

Early Detection of Maternal and Infant Health with Sustainable Midwifery Services



Helyv Yunida

Widyaiswara BBPK Ciloto-Indonesia, Mahasiswa Pasca Sarjana Universitas Negeri Jakarta-Indonesia

ABSTRACT: Continuity of care is continuous midwifery care starting from the mother during pregnancy until the mother experiences premenopause. At this time a woman needs good health services to avoid reproductive diseases so that she can carry out her role as a woman optimally, so as to prevent maternal and infant morbidity and mortality. This research design uses the SCLR (Study Case Literature Review) method. After the author carried out midwifery care using a comprehensive approach and SOAP documentation on Mrs. F from pregnancy, childbirth, postpartum, and BBL starting from January 4, 2022 - February 5 2022. Then the author will compare whether there is a gap or not, the gap between the care provided already given and existing theory. In pregnancy F has had midwifery care and no discrepancy was found between theory and real cases, Mrs. F received an examination according to the theory of pregnancy. Maternity care for Mrs. F there is no gap between the theory and the real case. Postpartum care for Mrs. F there is no gap between the theory and the real case. Mrs. F received 3 visits, namely: 6 hours, 6 days and 28 days of postpartum visits. Mrs. F is having a good postpartum period. Postpartum care for Mrs. F there is no gap between the theory and the real case. Mrs. F received 3 visits, namely: 6 hours, 6 days and 28 days of postpartum visits. Mrs. F is having a good postpartum period. Newborn care for Mrs. F there is no gap between the theory and the real case. BBL with good general condition, with normal vital signs. Strong in breastfeeding, after 28 days can 1 hour BBL suckle breast milk. Family planning care for Mrs. F there is no gap between the theory and the real case. After counseling Mrs. F chooses a 3-month injection KB with the approval of her husband. Planning to become a family planning acceptor for 3 months for 5 years.

KEYWORDS: Early Detection, maternal, Infant, midwifery services

PRELIMINARY

According to the WHO definition in Sarwono (2016: 7) maternal death is the death of a woman during pregnancy or during pregnancy within 42 days. Meanwhile, according to Sarwono (2016: 9) the perinatal mortality rate consists of the number of children who do not show signs of life at birth, plus the number of children who die in the first week of life, for 1000 live births. According to WHO, the maternal and infant mortality rates (MMR) are increasing. The maternal mortality rate increased by 300 cases from 2019 to around 4,400 deaths in 2020, while infant mortality in 2019 was around 26,000 cases, an increase of almost 40 percent to 44,000 cases in 2020, (Kompas, 2021). Meanwhile, in 2017 the world's MMR reached 295,000 people, in Southeast Asia it reached 58,000 people. Indonesia ranks 2nd in Southeast Asia with the highest number of MMR (WHO, 2019).

The Millennium Development Goals (MDGs) target is that the MMR is 102 per 100,000 live births (KH) and the IMR is 23 per 1,000 KH in 2015, requiring greater acceleration and hard work due to current conditions, MMR 307 per 100,000 KH and IMR 34 per 1000 KH. This was conveyed in the Minister of Health's remarks read by the Secretary General of the Ministry of Health, dr. Ratna Rosita Hendarji, MPH during the Maternity Planning and Complications Prevention (P4K) Campaign and Use of the MCH Handbook, in collaboration with the United Indonesia Cabinet Wives Solidarity (SIKIB), in Jakarta (3/2/2010).

Primary health services are estimated to reduce maternal mortality by up to 20%, but with an effective referral system, perinatal rates occur in referral hospitals. Although the quality of health services, the quality of health services, especially maternal and neonatal health services are influenced by many factors, the ability of health workers (midwives, doctors, specialists) is one of the main factors. One of the efforts that can be done is to provide effective maternal health services for pregnant/delivery/postpartum mothers with complications so that mortality and morbidity rates can be reduced. In carrying out these efforts, human resources are needed who have the ability to provide optimal services (Sarwono, 2016).

