

CLINICAL PRACTICE **20** GUIDELINE



Association of
Ontario **Midwives**
Delivering what matters.

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The views expressed in this guideline are strictly those of the Association of Ontario Midwives. No official endorsement by the Ministry of Health is intended or should be inferred.

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The AOM is committed, through our statement on Gender Inclusivity and Human Rights, to reflect and include trans, genderqueer and intersex communities in all aspects of our work.

In this document, there are references to sources that use gendered language to refer to populations of pregnant and birthing people. To accurately represent these sources, the AOM may have maintained gendered language.

The AOM supports research and knowledge translation that engages and reflects the entire childbearing population.

ABOUT THIS CPG

This clinical practice guideline (CPG) has been developed by and for midwives, contextualized within the midwifery model and philosophy of care and designed to provide information for midwives and clients engaged in complex decision-making. The information in this CPG is consistent with the best evidence available as of the date issued and is subject to change. The information in this guideline is not intended to dictate a course of action, but to inform clinical decision-making. Midwives should use their clinical judgment on how to interpret and apply the recommendations to individual circumstances. Local standards may cause practices to diverge from the suggestions within this guideline. If practice groups develop protocols that depart from a guideline, it is advisable to document the rationale for the departure.

Midwives recognize that client expectations, preferences and interests are an essential component in clinical decision-making. Informed choice discussions involve explaining community standards, which may include applicable CPGs, hospital and practice protocols (if available) used in the community to guide provision of care. For clients to make a fully informed decision, midwives need to make clients aware of recommendations from their own profession (e.g., CPGs, CMO standards), related professions (e.g., SOGC) and those used in their community (e.g., hospital, regional guidelines). Clients may choose a course of action that differs from the recommendations in this guideline, within the context of informed choice. When clients choose a course of action that diverges from a clinical practice guideline and/or practice group protocol, this should be well documented in their charts.

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AIM OF THE GUIDELINE

Statement of purpose

The goal of this document is to provide an evidence-based clinical practice guideline (CPG) on support for clients in early labour that is consistent with the midwifery philosophy and model of care. This guideline is for midwives in Ontario and all clients receiving midwifery care during early labour. Midwives in Ontario are encouraged to use this CPG as a tool in clinical decision-making.

Objective

The objective of this CPG is to provide a critical review of the research literature on approaches to care and support for clients in early labour. Evidence related to the following will be discussed:

- Definitions of active labour
- Prenatal education regarding labour
- Assessment of the labouring person and fetus in early labour
- Comfort measures and pain relief in early labour
- Promoting labour progress
- Client experiences of early labour

Outcomes of interest

The following outcomes were rated as either “critical” or “important,” following the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) process for each research question addressed in the guideline.

Critical outcomes:

- Neonatal mortality (intrapartum stillbirth and death in the first seven days)
- Birthing person mortality
- Composite of neonatal morbidity (e.g., NICU admission, neonatal infection/sepsis, respiratory distress, neonatal length of stay)
- Composite of birthing person morbidity (e.g., PPH, infection, uterine rupture, birthing person length of stay)
- Mode of delivery

Important outcomes:

- Duration of labour
- Admission to hospital

- Use of pharmacological pain management
- Augmentation/induction
- Client satisfaction
- Midwifery resources (e.g., human resources)
- Health-care equity

Literature search

A search of MEDLINE, CINAHL and the Cochrane Library from 1998 to 2025 was conducted using a defined search strategy. Reference lists of relevant systematic reviews and key papers were also reviewed. When synthesizing evidence, systematic reviews were prioritized; if no systematic reviews were found, randomized controlled trials (RCTs) and observational studies were retrieved.

Methods

This CPG uses the GRADE methodology for guideline development. The GRADE process determines the certainty of the evidence (how certain we are of the results) as well as the strength of the recommendation. Certainty of evidence in this CPG is rated from very low to high, according to five GRADE domains: risk of bias, inconsistency, indirectness, imprecision and publication bias. Methodological concerns about the included studies, variability across results, applicability of the evidence to our context, precision of the results and completeness of the evidence base are considered as part of these domains. The Diagnosis of Active Labour (DAL) Task Force’s (TF) judgments about the certainty of evidence reflect the group’s confidence that available evidence correctly reflects the true effect of an intervention and is sufficient to support decision-making.

Results from low certainty of evidence are described using such language as “may”; results from moderate certainty of evidence are described using such language as “probably” or “likely”; and results from high certainty of evidence are described without these qualifiers.

When RCT evidence was available, it was assessed using GRADE methodology. In instances where RCT evidence was not available, observational studies were assessed using GRADE.

CERTAINTY OF EVIDENCE	How certain we ought to be about an estimate of effect or association
High	Further research is very unlikely to change confidence in the estimate of effect. • This evidence provides a very good basis for decision-making.
Moderate	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate. • This evidence provides a good basis for decision-making.
Low	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate. • This evidence provides some basis for decision-making.
Very low	Any estimate of effect is very uncertain. • This evidence does not provide much of a basis for decision-making.

Based on: (1–3)

Recommendations in this CPG are based on formal ratings of the certainty of evidence and are described as either strong or weak according to the GRADE approach. The strength of recommendation reflects the extent to which the DAL Task Force is confident that the benefits of a recommended intervention outweigh its harms or vice versa. The strength of recommendation is influenced by the certainty of supporting evidence, the balance between desirable and undesirable effects and the perceived variability or uncertainty in clients' values and preferences with respect to the intervention. (1–5) Within this CPG, weak recommendations use the terminology “may” and strong recommendations use “should.”

Good practice statements represent guidance that the DAL TF deemed important but not appropriate for formal ratings of certainty of evidence, as there was no direct evidence on the research question. Good practice statements are made when the Task Force is confident that the action has a net benefit to the client and no sensible alternatives exist. (6)

Complete GRADE evidence tables used to summarize research and inform the recommendations in this guideline are available on the AOM website. A full description of the AOM's approach to clinical practice guideline development using GRADE is also available on the [AOM website](#).

TYPES OF STATEMENTS IN THIS CPG

- **Recommendations:** Action statements about the intervention based on the certainty of the evidence, clinical considerations, client preferences and values.
- **Good practice statements:** Statements whereby the net benefit of the intervention is large and unequivocal, and the TF has considered it useful to provide guidance to clinicians in this area. The evidence for good practice statements is typically difficult to collect and summarize, and therefore no formal rating of the certainty of evidence is undertaken.
- **Summary statements:** The TF has deemed a recommendation unnecessary according to standards of care.

STRENGTH OF RECOMMENDATION	The extent to which the TF is confident that the benefits of the recommended intervention outweigh its harms (or vice versa)
Strong	Benefits clearly outweigh risks and burdens (or vice versa). <i>Can be interpreted as:</i> • Most clients should be offered the intervention, assuming that they have been informed about and understand its benefits, harms and burdens. • Most clients would want the recommended course of action and only a small proportion would not.
Weak	Benefits, risks and burdens are closely balanced. <i>Can be interpreted as:</i> • The majority of clients would want the suggested course of action, but an appreciable proportion would not. • Values and preferences vary widely.

Based on: (1–4)

Review

This CPG was reviewed using a modified version of the AGREE instrument (Appraisal of Guidelines for Research and Evaluation) and the AOM Values-based Approach to CPG Development, as well as the consensus of the

Diagnosis of Active Labour Task Force (DAL TF), the Clinical Knowledge Translation (CKT) Committee, the Racial Equity Committee (REC), the Quality, Insurance and Risk Management (QIRM) Committee and the AOM Board of Directors.

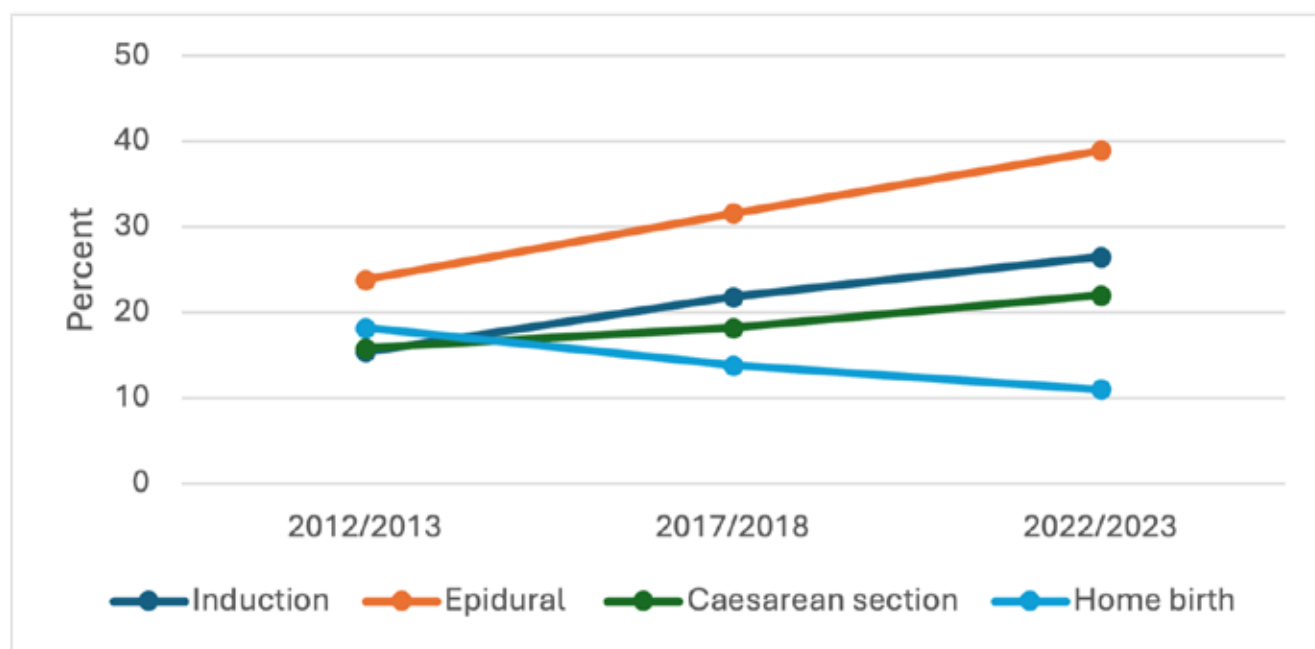
INTRODUCTION

The Ontario midwifery philosophy, approach and model of care are deeply rooted in the belief that pregnancy is a healthy state and that childbirth is a physiologic process. (7) Midwives are experts in physiologic birth, and they develop skills and clinical practices to facilitate this process. For example, they devote time to building strong relationships with clients, based on respect, trust and individualized care. They offer choice of birthplace, including home assessments and community births, enabling clients to remain out of the hospital, which is known to reduce interventions. (8–10) Continuity of care (a core tenet of midwifery), more time spent with clients, trusting midwife-client relationships and home care all support the physiologic processes of labour and birth.

