

Continuity of Care Midwifery Services for Mrs. P, 24 Years Old, at Mojogedang I Community Health Center, Karanganyar

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ABSTRACT

KEYWORDS

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Maternal and infant mortality rates remain major health challenges in Indonesia, underscoring the need for improved healthcare access and quality. Continuity of Care (CoC) addresses this issue through integrated monitoring from pregnancy to family planning. This qualitative case study applies the CoC approach to provide continuous midwifery care for Mrs. P at Puskesmas Mojogedang I (Mojogedang I Community Health Center). This research aims to explore aspects related to continuous midwifery care for Mrs. P and her baby through midwifery care processes during pregnancy, childbirth, newborn care, postpartum, and family planning. The third-trimester visit results showed that Mrs. P had second-degree obesity. During the delivery process, there was a second-degree perineal rupture, and Mrs. P experienced postpartum hemorrhage due to retained placenta fragments. No complications were found in the newborn. The baby, a female, was born on September 21, 2024, at 2:50 PM WIB, with a birth weight of 3,050 grams and a length of 49 cm. Uterine involution during the postpartum period progressed normally, and the mother chose intrauterine contraceptive use with an IUD (Intrauterine Device). The case assessment from pregnancy to delivery showed a correlation between second-degree obesity and the occurrence of postpartum hemorrhage due to retained placenta fragments. No discrepancies were found between theory and practice.

INTRODUCTION

The Maternal Mortality Rate (MMR) remains a major challenge in efforts to improve the quality of maternal and child health in Indonesia (Akbar, Putri, & Rachman, 2023). The MMR reflects the number of maternal deaths per 100,000 live births due to complications occurring during pregnancy, childbirth, or the postpartum period (Riva & Wang, 2025). The high MMR reflects the need to improve access to and quality of health services, including the management of pregnancy and childbirth complications, as well as improvements in facilities and transportation to health services (Manik, Triyoga, Siregar, Rochadi, & Poddar, 2021). Meanwhile, the Infant Mortality Rate (IMR) is a child health indicator that measures the number of infant deaths (0–1 years) per 1,000 live births. IMR is influenced by various factors, including access to immunization, adequate nutrition, a clean environment, and adequate basic health services (Prahutama & Sudarno, 2018). A high IMR can indicate low access to quality health services, particularly in managing premature births, neonatal infections, and other complications (Fikriyah et al., 2025). Efforts to reduce IMR are closely related to improving affordable and quality child health services. Good health services will ensure infection management, immunization, and support for exclusive breastfeeding, which contribute to an improved quality of life for newborns. Access to health facilities, such as hospitals, clinics, and

BPJS services, also plays a crucial role in improving IMR and related indicators (Webber, 2008).

According to the WHO, the global maternal mortality rate (MMR) decreased by 34% from 2000 to 2020, but the MMR in Indonesia in 2020 still reached 189 per 100,000 live births, far from the SDGs target (BPS, 2023). Meanwhile, the MMR in Central Java was 183 deaths per 100,000 live births (BPS, 2023). The main causes of MMR are hemorrhage, preeclampsia, infection, and complications of unsafe abortion (Ekwuazi, Chigbu, & Ngene, 2023). The global infant mortality rate (IMR) also decreased significantly to 27.4 per 1,000 live births in 2020 (World Population Review, 2024). The main causes of IMR include neonatal encephalopathy, infection, and complications of prematurity. The decline in MMR and IMR is supported by improvements in health services, such as immunization, exclusive breastfeeding, and maternal and infant care, in line with the SDGs goal of improving maternal and child health (Agha, & Sandell, 2014).