MMR is the number of maternal deaths during pregnancy, childbirth and the postpartum period due to lack of knowledge of mothers in maintaining their health. The maternal mortality rate in Indonesia, namely in 2018, was 2,012 cases and in 2019 there were 1,689 cases. IMR is the number of infant deaths in the first 28 days of life per 1000 live births. From the results of the Indonesian Demographic and Health survey, the number of infant mortality cases in 2018 was 401,000 and in 2019 it was 287,000 (Indonesian health profile 2019)

Early Detection of Maternal and Infant Health with Sustainable Midwifery Services

West Java is one of the top provinces as a contributor to maternal and infant mortality in Indonesia. According to a report from the West Java Health Office in 2015 it was stated that the number of cases of maternal mortality due to pregnancy, childbirth, and postpartum increased quite sharply from 748 cases in 2014 to 823 cases in 2015. This was revealed in the Discussion of the Movement for the Rescue of Mothers and New Babies. Born in West Java, Wednesday 30 November 2016. The discussion was held by the United States Aids for International Development (USAID) with the West Java Ministry of Health. In the discussion, it was also known that a similar condition also occurs in newborns. That is increasing from 3098 cases in 2014 to 3369 cases in 2015. On average every day in West Java Province in 2015 lost 2 mothers and 9 babies due to these deaths. There are many factors that influence the high cases of maternal mortality. One of them is the delay in handling patients in health facility services (hospitals and health centers). The delay could be due to being late in getting help, being late for referrals, and being late in getting facility services. This movement was initiated by the Expanding Maternal and Neonatal Survival (EMAS) program, which is a grant program from USAID. The program aims to help the Province of West Java to strengthen health facilities so that they can become a model for improving the quality of clinical services and strengthening an effective and efficient maternal and newborn referral system. (Bandung Minds of the People, 2016)

The infant mortality rate in West Java Province in 2017 was 3.4/1000 live births, a decrease of 0.53 points compared to 2016 of 3.93/1000 live births. The infant mortality rate of 3.4/1000 live births has exceeded the MDGs target which in 2015 should have reached 17/1000 live births. The maternal mortality rate in West Java in 2017 was 76.03 per 100,000 KH, when compared with the targeted proportion of MMR in 2017, the MMR in West Java Province was already below the 2015 MDGs national target. Efforts to reduce MMR and IMR were carried out by improve the quality of emergency obstetric and newborn services in at least 150 hospitals (PONEK) and 300 health centers (PONED) and strengthen an efficient and effective referral system between health centers and hospitals. In addition, the government and the community are also responsible for ensuring that every mother has access to quality maternal health services from pregnancy to childbirth by trained health workers. So that midwives as health workers carry out Continuity of Care (COC) (Ministry of Health 2015)

MMR and IMR during delivery and after delivery in Cianjur are still high. In the same period as the previous year, at least 30 mothers died during childbirth. And 100 babies died after being born. The high MMR and IMR are triggered by the high number of early marriages and the result of 3 being late and 4 being too late. This was conveyed by the Chairperson of the Cianjur Regency Indonesian Midwives Association (IBI), Liste Zulhijwati Wulan, when met at the Bale Rancage Women's Building, Jalan Siliwangi, Cianjur District/Regency, on Monday, September 19 2016. Liste said that there was no decline in AKI and IMR cases in Cianjur. His party has also made efforts with the Cianjur District Health Office to reduce this number, various maternal and infant health programs have also been pursued. However, various causes ranging from socio-cultural aspects to geographical conditions are still obstacles. "This is a condition that requires the attention of all parties, not only midwives or policy makers. It must involve all components, there are many things that contribute to the cause of the high MMR and IMR in Cianjur," he said. Met after the celebration of the 65th Anniversary of the Indonesian Midwife, improving maternal and child health in Cianjur became the main target of midwives. Focusing on strengthening the role of midwives in empowering women and families, it is hoped that midwives together with the community can suppress MMR and IMR. This is because community empowerment and improving maternal and infant health are the main indicators for reducing MMR and IMR. Liste revealed that there are 2 main reasons for the high MMR and IMR, namely socio-cultural aspects and geographical conditions. Socio-cultural aspects, mainly due to 3 too late and 4 too late. It was too late to decide, the family did not immediately decide that the mother/child being conceived should receive treatment. It's too late to refer transportation, because poor road infrastructure is also a problem. While 4 is too, Liste continued, is too young when giving birth under 20 years due to early marriage. Too old to give birth over 35 years, too many children more than 4 children, and too close to marriage with pregnancy. Geographical conditions also play a role in causing the high MMR and IMR. Road conditions, in remote areas, are an obstacle to speeding up access to first aid. And the unequal number of public health services (yankemas). He also admitted that the lack of medical personnel was another factor. In an ideal ratio, 1 midwife serves 1000 residents. Currently, there are only 700 midwives in Cianjur, this number is not enough to keep pace with the population. "Speaking of the ratio is still very lacking. Currently, in one village alone there are 1-2 midwives. That amount is not enough, (Pikiran Rakyat, 2016)

