



An AOM Clinical Practice Guideline Summary

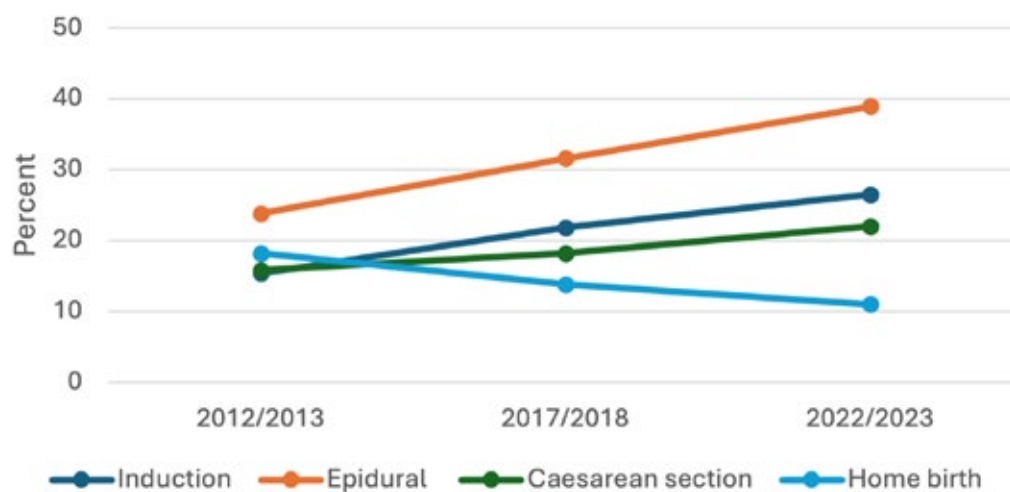
MIDWIFERY CARE DURING EARLY LABOUR

This summary provides easy access to essential content from **CPG No. 20 – Midwifery Care During Early Labour**, and it is intended for use in conjunction with the full-length CPG. For a complete analysis of the research relevant to midwifery care during early labour, along with all citations, refer to the full CPG.

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. (1) Despite the known benefits of physiologic birth, rates of intervention have risen consistently over recent decades.

Figure 1. Trends in the rates of interventions and home birth in Ontario midwifery



In certain cases, interventions during labour and birth are both necessary and beneficial, but they also present risks. Caesarean section rates have increased, with little evidence of associated decreases in morbidity and mortality for the birthing person and fetus, which points to an unnecessary reliance on surgical intervention. (2–6) The early labour period presents midwives with important opportunities to promote the physiologic processes of labour and birth.

DEFINING THE STAGES OF LABOUR

Labour stage	Dilation	Definition
Prelabour	None or non-progressive	The time when the birthing person's body starts to prepare for labour. This can include practice contractions (Braxton Hicks), fetal engagement in the pelvis and loss of the mucus plug.
First stage	Progressive	From the onset of regular uterine contractions that result in dilation and effacement of the cervix through to full cervical dilation.
Latent phase (early labour)	Slower dilation (0-6 cm)	The onset of uterine contractions that result in progressive effacement and dilation of the cervix up until the start of the active phase. In this stage, dilation occurs more slowly. The duration of this phase can vary significantly among individuals.
Active labour	Faster dilation (6-10 cm)	Regular, strong uterine contractions and cervical effacement proceeding to full cervical dilation.
Second stage	Full dilation (10 cm)	From full cervical dilation until delivery. In this stage, the birthing person pushes, and the baby moves through the birth canal.
Third stage	Full dilation (10 cm)	From immediately after birth until delivery of the placenta.

DEFINING ACTIVE LABOUR

Friedman and Zhang's labour curves

Standards for labour progression were largely shaped by Friedman's curve, developed in the 1950s. (7) However, current evidence illustrates that labour progression is slower than previously thought. In the early 2000s, Zhang studied labour progression, and he found that cervical dilation progressed at less than 1 cm per hour until around 6 cm, when labour began to progress more quickly. (8) Zhang concluded that 6 cm rather than 4 cm is a more appropriate marker for the beginning of the active phase.

