OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Timing of Birth

(indications and gestations for booking induction of labour and elective caesarean section)

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

This document should be read in conjunction with this Disclaimer

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Aim

This Clinical Practice Guideline aims to support personalised decision-making for the timing of birth at Women and Newborn Health Service (WNHS).

Background

Optimal timing of birth is a critical aspect of maternity care, balancing the benefits of fetal maturation against the risks of continuing the pregnancy. When obstetric complications are present, current best available evidence and collaboration between clinicians and women and her family is required to personalise care plans and ensure informed choice.

Key Points

- Women and Newborn Health Service (WNHS) defines “full term” as 39+0 to 40+6 weeks gestation.
- Optimal timing of birth balances fetal maturity with maternal and fetal risk; decisions should aim to maximise gestational age, where it is safe to do so.
- In uncomplicated pregnancies, where there are no maternal or fetal risk factors:
    - allowing gestation to continue until 39 weeks or later improves neonatal outcomes, including respiratory, feeding, and neurodevelopmental outcomes;
    - planned birth is not clinically indicated, and expectant management remains the recommended approach.
- In complicated pregnancies, where maternal and/or fetal pathology is present, planned birth may be indicated before 39 weeks if the risks of continuing the pregnancy outweigh the benefits of further gestation. Timing of birth must be individualised, guided by the specific clinical condition, evidence outlined in Table 1: Safe Timing of Birth, ongoing maternal-fetal assessment, the provision of information to support personalised decision-making and informed choice with the woman and her family.
- All information provided must be appropriate in terms of the woman and her family’s language and communication needs, health literacy and culture. For example, where there is uncertainty about English proficiency or other language barriers, Language Services must be engaged to ensure informed consent in accordance with WA Health MP0051/17 Language Services Policy.
- All women, families and/or babies who identify as Aboriginal or Torres Strait Islander should be offered the services of the Aboriginal Hospital Liaison Officer (AHLO) and Support Service (AHLSS), who play a crucial role in supporting patients through coordinated communication, care navigation, and ensuring culturally safe engagement across all points of care.

Definitions

Planned birth	A birth that is anticipated and prepared for, involving medical intervention, either as induction of labour (IOL) or elective caesarean section
Preterm	Before 37 weeks gestation
Early Term	Between 37 – 38+6 weeks gestation
Full Term	Between 39 – 40+6 weeks gestation
Prolonged pregnancy	≥41+0 weeks gestation (for management see WNHS Prolonged Pregnancy Clinical Practice Guideline)
Post Term	≥42 weeks+0 weeks gestation

Uncomplicated Pregnancy

In uncomplicated pregnancies, WNHS supports expectant management and the Australian Preterm Birth Prevention Alliance *Every Week Counts* campaign (Every Week Counts online resources [external link]). Accordingly, WNHS defines "full term" as 39 – 40+6 weeks. Therefore, in uncomplicated pregnancies where there are no maternal or fetal risk factors, induction of labour or planned caesarean before 39+0 weeks is not routinely supported and expectant management remains the recommended approach.

Complicated Pregnancy

There are certain situations where continuing a pregnancy to increase gestational age may increase the chance of complications for the baby or woman, particularly when health complications are already present during the pregnancy. In pregnancies with maternal and/or fetal pathology, the risks of continuing a pregnancy may outweigh the benefits of a later gestation birth. As such, it should be explained that public health messaging, including *Every Week Counts*, applies only to uncomplicated singleton pregnancy.

For some women, increased maternal and/or fetal surveillance towards the end of pregnancy may be indicated based on the accumulation of risk factors and can assist decision-making. Timing of elective birth may also need to be altered to meet any anticipated postnatal medical needs of the mother and/or neonate, particularly in the context of availability of specialist expertise.

Decisions regarding timing of birth for complicated pregnancies should therefore be guided using information in Table 1: Safe Timing of Birth, to provide information to women and their families to support informed decision-making and choice, and ensures consistency of guidance offered, based on best available evidence, whilst

allowing for decisions to be tailored to individual based on their specific circumstances and medical history.

Decision-Making Processes

Early recognition of complications in pregnancy alongside sensitive evidence-based communication with women around risk factors and their fears and anxieties should be part of standard pregnancy care. The assessment of risk should be continuous throughout the antenatal period, taking into account events during the pregnancy which may alter the risk (from booking).