Various improvements were made to the maximum extent possible in reducing MMR and IMR by improving health services, especially comprehensive midwifery care services that focus on maternal and infant care in accordance with midwifery service standards. The role of midwives is very much needed to reduce MMR and IMR, namely with Continuity of Care services that can detect early risk of complications in mother and baby. Based on the description above, continuous midwifery care is very important in reducing MMR and IMR which is the basis for me to carry out comprehensive midwifery care for Mrs. F at Rancagoong Cianjur.

1.2. Case Study Objectives

1.2.1 General Purpose

Able to provide comprehensive midwifery care within the scope of the Midwifery Care Of Project (Continuity Of Care) in accordance with the standards of midwifery care for Ny. F starting from Third Trimester Pregnancy, Childbirth, Newborn Baby, Postpartum and Family Planning at Rancagoong Cianjur

1.2.2 Special Purpose

Early Detection of Maternal and Infant Health with Sustainable Midwifery Services

- a. Providing Comprehensive Midwifery Care starting from the Third Trimester of Pregnancy to Ny. F at Pacet Cianjur Health Center
- b. Providing Comprehensive Midwifery Care in Spontaneous Delivery Ny. F at Rancagoong Cianjur
- c. Providing Comprehensive Newborn Midwifery Care at By. Mrs. F at Rancagoong Cianjur
- d. Providing Comprehensive Midwifery Care during the postpartum period to Ny. F at Rancagoong Cianjur
- e. Providing KB Comprehensive Midwifery Care to Ny. F at Rancagoong Cianjur

1.3 Benefits of Case Studies

The results of this case report are expected to be useful and provide a good contribution to various parties, namely:

1.3.1 For Clients and Society

So that clients and the public can detect things that may arise during pregnancy, childbirth or during the puerperium and family planning so that it is possible to immediately seek help and this case report is expected to be a medium of information for clients and as medical records for clients.

1.3.2 For BPM

This COC report is expected to be an input in providing comprehensive midwifery care services to mothers during the third trimester of pregnancy, childbirth, newborns, the postpartum period, and family planning services. To improve midwifery services.

1.3.3 For Educational Institutions

The results of this COC report are expected to be input or reference material in the library for learning and implementing comprehensive midwifery care for pregnant women, maternity, newborns, postpartum and family planning services.

1.3.4 For Writers

This COC report is expected to be a medium of learning and input for yourself. This COC report is an application of the theory of Midwifery Care that has been obtained in college.

RESEARCH METHODS

1.1. Research methods

This research design uses the SCLR (Study Case Literature Review) method. What is meant by case studies according to Soekidjo Notoatmojo (2012: 141) are: "how to examine a problem through a case consisting of a single unit. A single unit here can mean one person, a group of residents affected by a problem." Meanwhile, the Literature Review according to Syahbani and Rahmayanti (2020:46-47) is: "a systematic, explicit and reproducible method for identifying, evaluating and synthesizing research works and ideas that have been produced by researchers and practitioners. respondents in this study is one client. where the client is provided with services starting from pregnancy more than 36 weeks, until the baby is born and the mother gets counseling to become a family planning acceptor.