One factor that significantly contributes to high maternal mortality rates is obesity during pregnancy (Sandhu, 2021). Obesity increases the risk of various obstetric complications, including hypertension, gestational diabetes, and the need for cesarean delivery. These complications can trigger conditions that may be fatal if not managed appropriately and comprehensively (Manik et al., 2021). One serious complication associated with pregnancy and childbirth in obese mothers is retained placental remains (Langley-Evans, Pearce, & Ellis, 2022). Retained placental remains can lead to massive postpartum hemorrhage, infection, and potentially life-threatening shock (Nugraheni, 2024). Risk factors for retained placental remains include inadequate uterine contractions, a history of previous labor, and maternal obesity (Perlman & Carusi, 2019). Suboptimal management can worsen the prognosis and increase the likelihood of further complications, such as infertility and sepsis (Coviello, Grantz, Huang, Kelly, & Landy, 2015).

Continuity of Care (CoC) refers to the ongoing care provided to patients, especially mothers and babies, throughout various stages of health, such as pregnancy, childbirth, and the postpartum period (Andriani, Rachmadani, Natasha, & Saptari, 2022). In the context of achieving Sustainable Development Goals (SDGs) number 3, which targets reducing maternal mortality to less than 70 per 100,000 live births by 2030, the CoC approach plays a crucial role (Sharma, Pennell, Sharma, & Smith, 2024). With integrated and continuous care, midwives can detect and manage complications such as obesity and retained placenta earlier, thereby reducing the risk of morbidity and mortality (D'Haenens et al., 2020).

The relationship between CoC and the role of midwives includes monitoring and early detection of health risks from early pregnancy (Sandall, Soltani, Gates, Shennan, & Devane, 2015). Routine antenatal care allows midwives to detect signs of complications, such as preeclampsia or infection, enabling early intervention, prevention, and birth planning, all of which are crucial for the safety of both mother and baby. Based on the aforementioned background, the author is interested in providing continuous midwifery care (Continuity of Care) to Mrs. P, 24 years old, along with documentation from pregnancy, delivery, neonatal care, postpartum, and family planning at the Puskesmas Mojogedang I Karanganyar Health Center (Al-Hafez, Bicocca, Chauhan, & Berghella, 2022).

The general purpose of this report is to provide obstetric care in a CoC manner to Mrs. P, which includes pregnancy, childbirth, the postpartum period, neonates, and family planning,

using an obstetric management approach. The specific objectives are as follows: first, to provide pregnancy obstetric care to 24-year-old Mrs. P using an obstetric management approach; second, to provide intrapartum midwifery care to 24-year-old Mrs. P using an obstetric management approach; third, to provide postpartum obstetric care to 24-year-old Mrs. P; fourth, to provide midwifery care to the newborn of 24-year-old Mrs. P using an obstetric management approach; and fifth, to provide family planning midwifery care to 24-year-old Mrs. P. Furthermore, this report aims to prepare obstetric diagnoses, problems, and needs according to priorities in pregnant women, women in labor, postpartum women, neonates, and family planning clients, as well as to plan and implement obstetric care on a sustainable and continuous basis, including complication prevention, immediate action, and comprehensive measures such as counseling, support, collaboration, evaluation/follow-up, and referral, utilizing technology as needed based on evidence-based practice.

The time scope of this midwifery care is from September to November 2024. The place where this midwifery care is carried out is in the working area of the Puskesmas Mojogedang I, Karanganyar Regency. The scientific scope applied in this report is continuous midwifery care (Continuity of Care). The theoretical benefit of this report is that it is expected to be a source of literature and reference on continuous midwifery care (Continuity of Care). Practically, this report is useful for students to increase their experience, insight, and knowledge in providing sustainable midwifery services to pregnant women, women in labor, newborns, postpartum women, and family planning clients. For clients or the community, it is hoped that the application of this midwifery care can detect pathological disorders early and minimize maternal and infant mortality. Meanwhile, for the Puskesmas Mojogedang I, the practical benefit is that it can increase knowledge and support the provision of continuous midwifery care services so that complications of pregnancy, childbirth, newborns, and postpartum can be detected as early as possible.

