



DEFINING ACTIVE LABOUR

AN IMPLEMENTATION GUIDE FOR MIDWIVES

In 2026, the AOM published Clinical Practice Guideline No. 20 – Midwifery Care During Early Labour. This CPG provides the following recommendations for the definition of active labour and delaying continuous care:

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. 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.

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.

This document aims to support midwives to engage in discussions with interprofessional colleagues when implementing these recommendations. It is meant to be used in conjunction with the full CPG. For a complete analysis of the research, clinical considerations, values and preferences, and a discussion of how these recommendations were made, please refer to pages 7 through 12 of the CPG.

RESPONDING TO QUESTIONS ABOUT THESE RECOMMENDATIONS

1. What research supports these recommendations?

Standards for labour progression were largely shaped by Friedman's labour curve, developed in the 1950s. (15) This work defined active labour as starting at 4 cm and set thresholds for labour progress. However, current research suggests that these standards create unrealistic expectations for labour progress, and they may lead to premature diagnosis of dystocia and unnecessary interventions. (1) In the 2000s, Zhang set out to understand labour progression in a modern population. He found that cervical dilation progressed at less than 1 cm per hour until around 6 cm, when labour begins to progress more quickly (2), and he concluded that 6 cm rather than 4 cm is a more appropriate marker for the beginning of the active phase.

Further research was conducted to assess whether defining active labour at 6 cm was effective in reducing the rate of caesarean section without compromising the birthing parent or neonate's health and well-being. The findings show that applying the first- and second-stage labour management guidelines from the American

College of Obstetricians and Gynecologists (ACOG), including 6 cm as the definition of active labour, might slightly increase rates of spontaneous vaginal birth, with results suggesting 21 more spontaneous vaginal births per 1000. (3) The results also show 11 fewer caesarean sections per 1000 births.

Our certainty of this evidence is low, given 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. Five observational studies that examined this new definition also support these findings, showing a slight reduction in the odds of caesarean section and no increases in adverse outcomes for the birthing person or neonate. (4–8) The research affirms the safety of this definition of active labour, although further study is needed to understand the impact on caesarean section rates.

The timing of hospital admission was also examined, as earlier admission has been shown to increase interventions. Hospital admission at lower cervical dilation and before contractions are regular and less than five minutes apart is associated with an increased risk of oxytocin augmentation, epidural analgesia, caesarean section and NICU admission. (9–17)

2. How should these recommendations guide decision-making?

AOM CPGs are not intended to dictate a course of action; rather, they aim to inform clinical decision-making. Midwives should always use their clinical judgment to apply the recommendations to individual circumstances and involve clients in decision-making.

The recommendations support identification of active labour, to avoid premature diagnosis of dystocia and unnecessary interventions to accelerate labour. They also consider the research findings that labour progresses more slowly than once thought, and that increased monitoring in early labour is not associated with fewer adverse outcomes for the birthing person or neonate. The second recommendation, to delay continuous in-person clinical care, refers to continuous intrapartum care, where the midwife stays with the client. The CPG recognizes that during early labour, midwives should conduct phone and in-home assessments as needed; and at each contact, they should provide reassurance, education, coping suggestions and guidance about when to contact them again. The CPG further suggests that when assessing clients in early labour, midwives should make best efforts to do this at home or in another community setting, to avoid early hospital admission.

Furthermore, midwives should consider clients' unique circumstances, which may make it difficult for them to remain at home in early labour and who may require additional support. The CPG includes a comprehensive discussion of these considerations, such as when the birthing person has limited access to a home-like environment or faces challenges with moving from the community in which they reside to their chosen birth setting.

3. Why is it important to implement these recommendations?

Intervention rates during labour and birth have risen consistently over the past few decades. While interventions are both necessary and beneficial in certain cases, their overuse introduces avoidable risks. In particular, caesarean section rates have been rising with no corresponding improvements in birthing person and fetal outcomes, which suggests use beyond what is clinically indicated. (18–22)

These two recommendations aim to support safe, evidence-informed care while reducing unnecessary interventions. Implementation of these recommendations supports provincial goals, including Ontario's Quality-Based Procedures for Low Risk Birth. The policy aims to reduce the variation in caesarean section rates across the province via evidence-based guidelines that promote vaginal birth. (23,24)

Early labour provides important opportunities to support physiologic labour and birth. Slow or stalled progress in early labour is often characterized as abnormal, despite known variations in labour progress and duration. (25,26) This can result in a cascade of interventions, including caesarean section, for which non-progressive labour is a common indication. (27) Accurately defining active labour is important, as it helps ensure that clients in early labour are not prematurely diagnosed with dystocia, and it promotes physiologic birth.