1.2. Place and time

The research site was in Rancagoong Cianjur, while the research time was carried out for 14 days.

RESULTS AND DISCUSSION

After the author carried out midwifery care using a comprehensive approach and SOAP documentation on Mrs. F from pregnancy, childbirth, postpartum, and BBL starting from January 4, 2022 - February 5 2022. Then the author will compare whether there is a gap or not, the gap between the care provided already given and existing theory.

4.1 Pregnancy care

The assessment started at 38 weeks of gestation, the mother said that in the first trimester she made 2 antenatal visits at the Pacet Health Center, in the second trimester she had 2 antenatal visits at the Puskesmas and in the third trimester, she had 2 antenatal visits. According to the Federation of Obstetrics and Gynecology in Sarwono (2016: 213). Pregnancy is divided into 3 trimesters, Pregnancy is divided into three trimesters, namely:

- 1). First trimester: 0 to 12 weeks
- 2). Second trimester: 15 to 27 weeks
- 3). Third trimester: 28 to 40 weeks

Based on the above study, the author is of the opinion that there is no gap between facts and theory, so that the mother and fetus are in good health

In the current pregnancy history, the first day of the last menstrual period was found on 11-04-2021. Based on that date, the estimated delivery date is 18-1-2022 based on Carudin's theory (2017) calculated by the Naegle formula, namely the first day of menstruation plus seven, the last month of menstruation minus three and the year plus one.

According to Hesti's theory (2019) In carrying out antenatal checks, health workers must provide services according to the 10T standard, namely, T1 weight measurements are carried out every time they make an antenatal care visit, height measurements are carried out at the first antenatal care visit, T2 blood pressure measurements are carried out every time. perform ANC visits, T3 measurement of LILA is done when pregnant women make the first ANC visit, T4 measurement of uterine fundal height (TFU) at

Early Detection of Maternal and Infant Health with Sustainable Midwifery Services

24 weeks of gestation either using fingers or with a meter, T5 determine fetal presentation and fetal heart rate, status screening tetanus immunization, T6 give Tetanus Toxoid (TT) immunization if needed, TT status in pregnant women is at least TT2, T7 giving 90 tablets of blood added during pregnancy, T8 laboratory tests (blood type, Hb, Gds, uric acid, blood protein, HbsAg, VCT and syphilis), T9 case management is carried out by providing further treatment if there is an abnormality in pregnant women and if no further treatment can be carried out, then a referral is given, T10 a talk show (counseling) is given every time you make an ANC visit. (Wiyandani 2019)

In the case of Mrs. F, received all services according to the standard (10T), at the first ANC examination with a gestational age of 38 weeks, the results of the examination, Mrs. F with 156 cm TB, according to Diana (2017) the height of pregnant women with a height of less than 145 cm is classified as a risk factor, this shows Mrs. F is not a risk factor. Body weight before pregnancy 49 kg after pregnancy 58 kg with a weight gain of 9 kg during pregnancy, according to Diana's theory (2017) maternal weight gain during pregnancy indicates the mother's adaptation to fetal growth, the normal weight gain every week is 0.5 kg and the mother's weight gain from the beginning to the end of pregnancy was 6.50 to 16.50 kg, it shows that the weight gain experienced by Mrs. F is in the normal category.

On examination of the upper arm circumference, Mrs. F, the results of LILA 25 cm according to Diana (2017) theory suggest that LILA measurement is a way to determine the risk of protein energy deficiency, LILA measurement on the left side of LILA less than 23.5 cm is an indicator of poor or poor maternal nutritional status, so risk to give birth to LBW, from this it shows that LILA on Ny. F is normal, on ANC examination the Fetal Heart Rate is found to be 145x/minute according to the theory of Romauli (2017), FHR is normal between 120 to 160x/minute, this indicates that the FHR in Ny. F within normal limits. (Diana 2017)

Mrs. F has received TT immunization 2 times, according to Theory (Yunica, 2015) which states that TT immunization should be given before 8 months of pregnancy to get complete immunization. TT immunization for pregnant women is given 2 times with a dose of 0.5 cc to prevent tetanus neonatorum infection in the umbilical cord, this shows the correspondence between theory and reality.