METHOD

A. Research Methods

1. Research Design

The type of research used is qualitative research with a descriptive design of a case study with a *Continuity of Care* (CoC) approach, which is midwifery care that is carried out continuously and continuously by describing care for mothers starting from pregnancy, childbirth, newborn (BBL) to family planning (KB), containing recording and documenting the implementation of midwifery care using records development consisting of subjective data, objective data, analysis and management (SOAP).

2. Research Subject

The subject of this study is a pregnant woman in the third trimester who is in the working area of the Mojogedang I Health Center.

3. Location of Research Time

This continuous obstetric care or *Continuity of Care* (CoC) was carried out at the Mojogedang I Karanganyar Health Center on September 14, 2024 - October 31, 2024.

4. Data Collection Method

The data collection methods used in this research report are;

a. Interview

The data collection carried out in Mrs. P's obstetric care report is from the results of interviews conducted with clients and their families as well as midwives to find out what therapies and care are given to patients. Interviews were conducted directly by the author to patients and midwives, the instruments used ranged from the format of obstetric care for pregnant women to family planning.

b. Direct Observation

This data collection by direct observation is carried out by conducting direct observations by the author on patients and midwives including subjective data.

c. Physical Examination

Data collection was carried out by a physical examination directly to Mrs. P which included a head to toe physical examination, as well as a physical examination with inspection and palpation.

d. Medical Record Document Study

The data collection of medical record documents was carried out using Mrs. P's medical record documents at the Mojogedang I Karanganyar Health Center.

RESULT AND DISCUSSION

A. Pregnancy Care

The anamnesis obtained by the mother stated that she had made 14 ANC visits, the visits made were in accordance with the theory of Kamsiati (2023), namely in an effort to prevent obstetric complications and detect high risks early in pregnant women, a minimum of 6 ANC visits are required, with details of 2 times in the first trimester (gestational age 0-12 weeks), 1 time in the second trimester (gestational age 12-24 weeks), and 3 times in the third trimester (gestational age 24 weeks-before delivery), and at least 2 examinations by a doctor during the first visit in the first trimester and the fifth visit in the third trimester. Antenatal care provided is in accordance with the 10 T examination standards based on the Ministry of Health (2019), namely, measuring body weight, measuring height, measuring blood pressure, assessing nutritional status by measuring LILA, measuring the height of the uterine fundus, determining fetal presentation and fetal heart rate, screening TT immunization status and administering TT immunization, administering iron tablets (90 tablets during pregnancy), simple lab tests, case management, and consultation/counseling. The care provided during pregnancy is in accordance with theory.

1. Subjective Data

Based on the assessment conducted on Mrs. P during the gestational age of 37 weeks to 38 + 2 weeks, Mrs. P complained of pain in the pubic bone, this is one of the discomforts of the third trimester. According to Kamsiati (2023), pain in the pubic bone is caused by hormonal changes, especially an increase in the hormone relaxin, which softens the ligaments and joints to prepare for labor. Based on the discussion above, it can be concluded that there is no gap in the visits of pregnant women which are carried out once a week. The complaint felt by Mrs. P is discomfort of the third trimester, so there is no gap between the theory and the case.

2. Objective Data

Mrs. P's pregnancy examination complied with the Ministry of Health's ANC service standards (2018). The initial examination revealed an 11 kg weight gain, exceeding the ACOG recommended weight gain limit (5-9 kg for women with an obese BMI). However, her height

of 158 cm indicates no risk of cephalopelvic disproportion (CPD), and her MUAC measurement of 36 cm indicates no chronic energy deficiency (CED) (Ministry of Health, 2020). Her blood pressure was 120/80 mmHg, and a physical examination revealed all results within normal limits (Salsabilla, Amelia, & Anggraini, 2024).

The Leopold examination revealed a fetal position consistent with gestational age, with a TFU of 31 cm and a fetal weight of 3050 grams. The last laboratory examination on September 2, 2024, showed a hemoglobin level of 12.9 g/dL, a blood glucose level of 103 mg/dL, and negative urine protein, indicating that the mother was not anemic (Viandika & Septiasari, 2020). An ultrasound examination also showed a cephalic presentation and a fetal heart rate of 156 beats/minute, with a fetal weight of 2900 grams. Based on all examination results, Mrs. P was able to deliver spontaneously without significant health problems.