4. How do these recommendations align with existing guidelines?

There is no consensus among international guideline groups about active labour, with definitions ranging from 4 cm to 6 cm. (28–31) Table 1 below compares different groups' definitions of the first stage of labour. It is important to recognize that the AOM's definition of active labour does not align with the 2016 guideline from the Society of Obstetricians and Gynaecologists of Canada (SOGC). Given the differences in definitions, midwives will likely need to inform their interprofessional colleagues about the evidence base that was used in the AOM's definition of active labour.

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

	Latent phase	Active phase
Society of Obstetricians and Gynaecologists of Canada, 2016 (28)	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, 2023 (29)	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, 2024 (30)	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, 2018 (31)	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.

Key takeaways

- Current research suggests that 6 cm dilation rather than 4 cm is a more appropriate marker for the beginning of the active phase.
- Research consistently shows that hospital admission at a lower cervical dilation is associated with increased obstetric interventions, including caesarean section, oxytocin augmentation and epidural.
- Defining 6 cm as the start of active labour has not been found to increase the risk of adverse outcomes.
- Evidence supports these recommendations as a method to support physiologic birth and reduce unnecessary interventions while maintaining safe outcomes.
- There is a lack of consensus among international guideline groups on the definition of active labour.

5. How would implementation of these recommendations benefit the hospital and health-care systems?

In-person continuous clinical care and hospital admission in early labour places high demands on clinicians' time and resources. Additionally, caesarean sections are associated with high financial costs for longer hospital stays and postoperative care. Defining active labour as 6 cm dilation could reduce caesarean sections and may alleviate these financial costs, and some research bears this out.

Two US-based cost-effectiveness studies examined the cost savings associated with delaying hospital admission until active labour has begun.

A 2015 study developed a cost-effectiveness model to simulate a theoretical cohort of 3.2 million low-risk birthing people admitted to hospital at < 4 cm cervical dilation compared with delaying admission to > 4 cm dilation. (32) This model found that delaying admission until > 4 cm would result in 672 000 fewer epidurals, 67 232 fewer caesarean deliveries and an annual cost savings of \$694 million.

A 2023 study modelled a theoretical cohort of 1.4 million nulliparous birthing parents to compare 6 cm as the definition of active labour with a definition of 4 cm. (33) A threshold of 6 cm to define active labour resulted in 373 668 fewer caesarean deliveries and cost savings of \$980 million.

Although US studies have limited applicability in our context, these findings highlight the potential for resource optimization and cost savings at a systems level when a definition of 6 cm as the start of active labour is used.

6. How do elements of the midwifery model support implementation of these recommendations?

Midwives work within their legislated scope of practice and to their Standards of Practice, exercising expert knowledge, skills and judgment in providing client-centred assessments, education and intrapartum care.

Midwives offer assessments by phone, at home and at the clinic. This unique aspect of midwifery care enables clients to remain out of the hospital while still being supported and having access to a care provider in early labour.

Continuity of care, a core tenet of midwifery care, fosters trusting relationships between client and midwife. It has been suggested that the trusting relationships and individual support provided in continuity models may help clients feel able to stay at home for longer. (34)

Additionally, midwives can support clients with access to non-pharmacological pain management methods. Supporting clients to access these tools may enable them to cope better in early labour and feel comfortable remaining at home.

Data from the Better Outcomes Registry and Network (BORN) Ontario suggests that many midwives already practice according to these recommendations, with more midwifery clients arriving at the hospital at later cervical dilations compared to non-midwifery clients. Table 2 illustrates the cervical dilation of clients upon admission to hospital between May 2024 to April 2025. (35) Many midwives are also delaying continuous clinical care until later cervical dilations in the out of hospital setting. Among clients giving birth at home or at a midwifery clinic, 55.6% of nulliparas and 44% of multiparas had a cervical dilation of 6-10 cm upon the midwife's arrival to attend the birth. (35)

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.