During pregnancy, Mrs. F regularly took blood-supplementing tablets, according to Vivian's theory (2015) iron is very important to compensate for the increase in blood volume that occurs during pregnancy and to ensure fetal growth and development, during pregnancy as much as \pm 90 tablets. (Septiani 2017)

On Leopold's examination, it was found that the TFU 29 cm in the fundus was round, soft, and not bouncy (buttocks), Leopold II's right side of the mother's abdomen was hard, elongated like a board (back of the fetus) and the left side of the abdomen was palpated for the smallest part of the fetus (fetal extremities). Leopold III, the lowest part of the fetus is palpable, round, hard, bouncy, namely the head, Leopold IV has not entered the PAP (divergent), according to Diana (2017) Leopold palpation is an examination technique on the mother's abdomen to determine the position and location of the fetus by palpating the abdomen.

4.2 Maternity care

On 08-1-2022 at 03.05 WIB, Mrs. F came to PMB with complaints of regular heartburn and mucus mixed with blood, at 20.00 WIB. An examination was carried out at 03.10 WIB and the results were quiet urethral vulva, smooth vaginal wall, thin portio, 7 cm opening, amniotic membrane (+), head presentation, H III (2/5 parts), with his 3x10 "30". With the diagnosis Mrs. F G1P0A0 39+1 weeks pregnant single fetus alive intrauterine head percentage, active phase I inpartu. At 3:45 a.m. Mrs. F felt the urge to defecate and there were signs of labor, namely a pressing urge, pressure on the anus, protruding perineum and opening of the vulva, an internal examination was carried out with the results of a calm urethral vulva, smooth vaginal walls, not palpable portio, 10 cm opening, spontaneous rupture of membranes, cephalic presentation, H IV (0/5 parts), with his 3x10 "30" 10 cm opening, portio not palpable, membranes ruptured, cephalic presentation, left anterior fontanelle position, Hodge IV descent (0/5 parts) and no infiltration with the diagnosis of Mrs. F G1P0A0 38+4 weeks pregnant single fetus alive intra uterine head presentation, second stage of labor. At 04.15 the baby was born spontaneously, cried loudly, skin color was reddish, muscle tone was active, with JK: male, PB: 50 cm, weight: 2800 grams, did IMD immediately after the newborn was born, at 04.20 WIB the placenta was born spontaneously, and massage the uterine fundus for \pm 15 seconds. Check the placenta, complete cotyledon membranes to ensure that there is no placental remnant. At 04.25 Observing TTV, contractions, TFU, bladder, and blood loss every 15 minutes in the first 1 hour and every 30 minutes in the second 1 hour, obtained TTV within normal limits, TFU 2 fingers below the center, empty bladder bleeding during labor stage 1 - 4 is 300 cc.

According to the theory of Halimatusakdiah (2017) the average multiparous delivery is about 6 hours shorter, namely 7 hours in the first stage, 15 to 30 minutes in the second stage and 10 minutes in the third stage, this is in accordance with the case study where Mrs. The length of the first stage is 2 hours, the second stage is 40 minutes and the third stage is 10 minutes long. According to Soviyati (2016) the factors related to the length of labor are power, passage, passenger, psychology, position, and helper.

According to Walyani (2015) the entire process of the third stage usually lasts for 5-30 minutes so that there is no discrepancy between the case and the theory, after the placenta is born an estimation of bleeding is carried out on Ny. I bleed approximately 200 cc, according to Manuaba (2013) bleeding is considered normal if the amount does not exceed 400-500 cc, so that there is no gap between theory and case.