Impact of defining the start of active labour at 6 cm

Zhang's work inspired changing guidelines, including the 2014 consensus statement by the American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine, which defines active labour as beginning at 6 cm. (5) Upon release of these recommendations, research was conducted to assess whether the changes were effective in reducing the rate of caesarean delivery. This is the best available evidence to assess the impact of defining active labour at 6 cm of cervical dilation.

Results from a 2023 cluster RCT show that applying the ACOG guidelines on first- and second-stage labour management may result in a slight increase in the rate of spontaneous vaginal birth. (9) However, the study did not find a statistically significant reduction in the rate of caesarean birth. Our certainty in this evidence is low, due to varied compliance with the guidelines at the hospitals in this study. Importantly, no differences were found in adverse outcomes for the birthing person or neonate. Results from observational studies support these findings, showing a slight reduction in the odds of caesarean section and no increases in adverse outcomes for the birthing person or fetus. (10–14)

The Diagnosis of Active Labour Task Force (TF) recognized the importance of appropriately identifying active labour, to avoid premature diagnosis of dystocia. After assessing the evidence, the TF agreed that 6 cm for nulliparas and 4-6 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 parents 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 the research that suggests faster labour progression for multiparas, the TF decided on a range of 4-6 cm as the definition of active labour for multiparas.

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 HOSPITAL ADMISSION OR CONTINUOUS CLINICAL CARE

Cervical dilation at time of hospital admission

Research has endeavoured to explore outcomes based on timing of hospital admission. Findings from eight retrospective cohort studies show that hospital admission at less than 4 cm cervical dilation may increase the odds of caesarean section, oxytocin augmentation, epidural use and NICU admission, though it may slightly reduce the odds of postpartum hemorrhage. (15–22) Additional evidence from observational studies suggests that admission at less than 5 cm and less than 6 cm may also increase the odds of caesarean section.

Regularity of contractions at hospital admission

Findings from one observational study show that hospital admission before contractions were regular and less than five minutes apart may increase the odds of caesarean section, oxytocin augmentation and epidural use. (23)

Early labour assessment to delay hospital admission

One RCT compared participants who were admitted to hospital having had no assessment with those who were assessed, then advised to walk around outside or return home if they were not yet in active labour. (24) Results showed that receiving a labour assessment and avoiding early hospital admission, compared with immediate admission, may reduce the odds of caesarean section, oxytocin augmentation and epidural, as well as duration of the second stage of labour.

Overall, evidence consistently finds that hospital admission at lesser cervical dilation and before contractions are regular and less than five minutes apart is associated with increased obstetric intervention. Unfortunately, we were unable to identify any relevant research about 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 delaying continuous clinical care in the community setting. Additionally, in-person continuous care places a high demand on clinicians' time and resources. Therefore, delaying in-person continuous care can help preserve these resources and maintain continuity of carer.

The TF also weighed equity implications. There are several reasons why clients may be unable to remain at home in early labour and may need more support. The TF recognized that midwives must tailor care to meet their clients' specific circumstances.

Early labour can be a time of great uncertainty and anxiety for clients; midwives should consider these lived realities when providing care during this phase. The AOM's client handouts *Early Labour: What do I need to know?* and *Early Labour: Tips for support people* explain what to expect.

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.

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

Prenatal education

Evidence has demonstrated an association between prenatal education and increased self-efficacy, reduced fear of childbirth and reductions in anxiety. (25–27) Midwives play a vital role in delivering health counselling and education. These communication points can help clients understand what to expect in early labour:

- 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.

Prenatal classes

Findings from two RCTs of nulliparas who received prenatal education show that those who receive prenatal education are more likely to arrive at the hospital at greater than 3 cm cervical dilation (28) and make fewer hospital visits before the onset of active labour. (29)

The TF recognizes that clients may face barriers to accessing prenatal education, and it encourages midwives to facilitate access to free, culturally appropriate resources whenever possible, including online.

