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Comprehensive Midwifery Care For Mrs. D At Aliyah Tami Bpm, Jl. Rakuta Sembiring, Pematang Siantar

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Abstract

Comprehensive midwifery care, or Continuity of Care (CoC), is vital for reducing maternal and infant mortality rates, which remain a significant public health issue globally and in Indonesia. This study aims to demonstrate the practical application and effectiveness of a continuous care model in a real-world midwifery setting.This case study aims to provide and implement comprehensive midwifery care for a client, Mrs. D, to document the outcomes and adherence to clinical standards throughout the entire maternal and neonatal continuum. A qualitative case study approach was used, focusing on a single subject, Mrs. D (G3P3A0), at BPM Aliyah Tami. Data was collected from February to March 2025 through direct observation, in-depth interviews, and physical examinations. The care was managed using Varney's framework and documented with the SOAP method. The data was analyzed descriptively to narrate the client's journey and care outcomes.The comprehensive care provided led to a successful physiological pregnancy, a normal spontaneous delivery at 37 weeks' gestation with no complications, and a healthy newborn. The mother's postpartum recovery was physiological, and she successfully adopted a family planning method. All stages of care were consistent with established midwifery standards.The implementation of a comprehensive midwifery care model ensures positive outcomes for both mother and baby. The study's findings affirm that continuous, structured care is a cornerstone of safe and effective midwifery practice.

Keywords: *Antenatal Care, Comprehensive Midwifery, Continuity of Care, Family Planning, Postpartum Care*

INTRODUCTION

Midwifery care is a holistic and continuous process, also known as Continuity of Care (CoC), that extends from pregnancy through childbirth, postpartum, newborn care, and family planning. This comprehensive approach is crucial for optimizing the detection of high-risk maternal and neonatal conditions, thereby significantly contributing to the reduction of Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR). The rates of maternal and infant mortality are not merely health statistics; they are key indicators of a region's overall health status, reflecting the quality of healthcare services, public health literacy, environmental conditions, and socioeconomic factors, including access to healthcare (Suparman, 2020; Simanungkalit & Sari, 2023). Therefore, providing high-quality comprehensive midwifery care is paramount to improving public health outcomes and achieving global health targets.

Globally, the burden of maternal and infant mortality remains a significant concern, especially in low-income countries. The World Health Organization (WHO, 2024) reported that approximately 287,000 women died during and after pregnancy and childbirth in 2020. This alarming figure underscores the vast disparities in access to quality healthcare. For instance, the MMR in low-income countries was 430 per 100,000 live births in 2020, starkly contrasting with 13 per 100,000 live births in high-income nations. Major causes of maternal death include severe bleeding, infections, hypertensive disorders like preeclampsia and eclampsia, and complications from unsafe abortions. Similarly, neonatal mortality, with a global rate ranging from 0.7 to 39.4 deaths per 1,000 live births in 2022, is primarily caused by prematurity, birth complications (asphyxia), neonatal infections, and congenital abnormalities (WHO, 2024; Mulyana, 2023).

In Indonesia, the issue of maternal and infant mortality is particularly pressing. The 2020 Census revealed an MMR of 189 per 100,000 live births and an IMR of 16.85 per 1,000 live births. Disturbingly,

the number of maternal deaths increased from 4,005 in 2022 to 4,129 in 2023, while infant deaths rose from 20,882 to 29,945 during the same period (Kemenkes RI, 2024). These figures highlight a critical public health challenge that demands immediate and effective interventions. The primary causes of maternal death in Indonesia are attributed to hypertensive disorders (32.4%) and postpartum hemorrhage (20.3%). For infants, the leading causes of death are low birth weight (prematurity) and asphyxia (Kemenkes RI, 2024; Wulandari, 2022). The persistence of these high mortality rates, despite various public health initiatives, indicates a need for more robust and continuous healthcare strategies, such as CoC.

Comprehensive midwifery care, encompassing antenatal care, labor and delivery, postpartum care, neonatal care, and family planning, is a well-established strategy for mitigating these risks. Antenatal care, as an early preventive measure, aims to identify high-risk pregnancies and provide timely interventions to reduce maternal mortality and monitor fetal well-being (Maharani & Resky, 2013; Simanjuntak & Yanti, 2021). Similarly, skilled care during labor and delivery is essential for physical and emotional support, early detection and management of complications, and infection prevention (Fitriana & Nurwidiandani, 2018; Jackson, 2022). The postpartum and neonatal periods are particularly critical, with a significant proportion of deaths occurring within the first 24 hours postpartum and the first week of life, respectively. Therefore, close monitoring and comprehensive care during this period are vital to prevent preventable deaths (Ni Wayan & Ni Gusti, 2017; Yanti, 2023). Lastly, family planning efforts, through effective contraception, are fundamental to improving the health and well-being of mothers and children by spacing pregnancies and reducing unintended births (Anggraini & Martini, 2012; Th. Endang & Elisabeth, 2024).