TABLE 2. CERVICAL DILATION UPON ADMISSION TO HOSPITAL OR BIRTH CENTRE AMONG PREGNANT PEOPLE IN ONTARIO BETWEEN MAY 2024-APRIL 2025

	Midwifery Clients		Non-Midwifery Clients	
	Nulliparas	Multiparas	Nulliparas	Multiparas
0-3 cm	41.7%	29.4%	60.3%	45.9%
4-5 cm	30.5%	30.1%	27.3%	33.0%
6-10 cm	19.4%	26.1%	9.0%	18.1%
Unknown dilation	8.%	14.4%	3.4%	3.0%

7. What should midwives consider when implementing these recommendations at the local level?

Implementing these recommendations may present challenges for both midwives and hospital systems. As you integrate them into practice and engage in discussions with colleagues, it may help to reflect on the following considerations:

- How might existing hospital policies influence the ability to apply these recommendations? For example:
 - » If conducting a labour assessment in hospital, would discharging a client at 4 cm with regular contractions be supported by current hospital policy?
 - » In the context of a scheduled induction of labour, at what point might you be expected to provide a continuous presence, and might that misalign with the AOM CPG’s definition of active labour?
- What processes or channels are available to advocate for revisiting and updating hospital policies or protocols in light of this evidence?
- What impact could delayed hospital admission have on the flow and capacity of the labour and delivery unit?
- How might these recommendations shift labour support needs, and what are the potential positive and negative impacts for workload and practice?
- What strategies can support clear, effective interprofessional communication? In particular, how might these recommendations influence consultations with other providers? How can productive interprofessional relationships be maintained when midwifery definitions and assessments may differ from obstetrical standards?

