
POSITION STATEMENT

Midwifery Care during the Third Stage of Labor

The American College of Nurse-Midwives (ACNM) and its members are committed to providing evidence-based care for pregnant persons, newborns, and childbearing families. This document presents an overview of midwifery care during the third stage of labor to promote physiologic processes and prevent complications such as postpartum hemorrhage (PPH). PPH is the leading cause of severe maternal morbidity in the United States, and the fourth leading cause of maternal death.^{1,2} Postpartum hemorrhage is variously defined as blood loss of 500–1000 mL within 24 hours of birth, or blood loss with signs or symptoms of hypovolemia.³ Loss of 1000 mL or more has sometimes been defined as *major* or *severe* PPH.^{4,5} The administration of prophylactic oxytocin for the prevention of PPH is universally recommended by the World Health Organization, the International Federation of Obstetricians and Gynecologists, the International Confederation of Midwives, the American College of Obstetricians and Gynecologists, the Royal College of Obstetricians and Gynecologists, and the Association of Women’s Health, Obstetric, and Neonatal Nurses.^{3,5-8}

Active management of the third stage of labor (AMSTL) consists of administration of a prophylactic uterotonic, while expectant/physiologic management of the third stage reserves uterotonics for treatment of excess bleeding. The data to support active versus expectant management are mixed. The most recent Cochrane systematic review found low or very low-quality evidence thus decreasing confidence in the outcomes.¹ For all birthing people, regardless of their risk for hemorrhage, AMSTL may reduce severe bleeding and anemia. In a meta-analysis, women considered low risk had a reduction in blood loss and need for blood transfusion, but no difference in the incidence of severe (> 1000 mL) PPH.⁶ Higher quality studies are needed.

A consensus statement on physiologic normal birth developed by 7 US midwifery organizations examines the supporting evidence regarding the individual’s innate childbearing physiology and positive outcomes for mother and child.⁹ Optimal physiology during the third stage of labor is influenced by events during the first and second stages, the health of the mother, past obstetrical history, and provider practices. For healthy individuals who desire minimal intervention, physiologic management of the third stage of labor under specific circumstances may be appropriate. Expectant management is an option for the pregnant individual who has had a straightforward, normal first and second stage with no synthetic oxytocin for induction or augmentation, is essentially healthy, has had no prior history of postpartum hemorrhage, and has rapid access to treatments for unexpected hemorrhage. If these criteria are not met, then AMSTL should be recommended. It is the responsibility of midwives, using a shared decision-making model, to discuss with childbearing families the benefits of AMSTL as well as criteria for expectant/physiologic management of the third stage of labor so that they can make informed choices regarding labor and birth. We provide a description of both approaches.

Active Management of the Third Stage of Labor

AMSTL has been shown to reduce the incidence of PPH, the need for blood transfusion, and the use of therapeutic uterotronics during the third stage of labor and/or within the first 24 hours after birth.^{5,6} Oxytocin is the first-line medication of choice for AMSTL. It can be administered after birth of the fetal shoulder, after the baby is born, or after the birth of the placenta. Misoprostol, while not as effective as oxytocin, can be used as an alternative for AMSTL when given orally or sublingually.⁶ Use of ergometrine (methergine) as a uterotonic for AMSTL has been poorly studied; it should not be used in people with hypertension. Tranexamic acid historically has been an adjunctive therapy for PPH but has more recently been recommended for all cases of PPH regardless of etiology.^{10,11}

Few studies have examined the effects of postpartum synthetic oxytocin use on breastfeeding initiation and duration, infant behavior, and mother-infant bonding, or maternal endogenous oxytocin and prolactin production. The available literature does not conclude that oxytocin use affects breastfeeding outcomes, but the lack of quality research calls for further study.¹²

It is important to note that early cord clamping is no longer a recommended part of AMSTL. In a Cochrane review, investigators found no difference in outcomes related to maternal hemorrhage between women with early versus late cord clamping.¹⁴ Physiologic-based cord clamping is associated with multiple benefits for preterm and term infants.^{13,14} The practice of physiologic-based clamping should not affect a provider's ability to manage the delivery of the placenta.¹⁵

Uterine massage prior to delivery of the placenta does not change the length of the third stage and does not prevent PPH. Sustained uterine massage is not recommended as an intervention to prevent PPH in people who have received prophylactic oxytocin.⁵

Active management will include the following recommendations for physiologic management:

- Offer a uterotonic agent immediately after birth. Oxytocin is the preferred drug to prevent PPH.^{3,5-8}
- Provide physiologic-based cord clamping by clamping the umbilical cord after 3–5 minutes or more to maximize the benefits of placental transfusion.¹⁴
- Consider performing controlled cord traction (CCT). In the setting of prophylactic oxytocin administration, CCT does not prevent PPH, but may shorten the third stage of labor and reduce the need for manual removal of the placenta.¹⁵ The World Health Organization does not recommend the use of CCT by non-skilled birth attendants and considers CCT an optional step for skilled birth attendants.⁵ CCT is recommended in cesarean-section births.⁵
- Assessment of uterine tone and continuation of this assessment every 15 minutes for 2 hours is recommended.
- The Alliance for Innovation on Maternal Health evidence-based Obstetric Hemorrhage Patient Safety Bundle, initially released in 2015 and revised in 2022, is an interprofessional resource that may be utilized by midwives,

hospitals, and birth centers to establish guidelines for the prevention and management of PPH.^{3,7}

Expectant/Physiologic Management of the Third Stage

It is essential that the midwife carefully review all aspects of the individual's health and obstetrical history and progress during the first and second stages to assess risk for PPH. If the individual meets criteria for expectant/physiologic management of the third stage, the options of this approach versus AMSTL should be reviewed. The following actions will help support a physiologic approach to the third stage:¹⁶

- Continuously and unobtrusively observe the individual and the newborn for normal physiology to occur.
- Assess the individual's adaptation (signs of too much blood loss, discomfort).
- Maintain warmth of both the individual and newborn.
- Maintain privacy for the newborn.
- Encourage and assist the individual into an upright position.
- Encourage the individual to focus on the newborn.
- Other family or friends present should stay focused on the individual and newborn.
- Encourage the individual to empty her bladder.
- Maintain skin-to-skin contact between the individual and newborn.
- Following signs of placental separation encourage the individual to bear down to expel the placenta.
- Clamp and cut the cord after placental pulsation ceases or the placenta is expelled.
- Assist the individual into a comfortable position after expulsion.

The Hallmarks of Midwifery include evidence-based care, advocacy for non-intervention in normal processes in the absence of complications, shared decision-making, individualized care, and judicious use of technology. Yet, PPH can be minimized in all populations by use of prophylactic uterotonic. In conclusion, AMSTL as described above should be considered the standard of care and offered to individuals who do not meet criteria for expectant/physiologic management to reduce the risks associated with PPH.

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Note. Midwifery and midwives as used throughout this document refer to the education and practice of certified nurse-midwives (CNMs) and certified midwives (CMs) who have been certified by the American Midwifery Certification Board (AMCB).

Source: Clinical Practice & Documents Section of the Division of Standards & Practice

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