Common questions about contractions

What are contractions?

A contraction is a coordinated tightening and subsequent relaxation of the uterine myometrium, the muscular layer of the uterus. During labor, these waves help soften and thin the cervix, a process called effacement, and gradually open it, known as dilation. They also help the presenting part of the baby descend through the pelvis.

Contractions typically build gradually, reach a peak, and then fade. Some people first notice tightening across the front of the abdomen; others feel pressure in the pelvis, aching in the lower back, cramping similar to a menstrual period, or discomfort that wraps from the back toward the abdomen. The sensation may vary according to fetal position, parity, the stage of labor, and individual pain perception.

Contractions can occur before established labor. The uterus may contract intermittently during pregnancy without causing progressive cervical change. Therefore, the presence of tightening does not by itself establish that labor has begun. A clinician may need to assess the overall pattern, gestational age, cervical findings, fetal well-being, and other signs such as rupture of membranes.

How do Braxton Hicks contractions differ from true labor?

Braxton Hicks contractions are often described as practice contractions. They can occur throughout pregnancy and may become more noticeable toward the end. The abdomen may feel firm or tense, but the contractions are commonly irregular in timing and variable in intensity. They may settle after resting, drinking fluids, emptying the bladder, changing position, or reducing activity, although these measures are not a diagnostic test.

True labor contractions generally develop a more organized pattern. They tend to become progressively stronger, last longer, and occur at shorter intervals. Unlike many Braxton Hicks contractions, they usually continue despite rest or a change in position. However, there is no single sensation or timing pattern that applies to everyone, and early labor can remain irregular for a considerable period.

The most clinically meaningful distinction is progressive cervical change. Contractions that are painful or frequent do not necessarily mean that the cervix is dilating, while some cervical change can occur with relatively mild discomfort. Only an appropriately trained healthcare professional can evaluate this reliably. If you are uncertain, contacting your maternity service is reasonable rather than trying to classify the contractions alone.

How long do contractions last, and how far apart should they be?

Contraction duration refers to how long one contraction lasts, measured from the beginning of tightening until it has completely relaxed. Frequency or interval describes the time from the start of one contraction to the start of the next. These definitions matter because measuring from the end of one contraction to the beginning of the next can make the pattern appear longer than it is.

Early contractions may be brief, widely spaced, and inconsistent. As labor progresses, contractions commonly become longer, stronger, and closer together, although the transition is not always smooth. A pattern may temporarily slow, especially during early labor, and some people experience prodromal labor, in which contractions are intense or repetitive but do not produce established

labor.

Many maternity services use a practical threshold such as contractions occurring about every five minutes, lasting about one minute, and continuing for about one hour before advising a person with a low-risk pregnancy to call or come in. This is not a universal rule. Recommendations may differ for first or subsequent births, planned cesarean birth, distance from the hospital, previous rapid labor, multiple pregnancy, or pregnancy complications. Follow the individualized instructions provided by your clinician.

How should I time contractions?

Timing is most useful when it captures a trend rather than a single measurement. Use a clock, phone application, or written record. Note the start time, end time, duration, and start-to-start interval for several contractions. Also record whether the pattern is becoming more regular, whether the intensity is increasing, and whether other symptoms are present.

Start the timer when the tightening or pain begins.
Stop it when the contraction has fully eased.
Measure the next interval from the start of the first contraction to the start of the next.
Record the pattern for approximately 30 to 60 minutes unless your maternity team has advised you to call sooner.

Do not allow timing to delay urgent care. A contraction app cannot assess cervical dilation, fetal heart rate, amniotic fluid, bleeding, or maternal vital signs. If you have leaking fluid, significant bleeding, severe or continuous abdominal pain, reduced fetal movement, or symptoms before 37 weeks, contact your healthcare professional immediately according to your local maternity instructions.

What can make contractions more comfortable?

Comfort measures should be chosen in line with your pregnancy history and the advice of your maternity team. During early labor or uncomplicated uterine tightening, many people find it helpful to change positions, walk if safe, rest, use controlled breathing, take a warm shower or bath when appropriate, or

receive massage or firm counterpressure to the lower back. Hydration and light nutrition may be appropriate in early labor, depending on the instructions for your planned birth and any medical conditions.

During a contraction, relaxed shoulders, a loose jaw, and slow breathing may reduce unnecessary muscle tension. A support person can help with timing, reassurance, position changes, and communication with clinicians. If labor progresses, pharmacologic analgesia or regional anesthesia may be options, but these require individualized discussion with the maternity team and are not appropriate in every circumstance.

Comfort strategies do not determine whether labor is true or false, and relief does not rule out a clinically important problem. Stop an activity that causes dizziness, faintness, worsening pain, or other concerning symptoms, and seek professional guidance when needed.

When should I call my healthcare professional?

Call your obstetrician, midwife, labor ward, or maternity triage service whenever you are worried or unsure, especially if you have been given a personalized plan. Immediate assessment may be needed for vaginal bleeding that is more than light spotting, suspected rupture of membranes, continuous or severe abdominal pain between contractions, fever, fainting, chest pain, difficulty breathing, or a substantial reduction in fetal movement.

Possible preterm labor requires prompt attention. Regular contractions, pelvic pressure, menstrual-like cramps, low-backache, increased vaginal discharge, bleeding, or leaking fluid before 37 completed weeks should be reported urgently. Do not wait for contractions to meet a particular timing rule if you have a high-risk pregnancy or have been specifically told to attend earlier.

After your waters break, note the time and the color and odor of the fluid, and follow your maternity service’s instructions. Green or brown fluid may indicate meconium and should be reported. Bright-red bleeding, an umbilical cord visible at the vagina, or a strong urge to push with no time to reach the planned birth setting requires emergency help. Local emergency services should be used when immediate danger is suspected.