Case Report

MIDWIFERY CARE FOR MRS. D IN A VILLAGE, SUB-DISTRICT INGIN JAYA, THE DISTRICT OF ACEH BESAR

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ABSTRACT

Maternal and child health issues are crucial issues in healthcare because they directly impact the quality of future generations. One of the leading indicators of a country's health is the Maternal Mortality Rate (MMR). A high MMR indicates low-quality maternal healthcare services, including suboptimal antenatal care (ANC). Indonesia still faces challenges in reducing MMR, particularly in areas such as Aceh Besar Regency, which has a high maternal mortality rate.

The purpose of this case report is to provide midwifery care for Mrs. D in Ajee Cut Village, Ingin Jaya District, Aceh Besar Regency, and document the results in a SOAP (Social Action Plan). The first care was provided on February 14, 2025. After data collection, the mother complained of fatigue. The examination results indicated that the mother's and fetus's conditions were within normal limits. Based on the analysis, the mother, a G2P1A0 woman at 34 weeks and 5 days of gestation, was in good condition. The care provided included education on the causes of the complaints, how to manage them, nutritional needs during the third trimester, and danger signs of pregnancy. The mother demonstrated a good understanding and was willing to follow the recommendations. Follow-up care will be provided at the next visit according to the needs and development of the mother's pregnancy.

Keywords: Midwifery care, Pregnancy, sub-district Ingin Jaya, The district of Aceh Besar

INTRODUCTION

The Maternal Mortality Rate (MMR) is the death of a woman during pregnancy or within 42 days of delivery, deaths caused by pregnancy, childbirth, and postpartum, not due to other causes such as accidents.[1]. According to the World Health Organization (WHO), an estimated 287,000 maternal deaths occurred in 2020. The global MMR was 223 per 100,000 live births. This equates to 800 maternal deaths every day, or one maternal death every two minutes worldwide. [2].

Maternal mortality is a complex issue involving health, social, and economic impacts. Low-income countries have higher MMR 3. MMR in Sub-Saharan Africa is very high, around 545 per 100,000 live births. This figure accounts for around 70% of maternal deaths globally in 2020. MMR in Southeast Asia is 210 per 100,000 live

births [2]. Meanwhile, MMR in Indonesia is much higher than in neighboring countries such as Vietnam and China.[3]

According to the Indonesian Ministry of Health, the number of maternal deaths in Indonesia in 2023 was 4,482, an increase from 3,572 in 2022. The most common causes of maternal death were hypertension in pregnancy (412 cases), obstetric hemorrhage (360 cases), and obstetric complications (204 cases). [4]. Over the past five years, maternal mortality in Aceh province has decreased significantly compared to 2019. The number of maternal deaths in 2019 was 172 per 100,000 live births, and in 2022 it was 141/100,000 live births. The highest number of maternal deaths in 2022 occurred in the East Aceh district, with 14 deaths. [5]. Meanwhile, the Aceh Besar District Health Office recorded that the maternal mortality rate (MMR) in 2022 was 11, consisting of 6 pregnant women, one woman giving birth, and four postpartum women.[6].

The most common direct causes of the high MMR were hemorrhage (28%), infection (11%), and eclampsia (24%). A total of 529,000 women died from pregnancy and childbirth complications in 2000, and several others suffered disabilities. This mortality ratio is estimated at 400/100,000 live births. [7]. This is all because pregnant women are unaware of the importance of antenatal care (ANC).

Antenatal care is a regular pregnancy checkup to assess the condition of the mother and fetus, and then take corrective action to address any problems found. The goal is to identify issues that arise during pregnancy so that the health of the pregnant woman can be maintained and, most importantly, the health of the mother and baby until delivery. Most causes of MMR can be prevented through providing quality prenatal care.[8]

As one of the Sustainable Development Goals (SDGs), the global maternal mortality rate (MMR) target is 70 per 100,000 live births by 2030. The MMR in Indonesia remains well above the ASEAN average of 40 to 60 per 100,000 live births, while in Singapore it is very low, at only 2-3 per 100,000 live births. [8]. Improvements in the quality of maternal health services are needed to achieve this target, such as standardized ANC services, delivery assistance by trained medical personnel, optimal postpartum care, and specialized care and referrals in case of complications. [9].

The coverage of maternal health services for the fourth visit (K4) in Indonesia in 2023 was 85.6%, up from 86.2% in 2022. [4]. The achievement of maternal visits for the fourth visit (K4) in Aceh province in 2023 was 76.0%, while the coverage of services for the sixth visit (K6) reached 53.7%. Meanwhile, in Aceh Besar Regency, the coverage of pregnant women's fourth visit (K4) was 81.8%. [6]. Based on data from Ingin Jaya Community Health

Center in 2024, 478 pregnant women made their first ANC visit (K1), and 449 made their fourth visit (K4). Meanwhile, the number of pregnant women who made their sixth visit (K6) was 363.

