidence to recommend that:

- Women should be advised that an IOL at or beyond term may reduce the already small risk of perinatal death, although the optimal timing for offering IOL remains unclear.
- Women should be advised that there may be a slightly increased risk of an operative vaginal birth from an IOL at or beyond term compared to expectant management.
- Women should be advised that there is moderate evidence associating a reduced risk of a caesarean birth with IOL at or beyond term compared to expectant management.

There is some evidence to suggest that:

- A specifically designed information brochure explaining the induction process in plain language, including the actions and side effects of prostaglandin and the time involved in the process can improve women's knowledge and understanding.
- Midwives should ensure women and their families know that they have a choice about having an induction of labour.

## Good Practice Points

- Women should be informed that in most settings IOL may preclude other options such as home birth or birth on a midwifery led unit.
- Midwives should discuss with women how an induction may impact on their experiences and perceptions of pain.
- Organisations should provide education and resources to support midwives to communicate the absolute and relative risks associated with induction in a clear and understandable way.
- Midwives should follow professional standards and use their expert clinical judgement to provide information and facilitate women's decision-making. Information should be tailored to women's specific circumstances.
- Unless the clinical situation changes, midwives should not make frequent offers of this intervention.

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**The evidence and recommendations presented in this section were derived from a new systematic review developed for these guidelines and from existing high quality systematic reviews as referenced below:**

1. Coates R, Cupples G, Scamell A, McCourt C. (2018) Women's experiences of induction of labour; qualitative systematic review and thematic synthesis. *Midwifery* 69: 17-28 <https://doi.org/10.1016/j.midw.2018.10.013>
2. Lou S, Hvidman L, Uldbjerg N et al. (2018) Women's experiences of post term induction of labour: A systematic review of qualitative studies. *Birth (Early View)* <https://doi.org/10.1111/birt.12412>
3. Evans K, Pallotti P, Roberts J, Sands G, Eldridge J, Evans C, Spiby H. (2019) Non-pharmacological supportive interventions for women during induction of labour to promote comfort and wellbeing. Prospero registration CRD42019127728.
4. Middleton P, Shepherd E, Crowther CA. (2018) Induction of labour for improving birth outcomes for women at or beyond term *Cochrane Database of Systematic Reviews Issue 5*. Art. No.: CD004945. DOI: 10.1002/14651858.CD004945.pub4
5. Wood S, Cooper S, Ross S (2014) Does induction of labour increase the risk of caesarean section? A systematic review and meta-analysis of trials in women with intact membranes *BJOG: An International Journal of Obstetrics & Gynaecology* 121(6): 674-685
6. Rydahl E, Eriksen L, Mette J. (2019) Effects of induction of labour prior to post-term in low-risk pregnancies: a systematic review. *JBIR database of Systematic Reviews and Implementation Reports*. DOI: 10.11124/JBISRIR-2017-003587

# Improving women's experiences of induction of labour

## Context to the guidance

*Women's experience of IOL can be shaped by various factors. These may include the method, setting, information and support received from healthcare providers, family and friends, and women's perceptions of risk, control and choice.*

## Evidence summary

The ways in which IOL is discussed can result in women feeling they have no choice and cannot contribute to the decision-making process<sup>1,2,3</sup>. While some women are happy to receive direction from midwives and doctors, some feel powerless to challenge medical advice, especially if they feel their 'time is up'<sup>1,2,3</sup>. The sense of a time-limit can be due to hospital policies or from their own discomfort and fatigue<sup>1,3</sup> but can lead to a decision being rushed due to time pressure<sup>2</sup>. Some women may welcome an induction as a step towards the desired birth or to gain some sense of control over an unpredictable situation<sup>2,3</sup>. For other women IOL may require a shift in expectations for their birth and create feelings of resignation and disappointment<sup>2,3</sup>. Some women may also experience feelings of failure from having to be induced, believing their body to be incapable of birthing<sup>2,3</sup>. Women can feel disappointed when IOL policies limit their preparations for a normal birth in a low-risk setting<sup>1,3</sup>, or their birth choices (for instance, a home birth)<sup>1,2</sup>.

