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Midwifery care for Mrs "Y" at BPM Soraya Palembang

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Abstract---According to the World Health Organization (WHO) in 2015 the Maternal Mortality Rate (MMR) was recorded as many as 303,000 mothers died during pregnancy to childbirth. Based on the 2012 Indonesian Health Demographic Survey (IDHS), the MMR was recorded at 359 per 100,000 live births. While the number of MMR in Palembang City from 2013 to 2014 has decreased from 13 people/29,911 KH to 12 people/29,235 KH. The purpose of this study was to determine the provision of continuous midwifery care from pregnancy to the postpartum period for Mrs. "Y" at BPM Soraya Palembang. The method used was a midwifery management framework using SOAP at BPM Soraya Palembang on Mrs. "Y" aged 33 years and data was collected through interviews, observation, physical examination, documentation study and literature study. The results of this study after carrying out Midwifery Care during pregnancy, childbirth, postpartum, and newborns to Mrs. "Y" aged 33 years at BPM Soraya, the results of care obtained from all health education and care can be provided properly, as well as all processes can run smoothly and normally. In the study of Midwifery Care on Mrs. "Y" aged 33 years showed that overall there was no gap between theory and practice.

Keywords---midwifery care, pregnancy, childbirth, postpartum, newborns.

Introduction

Health development is the implementation of health efforts by the Indonesian people to increase awareness, will, and ability to live healthily for everyone, to realize an optimal level of public health (World Health Organization, 2015). Health development programs in Indonesia still prioritize efforts to improve the health status of mothers and children (KIA), especially in the most vulnerable groups, namely the health of pregnant women, postpartum women, postpartum women, and newborns (Anggraini et al., 2021). Thus, it is important to assess the health status and performance of maternal and child health efforts (Kemenkes RI, 2015). Health development in the 2015-2019 period is the Healthy Indonesia Program with the target of improving the health status and nutritional status of the community through health efforts and community empowerment supported by financial protection and equal distribution of health services (Kemenkes RI, 2017). Unequal health services are a problem that exists in various countries, especially in developing countries (International Confederation of Midwives, 2011). Therefore, the World Health Organization (WHO) formed the WHO Expert Community on The Midwife in Maternity Care which aims to ensure that every pregnant woman and breastfeeding woman can maintain perfect health so that women can give birth to healthy babies without interference and then you can take good care of your baby (Prawirohardjo, 2013).

The Maternal Mortality Rates (MMR) is very high in the world, with 800 women dying every day due to complications from pregnancy and childbirth (Raharjo & Ishartono, 2015). In 2013 more than 289,000 women died during and after pregnancy and childbirth (Kurniati et al., 2023). Based on data from the World Health Organization (WHO) in 2015, the maternal mortality rate (MMR) worldwide is estimated at 216/100,000 live births and the neonatal mortality rate fell by 47% between 1990-2015, namely from 36/1000 live births to 19/1000 births. live in 2015 (Lokugamage et al., 2022). The World Health Organization (WHO) estimates that every year 500,000 maternal deaths occur, most of which occur in developing countries (Kurniati et al., 2023). It is estimated that the maternal mortality rate (MMR) in developing countries is 100-200 times higher than in developed (industrial) countries (Kildea et al., 2016). In 2015, 303,000 mothers died from pregnancy to delivery (World Health Organization, 2015).

The UN session held in New York in 2015, aimed to agree on the adoption of Sustainable Development Goals (SDGs) for the 2015-2030 period. This sustainable development goal is to replace the Millennium Development Goals (MDGs). SDGs is a document containing an agreement to replace the MDGs which consists of 17 goals divided into 169 targets and around 300 indicators. This measure or indicator is by the needs of each country and is still in the process of being discussed (Prawirohardjo, 2013).

SDGs target, by 2030 there will be a reduction in the risk of Maternal Mortality Rate (MMR) which is less than 70/100,000 live births while the Infant Mortality Rate (IMR) target of SDGs in 2030 is to end and prevent deaths of infants and toddlers (Indonesian Ministry of Health, 2015). Based on data from the Association of South East Asian Nations (ASEAN), MMR in developed and developing countries is very different. For example, the MMR in Singapore is

3/100,000 live births, the MMR in Malaysia is 5/100,000 live births, the MMR in Thailand is 8-10/100,000 live births, the MMR in Vietnam is 50/100,000 live births, while in Indonesia it is in 2012 it was 359/100,000 live births. The still very high maternal mortality rate is very worrying because it is the highest in the Southeast Asia region (Indonesian Ministry of Health, 2015).