3. Analysis

The diagnosis and problems are established based on the results of the assessment that has been carried out in accordance with midwifery care, namely, Mrs. P, 24 years old, G2P1A0, 38+2 weeks pregnant, with Obesity Level II. The discomfort experienced by the mother in the form of pain in the pubic bone and complaining of swelling in the feet and hands, is a condition of discomfort experienced by pregnant women in the third trimester. Based on the Minister of Health Decree 320 of 2019, one of the midwife's competencies during pregnancy is providing midwifery care during pregnancy.

4. Management

Management was carried out by informing the mother that the condition of both mother and fetus was within normal limits and explaining that the presenting part of the fetus had begun to descend but had not yet entered the pelvic inlet, in accordance with the theory that the fetal head generally enters the pelvic inlet at gestational ages above 36 weeks (Sihotang et al., 2021). The mother was provided with IEC (Information and Communication) regarding the management of pubic bone pain, including adequate rest, comfortable positions, light stretching, warm compresses, and gentle massage (Kasmiasi, 2023). All examination results, treatment, and follow-up plans were communicated to the mother in accordance with integrated antenatal care standards (Ministry of Health of the Republic of Indonesia, 2018).

The mother's tetanus toxoid immunization status was confirmed and found to have reached TT5 in her first pregnancy, in accordance with the 10T service standards (Ministry of Health of the Republic of Indonesia, 2018). The mother was also educated about the risks of excessive weight gain, including macrosomia, prolonged labor, cesarean section, and fetal distress. However, the estimated fetal weight of 2,945 grams indicated that the baby was not macrosomic.

Education regarding preeclampsia and gestational diabetes was also provided. The examination revealed normal maternal blood pressure (120/80 mmHg), negative proteinuria, and a normal blood glucose level (103 mg/dL). However, continued monitoring was recommended given the family history of hypertension and the presence of third-trimester physiological edema.

Complementary midwifery care was provided, including recommendations for consuming green beans to help maintain hemoglobin levels and pelvic rocking to aid fetal head descent. The mother was also encouraged to maintain adequate nutrition and rest,

regularly take iron supplements and vitamins, understand third-trimester danger signs and signs of labor, and prepare for labor through the Birth Planning and Complication Prevention Program (P4K), in accordance with antenatal guidelines (Ministry of Health, 2019). Thus, the care provided aligned theory and practice, with no gaps identified.

B. Childbirth Care

1. Subjective Data

Saturday, September 21, 2024 at 06.00 WIB, Mrs. P, 24 years old G2P1A0, 39 weeks and 3 days pregnant, came to Mojogedang I Health Center with complaints of tightness from the back to the waist and in the stomach since 19.00 WIB (September 20, 2024) and started to be regular every 10 minutes at 05.30 WIB and blood mucus had come out. The mother's complaints are normal and in accordance with the signs of labor according to Patmawati (2023), in the form of contractions that come more frequently, are strong and regular.

2. Objective Data

On September 21, 2024, an initial examination revealed the mother's general condition was good, with composmentis consciousness, and vital signs within normal limits. Abdominal palpation revealed a McDonald's TFU of 31 cm with an estimated fetal weight of 3100 grams. The fetal heart rate (FHR) was monitored at 144 beats/minute, regular, within the normal range (Viandika & Septiasari, 2020). Uterine contractions occurred three times in 10 minutes, each lasting 30 seconds, consistent with signs of labor. An internal examination revealed a cervical dilation of 3 cm, efficacy of 30%, and 4/5 descent of the head in the Hodge II region, indicating preparation for labor.

At 2:00 PM WIB, the examination revealed a strong IHR of five times in 10 minutes, each lasting 45 seconds, a FHR of 152 beats/minute, and complete cervical dilation (10 cm). Signs of the second stage of labor appear, such as the urge to push and pressure on the anus, with the perineum protruding and the vulva opening. The second stage lasts for 50 minutes.