Decision-making about timing of birth for women should be based on the principles of informed choice and therefore be a collaborative and comprehensive discussion between health clinicians and the woman, which empowers her to make decisions about care that is individualised. Clinicians should be mindful of sharing information in a consumer-friendly language, and utilisation of interpreters where applicable.

This should include:

- The indication for planned birth based upon current best available evidence (guided by Table 1).
- Individualised maternal and/or fetal benefits, risks, alternatives and possible outcomes for timing of planned birth.
- Consideration of the woman's current situation, including both risk and safety in the cultural, social, emotional and financial contexts in which she exists.
- The risks and benefits of induction of labour/planned caesarean:
    - Including all information relating to WNHS processes, i.e. admission processes, likelihood of delay, methods of IOL, fetal surveillance and other details as required by the WNHS Induction of Labour Clinical Practice Guideline or the elective caesarean, pre-admission and preparation section of the Caesarean Birth Guideline.
    - At OPH, see also Osborne Park Hospital WNS: Caesarean Section - Elective (OPH).
- Any other requirements as per WA Health MP 0175/22 Consent to Treatment Policy.

Documentation Requirements

The details of all decision-making and discussions should be documented in the patient healthcare record, including:

Clinical indication details	The primary indication and supporting clinical findings including: • Planned gestation • IOL method • Discussion surrounding contingency planning (that would occur if IOL is postponed or if clinical picture changes)
Multidisciplinary input (if indicated)	For higher-risk cases, what multidisciplinary input was sought (e.g. Maternal Fetal Medicine [MFM]): • Names/designations • Date/time of discussion

Informed consent	• Ensure completion of consent form
	• Document that the patient was informed of:
	  ○ Indication for early birth
	  ○ Risks and benefits of early birth or prolonging the pregnancy
	  ○ Alternatives (including no intervention)
	• Document the woman's questions and the responses provided
	• Document relevant discussions
	• Interpreter use if applicable

Declines recommended care	• Woman plans to/has declined recommended care (documentation as per Partnering with the Woman who Declines Recommended Maternity Care Clinical Practice Guideline)
Neonatal planning	• For preterm births, consider the use of steroids as per corticosteroid guideline. • For births prior to 30 weeks, consider IV magnesium for fetal neuroprotection. • Referral to Complex Care and Neonatology for a Maternal Neonatal Management Plan (MNMP) if required.

Table 1: Safe Timing of Birth

Note: This is not an exhaustive list. For any other indications not included in the below table, timing of birth should be determined through personalised decision-making between the woman and clinician(s), integrating clinical assessment with efforts to optimise fetal maturity to ensure the safest possible timing for delivery.

Condition	Clinical Criteria	Gestation	Evidence
Alloimmunisation	Titres of antibodies known to cause haemolytic disease of the newborn stable at <1:32 (excluding Kell)	From 38+0	1
	Antibodies >1:32 OR anti-Kell	Recommendation guided by Maternal Fetal Medicine (MFM) service	
Cholestasis	Mild ICP (peak TSBA 19—39μmol/L)	Not indicated for IOL	3
	Moderate ICP (peak serum TSBA 40—99μmol/L)	From 38+0	
	Severe ICP (peak serum TSBA ≥100μmol/L)	From 35+0	
Congenital abnormality	Confirmed or suspected	Timing of birth should be determined through shared decision-making between the woman and clinician, integrating clinical assessment with efforts to optimise fetal maturity to ensure the safest possible timing for delivery.	

