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Midwifery Care Continuity Of Care (COC) Mrs. B, 39 Years Old, G4 P2012, 37/38 Weeks Of Gestation + IUFD Notopuro Regional General Hospital, Sidoarjo

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ABSTRACT

Objective: *This study aims to analyze the implementation of Continuity of Care (COC) midwifery care for Mrs. B, a 39-year-old woman (G4 P2012) at 37/38 weeks of gestation with Intrauterine Fetal Death (IUFD) at Notopuro Regional General Hospital, Sidoarjo. The study emphasizes holistic care addressing physical, psychological, social, and spiritual needs.* ***Method:*** *A descriptive case study approach was employed to provide an in-depth analysis of Mrs. B's condition. Data were collected through interviews, direct observations, and medical record reviews. The focus of care included pregnancy management, delivery, postpartum care, and psychosocial support.* ***Results:*** *The COC approach effectively facilitated comprehensive care for Mrs. B, integrating medical management of IUFD and psychosocial support to address emotional distress due to fetal loss and abandonment by her spouse. This care model promoted physical recovery and emotional resilience, contributing to Mrs. B's readiness for future reproductive health planning.* ***Novelty:*** *This study highlights the critical role of COC in managing IUFD cases by integrating continuous, patient-centered care that extends beyond physical treatment to encompass psychosocial recovery. The findings underscore the importance of personalized support systems for high-risk pregnancies to improve maternal health outcomes holistically.*

INTRODUCTION

Pregnancy is a physiological process that often brings significant changes in a woman's life. However, not all pregnancies proceed normally, as some may be accompanied by complications that have serious impacts, both physically and psychologically. One of the complications that can occur is Intrauterine Fetal Death (IUFD), which is the death of the fetus in the womb after 20 weeks of gestation. Based on WHO data (2021), it is estimated that around 2 million cases of IUFD occur each year worldwide, with the majority happening in developing countries. IUFD not only has physical impacts on the mother but also triggers psychosocial issues such as depression, anxiety, and post-traumatic stress [1].

The case of Mrs. B, a 39-year-old woman with a history of G4 P2012 at 37/38 weeks of gestation, illustrates the complexity of IUFD issues. In addition to facing the loss of the fetus, Mrs. B also has to deal with psychosocial issues due to being abandoned by her husband during the pregnancy. This situation highlights the importance of implementing midwifery care based on Continuity of Care (COC), which emphasizes holistic and continuous support to meet the mother's needs in physical, psychological, social, and spiritual aspects [2].

The COC approach is highly relevant in this case, as it enables healthcare professionals to provide comprehensive care, starting from the identification and management of IUFD, psychosocial support, to future pregnancy planning. Studies show that the COC model can not only improve maternal health but also help prevent future complications (Smith et al., 2020). Through continuous support, mothers who experience fetal loss can be better facilitated to recover both physically and mentally.

With this background, midwifery care in complex cases like Mrs. B's becomes important to ensure that the mother receives appropriate, needs-based, and sustainable care. This not only helps the mother in facing the existing challenges but also contributes to the overall improvement of maternal healthcare services.

RESEARCH METHOD

The research method used in this midwifery care is descriptive research with a case study type of research. This approach is used to conduct an in-depth investigation of an issue through a single unit, in this case, Mrs. B, 39 years old, G4P2012, with a gestational age of 37/38 weeks who experienced IUFD (Intrauterine Fetal Death). This case study analyzes various aspects related to Mrs. B's condition, including factors affecting her pregnancy, medical and obstetric actions taken, and Mrs. B's reactions to the interventions provided [4].

The research subjects were selected purposively, based on specific criteria relevant to the research objectives. The main subject is Mrs. B, who experienced pregnancy complications, while additional data were obtained from healthcare workers involved in the management of this case. The focus of care includes pregnancy, the delivery process, postpartum, and post-IUFD care. This approach allows for an in-depth analysis of the subject's condition and the clinical decision-making process by the medical team [5].

Data were collected through interviews with Mrs. B, direct observation during the midwifery care process, and review of medical records to obtain information on pregnancy history and medical actions. Data analysis was conducted using descriptive methods to detail each stage of midwifery care provided. The validity of the data is ensured through source triangulation, which involves comparing the results of interviews, observations, and medical record documents.

