What is the third stage of labor and what happens after birth

Defining the third stage of labor

The third stage of labor is the interval between birth of the baby and delivery of the placenta. In a vaginal birth, the baby has already passed through the birth canal, but the pregnancy is not physiologically complete until the placenta and membranes have separated from the uterus and come out through the vagina. This is sometimes described as delivery of the placenta, and it is a normal part of labor rather than an optional extra step.

After the baby is born, the uterus usually becomes smaller and firmer as the muscle fibers contract and retract. These contractions reduce the surface area where the placenta was attached. As the uterine wall changes shape, the placenta separates from the decidua, and blood collects behind it. The placenta then moves downward into the lower uterus and vagina, where one more push or gentle assistance may be needed.

Many people experience these contractions as mild cramping rather than the strong, coordinated contractions of active labor or pushing. However, sensation varies. A person who has had a long labor, an epidural, an instrumental birth, or uterine overdistension may experience the third stage differently. The care team’s focus is to support bonding while also watching for excessive bleeding,

retained placenta, or uterine atony, which means the uterus is not contracting firmly enough.

How placental separation and delivery happen

Placental separation and delivery usually occur through a sequence of visible and clinical signs. The uterus may rise in the abdomen and become rounder or firmer. The umbilical cord may appear to lengthen at the vulva. There may be a small gush of blood as the placenta separates. These signs are not interpreted in isolation; clinicians combine them with abdominal palpation, the amount of bleeding, and the person's overall condition.

Once the placenta has separated, it generally takes only a short time to push out, although the time to separation can vary. Some placentas deliver within a few minutes, while others take longer. A third stage lasting up to about an hour can occur, particularly when managed physiologically, but many actively managed third stages are shorter. Longer duration is clinically relevant because delayed separation may increase the risk of postpartum hemorrhage, especially if open maternal blood vessels at the placental site are not compressed effectively by uterine contractions.

After the placenta is delivered, the clinician examines it carefully. They look at the maternal surface, fetal surface, membranes, and umbilical cord to assess whether it appears complete. Retained placental tissue can prevent the uterus from contracting well and can increase the risk of bleeding or infection. If any part appears missing, or if bleeding is heavier than expected, further assessment and intervention may be needed. This is one reason the placenta is not simply discarded without inspection.

Active management and physiological management

There are two broad approaches to managing the third stage of labor: active management and physiological management. The right approach depends on clinical context, personal preference, local protocols, and whether any risk factors are present. It is reasonable to discuss preferences before birth, while also staying flexible if circumstances change.

Active management usually includes administration of a uterotonic medication

after birth, commonly oxytocin, to stimulate uterine contraction. Depending on local practice, it may also involve controlled cord traction, where a trained clinician applies gentle traction to the umbilical cord while supporting the uterus. The goal is to shorten the third stage and reduce the risk of postpartum hemorrhage prevention concerns, particularly in people with risk factors for heavy bleeding.

Physiological management means allowing the placenta to separate and deliver without routine uterotonic medication or cord traction, provided the situation remains low risk and stable. The uterus contracts naturally, and the person may push when there is an urge or when signs suggest the placenta is ready. This approach may be preferred by some people who want minimal intervention, but it requires careful observation and a plan to change course if bleeding becomes excessive or the placenta does not deliver in a safe timeframe.

Neither option is a moral test or a measure of how "natural" the birth was. Active management can be a protective medical strategy, and physiological management can be appropriate for selected low-risk situations with skilled monitoring. The most supportive plan is one that respects the birthing person’s values while prioritizing safety.

What happens immediately after birth

The minutes after birth can feel emotionally enormous. While the clinical team manages the third stage of labor, they may also support skin-to-skin contact, drying and warming the baby, assessment of breathing and tone, and initiation of feeding if desired and appropriate. In many uncomplicated births, these priorities can happen at the same time: the baby can be on the parent’s chest while the uterus is monitored and the placenta is delivered.

The healthcare team assesses maternal bleeding continuously. Some bleeding is expected because the placental site is a large vascular area. The key question is whether the uterus is contracting firmly enough to compress those vessels. A provider may palpate the abdomen to assess uterine tone. After placental delivery, abdominal massage may be used to encourage the uterus to stay firm, although it can be uncomfortable. The team may also check vital signs, the degree of fatigue or dizziness, and whether pain is consistent with normal postpartum cramping or suggests a complication.

If there are tears, an episiotomy, or bleeding from the genital tract, the perineum, vagina, and cervix may be examined. Repairs are typically performed with local, regional, or existing anesthesia as appropriate. If the birth was assisted with forceps or vacuum, or if bleeding is heavier than expected, the examination may be more detailed. These steps are not meant to interrupt the emotional importance of meeting the baby; they are part of preventing postpartum complications while preserving as much calm and dignity as possible.