Condition	Clinical Criteria	Gestation	Evidence
Diabetes			
• Consider fetal size when planning timing of birth; an EFW >4500g or >4cm difference between head circumference (HC) and abdominal circumference (AC) warrants counselling on the increased risk of shoulder dystocia. • For women with pre-existing diabetes, C80 is the preferred cervical ripening method if induction is required. ○ This approach reduces the risk of hyperstimulation, noting that terbutaline (the antidote) may precipitate DKA in women with diabetes.			
Gestational Diabetes	Managed with diet, optimal glycaemic control and no other maternal/fetal concerns	No indication for IOL	4 - 5
	Requiring insulin/OHA, normal fetal growth, no concerns of glycaemic control, and no other maternal/fetal concerns	From 39 to 39+6	
	Requiring insulin/OHA, suboptimal glycaemic control and/or suspected LGA	From 38 to 38+6	
Pre-existing/Overt	Overt DM, requiring insulin/OHA, normal fetal growth, no concerns of glycaemic control, and no other maternal/fetal concerns	From 39 to 39+6	4 - 5
	Overt DM, requiring insulin/OHA, suboptimal glycaemic control and/or suspected LGA	From 38 to 38+6	
	T1DM / T2DM / LADA / MODY well controlled, no other maternal or fetal concerns	From 38 to 38+6	
	T1DM / T2DM / LADA / MODY suboptimal glycaemic control and/or fetal growth concerns and/or other obstetric/medical complications	Timing of birth dependant on clinical presentation and guided by Obstetric Consultant	

Condition	Clinical Criteria	Gestation	Evidence
Fetal Growth Restriction / Small for Gestational Age Ultrasound Finding			
• UA Doppler abnormalities should take precedence over fetal biometry when determining the timing of birth. • MCA PI <5th centile guide frequency of surveillance only (ultrasound and CTG) and should not be used to initiate delivery before 37 weeks. • RCOG Good Practice Point: Offer serial fetal growth assessment and UA Doppler when AC or EFW is <10th centile or when growth velocity is reduced.			
Biometry abnormalities	Isolated SGA: AC or EFW between 3rd and 10th centile* (*with appropriate interval growth trajectory, normal UA PI Doppler, Normal MVP, and no concerns for maternal wellbeing)	39+0 to 39+6	6 - 10
	EFW or AC <3rd centile	37+0 to 37+6	
	EFW or AC <1st centile	36+0 to 36+6	
	Slowing growth trajectory falling >50 centiles on scans 14 days apart (with normal UA Dopplers, normal MVP and no concerns over maternal wellbeing.)	38+0 to 38+6	
Doppler abnormalities (in context of AC or EFW <10th centile, OR slowed growth falling >50 centiles [e.g. from 70th to or below 20th centile]**)** *Timing of birth recommendations should be Consultant-led; consider MFM input.*	Raised UA PI >95th centile	36+0 to 36+6	6 - 10
	UA: absent EDF	Consider delivery if 32+0 to 33+6. Plan delivery if 34+0 or over.	
	UA: reversed EDF	Consider delivery if 30+0 to 31+6. Plan delivery if 32+0 or over.	
	Other Doppler abnormalities including ductus venosus abnormalities and early onset FGR (<32 weeks of gestation)	Delivery planning guided by complete assessment of medical condition by Consultant, often involving MFM input.	

Condition	Clinical Criteria	Gestation	Evidence
Fetal macrosomia or large for gestational age – suspected	EFW >95th centile at or after 36 weeks of pregnancy, in the absence of gestational or pre-existing diabetes	Discuss options of IOL from 39 to 39+6	11 - 13
	EFW >5000g in woman without diabetes, or >4500g in women with diabetes	Discuss elective caesarean from 39+0 – 39+6	
Fetal presentation	Breech (for ELUSC)	≥39+0	
	Unstable lie	≥39+0	
IVF	Uncomplicated pregnancy, no other co-morbidities	39+0 to 39+6	14
Isolated hypertension (pre-existing or gestational)	Medicated, well controlled, stable	38+0 to 40+0	
	Suboptimal BP control	Recommendation based on shared decision-making between the woman and clinician, clinical assessment, and optimising fetal maturity for safe timing of birth	15 - 16
Maternal age (at EDD)	Age ≥40years	39+0 to 39+6	17 - 18
Maternal choice	Maternal choice in the absence of any other risk factors	From 39+0	
Multiple birth	DCDA, no other complications	37+0 to 37+6	
	MCDA, no other complications	36+0 to 36+6	
	Complex multiple pregnancy (triplets or higher order, monoamniotic twins, complication of monochorionicity)	Recommendation based on shared decision making between the woman and clinician, clinical assessment, and optimising fetal maturity for safe timing of birth. **Seek MFM advice.**	19