Midwives play a key role in reducing the maternal mortality rate (MMR) through the provision of quality prenatal care. Routine antenatal care (ANC) check-ups and education for pregnant women about the importance of prenatal care are key steps in preventing or reducing MMR. In Indonesia, health programs for pregnant women include standardized antenatal care (ANC) services, the Healthy Indonesia Program with a Family Approach (PIS-PK), the Iron Supplement (TTD) program, pregnancy classes, and the Integrated Health Post (Posyandu) program, which functions as a primary care center. All these programs aim to increase awareness, knowledge, and early detection of complications during pregnancy.[10]

Meanwhile, in developed countries, such as Sweden and Japan, maternal health programs focus not only on routine check-ups but also on family-centered care, psychosocial support, nutrition and mental health consultations, and regular home visits by midwives or nurses. In the UK, the NHS Maternity Transformation program even provides a digital app for pregnancy monitoring and direct access to healthcare services.[11]

A striking difference between programs in Indonesia and those abroad lies in service integration and access to technology. Developed countries tend to integrate maternal health services more effectively into digital systems and provide ongoing psychosocial support. Meanwhile, Indonesia still faces challenges in equitable access to services, the quality of health workers, and community awareness in remote areas. [12].

Evidence-based midwifery emphasizes the importance of family involvement in supporting pregnant women. Recent research shows that family support can improve maternal adherence to antenatal care (ANC) visits, reduce anxiety during pregnancy, and strengthen the bond between mother and fetus. The Family-Centered Maternity Care (FCMC) model is effective in increasing family support and postpartum maternal self-efficacy in breastfeeding. Furthermore, other studies have shown that family support significantly influences adherence to ANC visits, which positively impacts maternal and infant health. [13].

The purpose of this case report is to implement midwifery care for Mrs D, with a gestational age of 34 weeks, in Ajee Cut Village, Ingin Jaya Sub-District, the district of Aceh Besar, and to document using the midwifery documentation method (SOAP).

CASE

This case report was made on Friday, February 14, 2024, at 3:00 PM WIB and located in A village, Ingin Jaya

sub-District, the district of Aceh Besar. The subject of this case report is Mrs. D, 27 years old and living in the village. Subjective data obtained: this is her second pregnancy, and she has never had a miscarriage before, and is very happy with the current pregnancy. The mother said she had no complaints. The mother said that during her pregnancy, she often took morning walks and did housework as part of her daily routine. The mother said she had no history of systemic or hereditary diseases. The first day of her last menstrual period was June 15, 2024.

Objective data from the examination results are: Good general condition, Composmentis awareness. Anthropometric examination results: Height: 160 cm, Weight: 60 kg (before pregnancy: 56 kg), BMI: 21.8, MUAC: 24.5 cm, estimated date of delivery: March 22, 2025. Vital sign examination results: BP: 110/80 mmHg, pulse: 80 x/minute, respiration: 20x/minute, and temperature: 36.7 °C.

Physical examination results: eyes: red conjunctiva and sclera are not icteric. No thyroid gland swelling in the neck. Breasts: Protruding papillae, darkened areola, and no milk secretion. No surgical scars on the abdomen. Palpation results: Uterine fundal height: 26 cm (midpoint of the Xiphoideus Process (PX) - Center), the fundus is felt to be round and not bouncy (buttocks), the fetal back is on the mother's left. The lowest part of the fetus is supposed to be round, complex, and bouncy (head), and the fetus has not entered the pelvic inlet (convergent). Estimated fetal weight (EFW): 2,170 grams. Auscultation results: fetal heart rate (FHR): 140x/minute and no contractions. Genital examination: no swelling in the Bartholin's glands and Skene's glands. Extremity examination results: no edema and varicose veins in both legs. Patellar reflex: right (+) and left (+). Assessment results based on subjective and objective data are the second pregnant mother, who gave birth once and never miscarried (G2P1A0), gestational age 34 weeks 5 days, and the condition of the mother and fetus is good.

The planning and management of this case are as follows:

1) Inform the mother of the examination results that she has entered 34 weeks and 5 days of pregnancy. Both mother and fetus are in good condition.
2) Instruct the mother to increase her frequency of eating to 5–6 times per day in small, frequent portions and to consume high-calorie, nutrient-dense foods such as nuts, avocados, eggs, and lean meats. She should also increase her intake of complex carbohydrates and animal protein, and drink enough water to prepare for breast milk production and weight gain. The nutritional needs of pregnant women in the third trimester are approximately 2,450 kcal/day.

3) Encourage the mother to get sufficient rest, 1–2 hours during the day and 7–8 hours at night.
4) Remind the mother to continue taking the iron supplement once daily to prevent iron deficiency in pregnant women. It is recommended that the iron supplement be taken not with tea or coffee, as these can interfere with absorption. Instead, it should be taken with water or with a vitamin C tablet to accelerate iron absorption.
5) Explain to the mother about danger signs in pregnancy, namely vaginal bleeding, severe headache, swelling of the face and hands, heartburn, blurred vision, premature rupture of membranes, and lack of fetal movement.
6) Inform and remind the mother about labor preparations, such as: a). Estimated delivery date, b) Funds, c) Place of delivery, d) Transportation, e) Birth companion, f) Blood donation, g. Preparing a bag of maternal and infant needs.
7) Advise the mother to immediately go to a health facility if any complaints interfere with the mother's activities.