Many women do not feel fully informed about the various interventions offered as part of an IOL<sup>1</sup> and they can feel they have little control over making decisions once induction is started<sup>1,2,3</sup>. Women can feel fearful of increased interventions, the effect on future pregnancies, their relationship with their baby and their experience of motherhood<sup>1,2,3</sup>. However women's concern for their babies tends to overrule their concern about increasing interventions despite experiencing more pain from induction<sup>2</sup>.

Some women feel they receive too little information about IOL, and are poorly informed about their options, the associated risk and benefits and the time involved in the stages of the induction process<sup>1,2,3</sup>. Women experience IOL as a sequential set of steps with each having a set time frame to achieve results before moving onto the next intervention<sup>2,3</sup>. Women can experience delays during the induction process and long waits between admission to hospital and the actual induction<sup>3</sup>. Women may be unprepared for the length of time that induction will take, the possibility of staying in hospital overnight, and that partners may not be allowed to stay with them<sup>2,3</sup>. Compassion and support from healthcare providers and birth companions can enhance women's experiences throughout the induction process<sup>1,2</sup>. Good quality written information and information which is individualised to women's specific situations can improve women's knowledge and understanding<sup>1,3,4</sup>.

There is no review level evidence about women's experiences of different cervical ripening methods (mechanical or pharmacological).

There is some evidence that women who return home following cervical priming are more satisfied with their experience than women who remain in-patients and that returning home does not seem to affect women's anxiety, depression or infant feeding rates<sup>4</sup>. Women may also feel more in control when

having an outpatient induction and also more free to move around than in a ward setting<sup>2</sup>. In hospital settings some women feel they have little privacy but can still feel isolated without support<sup>2</sup>. Hospital wards are described by women as being places to endure, being noisy, busy and not conducive to rest<sup>2</sup>.

## Recommendations for Practice

There is some evidence to suggest that:

- Women should be given time to make decisions about post-term and other inductions of labour, after a balanced and comprehensive discussion about both the risks and benefits of an IOL.
- It is important for women to know the setting and possible timescale for induction.
- The risks and benefits of inductions which take into account women's specific situations need to be presented to promote women's involvement in decision-making.
- All women need to feel in control of the process of IOL and each intervention should be discussed beforehand and consented for separately during the process.
- Continuous and uninterrupted support from partners and family may improve women's experiences. This is reported as an advantage of returning home following cervical priming and should be facilitated where possible including the hospital setting.
- Women experiencing IOL need to have easy and timely access to midwifery advice and support and enabled to discuss their plan of care throughout the process.

## Good Practice points

- Midwives should ensure that women are informed that IOL is a series of procedures all of which have implications for their care and potential outcomes.
- Midwives should ask women about their needs during the induction process and wherever possible, provide women with supportive aids, spaces and privacy. Women should be informed about the local facilities and induction settings.
- Midwives and maternity services should enable women to have access to spaces to mobilise, birthing balls, water immersion, peaceful settings to rest and sleep and access to food and drink.

**The evidence and recommendations presented in this section were derived from a new systematic review developed for these guidelines and from existing high quality systematic reviews as referenced below:**

1. Akuamoah-Boateng J, Spencer R. (2018) Woman-centered care: Women's experiences and perceptions of induction of labour for uncomplicated post-term pregnancy: A systematic review of qualitative evidence. *Midwifery* 67: 46-56 <https://doi.org/10.1016/j.midw.2018.08.018>
2. Coates R, Cupples G, Scamell A, McCourt C. (2018) Women's experiences of induction of labour; qualitative systematic review and thematic synthesis. *Midwifery* 69: 17-28 <https://doi.org/10.1016/j.midw.2018.10.013>
3. Lou S, Hvidman L, Uldbjerg N et al. (2018) Women's experiences of post term induction of labour: A systematic review of qualitative studies. *Birth* (Early View) <https://doi.org/10.1111/birt.12412>
4. Evans K, Pallotti P, Roberts J, Sands G, Eldridge J, Evans C, Spiby H. (2019) Non-pharmacological supportive interventions for women during induction of labour to promote comfort and wellbeing. Prospero registration CRD42019127728.

