Week 37 of pregnancy: early full-term development and preparation for birth

Why 37 weeks is called early term

For many years, people commonly used the phrase "full term" for any pregnancy reaching 37 weeks. Modern obstetric classification is more precise. According to ACOG, early term is 37 0/7 to 38 6/7 weeks, full term is 39 0/7 to 40 6/7 weeks, late term is 41 0/7 to 41 6/7 weeks, and postterm is 42 0/7 weeks and beyond.

This terminology reflects outcome data: babies born at 37 or 38 weeks generally do very well, but as a group they have higher rates of respiratory problems, temperature instability, hypoglycemia, jaundice, feeding difficulties, and neonatal intensive care admission compared with babies born at 39 to 40 weeks. The goal is not to prevent medically necessary births at 37 weeks. If there is a maternal or fetal indication, delivery may be the safest option. But when there is no medical reason to deliver early, allowing pregnancy to continue can give the baby valuable developmental time.

Fetal development at 37 weeks

At 37 weeks, the fetus is typically gaining fat, refining neurologic control, and preparing for the physiologic transition from placental support to

independent breathing, feeding, glucose regulation, and thermoregulation. Measurements vary widely, and growth patterns are interpreted in the context of ultrasound findings, fundal height, parental genetics, placental function, and the pregnancy's overall course.

The lungs are much more mature than in earlier weeks, but respiratory adaptation still improves through 39 and 40 weeks. Surfactant production, fluid clearance mechanisms, and the coordination of breathing after birth continue to develop. The brain is also undergoing rapid growth and connectivity changes, supporting sleep-wake cycling, feeding coordination, arousal, and autonomic regulation.

The liver is preparing to process bilirubin and maintain glucose balance after the umbilical cord is clamped. Brown fat and subcutaneous fat stores help the newborn maintain body temperature. The immune system is also receiving maternal antibodies through the placenta, especially IgG, which helps provide early protection after birth. These processes are part of why the last weeks matter even when the baby appears fully formed.

What you may feel in your body

By week 37, many pregnant people feel physically stretched and emotionally ready. The is large, the baby may be low in the pelvis, and sleep may be interrupted by reflux, urinary frequency, hip discomfort, leg cramps, or difficulty finding a comfortable position.

Pelvic pressure: If the baby's head descends, you may feel more pressure in the pelvis, rectum, or pubic bone area.
Braxton Hicks contractions: Irregular tightening may become more noticeable. These often vary with hydration, activity, and rest.
Cervical discharge changes: Mucus may increase, and some people lose part of the mucus plug. A small amount of blood-tinged mucus can occur, but heavy bleeding is not normal.
Backache and cramping: Mild intermittent discomfort can happen as the body prepares, but persistent, worsening, or rhythmic pain should be discussed with your care team.
Swelling: Mild swelling of the feet and ankles is common, but sudden swelling of the face or hands, severe headache, or visual symptoms requires urgent

assessment.

Because normal late-pregnancy sensations can overlap with early labor or complications, it is reasonable to call your maternity unit or clinician whenever symptoms feel different, intense, or concerning.

Fetal movement and monitoring in week 37

Your baby may feel different because space is tighter, but the overall pattern of movement should remain reassuringly familiar. Movements may feel more like rolls, stretches, pushes, or sweeping motions rather than sharp kicks. A meaningful reduction in movement should never be dismissed as "just running out of room."

Many clinicians recommend paying attention to the baby’s usual active periods. Some use formal kick counts; others advise awareness of the daily pattern. If you notice decreased, absent, or markedly unusual movement, contact your healthcare team promptly for guidance. They may recommend evaluation with fetal heart rate monitoring, ultrasound assessment, or other testing depending on your history and symptoms.

If you have a high-risk pregnancy, such as hypertension, diabetes, fetal growth restriction, decreased amniotic fluid, multiple gestation, or prior pregnancy complications, your monitoring schedule may be more intensive. Follow the plan given by your obstetric clinician or maternal-fetal medicine specialist.

Signs of labor versus signs to call urgently

Labor often begins gradually, but it can also progress quickly. True labor contractions usually become more regular, longer, stronger, and closer together over time. They often continue despite hydration, position changes, or rest. You may also notice rupture of membranes, commonly described as a gush or ongoing leakage of fluid.

Contact your maternity care team for individualized instructions about when to come in, especially if you are group B strep positive, have had a previous cesarean, are planning a trial of labor after cesarean, live far from the hospital, or have pregnancy complications.

Call if contractions are regular and intensifying according to the timing guidance your clinician gave you.
Call right away if your water breaks, particularly if the fluid is green, brown, foul-smelling, or accompanied by fever.
Seek immediate advice for heavy vaginal bleeding, severe abdominal pain, or persistent severe headache.
Do not wait at home if fetal movement is decreased or absent.

Birth planning at early term

Week 37 is a good time to shift from broad planning to operational readiness. Confirm where to go, who to call, and what the after-hours process is. If you have a birth preferences document, keep it concise and flexible. The most useful plans communicate priorities while allowing the clinical team to respond to changing circumstances.

Consider preferences around pain management, mobility in labor, fetal monitoring, support people, delayed cord clamping when appropriate, newborn medications, infant feeding, and cesarean preferences if surgery becomes necessary. If you are scheduled for induction or cesarean delivery, ask your clinician to explain the medical indication, expected process, benefits, risks, alternatives, and what might change on the day of birth.

For uncomplicated pregnancies, elective delivery is generally not recommended before 39 weeks because babies born at 37 to 38 weeks have higher risks than those born at full term. However, medical indications such as preeclampsia, l concerns, fetal growth restriction, ruptured membranes, or other conditions may make earlier delivery appropriate. Your care team can explain how the risks of continuing pregnancy compare with the risks of birth at this gestational age.

Preparing for the newborn and postpartum period

Preparation at 37 weeks is not only about labor; it is also about the first days after birth. Newborns born at early term may breastfeed or bottle-feed well, but some are sleepier or less coordinated than babies born later. Feeding assessment, weight monitoring, jaundice screening, and follow-up appointments are important.

Pack essentials for yourself and your baby, but also plan for recovery. Arrange transportation, childcare for older children, pet care, meal support, and help with household tasks. If you plan to breastfeed or chestfeed, identify lactation support in advance. If you plan to formula feed or combination feed, make sure you understand safe preparation and feeding cues.

Postpartum mental health also deserves preparation. Mood swings and tearfulness can occur, but persistent sadness, anxiety, intrusive thoughts, panic, inability to sleep even when the baby sleeps, or thoughts of self-harm require prompt professional help. Tell your partner, family, or support person what signs to watch for and how to contact your clinician.

Emotional readiness and the waiting period

The final weeks can feel emotionally contradictory. You may be eager to meet your baby and, at the same time, anxious about labor, parenting, or medical uncertainty. It is common to oscillate between excitement, impatience, nesting energy, fatigue, and vulnerability.

Try to focus on what is controllable: attending appointments, monitoring fetal movement, resting when possible, eating regularly, staying hydrated, and clarifying your questions. If anxiety is escalating or interfering with sleep and daily function, tell your healthcare professional. Support is part of prenatal care, not an extra luxury.

If you have been following earlier pregnancy milestones, it may help to reflect on how far you and your baby have come, from the and early movements to third-trimester growth and positioning. Week 37 is close to the end, but it is also a meaningful developmental stage in its own right.