Midwives and midwifery organizations, including the International Confederation of Midwives, have long promoted physiologic birth (11,12), as it is well established that unnecessary interventions disrupt the physiologic process and present risks for the birthing person and infant. (13–17) Meanwhile, spontaneous vaginal birth is associated with a lower risk of morbidity and mortality for the birthing person (18,19), improved attachment between birthing person and infant (19), improved chest/breastfeeding (19,20), lower rates of postpartum depression (21–23) and a better birth experience. (19)

Despite these known benefits, rates of intervention during labour and birth have risen consistently over the past decades. Though midwifery clients in Ontario have much lower intervention rates than the provincial average, midwifery has not been immune to the increase. In 2003, 14.5% of midwifery clients gave birth via caesarean section. (24) Twenty years later, in 2023, this number had increased to 22%. (25) A similar trend has been seen in induction and epidural rates. In 2012–13, 15.4% of midwifery clients were induced (26), and 23.8% received an epidural (27), with these numbers rising to 26.5% (26) and 43.9% (28), respectively, in 2022–23. These rates of intervention have coincided with a decrease in home births; 24% of midwifery clients gave birth at home in 2003–04, with this number falling to 11% in 2022–23. (29) Figure 1 outlines the trends for rates of induction, epidural, caesarean section and home birth in Ontario midwifery. Furthermore, scope of practice has expanded, resulting in midwives caring for clients with more complex medical needs (30), which may contribute to higher rates of intervention. Other factors that may drive this trend include changes in client choices and constraints on the health-care system. (31,32)

FIGURE 1. TRENDS IN THE RATES OF INDUCTION, EPIDURAL, CAESAREAN SECTION AND HOME BIRTH



Interventions during labour and birth are both necessary and beneficial in certain cases, but they also present risks. Caesarean section rates have increased rapidly, with little evidence of associated decreases in birthing person and fetal morbidity and mortality, pointing to an unnecessary reliance on medical intervention. (31,33–36) The over-reliance on technology must be contextualized within the current cultural milieu, which centers risk-based medicine and has led to the dominant belief that birth is inherently risky and needs to be managed. (37) This is borne out in research that documents a strong association between fear of childbirth and preference for caesarean section. (38) Concerns about the rising rates of intervention have prompted other organizations, including the American College of Obstetricians and Gynecologists (ACOG) and the World Health Organization (WHO) to call for fewer unnecessary caesarean sections. (34,35,39)

DEFINING THE STAGES OF LABOUR

Standardized definitions of the stages and phases of labour can support assessment, define progress and indicate when to intervene, although it is important to recognize that the definitions and categorizations described remain subjective and inexact.

Prelabour is when the birthing person's body starts to prepare for labour, beginning in the second or third trimester. During this time, contractions are not associated with regular dilation or cervical change. These can include practice contractions (also known as Braxton Hicks contractions), fetal engagement in the pelvis and loss of the mucus plug. The presence of such symptoms is not necessarily an indication that early or active labour will begin soon. Prelabour is sometimes called “prodromal labour” or “false labour.” This CPG uses the term “prelabour,” as it is the clearest; “prodromal labour” is not consistently described in the research literature, and “false labour” may invalidate clients' experiences.

The **first stage of labour** occurs from the onset of regular uterine contractions that result in dilation and effacement of the cervix through to full cervical dilation. The first stage consists of the latent phase, also known as early labour, and the active phase. While there is no clear consensus in the research on the definitions of the onset of labour and the latent and active phases of the first stage, studies frequently use a specified combination of cervical dilation, cervical effacement and regular contractions to indicate the onset of the latent and active phases. (43)

The early labour period presents important opportunities to promote the physiologic processes of labour and birth. Slow or stalled progress in early labour is often characterized as pathological, which can result in a premature diagnosis of dystocia, despite the known variations in labour progress and duration. (32,40) This can lead to inductions (e.g., via oxytocin, artificial rupture of membranes) and a cascade of interventions, including caesarean section, for which non-progressive labour is a common indication. (41) Our understanding of labour progress has shifted over the past decades, and current evidence suggests that labour progresses more slowly than previously described in the literature. (42) This guideline provides a midwifery analysis of the research on labour progression, defines the onset of active labour and examines midwifery approaches to support clients in early labour.

Table 1 outlines definitions of early and active labour from international guideline groups.

The latent phase, referred to throughout this CPG as **early labour**, is considered the time from the onset of uterine contractions that result in progressive effacement and dilation of the cervix up until the start of the active phase. Early labour is not necessarily continuous, as contractions may start and stop. During this phase, dilation occurs slowly.

The **active phase** is characterized by regular, strong uterine contractions and cervical effacement, proceeding to full cervical dilation. In this phase, dilation occurs more rapidly.

The **second stage of labour** is the time from full cervical dilation until delivery of the baby. The **third stage** takes place immediately after delivery of the baby through delivery of the placenta.

While labour is typically categorized using these classifications, they do not adequately acknowledge that labour is a continuous process that can vary substantially from person to person. (43,44) Moreover, these definitions are complicated by variability in labour progress, the lack of a clear definition of labour onset and the fact that early labour is still not well understood. (43,45) As a result, while emphasis has been placed on labour as a continuous process, international guideline groups continue to reference distinct stages and phases.

TABLE 1. INTERNATIONAL GUIDELINE GROUPS DEFINITIONS OF THE FIRST STAGE OF LABOUR

	Latent phase	Active phase
Society of Obstetricians and Gynaecologists of Canada (SOGC) 2016 (46)	Presence of uterine activity resulting in progressive effacement and dilation of the cervix, proceeding to active phase. It is complete when a nulliparous woman reaches 4 cm dilation, and a parous woman reaches 4 to 5 cm. Cervical length is generally less than 1 cm	Presence of a pattern of contractions leading to cervical effacement and dilation at 4 cm or greater in a nulliparous woman or 4 to 5 cm dilation in a parous woman
National Institute for Health and Care Excellence (NICE) 2023 (47)	A period of time, not necessarily continuous when: • There are contractions • There is some cervical change, including cervical position, consistency, effacement and dilation up to 4 cm	When there are regular contractions and there is progressive cervical dilation from 4 cm
American College of Obstetricians and Gynecologists (ACOG) 2024 (48)	Characterized by gradual and relatively slower cervical dilation that starts on perception of regular uterine contractions and ends when rapid cervical change initiated	The phase of rapid cervical change that continues until complete cervical dilation. Cervical dilation of 6 cm should be considered the start of the active phase
World Health Organization (WHO) 2018 (49)	A period of time characterized by painful uterine contractions and variable changes of the cervix, including some degree of effacement and slower progression of dilation up to 5 cm for first and subsequent labours	A period of time characterized by regular, painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilation from 5 cm until full dilation for first and subsequent labours

THE PHYSIOLOGY OF EARLY LABOUR

Complex physiologic changes occur during the final weeks of pregnancy and the onset of labour that prepare birthing people and fetuses for labour and birth. (50) While these changes are not well understood, they are likely multi-factorial, involving mechanisms in the gestational person, the fetus and the placenta.

Labour onset represents the culmination of biochemical changes in the uterus and the cervix. These result from endocrine (systemic or broad effect) and paracrine (localized effect) signals from the birthing person and fetus, fetal membranes and placenta. (51) The total length of labour can vary widely, and there is no standardized definition for what constitutes a typical labour duration (52); nor have specific causes that prolong early labour been identified. (45) Labour is influenced by several factors in the birthing person, including parity, birth interval, psychological state, pelvic shape and size, as well as presentation and position of the fetus. Research suggests that labour may progress more quickly in multiparas (45,53,54), while malposition is often

associated with a longer early labour (53) and a longer first stage, in particular. (55–57) Labour progress is also influenced by an interplay of various hormones, including prostaglandins, oxytocin, endorphins and catecholamines. Disruptions to these hormonal systems can affect labour progress. For example, anxiety can increase the production of catecholamines (i.e., epinephrine and norepinephrine), resulting in decreased oxytocin, which can disrupt labour. (58)

Evidence on the associations between longer early labour and adverse outcomes for the birthing person and neonate is mixed, with some evidence suggesting that longer early labour increases rates of five-minute Apgar scores less than 7 (53,59,60), neonatal intensive care unit (NICU) admissions (53,59,61–63) and postpartum hemorrhage (PPH) (61,63), while other research finds no significant differences in these outcomes. (53,62,64) This evidence is complicated by varying definitions of early labour and long labour. Some studies define the start of early labour as the onset of painful contractions, while others use the time of

admission to hospital. Definitions of the start of the active phase also varied, ranging from 3 cm to 6 cm of cervical dilation; and definitions of long early labour range from longer than eight hours to longer than 42 hours. (53,63)

Evidence further suggests that longer early labour may correlate with induction with oxytocin, administration of epidural analgesia and caesarean section, as well as a longer active phase of the first stage of labour. (53,61,62,64) However, long early labour in and of itself is not predictive of the need for epidural, oxytocin and/

or caesarean section, as physical or physiologic processes may occur that contribute to this need. It is also difficult to isolate any direct interaction between longer early labour and the need for induction or caesarean section, as there is an association between epidural analgesia and instrumental birth or caesarean section. (65,66) It is important for midwives to recognize that the complex physical, psychological and emotional experience of labour affects every person differently and that each labour is unique. (58)

DEFINING ACTIVE LABOUR

As our understanding of labour progression has evolved and the guidelines have changed, researchers have turned their attention to appropriately defining the onset of active labour.

Friedman's curve

Modern definitions of early and active labour are largely based on Friedman's labour curve, developed in the 1950s. (67) Friedman divided the process into first, second and third stages and further subdivided the first stage into four phases: the latent phase¹ (also known as early labour), the acceleration phase, a phase of constant maximal dilation and a deceleration phase. The latent phase was defined as beginning with the birthing person's perception of regular contractions. Friedman found that the mean duration of the latent phase was 8.6 hours for nulliparas and 5.3 hours for multiparas. The 95th percentile for duration of the latent phase was 20.6 hours for nulliparas and 13.6 hours for multiparas. Based on the 95th percentile threshold, Friedman stated that a prolonged latent phase was > 20 hours in nulliparas and > 14 hours in multiparas. The onset of the active phase was defined as the point at which the rate of cervical dilation significantly increases. According to Friedman's curve, cervical dilation of 4 cm was considered the beginning of the active phase. During this phase, cervical dilation progressed linearly at a minimum of 1.2 cm per hour in nulliparas and 1.5 cm per hour in multiparas. Cervical change slower than 1 cm/h was defined as protracted labour.

No change in cervical dilation for more than two hours in the active phase was defined as labour arrest. (68)

There are several important critiques of Friedman's research. He exclusively included white participants, which would be deemed inappropriate nowadays, and it indicates that his findings are not directly transferable to the midwifery population today. Moreover, since the 1950s, changes have occurred in pregnant populations as well as labour management that make Friedman's work less applicable to the current context. The age and body mass index (BMI) of birthing individuals have increased, and such interventions as induction, epidural analgesia and oxytocin use have become more common. Conversely, the interventions used in Friedman's study, including forceps, Demerol and scopolamine are less common or absent from labour management today. (69)

Despite these critiques, Friedman's standards have been widely implemented and embedded into practice through labour partograms, which commonly define active labour as beginning at 4 cm cervical dilation. (70–72) The application of Friedman's thresholds has contributed to unrealistic expectations for labour progress and may result in premature diagnosis of dystocia and unnecessary interventions.

¹ To accurately represent research sources, this CPG uses the term "latent phase" when referring directly to research. Otherwise, for general references, this CPG uses "early labour."