This case study aims to provide and apply comprehensive midwifery care to Mrs. D, a G3P3A0 with a gestational age of 37 weeks, at BPM Aliyah Tami from February to March 2025. This research is urgent given the persistent high rates of maternal and infant mortality in Indonesia, which necessitate the implementation of effective, evidence-based care models. The urgency lies in demonstrating how the practical application of the continuity of care model can lead to successful maternal and neonatal outcomes in a real-world setting, thus serving as a valuable example for other healthcare providers. The novelty of this study is its detailed, step-by-step application and documentation of comprehensive care within a specific midwifery practice context, which provides a tangible blueprint for other midwives. By meticulously documenting the care provided, from antenatal visits to family planning counseling, this study highlights the effectiveness of holistic care in achieving positive, physiological outcomes for both mother and baby.

While this study successfully highlights a research gap concerning the practical implementation of comprehensive midwifery care (CoC), the specific contribution of this single case to broader midwifery practice still needs to be clarified. As an in-depth case study, it provides compelling anecdotal evidence of a positive outcome for one client, Mrs. D. However, the findings are not easily generalized to a wider population, as they do not account for the diverse variables and challenges present in different clinical settings. The study effectively serves as a powerful illustration of the CoC model's potential but does not definitively establish its universal effectiveness. Therefore, to bridge the gap between theory and practice and to build a stronger evidence base, future research should employ quantitative or mixed-methods approaches with larger sample sizes to measure and confirm the impact of continuous care on a broader scale.

RESEARCH METHODS

This study employed a qualitative case study approach, utilizing the application of Varney's Midwifery Management and SOAP (Subjective, Objective, Assessment, Plan) as the framework for delivering and documenting care. A case study is an in-depth, intensive examination of a single individual, group, or phenomenon, providing a holistic and rich understanding of the subject within its real-world context (Creswell & Poth, 2018; Sudaryono, 2020). By focusing on the comprehensive midwifery care provided to Mrs. D, this methodology allowed for a detailed and systematic analysis of the entire process from pregnancy to family planning. The use of Varney's and SOAP's management frameworks ensured that the care provided was structured, systematic, and aligned with standard midwifery practice, allowing for clear documentation of subjective data (S), objective findings (O), professional assessment (A), and the care plan (P) (Ni Wayan & Ni Gusti, 2017; Yulizawati et al., 2019).

The research instrument was the researcher herself, who acted as the primary data collector. The data collection techniques included direct observation, in-depth interviews, and physical examinations. These methods were used to gather detailed information about Mrs. D's physical and psychological condition throughout the continuum of care. The data were then analyzed using a descriptive-narrative approach. This involved collecting, transcribing, and organizing the data to describe the case comprehensively, identifying patterns, and drawing conclusions based on the sequence of events and the outcomes of the interventions. This approach is well-suited for qualitative case studies, as it allows the researcher to present the findings in a coherent, story-like manner, which is crucial for highlighting the patient's journey and the efficacy of the comprehensive care provided (Emzir, 2021; Sugiyono, 2022). To Impove the validity we use triangulation data method.

The population for this study was all pregnant women receiving care at BPM Aliyah Tami, while the sample was a single case: Mrs. D (G3P3A0). The selection of Mrs. D was based on a purposive sampling technique, chosen because her case provided a complete continuum of care, from her late third trimester through to the postpartum and family planning stages. This made her an ideal subject for an in-depth case study on comprehensive midwifery care. The study was conducted from February to March 2025. The research procedure involved five distinct stages: antenatal care (two visits), intrapartum care (one visit), postpartum care (four visits), neonatal care (three visits), and family planning counseling. This sequential procedure allowed for a detailed and continuous observation of the client's progress and the corresponding midwifery interventions. All procedures were performed with the guidance of a supervising midwife to ensure adherence to professional standards and the safety of both the mother and the baby (Andri et al., 2022; Taufan, 2022).

