What happens immediately after birth

The first seconds: breathing, warmth, and a rapid visual assessment

Immediately after birth, the care team’s attention is divided between two closely connected patients: the newborn and the person who has just given birth. For the baby, the first task is cardiorespiratory transition. In utero, the placenta performs gas exchange; after birth, the newborn’s lungs must expand, pulmonary vascular resistance must fall, and oxygenation must shift to breathing air. A strong birth cry is often the first obvious sign of this transition, but not every healthy baby cries dramatically.

Most babies are placed onto the birthing parent’s chest or abdomen if they are vigorous and the clinical situation allows. The baby is dried promptly and covered with a warm towel or blanket because newborns lose heat quickly through evaporation and their relatively large surface area. Preventing hypothermia is not just about comfort; cold stress can increase oxygen and glucose consumption.

At the same time, clinicians make a rapid assessment: tone, breathing effort, color, heart rate, and overall responsiveness. If a baby is not breathing adequately, has poor tone, or needs resuscitation, the team may move the baby to a warmer for airway positioning, stimulation, oxygen support, or more advanced neonatal care. This can be emotionally difficult, but it is done to

support the baby’s transition as safely and efficiently as possible.

Apgar scores and early newborn observation

One of the first structured assessments is the Apgar score, usually assigned at one minute and five minutes after birth. It evaluates five signs: heart rate, respiratory effort, muscle tone, reflex response, and skin color. Each category receives a score from 0 to 2, for a maximum of 10. Most babies score 7 or higher by five minutes, although a lower one-minute score can improve quickly as the baby clears lung fluid and establishes breathing.

The Apgar score is a clinical communication tool, not a prediction of a child’s long-term health. A baby who needed brief stimulation may have a lower initial score and then recover well. Conversely, a persistently low score may prompt continued assessment, support, and possible neonatal specialist involvement.

Observation continues even when everything appears normal. The team watches breathing pattern, temperature, color, tone, and feeding readiness. Newborns often have irregular breathing with brief pauses, occasional sneezes, or mucus sounds as fluid clears. Clinicians distinguish these common transitional findings from concerning signs such as persistent grunting, chest retractions, central cyanosis, or poor responsiveness. If you are unsure about what you are seeing, it is appropriate to ask the nurse, midwife, pediatrician, or neonatal clinician to explain it in real time.

Skin-to-skin contact after birth and the sensitive first hour

When the baby and birthing parent are stable, uninterrupted skin-to-skin contact after birth is strongly encouraged. The naked or diapered baby is placed prone on the parent’s bare chest and covered with warm blankets. This helps the newborn maintain temperature, stabilize heart rate and breathing, and begin early behavioral adaptation. It can also support oxytocin release, bonding, and the first feeding.

The first hour after birth is often described as a biologically sensitive period, particularly after vaginal birth. Research on early skin-to-skin contact describes a predictable sequence of newborn behaviors. The baby may begin with the birth cry, then enter a relaxation phase with little activity,

followed by awakening with small movements, and later an active phase with more determined movements, rooting, and efforts to reach the breast or chest.

These behaviors can look slow and subtle. A newborn may bob the head, lick, smell, nuzzle, flex the legs, or make small crawling motions. This does not mean the baby is failing to feed; it may be part of the normal progression toward latch. Immediate skin-to-skin contact has been associated with increased breastfeeding initiation and reduced formula supplementation, although feeding plans should always be individualized and supported without shame.

Skin-to-skin may also be possible after cesarean birth, depending on anesthesia, surgical stability, temperature, and staffing. If the birthing parent is unable to hold the baby immediately, another parent or support person may be able to provide skin-to-skin while the clinical team completes necessary care.

The third stage of labor: placenta delivery and uterine tone

Even after the baby is born, labor is not quite finished. The third stage of labor is the period from birth of the baby to delivery of the placenta. The placenta must separate from the uterine wall and pass through the birth canal, or be removed through the uterine incision during cesarean birth. In many settings, active management includes giving oxytocin after delivery to stimulate uterine contractions, reduce bleeding, and help expel the placenta.

After a vaginal birth, the placenta often delivers within about 30 minutes, though timing and management vary by clinical context and local protocol. You may feel more cramping or pressure, and the clinician may ask you to push gently. They may also assess the uterus by palpating the abdomen. A firm, well-contracted uterus helps compress the blood vessels where the placenta was attached.

