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Midwifery Care Continuity Of Care For Mrs. M, 31 Years Old, G1p0a0, 33/34 Weeks Gestation, Single Live Fetus With Breech Presentation + Grade 2 Obesity + Cpd + Disability (Speech Impairment) At Rsia Pura Raharja Surabaya City

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ABSTRACT

Objective: *This study aims to provide Continuity of Care (COC) midwifery services for pregnant, laboring, postpartum women, newborns, and family planning clients, ensuring comprehensive and sustainable care, particularly for cases with complex conditions.* ***Method:*** *A descriptive case study approach was employed, utilizing primary and secondary data collected through interviews, observations, examinations, and documentation reviews, analyzed according to midwifery care management. The case involved Mrs. M, a 31-year-old primigravida at 33/34 weeks of gestation with a breech presentation, grade 2 obesity, cephalopelvic disproportion (CPD), and speech impairment, conducted at RSIA Pura Raharja, Surabaya, starting December 9, 2024.* ***Results:*** *The implementation of COC midwifery care facilitated continuous monitoring and comprehensive management of Mrs. M's condition, improving maternal and fetal health outcomes while fostering trust and satisfaction in healthcare services.* ***Novelty:*** *This study highlights the integration of evidence-based midwifery care tailored for pregnant women with disabilities, emphasizing the role of COC in enhancing maternal and neonatal health while contributing to the reduction of maternal and infant mortality rates.*

INTRODUCTION

Pregnancy is a sequence of events that normally consists of fertilization, implantation, embryonic growth, fetal growth, and ends with childbirth. When the spermatozoon meets the ovum, the beginning of pregnancy starts. Every pregnancy always begins with conception and implantation of the result. The normal duration of pregnancy is 280 days or 9 months and 7 days, calculated from the first day of the last menstrual period [3].

Based on SDGs data, the target for 2030 is to reduce the Maternal Mortality Rate (MMR) to below 70/100,000 live births, the Infant Mortality Rate (IMR) by 12/1,000 live births, and the Under-Five Mortality Rate (U5MR) from 25/1,000 (Bappenas, 2020). The Maternal Mortality Rate (MMR) according to the World Health Organization (WHO) in 2020 was 295,000, and the IMR was 2,350,000 (WHO, 2021). According to East Java Health Office data in 2019, the MMR reached 89.81/100,000 live births, and from 2017-2020, the number of infant deaths in East Java decreased, with the IMR decreasing by 12/1,000 live births and the U5MR from 25/1,000 (Bappenas, 2020).

The purpose of this case study is to provide Continuity of Care Midwifery as an effort to reduce risks occurring during pregnancy, childbirth, newborn period, postpartum, and contraceptive selection. Titled Continuity of Care Midwifery for Mrs.

M, 31 Years Old, G1P0A0, 33/34 Weeks Singleton Alive with Breech Presentation + Grade 2 Obesity + CPD + Disability (Speech Impairment) at RSIA Pura Raharja, Surabaya City.

RESEARCH METHOD

In writing this case study, a qualitative descriptive method with the Continuity Of Care (COC) midwifery care model was used, which is a form of continuous midwifery care provided to mothers and babies, starting from the third trimester of pregnancy, childbirth, postpartum care (nifas), newborn care, and extending to family planning program planning.

Data collection in this case study was conducted through the examination of both subjective and objective data, which included anamnesis and physical examination covering vital signs, obstetric examination, and supporting examinations such as laboratory tests, followed by management and evaluation. This is followed by contact or care provision starting from the third trimester of pregnancy until the mother gives birth, and continued with postpartum care until the inter-pregnancy period (Family Planning). In this case study, the subjects used are third-trimester pregnant women, followed by the postpartum process, newborns, and Family Planning for Mrs. M, aged 31, at RSIA Pura Raharja, Surabaya City.

