

Innovation of Natural Therapy in Continuity of Care (CoC) Midwifery

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Abstract

Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) are key indicators of a nation's health status. Elevated rates are often associated with unmonitored complications during pregnancy and childbirth. The Continuity of Care (CoC) approach provides a continuous care model that enables early detection of potential complications through sustained relationships between midwives and patients. This study aims to provide comprehensive midwifery care to Mrs. Y (41 years old) and Mrs. D (22 years old), encompassing the third trimester of pregnancy, labor, newborn care, postpartum care, and family planning services. The research employed a descriptive observational design using Varney's seven-step midwifery management approach and SOAP documentation. The results showed that both patients experienced physiological pregnancies. The labor process was normal, with care focusing on pain management for Mrs. Y and comprehensive management of stages I–IV of labor for Mrs. D. The newborns were healthy, supported by the implementation of Early Initiation of Breastfeeding (EIB). The postpartum period progressed without complications, facilitated by education on nutrition and breastfeeding techniques. At the end of the care period, both patients chose long-term contraceptive methods, with Mrs. Y opting for tubectomy (MOW). In conclusion, the implementation of CoC effectively supports a safe reproductive process and minimizes the risk of complications through continuous monitoring and patient education.

Keywords: Continuity of Care; Midwifery Care; Pregnancy; Childbirth; Newborn; Postpartum Care

Introduction

In 2020, the Ministry of Health estimated that by 2024, the Maternal Mortality Rate (MMR) in Indonesia would reach 183 per 100,000 live births, and decline to 131 per 100,000 live births by 2030. These figures remain far from the targets set by the Sustainable Development Goals (SDGs) (Aisah et al., n.d.). The high maternal mortality rate in Indonesia is influenced by multiple factors, including the behavior of pregnant women who do not utilize Antenatal Care (ANC) services, leading to high-risk pregnancies. Additionally, deliveries assisted by unskilled health personnel and births occurring outside healthcare facilities contribute to suboptimal emergency management and delays in treatment, ultimately resulting in maternal and infant mortality (Suarayasa, 2020).

According to the World Health Organization (WHO), the Maternal Mortality Rate (MMR) remains critically high; approximately 810 women die each day worldwide due to complications related to pregnancy or childbirth, and about 295,000 women die annually during and after pregnancy and delivery. The maternal mortality rate in developing countries reaches 462 per 100,000 live births, compared to 11 per 100,000 live births in developed countries (Setyoningsih, 2024).

Maternal health is one of the targets outlined in the third goal of the 2030 Agenda for Sustainable Development, which aims to reduce the global MMR to 70 per 100,000 live births. In Indonesia, MMR remains high and continues to be a major public health problem. The success of maternal health programs is commonly assessed using the Maternal Mortality Rate (MMR) as a key indicator. Maternal death is defined as any death occurring during pregnancy, childbirth, or the postpartum period due to causes related to or aggravated by the pregnancy or its management, excluding accidental or incidental causes. MMR represents the number of such deaths per 100,000 live births.

Based on the 2018 Central Java Provincial Health Profile, the number of maternal deaths in Central Java was 421 cases, reflecting a decrease compared to 475 cases in 2017. Consequently, the maternal mortality rate declined from 88.05 per 100,000 live births in 2017 to 78.60 per 100,000 live births in 2018. The highest number of maternal deaths occurred in Grobogan Regency (31 cases), followed by Brebes (30 cases) and Demak (23 cases). Based on age groups, the highest proportion of maternal mortality occurred among women aged >35 years (31.35%), while the lowest occurred among those aged <20 years (3.56%). Furthermore, the

causes of maternal mortality are closely related to maternal conditions, commonly described by the “4 Too’s” criteria: too old (>35 years), too young (<20 years), too many children (>4), and birth intervals that are too short (<2 years).

Efforts to accelerate the reduction of the Maternal Mortality Rate (MMR) focus on ensuring that every mother has access to quality healthcare services. These include antenatal care, delivery assisted by skilled health personnel in healthcare facilities, postnatal care for both mother and infant, referral services for complications, and family planning (KB), including postpartum family planning (Jasmiati et al., 2023). One strategy to improve the quality of maternal and child health services is the implementation of continuous care, known as Continuity of Care (CoC) (Raraningrum, 2021).