During the third stage of labor, beginning at 2:51 PM WIB (Western Indonesian Time), an examination revealed a midline position with strong contractions, and no second fetus. The umbilical cord was visible at the vulva, but there was no gush of blood. The third stage lasted 5 minutes, and the placenta was delivered spontaneously at 2:55 PM WIB, weighing approximately 500 grams and with incomplete cotyledons (Faris & Faturrahmah, 2024). After delivery, an exploration was performed for the remaining placenta and oxytocin and metrazine were administered to prevent bleeding.

Postpartum hemorrhage was found to be approximately 500 cc, with a second-degree perineal tear (vaginal mucosa, perineal skin, and perineal muscles). Due to ongoing bleeding, the mother was referred to Dian Pertiwi Karanganyar Hospital at 3:30 PM WIB for further treatment, including perineal hedging and local anesthesia with 1% lidocaine on the perineal area to be sutured (Hejaz, Skafe, & Awawdeh, 2020). This examination aligns with existing theory and practice.

3. Analysis

The diagnosis and problems were established based on the assessment of subjective data and objective data in accordance with the obstetric diagnosis, namely, Mrs. P, 24 years old, G2P1A0, gestational age 39 weeks 3 days with inpartu stage I, II, III. The problems felt by the mother include, pain in the waist, pain due to increasingly frequent and regular contractions, and postpartum bleeding due to retained placental remains. The problem of pain in the waist

and increasingly frequent contractions and pain experienced by Mrs. P is normal and in accordance with the signs of labor according to Patmawati (2023), in the form of his coming more frequently, strongly and regularly. Meanwhile, the bleeding experienced by Mrs. P must be immediately handled by performing an exploration of the remaining placenta, but if after the procedure there is still bleeding or the midwife is not sure because there are still remaining parts of the placenta left behind, then a referral to the hospital is necessary for curettage by an obstetrician.

4. Management

During the first stage, labor progress was observed every 30 minutes (FHR, HIS, Pulse) and every 4 hours (BP, VT, and decrease), in accordance with Diana's theory (2019). The mother was encouraged to meet nutritional needs, provided motivation, and practiced relaxation techniques during contractions. The mother was placed on her left side for maternal comfort and improved fetal positioning (Wulan, 2023). Back massage using counter-pressure massage techniques was performed to relieve pain and improve oxygenation (Natasa, 2021). Management also included preparing delivery equipment in accordance with Evidence-Based Midwifery.

During the second stage, the mother was informed about full dilation and signs of labor, provided mental support, and encouraged to eat/drink during contractions and choose a comfortable position (Yulizawati, 2019). Delivery was performed according to the 60-step APN (Nurjasmi, 2021), with the baby born spontaneously, female, and with an Apgar score of 8/9/10. The baby underwent Early Breastfeeding Initiation (IMD) at 14.55 WIB, in accordance with the theory about the benefits of IMD for maternal and infant health (Bidan & Eksklusif, 2023).

During the third stage of labor, a 10 IU oxytocin injection was administered, the umbilical cord was clamped and cut, and the placenta was examined. The placenta was delivered with several torn cotyledons, and a placental exploration was performed to prevent bleeding. The third stage of labor experienced approximately 500 cc of bleeding, and a second-degree perineal laceration was treated with 1% lidocaine anesthesia and a surgical procedure. The mother was then referred to the hospital for further treatment. Postpartum treatment was in accordance with the Indonesian Ministry of Health (2019), including the administration of vitamin A supplements and iron tablets.

All management was carried out in accordance with existing theory and guidelines, with no gaps between theory and practice.

C. Postpartum Midwifery Care

1. Subjective Data

During her first postpartum visit, the mother complained of stomach cramps. According to Nurafifah & Kusbiantoro (2019), the stomach cramps she experienced were a sign of uterine involution. She reported a small amount of breast milk production. According to Maurya & Yadav (2015), breast milk production occurs due to increased levels of the hormones oxytocin and prolactin. She reported having urinated once but not yet had a bowel movement. According to Hutabarat (2021), the digestive system experiences a decrease in tone and function within the hours after delivery.