RESULTS AND DISCUSSION

Pregnancy

During her pregnancy, Mrs. M underwent antenatal examinations at the community health center once for pregnancy screening, at an independent midwife's practice three times, and at the obstetrics polyclinic twice, with visit frequencies in the first trimester: three times, in the second trimester: three times, and in the third trimester: three times. According to the theory, antenatal visits should be conducted at least four times during the mother's pregnancy, in accordance with government policy based on WHO regulations (Ministry of Health of the Republic of Indonesia, 2016). Pregnant women's visits to healthcare services are recommended as follows: once in the first trimester, once in the second trimester, and at least twice in the third trimester. (Kemenkes RI 2016).

On 08/11/2024, Mrs. M, 31 years old, with a current gestational age of 33/34 weeks, came for a check-up at the obstetrics clinic with a disability (speech impairment). Mrs. M, assisted by her husband, reported currently experiencing back pain and occasional difficulty sleeping due to frequent urination at night, and active fetal movement. In pregnant women in the third trimester, according to the theory proposed by (Cheung & Lafayette, 2013), frequent urination is reported by 60% of mothers during pregnancy due to increased glomerular filtration rate. It is reported that 59% occurs in the first trimester, 61% in the second trimester, and 81% in the third trimester. The complaint of frequent urination is due to the pressure on the bladder by the enlarging uterus, which reduces bladder capacity and increases urination frequency (Sarifah &

Leonita, 2021).

Results of the subjective data assessment: Last Menstrual Period (LMP) 15/03/2024 and Estimated Due Date (EDD) 22/12/2024, married once (1.5 years), currently first pregnancy, no previous medical history, no allergy history, medication history includes prenatal vitamins and iron supplements.

Results of the objective data examination: general condition good, weight: 81.5 kg, height: 145 cm, blood pressure: 120/70 mmHg, pulse: 78 beats/minute, respiratory rate: 19 breaths/minute, temperature: 37.1 °C, ultrasound examination results: fetal weight appropriate for gestational age, adequate amniotic fluid, fetal heart rate 132 beats/minute, breech position.

Based on the assessment and examination results, the midwifery care for Mrs. M, a 31-year-old G1P0A0 at 33/34 weeks of gestation with a single living fetus in a breech position + grade 2 obesity + CPD + disability (speech impairment), includes: advising the mother to drink more during the day and reduce fluid intake at night to minimize frequent urination while sleeping, teaching the mother the prostration position to avoid the breech position, advising the mother to continue taking prenatal vitamins, and explaining to the mother to return for a follow-up in 2 weeks.

On November 22, 2024, Ms. M, with a gestational age of 35/36 weeks, came for a pregnancy check-up with complaints of cramps and pain in the lower abdomen, and active fetal movements. According to the American Pregnancy Association (APA), cramps usually occur when the uterus expands, causing the ligaments and muscles supporting it to stretch. Cramps are also a sign of contractions or pressure from the baby.

Examination results: Weight: 82 kg, Height: 145 cm, BMI: 39 kg/m², Blood Pressure: 110/70 mmHg, Pulse: 82 beats/minute, Respiratory Rate: 18 breaths/minute, Temperature: 36.7°C, Ultrasound results: Fetal Heart Rate: 144 beats/minute, Amniotic Fluid: Adequate, No umbilical cord entanglement, Fetal Weight: 3420 grams, Baby's head position: Breech.

Midwifery care in collaboration with an obstetrician for Mrs. M, 31 years old, G1P0A0, 35/36 weeks single live fetus in breech position + CPD + obesity + disability (speech impairment): explaining to the mother and family that the examination results are good, and explaining that the breech position of the baby suggests that delivery should be done via C-section to avoid the baby being stuck during vaginal delivery. The mother and family agreed to the C-section delivery on 12/12/2024.

The cesarean section operation was performed to prevent the death of the fetus or the mother due to the dangers or complications that would occur if the mother gave birth vaginally (Sukowati et al, 2010). According to Oxorn (2010), indications for a cesarean section include a narrow pelvis and mechanical dystocia, previous surgery, toxemia gravidarum, and fetal distress indications.