This research pays attention to the principles of research ethics by obtaining informed consent from subjects, maintaining the confidentiality of identities, and respecting the rights of subjects. The results of this study are expected to contribute to the development of midwifery care practices in cases of pregnancy with IUFD complications.

RESULTS AND DISCUSSION

Pregnancy

During her pregnancy, Mrs. B, 39 years old, G4P2012, made six visits to healthcare facilities. In the first trimester, Mrs. B made two visits, during which she reported mild nausea and vomiting consistent with normal pregnancy symptoms. These complaints

occur due to hormonal changes, particularly the increase in hCG hormone levels, which are commonly experienced by pregnant women in the early stages of pregnancy [8].

In the second trimester, Mrs. B made three visits to the midwife. At 22 weeks of gestation, Mrs. B complained of intermittent dizziness. This is in accordance with the theory of Khairoh and Miftahul (2019) which states that dizziness during the second trimester of pregnancy can be caused by hormonal changes, postural hypertension, or fatigue. The midwife advised Mrs. B to consume nutritious food, meet her fluid needs, and get enough rest [7].

At 28 weeks of pregnancy, Mrs. B complained of leg cramps, especially at night. Leg cramps in the second and third trimesters often occur due to increased pressure on the leg muscles, changes in blood circulation, or mineral deficiencies such as magnesium and calcium [9]. To address this, midwives provide education on the importance of consuming calcium-rich foods, doing light stretches before bed, and avoiding standing for too long.

In the third trimester, Mrs. B returned for three visits. At 31 weeks of gestation, Mrs. B complained of more vaginal discharge than usual, but without any itching or unpleasant odor. According to Marmi (2011), increased vaginal secretion during the third trimester is normal due to increased estrogen levels and blood flow to the pelvic area. Midwives provide education on the importance of maintaining genital hygiene by washing with clean water, avoiding the use of scented soaps that can cause irritation, and promptly changing underwear if it becomes wet [8].

However, at 37 weeks of pregnancy, Mrs. B did not feel fetal movements for more than 12 hours. An ultrasound examination (USG) at RSUD NOTOPURO confirmed the diagnosis of IUFD (Intrauterine Fetal Death). IUFD in advanced pregnancy is often associated with complications such as hypertension in pregnancy, gestational diabetes, or infections, although in some cases the cause can be idiopathic (Kemenkes RI, 2020). In Ms. B's case, older age and psychological stress due to her husband's abandonment also have the potential to affect her pregnancy condition.

The midwifery approach for Ms. B was carried out with consideration of her physical and emotional condition. The midwife collaborated with the obstetrician to plan the delivery process and provide psychosocial support to help Ms. B cope with the loss of her fetus. This handling refers to the guidelines from the Indonesian Ministry of Health (2020) which emphasize a holistic approach to IUFD cases, including a comprehensive evaluation of the mother's condition as well as psychological and spiritual support.

Childbirth

Ms. B arrived at RSUD NOTOPURO on September 9, 2024, with a gestational age of 37/38 weeks and a diagnosis of Intrauterine Fetal Death (IUFD). No cervical dilation was found during the initial examination. Considering the gestational age and the higher risk of complications if the IUFD pregnancy is not terminated promptly, the medical team recommends termination of the pregnancy through labor induction.

The induction process begins with the administration of misoprostol intravaginally to ripen the cervix until the pelvic score reaches more than 5. Misoprostol, a synthetic prostaglandin often used for labor induction, works by stimulating uterine contractions and softening and dilating the cervix [10]. After two doses of misoprostol given at six-hour intervals, Ms. B's pelvic score increased to 6.

After the cervix is considered sufficiently mature, it is followed by the administration of an oxytocin drip to induce more regular uterine contractions. Oxytocin, a uterotonic hormone, is recommended in the Kemenkes RI (2020) childbirth guidelines to improve the efficiency of labor. The dose of oxytocin is titrated slowly according to protocol, with close monitoring of contraction patterns, maternal vital signs, and uterine response [6].

At 2:00 PM WIB, after about six hours of administering oxytocin, Mrs. B began to show signs of the active phase of labor with progressive cervical dilation. The midwife team provided full support during the delivery process, both physically and emotionally, considering Mrs. B's vulnerable psychological condition due to the loss of her fetus and the emotional burden of being abandoned by her husband.