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

The impact of continuity of care on early labour specifically is not well understood. One Australian RCT compared caseload midwifery with standard care. (30) Results show that caseload midwifery may be associated with a slightly shorter interval between hospital admission and birth. Results also show that those in the caseload midwifery group were admitted at slightly higher cervical dilations than those in standard care.

There is growing understanding that continuity is multi-faceted. 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). (31)

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

Qualitative research indicates that clients benefit from non-clinical support (e.g., from partners, family, friends, doulas) in early labour. However, when a support person is feeling anxious, it can exacerbate the labouring person's own anxiety and uncertainty. (32,33) Having a support person, such as a doula, who is knowledgeable about birth can be beneficial. The TF recognizes the challenges in accessing and affording doula care, and it notes that lay people can also provide excellent support.

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

A 2017 Cochrane review compared outcomes of home visits in early labour with phone assessments. (34) Results suggest that a home visit may make little to no difference in the risk of caesarean section, instrumental vaginal birth, oxytocin augmentation or epidural or other regional anesthesia. However, results suggest that home assessment may reduce the risk of neonatal admission to special care, and it may reduce the likelihood of hospital admission at less than 3 cm cervical dilation.

There is a lack of clear evidence to support home visits over phone assessments, and although early labour itself does not necessarily warrant an in-person assessment, midwives may complete one for several reasons, including to address a clinical indication or reassure a client. There is a need for more research about virtual visits through video calls.

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 that compares specific assessments in early labour, nor the optimal timing of in-person assessments for the birthing parent or fetus.

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

Results from a 2025 meta-analysis show that admission EFM probably increases the risk of continuous EFM during labour, but that it makes little to no difference in the risk of caesarean section, instrumental vaginal delivery, NICU admission, or fetal and neonatal mortality. (35) This evidence demonstrates that admission EFM shows no improvement in outcomes for the birthing person or fetus, and therefore the TF strongly supports the use of IA at first contact, in the absence of clinical concerns.

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.

EFFECTIVE COPING MECHANISMS AND PAIN RELIEF AT HOME IN EARLY LABOUR

Clients may access a variety of support strategies in early labour for coping, conserving energy and distraction. As well, clients may have specific cultural practices around labour and birth. Midwives should support their clients in performing these cultural practices.

Aromatherapy: The use of oils massaged into the skin, inhaled or used alongside hydrotherapy may help reduce pain and may slightly reduce anxiety. It is thought that essential oils can promote relaxation. (36–41)

Acupressure: Using the hands to stimulate pressure points may result in a clinically meaningful reduction in pain, as it is hypothesized to enhance blood flow, decrease pain perception and help produce endorphins. (42,43)

Massage: The research literature describes various massage techniques. Findings suggest that massage may reduce pain and anxiety in early labour by relaxing tense muscles, increasing endorphin production and distracting the birthing person. (44–50)

TENS: Only one study was found that investigated the effectiveness of TENS, and it concluded that TENS may make little to no difference in lower back or abdominal pain. However, TENS remains popular, as a distraction and to increase a sense of control over pain. (51)

Music: Listening to music may make little to no difference in pain and anxiety, but it can provide entertainment, foster relaxation and distract the birthing person. (52)

Breathing techniques: Lamaze breathing makes little to no difference in reducing anxiety in early labour. (53)

Birth ball: There is mixed evidence about the effectiveness of birth balls for reducing pain and anxiety, but they may facilitate movement and more comfortable positioning. (54,55)

Acetaminophen: We did not identify any research that examined taking oral acetaminophen during early labour, although there is some research into the use of intravenous acetaminophen for pain relief during active labour. This research suggests that intravenous acetaminophen provides a modest reduction in pain with few adverse effects. (56)

Additional research is needed about the most effective way to implement many of these techniques. Despite the limited available evidence, these methods are generally considered low risk, with few to no harms noted, and clients largely find them acceptable.

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.

Hydrotherapy

A 2018 Cochrane review that included eight RCTs found that birthing parents who undergo water immersion in the first stage of labour have less use of regional analgesia, with no effect on caesarean section rates. (57) However, this research did not specifically examine water immersion in early labour.