Condition	Clinical Criteria	Gestation	Evidence
No or minimal antenatal care		Recommendation based on shared decision-making between the woman and clinician, clinical assessment, and optimising fetal maturity for safe timing of birth.	
Obesity	BMI >50	39+0 to 39+6	20
Placental complications			
• Timing of birth for women with suspected, confirmed, or symptomatic placental complications should be guided by clinical judgement, the multidisciplinary team and the goal of optimising fetal maturity.			
Placenta Praevia	Asymptomatic	36 to 37+6	
	Placenta Praevia with history of bleeding and risk factors of pre-term birth	From 34 to 36+6	
Placenta Accreta Spectrum	Asymptomatic	From 35+0 to 36+6	21 - 23
Vasa Praevia	Asymptomatic	From 36+0 to 36+6 **From 34+0 if risk factors for preterm birth.**	21 - 23
Polyhydramnios	Polyhydramnios (in the absence of any other risk factors)	• AFI <30, expectant management. • AFI >30, discuss with MFM.	

Condition	Clinical Criteria	Gestation	Evidence
Pre-eclampsia	Mild – as per WNHS guideline Asymptomatic Stable BP	From 37+0	
	Moderate – severe symptoms and/or maternal or fetal deterioration	Timing of birth should be determined through shared decision-making between the woman and clinician, integrating clinical assessment with efforts to optimise fetal maturity to ensure the safest possible timing for delivery. **Birth should be considered at any gestation in the event of maternal or fetal deterioration.**	15 - 16
Pre Labour ROM at Term	≥37+0, GBS negative/ unknown, no meconium	IOL by 24 hours post ROM	24 - 25
	≥37+0, GBS positive and/or meconium-stained liquor	Immediate IOL	
PPROM	<37+0, no other clinical concerns, GBS negative	From 37+0	
	34+0 to 36+6, GBS positive	Recommend immediate IOL, commence antibiotic prophylaxis	
	<37+0, no other clinical concerns, GBS unknown	Recommend rapid GBS PCR to guide timing of birth considerations	

Condition	Clinical Criteria	Gestation	Evidence
Previous Caesarean	Previous LUSCS	From ≥39+0	2
	• ≥ 2 previous caesareans • Previous myomectomy or other uterine surgery • History of uterine scar dehiscence and/or rupture (where no history of early labour)	From ≥39+0	2
	• Previous classical or other extended uterine incision not suitable for labour • History of uterine rupture with history of early labour	37+0 to 38+0	
	<37+0, with maternal and/or fetal concerns	Timing of birth recommendation should be based on clinical grounds	

Compliance Monitoring

- Compliance to this guideline will be monitored as per the Midwifery and Obstetrics Clinical Practice and Outcomes Committee's (MOCPOC) Compliance Monitoring Framework (CMF).
- The audit results and recommendations are to be tabled at MOCPOC for approval, with low compliance escalated to Clinical Governance Committee.
- Any issues pertaining to the use of this guideline are to be escalated to MOCPOC for review.

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Related external policies, legislation and standards

Medicines and Poisons Act 2014

WA Health MP0051/17 Language Services Policy

WA Health MP 0175/22 Consent to Treatment Policy

Related WNHS policies, guidelines and procedures

WNHS Obstetrics and Gynaecology Clinical Guidelines:

- Caesarean Birth
- Induction of Labour*
- Prolonged Pregnancy
- Partnering with the Woman who Declines Recommended Maternity Care Clinical Practice Guideline

Osborne Park Hospital Women and Newborn Services Guidelines

- Caesarean Section – Elective*

Perioperative Services

- Complex Surgical Care in Perioperative Patients*

WNHS Policy

- Elective Surgery Waitlist and Non-Attendance Management*

* Available to WA Health staff via SharePoint

Useful resources and related forms

Consumer information: Every Week Counts (external website)

Healthcare professionals: Every Week Counts (external website)

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

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NSQHS Standards (v2) applicable:	1: Clinical Governance, 2: Partnering with Consumers, 5: Comprehensive Care, 6: Communicating for Safety, 8: Recognising and Responding to Acute Deterioration
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Version history

Version number	Date	Summary
1	July 2023	• 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
1.1	Dec 2023	• Minor amendment- hyperlink changed to AMA guideline in appendix
2	Sept 2026	• Major amendment – to remove IOL processes and redefine scope of document to focus on Timing of Birth. • Table added with updated recommendations reflective of evidence-based practice and Every Week Counts.

This document can be made available in alternative formats on request for a person with a disability.

Within the Department of Health WA, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

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