At 8:30 PM WIB, the baby was born spontaneously weighing 3,200 grams, measuring 49 cm, and in IUFD condition. After birth, the placenta was successfully delivered completely without complications such as postpartum hemorrhage. Active Management of the Third Stage of Labor (AMTSL) was performed, including the administration of a single intramuscular dose of oxytocin to prevent postpartum hemorrhage [12].

During the labor process, the healthcare team also focuses on providing psychological support for Mrs. B. Full support from the midwife is necessary to help Mrs. B cope with feelings of loss and prevent the occurrence of postpartum depression, which is more common in mothers with a history of IUFD [13].

The management of IUFD delivery in this case is in accordance with obstetric service standards that emphasize a holistic and evidence-based approach. The healthcare team also ensured that Ms. B received complete information about her condition and prognosis to enhance her confidence and involvement in decision-making during the delivery process.

Childbirth

Postpartum Period in the Hospital

After giving birth on September 9, 2024, Mrs. B underwent postpartum care at RSUD NOTOPURO for three days for intensive monitoring. On the first day, the vital signs examination showed blood pressure 120/80 mmHg, body temperature 36.8°C, and a pulse rate of 80 beats per minute. Bleeding within normal limits with moderate lochia rubra. The fundus uteri is palpable below the umbilicus with a firm consistency, indicating a well-progressing involution process [6].

The midwife provided education on perineal care and pain management. Ms. B was also given analgesics as per the doctor's recommendation to alleviate pain from

uterine contractions (afterpains) and perineal wounds, as well as cripsa tablets to inhibit breast milk production. To prevent thrombosis, the midwife recommends early mobilization and paying attention fluid and nutrient intake. The patient was also given iron and vitamin supplements to expedite recovery [14].

On the second and third days, the medical team continued to monitor Mrs. B's physical and psychological condition. Although her physical condition is stable, Mrs. B shows signs of emotional stress due to the loss of her baby and family conflicts. Therefore, psychological counseling was provided to support the process of self-acceptance and mental recovery. The patient was allowed to go home on the third day with instructions for a postpartum check-up within seven days.

Postpartum Period After Returning Home

After being discharged from the hospital, the midwife continued to monitor Mrs. B through home visits and remote communication. The first visit was conducted one week after childbirth. During this visit, the midwife ensured that the conditions of uterine involution, lochia, and perineal wounds remained good. The uterine fundus was palpated but could not be measured, and the lochia changed to serosa, in accordance with the normal progression of the postpartum period [15]. Ms. B reported no significant physical complaints, but still feels anxious and sad.

The midwife continues to provide psychological support using therapeutic communication techniques. Education about the importance of maintaining a proper diet, hydration, and adequate rest is still emphasized. Mrs. B was also advised to engage in light activities at home to improve blood circulation and prevent postpartum complications, such as infections or thrombosis.

Postpartum Checkup

At the second check-up, four weeks after childbirth, Mrs. B's physical condition was fully stable. However, the feeling of loss remains a challenge. The midwife collaborates with a psychologist to continuously support the patient's mental health. Ms. B was also provided with information about suitable contraceptive methods to prevent future pregnancies, considering her age and complex obstetric history (Ministry of Health of the Republic of Indonesia, 2020).

Family Planning

After the postpartum period of Mrs. B, one of the important interventions in midwifery care is providing education on family planning (FP). Postpartum and considering her age as well as her physical and mental condition, Mrs. B needs a holistic approach in choosing the appropriate family planning method. At the age of 39 and after experiencing a fetal loss (IUFD), as well as facing severe household problems due to her husband leaving, Mrs. B requires special attention in family planning that can support her physical and emotional well-being.

Selection of Family Planning Methods

During the first postpartum visit, the midwife evaluated Mrs. B's condition and identified factors that need to be considered in choosing a contraceptive method. Mrs. B

stated that she does not plan to get pregnant in the near future considering the emotional factors she is currently facing. Therefore, the selection of contraceptive methods needs to consider the patient's age, medical history, and psychological comfort.

Based on the recommendations of the Indonesian Ministry of Health (2020), several methods that can be considered for older women (≥35 years) who have just given birth, such as Mrs. B, include hormonal contraception (birth control pills, injections, implants), IUD (Intrauterine Device), or sterilization. In this case, after counseling on various contraceptive options, Mrs. B chose to use an IUD (intrauterine device) because this method is effective, can be used long-term, and does not affect hormones that could worsen her emotional condition [16].