One RCT suggests that a bath before 5 cm cervical dilation may increase the use of pharmacological analgesia and oxytocin. (58) It has been hypothesized that water immersion before active labour may slow or stop contractions, which may explain the increased use of analgesia and oxytocin.

Pooled data from two RCTs suggests that a shower in early labour may make little to no difference in pain level, but it may reduce anxiety. (59,60)

Overall, there is a lack of evidence about hydrotherapy in early labour, and the existing evidence is limited by very small sample sizes. A larger body of evidence about 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. If contractions slow or stop when the birthing person is immersed, it may help for them to leave the water until labour resumes. 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 FATIGUE IN EARLY LABOUR

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.

Promoting rest in early labour

Dimenhydrinate (Gravol)

We did not identify any research that examined the effectiveness of oral dimenhydrinate during early labour. Despite the lack of evidence, dimenhydrinate is commonly used in early labour in the home setting, and it is an option before offering an opioid in the hospital setting. (61)

Opioids

Results from one cohort study suggest that therapeutic rest in early labour may increase the likelihood of being admitted to the hospital in active labour (at cervical dilation greater than 6 cm). Therapeutic rest may reduce the risk of induction of labour and labour augmentation; it may make little to no difference in the use of neuraxial anesthesia; and it may increase the risk of caesarean section. (62)

Results from another retrospective cohort study showed that therapeutic rest in early labour may increase the odds of NICU admission and caesarean section. However, it may reduce the odds of neonatal resuscitation and oxytocin augmentation, and it may make little to no difference in the odds of epidural. (63)

The evidence about therapeutic rest is limited and of very low certainty, due to small sample sizes and several methodological issues. Though there are potential side effects, the consensus is that therapeutic rest is safe when used appropriately and when the risks are balanced with the benefits of allowing rest in early labour. More research into optimal medications and dosages is needed.

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. Initiation of epidural was considered late after 5 cm dilation in two studies, 4 cm in five studies and 2 cm in one study. Results showed that early initiation of epidural may make little to no difference in the risk of caesarean section, the need for oxytocin augmentation or the length of the latent phase. (64)

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. There is a need for additional research that compares participants who receive an epidural at less than 6 cm cervical dilation with those who receive epidural at 6 cm cervical dilation or greater. Despite these limitations, this 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 outcomes. It should be noted that while epidurals provide very effective pain relief, they are also accompanied by significant potential side effects, such as hypotension, urinary retention, nausea and vomiting, fever and headache. Epidural use may also affect the labour experience by increasing monitoring and limiting movement.

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.

Non-pharmacological methods to promote labour progress

Results from one RCT suggest that nipple stimulation may reduce the likelihood of receiving oxytocin augmentation and may shorten the duration of early labour. (65)

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 about their use in early labour specifically.

Despite this, the TF considered the benefits of non-pharmacological methods to promote physiologic birth.

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 for promoting progress in early labour

Induction for early labour greater than 18 hours

Results from one RCT suggest that early induction may reduce the risk of caesarean section, and it may make little to no difference in the odds of epidural use. (66)

Induction for early labour greater than eight hours

Results from a 2019 RCT suggest that early induction may make little to no difference in the risk of caesarean section; may make little to no difference in the risk of epidural use; and may decrease the risk of admission to the neonatal unit. (67)

Timing of oxytocin administration

Results from a 2022 retrospective cohort suggest that receiving oxytocin at less than 5 cm dilation, compared with 6-10 cm, may increase the odds of operative delivery, and it may make little to no difference in the odds of epidural use. (68)

The TF acknowledges that the decision to induce during early labour is complex, and it must take into account the complete clinical picture. Inductions require more time and resources, including a longer continuous presence from the midwife, and they may impact continuity of care. As long as birthing person and fetal status is reassuring, a 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

Given the trends in Ontario toward increased use of 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 birthing parents' physical, emotional and cultural needs in early labour.

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