During her second postpartum visit, the mother reported no complaints, while during her third and fourth postpartum visits, she reported frequent nighttime sleep due to breastfeeding.

According to (Huang, Hu, Wang, & Luo, 2022), breastfeeding mothers need at least 8 hours of rest per day.

2. Objective Data

Examination of Mrs. P's vital signs during the postpartum period showed results that were within normal limits. Blood pressure stabilized within 24 hours after delivery, with the mother's pulse rate remaining within the range of 60-80 beats per minute, as per Hauspurg & Jeyabalan (2022). Body temperature increased slightly (0.2-0.5°C) due to increased metabolic activity and caloric needs after delivery, but the respiratory rate remained normal at 12-16 breaths per minute.

A breast examination revealed breast enlargement during pregnancy, and after delivery, Mrs. P produced a small amount of breast milk. This is due to the influence of increased estrogen, which prepares for milk production and lactation (Pooja Maurya & Latika Yadav, 2015). Early initiation of breastfeeding (IMD) was carried out even though breast milk was not yet flowing smoothly, with colostrum beginning to flow.

An abdominal examination revealed a decrease in the size of the uterine fundus, in accordance with the theory of Sulfianti et al. (2021), where the weight of the uterus decreased gradually after delivery, from the level of the navel to 1 finger below the navel after the placenta was delivered, and was not palpable above the symphysis pubis in the second week. After 6 weeks, the size of the uterus decreased further.

Examination of the perineum and vulva showed conditions consistent with the postpartum period, where the vulva and vagina remained loose for several days after delivery and returned to normal within 3 weeks (Reni Heryani, 2021). Mrs. P's lochia discharge also aligns with Wahyuni's (2018) theory, which describes changes in lochia from rubra (1-3 days), sanguineous (2-7 days), serosa (3-7 days), to alba (>14 days). All these findings align with existing theory and demonstrate no gap between the assessment and theory.

3. Analysis

Based on subjective and objective data, it can be seen that Mrs. P, 24 years old, P2A0, had a normal postpartum period. The problems experienced by the mother during the postpartum period were stomach cramps, frequent late night sleep, and low breast milk supply.

4. Management

Postpartum management involves providing information that the mother is generally in good condition and that abdominal pain due to uterine involution is normal (Sulfianti et al., 2021). Mothers are encouraged to get at least 8 hours of rest per day (WHO & UNICEF, 2015), and are educated about postpartum warning signs such as bleeding, fever, or swollen breasts, which require immediate treatment (Ministry of Health, 2019).

Mothers are taught proper breastfeeding techniques and are provided with information on the benefits of breast care to stimulate milk supply (Nurul Fajar Rina et al., 2021). Furthermore, mothers are encouraged to consume a balanced, nutritious diet and eat dates to increase breast milk volume, which contain carbohydrates, calcium, potassium, and the hormone prolactin, which stimulates milk production (Fetrisa, Siska, & Rahmadheny, 2025). Breastfeeding on demand, or every 2 hours, and exclusive breastfeeding for 6 months are encouraged, in accordance with WHO recommendations (Gavine et al., 2024).

Mothers are also taught about personal hygiene and are provided with information on family planning using the Klop KB application, in accordance with Government Regulation of

the Republic of Indonesia Number 87 of 2014 (Central Java Health Office, 2020). Mothers are encouraged to take FE tablets for at least 40 days after delivery, in accordance with the guidelines of the Indonesian Ministry of Health (2019). All actions taken were in accordance with Minister of Health Regulation Number 97 of 2014, which includes checking blood pressure, pulse, temperature, and recommendations for exclusive breastfeeding (Nurjismi, 2021). Based on the care provided, no gaps were found between theory and practice.