Implementation of Family Planning

During the family planning control visit conducted two months after delivery, the midwife performed the IUD insertion with a procedure that was safe and comfortable for Ms. B. During the procedure, Mrs. B showed anxiety, which is a common reaction after a pregnancy with complications such as IUFD. The midwife provided an explanation about the IUD insertion process, as well as the possible side effects that may arise, such as changes in menstrual patterns and mild pain in the first few days after insertion [11]. Additionally, it is important for Ms. B to undergo follow-up monitoring in the first three months after the IUD insertion.

After the IUD insertion, the midwife provided education on the importance of routine check-ups every three months to ensure the IUD remains in the correct position and to prevent complications, as well as offering psychological support to help Ms. B through the emotional and physical recovery process post-delivery and miscarriage. Thus, this family planning program not only targets physical aspects but also pays attention to the patient's mental health.

Continued Support

For several months after the IUD insertion, Ms. B had regular check-ups with the midwife. During each visit, the midwife evaluates Mrs. B's physical and psychological condition, including the emotional impact of using the contraceptive device. In each visit, Mrs. B feels more at ease knowing that she does not have to worry about an unwanted pregnancy in the near future.

A holistic approach, which involves physical examinations, education about reproductive health, and psychological counseling, is important in family planning for patients with complex cases like Mrs. B. The selection of the appropriate contraceptive method based on personal needs and conditions, along with continuous support, ensures that Mrs. B can plan her family's future better.

Several changes in aspects that occurred in Ms. B are as follows:

Psychological Aspects

1. Grief and Loss: The mother experiences profound sadness due to the loss of the long-awaited baby. These feelings can trigger depression, anxiety, and sleep disturbances.

2. Guilt: The mother may feel guilty because she feels unable to protect her baby. This can worsen the sadness and create feelings of worthlessness.
3. Fear: The mother may experience fear regarding the next pregnancy or fear of losing another baby.
4. Feeling of Identity Loss: The mother may feel a loss of identity as a mother because her baby could not be born.

Psychosexual Aspect

1. Difficulties in Intimate Relationships: The loss of a baby can affect intimate relationships, and since the mother was also abandoned by her husband, she may have difficulty rebuilding her sexual relationship.
2. Discomfort with the Body: Mothers may feel uncomfortable with their bodies due to physical changes during pregnancy and childbirth.
3. Difficulty in Self-Acceptance: The mother may have difficulty accepting herself as a mother who cannot give birth to a healthy baby.
4. Feeling of Losing Control: The mother may feel a loss of control over her body and pregnancy.

Social Aspect

1. Social Support: Mothers need social support from family, friends, and the community to cope with grief.
2. Expression of Condolences: Expressions of condolences from close friends and family can help the mother cope with her grief.
3. Mental Health Services: The mother needs professional mental health services to address depression, anxiety, and sleep disorders.

How to Overcome

1. Cognitive Therapy: Cognitive therapy can help mothers change negative thought patterns.
2. Family Support: Family support is very important to help the mother cope with grief.
3. Physical Activity: Physical activity can help reduce stress and improve mood.
4. Treatment: Treatment can help address depression, anxiety, and sleep disorders.
5. Reproductive Health Services: Reproductive health services can help mothers understand and address issues with subsequent pregnancies.

It is important to remember that each individual has different experiences and reactions. Therefore, it is important to understand and support mothers who experience the loss of a baby in the womb.

CONCLUSION

Fundamental Finding : The Continuity of Care (COC) midwifery approach for Mrs. B, a 39-year-old pregnant woman with a history of intrauterine fetal death (IUFD) at 37/38 weeks of gestation, highlights the significance of a holistic and continuous care model that addresses both physical and emotional well-being throughout pregnancy,

childbirth, postpartum, and contraceptive use. **Implication :** This comprehensive care strategy emphasizes the necessity of integrating psychosocial support and personalized family planning to improve maternal health outcomes, particularly for mothers with high-risk pregnancies and emotional distress. **Limitation :** However, this case study is limited by its focus on a single patient, which may restrict the generalizability of the findings to broader populations with varying socio-economic and health backgrounds. **Future Research :** Further research should explore the effectiveness of COC interventions across diverse patient groups and investigate specific psychosocial support mechanisms that can enhance recovery and reproductive health decision-making in postpartum women with similar complications.

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