Labor

On 12/12/2024, Ms. M came to RSIA Pura Raharja Surabaya. Ms. M provided a delivery referral indicating that a planned C-section was necessary due to the baby's

breech position and a height of less than 146 cm. Current complaints include active fetal movement and frequent stiffness and cramps in the lower abdomen. According to (Varney, 2015), cephalopelvic disproportion (CPD) describes the mismatch between the size of the fetus and the pelvis to accommodate the passage of the fetus. CPD can cause obstructed labor, and mothers tend to have difficulty delivering normally. In addition to height, the risk factors for CPD include: head size or fetal weight exceeding 4000 grams, obesity, teenage pregnancy, and gestational diabetes.

From the general examination results, Ms. M's general condition is good, with a conscious state, Lila 30 cm, weight: 82 kg, height: 145 cm, BMI: 39 kg/m². (obesitas grade 2). In this examination, Mrs. M is experiencing obesity during pregnancy, where excess weight is a condition of fat accumulation due to an imbalance between energy intake and energy expenditure. A pregnant woman is considered obese if her body mass index (BMI) is greater than or equal to 30 kg/m². Being overweight and obesity are among the high-risk obstetric conditions, proven to be associated with an increased incidence of complications during pregnancy, such as a higher rate of spontaneous abortion, fetal congenital anomalies, fetal growth restriction, impaired glucose tolerance and gestational diabetes, pregnancy-induced hypertension, and even maternal and fetal mortality.

Vital signs examination: BP: 110/70 mmHg, Pulse: 83 beats/min, Temperature: 37.2°C. Obstetric examination: Fundal Height (FH) 31 cm, Fetal Heart Rate (FHR) 132 beats/min, palpation shows hard areas in the fundus and lower abdomen converging and feeling soft. (posisi bayi sungsang). According to Nurdiyana S. (2020). The characteristics of breech delivery are healthy reproductive age, multiparous, term pregnancy (37-42 weeks), delivery performed abdominally (C-section), occurring with normal birth weight. (2500 – 4000 gram). Supporting examination results: Hb 12.3 g/dl, HIV (non-reactive), and HBsAg (non reaktif). Doctor's advice for SC delivery with the diagnosis of Ms. M, 32 years old, G1P0A0, 38/39 weeks single living fetus, CPD + breech presentation + obesity + disability disorder (Speech-impaired).

Newborn

On December 8, 2024, at 1:15 PM, Ms. M gave birth with the initial examination showing: the baby was born crying strongly, skin appeared reddish, active response, good muscle tone, birth weight: 3450 grams, body length: 50 cm, chest circumference: 33 cm, abdominal circumference: 33 cm, heart rate: 142 beats/minute, respiration: 44 breaths/minute, and temperature: 37°C, APGAR score: 8-9. The diagnosis was that Ms. M's newborn was a term neonate according to gestational age.

A normal newborn is a baby born from a pregnancy of 37 to 42 weeks and a birth weight of 2500 - 4000 grams. Signs of a normal newborn include being born at term between 37-42 weeks, a weight of 2500 - 4000 grams, a length of 48 - 52 cm, a chest circumference of 30 - 38 cm, a head circumference of 33 - 35 cm, a heart rate of 120-160 beats/minute, a respiratory rate of ± 40 - 60 breaths/minute, reddish and smooth skin due to sufficient subcutaneous tissue, an APGAR score > 7, active movements, and the baby crying strongly immediately after birth.

At this stage of midwifery care, among other things, keeping the baby warm, suctioning mucus, performing umbilical cord care with triple D, then skin-to-skin contact for IMD. After that, a 1 mg vitamin K injection is given in the left thigh, followed by eye ointment, physical examination, and 1-2 hours later, a 0.5 IM Hepatitis B vaccination is given in the right thigh. In accordance with the Minister of Health Regulation No. 25 of the year (2014).