REFERENCES

1. FRIEDMAN EA. Primigravid labor; a graphicostatistical analysis. *Obstetrics and gynecology*. 1955 Dec;6(6):567–89. doi:10.1097/00006250-195512000-00001 PubMed PMID: 13272981.
2. Zhang J, Landy HJ, Ware Branch D, Burkman R, Haberman S, Gregory KD, et al. Contemporary patterns of spontaneous labor with normal neonatal outcomes. *Labor C on S, editor*. Vol. 116. 2010 Dec;Comment in: *Lancet*. 2019 Jan 26;393(10169):300–301 PMID: 30581040 [<https://www.ncbi.nlm.nih.gov/pubmed/30581040>] 116(6):1281–7.
3. Wood S, Skiffington J, Brant R, Crawford S, Hicks M, Mohammad K, et al. The REDUCED trial: a cluster randomized trial for REDucing the utilization of CEsaean delivery for dystocia. *Am J Obstet Gynecol*. 2023 May;228(5S):S1095–103. doi:10.1016/j.ajog.2022.10.038 PubMed PMID: 37164490.
4. Bell AD, Joy S, Gullo S, Higgins R, Stevenson E. Implementing a Systematic Approach to Reduce Cesarean Birth Rates in Nulliparous Women. *Obstetrics and gynecology*. 2017;130(5):1082–9. doi:<https://dx.doi.org/10.1097/AOG.0000000000002263>
5. Wilson-Leedy JG, DiSilvestro AJ, Repke JT, Pauli JM. Reduction in the Cesarean Delivery Rate After Obstetric Care Consensus Guideline Implementation. *Obstetrics and gynecology*. 2016 Jul;128(1):145–52. doi:10.1097/AOG.0000000000001488 PubMed PMID: 27275806.
6. Rosenbloom JL, Stout MJ, Tuuli MG, Woolfolk CL, Lopez JD, Macones GA, et al. New labor management guidelines and changes in cesarean delivery patterns. *Am J Obstet Gynecol*. 2017;217(6):689.e1–689.e8. doi:<https://dx.doi.org/10.1016/j.ajog.2017.10.007>
7. Thuillier C, Roy S, Peyronnet V, Quibel T, Nlandu A, Rozenberg P. Impact of recommended changes in labor management for prevention of the primary cesarean delivery. *Am J Obstet Gynecol*. 2018;Comment in: *Am J Obstet Gynecol*. 2019 Jul;221(1):78–79 PMID: 30926266 [<https://www.ncbi.nlm.nih.gov/pubmed/30926266>] Comment in: *Am J Obstet Gynecol*. 2019 Jul;221(1):78 PMID: 30940560 [<https://www.ncbi.nlm.nih.gov/pubmed/30940560>] 218(3):341.e1–341.e9. doi:<https://dx.doi.org/10.1016/j.ajog.2017.12.228>
8. Main EKMD, Chang SC, Cape V, Sakowski C, Smith H, Vasher J, et al. Safety Assessment of a Large-Scale Improvement Collaborative to Reduce Nulliparous Cesarean Delivery Rates. Vol. 133. 2019 Apr;Comment in: *Obstet Gynecol*. 2019 Apr;133(4):611–612 PMID: 30870282 [<https://www.ncbi.nlm.nih.gov/pubmed/30870282>] 133(4):613–23. doi:10.1097/AOG.0000000000003109
9. Kjerulff KH, Attanasio LB, Vanderlaan J, Sznajder KK. Timing of hospital admission at first childbirth: A prospective cohort study. *PLoS One*. 2023;18(2):e0281707. doi:<https://dx.doi.org/10.1371/journal.pone.0281707>
10. Kauffman E, Souter VL, Katon JG, Sitcov K. Cervical Dilation on Admission in Term Spontaneous Labor and Maternal and Newborn Outcomes. Vol. 127. 2016 Mar;127(3):481–8. doi:<https://doi.org/10.1097/aog.0000000000001294>
11. Anjum N, Memon Z, Sheikh S, Naz U. Relationship Between Cervical Dilatation At Which Women Present In Labor And Subsequent Rate Of Caesarian Section. *J Ayub Med Coll Abbottabad*. 2020;32(1):58–63.
12. Balcik Colak M, Ozturk Can H. Effects of the time of pregnant women's admission to the labor ward on the labor process and interventions. Vol. 42. 2021 Apr;42(4–6):563–79. doi:10.1080/07399332.2020.1716763
13. Chuma C, Kihunrwa A, Matovelo D, Mahendeka M. Labour management and Obstetric outcomes among pregnant women admitted in latent phase compared to active phase of labour at Bugando Medical Centre in Tanzania. *BMC Pregnancy Childbirth*. 2014;14:68. doi:<https://dx.doi.org/10.1186/1471-2393-14-68>
14. Holmes P, Oppenheimer LW, Wen SW. The relationship between cervical dilatation at initial presentation in labour and subsequent intervention. *BJOG*. 2001;108(11):1120–4. doi:10.1111/j.1471-0528.2003.00265.x
15. Gjaerum R, Johansen IH, Oian P, Bernitz S, Dalbye R. Associations between cervical dilatation on admission and mode of delivery, a cohort study of Norwegian nulliparous women. *Sex Reprod Healthc*. 2022;31:100691. doi:10.1016/j.srhc.2021.100691
16. Miller YD, Armanasco AA, McCosker L, Thompson R. Variations in outcomes for women admitted to hospital in early versus active labour: an observational study. Vol. 20. 2020 Aug 17;20(1). doi:10.1186/s12884-020-03149-7
17. Seravalli V, Strambi N, Castellana E, Salamina MA, Bettini C, Di Tommaso M. Hospital Admission in the Latent versus the Active Phase of Labor: Comparison of Perinatal Outcomes. *Children*. 2022 Jun;9(6):924–N.PAG. doi:10.3390/children9060924
18. Baker M, Isabelle M, Stabile M, Allin S. Accounting for the Rising Caesarean Section Rate in Canada: What Are the Roles of Changing Needs, Practices, and Incentives? *Canadian Public Policy*. 2022 Mar 1;48(1):36–73. doi:10.3138/cpp.2021-017
19. Ye J, Zhang J, Mikolajczyk R, Torloni MR, Gülmezoglu AM, Betran AP. Association between rates of caesarean section and maternal and neonatal mortality in the 21st century: a worldwide population-based ecological study with longitudinal data. *BJOG*. 2016 Apr;123(5):745–53. doi:10.1111/1471-0528.13592 PubMed PMID: 26331389.
20. World Health Organization. WHO Statement on Caesarean Section Rates [Internet]. 2015 [cited 2025 Jul 20]. Available from: https://iris.who.int/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf?sequence=1
21. Caughey AB, Cahill AG, Guise JM, Rouse DJ. Safe prevention of the primary cesarean delivery. American College of Obstetricians and Gynecologists (College) S for MFM, editor. *Am J Obstet Gynecol*. 2014;210(3):179–93. doi:<https://dx.doi.org/10.1016/j.ajog.2014.01.026>
22. Gregory K, Jackson S, Korst L, Fridman M. Cesarean versus Vaginal Delivery: Whose Risks? Whose Benefits? *Am J Perinatol*. 2012 Jan 10;29(01):07–18. doi:10.1055/s-0031-1285829