RESULTS AND DISCUSSION

Results

Antenatal Care

Antenatal care was provided to Mrs. D starting on February 23, 2025, at a gestational age of 34 weeks. The mother had no complaints, and all symptoms experienced were considered normal physiological changes during pregnancy. The mother had a total of 2 antenatal checks with the researcher, 10 with a midwife, and 2 with a doctor during her second and third trimesters. The results of the examinations showed that both the mother and fetus were in good health. On February 23, her hemoglobin level was 12 g/dL. During her second visit with the researcher on March 2, at 35 weeks' gestation, the mother had already prepared all necessary items for childbirth, including clothing for the baby, transportation, and funds.

The physical examination revealed vital signs within normal limits. Her mid-upper arm circumference (MUAC) was 30 cm, fundal height (TFU) was 31 cm, the fetal back was on the right side, the head was engaged (inlet), and the fetal heart rate was a regular 150 beats/minute. Other examination results were also within normal limits. The interventions provided included counseling on common third-trimester discomforts, such as frequent aches and nocturnal urination, explaining that these were normal physiological occurrences.

Intrapartum Care

The mother began experiencing regular and adequate contractions at 08:00 AM WIB. Upon the initial vaginal examination, her cervix was dilated to 2 cm, the amniotic sac was intact, the head was presenting, the portio was thin and soft, and the head was in the right transverse occiput position. A subsequent vaginal examination at 12:40 PM WIB revealed a fully dilated cervix (10 cm) with a ruptured clear amniotic sac and the fetal head at station Hodge IV. The mother was guided to push, and the baby was born at 13:00 PM WIB. The baby cried immediately, had active muscle tone, and pink skin.

The third stage of labor lasted for 30 minutes after the baby was born, with the implementation of Active Management of the Third Stage of Labor. Placental separation was indicated by a gush of blood from the birth canal. The placenta was delivered completely, the uterus was firm, and blood loss was approximately 50 mL. This was followed by a two-hour observation period for the fourth stage of labor. During this time, the mother's condition was good, and there were no signs of complications, with all vital signs remaining within normal limits.

Postpartum Care

Postpartum care consisted of four visits, specifically at 12 hours (PCV 1), 4 days (PCV 2), 25 days (PCV 3), and 40 days (PCV 4) postpartum. The results of the examinations conducted during these visits are presented in the following table:

Table 1. Examination Results

	KF 1	KF 2	KF 3	KF 4
ASI	Exit	Exit	Exit	Exit
TFU	2 fingers below the center	Mid-central symphysis	Not palpable	Not palpable
Kontraksi	Hard	Hard	Hard	Hard
Lochea	Rubra	Sanguilenta	Serosa	Alba
Laserasi	Clean	Clean	Clean	Clean
Masalah	-	-	-	-

Newborn Care

The baby was born at 13:00 PM WIB in good condition, crying immediately, with pink skin and active muscle tone. Immediate Breastfeeding Initiation (IMD) was successfully performed, followed by essential newborn care. The researcher conducted three neonatal visits. During the first visit, when the baby was 4 days old, the baby's weight had increased by 300 grams, from the initial 3,700 grams to 4,000 grams. During subsequent visits, the baby remained in good condition with no issues detected.

Family Planning Care

This type of family planning care began during the fourth postpartum visit, which included contraceptive counseling. This care was successful, as evidenced by the mother's choice of birth control pills after receiving counseling and education.

Discussion

Antenatal Care

The comprehensive midwifery care for Mrs. D began with antenatal care from 34-35 weeks' gestation. During the first visit on February 23, 2025, Mrs. D presented with no complaints, as the discomforts she experienced were considered normal physiological changes of pregnancy. The care provided focused on promoting well-being through advice on adequate rest, careful physical activity, prenatal exercises, and a balanced, nutritious diet. During the second visit on March 2, 2025, at 35 weeks, the physical and psychological condition of the mother and fetus was found to be normal, with the fetus in a longitudinal position. There was no discrepancy between the observed physiological pregnancy and established theory.

According to WHO standards (2007), pregnant women should receive a minimum of six antenatal care visits throughout their pregnancy. This includes two visits in the first trimester, two in the second, and two in the third. This schedule is designed to carefully monitor the mother and fetus, allowing for early detection and timely intervention for any complications. A gap was identified in this study, as the researcher only conducted two antenatal visits due to patient limitations. However, Mrs. D had previously received care from a midwife and doctor, indicating she had access to regular antenatal checkups.