Critiques of Models of Labour Progression

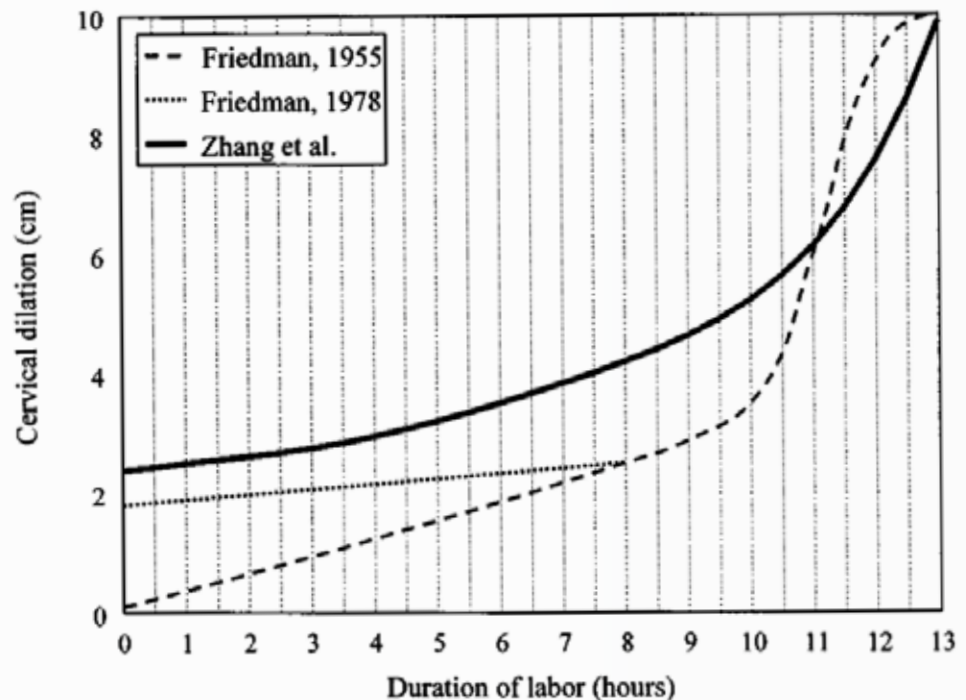
Developing a model of labour progression is challenging in several ways. The assessment of dilation is imprecise and can be inaccurate, as there is variability in providers' assessments of cervical dilation. (204–206) The work on labour curves primarily includes “normal” births, defined as those that experience spontaneous labour onset and vaginal delivery. Since the study groups are largely “normal,” this means that the curves identify outliers but are less helpful in describing the impact of intervening on those outliers, including what interventions should be used and the optimal timing for them. There is also no standardized way that labour progresses. (52) Total length of labour varies widely and is influenced by several factors, including the birthing person's parity, birth interval and psychological state, presentation and position of the fetus and any interventions administered. (50,69) Due to these challenges, there have been critiques of using labour curves to dictate management. Many have suggested that using cervical dilation alone is inadequate for identifying active labour. (206,207) Researchers have also questioned the applicability of guidelines that fail to address individual variation in labour progression, as basing management solely on the findings of these curves oversimplifies the process. (208–210)

Zhang's curve

In the early 2000s, new research into labour progress emerged. Zhang examined labour progress in a modern, diverse population. In this study, 60% of the nulliparas were white, 12% Black, 20% Hispanic, 4% Asian Pacific Islanders, and 4% identified as another race. Nearly half of the participants received oxytocin for augmentation, and 80% received an epidural. Results show that latent phase duration varies based on both cervical dilation at admission and parity, suggesting that duration of the latent phase may vary widely. (42,73)

Zhang's research found that the rate of active phase dilation was significantly slower than described by Friedman, varying from 0.5 to 0.7 cm/h for nulliparas and 0.5 to 1.3 cm/h for multiparas. (42) Zhang reported that cervical dilation progresses at less than 1 cm per hour until around 6 cm, when labour begins to progress more quickly. Figure 2 compares the average patterns of labour progression found by Friedman and Zhang. It illustrates that in Zhang's findings, the transition to the active phase is more gradual than in Friedman's results.

FIGURE 2. COMPARISON BETWEEN THE FRIEDMAN CURVE AND THE ZHANG CURVE



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Additional research supports Zhang's findings, with studies showing large variations in the duration of early labour. Across available studies, the reported mean duration for nulliparas ranged from 5.1 to 21.3 hours and 2.2 to 12.7 hours for multiparas, which reflects a longer duration than previously understood. (52,53,67,75,76) The 95th percentile for duration of the latent phase across studies ranged from 10.3 to

57 hours for nulliparas and 5.4 to 33 hours for multiparas. This variation can be attributed in part to the use of different definitions for the start and end points of early labour.

Zhang concluded that 6 cm rather than 4 cm is a more appropriate marker of the beginning of the active phase.

Non-progressive early labour

There is no standardized definition for non-progressive early labour, as there is no certainty on what it looks like. This is because of the wide variation in the length of early labour reported in the research and the uniqueness of each labour. In response, the TF chose not to define non-progressive early labour. Interventions during early labour should be based on the status of the birthing person and fetus rather than a predetermined time limit.

Impact of defining the start of active labour at 6 cm

Zhang's work inspired changes to guidelines, including the 2014 consensus statement by ACOG and the Society for Maternal-Fetal Medicine, which defines active labour as beginning at 6 cm. (35) Upon the release of these recommendations, research was conducted to assess whether the changes were effective in reducing the rate of caesarean delivery. This research focuses on the implementation of ACOG's first and second stage labour management guidelines, including the definition of the onset of active labour at 6 cm of cervical dilation. This is the best available evidence to assess the impact of defining active labour at 6 cm of cervical dilation. A 2023 cluster RCT (n = 44 695; *low certainty of evidence*) shows that applying the ACOG guidelines may result in a slight increase in the rate of **spontaneous vaginal birth**: 21 more (from two more to 41 more) per 1000. (77) However, they did not find a statistically significant reduction in the rate of **caesarean birth**: 11 fewer (from 29 fewer to nine more) per 1000. It is important to note that compliance with the guidelines at the intervention sites was low, at 31%. This may account for the lack of differences seen between the intervention and control groups. The authors state that the larger reductions in primary caesarean birth occurred at hospitals with higher compliance, which suggests that if compliance were higher a greater effect may have been observed.

Five observational studies have also been published that examine the impact of the ACOG guidelines. Findings from the observational data show a slight reduction in the odds of caesarean section, with ORs ranging from

0.63 to 1.14. (78–82) Importantly, both the RCT and observational studies show that implementing the ACOG guidelines did not increase rates of adverse outcomes for the birthing person or neonate.

Task force remarks, clinical considerations, values and preferences

Current evidence illustrates that labour progression is slower than was once thought and that Friedman's standards are unrealistic for most clients. Those who arrive at the hospital in early labour may be held to standards of progress for active labour, which can result in diagnosis of failure to progress and unnecessary interventions. The TF recognized the importance of appropriately identifying active labour to avoid premature diagnosis of dystocia. The TF also acknowledges a lack of consensus among international guideline groups on the definition of active labour. After assessing the evidence, the TF agreed that 6 cm for nulliparas and 4 to 6 cm for multiparas should be considered the start of the active phase. This recommendation was based on several pieces of evidence. First, Zhang's research on a modern, diverse population of birthing people suggests that labour progress is slower than previously thought, and it indicates that 6 cm should be considered the start of the active phase. Evidence suggests that using 6 cm as the definition of active labour is not associated with any increased risk for the birthing person or fetus. Recognizing that labour may progress faster for multiparas, the TF used a range of 4 to 6 cm as the definition of active labour for multiparas.

The TF acknowledged the need for further research into methods beyond cervical dilation for identifying active labour. Cervical examinations can be uncomfortable and pose an infection risk. (50) It is well established that they should be used judiciously, meaning that relying on cervical dilation alone to diagnose active labour may be unreasonable. The TF determined that contraction strength and regularity were important elements to consider when diagnosing active labour, particularly in multiparas, recognizing the impact of parity on speed of labour progress. Despite the limited evidence about contractions, based on their clinical expertise the TF valued providing guidance on contraction patterns that could indicate active labour, typically a 3-1-1 pattern for nulliparas and a 5-1-1 pattern for multiparas.

3-1-1 NULLIPARA CONTRACTION PATTERN

3

Contractions that are 3 minutes apart, from the beginning of one contraction to the beginning of the next

1

That last for 1 minute

1

With the pattern lasting for at least 1 hour

Recommendation

1. Regular contractions, effacement and cervical dilation of 6 cm for nulliparas and 4 to 6 cm for multiparas should be considered the start of the active phase of labour.

Strong recommendation: low certainty of evidence

This recommendation recognizes the importance of accurately defining the active phase of labour, to avoid premature diagnosis of dystocia. It affirms the research that labour progression is slower than once thought, that the experience of labour varies across individuals and that a definition of 6 cm dilation reduces interventions without increasing risk. It also acknowledges midwives' skill in assessing the full clinical picture and using their clinical judgment in determining if a client is in active labour.

TIMING OF ADMISSION TO HOSPITAL OR CONTINUOUS CLINICAL CARE

It is often recommended that birthing individuals delay hospital admission until active labour has begun, to help reduce interventions. As a result, research has aimed to explore outcomes based on timing of admission to hospital.

Cervical dilation at time of admission to hospital

A meta-analysis of eight retrospective cohort studies (n = 23 933) shows that admission to hospital at less than 4 cm cervical dilation may increase the odds of **caesarean section**: 93 more (from 61 more to 132 more) per 1000 (*low certainty of evidence*). (9,83–89)

Additional evidence from two observational studies (*very low certainty of evidence*) suggests that admission to hospital at less than 5 cm dilation (aOR 2.38, 95% CI 1.40–4.00) and less than 6 cm (RR 3.73, 95% CI 1.94–7.16) may increase the odds of **caesarean section**. (8,90)

When results are stratified by parity, similar results are observed. Though we are uncertain of these results, three observational studies (*very low certainty of evidence*) suggest that admission to hospital at less than 4 cm dilation in nulliparas (OR 1.76, 95% CI 1.33–2.32) and multiparas (OR 2.66, 95% CI 1.29–5.48) may increase the odds of **caesarean section**. (9,86,89) One observational study (*very low certainty of evidence*) found that admission to hospital at less than 6 cm in nulliparas (RR 2.35, 95% CI 0.90–6.13) and multiparas (RR 4.36, 95% CI 1.80–10.52) may increase the odds of **caesarean section**. (8)

Earlier admission to hospital has also been associated with increased risk of other interventions. Observational studies (*very low certainty of evidence*) show that admission to hospital at less than 4 cm dilation may increase the odds of **oxytocin augmentation** (OR 2.45, 95% CI 1.87–3.21) (9,84–89), **epidural use** (OR 2.83, 95% CI 2.34–3.42) (9,86–89) and **NICU admission** (OR 1.29, 95% CI 1.11–1.51) (9,83,85,87–89).

Four observational studies (*very low certainty of evidence*) found that earlier admission to hospital at less than 4 cm dilation may slightly reduce the odds of **PPH** (OR 0.79, 95% CI 0.43-1.43). (83,85,87,88)

Regularity of contractions at admission to hospital

One observational study (*low certainty of evidence*) of 1656 participants found that admission to hospital before contractions were regular and less than five minutes apart may increase the odds of **caesarean section**: 84 more (from 40 more to 132 more) per 1000; **oxytocin augmentation**: 217 more (from 167 more to 264 more) per 1000; and **epidural use**: 82 more (from 50 to 107 more) per 1000. (91)

Early labour assessment to delay hospital admission

To better understand the impact of delaying hospital admission, a 1998 RCT (n = 209) examined the outcomes from a labour assessment program. (92) Participants in the experimental group were assessed upon arrival at the hospital. If they were not in active labour (defined as the presence of regular, painful contractions and cervical dilation > 3 cm), they were instructed to walk around outside or return home. Participants in the control group were immediately admitted to the labour and delivery unit with no assessment. Results show that receiving an early labour assessment and avoiding early admission compared with immediate admission to hospital may reduce the odds of **caesarean section** (OR 0.70, 95% CI 0.27-1.81), but we are very uncertain of these results, due to deviations from the intended intervention, the low number of events and a small sample size (*very low certainty of evidence*).

Additionally, this study found that early labour assessment may reduce **oxytocin augmentation**: 174 fewer (from 264 fewer to 52 fewer) per 1000; **epidural use**: 114 fewer (from 275 fewer to 10 fewer) per 1000; and the **length of the second stage of labour**, MD 18.20 minutes (95% CI -35.88 to -0.52; *low certainty of evidence*). Participants who underwent assessment were more likely to rate the birth experience as positive than those who were directly admitted to the hospital.