After delivery of the placenta, the clinician inspects it to check whether it appears complete. Retained placental tissue can increase bleeding risk and may require further evaluation or intervention. The team also assesses vaginal, cervical, labial, and perineal tissues for lacerations and repairs them when needed, using local, regional, or existing anesthesia depending on the situation.

Bleeding is expected, but heavy bleeding is not ignored. Nurses and clinicians frequently check uterine tone after delivery, vital signs, and the amount of blood loss. Fundal massage may be uncomfortable, but it is used to encourage uterine contraction if the uterus feels boggy. If bleeding is more than expected, the team may use additional uterotonic medication, examine for lacerations or retained tissue, start intravenous fluids, obtain labs, or escalate care quickly.

Early feeding, colostrum, and newborn energy needs

Many babies show feeding cues in the first hour or two: rooting, hand-to-mouth movements, licking, mouthing, or increased alertness. If breastfeeding is planned, the first milk, colostrum, is produced in small volumes but is rich in immunologic and nutritional components. Small amounts are appropriate for the newborn stomach, especially in the earliest hours.

Some babies latch quickly; others need time, positioning help, or hand expression of colostrum. A medically literate parent may still need hands-on support because feeding is a learned dyad: both the baby and parent are adapting. Ask for help with latch mechanics, pain, nipple shape after feeds, audible swallowing, and signs of transfer if breastfeeding is uncomfortable or uncertain.

If formula feeding is planned or medically indicated, the team can guide safe preparation, volume, and feeding cues. Families sometimes feel pressure around feeding decisions in the immediate postpartum period. Compassionate care should focus on adequate nutrition, parental goals, infant safety, and informed choice.

Some newborns require closer glucose monitoring, especially if they are late preterm, small or large for gestational age, exposed to certain maternal conditions such as diabetes, or symptomatic. Low blood sugar is managed according to clinical protocols and may involve feeding support, expressed colostrum, donor milk or formula where available, glucose gel, or intravenous dextrose. Parents should not try to diagnose or treat suspected hypoglycemia without the newborn team.

Routine newborn medications, measurements, and screening

After the initial transition, standard newborn care is offered according to local policy, medical history, and parental consent requirements. Vitamin K is commonly given by injection to prevent vitamin K deficiency bleeding, a rare but potentially serious hemorrhagic condition. Some settings also offer eye medication to reduce the risk of certain newborn eye infections. The hepatitis B vaccine may be offered shortly after birth, especially as part of routine infant immunization schedules.

Measurements usually include weight, length, and head circumference. These may be done after the first skin-to-skin period if the baby is stable, because many non-urgent tasks can safely wait. Identification bands are placed, and footprints or security procedures may be performed depending on the facility.

Additional screening may occur during the first hours or before discharge. Hearing screening is commonly performed in the newborn period. Pulse oximetry screening for critical congenital heart disease may be used in many settings, usually after the immediate transition rather than in the first minutes. Newborn blood spot screening is also performed according to regional timing guidelines. Because specific tests vary by country, state, and hospital, it is reasonable to ask what is routine, what is optional, and what each intervention is meant to prevent or detect.

The birthing parent’s immediate recovery

For the person who has given birth, the immediate postpartum period involves rapid physiologic adjustment. The uterus contracts, blood volume shifts, and hormones change abruptly after placental separation. Nurses or midwives monitor blood pressure, pulse, temperature, uterine firmness, bladder status, pain, and vaginal bleeding. If regional anesthesia was used, leg strength and sensation are assessed before standing.

After vaginal birth, perineal swelling, laceration repair, hemorrhoids, and uterine cramping are common concerns. Ice packs, oral analgesics, topical measures, and positioning may be offered based on individual circumstances. After cesarean birth, monitoring includes the incision, uterine tone, bleeding, pain control, nausea, mobility, and effects of anesthesia. Recovery after cesarean birth may begin in a post-anesthesia area before transfer to a

postpartum room.

Emotional responses vary widely. Some parents feel euphoric, relieved, shaky, tearful, detached, or overwhelmed. These reactions can coexist with love and concern for the baby. Shivering is also common after birth and may relate to physiologic stress, temperature shifts, medications, or anesthesia. Tell your care team if you feel faint, short of breath, confused, have chest pain, severe headache, visual symptoms, or bleeding that seems excessive.