The Maternal Mortality Rate (MMR) in Indonesia is still high compared to ASEAN countries. Based on the 2012 Indonesian Health Demographic Survey (SDKI), the Maternal Mortality Rate (MMR) in Indonesia reached 359/100,000 live births. The cause of AKI in Indonesia is bleeding (41.7%), followed by pulmonary embolism (1 case), suspected cardiogenic shock (1 case), eclampsia (1 case), suspected TB (1 case), and hypertension in pregnancy (1 case). , and others. Meanwhile, the Infant Mortality Rate (IMR) in Indonesia reaches 32/1000 live births. Causes include asphyxia, low birth weight, and neonatal infections (Indonesian Health Profile, 2015).

The maternal mortality rate in Indonesia fell from 4,999 in 2015 to 4912 in 2016 and in 2017 there were 1712 cases. The causes include bleeding (42%), eclampsia/preeclampsia (13%), abortion (11%), infection (10%), prolonged labor/obstructed labor (9%), and other causes (15%) (Yuceline, Bhertha et al., 2022). Likewise, the number of infant deaths fell from 33,278 in 2015 to 32,007 in 2016, and in 2017 there were 10,294 cases. Causes of IMR in Indonesia include low birth weight (39%), asphyxia (31%), sepsis (1.2%), congenital abnormalities (15%), jaundice (2.1%), pneumonia (1.7%), others (10%) (Kemenkes RI, 2017).

From data from the South Sumatra Province health service, the number of MMR in South Sumatra Province in 2014 it was 155 per 100,000 KH. This data has increased compared to 2013, namely 146 per 100,000 KH. The number of maternal deaths is still high due to inaccurate early detection of risk factors by health workers, inadequate handling of childbirth / not according to existing procedures and the referral system does not comply with manual referral network procedures. Meanwhile, the IMR in South Sumatra Province was reported in 2014 to be 3.7 per 1000 live births, higher than in 2013 which was 2.8 per 1000 live births. Causes of IMR in South Sumatra Province include LBW, Down syndrome, neonatal infections, intracranial hemorrhage, cyanosis, heart defects, respiratory distress syndrome, post-op hydrocephalus, and others (Indonesian Health Profile, 2015).

The number of MMR in Palembang City based on the 2013 South Sumatra Health Profile was 13 people out of 29,911 KH. Meanwhile, in 2014, the number decreased by 12 people from 29,235 KH. The causes include bleeding followed by pulmonary embolism, suspected cardiogenic shock, suspected TB, hypertension in pregnancy, and others. Meanwhile, the number of IMR in 2014 was 52 infant deaths out of 29,235 KH. Causes include LBW, Down syndrome, neonatal infections, intracranial hemorrhage, cyanosis, heart defects, and others (Profil Dinas Kesehatan Sumatera Selatan, 2015).

Pregnancy examinations are very important for pregnant women to determine fetal growth and maternal health. Almost all pregnant women in Indonesia

(95.4%) have had a pregnancy check-up (K1) and the frequency of pregnancy at least 4 times during their pregnancy is 83.5%. Meanwhile, the coverage for first pregnancy checks in the first trimester is 81.6% and the frequency of ANC or K4 (at least 1 time in the first trimester, at least 1 time in the second trimester, and at least 2 times in the 3rd trimester) is 70.4% (Riset Kesehatan Dasar, 2013).

Achievement of health services for pregnant women can be assessed using indicators of coverage for the first visit (K1) and repeat visits (K4). In 2014, the coverage of antenatal care for pregnant women in Indonesia experienced a significant decline, with K1 coverage reaching 94.99% and K4 coverage of 86.70% compared to the coverage of antenatal care for pregnant women in 2013 for K1 reaching 95.25% and Q4 was 86.85%. Nationally, the work indicators for K4 pregnant women's health service coverage in 2014 did not reach the Ministry of Health's 2014 Strategic Plan (Renstra) target of 95% (Indonesian Health Profile, 2015). K4 coverage in Indonesia in 2016 decreased again, namely by 85.35%. Even though there was a decline in 2016, the coverage of K4 pregnant women's health services in 2016 met the Ministry of Health's Strategic Plan (Renstra) target of 74% (Profil Kesehatan Indonesia, 2016).

Coverage of antenatal care for pregnant women K1 and K4 in South Sumatra Province in 2014 was 98.0% and 93.53% with a difference between K1 and K4 of 4.47%. Even though the difference between K1 and K4 is still below 10%, it should still be a concern that there are still pregnant women whose pregnancy checks have not reached 4 times during their pregnancy. K1 coverage for Palembang City in 2014 was 99.84% and K4 was 96.64% (Indonesian Health Profile, 2015). In 2016, K4 coverage in South Sumatra Province experienced a significant increase, namely 97.78%. This means that the 2016 Strategic Plan (Renstra) target has been met, namely 74% (Profil Kesehatan Indonesia, 2016).