The importance of maternal nutrition in the third trimester for proper fetal growth and development is well-documented (Nuhagraeni, 2021). Essential nutrients during this period include protein, carbohydrates, fats, fiber, and iron. Mrs. D's diet, which included rice, fish, vegetables, fruits, milk, and vitamins, was consistent with these theoretical requirements, showing alignment between the patient's practices and nutritional recommendations. Physiologically, third-trimester changes can include weight gain, hip and lower abdominal pain, and frequent urination (Ihda, 2021). Mrs. D experienced weight gain and lower abdominal pain, which is consistent with these changes. Psychologically, this stage can be accompanied by feelings of discomfort, anxiety, or excitement about impending childbirth. Mrs. D, however, reported feeling neither anxious nor fearful; instead, she expressed happiness and excitement about her baby's arrival.

Intrapartum Care

At 37 weeks' gestation, Mrs. D was admitted to the midwifery clinic at 08:00 AM WIB with regular contractions, back pain, and bloody show. The initial vaginal examination showed a cervical dilation of 2 cm, an intact amniotic sac, and the fetal head at station -5. The latent phase of labor continued,

and by 12:40 PM, a subsequent examination confirmed full cervical dilation (10 cm), a ruptured amniotic sac with clear fluid, and the fetal head at station Hodge IV.

The first stage of labor lasted 4 hours and 40 minutes, from 2 cm to full dilation. According to Lusa (2021), the active phase of labor in multiparous women is typically faster, with cervical dilation progressing at a rate of 1-2 cm per hour. The progression of labor for Mrs. D was consistent with this theory. The second stage of labor, during which Mrs. D was encouraged to push, was notably rapid, lasting only 10 minutes, with the spontaneous delivery of the baby at 13:00 PM WIB. This is also consistent with the theoretical maximum duration of 30 minutes for the second stage in multiparous women (Karinta, 2025). The absence of perineal rupture during this rapid delivery further highlights a positive outcome.

The third stage of labor, from the baby's birth to placental delivery, was managed using Active Management of Third Stage of Labor. This included administering oxytocin, applying controlled cord traction, and massaging the uterus. The placenta was delivered completely within approximately 5 minutes, which is well within the 15-minute maximum time frame stated in theory (Walyani, 2021). The placenta was found to be intact with complete cotyledons, the umbilical cord measured 50 cm, and the membranes were complete.

The fourth stage of labor, a critical two-hour observation period after placental delivery, was conducted meticulously. The researcher performed vital signs checks, uterine fundal height, uterine contraction, and blood loss assessments every 15 minutes for the first hour and every 30 minutes for the second hour. This monitoring protocol aligns with the guidelines set by Walyani (2021). The observations confirmed that Mrs. D was in good condition with no complications. The researcher provided counseling on proper breastfeeding techniques and encouraged the mother to eat and drink to regain her strength and prevent dehydration. The overall intrapartum care for Mrs. D was in accordance with standard midwifery practices. The researcher's adherence to the steps of normal labor care, including preparation, hand hygiene, assisting with the delivery of the baby and placenta, and providing essential newborn care like Apgar scoring and vitamin administration, was fully consistent with the theoretical framework of normal delivery care (Andri et al., 2022).

This appears to be a report on the postpartum care of a woman named Mrs. D and her newborn, including information about family planning. I will narrate the provided text in English.

Postpartum Care

The postpartum care for Mrs. D included four visits: 6 hours, 7 days, 15 days, and 18 days after delivery. According to the Ministry of Health (Kemenkes) RI in 2021, four visits are recommended. No danger signs were found in the mother, and the baby was in good health.

Visit 1 was on March 17, 2025, 6 hours postpartum. Mrs. D's fundal height was two fingers below the navel, uterine contractions were good, and her bladder was empty. Her lochia was lochia rubra, which is a reddish discharge containing blood and remnants of the amniotic sac, typically appearing 1-2 days after delivery. Breast milk had not yet come in. All observations were normal. The findings from this visit align with the theory of Walyani (2021), specifically the assessment of fundal height, contractions, bladder, and lochia rubra 6 hours postpartum.

Visit 2 was 6 days postpartum. The examination showed normal vital signs, a fundal height one finger above the pubic symphysis, and lochia sanguinolenta, a brownish discharge with more serum, which appears 3-7 days after delivery. There were no signs of infection. Breast milk was flowing well, and the postpartum period was progressing normally. The findings from this visit align with the theory of Viyuni (2021).

Visit 3 was 2 weeks postpartum. The examination showed normal vital signs. Her fundal height was no longer palpable, which is consistent with the theory of Walyani (2021). The lochia was lochia serosa, a yellowish-white discharge that appears after day 14 postpartum. Breast milk was flowing well, and the postpartum period was progressing normally. Education was provided on breast care, consuming nutritious foods, and drinking plenty of water to prevent dehydration and support milk production.