Task force remarks, clinical considerations, values and preferences

The TF considered the evidence, which consistently finds that admission to hospital at lower cervical dilations and

before contractions are regular and less than five minutes apart is associated with increased obstetric intervention, including caesarean section, oxytocin augmentation and epidural analgesia. While the mechanism behind this association remains unclear, it is possible that birthing people who arrive at the hospital earlier in their labour inherently require more intervention. For example, for some clients the pain and/or exhaustion associated with slow progress in early labour may prompt them to go to the hospital sooner than those experiencing shorter early labour. (93) However, it is equally plausible that admission to hospital in early labour exposes clients to a medicalized environment where they are held to the standards of progress for active labour when they are only in early labour. This could inaccurately lead to a diagnosis of “slow progress,” prompting unnecessary interventions to accelerate labour. It has also been suggested that once admitted to hospital, clients may become impatient and clinicians are motivated to use resources efficiently, triggering the use of interventions. (31,90)

The TF acknowledges that the research on delaying hospital admission does not take into account clients who have out-of-hospital births. Unfortunately, we were unable to identify any research in the out-of-hospital setting. The TF extrapolated the findings from the hospital-based research, which indicates that increased monitoring in early labour is not associated with benefits for the birthing person, to recommend the delay of continuous clinical care in the community setting. Additionally, in-person continuous care places a high demand on clinician time and resources. Thus, delaying in-person continuous care can help preserve these resources and maintain continuity of carer.

Important equity implications were also weighed. There are several reasons why clients may not be able to remain at home in early labour and may need more support. Underhoused or homeless clients may not have an appropriate space to stay in early labour. Those who rely on public transportation may arrive at the hospital earlier to avoid taking transit when contractions are closer together. Clients with disabilities that might increase the time it takes to move from home to their chosen birth setting may factor that into their planning. Those who lack a support system, or who have mental health challenges or a history of trauma, may need additional support in early labour that is not as readily available at home. Weather and logistical concerns may also have an impact. Clients who live farther away from the hospital may need to consider distance when planning their arrival time, and weather conditions may influence when the midwife decides to arrive at the home or advise the

client to attend the hospital. The TF recognized that midwives must tailor care for their clients to best meet their specific circumstances. Creative strategies to support clients during this time may include involving doula support, asking clients to relocate with friends or family closer to hospital if possible, having them attend early labour lounges or the midwifery clinic, or facilitating early admission to hospital for comfort measures without beginning continuous in-person labour management and clinical care.

Despite the benefits of remaining at home in early labour, many clients are uncomfortable with the idea of delaying care. Early labour can be a time of great uncertainty and anxiety for clients; midwives should consider these lived realities when providing care during this time. Throughout this guideline, we discuss methods and tools that can help clients feel able and safe to remain at home in early labour. Additionally, the AOM's client handouts *Early Labour: What do I need to know?* and *Early Labour: Tips for support people* provide information on what to expect in early labour.

Recommendation

2. Midwives should delay hospital admission or continuous intrapartum clinical care in the community until the onset of active labour, unless otherwise indicated.

Strong recommendation: very low certainty of evidence

This recommendation recognizes the evidence indicating that later admission to hospital is associated with fewer interventions, and it affirms delaying continuous clinical care as a means to achieve low-intervention physiologic labour and birth. It also acknowledges midwives' skills in assessing the full clinical picture and using their clinical judgment in determining if they should stay with the client in the community or admit the client to the hospital.

Ending Forced Birth Evacuations: A Call for Justice

This CPG recommends staying at home until active labour begins. In making this recommendation, we acknowledge that many First Nations, Inuit and Metis (FNIM) individuals who live in rural or remote communities face forced birth evacuations and must leave their communities in the weeks before birth to access intrapartum care. (118) This long-standing, harmful practice of evacuating healthy, low-risk pregnant people to give birth far from home is traumatic. It puts the birthing person at risk of exposure to anti-Indigenous racism in the health-care system, and it results in poorer outcomes for birthing individuals and their infants. These clients may require additional supports to ensure their safety and culturally appropriate care.

Bringing birth home for Indigenous communities is central to reconciliation in health care. It means reclaiming and returning pregnancy, birth and early parenting care, as well as all aspects of the reproductive continuum, to Indigenous communities. It restores Indigenous midwifery and supports self-determination across the perinatal journey with care that is culturally grounded, relationship based and informed by ceremony and Indigenous knowledge. The AOM has endorsed the National Council of Indigenous Midwives (NCIM) position statement on forced birth evacuations, and it supports the return of birth to Indigenous communities through advocacy for the development, expansion and sustainment of Indigenous Midwifery Programs.

STRATEGIES TO SUPPORT THE DELAY OF CLINICAL CARE UNTIL THE ONSET OF ACTIVE LABOUR

There is no one standardized way that the onset of labour is experienced, and it is often a time of uncertainty for birthing people. Many report the symptoms as being different than they expected or feeling unsure whether their labour has begun. (44,94) Symptoms of early labour may include recurrent pain, non-recurrent pain, watery discharge, loss of amniotic fluid, blood-stained mucous loss, gastrointestinal symptoms, nausea, emotional upheaval and sleep disturbances. (58,95–97)

Anxiety and uncertainty are some of the main reasons clients reach out to their midwife. (98,99) The labouring person often experiences stress when determining if they should go to the hospital (100), and they can perceive the advice to stay at home as a one-size-fits-all response, rather than advice tailored to their specific circumstances. (94,101) When a client is sent home from the hospital because they are not yet in active labour, it can be discouraging and increase their anxiety. (102) When a midwife conducts a home assessment, then

leaves to return later, the client can remain uncertain about their progress if the reason for departure is not clearly communicated. There are several strategies and approaches that midwives can use to support clients in this phase.

Prenatal education

Prenatal education has been suggested as a method to reduce anxiety, and systematic reviews have demonstrated an association between prenatal education and increased self-efficacy (103,104) and reduced fear of childbirth. (105) Despite preparing for labour, many birthing people report that early labour was different than they anticipated. (106) Midwives, through their commitment to informed choice, are tasked with an important role to deliver health counselling and education throughout pregnancy, labour and birth. The communication points listed in Figure 3 can help clients understand what to expect in early labour.

FIGURE 3. PRACTICE POINTS FOR COMMUNICATION

DISCUSS WITH CLIENTS:

- The signs and symptoms of early labour and how they can differ in individuals.
- That the duration of early labour can vary widely.
- What to expect, including the benefits of staying at home and delaying hospital admission.
- What care entails, including when their midwife will stay with them at home and/or when they will be admitted to the birth centre or hospital.
- Coping mechanisms.
- The differences between early and active labour.
- When and how to contact their midwife.
- That every experience is unique, and plans may need to change during labour.
- If plans change, midwives are well equipped to adapt to the situation.

CMO Practice Advice: Supporting Clients in Early Labour

The College of Midwives of Ontario (CMO) has identified a trend of clients feeling dismissed, confused or unsupported during early labour. This stresses the importance of clear communication in early labour. The CMO offers guidance on how midwives can strengthen communication during early labour: [Practice Advice: Supporting Clients in Early Labour](#).

Prenatal classes

While the information midwives provide to clients in prenatal appointments is essential, additional prenatal education in the form of classes can help prepare pregnant people for early labour. A systematic review examining perspectives on managing early labour found that birthing individuals want realistic information about labour, and that antenatal classes were more helpful in accessing that information compared with textbooks or the internet. (106)

We identified two RCTs that examined how prenatal classes can increase pregnant people's understanding of active labour and help them identify it. We were unable to combine these studies into a meta-analysis, however, as they presented data for different outcomes.

One RCT (*moderate certainty of evidence*) that enrolled 1193 nulliparas in a prenatal education program between 30 and 35 weeks shows that those who attend educational sessions are probably more likely to **arrive at the hospital at > 3 cm cervical dilation** than those who do not: 162 more (from 97 more to 234 more) per 1000. (107)

A second RCT of nulliparas (n = 208; *low certainty of evidence*) shows that receiving antenatal education about identifying active labour may reduce the **number of visits to the labour suite before the onset of active labour**: 278 fewer (from 363 fewer to 159 fewer) per 1000. (108)

Our confidence in these results is low, because 15% of the sample was lost to followup.

Task force remarks, clinical considerations, values and preferences

The TF acknowledges that research evaluating prenatal classes is challenging to assess, as the aims, content and delivery method of these programs vary widely. Additionally, clients' prenatal education needs and preferences may vary, although there is consensus that prenatal education is particularly useful for nulliparas.

There are, however, barriers to accessing prenatal education. Pregnant individuals who are older and more educated are more likely to attend prenatal classes. (109) A qualitative study aimed at understanding the delivery of prenatal health promotion in Ottawa, Ontario, identified transportation, finances, stigma/shame and language as barriers to access. (110) Stigma and shame and distrust of the health-care system were identified as barriers faced by pregnant people who are Indigenous, immigrants, racialized, adolescent or low income. These barriers arise from systemic discrimination and racism in the health-care system as well as disparities in structural determinants of health. Midwives are well positioned to address these barriers by providing education at prenatal appointments and directing clients to available resources, such as free prenatal classes, culturally appropriate services and online resources.

Recommendation

3. Midwives should discuss the benefits of prenatal education and help facilitate access to culturally appropriate, evidence-based prenatal education, as requested by clients.

Strong recommendation: low certainty of evidence

This recommendation acknowledges the client as the primary decision-maker and the skill of midwives in supporting clients to access information and resources.

Continuity of care

It is well established that midwifery continuity of care models reduce the need for interventions, increase birthing person satisfaction (111) and engender trust and confidence through personalized care. (112) In continuity models, the client receives care from a known midwife, or a small team of midwives, through the antepartum, intrapartum and postpartum periods. A 2024 Cochrane review showed that birthing people who receive care in a midwifery continuity of care model were less likely to experience a caesarean section or instrumental birth and were more likely to have a spontaneous vaginal birth. (111)

The impact of continuity of care on early labour specifically is less understood. One Australian RCT compared caseload midwifery with standard care. Participants randomized to caseload midwifery received care from a primary midwife with support from backup midwives. Participants randomized to standard care received either midwifery or obstetric trainee care, with varying levels of continuity- or community-based general practitioner care. Results show that caseload midwifery may be associated with a slightly shorter interval between hospital admission and birth. (113) Participants in the caseload midwifery group had a **median time from admission to birth** of 9.1 hours, and those in the standard care group had a **median time** of 10.2 hours,

with a difference in medians of 1.1 hours (*high certainty of evidence*). The results also show that those in the caseload midwifery group were admitted to hospital with slightly higher cervical dilations than those in standard care.

Study authors hypothesize that several elements of caseload midwifery care may aid the birthing person's ability to stay at home for longer. These may include different antenatal preparation for labour and birth, more communication with their midwife in early labour and greater confidence in themselves as a result of their relationship with a known midwife. The authors also suggest that the caseload model may enable midwives to provide individualized support and advice to clients before admission to hospital, which contributes to the birthing person feeling able to remain at home for longer. Qualitative research shows that pregnant people who receive care from midwifery continuity models generally report more positive experiences throughout pregnancy, labour and postpartum than those who receive other models of care. (111)

Task force remarks, clinical considerations, values and preferences

Continuity of care is an important component of the Ontario midwifery model and is generally highly valued

by midwives and clients. However, there is growing understanding that continuity of midwifery care is multi-faceted, and it includes other elements that contribute to client satisfaction beyond having a known midwife, such as effective communication and a consistent approach to care. A 2024 study of Ontario midwifery clients illustrates that continuity is a multi-layered concept, consisting of relational continuity (trusting relationship and personalized care), informational continuity (effective, consistent communication) and management continuity (coordinated care and consistent policies). (114) Participants rated having a known midwife as important in moments of vulnerability (e.g., emergencies or when receiving bad news), but it mattered less for routine elements of care (e.g., answering pager calls). Additionally, in this study, client satisfaction remained high even when a known midwife was not present at their labour and birth, suggesting that effective communication and consistency in care result in client satisfaction even with less relational continuity. Further research is needed to investigate how these elements of continuity affect outcomes, particularly as midwives work in increasingly diverse models of care.