Continuity of Care (CoC) in maternal health aims to improve service quality through a continuous relationship between patients and healthcare providers. To support this effort, midwives are expected to monitor pregnant women from the first antenatal visit (K1) through delivery, as well as monitor newborns for signs of infection or postnatal complications. In addition, midwives act as facilitators for couples of reproductive age in accessing family

planning services. Therefore, the author intends to implement comprehensive midwifery care through the Continuity of Care (CoC) approach. This approach represents a holistic model of care covering pregnancy, labor, newborn care, postpartum, neonatal care, and family planning. It emphasizes sustained service quality over time through continuous interaction between patients and healthcare providers. Midwifery services should be provided from the preconception period, early pregnancy, all trimesters, childbirth, and up to six weeks postpartum (Gitasari et al., 2025).

This midwifery care is an application of the roles, functions, and responsibilities of midwives in providing services to clients and serves as an effort to reduce both the Maternal Mortality Rate (MMR) and the Infant Mortality Rate (IMR) (Gita & Widowati, 2024). Continuity of Care (CoC) is also a patient-centered learning model in which students gain direct clinical experience. Through active participation in CoC, students are able to develop competencies in providing woman-centered care. To achieve effective Continuity of Care, students are required to deliver comprehensive midwifery care across antenatal, intranatal, and postnatal periods to different patients (Gitasari et al., 2025).

Based on the background above, the author is interested in providing Continuous Midwifery Care for Mrs. Y, 41 years old, G3P2A0, covering pregnancy, labor, newborn care, and postpartum at PMB Asih Ariani, S.SiT., M.Kes., as well as for Mrs. S, 33 years old, G3P2A0, at TPMB Syarifah Sriyasmu, Mranggen.

Method

The materials and methods used in these two Continuity of Care (CoC) midwifery case studies employed a descriptive observational design with a case study approach. The care management model applied followed Varney's seven-step management process, which is systematic and includes: data collection, data interpretation, identification of potential diagnoses, immediate intervention, planning, implementation, and evaluation of care.

Data were collected through anamnesis (interviews), head-to-toe physical examinations, direct observation, and document review using the patients' Maternal and Child Health (MCH) handbooks (KIA books). The entire continuum of care was documented using the SOAP format (Subjective, Objective, Assessment, and Plan).

The scope of care was carried out at PMB Asih Ariani and TPMB Syarifah Sriyasmu, encompassing comprehensive monitoring of third-trimester pregnancy, labor and delivery, newborn care, postpartum care, and family planning services.

Results and Discussion

The results of the Continuity of Care (CoC) midwifery care for Mrs. Y at PMB Asih Ariani and Mrs. D at TPMB Syarifah Sriyasmu indicate that both patients completed their third-trimester pregnancies under physiological conditions, despite experiencing common complaints such as back pain and frequent urination. During labor, both patients delivered spontaneously and normally without severe complications. Mrs. Y required special attention in terms of pain management and psychological support due to her age (41 years), while Mrs. D received continuous assistance from cervical dilation through placental delivery.

The newborns were healthy, with normal birth weights. Immediate Breastfeeding Initiation (IBI/IMD) was successfully implemented, followed by standard prophylactic interventions such as eye ointment and Vitamin K₁ administration. During the postpartum period, routine monitoring ensured proper uterine involution and effective

lactation. Both patients subsequently chose contraceptive methods, with Mrs. Y opting for tubectomy (MOW) as a permanent method.

Based on the analysis, the success of the reproductive process in both cases was strongly influenced by the Continuity of Care (CoC) approach, which facilitated early risk detection during pregnancy. All complaints were classified as physiological and were effectively managed through education and supportive care. The implementation of mother-friendly care during labor reduced anxiety and supported smooth progression through all stages of labor. No discrepancies were identified between theory and practice, as all procedures adhered to midwifery care standards. The CoC model provided a strong sense of safety and trust through consistent care from pregnancy to family planning.

Midwifery Care During Pregnancy for Mrs. Y

This section describes the management of Mrs. Y, a 41-year-old G3P2A0 at 39 weeks of gestation, presenting with nausea and occasional vomiting. The discussion includes clinical reasoning, literature comparison, and evaluation of care.

Subjective data indicated that this was her third pregnancy, with the last

menstrual period (LMP) on March 1, 2025. Her Mid-Upper Arm Circumference (MUAC) was 27 cm. She reported nausea and occasional vomiting during pregnancy.