# Membrane sweeps

## Context to the guidance

*Membrane sweeping can be offered to women as one way to reduce the need for formal induction and is recommended in UK policy as a way to avoid prolonged pregnancy. NICE guidance [CG70] recommends that nulliparous women are offered a membrane sweep at the 40 and 41 week antenatal visit and parous women at 41 weeks<sup>1</sup>. Additional membrane sweeping may be offered if labour does not start spontaneously<sup>1</sup>. Although membrane sweeps may be seen as a routine intervention by midwives, it is not an inconsequential procedure for women. Midwives should discuss the reasons for offering a membrane sweep and provide women with time to decide. Membrane sweeping involves a vaginal examination to assess the cervix which women can be unprepared for and may find painful or distressing.*

## Evidence summary

There is moderate evidence that women who have a sweep are more likely to go into spontaneous labour and less likely to have an IOL<sup>2</sup>. There is some evidence that membrane sweeping is generally safe for women with no other complications of pregnancy<sup>2</sup>.

There is low quality evidence to suggest an increased risk of pre-labour rupture of membranes for women having a membrane sweep<sup>2</sup>, however further studies are needed to improve confidence in the findings.

There is limited evidence to suggest there are no significant differences between women who had a membrane sweep and women who did not have a membrane sweep for:

1. The number of admissions to neonatal unit;
2. APGAR scores below seven;
3. Meconium-stained liquor;
4. Instrumental births;
5. Post-partum haemorrhage;
6. Labour augmentation;
7. Antenatal bleeding; and
8. Hypertension<sup>2</sup>.

There is some evidence to suggest that women are not well informed about membrane sweeping<sup>3</sup>, and there is limited evidence to suggest that consent is not always properly taken prior to a membrane sweep<sup>3</sup>. Overall, little evidence has been identified about women's information needs, decision-making and experience of membrane sweeping and more research is required to identify ways to support women's decision-making and ensure informed consent is obtained.

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## Recommendations for Practice

There is some evidence to suggest that:

- Women should be offered a sweep prior to formal induction as per the NICE guidelines.
- Women are more likely to go into spontaneous labour if they have a membrane sweep at or after 40 weeks.
- Informed consent should be obtained and documented for a membrane sweep as an invasive procedure.

## Good Practice Points

- Clear and understandable information should be presented about the risks and benefits of a sweep and the procedure should be explained in detail.
- Membrane sweeps should be discussed in an antenatal appointment prior to 40 weeks so that women have time to make considered decisions.
- Side effects of membrane sweeps, such as pain during the procedure and light vaginal bleeding and cramps afterwards should be discussed with women prior to consent for the procedure. This will support women to make an informed decision about a sweep and may alleviate worry if women experience these side effects.
- If a woman declines membrane sweeping, this decision must be respected and supported.
- Unless the clinical situation changes, midwives should not make frequent offers of this intervention.

**The evidence and recommendations presented in this section were derived from a new systematic review developed for these guidelines and from existing high quality systematic reviews as referenced below:**

1. NICE (2008) Inducing labour: Clinical guideline CG70. <https://www.nice.org.uk/guidance/cg70/chapter/guidance#setting-and-timing>
2. Avdiyovski H, Haith-Cooper M, Scally A. (2019) Membrane sweeping at term to promote spontaneous labour and reduce the likelihood of a formal induction of labour for post maturity: a systematic review and meta-analysis, *Journal of Obstetrics and Gynaecology*, 39:1, 54-62, DOI: 10.1080/01443615.2018.1467388
3. Evans K, Spiby H, Borrelli, S, Eldridge J, Sands G, Pallotti P, Roberts J, Evans C. (2019) Women's information needs, decision-making and experiences of membrane sweeping to promote spontaneous labour. Prospero registration CRD42019127729.

# Returning home following cervical priming

## Context to the guidance

*There is a growing trend to offer the choice to go home between cervical priming treatment and the continuation of IOL (usually for between 24–48 hours) for women who are having uncomplicated post-dates inductions of labour. This care pathway is often also called 'outpatient induction'. The NICE quality statement [QS60] states that 'women who have induction of labour (labour that is artificially started using a pessary, tablet or gel) started in a hospital maternity unit and then go home to wait for the induction to work are offered monitoring for a time before they leave the unit, and given information about who to contact if contractions start or they have any concerns and about the type of pain relief available' <sup>1</sup>.*

## Evidence summary

The current evidence base of the risks and benefits for returning home following cervical priming is not yet established, data is limited and requires updating. There is limited evidence reporting women's experiences which indicates that women who return home after methods for cervical priming (pharmacological or mechanical methods) have a more positive experience of IOL<sup>2,3</sup>.