Summary Statement

Continuity of care plays an important role in supporting clients to remain at home in early labour.

Access to non-clinical support in early labour

Non-clinical support people (e.g., partners, family, friends, doulas) are an important source of support in early labour, and they can be beneficial to remaining at home during this phase. A systematic review of qualitative evidence on experiences in early labour found that support from partners, such as offering massage or encouraging movement, was helpful. It was also reported that the support offered from female relatives, such as mothers or sisters, helped some birthing people feel safe and relaxed in early labour. (106)

However, qualitative research also suggests that partners often feel anxious and unsure of their role, and when a support person feels anxious, it can exacerbate the labouring person's own anxiety and uncertainty. (106,115) Respondents in several qualitative studies report that their support person's anxiety and/or discomfort at seeing them in pain prompted them to go to the hospital in early labour, even though some believed they could have remained longer at home. (106,116,117) This suggests that having a support person who is knowledgeable about

birth, such as a doula, could be beneficial for labouring people. Additionally, providing support people with information about what to expect and how to best support their partner in early labour may be helpful.

Task force remarks, clinical considerations, values and preferences

While a doula can be a valuable resource, given financial and availability constraints not all clients can access one. Lay people, such as partners, family and/or friends, can also provide excellent support. It is important to acknowledge that not all clients have access to their support systems during labour. For example, clients affected by intersecting social and socioeconomic factors, including unstable housing or recent immigration, may not have close family or friends available. Many FNIM birthing people face forced birth evacuations and must leave their communities to access care, which results in reduced access to culturally significant supports, including their families, community members and the land. (118)

Good practice statement

4. Midwives should discuss the benefits of non-clinical support people in early labour. This discussion may include:
- Information for support people about what to expect in early labour and how to best support the birthing person
 - Information about other kinds of support available (e.g., doulas)
 - Information about organizations that may offer labour support volunteers to those who qualify, particularly equity-deserving groups

Good practice statement

This good practice statement recognizes the evidence illustrating the value of non-clinical support people in labour and midwives' skills in providing health information to clients.

Connecting with clients in early labour

Interactions with health-care providers play an important role in shaping birthing persons' experiences. (58,94,119,120) The ability to contact a midwife in early labour and receive advice, support and reassurance can help clients feel confident to remain at home. (98)

Birthing people seek clear information about what to do next and reassurance that what they are experiencing is normal. They wish to be heard, respected and treated as individuals. (94,106)

A 2017 Cochrane review (*very low certainty of evidence*) compared outcomes of a home visit with a telephone assessment in early labour. Results suggest that a home visit may make little to no difference in the risk of **caesarean section** (RR 1.05, 95% CI 0.95-1.17), **instrumental vaginal birth** (RR 0.95, 95% CI 0.79-1.15), **augmentation** (RR 0.96, 95% CI 0.88-1.04) or **epidural/any regional anesthesia** (0.95, 95% CI 0.50-1.42). (121)

However, results suggest that home assessment may reduce the risk of **neonatal admission to special care** (RR 0.84, 95% CI 0.50-1.42) and reduce the likelihood of **being admitted to the hospital at < 3 cm cervical dilation** (RR 0.72, 95% CI 0.48-1.09). We are very uncertain of this evidence, as a significant number of participants did not receive their intended intervention, and all outcomes had wide confidence intervals.

As digital health care becomes more common, virtual visits through video calling have been proposed as a way to connect with clients and evaluate the labouring person's visual cues without the need to travel to them. Although virtual visits are a potentially useful tool, they have not yet been widely implemented. Several qualitative studies assess perspectives on video calls in early labour. (122-126) Overall, clients and midwives are positive about

their use. Both groups assert that video calling helps facilitate more accurate assessments, and it can foster connection between the midwife and the client. However, several barriers have been identified, including access to technology and privacy concerns.

Task force remarks, clinical considerations, values and preferences

The TF noted a lack of clear evidence to support home visits over phone assessment. The TF acknowledges that early labour alone is not an indication for an in-person assessment, but that midwives may complete an in-person assessment in early labour for several reasons, including to address a clinical indication or reassure a client experiencing anxiety or having difficulty coping. In making this determination, midwives consider several factors, including the clinical picture, whether the client has stable housing, distance to the client and hospital, and appropriateness of phone assessments given possible language barriers or access issues. Home visits may be particularly useful for clients with disabilities, as they can help eliminate accessibility barriers. (127)

As virtual visits become increasingly accessible, there is a need for more research into their implementation. If midwives choose to conduct virtual visits, the technology used should comply with privacy and security requirements. When conducting in-person or virtual assessments, midwives should consider the need for translation, ideally through a medical translation service, while recognizing the financial barriers to accessing these services. Lastly, regardless of the place or method of assessment, qualitative research demonstrates clients' desire for clear communication and reassurance in early labour.

Recommendation

5. When a client contacts their midwife in early labour, midwives should provide an initial assessment over the phone and determine whether an in-person assessment is indicated.

If an in-person assessment is deemed unnecessary at the time of contact, midwives should provide reassurance, education, suggestions for coping and guidance about when the client should call them again.

In determining the location of follow-up assessments (e.g., phone, at home, clinic, birth centre or hospital), consider the clinical picture. Where possible, midwives should consider assessing a client in early labour at home or in the community to avoid early hospital admission.

Strong recommendation: very low certainty of evidence

This recommendation acknowledges the midwifery values of physiologic birth, continuity of care and choice of birthplace. It also recognizes midwives' clinical judgment and skills in early labour assessment.

EFFECTIVE ASSESSMENTS IN EARLY LABOUR

Birthing person and fetal assessment

We did not identify any research comparing specific assessments in early labour or the optimal timing of in-person assessments. Birthing people are encouraged to stay at home in early labour. When midwives do an assessment in early labour, it is typically to rule out active labour or prelabour rupture of membranes (PROM) or because the client is having difficulty coping. In these situations, assessment in early labour may include cervical examination (if PROM is not suspected), evaluation of contractions and recording of the pregnant person's vital signs (pulse, blood pressure and temperature).

While cervical exams can be an important assessment tool in labour generally, there are limited clinical indications for their use in early labour specifically. Reasons for a cervical exam in early labour may include to identify the presentation and position of the fetus, to ascertain cervical dilation or

effacement if needing to confirm active labour and/or by client request. (50,128) Given that cervical exams can be uncomfortable or distressing for some, and repeated exams may pose an infection risk, particularly after a client's water has broken, it is important that cervical exams are used judiciously when information is required that cannot be confirmed from external observation or assessments of the labouring person. (50,128) The judicious use of cervical exams may form part of a midwife's approach to providing trauma-informed care; they should always be accompanied by an informed choice discussion with the client and performed only after consent is provided.

We did not identify any evidence about the optimal methods and frequency of fetal assessment in early labour. Common assessments in early labour may include asking the birthing person about fetal movements and assessing position and heart rate.

Good Practice Statement

6. Initial in-person assessment in early labour should be tailored to the clinical picture. Indications for in-person assessment may include evaluation for active labour or rupture of membranes; concerns about vaginal bleeding and fetal or birthing person well-being; or the need for additional support.

Assessments may include cervical exams, evaluation of contractions, fetal position, fetal heart rate and recording of the birthing person's vital signs.

If during the in-person assessment, the midwife rules out active labour, the midwife should provide reassurance, education, suggestions for coping and guidance on when the client should contact them again.

Good practice statement

This good practice statement recognizes midwives' skills in assessing and monitoring clients and tailoring care to the clinical circumstances.

Fetal assessment at initial contact in early labour: Intermittent auscultation vs. electronic fetal monitoring

A 2025 meta-analysis of five studies (n = 16 341) examined the use of electronic fetal monitoring (EFM) on admission to hospital compared with intermittent auscultation (IA). (129) Participants in this study were low-risk birthing people with term pregnancies and singleton fetuses. Admission EFM was defined as a brief recording of fetal heart rate and uterine activity performed upon admission to the labour ward or assessment unit. IA was defined as intermittent monitoring using a Pinard stethoscope or Doppler device, without continuous waveform display.

Results show that admission EFM probably increases the risk of **continuous EFM during labour**: 111 more (from 24 more to 213 more) per 1000 (*moderate certainty of evidence*). Admission EFM may make little to no difference in **caesarean section**: four more (from seven fewer to 17 more) per 1000, **instrumental vaginal delivery**: nine more (from seven fewer to 27 more) per 1000, **NICU admissions**: two more (from three fewer

to 10 more) per 1000, or **fetal and neonatal deaths**: zero fewer (from zero fewer to two more) per 1000 (*low certainty of evidence*). This evidence demonstrates that admission EFM showed no improvement in birthing person or fetal outcomes.

Task force remarks, clinical considerations, values and preferences

We did not identify any studies examining the optimal frequency of fetal heart rate assessment in early labour. The Society of Obstetricians and Gynaecologists of Canada (SOGC) and the National Institute for Health and Care Excellence (NICE) in the UK state that assessment of fetal heart rate should occur at first contact with a birthing person in suspected or established labour. (46,47) The SOGC recommends IA on admission for healthy term birthing people presenting in labour, early labour, or query labour in the absence of risk factors for adverse perinatal outcome. (130) As the research demonstrates that admission EFM is not associated with decreases in adverse outcomes for the birthing person and fetus, the TF valued making a strong recommendation for IA.

Recommendation

7. In the absence of clinical concerns, midwives should use intermittent auscultation on first in-person contact in early labour.

Strong recommendation: low certainty of evidence

This recommendation recognizes midwives' skills in assessment and monitoring clients, and their expertise in using IA and providing one-to-one care.

Research Gap

The TF was interested in understanding the effectiveness of fetal assessment in clients experiencing a long early labour as some midwifery practices in Ontario commonly conduct fetal surveillance after 24 hours of labour. We were unable to identify any research assessing if this practice improves outcomes. There is a need for more research on the effectiveness of fetal assessment among those experiencing a long early labour.

Supportive strategies in early labour largely involve providing guidance on coping measures, methods to conserve energy (rest and nutrition), distraction and pain relief techniques, with the goal of supporting the birthing person to remain at home during this phase of labour. (58,131) It is well supported by evidence that clients are encouraged to rest, eat, drink and move as they wish in early labour. (58,132,133) Midwifery care is unique as a wide variety of comfort measures and non-pharmacological pain management techniques may be offered in home, birth centre and hospital settings, many of which may not be available to non-midwifery clients accessing care exclusively in a hospital setting. Furthermore, clients who labour at home have greater control over their physical environment. A sensory friendly environment including dimming the lights and minimizing noise may be particularly helpful for neurodivergent clients. (134)

Available evidence on coping and pain relief measures specifically used in early labour is described below; the TF recognizes that additional measures may be used beyond what is described below.

Aromatherapy

Aromatherapy uses essential oils to foster relaxation and reduce pain and anxiety. (135) Oils can be massaged into the skin, inhaled, or used in conjunction with hydrotherapy. (50) We identified six RCTs that randomized participants to essential oil inhalation or standard care. The essential oils used in these studies included damask rose, lavender, geranium rose, citrus, jasmine, and orange. (136–141) Pooled results from six RCTs ($n = 621$; *low certainty of evidence*) suggests that aromatherapy may result in a clinically significant reduction in pain. On a 10-point scale, the mean **pain score** was 3.63 in the experimental group and 5.41 in the control group, MD -1.78 (95% CI -2.75 to -0.82 , $p = 0.0003$).