Maternal health efforts are carried out to encourage every birth to be assisted by trained health workers, namely specialist obstetricians and gynecologists (SpOG), general practitioners, and midwives, and efforts can be made in health service facilities. (Yuriah et al., 2022). In general, the coverage of birth assistance by health workers in Indonesia increases every year. National coverage in 2013 was 90.88%, and this figure has been able to meet the 2013 Ministry of Health Strategic Plan target of 89% (Indonesian Health Profile, 2015).

The success of postpartum maternal health efforts is measured through the indicator of postpartum maternal health service coverage (KF3) (Yuriah & Kartini, 2022). The coverage of postpartum visits (KF3) in Indonesia in the last 6 years has increased, namely from 17.9% in 2008, 55.58% in 2009, 73.61% in 2010, 76.96% in 2011, 85.16% in 2012, and 86.64% in 2013 (Prawirohardjo, 2013). Midwives have a very important role in providing midwifery care that focuses on women (Woman Centered Care) on an ongoing basis (continuity of care). Midwives provide comprehensive, independent, and responsible care for sustainable care throughout a woman's life cycle (Nuryani et al., 2022).

Based on BPM Soraya's data on antenatal visits, in 2016 357 pregnant women had their pregnancies checked, with service coverage totaling K1 for 245 people, K4 coverage 98 people, and repeat visits for 144 people. While the number of

women giving birth normally at BPM Soraya in 2017 was 212 people, 13 people were referred to giving birth (Yazdani et al., 2023). Based on the results of a survey that I conducted with Mrs. "Y" with a gestational age of 30 weeks, I am interested in carrying out continuous midwifery care (continuity of care) starting from the pregnancy period, delivery period, postpartum period, interval period and newborn care as well as documenting the obstetrics that have been carried out on pregnant women, maternity, postpartum and newborn babies at BPM Soraya in 2018.

Method

Research design is the arrangement or design of the research that will be carried out. This report was written using the case study method. A case study is a research method by examines a problem through a case consisting of a single unit. The unit that is the case is analyzed in depth both from aspects related to the circumstances of the case itself, influencing factors, special events that arise in connection with the case, as well as the case's actions and reactions to a particular treatment or exposure (Shahinfar et al., 2021). The sample in this case study is Mrs. "Y" a third-trimester pregnant woman aged 33 years with her third child who is willing to sign the recommended informed consent form.

The time for reviewing the final assignment report was carried out in December 2017-June 2018. The place where midwifery care was carried out was at the Soraya Independent Practicing Midwife. The location is on Jl. H. Sanusi Lrg. Dasuki No. 2905 RT 32 RW 05 Lebong Searang, Palembang City. The data collection technique in this case study is through interviews (anamnesis), physical examination, and supporting examinations on Mrs. "Y" at BPM Soraya Palembang in 2018.

The data in this case study uses primary data and secondary data. Primary data often called the first hand of information is a source of information that comes directly from those who have the authority and responsibility for the data, while secondary data is data obtained indirectly through intermediary media (obtained and recorded by other parties) (Muthoharoh et al., 2022). Primary data was obtained through interviews (anamnesis), physical examination, and supporting examinations, while secondary data was obtained by looking at and recording the registration books for pregnant women, birth mothers, postpartum mothers, and babies as well as Mrs. KIA Book. "Y" at BPM Soraya Palembang in 2018.

The data collection instruments used in this case study were the Pregnancy Midwifery Care assessment format, MCH book, and pregnancy examination tools. The pregnancy examination tools include scales, height measurement, axillary thermometer, blood pressure monitor, stethoscope, clock, flashlight, metalline, monoscopic, LILA tape, reflex hammer, blood lancet, and haemometer.

Results and Discussion

In this case study the author will discuss the midwifery care provided to pregnant, maternity, postpartum, and newborn mothers which is carried out from the third trimester of pregnancy, namely 30 weeks to 4 weeks and 1 day

postpartum starting from January 31, 2018 - 08 May 2018 at BPM Soraya Palembang.

Pregnancy

The first ANC visit was on January 31 2018, at 15.00 WIB

The implementation of midwifery care for pregnant women at BPM Soraya is the same as the theory obtained, starting from the assessment to the implementation of midwifery care. This is to the theory which states that antenatal care is care provided to pregnant women from confirmation of conception until delivery (Yazdani et al., 2023).