## Recommendations for Practice

There is some evidence to suggest that:

- Midwives should advise women that the information to determine the risks and benefits of outpatient induction is still emerging. The current evidence is limited but reports similar maternal and neonatal outcomes to those who are an inpatient for the duration of the induction process.
- Women and families who return home following their IOL report a better experience of the induction process than those who are an inpatient for the duration of the induction, therefore this should be facilitated where possible in relation to individual circumstances and local service provision.

## Good Practice Points

- Midwives should advise that not all women will be able to return home during induction, as this depends on the method of induction, reason for induction and other individual factors, and the local care system.
- Midwives should ensure that women who return home know how to call a midwife if they want or need to.
- Midwives should ensure that families have suitable plans for returning to hospital, especially if they are located far from the unit or if transport may be difficult.

**The evidence and recommendations presented in this section were derived from a new systematic review developed for these guidelines; from existing high quality, systematic reviews:**

1. NICE (2014) Quality statement 2: Safety and support for women having labour induced as outpatients. Inducing labour: Quality standard [QS60]. <https://www.nice.org.uk/guidance/qs60/chapter/Quality-statement-2-Safety-and-support-for-women-having-labour-induced-as-outpatients>
2. Evans K, Pallotti P, Roberts J, Sands G, Eldridge J, Evans C, Spiby H. (2019) Non-pharmacological supportive interventions for women during induction of labour to promote comfort and wellbeing. Prospero registration CRD42019127728.
3. Coates R, Cupples G, Scamell A, McCourt C. (2018) Women's experiences of induction of labour; qualitative systematic review and thematic synthesis. Midwifery 69: 17-28 <https://doi.org/10.1016/j.midw.2018.10.013>

# Supporting women who wish to use complementary therapies to induce labour

## Context to the guidance

*Some women wish to use complementary therapies to effect an IOL, either instead of or prior to a medical induction. Midwives may be asked to provide specific advice regarding the safety and effectiveness of particular complementary therapies.*

## Evidence summary

There is some evidence that acupuncture may improve the Bishop's score within 24 hours but does not seem to impact upon induction rates or associated outcomes<sup>1</sup>. Available evidence suggests acupuncture and acupressure make no difference to the likelihood of a formal IOL being required or to the likelihood of caesarean section, instrumental birth and maternal and neonatal outcomes compared to sham (mock) therapies<sup>1</sup>. While some women may choose self-hypnosis as a coping strategy in labour, there is no evidence available that hypnosis is an effective means of IOL<sup>2</sup>.

There is some evidence that herbal preparations may have an effect on the start of labour but there is no safety data of good quality nor guidance for which herbs may be used<sup>3</sup>. There is no review level evidence on using other complementary therapies to induce labour.

## Recommendations for practice

There is some evidence to suggest that:

- If women chose to discuss complementary therapies for IOL, midwives should advise that acupuncture may improve cervical ripening but hypnosis and acupressure are not supported as effective methods of IOL by the available evidence.

## Good Practice points

- Women should be informed that there is no data on the safety of herbal preparations and some preparations may be harmful.
- Midwives should encourage women to discuss their birth plans for induction, including any complementary therapies they would like to use. There is some evidence (see RCM Midwifery Care in Labour Guidance) that women may find complementary therapies support their coping in labour.

**The evidence and recommendations presented in this section were derived from existing high quality systematic reviews as referenced below:**

1. Smith C, Marmour M, Dahlen H. (2017) Acupuncture or acupressure for induction of labour. Cochrane Database of Systematic Reviews Issue 10. Art. No.: CD002962. DOI: 10.1002/14651858.CD002962.pub4
2. Nishi D, Shirakawa M, Ota E, Hanada N, Mori R. (2014) Hypnosis for induction of labour Cochrane Database of Systematic Reviews Issue 8. Art. No.: CD010852. DOI: 10.1002/14651858.CD010852.pub2
3. Zamawe C, King C, Jennings HM, Mandiwa C, Fottrell E. (2018) Effectiveness and safety of herbal medicines for induction of labour: a systematic review and meta-analysis. BMJ Open 8: e022499. doi: 10.1136/bmjopen-2018-022499





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