Spielberger's State-Trait Anxiety Inventory (STAI) was used to determine the level of anxiety participants experienced. On this scale, scores range from 20 to 80, with 20 to 39 indicating low anxiety, 40 to 59 moderate anxiety and 60 to 80 high anxiety. Pooled results from four RCTs show that **anxiety** may be slightly lower among those who used aromatherapy compared with those who did not, although both groups still had mean scores demonstrating moderate anxiety: 45.27 vs. 54.56, MD -9.29 (95% CI -15.88 to -2.69 , $p = 0.006$).

Acupressure

Acupressure is based on the same principles as acupuncture, except the practitioner uses their hands to stimulate the points. (58,142) It has been proposed that pain relief may be achieved through acupressure by enhancing blood flow, decreasing pain perception and stimulating the body to produce endorphins. (142)

We identified three trials (*low certainty of evidence*) that examined acupressure in early labour. Two of the three studies were meta-analyzed; pooled data ($n = 144$) shows that acupressure in early labour may result in a clinically meaningful reduction in pain. On a 10-point scale, the mean **pain score** was 4.62 in the experimental group and 6.28 in the control group, MD -1.55 (95% CI -3.13 to 0.03 , $p = 0.05$). (143,144) A third trial ($n = 100$) reported median pain scores and could not be meta-analysed, but results are consistent with the pooled data, suggesting that those who receive acupressure in early labour have lower pain scores than those who do not. (145)

Massage

Massage can help relax tense muscles, increase the production of endorphins, serve as a distraction for the birthing person, and decrease anxiety, resulting in reduced pain. (146,147) We identified seven RCTs that examined the impact of massage on pain in early labour. These studies used different massage interventions and assessed pain using different scales.

One RCT ($n = 60$; *low certainty of evidence*) suggests that 30-minute massage in early labour may reduce pain and anxiety. (148) The massage included abdominal effleurage, sacral pressure and shoulder and back kneading. Pain was measured on the present behavioural intensity scale, ranging from 0 to 4. The mean **pain score** was 0.73 among those who received massage and 1.3 in the control group, MD -0.57 (95% CI -0.84 to -0.30 , $p < 0.0001$). On a scale of 100, the mean **anxiety score** was 37.2 among those who received massage and 53.47 in the control group, MD -16.27 (95% CI -27.03 to -5.51 , $p = 0.003$).

A second RCT ($n = 77$; *low certainty of evidence*) suggests that Swedish massage in early labour may reduce pain. (149) Pain was measured using the short-form McGill Pain Questionnaire. On this scale, higher scores indicate higher levels of pain, with a maximum score of 45. The mean **pain score** was 13.3 in the experimental group and 16.9 in the control group, MD -3.60 (95% CI -6.95 to -0.25 , $p = 0.04$).

One RCT (n = 154; *low certainty of evidence*) found that foot reflexology, applying pressure to specific points on the feet, may make little to no difference in anxiety in early labour. (150) On the STAI, the mean **anxiety score** was 47.77 among those who received foot reflexology and 51.72 in the control group, indicating that both groups had clinically significant anxiety symptoms, MD -3.95 (95% CI -7.01 to -0.89, p = 0.01).

A meta-analysis of three RCTs (n = 202; *very low certainty of evidence*) showed that low back massage may reduce pain in early labour, although we are very uncertain of these results. (151–153) On a 10-point scale, the mean **pain score** was 5.12 among those who received massage and 6.82 in the control group, suggesting a clinically significant reduction in pain, MD -1.77 (95% CI -2.26 to -0.128, p < 0.0001). We are very uncertain of this evidence, due to concerns about randomization and the small sample size.

Finally, one quasi-experimental study (n = 40; *very low certainty of evidence*) suggests that receiving massage and instruction on breathing techniques may reduce pain in early labour, although we are very uncertain of these results. (154) On a 10-point scale, the mean **pain score** was 1.75 in the experimental group and 3.00 in the control group, MD -1.25 (95% CI -1.97 to -0.53, p = 0.0007). We are very uncertain of this evidence, due to concerns about randomization and the small sample size.

Transcutaneous electrical nerve stimulation

Transcutaneous electrical nerve stimulation (TENS) is a therapy in which a small device is used to distribute low-intensity electrical charges across the skin. (50) A 1988 study (n = 275; *very low certainty of evidence*) suggests that using TENS in early labour may make little to no difference in low back pain or abdominal pain, although we are very uncertain of this evidence, due to concerns about blinding and the small sample size. (155) On a scale of 100, the mean **low back pain score** was 33 among those who used TENS and 35 in the control group, MD -2.00 (95% CI -9.69 to 5.69, p = 0.61). The mean **abdominal pain score** was 57 among those who used TENS and 56 in the control group, MD 1.00 (95% CI -5.40 to 7.40, p = 0.76).

TENS is popular among birthing people as a form of distraction and to increase their sense of control over their pain. (156) One qualitative study (n = 272) from the US found that 78% of participants who used TENS reported that it helped manage their pain, and 80% said they would recommend TENS in early labour. (157)

Music

Music can be a form of entertainment and distraction in early labour and may help foster relaxation. (50) Pooled results from two RCTs (n = 192; *very low certainty of evidence*) suggest that listening to music in early labour may make little to no difference in pain and anxiety, although we are very uncertain of these results. (158) On a 10-point scale, the mean **pain score** for those in the experimental group who listened to music was 4.81 compared with 5.54 in the control group, MD -0.73 (95% CI -1.01 to -0.45, p < 0.0001). The mean **anxiety score** in the experimental group was 5.05 compared with 5.13 in the control group, MD 0.08 (95% CI -1.86 to 2.02, p = 0.93). These scores do not indicate a clinically meaningful difference in pain or anxiety.

Breathing techniques

One RCT (n = 70; *very low certainty of evidence*) suggests that Lamaze breathing techniques make little to no difference in reducing anxiety in early labour, although we are very uncertain of these results. (159) On the STAI, the mean **anxiety score** was 38 among those who used breathing techniques and 38.22 in the control group, MD -0.22 (95% CI -1.77 to 1.33, p = 0.78). These results do not suggest a clinically meaningful reduction in anxiety.

Birth ball

Using a birth ball has been hypothesized to reduce pain and anxiety in labour by promoting effective positioning, movement and self-efficacy. (160) We identified two studies that assessed the effectiveness of birth ball exercises in early labour.

One observational study (*very low certainty of evidence*) compared the pain and anxiety levels of 181 participants before and after they completed birth ball exercises. (161) They were taught four birth ball exercises: gently bouncing on the ball, tilting the pelvis forward and backward, rocking the pelvis in a circular motion, and kneeling and hugging the birth ball while rocking the pelvis back and forth. Results from this study suggest that birth ball exercises may reduce pain and anxiety in early labour. On a 10-point scale, the mean **pain score** was 5.3 before the birth ball exercises and 4.3 after the exercises, MD 1.0 (95% CI 0.8 to 1.3, p < 0.001). On a 10-point scale, the mean **anxiety score** was 5.2 before the birth ball exercises and 3.7 after the exercises, MD 1.5 (95% CI 1.3 to 1.8, p < 0.001).

One RCT (n = 144; *very low certainty of evidence*) provided a birth ball and an educational video on how to use it at home in early labour to those in the intervention group.

(162) Results suggest that using the birth ball makes little to no difference in pain, although we are very uncertain of these results. On a 10-point scale, the mean **pain score** was 6.5 in the birth ball group and 6.3 in the control group, MD 0.2 (95% CI -0.44 to 0.84, $p = 0.54$). We are very uncertain of these results, due to concerns about deviations from the intended intervention, high rates of loss to follow-up, the small sample size and wide confidence intervals.

Acetaminophen

Acetaminophen (Tylenol) is commonly used in early labour to reduce pain, although there is very little research on its effectiveness. We did not identify any research that examined taking acetaminophen orally during early labour, although there is some research on intravenous acetaminophen during active labour as a method of pain relief. This research suggests that intravenous acetaminophen provides a modest reduction in pain with few adverse effects. (163)

Task force remarks, clinical considerations, values and preferences

Additional research is needed on the most effective ways to implement many of these techniques, such as the best delivery methods for aromatherapy, the exact breathing

techniques, and how the training of the person providing massage (e.g., a massage therapist, a doula, the birthing person's partner) affects outcomes.

However, despite the limited available evidence, these techniques are generally considered low risk, with few to no harms noted, and they are largely acceptable to clients. Many consist of elements that midwives and clients value, including 1:1 support, being present and physical touch. One caution about these techniques concerns their overuse to the point of physical or mental fatigue. The use of these techniques for pain management should coincide with strategies that naturally promote rest and conserve energy.

Additionally, while some of these techniques are free or low cost, barriers to their use may remain. Financial constraints and availability can limit clients' access to several of these methods. Some, for example aromatherapy, are not available in the hospital setting. Clients may also lack a supportive environment to use these methods for many reasons, including limited space for labouring or unstable housing. A lack of knowledge on the part of the midwife and/or the client, as well as personal philosophies or cultural attitudes, may also affect their use. (164) Midwives should communicate with their clients about the techniques they can support.

Recommendation

8. Midwives should discuss techniques for rest, distraction, coping, pain and/or anxiety management in early labour, including but not limited to: acetaminophen, aromatherapy, acupressure, massage, TENS, music, breathing exercises and birth balls.

Strong recommendation: very low certainty of evidence

This recommendation recognizes the client as the primary decision-maker.

Supporting cultural practices around labour and birth

Clients may have specific cultural practices around labour and birth, including traditions, food, prayer, rituals or ceremony. These sacred practices can serve as important sources of connection, healing and medicine during labour and birth. In many cultures, "birth is a ceremony to celebrate new life, acknowledging the passing from the spiritual world into the physical world." (211) There are many different rituals and ceremonies that individuals may incorporate into their labour or birth, including smudging, drumming, singing, bathing and preparing the birth space. (212) It is essential for midwives to honour these sacred ceremonies and advocate for their clients to be able to perform their cultural practices. Recognizing the profound spiritual significance of labour and birth and supporting birthing persons' access to perform their sacred cultural ceremonies is critical in protecting the health and rights of all birthing people. (211)

Hydrotherapy

Water immersion as a method of pain management has a long history and is popular among birthing people. (50,165) A 2018 Cochrane review including eight RCTs (n = 2652) found that those who experience water immersion in the first stage of labour have less use of regional analgesia, with no effect on the risk of caesarean section. However, this research did not examine water immersion specifically in early labour. (166)

Baths

One RCT (n = 200; *low certainty of evidence*) suggests that a bath before 5 cm of cervical dilation may increase the need for **pharmacological analgesia**: 230 more (from 74 more to 479 more) per 1000; and **oxytocin**: 270 more (from 105 more to 504 more) per 1000. (167) It has been hypothesized that water immersion before the birthing person is in active labour may slow or stop contractions, which may explain the increase in analgesia and oxytocin. In this study, the time between established labour and delivery was 9.80 hours in the early bath group and 8.48 hours in the late bath group.

Showers

Pooled data from two RCTs (n = 184; *low certainty of evidence*) suggests that a shower in early labour may make little to no difference in pain but may reduce anxiety. (168,169) On a 10-point scale, the mean pain score was

4.73 among those who showered and 5.56 in those who did not, resulting in a non-clinically meaningful difference in **pain**, MD -0.83 (95% CI -1.32 to -0.34, p = 0.0008).

Anxiety was assessed using STAI. The mean anxiety score was 32.85 among those who showered compared with 50.69 in those who did not, suggesting a meaningful reduction in **anxiety** among those who showered, MD -17.85 (95% CI -19.19 to -16.51, p < 0.0001).