In the case of Mrs "Y" a review of the mother's biodata, the mother's identity, and the reason for her arrival was carried out, this is necessary to find out complications as early as possible. Apart from that, the mother and family's health history, the mother's menstrual history, current pregnancy history, marital history, and family planning history are also studied. The author also needs to examine reactions regarding patterns of meeting daily needs and knowledge about antenatal care, all done systematically. After that, a physical examination is carried out (Nuryani et al., 2022).

The results of the history and examination carried out by the author on Mrs "Y" show that the pregnancy process is currently proceeding normally. During pregnancy, Mrs "Y" had her pregnancy checked 9 times, namely 2 times in the first trimester, 2 times in the second trimester, and 5 times in the third trimester. This visit was by Shahinfar et al., (2021) theory. Which states that pregnant women need a minimum of four visits during pregnancy, one visit in the first trimester (before the 14th day), one visit in the second trimester (before the 28th week), and two visits in the third trimester (before the 28th week). between weeks 28-40).

Mrs "Y" has carried out an ANC examination and received midwifery services including 10 Ts which are by the (Rahmawati & Sriwenda, 2023). The weight examination results obtained by the author for Mrs "Y" were 90 kg and her weight before pregnancy was 80 kg. Mrs. "Y" experienced a weight gain of 10 kg during pregnancy. This shows that the mother experiences a weight gain of 1.3 kg every month. According to the theory of Anggraini et al., (2021), according to BMI calculations, Mrs "Y" is obese and should gain 5.5-6.8 kg of weight during pregnancy, so according to management, a diet is recommended for pregnant women. The mother's height is within normal limits, namely 162 cm. This is normal because it is by the Lokugamage et al., (2022) theory which states that measuring a pregnant woman's height of less than 145 cm increases the risk of CPD (Cephalo Pelvic Disproportion).

The results of the blood pressure examination carried out by the author on Mrs "Y" were normal 120/80 mmHg, this is by theory which states that normal blood pressure is 110/80-120/80 mmHg. Hypertension found in the first trimester indicates the possibility of chronic hypertension, while hypertension that occurs after the first trimester is likely hypertension that arises in pregnancy.

Determining nutritional status by measuring LILA, namely the examination results obtained were 29 cm. From the results of the examination carried out by the author, Mrs "Y" did not experience KEK (Chronic Energy Deficiency). This is by the theory of Pusklatnakeds (2014) which states that the normal LILA for pregnant women is at least 23.5 cm. If it is less than 23.5 cm then the pregnant woman is said to be KEK (Chronic Energy Deficiency). Pregnant women with CED will be able to give birth to low birth weight (LBW) babies.

The author has carried out a palpation examination with the results of Leopold I, mid-central uterine fundus height and px (Mcd 30 cm), this is to the theory of Prawirohardjon (2013) which says that at the age of 30 weeks, the uterine fundus height (TFU) is in the mid-center and px. In Leopold I, the upper part of the fundus feels round, soft, and not bouncy (buttocks), Leopold II, the right part of the mother's stomach feels long, and hard like a board (fetal back) and the left part of the mother's stomach feels small parts of the fetus (extremities), Leopold III the lowest part feels round, hard and bouncy (head), Leopold IV the fetal head has not yet entered the pelvic outlet (PAP) or is convergent. This is by the interpretation of fetal weight based on Johnson's Tossec theory obtained by the formula fundus height (cm) - (11/12/13) x 155 grams = (30 cm - 13) x 155 grams = 2635 grams. The results of Leopold's examination are to the theory of Rukiah, et al (2013) which states that the Leopold I examination aims to determine the height of the fundus and feel the part of the fetus in the fundus, Leopold II aims to find out the part of the fetus on the right or left side of the mother's abdomen, Leopold III aims to determine the part of the fetus that is below the uterus, Leopold IV aims to find out the part of the fetus that is below and to find out whether this part has entered/passed through the upper pelvic inlet.

In the DJJ examination carried out by the author on Mrs "Y", the results of the DJJ examination were found to be with a frequency of 133 times/minute, by the theory of Nuryani et al., (2022) which states that the DJJ assessment is carried out at the end of the first trimester and thereafter at every antenatal visit. A slow FHR of less than 120 times/minute or a fast FHR of more than 160 times/minute indicates fetal distress. In the TT immunization screening, Mrs "Y"'s TT status was TT 2 from her third child which was given on January 31 2018. This is by the theory of Kurniati et al., (2023) which states that to prevent neonatal tetanus, pregnant women must receive TT immunization.

