Preparing for birth in third trimester

Understanding the third trimester: what your body is preparing to do

The third trimester begins around week 28 and continues until birth, which commonly occurs near 40 weeks but can vary. During this period, fetal weight gain accelerates, the uterus expands upward and outward, and the placenta continues to support oxygen and nutrient exchange. Many people notice stronger fetal movements, pelvic pressure, Braxton Hicks contractions, shortness of breath, reflux, back discomfort, leg cramps, swelling, constipation, and difficulty sleeping.

These symptoms are often physiologic, meaning they arise from normal pregnancy adaptations. For example, progesterone slows gastrointestinal motility, which can contribute to constipation and heartburn. Venous return from the legs can be reduced by uterine pressure, contributing to ankle swelling. The diaphragm may feel compressed until the baby settles lower into the pelvis, sometimes called lightening.

Normal does not mean insignificant. Persistent discomfort can affect mood, sleep quality, nutrition, and mobility. Bring symptoms to prenatal visits, especially if they are new, worsening, one-sided, associated with headache or visual changes, or interfere with eating, hydration, breathing, or daily

function. Your clinician can help distinguish expected late-pregnancy discomfort from concerns that require evaluation.

Keep prenatal care active and purposeful

In late pregnancy, prenatal visits usually become more frequent. The exact schedule depends on local practice, medical history, and pregnancy risk factors. These appointments may include blood pressure measurement, urine testing when indicated, assessment of fetal growth, discussion of fetal movement, review of symptoms, screening for group B streptococcus, and planning for labor and delivery.

Use each visit strategically. It can help to bring a concise list of questions rather than trying to remember everything in the exam room. Topics to clarify include:

When to call the maternity unit or clinician for contractions, leaking fluid, bleeding, reduced fetal movement, or pain.
How your hospital or birth center handles triage, admission, fetal monitoring, pain relief, and support people.
Whether you have any medical factors that could influence timing or mode of birth, such as prior cesarean birth, breech presentation, placenta-related concerns, hypertension, diabetes, fetal growth concerns, or multiple pregnancy.
Who to contact after hours and which entrance to use if labor begins at night.
What postpartum follow-up schedule is recommended, especially if you have hypertension, mood symptoms, surgical birth, significant bleeding, or chronic medical conditions.

Preparation is safer when it is personalized. Online checklists are useful, but they should not replace guidance from your obstetrician, midwife, family physician, or maternal-fetal medicine specialist.

Create a birth plan that supports communication, not perfection

A birth plan is a short written summary of your preferences for labor, birth, and immediate newborn care. It is not a contract and cannot predict how labor will unfold. Its value is in helping you discuss priorities with your care team before decisions become urgent.

Consider including preferences in these areas:

Labor environment: lighting, music, movement, positioning, use of a shower or tub if available, and who will be present.
Pain management: nonpharmacologic techniques, nitrous oxide where available, intravenous medications, epidural analgesia, or preferences about when options should be offered.
Monitoring and procedures: fetal monitoring approach, intravenous access, amniotomy, induction or augmentation, and how you would like information explained.
Birth preferences: pushing positions, coached versus spontaneous pushing when clinically appropriate, mirror use, and support for vaginal birth or cesarean birth if needed.
Newborn care: delayed cord clamping if appropriate, skin-to-skin contact, infant feeding plans, vitamin K, eye prophylaxis, vaccines, and rooming-in.

Keep the document brief, ideally one page. Use clear language such as, "If medically appropriate, I prefer..." or "Please explain the reason, benefits, risks, and alternatives before nonurgent interventions." This signals collaboration and allows clinicians to adapt recommendations to the clinical situation.

Learn the difference between practice contractions, early labor, and urgent symptoms

Braxton Hicks contractions are irregular uterine tightenings that may increase in the third trimester. They often ease with hydration, rest, or position changes and do not become progressively stronger, longer, and closer together in a consistent pattern. True labor contractions tend to intensify, occur more regularly, and cause cervical change. Some people also notice mucus plug discharge, pelvic pressure, backache, diarrhea, or rupture of membranes.

Your care team should give you individualized instructions about when to call or come in. Common reasons to seek prompt advice include regular painful contractions before 37 weeks, rupture of membranes, vaginal bleeding, reduced fetal movement, severe abdominal pain, fever, severe headache, visual changes, chest pain, shortness of breath, fainting, or sudden significant swelling of

the face or hands.

If you are unsure whether symptoms are labor or a warning sign, it is appropriate to call your maternity triage line. Clinicians would rather help you assess early than have you wait at home with symptoms that need evaluation.

Pack and organize before the final weeks feel urgent

Many families find it helpful to pack a hospital or birth center bag around 34 to 36 weeks, earlier if there is a higher chance of preterm birth or a long travel distance. The goal is not to pack everything, but to remove avoidable friction when labor begins.