After providing education, the researcher, who is also a midwife, evaluates the mother's understanding of the information conveyed. Evaluation results: The mother can repeat what was expressed during the care and understands the explanation.

The evaluation of the implementation of midwifery care was conducted on Tuesday, February 25, 2024, at 4:00 PM WIB at the mother's home. Evaluation results: The mother has started eating tofu, tempeh, eggs, meat, vegetables, and fruit. The mother has also started taking 1-2 hour naps every day. She has also prepared clothes and other necessities for delivery. During this visit, the mother reported no complaints. The midwife then provided education on breastfeeding preparation during pregnancy, signs of labor, Early Initiation of Breastfeeding (IMD), and postpartum family planning. The mother understood what was explained.

DISCUSSION

A healthy pregnancy requires physical and mental preparation. Pregnancy planning should begin before conception. A well-planned pregnancy will positively impact the fetus's condition and improve the mother's physical and psychological adaptation to pregnancy. Preparatory measures for pregnancy include managing the mother's nutrition. Good nutrition also plays a role in the formation of healthy sperm and eggs. Good nutrition plays a role in preventing anemia during pregnancy, bleeding, infection, and pregnancy complications such as congenital abnormalities. [14].

In this case, the mother's complaint of fatigue is a discomfort experienced during the third trimester of pregnancy. Fatigue is caused by anatomical and physiological changes in the body due to fetal growth, including

weight gain, abdominal enlargement, and increased uterine fundal height. Physical changes in pregnant women, especially in the third trimester, can cause various discomforts such as frequent urination, shortness of breath, back pain, heartburn, constipation, insomnia, dyspnea, perineal discomfort, calf muscle cramps, varicose veins, ankle edema, Braxton Hicks contractions, mood swings, and increased anxiety. [15].

Counselling provided to mothers focuses on meeting nutritional needs during the third trimester of pregnancy. During this period, a pregnant woman's daily energy needs increase to approximately 2,450 kcal to support fetal growth, placental development, and physiological changes in the mother's body. The ideal total weight gain during pregnancy is estimated to be around 11.5 kg, depending on pre-pregnancy nutritional status. To help meet these daily calorie needs, mothers are advised to consume a balanced, nutritious diet consisting of complex carbohydrates (such as brown rice, potatoes, or whole wheat bread), animal and plant proteins (such as eggs, fish, tofu, tempeh), healthy fats (such as avocado, nuts, and olive oil), and fresh fruits and vegetables rich in vitamins and minerals. Furthermore, mothers are also advised to eat small, frequent meals (4–5 times a day) to maintain a stable energy intake and prevent nausea or bloating. This education is provided to help mothers maintain a healthy diet, meet daily calorie needs, and support optimal fetal growth and development. [16].

Meanwhile, water is the best source of fluid and aids digestion, removes toxins, is a component of blood cells, regulates the body's acid-base balance, and helps regulate body temperature. Water needs increase during pregnancy to support fetal circulation, amniotic fluid production, and increase blood volume. Pregnant women need to drink 2-3 Liters of water per day (8-12 glasses). [17].

The following counselling session focused on the benefits of iron for pregnant women to prevent iron deficiency. Iron tablets should be taken regularly once daily, with a minimum of 90 tablets taken throughout pregnancy.[18] Next, counselling about adequate rest for pregnant women, namely a minimum of 7-8 hours at night and 1-2 hours during the day [19].

Mothers should know and understand the danger signs that often occur during pregnancy, such as vaginal bleeding, severe headaches, blurred vision, swelling of the face and hands, vaginal discharge, decreased fetal movement, and severe abdominal pain. The first care has been carried out, and the mother feels delighted with the pregnancy she has been waiting for. During this pregnancy, the mother has implemented a healthy lifestyle, including light exercise such as walking and gymnastics. During the care given, the mother is very attentive and always

ready to ask anything she does not understand about her pregnancy [21].

CONCLUSION

Midwifery care was provided to a pregnant woman, Mrs. D, in Village A, Darul Imarah District, Aceh Besar Regency, on February 14, 2025. The mother was 27 years old. The examination results showed that the mother was 34 weeks and 5 days pregnant, with a history of pregnancy: second pregnancy, one birth, and no miscarriage (G2P1A0). The estimated delivery date was March 22, 2025. The mother's and the fetus's condition was good. The midwife provided counselling on nutritional needs during pregnancy, including water, adequate rest, P4K, and signs of pregnancy danger. The mother understood what the midwife or researcher conveyed.

ETHICS APPROVAL

Pregnant women and witnesses (health center midwives) sign informed consent forms before care is provided.

CONFLICT OF INTERESTS

The research team declares that there is no conflict of interest in this research.

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