Giving Fe tablets to pregnant women according to Muthoharoh et al., (2022) theory is a minimum of 90 tablets during pregnancy to prevent anemia in pregnant women. At this visit, Mrs "Y" was also given blood-boosting tablets/Fe tablets. So there is no gap between theory and practice. Overall, there were no abnormalities or complications that occurred to Mrs "Y" during pregnancy, this was because the ANC examination at BPM Soraya was by midwifery service standards, and Mrs "Y" always had her pregnancy checked and was willing to follow the recommendations given by the midwife. so that there is no gap between existing theory and reality in BPM Soraya.

The second ANC visit was on March 3 2018, at 15.30 WIB

The second ANC was carried out, Mrs "Y"'s ANC examination received midwifery services including 10 Ts which were by the Pusdiklatnakes (2014) theory. The weight examination results obtained by the author for Mrs "Y" were 91 kg and her weight before pregnancy was 80 kg. Mrs "Y" experienced a weight gain of 11 kg during pregnancy. This shows that the mother has gained approximately 1.3 kg in weight. According to the theory of Nuryani et al., (2022), according to the BMI calculation, Mrs. "Y" is obese and should gain 5.5-6.8 kg of weight during pregnancy, so according to management, a diet is recommended for pregnant women. The mother's height is still within normal limits, namely 162 cm. This is still normal because it is by the Mose et al., (2023) theory which states that measuring a pregnant woman's height of less than 145 cm increases the risk of CPD (Cephalo Pelvic Disproportion).

The results of the blood pressure examination carried out by the author on Mrs "Y" were still normal, namely 110/80 mmHg, this is by the Pusdiklatnakes (2014) theory which states that normal blood pressure is 110/80-120/80 mmHg. Hypertension found in the first trimester indicates the possibility of chronic hypertension, while hypertension that occurs after the first trimester is likely hypertension that arises in pregnancy.

Determining nutritional status by measuring LILA, namely the examination results obtained were 29 cm. From the results of the examination carried out by the author, Mrs "Y" did not experience KEK (Chronic Energy Deficiency). This is by the Kildea et al., (2016) theory which states that the normal LILA for pregnant women is at least 23.5 cm. If it is less than 23.5 cm then the pregnant woman is said to be KEK (Chronic Energy Deficiency). Pregnant women with CED will be able to give birth to low birth weight (LBW) babies.

The author has carried out a palpation examination with the results of Leopold I, the height of the uterine fundus is 2 fingers below the xiphoid process (Mcd 32 cm), this is according to the theory of Prawirohardjon (2013) which says that at the age of 34 weeks 3 days the height of the uterine fundus (TFU) is on 3 fingers below the xiphoid process. In Leopold I, the upper part of the fundus feels round, soft, and not bouncy (buttocks), Leopold II, the right part of the mother's stomach feels long, and hard like a board (fetal back) and the left part of the mother's stomach feels small parts of the fetus (extremities), Leopold III the lowest part feels round, hard and bouncy (head), Leopold IV the fetal head has not yet entered the pelvic outlet (PAP) or is convergent. This is by the interpretation of fetal weight based on Johnson's Tossec theory obtained by the formula fundus height (cm) - (11/12/13) x 155 grams = (32 cm - 13) x 155 grams = 2945 grams. The results of Leopold's examination are to the theory of Mose et al., (2023) which states that the Leopold I examination aims to determine the height of the fundus and feel the part of the fetus in the fundus, Leopold II aims to find out the part of the fetus on the right or left side of the mother's abdomen, Leopold III aims to determine the part of the fetus that is below the uterus, Leopold IV aims to find out the part of the fetus that is below and to find out whether this part has entered/passed through the upper pelvic inlet.

In the DJJ examination carried out by the author Mrs "Y", the results of the DJJ examination were found to be with a frequency of 140 times/minute, by the theory of Lokugamage et al., (2022) which states that the DJJ assessment is carried out at the end of the first trimester and thereafter at every antenatal visit. Slow FHR of less than 120 times/minute or fast FHR of more than 160 times/minute indicates fetal distress.

Giving Fe tablets to pregnant women according to the Ristica (2019) theory is a minimum of 90 tablets during pregnancy to prevent anemia in pregnant women. At this visit, Mrs "Y" was also given blood-boosting tablets/Fe tablets. So there is no gap between theory and practice. A hemoglobin examination was carried out on Mrs "Y" and the result was 11.4 gr/dl, so it can be concluded that Mrs "Y" does not have anemia. This is by the Pusdiklatnakes (2014) theory which states that pregnant women are said to be anemic if the mother's blood hemoglobin is <11 gr%.

Overall, there were no abnormalities or complications that occurred to Mrs "Y" during pregnancy, this was because the ANC examination at BPM Soraya, Am.Keb was by midwifery service standards and Mrs "Y" always had her pregnancy checked and was willing to follow the recommendations. given by midwives so that there is no gap between existing theory and reality at BPM Soraya, Am.Keb Palembang.

