## Decreased or no baby movement before labor

## What movement should feel like near term

Fetal movements include kicks, rolls, swishes, stretches, and turns. As pregnancy advances, the character of movement can change: sharp kicks may become more of a rolling, stretching, or pressing sensation as the fetus occupies more of the uterus. This change in sensation can be normal, but the fetus should remain active right up to labor and birth.

There is no single number of movements that is normal for every pregnancy. The most useful reference point is your baby’s established daily pattern, including the times of day when movement is usually most noticeable. Fetuses commonly have sleep cycles, often lasting 20 to 40 minutes and rarely longer than about 90 minutes. Maternal activity, distraction, position, and an anterior placenta can also affect how easily movement is perceived. These factors may explain why a movement is less obvious, but they should not be used to dismiss a meaningful change from your baby’s usual pattern.

Near labor, people sometimes hear that the baby "runs out of room" and therefore moves less. This is misleading. Less room may alter the quality of movement, but it does not make a sustained reduction or no movement expected. Reduced fetal movement near term warrants contact with a maternity professional.

## When to contact maternity care urgently

Call your maternity triage line, labor and delivery unit, midwife, or obstetric clinician immediately if you notice that your baby is moving less than usual, movements have become distinctly weaker, the usual pattern has changed, or you cannot feel movement. This applies whether you are at term, in early labor, or have a planned induction or cesarean birth approaching.

Do not wait for a routine appointment, the next morning, or the onset of regular labor contractions. Do not rely on a home Doppler, smartwatch, or phone application for reassurance. Hearing a heartbeat with a consumer device cannot establish that the fetus is well, and it can delay needed assessment.

Contact emergency maternity care without delay when reduced movement occurs alongside vaginal bleeding, suspected rupture of membranes, green or brown amniotic fluid, severe abdominal pain between contractions, severe headache, visual disturbance, sudden swelling, fever, or feeling acutely unwell. These features can require urgent evaluation for maternal or fetal complications.

While arranging care, follow the instructions given by your local service. Lying on your side in a quiet environment may help you focus on sensation, but it must not become a prolonged attempt to test the baby at home. If movement is absent or clearly reduced, the priority is prompt professional contact.

## Why decreased movement can occur

Reduced perception of movement can occur for benign reasons, including fetal sleep, maternal activity, an anterior placenta, and changes in fetal position. Sedating medications and maternal illness may also affect perception or fetal activity. However, a change in movements may sometimes be associated with reduced placental reserve, fetal growth restriction, low amniotic fluid, fetal anemia, infection, or another condition affecting fetal oxygenation or wellbeing.

The purpose of urgent assessment is not to assume that one of these conditions is present. It is to identify whether there is objective evidence of fetal compromise and to decide whether further monitoring or treatment is needed.

Many people assessed for a single episode of reduced movement have reassuring results and continue their pregnancies safely.

Risk is interpreted in context. Clinicians may consider gestational age, blood pressure, fetal growth, pregnancy complications, prior obstetric history, diabetes, hypertension, smoking exposure, bleeding, fluid loss, and the timing and recurrence of the movement concern. A person who presents repeatedly should be assessed again; a previous reassuring visit does not make a new episode unimportant.

**What assessment at the maternity unit may involve**

At the maternity unit, the clinical team will usually ask about the timing and nature of the change, your gestational age, associated symptoms, and relevant pregnancy history. They may check maternal observations such as blood pressure and assess the abdomen for uterine tenderness, fetal size, lie, and presentation. The exact pathway varies by gestation and local protocol.

Electronic fetal monitoring, often called cardiotocography or CTG, is commonly used later in pregnancy. It records the fetal heart rate and uterine activity over time. Clinicians look for features such as baseline heart rate, variability, accelerations, and decelerations. A reassuring CTG is valuable, but it is interpreted alongside the whole clinical assessment rather than in isolation.

An ultrasound may be recommended when there are ongoing concerns, risk factors, recurrent reduced movement, uncertainty about fetal growth, or a need to evaluate amniotic fluid. Ultrasound can assess fetal growth, fluid volume, anatomy when relevant, and sometimes blood flow in the umbilical artery using Doppler studies. Not every person requires every test, and a scan is not always available immediately if the initial assessment is reassuring and clinical risk is low.

**Movement concerns during early labor**

Labor does not remove the need to pay attention to fetal movement. Contractions, discomfort, fatigue, and focus on other sensations can make movement harder to notice, but a marked decrease or no movement before active

labor should still be reported. Tell the midwife or labor unit specifically that you have noticed a change, rather than assuming it is part of labor.

Once labor is established, the approach to fetal surveillance depends on individual risk and the labor setting. Some low-risk labors use intermittent auscultation, where the fetal heart rate is checked at defined intervals. Continuous CTG may be advised when there are risk factors, concerns about fetal wellbeing, certain medications, induction methods, meconium-stained fluid, or an abnormal heart-rate finding.

Decreased fetal movement near labor does not by itself prove fetal distress or mean that an immediate birth is necessary. Guidelines emphasize that, where assessment finds no objective evidence of fetal compromise, there is no automatic indication to expedite birth. Decisions about induction, augmentation, or cesarean birth should be individualized, based on monitoring, gestational age, cervical findings, maternal health, and shared discussion with the care team.

**After a reassuring assessment and with recurrent episodes**

A reassuring assessment is good news, and most people can return home with clear instructions on when to call again. Continue to notice your baby’s usual movement pattern rather than starting repeated, anxiety-driven checks throughout the day. Ask your clinician what local advice they recommend for monitoring and whom to contact outside office hours.

Seek reassessment for any later reduction, even if a CTG or ultrasound was normal earlier that day or week. Recurrent presentations can lead clinicians to consider additional surveillance, growth assessment, and discussion of timing of birth. Evidence suggests recurrent reduced fetal movement is associated with higher rates of induction, although this does not necessarily translate into increased adverse outcomes. This distinction matters: repeat review is a cautious clinical response, not proof that something is wrong.

It can help to prepare a brief record before calling: when you last felt normal movement, what has changed, whether you have felt any movement at all, your gestational age, and any associated symptoms such as fluid leakage, bleeding, contractions, headache, or visual changes. Do not delay the call to make a

detailed record. Your perception of a genuine change is sufficient reason to seek advice.