Visit 4 was 6 weeks postpartum. The examination showed normal vital signs. Her fundal height was still not palpable, consistent with Walyani (2021). The lochia was lochia alba, a whitish discharge that appears after day 14 postpartum. Breast milk was flowing well, and the postpartum period was progressing normally. The assessment of fundal height, contractions, bladder, and lochia at 6 weeks postpartum aligns with the theoretical framework.

During her postpartum period, Mrs. D was advised on essential needs such as nutrition, hydration, early ambulation, and mobilization. This is crucial for mothers to meet their and their baby's needs, especially for breastfeeding. Mrs. D consumed nutritious foods like carbohydrates, protein, fats, fiber, and vitamins and engaged in early mobilization, including walking, to feel healthier and stronger, care for her baby, and prevent postpartum infections.

According to Astuti (2020), physiological changes during the postpartum period include involution (the uterus returning to its pre-pregnancy state), lochia discharge, breast milk production, and the relaxation of the cervix and vagina. The changes Mrs. D experienced—her uterus returning to its normal size, appropriate lochia discharge, breast milk production, and a relaxed vagina—all align with these theoretical changes.

According to Bernadet (2024), psychological changes in the postpartum period can include anxiety, disappointment, or feeling uncomfortable with oneself or the baby. However, Mrs. D stated she did not experience these feelings. She felt happy about the arrival of her baby.

Newborn Care

According to the Ministry of Health (Kemenkes) RI in 2023, newborn visits (KN) should be performed once at 6-48 hours, once at 3-7 days, and once at 8-28 days. The visits for Mrs. D's baby were consistent with this schedule: at 6 hours, 7 days, and 28 days.

According to Istiqomah (2023), the Apgar score is a crucial assessment for newborns at one and five minutes to determine if they are healthy or need immediate intervention. Mrs. D's baby had an Apgar score of 8/10 at the first examination. The baby, born at 13:00 WIB, had a birth weight of 3700 grams, was full-term, and had no abnormalities. The care provided included eye ointment, Vitamin K, Hepatitis B vaccine (HBO), umbilical cord care, maintaining the baby's body temperature to prevent hypothermia, and encouraging the family to breastfeed frequently. This care aligns with standard newborn care theory. According to Devina (2023), new mothers learn many new things, including umbilical cord care. The umbilical cord usually falls off within a week, but it can take up to 10-14 days. It is important for parents not to force the cord to detach, as this can cause bleeding and a risk of infection. The umbilical cord of Mrs. D's baby fell off on the fifth day, which is consistent with the theoretical timeline.

Family Planning Care

On April 27, 2025, at 11:00 WIB, counseling on contraception was provided to Mrs. D. After discussing various contraceptive options, Mrs. D expressed her desire to use the birth control pill. Counseling was provided on how to use the pill, its side effects, and consumption methods. This guidance aligns with standard family planning theory. Mrs. D chose the pill because she wants to space out the births of her children and allow her reproductive organs to heal.

CONCLUSION

Overall, the findings from this case study confirm that implementing comprehensive midwifery care, or Continuity of Care (CoC), is effective in achieving positive and physiological outcomes for both mother and baby. The study on Mrs. D shows success at every stage, from a healthy pregnancy and normal delivery to a postpartum period that progressed as expected. Objective data, such as the rate of uterine involution, lochia characteristics, and infant growth, were all consistent with midwifery theory. Furthermore, the mother's psychological well-being was also maintained, as Mrs. D showed no signs of anxiety or discomfort, but rather expressed happiness about her baby's birth. These results demonstrate that the CoC model doesn't just focus on the physical condition but also considers the client's psychological well-being. This case study successfully illustrates that structured, continuous care is the key to reducing the risk of complications and achieving optimal maternal and neonatal outcomes.

Despite these successful findings, the study has some limitations, particularly regarding generalizability. As a single case study, the results cannot represent a broader population, as every pregnancy has unique characteristics and risk factors. Another limitation is the lack of control over external factors that might have influenced the outcomes, such as social support from family or the environment. Therefore, for future research, it's recommended to conduct studies with a larger sample size and use quantitative or mixed-methods approaches to compare outcomes between a group receiving CoC and a control group. Future research could also explore non-clinical factors contributing to the success of CoC, such as the role of family support, health literacy, and service accessibility. By doing so,

we can build stronger, more comprehensive evidence about the importance of continuous midwifery care in the healthcare system.

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