Bleeding, uterine tone, and postpartum hemorrhage

Postpartum bleeding is expected, but heavy or rapidly increasing bleeding is not something to "wait out." Postpartum hemorrhage is a major reason the third stage is managed carefully. The most common mechanism is uterine atony, when the uterus does not contract strongly enough after the placenta separates. Other causes can include retained placenta, genital tract trauma, clotting problems, or uterine rupture in rare situations.

Clinicians pay close attention to the amount of blood loss, but visual estimation can be imprecise. They may also use clinical signs such as pulse, blood pressure, pallor, dizziness, level of alertness, and uterine firmness. A person can look well initially and then deteriorate if bleeding continues. This is why frequent checks are normal in the immediate postpartum period, even when the birth itself seemed straightforward.

Management depends on the cause and severity. The team may massage the uterus, give or repeat uterotonic medication, empty the bladder, inspect for trauma, assess whether the placenta is complete, provide intravenous fluids, draw blood tests, or escalate to additional procedures. The exact response should be guided by trained clinicians and local emergency protocols. From the birthing person's perspective, it is important to report feeling faint, unusually weak, short of breath, confused, cold and clammy, or aware of sudden heavy bleeding.

The placenta, cord, and early newborn care

The umbilical cord connects the baby to the placenta during pregnancy, but after birth the baby transitions to breathing air and independent circulation. Timing of cord clamping can vary depending on the baby's condition, the

parent's condition, and local practice. If the baby is vigorous and no emergency intervention is needed, some teams delay clamping for a period. If urgent resuscitation or maternal stabilization is needed, priorities may shift quickly.

Once the cord is clamped and cut, attention remains on both patients: the postpartum parent and the newborn. The baby may be assessed for breathing, heart rate, color, tone, temperature, and feeding readiness. The parent may be assessed for bleeding, uterine tone, pain, blood pressure, and lacerations. These parallel assessments are one reason the room may seem busy even after the baby has arrived.

Some families want to see the placenta or have it explained. Clinicians can often point out the umbilical cord insertion, membranes, and placental surfaces. If there were concerns such as fetal growth restriction, infection, bleeding, abnormal cord insertion, or preterm birth, the placenta may be sent for pathology according to hospital policy. If families have cultural or personal preferences about the placenta, these should be discussed with the care team in advance, because safety rules and legal requirements vary.

The first hours of postpartum recovery

After the third stage ends, recovery continues. The uterus keeps contracting to reduce bleeding and begin postpartum uterine involution, the gradual return toward its nonpregnant size. Cramping may be more noticeable during breastfeeding or chestfeeding because oxytocin release can stimulate uterine contractions. These cramps can be surprising, especially after subsequent births, but they often reflect the uterus doing necessary work.

Lochia, the normal postpartum vaginal discharge of blood, mucus, and uterine tissue, begins after birth and changes over time. In the first hours it can be like a heavy period, but soaking pads rapidly, passing very large clots, or feeling unwell with bleeding needs urgent assessment. The care team may check the fundus, monitor vital signs, assess urine output, and encourage bladder emptying because a full bladder can interfere with uterine contraction.

Emotionally, the immediate postpartum period can include relief, joy, shakiness, tears, numbness, or overwhelm. None of these reactions makes someone

a "bad" parent. Birth involves pain, hormones, exertion, blood loss, and sometimes unexpected interventions. Supportive care includes clear explanations, consent for examinations whenever possible, warmth, hydration if allowed, pain relief options, help positioning the baby, and space to process what just happened. If the birth was frightening or complicated, asking the team to debrief later can be very helpful.

Questions to discuss with your care team

Because third-stage care can happen quickly, it helps to discuss preferences before labor or during early labor if possible. Useful questions include whether active management is routine in the birth setting, what uterotonic medication is typically used, how retained placenta is managed, when the team recommends switching from physiological to active management, and how postpartum hemorrhage risk is assessed.

You may also want to ask how skin-to-skin contact is supported during the third stage, whether delayed cord clamping is usually offered, how the placenta is examined, and what symptoms should prompt urgent help after discharge. If you have a history of postpartum hemorrhage, retained placenta, uterine surgery, clotting disorder, anemia, multiple pregnancy, prolonged labor, or induction or augmentation with oxytocin, individualized planning is especially important.

The key message is that the third stage is usually brief and uneventful, but it deserves respect. It is a transition from pregnancy to postpartum physiology, and it is one of the moments when attentive care can prevent serious complications. You should feel able to ask what is happening, request pain relief, clarify consent, and speak up if something feels wrong.