The third ANC visit was on March 27 2018, at 14.00 WIB

After the third ANC was carried out, Mrs "Y" complained of frequent urination, this is by the theory of Raharjo & Ishartono (2015) which states that during pregnancy the kidneys work harder so that the kidneys filter blood whose volume increases by 30-50% or more and due to pressure on the uterus. which enlarges so that pregnant women often urinate.

Mrs "Y" has carried out an ANC examination and received midwifery services including 10 Ts which are by the (Mose et al., 2023). The weight examination results obtained by the author for Mrs "Y" were 91.5 kg and her weight before pregnancy was 80 kg. Mrs "Y" experienced a weight gain of 11.5 kg during pregnancy. This shows that the mother has gained approximately 1.3 kg in weight. According to the theory of Dewi, et al (2015), according to BMI calculations, Mrs "Y" is obese and should gain 5.5-6.8 kg of weight during pregnancy, management such as a diet for pregnant women increases Mrs "Y's weight." did not increase too much, which means the success of the diet program for pregnant women carried out by Mrs "Y". The mother's height is still within normal limits, namely 150 cm. This is still normal because it is by the Anggraini et al., (2021) theory which states that measuring a pregnant woman's height of less than 145 cm increases the risk of CPD (Cephalo Pelvic Disproportion).

The results of the blood pressure examination carried out by the author on Mrs "Y" were normal 110/80 mmHg, this is by the Kurniati et al., (2023) theory which states that normal blood pressure is 110/80-120/80 mmHg. Hypertension found in the first trimester indicates the possibility of chronic hypertension, while

hypertension that occurs after the first trimester is likely hypertension that arises in pregnancy.

Determining nutritional status by measuring LILA, namely the examination results obtained were 29 cm. From the results of the examination carried out by the author, Mrs "Y" did not experience KEK (Chronic Energy Deficiency). This is by the theory of Pusdiklatnakeds (2014) which states that the normal LILA for pregnant women is at least 23.5 cm. If it is less than 23.5 cm then the pregnant woman is said to be KEK (Chronic Energy Deficiency). Pregnant women with CED will be able to give birth to low birth weight (LBW) babies.

The author has carried out a palpation examination with the results of Leopold I, the height of the uterine fundus is midway between the xiphoid process - the center (Mcd 34 cm), this is to the theory of Sulistyawati (2012). In Leopold I, the upper part of the fundus feels round, soft, and not bouncy (buttocks), Leopold II, the right part of the mother's stomach feels long, and hard like a board (fetal back) and the left part of the mother's stomach feels small parts of the fetus (extremities), Leopold III the lowest part feels round, hard and bouncy (head), Leopold IV the fetal head has entered the pelvic outlet (PAP) or is diverging. This is by the interpretation of fetal weight based on Johnson's Tossec theory obtained by the formula fundus height (cm) - (11/12/13) x 155 grams = (34 cm - 11) x 155 grams = 3565 grams. The results of Leopold's examination are to the theory of Yuriah et al. (2022) which states that the Leopold I examination aims to determine the height of the fundus and feel part of the fetus in the fundus, Leopold II aims to find out the part of the fetus on the right or left side of the mother's abdomen, Leopold III aims to determine the part of the fetus that is below the uterus, Leopold IV aims to find out the part of the fetus that is below and to find out whether this part has entered/passed through the upper pelvic inlet.

In the DJJ examination carried out by the author on Mrs "Y", the results of the DJJ examination were a frequency of 136 x/minute, according to the theory of the Health Center for Education and Training (2014) which states that the DJJ assessment is carried out at the end of the first trimester and thereafter at every antenatal visit. A slow FHR of less than 120 times/minute or a fast FHR of more than 160 times/minute indicates fetal distress.

Giving Fe tablets to pregnant women according to the Pusdiklatnakes (2014) theory is a minimum of 90 tablets during pregnancy to prevent anemia in pregnant women. At this visit Mrs "Y" was also given blood-boosting tablets/Fe tablets. So there is no gap between theory and practice. A hemoglobin examination was carried out on Mrs "Y" and the results were 11.5 gr/dl, so it can be concluded that Mrs "Y" does not have anemia. This is by the Ristica (2019) theory which states that pregnant women are said to be anemic if the mother's blood hemoglobin is <11 gr%.