D. Newborn Care (BBL)

1. Subjective Data

Based on the subjective data review of the first to third visits to Mrs. P, the mother stated that she had given birth to her baby spontaneously and normally on September 21, 2024, at 2:50 PM WIB. The mother stated that the baby was a girl. The mother stated that the baby was already able to breastfeed. The mother stated that the baby's umbilical cord had fallen off on the morning of September 26, 2024. This is in line with the Indonesian Ministry of Health (2018), which states that the remaining umbilical cord will fall off with a length of release ranging from 1-7 days.

2. Objective Data

Based on the examination, objective data showed that Mrs. P's baby was in normal condition. The baby was born spontaneously with a strong cry and active movements. The assessment included the baby's body color, breathing, heart rate, and muscle tone, as well as the Moro reflex, sucking, rooting, tonic neck, and walking, all of which were within normal limits. The baby's APGAR score was 8/9/10, in accordance with Octaviani Chairunnisa & Widya Juliarti (2022), which stated that babies born in a vertex presentation, with a gestational age of 37-42 weeks and a birth weight of 2500-4000 grams, and an APGAR score > 7, indicate the baby is in good health. Mrs. P's baby had a bowel movement on the 2nd day and urinated on the 1st day after birth, which is in accordance with IDAI (2014), which states that newborns will usually urinate within the first 24 hours and defecate within the first 48 hours.

Anthropometric examination of the baby showed LD 34 cm, LK 33.5 cm, BB 3050 grams, PB 49 cm, and LILA 11 cm, which are in accordance with the standards of Octaviani Chairunnisa & Widya Juliarti (2022) for normal babies with a body weight of 2500-4000 grams and a body length of 48-52 cm. The increase in the baby's weight from 2900 grams to 3100 grams on the 8th day is also in accordance with the Ministry of Health (2019), which indicates an increase in the baby's weight of around 170-220 grams. At the last visit, the baby's vital signs showed a temperature of 36.8°C, respiration 42 times/minute, and pulse 108 times/minute, which are in accordance with the normal range according to Jamil (2017) and the Ministry of Health (2018) for babies. This examination did not show any discrepancies between the theory and the results obtained.

3. Analysis

Based on the subjective and objective data assessment, the obstetric diagnosis for Mrs. P's newborn was normal. The baby experienced no problems until the third neonatal visit.

4. Management

Management provided to the mother and baby includes providing information that the baby is healthy and identifying danger signs in the newborn, such as refusal to breastfeed, seizures, or fever, as per Jamil (2017). The mother is informed about how to maintain the baby's body temperature by fully clothed and maintaining a clean and dry umbilical cord care (Battya,

2019). The mother is encouraged to exclusively breastfeed for 6 months and breastfeed the baby on demand every 2 hours, as per WHO recommendations (Dewanti & Novianti, 2022).

The mother is also encouraged to burp the baby after breastfeeding to prevent gas (Hasriantirisna, 2023). Furthermore, the mother is informed that the baby has received eye ointment, vitamin K, and an HBO injection, as per the Indonesian Ministry of Health guidelines (2018). Care provided is in accordance with the guidelines for the first neonatal visit, including a physical examination, administration of vitamin K, eye ointment, and Hepatitis B immunization (Indonesian Ministry of Health, 2018).

Congenital Hypothyroidism (CHS) screening was conducted in accordance with the Indonesian Ministry of Health (2022), by taking a blood sample from the baby's heel at 48-72 hours of age. Mothers were also encouraged to expose their babies to sunlight and engage in tummy time to support gross motor development. Furthermore, mothers were informed that their babies would receive BCG and Polio 1 immunizations at one month of age, in accordance with the Indonesian Ministry of Health (2018). Based on the care provided, no gaps were found between theory and practice.