Task force remarks, clinical considerations, values and preferences

There is a lack of evidence on hydrotherapy in early labour, and the existing evidence is limited by very small sample sizes. There is also no research examining hydrotherapy at home in early labour specifically. However, a larger body of evidence on water immersion in the first stage of labour shows positive outcomes, and qualitative research reports high levels of satisfaction, including that it can help decrease anxiety and increase relaxation. (146,170)

One concern regarding baths is that they may slow or stop contractions during early labour. (58) If contractions slow or stop when the birthing person is in the water, it may be helpful for them to get out of the bath until labour becomes re-established. (58,171) However, if slowing of contractions is desirable, to allow the birthing person to rest, a bath may be beneficial.

Recommendation

9. Midwives may discuss hydrotherapy with clients as an option to manage pain and/or anxiety in early labour, according to client preferences and the clinical picture.

Weak recommendation: low certainty of evidence

This recommendation acknowledges midwives' clinical judgment and recognizes the client as the primary decision-maker. Hydrotherapy can be used as a strategy to help the birthing person rest, especially for clients experiencing long early labour. Midwives must balance the benefits and harms and consider client preferences.

ADDRESSING PAIN AND/OR FATIGUE IN EARLY LABOUR

Early labour can be painful and stressful, and clients' ability to cope in this phase can vary. (58,172) In early labour, they can become exhausted, discouraged and hopeless, particularly if they do not progress as they had hoped or expected. (58,172) Many who have a long early labour associate it with a more negative birth experience. (173) While initial management of early labour includes reassurance, as well as guidance on coping mechanisms

and pain relief, some clients may need support beyond these methods. (58)

Depending on the clinical situation and the client's wishes, strategies that allow rest or promote contractions can be offered. When supporting clients in early labour, midwives should provide individualized information and centre the client in all decision-making. (174)

Promoting rest in early labour

Therapeutic rest refers to the use of medication to allow for rest, or to alleviate the pain, anxiety or insomnia of early labour. (175,176) Several different medications can be used, and the choice of medication can vary, depending on the client and clinical setting. (58)

Dimenhydrinate

Dimenhydrinate (Gravol) is commonly used in early labour in the home setting, to reduce nausea and to help the birthing person rest. We did not identify any research examining the effectiveness of oral dimenhydrinate during early labour; however, research from the 1960s examined the use of intravenous dimenhydrinate. This research had varying results, with some studies suggesting that dimenhydrinate resulted in reduced need for other analgesics and may shorten the duration of labour (177–180), while others found no significant effect. (181,182) Additionally, one qualitative study of midwives in B.C. reported midwives recommending dimenhydrinate to help clients rest. (131) Although no research was identified that compared dimenhydrinate with opioids, dimenhydrinate is an option during early labour at home before offering to administer an opioid in the hospital setting.

Opioids

Opioids are also commonly used in early labour to facilitate rest. We identified one prospective cohort study (n = 82; *very low certainty of evidence*) where participants were offered therapeutic rest if they were in early labour (defined as painful contractions and cervical dilation of ≤ 5 cm) with reassuring fetal and birthing person status and no indication for labour and delivery. Participants received 10 to 15 mg of intramuscular morphine sulfate, administered along with 25 mg of intramuscular promethazine, then were discharged home. (183) Participants who declined therapeutic rest were discharged with no treatment. Results suggest that therapeutic rest in early labour may increase the likelihood of **being admitted to the labour and delivery unit in active labour (≥ 6 cm)** (aRR 1.87, 95% CI 0.44-7.89); may reduce the risk of **induction of labour** (aRR 0.15, 95% CI 0.04-0.54); may reduce the risk of **labour augmentation** (aRR 0.89, 95% CI 0.67-1.17); may make little to no difference in the use of

neuraxial anesthesia (aRR 1.01, 95% CI 0.84-1.23); and may increase the risk of **caesarean section** (aRR 1.45, 95% CI 0.33-5.43). Overall, study participants were satisfied with therapeutic rest. Meanwhile, 30% reported side effects, including grogginess, nausea and itching. Despite the side effects, 93% reported that they would use them again, and 96% said they would recommend them to a friend. We are very uncertain of these results, due to concerns about confounding, the small sample size and wide confidence intervals.

A second retrospective cohort study (n = 800; *very low certainty of evidence*) compared those who received therapeutic rest with those who did not. (184) The most frequently used medication in this study was a combination of 1000 mg paracetamol, 0.125 mg triazolam and 25 or 50 mg codeine. Results show that receiving therapeutic rest in early labour may increase the odds of **NICU admission** (aOR 1.2, 95% CI 0.4-3.1) and **caesarean section** (aOR 1.2, 95% CI 0.5-2.9); but it may reduce the odds of **neonatal resuscitation** (aOR 0.7, 95% CI 0.31-4.00) and **oxytocin augmentation** (aOR 0.8, 95% CI 0.4-1.5); and it may make little to no difference in the odds of **epidural** (aOR 0.9, 95% CI 0.5-1.6). We are very uncertain of these results, due to concern about confounding, the small sample size and wide confidence intervals.

Task force remarks, clinical considerations, values and preferences

The evidence on therapeutic rest is limited and of very low certainty, due to small sample sizes and several methodological issues. The TF noted that some clients can have adverse reactions to these medications, and they therefore balanced this risk with the benefit of allowing the birthing person to rest in early labour. Side effects of opioid use can include respiratory depression, dizziness, nausea/vomiting, sedation and decreased gastric emptying, as well as respiratory depression for the neonate. (50,185) Side effects depend on several factors, including the dose and the birthing person's metabolism of the drug and the time between administration and birth. (50) Though there are potential side effects, the consensus is that therapeutic rest is safe when used appropriately. (45,58,185) There is a need for more research on the optimal medications and doses.

Recommendation

10. Midwives may offer therapeutic rest to support pain management and rest in early labour.

Weak recommendation: very low certainty of evidence

This recommendation recognizes the lack of evidence about the optimal medications and dose for therapeutic rest. It also acknowledges midwives' skills in assessing and monitoring clients and tailoring care to the clinical circumstances.

Timing of epidural

A 2014 Cochrane review of nulliparous term participants examined the impact of early and late initiation of epidural. In the review, initiation of epidural was considered late after 5 cm dilation in two studies, 4 cm in five studies and 2 cm in one study. (186)

A meta-analysis of nine RCTs (*low certainty of evidence*) shows that early initiation of epidural may make little to no difference in the risk of **caesarean section**: four more (from nine fewer to 18 more) per 1000. The certainty of evidence was rated low, due to concerns about the composition of the groups: six out of the nine studies had no clear divisions between the early and late epidural groups. As well, the confidence interval crosses the null.

A meta-analysis of seven RCTs ($n = 15\,319$; *low certainty of evidence*) shows that early initiation of epidural may make little to no difference in the need for **oxytocin augmentation**: two fewer (from 17 fewer to 12 more) per 1000. The certainty of evidence was rated low, due to concerns about the composition of the groups: four out of the seven studies had no clear divisions between the early and late epidural groups. Additionally, the confidence interval crosses the null.

One study ($n = 12\,793$; *moderate certainty of evidence*) found that receiving an early epidural makes little to no difference in the **length of the latent phase**, MD -6.00 minutes (95% CI -7.91 to -4.09). (187) Results from observational studies support this finding, suggesting that the timing of epidural makes little to no difference in the total length of labour. (188,189)

Task force remarks, clinical considerations, values and preferences

When reviewing the evidence on timing of epidural, it is important to note that the definition of late epidural initiation does not align with our definition of active labour. Most participants receiving “late” epidural are

still considered to be in early labour, according to our definition of active labour as beginning at 6 cm of cervical dilation. This may contribute to the lack of observed differences between the groups. Moreover, the evidence is limited by the heterogeneity in the epidural technique, dose and type of medication used. To inform our research question, there is a need for additional research that compares those who receive an epidural at less than 6 cm cervical dilation with those who receive it at 6 cm cervical dilation or greater.

Despite these limitations, the evidence suggests that if a client wants an epidural, the timing of initiation (early or late in the first stage of labour) may make little to no difference in outcome. It should be noted that while epidurals provide very effective pain relief, they are also accompanied by important potential side effects, including hypotension, urinary retention, nausea/vomiting, fever and headache. (50,51,190–192) As well, epidurals can affect the labour experience. Epidurals may limit mobility and may require increased monitoring for the birthing person and fetus, including EFM and frequent blood pressure monitoring. An IV will be inserted during an epidural, and a urinary catheter may be required. (58) It is important that clients are aware of these risks and understand how an epidural may affect their labour experience.

The TF noted potential equity and resource considerations with epidurals, which may not be available in smaller hospitals or in rural or remote communities. Hospital policies may prohibit epidural use in early labour without a plan for induction. In some circumstances, a client may need to wait for an epidural. In qualitative research, birthing people have reported negative experiences while waiting for an anaesthetist to become available and having no other pain management options in the meantime. (193) In these situations, midwives should offer alternative pain relief in the interim.

Recommendation

11. Midwives may discuss with clients the use and timing of epidural in early labour. This discussion should include:

- How an epidural is administered
- What clients can expect after receiving an epidural
- The risks and benefits of epidural use in early vs. active labour
- Alternative methods of pain relief
- Client values and preferences

Weak recommendation: very low certainty of evidence

This recommendation recognizes the client as the primary decision-maker, and it supports midwives in retaining primary care for the monitoring and maintaining of epidural analgesia.

METHODS TO PROMOTE PROGRESS IN EARLY LABOUR

Early labours vary widely in duration, and a long early labour is not inherently pathological. When indications arise for promoting progress in early labour, midwives offer options that consider appropriate use of technology. To support the physiologic processes of labour and birth, they aim to move from less to more interventionist approaches as needed.

Non-pharmacological methods to promote progress in early labour

Several non-pharmacological methods have been theorized to help promote progress in labour; however, most research into these methods does not focus specifically on early labor. (58,194–196) Nipple stimulation was the only non-pharmacological method that had evidence on its use to promote contractions specifically in early labour.

Nipple stimulation

It is theorized that nipple stimulation promotes labour progress through the production of endogenous oxytocin. (196,197) A 2022 RCT (n = 220; *very low certainty of evidence*) randomized individuals to an intervention group where they received training by a midwife to massage their nipples one by one for two minutes between contractions. (198) Nipple stimulation continued until delivery, unless the labouring person had five or more contractions in 10 minutes, at which point it was stopped. Results suggest that nipple stimulation may reduce the

likelihood of receiving **oxytocin augmentation** (OR 0.58, 95% CI 0.33–1.03), and it may shorten the **duration of early labour**; the median length of early labour was 3.2 hours in the nipple stimulation group versus 4.8 hours in the control. We are very uncertain of this evidence, due to unclear information about the intervention, small sample size and wide confidence intervals.

Task force remarks, clinical considerations, values and preferences

Recent research demonstrates strong support among Ontario midwives for nipple stimulation to augment labour when contraction patterns slow (199), although not all clients will be interested in this method. There is a need for more research on the optimal protocol for nipple stimulation. In qualitative research, Canadian midwives report using different protocols for how the nipples were stimulated (e.g., unilaterally, bilaterally, by hand, by pump) and the duration of stimulation. (199)

For other non-pharmacological methods, such as movement, acupuncture, sexual activity, herbal tinctures, castor oil and stretch and sweep, there continues to be a lack of evidence on their use in early labour specifically. Despite this, the TF considered the benefits of non-pharmacological methods to protect physiologic birth, such as facilitating the release of natural hormones and reducing the need for synthetic oxytocin; promoting client empowerment; and preserving labour and birth in community settings.

Recommendation

12. Midwives may discuss options for non-pharmacological methods of promoting contractions in early labour. An informed choice discussion should include:

- Risks and benefits of each method
- Alternatives for management
- Considerations for next steps after one or more of these methods have been used
- Client values and preferences

Weak recommendation: very low certainty of evidence

This recommendation recognizes the benefits of physiologic processes that can encourage the release of oxytocin. It also recognizes midwives' skills in assessing and monitoring clients and tailoring care to the clinical circumstances.