Overall, there were no abnormalities or complications that occurred to Mrs "Y" during pregnancy, this was because the ANC examination at BPM Soraya, Am.Keb was by midwifery service standards and Mrs "Y" always had her pregnancy checked and was willing to follow the recommendations. given by

midwives so that there is no gap between existing theory and reality at BPM Soraya, Am.Keb Palembang.

Labor

In labor, Mrs "Y" gave birth normally with a full-term pregnancy, namely at 39 weeks 4 days (term). Mrs "Y"'s delivery is said to be normal because it is by the theory of Rukiah, et al, (2014) which states that labor is the process of expelling the fetus which occurs in a full-term pregnancy (37-42 weeks) and is born spontaneously with a posterior head presentation which takes place within 18 hours. , without complications in the mother or fetus. The mother gave birth spontaneously with a cephalic presentation, labor proceeded normally. This process starts with adequate contractions, signs of stage II symptoms and ends with the birth of the placenta.

First stage of labor on April 8 2018, at 18.35 WIB

During the first stage of labor, Mrs "Y" came to BPM Soraya with her family, claiming to be 9 months pregnant with her third child, she had never had a miscarriage, and still felt fetal movement. The mother complained of pain in her lower abdomen down to her waist since 14.00 WIB, accompanied by mucus mixed with blood from the mother's genitals since 17.00 WIB. Mother admitted that the water had not come out yet. Mother feels anxious, anxious about this condition. At 19.00 WIB the author carried out an internal examination with the results of a thick portion, opening 2 cm, flattening 25%, positive amniotic fluid (intact), the bottom of the head, left front small fontanel pointer, decreased hodge II (4/5). This means that Mrs "Y" has shown signs of inpartu. This is by the theory of Prawirohardjo (2013) which states that when labor occurs, the waist feels painful, uterine contractions become stronger, and mucus is released accompanied by blood from the vagina.

Labor in the first stage of the active phase in the case of Mrs. "Y" lasted \pm 6 hours from 2 cm dilated to 10 cm (complete) so it can be estimated that the length of the first stage in the case of Mrs. "Y" was \pm 6 hours. This is by the theory of Nuryani et al. (2022) which states that the length of the first stage of labor lasts 10-12 hours in primiparas and 6-8 hours in multiparas. Based on the Friedman curve, the calculation of opening in primigravida is 1 cm/hour and multigravida opening is 2 cm/hour.

In the first stage of the active phase, based on the theory, monitoring the progress of labor is carried out using a partograph which includes: the condition of the mother (pulse every 30 minutes, blood pressure every 4 hours, temperature every 4 hours and urine every 2-4 hours) and the condition of the fetus (FHR every 30 minutes , amniotic color, infiltration/molasses). Open the cervix every 4 hours, lower the head every 4 hours, and uterine contractions every 30 minutes and monitor for signs of the second stage such as forceful urges, anus and vulva opening, and perineum protruding. During the first phase of Mrs "Y's active phase, the author carried out monitoring according to this theory and the partograph did not cross the alert line (Shahinfar et al., 2021).

During the 1st active phase, the author controlled the pain in Mrs "Y" with sequential movements or stroking using the palm which applied gentle pressure to the surface of the body in a circular direction repeatedly and the result was that Mrs "Y" felt that the pain she was feeling could be felt. under control. This is by Shahinfar et al (2021), which states that controlling pain can be done by rubbing sequentially using the palm which applies gentle pressure to the surface of the body in a circular direction repeatedly. Effleurage (wiping) has a sedative effect, which is calming, so it is always used at the beginning and end of the procedure.

Second stage of labor on April 8 2018, 23.00 WIB

The second stage of labor occurs at 23.00 WIB. Mrs "Y" said she wanted to pass, felt the pain getting stronger and more frequent and felt like she wanted to defecate. The author carried out an inspection examination, with the results of increasing amounts of blood mixed with mucus, and signs of stage II, such as the anus and vulva opening, the perineum protruding, the fetal head visible at the vaginal introitus and the opening being complete. This is under the theory of Ristica (2019), namely that the mother feels the urge to push, the pressure in the rectum and vagina increases, the vulva and anal sphincter appear to open, and the discharge of mucus and blood increases. Meanwhile, the sure sign of the second stage is that the cervix is completely open and the baby's head is visible at the vaginal introitus.

When assisting with childbirth, the use of equipment such as personal protective equipment (PPE) has begun to be implemented in practice areas to assist with childbirth such as using aprons, hand scoops, boat shoes, but for goggles, masks and head coverings are not used for reasons of practice area. less effective and can make patients feel irritated. Therefore, according to the author, this does not need to be done, apart from that the instruments used such as parturition sets, heating sets, and resuscitation sets as well as handscoons are used in sterile conditions so that birth assistance takes place safely and cleanly by the principles of normal birth care (Prawirohardjo, 2013).