Postpartum

First postpartum visit (PPV1) at 6 hours post-CS. Ms. M complained of still feeling drowsy and experiencing pain at the surgical site after being moved from the recovery room to the inpatient room. The patient reported having passed gas and being able to mobilize slightly to the right and left. General examination of Ms. M: BP 110/60 mmHg, pulse 78 bpm, temperature 36.6 °C, RR 20 breaths/min. the condition of the surgical wound is good, no seepage, UT. 300 cc. The height of the uterine fundus is 2 fingers below the navel, uterine contraction is good, bleeding is 20 cc dark red. (lockhea rubra). Lochia is a fluid that originates from the uterine cavity and vagina during the postpartum period. Lochia rubra, lasting 1-3 days, is red in color due to the presence of fresh blood and remnants of the amniotic membrane, decidua, and vernix caseosa. Lochia sanguinolenta, yellow-red in color, contains blood and lasts 3-7 days. Lochia serosa, yellow in color due to the presence of serum, decidual tissue, leukocytes, and erythrocytes, lasts 7-14 days. Lochia alba, white in color, consists of leukocytes and decidual cells and lasts for the next 14 days to 2 weeks.

Midwifery care for Mrs. M 6 hours post-C-section includes preventing postpartum hemorrhage due to uterine atony, providing counseling and explanations on how to prevent bleeding due to uterine atony to the mother and family, teaching exclusive breastfeeding as an effort to increase oxytocin hormone which helps keep the uterus contracted to prevent uterine atony and bleeding. Helping with personal hygiene by wiping and changing the mother's clothes, and advising the mother to rest and mobilize adequately.

Second postpartum visit (KF2) on the 7th day post-delivery, Mrs. M came for stitch control at the obstetrics clinic with complaints of reduced surgical wound pain, normal bowel/bladder movements, lochia still reddish-brown, and lower abdominal pain, with smooth breastfeeding. General examination: general condition good, BP 120/70 mmHg, pulse 80 x/minute, RR 18 x/minute, T 37°C, height of the uterine fundus mid-pubis to symphysis, uterine contraction good and surgical wound condition good, pus (-), dry stitches with no seepage.

Midwifery care for Mrs. M post-C-section 7 days is as follows: performing wound care, ensuring the mother has no fever and no signs of infection, ensuring the mother can breastfeed in the correct position, advising the mother to drink enough fluids and eat nutritious food for recovery and to increase breast milk production. Inform the mother and family that if there are any complaints at any time, they should immediately go to the nearest healthcare facility. Signs of danger during the postpartum period include

bleeding, fever lasting more than two days, foul-smelling discharge from the birth canal, swollen and painful red breasts, preeclampsia, and depression (Kemenkes, 2020).

Family Planning

Family planning is an important point that must be prepared after marriage. With thorough family planning, couples can develop themselves and their careers. The ability to plan pregnancies, including choosing contraception, is also believed to improve mental health and happiness for women.

According to BKKBN, IUD stands for intrauterine device, which can also be referred to as a spiral contraceptive made of plastic and shaped like the letter T, inserted into the uterus to prevent pregnancy. The advantages of the IUD are that it can be removed at any time, is non-hormonal, and long-term.

Mrs. M, with her husband's approval, has been using the IUD, which was inserted during her C-section delivery. Mrs. M and her husband feel that the IUD is the right contraceptive for her given her excess weight and C-section delivery. Therefore, based on the doctor's explanation, they both agreed to use the IUD. examination results: general condition good, conscious and alert, blood pressure 110/60 mmHg, pulse 78 beats/minute, temperature 36.6 °C, respiratory rate 20 breaths/minute. Ultrasound examination results: IUD position good.

CONCLUSION

Fundamental Finding : Continuous Midwifery Care for Mrs. M at RSIA Pura Raharja Surabaya shows success in managing high-risk pregnancies with complications such as breech presentation, obesity, and disability (speech impairment), through safe cesarean delivery and optimal postpartum care. **Implication :** The application of comprehensive and individualized midwifery care can enhance the quality of service, the safety of mothers and babies, as well as patient and family satisfaction, especially in cases of high-risk pregnancies. **Limitation :** This study is descriptive in nature and based on a single case, so it cannot yet be generalized to a larger population with similar risk characteristics. **Future Research :** Further research with a comparative or longitudinal study design on a larger population is needed to evaluate the effectiveness of continuous midwifery care in managing various high-risk pregnancy conditions.

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