The preparation of the implementation in the first stage is carried out according to theory including counseling on relaxation

Early Detection of Maternal and Infant Health with Sustainable Midwifery Services

techniques, labor observation is carried out according to the theory, namely FHR, his and pulse every hour, cervical opening, lowering of the lowest part of the fetus and blood pressure every 4 hours or at any time if any. second stage symptoms. In the second to fourth stage of the intervention, namely assisting the birth of babies with APN according to JNPK-KR (2017), as far as possible childbirth is assisted with 60 steps of APN, this shows the compatibility between theory and real cases.

4.3 Newborn Care

Baby Mrs. F was born on 8-02-2022, at 03.36 WIB, was born normal with male gender. The general condition was good, composmentis consciousness, the baby cried strongly, the skin color was reddish and the baby's movements were active, the temperature was 36.6 0C, the pulse was 119 x/minute, there was no abnormality in breathing 45x/minute, the head circumference was 31 cm, the chest circumference was 30 cm. On physical examination, the results were normal UUB head, normal UUK, normal head shape, round, no caput succedeneum, no cephalhematoma. Normal face, no abnormalities, redness. Left and right symmetrical eyes, clean, no abnormalities. Ears are symmetrical, normal, clean. Normal nose shape, clean, no nostril breathing. Normal mouth shape, no palatoschisis, no labioschisis. Neck no jugular vein enlargement, no lymph node enlargement and thyroid, neck movement is good. There is no chest wall retraction, the heart rhythm is steady and loud. Abdomen normal, no umbilical cord bleeding, umbilical cord has not been separated. Extremities of toes and hands complete, normal, active movement. Female anogenitalia, vaginal opening, labia minora and majora, anus (+), meconium (+) positive sucking reflex, positive rooting reflex, positive tonicneck reflex, positive Moro reflex, positive graps reflex, positive babynski reflex.

From the results of the examination, the diagnosis of term neonates was obtained according to the gestational age of 6 hours. The care provided is fostering a good relationship with the mother, conducting examinations to the mother, explaining the results of the examination to the mother and family that the baby is in good condition and without any abnormalities, giving eye ointment and vitamin K, giving HB 0 immunization, teaching the mother how to bathe the baby. and umbilical cord care, encourage mothers to maintain warmth and personal hygiene of their babies, encourage mothers to breastfeed their babies as often as possible, explain to the mother the danger signs of a newborn, notify the mother of a repeat visit if the baby has complaints or comes in 1 week. Documenting the results of the inspection.

According to the theory (Dewi 2015) Newborns or neonates are divided into several classifications, Low Birth Weight (LBW) Babies born with birth weight < 2500 grams regardless of gestational age. Adequate/Normal Birth Weight Babies born with birth weight >2500-4000 grams. More birth weight Babies born with birth weight >2500 grams it shows that the baby's weight Mrs. F is normal or sufficient.

According to the theory (Dewi 2015) Normal newborns have the characteristics of a birth weight of 2500-4000 grams, 37-40 weeks of gestation, the baby cries immediately, moves actively, has reddish skin, sucks breast milk well and has no congenital defects. Normal newborns have a length of 48-52 cm, chest circumference 30-38 cm, arm circumference 11-12 cm, heart rate 120-160 x/minute, breathing 40-60x/minute, APGAR value > 7, reflexes well formed (rooting, sucking, morro, grasping), female anogenitalia with vaginal opening, labia minora and majora present, meconium has passed in the first 24 hours and is brownish black in color. In the case shown, Mrs. F has the characteristics of a normal baby, it shows that there is no gap between theory and practice.

According to Mochtar's theory (2015) the standard of service for neonatal visits is KN1 6-48 hours, KN 2 3-7 days, KN 3 8-28 days, and the care provided for the 6-hour neonatal is nutritional needs by giving breast milk as often as possible, cord care center, left open and kept dry and clean, keeping baby safe and baby warning signs. This shows that there is no gap between theory and case.

