

## What are the stages of labor and overview step by step



### 1. The big picture: what labor is doing physiologically

Labor is the coordinated process of uterine contractions, cervical remodeling, fetal descent, and birth. The cervix does not simply "open" at the end; it first becomes softer and thinner, a process called effacement, and then it dilates from closed to 10 centimeters. At the same time, the uterus becomes more efficient at producing contractions that help move the fetus downward.

Clinically, this is why labor is staged by cervical change rather than by pain alone. Contractions may be present before active change begins, and some people notice a gradual pattern of tightening, pelvic pressure, back discomfort, or changes in discharge before things become clearly progressive. If membranes rupture before contractions, the story can still be normal, but it deserves clinical attention because the sequence can vary.

The standard framework divides labor into three stages: the first stage ends at full dilation, the second stage ends with birth of the baby, and the third stage ends with delivery of the placenta.

### 2. First stage: latent labor to active labor

The first stage is usually the longest part of labor. It starts when regular uterine contractions are associated with progressive cervical change and ends when the cervix is fully dilated. Clinicians often divide it into a latent phase and an active phase because the pace of change is different in each part.

In the latent phase, contractions may be irregular or only moderately uncomfortable. The cervix continues to efface and begin dilating, but progress is often slow. This is the phase in which people commonly wonder whether they are in real labor or still in an early, less predictable pattern. Emotional support and patience matter here because the body is doing important work even when the changes are subtle.

The active phase of the first stage, sometimes called the active first stage of labor, is when cervical dilation usually becomes more rapid and contractions tend to be stronger, longer, and closer together. This is the part most people think of as "labor." Even so, the experience is variable: some people progress gradually, while others move faster than expected. The key clinical point is not intensity alone, but whether the cervix is continuing to change.

A helpful mental model is to think of this stage as preparation plus opening. The body is not yet delivering the baby, but it is building the conditions needed for the rest of labor to happen safely.

### **3. Second stage: full dilation to birth of the baby**

The second stage begins once the cervix is fully dilated and ends with the birth of the baby. It is often divided into a passive phase and an active phase. In the passive phase, the baby continues to descend, and the person in labor may feel rectal pressure or an increasing urge to bear down, but organized pushing may not begin immediately.

During the active phase, uterine contractions and maternal expulsive efforts work together to move the baby through the birth canal. This is not a single movement but a sequence of mechanical events known as the cardinal movements of labor. These steps are what make a vaginal birth possible in the setting of the maternal pelvis and soft tissues.

Engagement and descent: the presenting part enters and moves lower in the

pelvis.

Flexion: the fetal chin tucks, presenting a smaller head diameter.

Internal rotation: the head rotates to align with the pelvic outlet.

Extension: the head extends as it passes under the pubic arch.

Restitution and external rotation: the head realigns with the shoulders.

Expulsion: the shoulders and body are delivered.

When people hear the term crowning, it refers to the point at which the fetal head becomes visible at the vaginal opening and no longer retreats between contractions. That visual milestone usually means birth is close, but the exact pace still depends on maternal and fetal factors.

#### **4. Third stage: delivery of the placenta and immediate afterbirth**

The third stage begins after the baby is born and ends when the placenta is delivered. This stage is usually shorter than the first two, but it remains medically important because the uterus must contract effectively to separate the placenta and reduce bleeding.

In practical terms, the placenta detaches from the uterine wall, passes through the cervix, and is delivered. After that, the care team typically checks uterine tone, bleeding, and the completeness of the placenta and membranes. The goal is to confirm that the uterus is contracting well and that there is no retained placental tissue.

This part of labor can feel anticlimactic to families who expect the process to end the moment the baby arrives, but it is a normal and necessary final step. It also helps explain why clinicians continue monitoring after birth rather than ending observation immediately. For the patient, the focus often shifts from contractions and pushing to warmth, bonding, and recovery.

#### **5. How the stages can feel different from person to person**

Although the stages are defined clinically, the lived experience is not identical for everyone. The first stage may stretch over many hours, especially in a first birth, and it may feel like a slow build with pauses, sleep, appetite changes, or intermittent discomfort. In other pregnancies, cervical change and contraction patterns may move more quickly, which is one reason the

same symptoms are interpreted differently by clinicians depending on parity and context.

The second stage also varies. Some people feel a strong urge to bear down as soon as they are fully dilated, while others spend time in a passive descent phase before active pushing begins. Position, epidural analgesia, fetal station, and maternal exhaustion can all influence how quickly the process progresses.

The important takeaway is that labor is dynamic, not linear in a perfectly predictable way. A person can be in labor even when the pattern is not dramatic, and progress can happen in increments. That is why obstetric teams rely on repeated assessment rather than one moment in time.

If you are trying to understand your own labor, it is reasonable to ask your clinician which phase you are in, what the cervix is doing, and what they are watching next.

## **6. Step-by-step overview for patients and families**

If you want the shortest possible roadmap, labor often looks like this:

Contractions become coordinated enough to cause progressive cervical effacement and dilation.

The cervix moves through the latent phase and then the active phase as change speeds up.

Once the cervix reaches full dilation, the second stage begins.

The baby descends, rotates, and eventually crowns and is born.

The placenta is delivered in the third stage, and the uterus is monitored afterward.

That sequence is helpful because it shows why labor is more than "pain plus pushing." Each stage has a different physiologic goal. The first stage prepares the cervix, the second stage delivers the baby, and the third stage finishes the birth process and supports maternal recovery. Understanding the structure can make the experience feel less mysterious, especially when contractions or membrane rupture occur in an unexpected order.

For families, the best next step is not trying to label every sensation at home. Instead, use the pattern of contractions, membrane status, bleeding, and fetal movement as part of an ongoing conversation with the maternity team. Clinical reassessment is what determines whether the pattern fits normal labor or needs closer review.