Nausea and vomiting are associated with hormonal changes, particularly increased Human Chorionic Gonadotropin (HCG), which peaks at 12–16 weeks of gestation and affects gastrointestinal function. Studies show that 50–90% of pregnant women experience nausea, with approximately 25% requiring rest from daily activities (Febiana Sholeha, 2023).

Non-pharmacological management such as ginger consumption is effective due to its essential oils and gingerol content, which help reduce nausea and improve circulation.

At 21 weeks, the patient reported back pain, and at 37 weeks, she experienced Braxton Hicks contractions and fatigue-related abdominal discomfort. Objective findings showed stable vital signs (BP: 99/77 mmHg, Pulse: 80 bpm, RR: 20/min, Temp: 36.5°C) and weight gain from 55 kg to 62 kg, which is consistent with recommended pregnancy weight gain standards.



Figure 1. Antenatal Care (ANC) Documentation

Newborn Care for Mrs. Y's Baby

Assessment indicated a normal newborn with no complications. Care included drying, warming, Immediate Breastfeeding Initiation (IBI), and health education on exclusive breastfeeding, cord care, and hygiene. Preventive care included Vitamin K injection and Hepatitis B (HB-o) immunization.



Figure 2. Newborn Baby

Postpartum Care for Mrs. Y

On the second postpartum day, Mrs. Y experienced delayed lactation and lacked knowledge of breastfeeding techniques. Oxytocin massage was applied to stimulate milk production by activating the let-down reflex. Pain at

the surgical site was reported, which is common following cesarean section, with varying pain thresholds among mothers. Psychological adaptation is crucial in postpartum care. Emotional stress can inhibit milk production; therefore, family support and education are essential.

Family Planning Care

During the fourth visit, Mrs. Y confirmed her decision to undergo tubectomy (MOW). Proper counseling was provided to reduce anxiety and ensure informed decision-making regarding effectiveness and side effects.

Midwifery Care for Mrs. D

Mrs. D received complete antenatal care (4 visits), meeting recommended standards. At 39 weeks and 2 days, she presented in normal condition with no deviations from clinical guidelines.

Labor and Delivery Care for Mrs. D

Mrs. D experienced labor beginning at 16:30 WIB with cervical dilation of 7 cm. Stage I lasted 1 hour, Stage II lasted 30 minutes, and the baby was delivered spontaneously. Active management of the third stage included oxytocin administration, controlled cord traction, and uterine massage. The placenta was delivered within 5 minutes, with no complications. Stage IV monitoring was

conducted for 2 hours, consistent with standard protocols.



Figure 3. Intrapartum Care

Newborn Care for Mrs. D's Baby

A healthy male infant was born weighing 3,100 grams and measuring 50 cm, with Apgar scores of 7–10. Care included thermal regulation, breastfeeding support, and administration of Vitamin K and HB-o immunization.

Postpartum Care for Mrs. D

The postpartum period was normal, with no complications. Care included monitoring maternal recovery, infant care, and health education. Postpartum visits were conducted at 6–8 hours, 6 days, and 6 weeks to ensure maternal and neonatal well-being.



Figure 4. Postpartum Breastfeeding

Conclusion

The implementation of Continuity of Care (CoC) for Mrs. Y at PMB Asih Ariani and Mrs. D at TPMB Syarifah Sriyasmu was successfully carried out, encompassing the third trimester of pregnancy, labor, newborn care, postpartum care, and family planning services. The monitoring results indicate that the entire reproductive process for both patients progressed physiologically without complications that could endanger the lives of the mother or infant.

During pregnancy, minor complaints were effectively managed through appropriate education and supportive care. In the labor stage, the application of mother-friendly care facilitated smooth and spontaneous deliveries. The newborns were in good health following standard initial procedures, and the postpartum period proceeded without significant complications.

Overall, the Continuity of Care approach proved effective in ensuring a safe reproductive process, while also supporting informed decision-making in family planning, including the selection of a long-term contraceptive method (tubectomy/MOW) by Mrs. Y.

Conflict of Interests Statement

The authors declare that there are no conflicts of interest regarding the publication of this study. This research was conducted independently without any financial support, sponsorship, or personal relationships that could have influenced the results or interpretation of the findings.

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