4.4 Postpartum Care

Mother said she wanted to check and said the left nipple was a little sore due to blisters. The results of the examination showed that the general condition of the mother was good, composmentis awareness, stable emotional state, blood pressure 80/60 mmHg, pulse 80 x/minute, temperature 36.3 0C, breathing 21 x/minute, prominent nipple chest, pain due to nipple blisters. milk on the left, breast feels hard and large, TFU in the middle of the center of the symphysis, discharge lochea sanguilenta white with red chalky and odorless, no signs of infection and no edema. From the results of the examination, the diagnosis of P1A1 post partum was 6 days.

According to Sukma (2017) uterine involution when the baby is born is as high as the TFU as high as the center, when the placenta is born the TFU is two fingers below the center, one week the TFU is mid-central-symphysis, two weeks the TFU is not palpable above the symphysis, six weeks the TFU is getting smaller, eight weeks of normal TFU. This shows that there is no gap between theory and case.

According to Sukma (2017) the types of lochea during the puerperium are red lochea rubra for 2 days postpartum, red yellow lochea sanguinolenta on the 3-7th day postpartum, yellow lochea serosa on 7-14 days postpartum, lochea alba white discharge on the day after 2 weeks, lochia purulenta foul smelling. This shows in the case of Mrs. F type of lochea is sanguinolenta, the theory shows that there is no gap with the real case.

According to Anjasmoro (2014) problems that are still often encountered during the puerperium are breast problems such as breast milk dams, abscesses, mastitis, sore nipples. Breast milk does not flow easily and the baby is difficult to latch on to suck milk. Mother has a fever sometimes, but it usually goes away within 24 hours. This can be anticipated with breast care and breastfeeding

Early Detection of Maternal and Infant Health with Sustainable Midwifery Services

immediately after delivery because if it is not fed properly or is not emptied completely, there will be damming of breast milk. Breast milk dam is a problem that occurs in breastfeeding mothers where the glands and milk ducts are blocked so that the discharge is not smooth. according to Meutia Ayu Putri in Jemmima Karyssa Rompies, (2019). The wrong technique in breastfeeding can cause nipple blisters and cause pain when breastfeeding. As a result, mothers do not want to breastfeed their babies and there is a dam of breast milk.

This shows in the case of Mrs. F, the cause of sore nipples is due to the wrong breastfeeding technique, where the baby's mouth should enter the areola of the mammae, so that milk does not come out. Because it doesn't come out, the baby is bitten by the nipple, according to Mutia, 2019, the hardening of the breast also sometimes feels burning, then pain appears, causing discomfort caused by the blisters on the nipple. this is in line with the journal Atiul Impartina (2017) "the relationship of postpartum mother's knowledge about breastfeeding techniques with the incidence of breast milk dams" based on the results of the analysis showing a significant relationship between postpartum mother's knowledge about breastfeeding techniques and the incidence of breast milk dams. The care given is to tell the mother that the complaints experienced are breast milk dams, namely due to an increase in venous and lymph flow in the breasts, causing breast engorgement and pain that causes breast engorgement, namely incomplete emptying of the breasts, inactive baby sucking factors and position factors. improper feeding of the baby. Tell the mother how to deal with the complaints that the mother feels with warm water compresses to reduce pain, tell the mother the right way to breastfeed, that is, before feeding the baby, remove a little milk and apply it to the nipple and areola, put the baby's head on 1 arm, the baby's head is in an arc the mother's elbow and the baby's buttocks are on the mother's forearm, the baby's stomach and the mother's stomach are pressed together, position the baby with the ears and arms in a straight line, feed the baby until most of the areola enters the baby's mouth and teach the mother how to do breast care. From the theory shows that there is no gap with the real case.

4.5. Family Planning Care

On Saturday, February 12, 2022, 36 days post partum, the mother said she had no complaints and had not had her period. From the results of the examination, it was found that the general condition was good, composmentis awareness, stable emotional state, normal vital signs, blood pressure 110/80 mmHg, pulse 80 x/minute, temperature 36.0 C, breathing 20 x/minute. On physical examination, the eyelids were not edematous, the conjunctiva was pink, the sclera was white, the milk output was smooth, the fundal height of the uterus was not palpable, and the discharge of lochia alba was yellowish white. The care provided encourages mothers to continue breastfeeding until the baby is 6 months old and give the mother a 3-month injection of birth control. In the case of Mrs. F 21 years old P1A0 wants to use 3-month injectable contraception, the reason for choosing 3-month injectable contraception is because it doesn't interfere with breast milk production. This is in accordance with the theory (Anissa Karnesyala, 2021). Depo Medroxyprogesterone Acetate injection has no effect on breast milk. Based on these results, it can be concluded that there is no gap between theory and case.