Useful items often include:

Identification, insurance information, hospital registration forms if needed, and a copy of your birth preferences.
Comfortable clothing for labor and postpartum, nursing or feeding-friendly tops if desired, socks, slippers, and a going-home outfit.
Toiletries, glasses or contact lens supplies, lip balm, hair ties if used, phone charger, and any approved personal medical devices.
Items for comfort: a pillow from home, small fan, music playlist, massage tool, or aromatherapy only if allowed by the facility.
Newborn items: a weather-appropriate going-home outfit, diapers if your facility does not provide them, and an installed infant car seat for discharge.
Support person items: snacks, change of clothes, charger, medications, and contact list.

Separately, complete pre-registration if your facility offers it. Confirm where to park, which entrance to use, how to reach labor and delivery after hours, and whether there are visitor policies or infectious disease screening requirements. These details can change, so verify them close to your due date.

Prepare your body with realistic self-care

Physical preparation in the third trimester should be gentle, consistent, and cleared with your clinician if you have pregnancy complications. Movement such as walking, prenatal yoga, stretching, or pelvic mobility exercises may support

comfort, circulation, and endurance. Pelvic floor physical therapy can be helpful for some people, particularly those with pelvic girdle pain, urinary symptoms, prior pelvic floor dysfunction, or concerns about postpartum recovery.

Common symptom strategies include smaller meals for reflux, fiber and fluids for constipation, side-lying rest for comfort, leg elevation for mild swelling, and pillows for sleep positioning. These measures may help, but persistent or severe symptoms deserve medical guidance. Avoid starting supplements, herbal products, or over-the-counter medications without checking with a healthcare professional, because safety depends on your medical history, gestational age, and other medications.

Sleep can become fragmented late in pregnancy. If possible, plan shorter rest periods during the day, reduce evening reflux triggers, and create a wind-down routine. If insomnia is severe, associated with anxiety or depression, or worsened by pain, discuss it at a prenatal visit rather than assuming it is simply part of pregnancy.

Build your support and decision-making team

Birth preparation includes deciding who will support you and how they can help. A partner, family member, friend, doula, or other support person can assist with timing contractions, offering comfort measures, asking clarifying questions, and helping communicate preferences. The best support person is not necessarily the person most excited about the baby; it is someone who can remain calm, respectful, and responsive to your needs.

Discuss scenarios in advance. Who will drive or call transportation? Who will care for older children or pets? Who has permission to receive updates? What should your support person do if you are in pain, overwhelmed, or need quiet? If a cesarean birth becomes necessary, who will accompany you if permitted? Planning for these possibilities can reduce conflict and confusion.

Childbirth education classes, breastfeeding or chestfeeding classes, newborn care classes, and hospital tours can be valuable, especially for first-time parents or anyone giving birth in a new setting. Even medically literate people benefit from learning the specific workflows of the facility where they will deliver.

Plan for postpartum before the baby arrives

Postpartum preparation is part of birth preparation. After delivery, the body must recover from pregnancy and birth while also supporting feeding, sleep disruption, hormonal shifts, and emotional adjustment. The early postpartum period can be medically important, particularly for blood pressure disorders, infection, hemorrhage recovery, thromboembolic risk, wound healing, lactation concerns, and mood disorders.

Before birth, consider arranging:

Postpartum help for meals, laundry, transportation, older children, and household tasks.
A feeding support plan, including lactation consultation if you plan to breastfeed or chestfeed, and formula preparation education if formula feeding or combination feeding.
Basic recovery supplies such as pads, comfortable underwear, perineal care items, and any clinician-recommended wound care supplies.
A safe sleep space that follows current safety guidance: firm, flat surface, no loose bedding, and baby placed on the back unless your pediatric clinician advises otherwise for a specific medical reason.
Emergency contacts, pediatrician information, and a plan for postpartum mental health support.

It is also wise to discuss contraception, return to activity, sexual health, pelvic floor symptoms, and follow-up appointments before discharge or at prenatal visits. These topics are medical, practical, and deeply personal; your preferences and clinical context both matter.

Prepare emotionally for uncertainty

Many people enter the third trimester with a strong hope for a particular birth experience. Hope is healthy. At the same time, labor can change quickly because of fetal heart rate patterns, maternal blood pressure, infection concerns, labor progress, bleeding, fetal position, or other clinical factors. Emotional preparation means making room for both preference and flexibility.

One useful approach is to identify your core values rather than only your ideal sequence of events. For example, you may value informed consent, mobility, pain relief, minimal interventions, immediate bonding, cultural or spiritual practices, privacy, or having your support person involved. If the plan changes, these values can still guide decision-making.

If you have a history of birth trauma, pregnancy loss, infertility treatment, sexual trauma, anxiety, depression, or medical mistrust, consider discussing this with your care team before labor. Trauma-informed planning may include consent before touch whenever possible, explaining procedures step by step, limiting unnecessary personnel, or creating signals for when you need a pause. You deserve respectful, individualized care.