Pharmacological methods of promoting progress in early labour

In some circumstances, pharmacological methods of induction in early labour may be warranted. (45) For the purposes of this CPG, the TF has aligned with the Better Outcomes Registry and Network (BORN) of Ontario on definitions of induction and augmentation of labour. Any method (e.g., amniotomy, misoprostol or oxytocin) administered prior to the onset of active labour is considered an induction, while augmentation refers to interventions provided after the onset of active labour. Since the focus of this CPG is promoting progress in early labour, before active labour begins, the term “induction” is used.

Induction among clients with early labour greater than 18 hours

A 2014 RCT (n = 129; *very low certainty of evidence*) of nulliparas compared early induction with expectant management among those experiencing prolonged early labour, defined as: continuous contractions impeding rest for over 18 hours, cervical dilation of less than 4 cm and intact membranes. (200) All participants initially received medication for therapeutic rest. After five hours, if the person was still in early labour, induction was performed for those assigned to early induction. The method of induction was chosen according to the ripeness of the cervix (intravaginal prostaglandin E2 or transcervical catheter and/or amniotomy). If no progress occurred after amniotomy, oxytocin was administered. Results suggest that early induction may reduce the risk of **caesarean section** (OR 0.50, 95% CI 0.23-1.08), and it may make little to no difference in the odds of **epidural use** (OR 1.02, 95% CI 0.31-3.34), but we are very uncertain of these results, due to deviations from the intended intervention, the small sample size and wide confidence intervals.

Induction among clients with early labour greater than eight hours

A 2019 RCT (n = 308; *very low certainty of evidence*) investigated induction of labour compared with expectant management in term nulliparas experiencing prolonged early labour, defined as: overnight hospitalization of at least eight hours for latent phase of labour, persistent contractions of at least one in 30 minutes, cervical dilation ≤ 3 cm and intact membranes. (201) The methods of induction included amniotomy, oxytocin infusion (or a combination of amniotomy and oxytocin) or vaginal dinoprostone pessary. Results from this study suggest that receiving induction may make little to no difference in the risk of **caesarean section** (RR 1.04, 95% CI 0.70-1.55) or **epidural use** (RR 1.07, 95% CI 0.60-1.90) and may decrease the risk of **admission to the neonatal unit** (RR 0.71, 95% CI 0.26-1.95). We are very uncertain of these results, due to concerns about deviations from the intended intervention, the small sample size and wide confidence intervals. Additionally, this study used less than eight hours as the threshold for prolonged early labour. Current research suggests that the average length of early labour may be much longer, which indicates that the research is not applicable to the midwifery context, where clients are not seeking prompt inductions.

Timing of oxytocin administration

A 2022 retrospective cohort study (n = 386; *very low certainty of evidence*) examined outcomes based on participants' cervical dilation when they received oxytocin. (202) Results suggest that receiving oxytocin at ≤ 5 cm, compared with 6 to 10 cm, may increase the odds of **operative delivery** (OR 1.28, 95% CI 0.78-2.08), and it may make little to no difference in the odds of **epidural use** (OR 0.91, 95% CI 0.48-1.73). We are very uncertain of this evidence, due to concerns about confounding, small sample size and wide confidence intervals.

In this study, 28.5% of participants who received oxytocin at ≤ 5 cm reported a negative birth experience, while 19% of those who received it at 6 to 10 cm reported a negative experience. Receiving oxytocin at ≤ 5 cm may increase the odds of a **negative birth experience** (OR 1.76, 95% CI 1.05–2.95; *very low certainty of evidence*). The authors suggest that their findings support the shift toward a definition of active labour at a higher cervical dilation.

Task force remarks, clinical considerations, values and preferences

The TF acknowledges that the decision to induce in the early labour period is complex. It must take into account

the complete clinical picture and the risks and benefits of induction. For example, amniotomy is associated with increased risk of infection and cord prolapse (58,203), and oxytocin is associated with uterine hyperstimulation. (203) Induction requires increased time and resources, including a longer continuous presence from the midwife and a higher likelihood that continuity of care is disrupted. Evidence also suggests that receiving one intervention can result in the need for more, resulting in a cascading effect. (15,58) As long as the status of birthing person and fetus is reassuring, long early labour alone is not pathological and not an indication for intervention.

Recommendation

13. After considering strategies for pain management, therapeutic rest and non-pharmacological induction, midwives may discuss induction in early labour. An informed choice discussion should include:

- Risks and benefits of induction
- Alternatives for labour management
- Different methods available in their community and/or hospital settings
- What to expect after induction, including possible transfer of care
- Clients' values and preferences

Weak recommendation: very low certainty of evidence

This recommendation recognizes midwives' skills in assessing and monitoring clients and tailoring care to the clinical circumstances. It also acknowledges the importance of supporting physiologic, low-intervention labour and birth.

CONCLUSION

Early labour can be a time of great excitement for individuals and families as they prepare to meet their baby, but it can also bring uncertainty and anxiety. This CPG provides a critical overview of the evidence on labour curves and how it has contributed to a new understanding about the definition of active labour. The CPG further explores strategies to help clients cope with early labour at home, guidance on how to address pain and fatigue and which interventions promote labour progress when clinically indicated.

Midwives and the Ontario midwifery model of care provide individualized, client-centred care based in informed choice and continuity, which supports the physiologic processes of labour and birth. They provide comprehensive care and employ strategies and practices, many unique to the midwifery model, to empower clients during early labour. The evidence clearly indicates that

many aspects of the Ontario midwifery model of care support remaining at home in early labour, which is associated with a decreased risk of interventions. These practices and approaches include giving clients access to evidence-based prenatal education; providing continuity of care; assessing clients by phone or at home and giving reassurance; and offering comfort measures and non-pharmacological pain relief. When early labour slows or stops, midwives are skilled in supporting clients and escalating care as needed.

Given the trends in Ontario toward increased interventions, the promotion of physiologic birth is critical. Midwives' clinical skills and judgment, alongside their commitment to building strong, trusting relationships with clients, positions them well to support clients' physical, emotional, and cultural needs in early labour.

SUMMARY OF GOOD PRACTICE STATEMENTS AND RECOMMENDATIONS

1. Regular contractions, effacement, and cervical dilation of 6 cm for nulliparas and 4 to 6 cm for multiparas should be considered the start of the active phase of labour.

Strong recommendation: low certainty of evidence

This recommendation recognizes the importance of accurately defining the active phase of labour, to avoid premature diagnosis of dystocia. It affirms the research that labour progression is slower than once thought, that the experience of labour varies across individuals and that a definition of 6 cm dilation reduces interventions without increasing risk.

2. Midwives should delay hospital admission or continuous intrapartum clinical care in the community until the onset of active labour, unless otherwise indicated.

Strong recommendation: very low certainty of evidence

This recommendation recognizes the evidence indicating that later admission to hospital is associated with fewer interventions and affirms delaying continuous clinical care as a means to achieve low-intervention physiologic labour and birth.

3. Midwives should discuss the benefits of prenatal education and help facilitate access to culturally appropriate, evidence-based prenatal education, as requested by clients.

Strong recommendation: low certainty of evidence

This recommendation acknowledges the client as the primary decision-maker and the skill of midwives in supporting clients to access information and resources.

4. Midwives should discuss the benefits of non-clinical support people in early labour. This discussion may include:
 - Information for support people about what to expect in early labour and how to best support the birthing person
 - Information about other kinds of support available (e.g., doulas)
 - Information about organizations that may offer labour support volunteers to those who qualify, particularly equity-deserving groups

Good practice statement

This good practice statement recognizes the evidence illustrating the value of non-clinical support people in labour and midwives' skills in providing health information to clients.

5. When a client contacts their midwife in early labour, midwives should provide an initial assessment over the phone and determine whether an in-person assessment is indicated.

If an in-person assessment is deemed unnecessary at the time of contact, midwives should provide reassurance, education, suggestions for coping and guidance about when the client should call them again.

In determining the location of follow-up assessments (e.g., phone, at home, clinic, birth centre or hospital), consider the clinical picture. Where possible, midwives should consider assessing a client in early labour at home or in the community to avoid early hospital admission.

Strong recommendation: very low certainty of evidence

This recommendation acknowledges the midwifery values of physiologic birth, continuity of care and choice of birthplace. It also recognizes midwives' clinical judgment and skills in early labour assessment.

6. Initial in-person assessment in early labour should be tailored to the clinical picture. Indications for in-person assessment may include evaluation for active labour or rupture of membranes; concerns about vaginal bleeding and fetal or birthing person well-being; or the need for additional support.

Assessments may include cervical exams, evaluation of contractions, fetal position, fetal heart rate and recording of the birthing person's vital signs.

If during the in-person assessment, the midwife rules out active labour, the midwife should provide reassurance, education, suggestions for coping and guidance on when the client should contact them again.

Good practice statement

This good practice statement recognizes midwives' skills in assessing and monitoring clients and tailoring care to the clinical circumstances.

7. In the absence of clinical concerns, midwives should use intermittent auscultation on first in-person contact in early labour.

Strong recommendation: low certainty of evidence

This recommendation recognizes midwives' skills in assessment and monitoring clients, and their expertise in using IA and providing one-to-one care.

8. Midwives should discuss techniques for rest, distraction, coping, pain and/or anxiety management in early labour, including but not limited to: acetaminophen, aromatherapy, acupressure, massage, TENS, music, breathing exercises and birth balls.

Strong recommendation: very low certainty of evidence

This recommendation recognizes the client as the primary decision-maker.

9. Midwives may discuss hydrotherapy with clients as an option to manage pain and/or anxiety in early labour, according to client preferences and the clinical picture.

Weak recommendation: low certainty of evidence

This recommendation acknowledges midwives' clinical judgment and recognizes the client as the primary decision-maker. Hydrotherapy can be used as a strategy to help the birthing person rest, especially for clients experiencing long early labour. Midwives must balance the benefits and harms and consider client preferences.

10. Midwives may offer therapeutic rest to support pain management and rest in early labour.

Weak recommendation: very low certainty of evidence

This recommendation recognizes the lack of evidence about the optimal medications and dose for therapeutic rest. It also acknowledges midwives' skills in assessing and monitoring clients and tailoring care to the clinical circumstances.

11. Midwives may discuss with clients the use and timing of epidural in early labour. This discussion should include:
 - How an epidural is administered
 - What clients can expect after receiving an epidural
 - The risks and benefits of epidural use in early vs. active labour
 - Alternative methods of pain relief
 - Client values and preferences

Weak recommendation: very low certainty of evidence

This recommendation recognizes the client as the primary decision-maker, and it supports midwives in retaining primary care for the monitoring and maintaining of epidural analgesia.

12. Midwives may discuss options for non-pharmacological methods of promoting contractions in early labour. An informed choice discussion should include:
 - Risks and benefits of each method
 - Alternatives for management
 - Considerations for next steps after one or more of these methods have been used
 - Client values and preferences

Weak recommendation: very low certainty of evidence

This recommendation recognizes the benefits of physiologic processes that can encourage the release of oxytocin. It also recognizes midwives' skills in assessing and monitoring clients and tailoring care to the clinical circumstances.

13. After considering strategies for pain management, therapeutic rest and non-pharmacological induction, midwives may discuss induction in early labour. An informed choice discussion should include:
- Risks and benefits of induction
 - Alternatives for labour management
 - Different methods available in their community and/or hospital settings
 - What to expect after induction, including possible transfer of care
 - Clients' values and preferences

Weak recommendation: very low certainty of evidence

This recommendation recognizes midwives' skills in assessing and monitoring clients and tailoring care to the clinical circumstances. It also acknowledges the importance of supporting physiologic, low-intervention labour and birth.

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