CLOSING

5.1. Conclusion

After the author conducted midwifery care during pregnancy, childbirth, postpartum, newborn and family planning, it can be concluded as follows:

5.1.1 Pregnancy Care

In pregnancy F has had midwifery care and no discrepancy was found between theory and real cases, Mrs. F received an examination according to the theory of pregnancy

5.1.2 Childbirth Care

Maternity care for Mrs. F there is no gap between the theory and the real case. Mrs. F gave birth at term in good health, after receiving 3 visits, namely 6 hours post partum, 6 days post partum and 28 days post partum.

5.1.3. Postpartum Care

Postpartum care for Mrs. F there is no gap between the theory and the real case. Mrs. F received 3 visits, namely: 6 hours, 6 days and 28 days of postpartum visits. Mrs. F is having a good postpartum period

5.1.4. New born baby care

Newborn care for Mrs. F there is no gap between the theory and the real case. BBL with good general condition, with normal vital signs. Strong in breastfeeding, after 28 days can 1 hour BBL suckle breast milk.

5.1.3 Family planning care

Family planning care for Mrs. F there is no gap between the theory and the real case. After counseling Mrs. F chooses a 3-month injection KB with the approval of her husband. Planning to become a family planning acceptor for 3 months for 5 years.

5.2 Suggestions

5.2.3 For patients

It is hoped that it can provide information and increase knowledge about pregnancy, childbirth, postpartum, caring for newborns, and family planning

Early Detection of Maternal and Infant Health with Sustainable Midwifery Services

5.2.4 For institutions

It is hoped that it can develop the application of midwifery care education with continuity of care appropriately in the learning process and improve learning practices to be more effective and efficient, so that the quality of human resources can improve.

5.2.5 For Health workers

It is hoped that it can improve the quality of services in providing sustainable midwifery care

REFERENCES

- 1) Kompas, (2020), maternal and infant mortality rates according to who 2020, <https://www.google.co.id/search?q=numbers+deaths+mothers+and+babies+according+to+who+2020&sxsrf=APq> -
- 2) Indonesian Ministry of Health, (2022), To Reduce Maternal Mortality and Infant Mortality Needs Hard Work, Published On : Wednesday, 03 February 2010 06:27:34, Read : 146,365 Times
- 3) Surya fikri Asshidiq, (2016), Highest Maternal and Infant Mortality Rate in West Java, Bandung Thoughts of the People, December 1 2016, 01:39 WIB
- 4) Ira Vera Tika, (2016), High Maternal and Infant Mortality Rates in Cianjur, - 19 September 2016, 08:09 WIB, People's Mind
- 5) 5.understanding of pregnancy according to Sarwono, (2018), <https://www.google.co.id/search?q=pengertian+pregnancy+according+sarwono+2018&biw=1920&bih=961&sxsrf=APq>
- 6) Sarwono Prawirohardjo, (2016), Midwifery Science, 4th Edition, 5th Printing PT Bina Pustaka Sarwono
- 7) Zulvikar and Mayu (2020), Literature Review Writing Guide for the Faculty of Medicine and Health Sciences, Maulana Malik Ibrahim State Islamic University Malang
- 8) Soekidjo Notoatmodjo (2012), Health Research Methodology Revised Edition, Rineka Cipta Publisher, ISBN979-518-351-6



There is an Open Access article, distributed under the term of the Creative Commons Attribution – Non Commercial 4.0 International (CC BY-NC 4.0) (<https://creativecommons.org/licenses/by-nc/4.0/>), which permits remixing, adapting and building upon the work for non-commercial use, provided the original work is properly cited.