Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Timing of Birth

Good practice point

OFFICIAL

Aim

To promote evidence-based guidelines for the timing of birth in both uncomplicated and complicated pregnancies. It emphasizes that in low-risk pregnancies, allowing gestation to continue until 39 weeks or later improves neonatal outcomes, including reduced respiratory and feeding problems and better brain development. Conversely, in pregnancies with complications such as fetal growth restriction or pre-eclampsia, earlier delivery may be necessary to minimize risks to both the mother and baby. This GPP underscores the importance of adhering to international and national guidelines, engaging in shared decision-making, and ensuring informed consent to optimize perinatal outcomes.

Full-term birth in healthy pregnancies

Evidence shows that, in uncomplicated pregnancies, each extra week of gestation up to 39 weeks improves neonatal outcomes. Campaigns such as *Every Week Counts* and the *The Whole Nine Months* highlight that babies born at 39–40 weeks have fewer respiratory and feeding problems and lower nursery admission rates than those born at 37–38 weeks. Infants born closer to 40 weeks also show better brain development and school-age cognitive outcomes. Accordingly, international and national guidelines now define “full term” as 39–40+6 weeks. For uncomplicated pregnancies, routine induction of labour or planned caesarean before 39+0 is medically inadvisable and ethically unsound.

Exceptions – Complicated pregnancies

The above does ***not*** apply when obstetric complications are present. In pregnancies with fetal growth restriction (FGR), pre-eclampsia, hypertension, pre-existing or complex diabetes, oligohydramnios, cholestasis, or other maternal/fetal pathology, the risks of continuing beyond 37–38 weeks may outweigh the benefits of a later birth.

Small-for-gestational-age fetuses (usually defined as <10th percentile) carry a **higher risk of stillbirth**; in fact, SGA is the single biggest risk factor for stillbirth, and many such fetuses require early birth to reduce the chance of perinatal death. Similarly, there is consistent evidence that women with pre-eclampsia should be delivered at 37 weeks to optimise perinatal outcomes. Decisions regarding timing and mode of birth for these complicated pregnancies should involve senior clinicians, with reference to local and international guidelines to support information provision to women and their families to support shared decision making.

Increased risks if prolonged

In complex pregnancies, extending gestation can significantly increase perinatal morbidity. For example, FGR increases intrauterine death risk roughly to 1.5% if estimated fetal weight is <10th percentile (and to ~2.5% if <5th) – about double the baseline risk in normally grown fetuses. Likewise, untreated pre-eclampsia carries maternal and fetal risks that rise rapidly with gestation. Therefore, clinicians must distinguish routine from high-risk situations:

planning for full-term birth is appropriate in the former, while timing of birth in pregnancies with complications needs to be individualised based on the degree of complexity and associated perinatal risk.

Key practice points

- **Uncomplicated pregnancies:** Aim for spontaneous or electively planned birth at or after 39+0 weeks. Avoid routine induction or caesarean before 39 weeks without a clear medical indication. Counsel women that delaying birth until 39–40 weeks (if safe) reduces NICU admission and supports optimal fetal brain development.
- **Complicated pregnancies:** Apply condition-specific timing derived from local and international guidelines.
- **Counselling and consent:** Explain that public-health messages about “every week counts” apply only to healthy pregnancies. In uncomplicated pregnancies, elective early delivery has no maternal benefit and carries neonatal downsides (more respiratory support, NICU time, potential long-term learning issues). Conversely, in complicated pregnancies emphasise that prolonging gestation can lead to stillbirth or severe neonatal morbidity. Document informed consent for the timing of birth, ensuring the plan reflects current evidence and guidelines, and apply the principles of shared decision-making in determining the optimal time and mode of birth.
- **Follow evidence and guidelines:** Stay up to date with RANZCOG, NICE, ACOG and WHO recommendations on timing. (For example, WHO recommends not inducing uncomplicated pregnancies before 41 weeks.) In audits, services are encouraged to monitor and reduce unwarranted early deliveries in low-risk cases.

Summary

In summary, aim for 39+0 weeks in uncomplicated pregnancies, but carefully consider earlier birth in the presence of fetal or maternal pathology. Preterm or early-term birth is often *safer* than term birth when complications like FGR or pre-eclampsia are present. Adhering to this evidence-based approach will minimise perinatal mortality and morbidity across all patient groups.

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