

Complete guide to first hour after birth



Why the first hour matters

Birth requires an abrupt switch from placental support to independent breathing and circulation. As the lungs aerate, pulmonary vascular resistance falls, blood flow through the lungs rises, and fetal circulatory pathways begin functionally closing. Most term newborns accomplish this newborn cardiopulmonary transition with drying, warmth, positioning, and observation rather than active resuscitation.

For a stable parent-baby pair, early uninterrupted skin-to-skin contact supports newborn thermoregulation, cardiorespiratory stability, early feeding behaviors, and connection. The World Health Organization recommends initiating breastfeeding within one hour after birth and encouraging skin-to-skin contact as soon as possible. This period also gives the newborn access to colostrum, the concentrated early milk containing nutrients and immunologic components.

The golden hour is a care principle, not a pass-or-fail event. A medically necessary interruption does not mean that bonding or feeding has been irreparably harmed. Skin-to-skin contact after birth and feeding support can begin or resume when both patients are stable. Partners or another support person may also provide supervised skin-to-skin contact if the birthing parent

is temporarily unable to do so.

The first minutes: breathing, warmth, and initial assessment

Immediately after birth, the team rapidly evaluates muscle tone, breathing or crying, color, gestational maturity, and overall responsiveness. A vigorous newborn is usually dried and placed prone on the parent's bare chest, with the head turned to keep the airway visible. Wet linens are removed and warm blankets or a cap may be added. Staff continue observing breathing, color, tone, and temperature without necessarily moving the baby to a warmer.

Routine suctioning is generally unnecessary for a vigorous newborn; secretions may be wiped away when needed. If breathing is ineffective, the heart rate is low, or tone is poor, clinicians follow neonatal resuscitation protocols. Interventions may include stimulation, airway positioning, positive-pressure ventilation, supplemental oxygen guided by pulse oximetry, chest compressions, or medications. Effective ventilation is the central intervention when a newborn is not breathing adequately.

Umbilical cord management depends on clinical circumstances and local policy. Delayed cord clamping is commonly considered for stable term and preterm infants, but timing may change when immediate resuscitation or maternal treatment is required. Families can discuss preferences in advance while recognizing that the bedside team must respond to the newborn's and parent's condition.

Apgar scoring and ongoing newborn observation

The Apgar score is recorded at one and five minutes after birth. It evaluates five domains: heart rate, respiratory effort, muscle tone, reflex response, and color. Each receives zero, one, or two points. The score communicates how the newborn is adapting and whether support is having an effect; it is not, by itself, a diagnosis or a reliable forecast of later neurologic development.

If the five-minute score remains below the expected range, scoring may continue at five-minute intervals while care proceeds. Resuscitation should never be delayed to calculate a score. Clinicians make treatment decisions from real-time findings, particularly breathing and heart rate.

During the remainder of the hour, staff look for persistent grunting, nasal flaring, chest retractions, central cyanosis, apnea, abnormal tone, poor perfusion, or temperature instability. They may count respirations and heart rate and measure temperature while the newborn remains on the parent's chest. Blood glucose monitoring in newborns is not universally required, but it may be recommended for infants with risk factors such as prematurity, growth restriction, maternal diabetes, being large for gestational age, hypothermia, or clinical signs concerning for hypoglycemia.

Skin-to-skin contact and the first feeding

During uninterrupted skin-to-skin contact, many alert newborns move through recognizable behaviors: resting, opening their eyes, bringing hands toward the mouth, rooting, and moving toward the breast or chest. This progression varies, and some babies are sleepy after medications, a long labor, assisted birth, or cesarean delivery. There is no need to rush or force attachment.

Feeding support may include comfortable positioning, observing feeding cues, helping the baby align nose-to-nipple, and assessing latch and milk transfer. A newborn feeding assessment considers attachment, sucking rhythm, swallowing, maternal comfort, and the baby's clinical status. Colostrum is produced in small volumes suited to the newborn's stomach capacity. Hand expression may be useful when direct feeding is delayed, but technique and any supplementation plan should be individualized with the maternity or neonatal team.

Close supervision is essential. The baby's face, nose, and mouth should remain visible, the neck should be in a neutral position, and the parent should be awake and able to respond. If the parent is sedated, exhausted, nauseated, or medically unstable, another alert adult and a clinician should assist, or the baby should be placed in a separate safe sleep space.

Care of the birthing parent during the hour

Attention to the newborn should not obscure immediate postpartum recovery. After placental delivery, the uterus must contract to compress the blood vessels that supplied the placenta. Clinicians assess uterine tone after delivery, vaginal bleeding, blood pressure, pulse, temperature when indicated,

pain, and the condition of the perineum or surgical incision. They also monitor placental completeness and watch for signs associated with postpartum hemorrhage risk.

Uterine massage may be performed if the uterus feels soft or bleeding is excessive. Uterotonic medication is commonly used according to local protocols to prevent or manage hemorrhage. Repair of perineal or vaginal trauma can often occur while the baby remains skin-to-skin, provided positioning is safe. The parent may experience shaking, thirst, nausea, cramping, fatigue, or intense emotions; staff can explain what is expected and address discomfort.

Following regional or general anesthesia, monitoring may include respiratory status, oxygen saturation, motor and sensory recovery, nausea, itching, and pain. Report heavy or rapidly increasing bleeding, faintness, chest pain, breathing difficulty, severe headache, escalating abdominal pain, or a sudden sense that something is wrong immediately.

Routine procedures and when separation may occur

When both patients are stable, many routine newborn procedures can wait until after initial contact and feeding. Depending on the facility, later care may include weight and measurements, a complete physical examination, identification bands, vitamin K prophylaxis, eye prophylaxis where recommended, and vaccines offered under national or local guidance. Screening tests such as hearing assessment, newborn blood-spot screening, and pulse oximetry screening usually occur later rather than during the first hour.

Temporary newborn separation may be needed for respiratory distress, significant prematurity, congenital anomalies requiring evaluation, persistent hypoglycemia, infection concerns, or other instability. Parent-related reasons include hemorrhage, urgent surgery, severe hypertension, impaired consciousness, or complications of anesthesia. Ask where the baby is going, what support is being provided, whether a support person can accompany the baby, and when updates or reunification are expected.

If separation occurs, the care team can help preserve connection through photographs, verbal updates, touch when clinically appropriate, and early milk expression. These measures do not replace contact, but they can support

families through an unexpected situation. Necessary treatment takes precedence over routine preferences, and care should be revisited as soon as clinical conditions improve.

Cesarean birth, special circumstances, and practical preparation

After a cesarean birth, early contact may still be possible in the operating room or recovery area. The newborn can sometimes be positioned across the upper chest while staff protect the sterile field, intravenous lines, monitors, and airway. Assistance is usually required because the parent cannot safely hold the baby independently. Nausea, low blood pressure, shivering, pain, or sedation may delay contact, and general anesthesia requires alternative plans until the parent is alert.

Preterm or medically vulnerable newborns may need a warmer, respiratory support, glucose management, or neonatal unit admission. When direct breastfeeding is not initially possible, clinicians may recommend hand expression or pumping based on the situation. Timing and use of expressed colostrum should be coordinated with neonatal professionals rather than improvised.

Before labor, consider discussing immediate post-birth monitoring, delayed cord clamping, skin-to-skin contact, feeding intentions, cesarean preferences, and who should accompany the baby if separation is necessary. Present these as informed preferences rather than rigid requirements. At the bedside, useful questions include what clinicians are observing, which procedure is urgent, what can safely wait, and how contact can be supported. Flexibility is not failure; it is a compassionate response to the realities of birth.