23. The Provincial Council for Maternal and Child Health & Ministry of Health and Long-Term Care. Quality-Based Procedures: Clinical Handbook for Low Risk Birth [Internet]. 2017 [cited 2026 Mar 22]. Available from: <https://www.ontario.ca/files/2023-12/moh-qbp-clinical-handbook-low-risk-birth-en-2023-12-11.pdf>
24. Provincial Council for Maternal and Child Health. Quality-Based Procedure Low Risk Birth Toolkit [Internet]. 2018 [cited 2026 Mar 22]. Available from: <https://pcmch.on.ca/wp-content/uploads/2022/02/Low-Risk-Birth-QBP-Toolkit-18-05-15.pdf>
25. Maaløe N, Kujabi ML, Nathan NO, Skovdal M, Dmello BS, Wray S, et al. Inconsistent definitions of labour progress and over-medicalisation cause unnecessary harm during birth. *BMJ*. 2023 Dec 6;383:e076515. doi:10.1136/bmj-2023-076515 PubMed PMID: 38084433.
26. Weckend M, McCullough K, Duffield C, Bayes S, Davison C. Failure to progress or just normal? A constructivist grounded theory of physiological plateaus during childbirth. *Women Birth*. 2024 Feb;37(1):229–39. doi:10.1016/j.wombi.2023.10.003 PubMed PMID: 37867094.
27. Dunn SI, Guo Y, Dimanlig-Cruz S, Murphy MSQ, Scremin Souza SC, White RR, et al. Evaluation of Cesarean Delivery Rates across Ontario from 2012 to 2019 Using the Modified Robson Classification System: A Population-Based Study. *J Obstet Gynaecol Can*. 2025 Sep 19;47(12):103131. doi:10.1016/j.jogc.2025.103131 PubMed PMID: 40976408.
28. Lee L, Dy J, Azzam H. Management of Spontaneous Labour at Term in Healthy Women. *J Obstet Gynaecol Can*. 2016 Sep;38(9):843–65. doi:10.1016/j.jogc.2016.04.093 PubMed PMID: 27670710.
29. National Institute for Health and Care Excellence. Intrapartum Care [Internet]. 2023 [cited 2024 Jan 8]. Available from: <https://www.nice.org.uk/guidance/ng235> PubMed PMID: 37871143.
30. First and Second Stage Labor Management: ACOG Clinical Practice Guideline No. 8. *Obstetrics and gynecology*. 2024 Jan 1;143(1):144–62. doi:10.1097/AOG.0000000000005447 PubMed PMID: 38096556.
31. Geneva: World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience [Internet]. 2018 [cited 2024 Jan 9]. Available from: <https://iris.who.int/bitstream/handle/10665/260178/9789241550215-eng.pdf?sequence=1> PubMed PMID: 30070803.
32. Tilden EL, Lee VR, Allen AJ, Griffin EE, Caughey AB. Cost-Effectiveness Analysis of Latent versus Active Labor Hospital Admission for Medically Low-Risk, Term Women. *Birth*. 2015 Sep;42(3):219–26. doi:10.1111/birt.12179 PubMed PMID: 26095829.
33. Schmidt EM, Hersh AR, Tuuli M, Cahill AG, Caughey AB. Considering Criteria for Active Phase Labor Management of Nulliparous Women: A Cost-Effectiveness Analysis. *Am J Perinatol*. 2023 Jan;40(1):99–105. doi:10.1055/s-0041-1728836 PubMed PMID: 33940649.
34. McLachlan HL, Forster DA, Davey MA, Farrell T, Gold L, Biro MA, et al. Effects of continuity of care by a primary midwife (caseload midwifery) on caesarean section rates in women of low obstetric risk: the COSMOS randomised controlled trial. *BJOG*. 2012;Comment in: *Pract Midwife*. 2012 Nov;15(10):40-2 PMID: 23243833 [<https://www.ncbi.nlm.nih.gov/pubmed/23243833>] Comment in: *J Midwifery Womens Health*. 2013 Jan-Feb;58(1):110-1 PMID: 23374496 [<https://www.ncbi.nlm.nih.gov/pubmed/23374496>]119(12):1483–92. doi:<https://dx.doi.org/10.1111/j.1471-0528.2012.03446.x>
35. Better Outcomes Registry and Network (BORN) Ontario. Years Provided: (2021 to 2025). Resource Type: Tabulated data. Data Extracted on 1 May, 2026.