E. Family Planning (FP) Midwifery Care

1. Subjective Data

Based on the latest subjective data review on Mrs. P, the mother said that she had previously used a 3-month injection contraceptive for 2 years and then stopped because she wanted to change the method because Mrs. P had not had a period for 11 months while using the 3-month injection contraceptive, then she had used an IUD for 1 year and stopped because she complained of menstruation for almost 1 month, and the last time before getting pregnant she used a 1-month injection contraceptive for 1 year and then stopped because she wanted a child immediately, when using this 1-month injection contraceptive, the mother said there were no complaints. The mother said that there was still discharge from the birth canal in the form of lochia serosa +/- 3 cc and had not had sexual intercourse with her husband, the mother said that she had discussed with her husband that the contraceptive that would be used until her baby was 6 months old was a condom contraceptive because while being a housewife at home, Mrs. P always gave exclusive breastfeeding every 2 hours and had not had a period. After Mrs. P's baby was 6 months old, she would use an IUD based on the results of the discussion that had been held with her husband. This is in accordance with the Indonesian Ministry of Health (2021), which states that service providers need to confirm the client's complaints before providing information or helping clients make decisions regarding their family planning methods.

2. Objective Data

Based on the examination, the mother's general condition was good, *compos mentis* consciousness, blood pressure 110/70 mmHg, pulse 86 beats/minute, respiration 20 breaths/minute, temperature 36.3°C. A breast examination revealed no lumps, and breast milk was released. A fundal height (FH) examination revealed the FH was no longer palpable, and the bladder was empty. There was vaginal discharge. According to the Ministry of Health (2021), an IUD is a non-hormonal birth control method (for copper IUDs) and does not affect breast milk production. Breastfeeding mothers can use an IUD without worrying about impacts on the quality or quantity of breast milk, making it safe for mothers who exclusively breastfeed. The IUD remains effective even after insertion after six months of breastfeeding. The

effectiveness of the IUD as a contraceptive reaches more than 99% and is not affected by the length of breastfeeding. This means that if a new mother decides to use an IUD after six months of breastfeeding, the IUD will still function optimally as a long-term contraceptive. Based on the case study and the theory described, no gaps were found.

3. Analysis

Based on subjective and objective data, it is known that Mrs. P, 24 years old, P2A0, is a new candidate for IUD use. There are no problems in making the decision to use IUD.

4. Management

Management includes providing information to the mother regarding examination results indicating her condition is within normal limits. The mother is informed about the definition and various contraceptive methods using the Klop KB application, which functions to assess the medical eligibility of prospective contraceptive users, such as smoking, diabetes mellitus, and HIV (Wahyuningsih & Tridiyawati, 2023). The mother is also provided with information about safe contraceptive methods for breastfeeding mothers, specifically the use of the IUD.

According to the Ministry of Health (2021), the Copper IUD works by exploiting a mild inflammatory reaction in the uterus, which makes it difficult for sperm to reach and fertilize the egg, and reduces sperm resistance, thereby reducing the chance of fertilization. The IUD is more than 99% effective in preventing pregnancy and does not affect breast milk production. It is a long-term contraceptive method that is effective for 5-10 years, reducing the burden on mothers of remembering daily or weekly doses.

Family planning services involve good communication with patients, providing comprehensive information about available contraceptive methods, and assisting patients in making appropriate choices (Ministry of Health, 2021). Based on the family planning care provided, no gap was found between theory and practice.

CONCLUSION

Continuous obstetric care for Mrs. P is carried out at the Mojogedang I Health Center starting from pregnancy, childbirth, postpartum period, newborns, to family planning, with a Continuity of Care approach in accordance with the Ministry of Health 320 of 2020. During the third trimester of pregnancy, three visits were made, with normal complaints such as pain in the vaginal bones and swelling in the legs, and were given pelvic rocking exercises and recommendations for mung bean consumption. Delivery took place normally in 50 minutes, with management of placental remainder using oxytocin and metergin. Postpartum care and newborns are given with 3 visits, including breast care and recommendations for the consumption of date juice, as well as examination of babies who show good condition. Finally, family care is planned by education through the Klop KB application, and decision-making is carried out with the husband, without a gap between theory and practice in each stage of care provided.

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