How the third stage begins and progresses

When the third stage starts

The third stage of labor begins the moment the baby is fully born. The cervix is no longer the main focus, and the clinical priority shifts to placental separation, uterine contraction, bleeding control, and early assessment of both parent and newborn. Even when the room feels emotionally centered on the baby, the birthing parent remains under close observation.

At this point, the placenta is still attached to the uterine wall. It has been functioning as the interface for oxygen, nutrient transfer, and waste removal throughout pregnancy. Once the baby is born, uterine volume suddenly decreases. This reduction, along with continued uterine contractions, helps shear the placenta away from its implantation site.

During these first minutes, clinicians also consider cord management. In many births, delayed cord clamping is used when parent and baby are stable, allowing time for placental transfusion from the placenta to the newborn. The timing may differ if urgent newborn resuscitation or maternal instability requires a different approach. This is one reason third-stage care is individualized rather than purely routine.

How placental separation happens

Placental separation is a mechanical and vascular event. After birth, the uterus contracts and retracts. Retraction means that uterine muscle fibers shorten and maintain that shortened state, compressing the blood vessels that supplied the placental bed. As the uterine wall becomes smaller and thicker, the placenta, which cannot contract in the same way, begins to peel away.

Clinicians watch for classic placental separation signs. These may include a sudden small gush of blood, apparent lengthening of the umbilical cord outside the vagina, and a uterus that becomes firmer, more globular, and often rises slightly in the abdomen. These signs are helpful but not perfect; assessment depends on the whole clinical picture, including bleeding and maternal condition.

Separation can occur centrally, with blood collecting behind the placenta before it is expelled, or marginally, where separation begins at an edge and bleeding may be seen earlier. In either pattern, the uterus needs to remain well contracted. A soft or boggy uterus after birth can indicate uterine atony, a major contributor to postpartum hemorrhage. Clinicians commonly palpate the fundus, the top of the uterus, to assess tone while also estimating blood loss.

Active management and physiologic management

Third-stage care is often described as either active management or physiologic, sometimes called expectant, management. In practice, care may include elements of both depending on the setting, clinical risk factors, and the preferences discussed with the healthcare team.

Active management usually includes uterotonic medication after birth, most commonly oxytocin where available and appropriate. A uterotonic helps the uterus contract effectively, supporting placental separation and reducing bleeding from the placental bed. Active management may also include controlled cord traction, performed by a trained clinician while supporting the uterus to reduce the risk of uterine inversion, and assessment or massage of the uterus after delivery of the placenta if indicated.

Physiologic management relies more on the body’s own contractions, avoiding

routine traction and typically waiting for spontaneous placental delivery. It may be chosen in selected low-risk circumstances with appropriate monitoring and a plan to intervene if bleeding increases, the placenta does not deliver, or the parent becomes unwell.

Neither approach should be understood as a moral choice or a measure of how "natural" the birth was. The safest plan is the one matched to the person’s clinical situation. Risk factors such as a previous postpartum hemorrhage, prolonged labor, multiple pregnancy, chorioamnionitis, magnesium sulfate use, operative birth, or uterine overdistension may influence recommendations.

Delivery of the placenta

Once separation is likely, the placenta may descend into the lower uterus and vagina. The birthing parent may feel mild to moderate contractions again, pressure, or an urge to push. Compared with birth of the baby, delivery of the placenta is usually much less intense, but sensations vary. Some people barely notice it while focused on their newborn; others feel cramping, shaking, or fatigue.

During active management, a clinician may use controlled cord traction only when there are signs of separation and the uterus is well supported. The goal is not to pull the placenta off the uterine wall, but to guide out a placenta that has already separated. Pulling too early or without proper counter-support is avoided because it can cause complications.

After the placenta emerges, the membranes should follow. The clinician usually inspects the placenta, cord, and membranes to check that they appear complete. This inspection matters because retained fragments can interfere with uterine contraction and increase the risk of delayed bleeding or infection. The umbilical cord may also be examined for the number of vessels and any notable features, although findings must be interpreted in context.

Many placentas deliver within minutes, but timing varies. If the placenta has not delivered within the expected window, or if bleeding becomes heavy at any time, the team may recommend additional steps. These decisions are guided by local protocols, the amount of bleeding, uterine tone, vital signs, and whether separation signs are present.

Bleeding, uterine tone, and postpartum hemorrhage prevention

Some bleeding is normal in the third stage because the placental site is a large vascular surface. The key question is whether the uterus is contracting strongly enough to compress those vessels. A firm, central uterus is reassuring; a boggy uterus may need prompt attention.

Postpartum hemorrhage prevention is a central goal of third-stage care. Clinicians may estimate or quantitatively measure blood loss, check pulse and blood pressure, assess skin color and level of alertness, and ask about dizziness, nausea, or feeling faint. Blood loss can be underestimated visually, so many maternity units use structured approaches to recognition and escalation.

If bleeding is more than expected, the team may massage the uterus, give or repeat uterotonic medication according to protocol, empty the bladder if it is preventing uterine contraction, examine the birth canal for lacerations, or evaluate whether placental tissue remains. These are clinical interventions that require trained assessment. A person giving birth should not be expected to distinguish normal from abnormal bleeding on their own.

Emotional reassurance also matters. Rapid movement in the room during bleeding management can feel frightening, especially immediately after birth. It is reasonable to ask, when possible, "What are you concerned about?" or "What is the next step?" Clear communication can help preserve a sense of safety while the team acts efficiently.

When progression is slower or incomplete

A third stage that does not progress as expected may raise concern for retained placenta. This term generally means the placenta has not delivered within the time frame used by the care setting, or that placental tissue remains after apparent delivery. Time thresholds vary by guideline and whether active or physiologic management is being used, but persistent non-delivery, increasing bleeding, or maternal instability warrants prompt evaluation.

Reasons for delayed placental delivery can include uterine atony, a placenta trapped behind a closing cervix, or abnormal adherence of placental tissue to

the uterine wall. Placenta accreta spectrum is uncommon but serious and is usually considered in the context of risk factors such as placenta previa or prior uterine surgery. Clinicians avoid casual assumptions and assess carefully because management differs.

If the placenta is retained, possible management may include additional uterotonics, bladder emptying, controlled techniques by an experienced clinician, examination, anesthesia support, or manual removal in an appropriate setting. The exact approach depends on bleeding, pain control, infection risk, birth setting, and local protocols.

After the placenta is delivered, monitoring continues. The first hour after birth is sometimes called the fourth stage, a period when uterine tone, bleeding, blood pressure, pulse, perineal trauma, pain, and newborn transition remain important. In other words, the end of the third stage is not the end of clinical observation; it is a handoff into early postpartum recovery.