Mrs "Y"'s second stage of labor lasted \pm 35 minutes. This is to the theory of Prawirohardjo (2013) which states that the second stage in primiparas lasts 1-1.5 hours and in multiparas 0.5-1 hour. After the baby is born, it is dried and then placed directly on the mother's stomach, for direct contact and IMD (Early Initiation of Breastfeeding) for the first 30 minutes to 60 minutes. This is by theory which states that after the baby is born, place the baby so that there is contact between the mother's skin and the baby's skin/IMD (Early Initiation of Breastfeeding).

Third stage of labor on April 8 2018, 23.40 WIB

At 23.40 WIB, the author carried out active management of the third stage which lasted 5 minutes on Mrs "Y", namely by giving an IM injection of 10 IU oxytocin in the upper 1/3 of the outer thigh (distal lateral), after ensuring no second fetus was using hold the umbilical cord closer to the vulva to prevent avulsion (breaking), place the other hand on the mother's abdomen (covered with cloth)

just above the pubic symphysis to feel strong contractions, then tense the umbilical cord when strong contractions occur with one hand and the other (on the abdominal wall) presses the uterus towards the lumbar spine and the mother's head (Dorso cranial) to prevent uterine inversion, then when the placenta separates, which is characterized by a rounded uterus, elongated umbilical cord, and a sudden gush of blood from the birth canal. The author performs controlled stretching of the umbilical cord (PTT) with dorso cranial movements, helping the birth of the placenta with a clockwise twisting movement. After that, the author massaged the uterine fundus while checking the integrity of the placenta. This is by Prawirohardjo (2013) which states that active management of the third stage is carried out to produce more effective uterine contractions, to shorten the time and prevent bleeding, which consists of giving oxytocin injections in the first 1 minute after the baby is born, tensioning the umbilical cord. under control (PTT) and uterine fundus massage.

Fourth stage of labor on April 8 2018, 23.55 WIB

The fourth stage lasts for 2 hours starting when the placenta is born until the first 2 hours postpartum. By monitoring the mother's pulse and bladder condition every 15 minutes during the first hour after delivery and every 30 minutes during the second hour after delivery. During the fourth stage, Mrs "Y" had a 2nd-degree tear in the birth canal in the perineal skin and perineal muscles so suturing was carried out. The height of the uterine fundus is 2 fingers below the center, lochea rubra is released, the bladder is not full. This is by the theory.

The results of fourth stage observations on Mrs "Y" were normal TTV 110/70-110/80 mmHg, temperature 36.6 °C-36.7°C, uterine fundus height 2 fingers below the center, good contractions, firm consistency, bladder not full, lochia rubra, blood loss during the birth process, namely in the first stage ± 30 cc, second stage ± 75 cc, third stage ± 100 cc, fourth stage ± 95 cc, the amount of blood loss experienced is ± 300 cc. In the case of Mrs "Y" it is within normal limits and the results of monitoring the results of the IV stage are attached to the medical examination. This is by the theory of Ristica (2019) which states that labor bleeding is considered normal if the amount does not exceed 400-500 cc.

Postpartum

The postpartum visit was carried out by the author on Mrs "Y" to assess the status of the mother and newborn, and to prevent, detect, and treat problems that occurred at 6 hours postpartum, 6 days postpartum, 2 weeks postpartum, and 6 weeks postpartum. This is by Yazdani et al (2023) theory which states that the first postpartum visit is 6-8 hours postpartum, the second visit is 6 days postpartum, and the third visit is 2 weeks 5 days postpartum.

Postpartum Period at 6 Hours Post Partum April 9 2018, 05.55 WIB

During Mrs "Y's postpartum period, the process proceeded normally. First postpartum care is carried out by the theory of the KIA Book (2016), namely for the first visit 6-8 hours postpartum. Based on the results of the anamnesis, Mrs "Y" complained that her stomach still felt bloated, and based on the results of the

physical examination, it was found that the mother's general condition looked good, compos mentis consciousness, blood pressure 120/80 mmHg, pulse 80 x/minute, temperature 36.6oC, RR 21 x/minute, the breasts are not swollen and the milk has come out. The uterus feels hard, TFU is 3 fingers below the center, uterine contractions are good, the perineum has a grade 3 suture wound, lochia rubra and the mother can mobilize, that is, she can get out of bed and walk to the bathroom. By the theory of Shimpuku et al (2023), the lochea that is released 1-2 days postpartum is lochea rubra. There is no gap between theory and practice.

Not only during pregnancy, according to Shahinfar et al (2021), the postpartum period also requires the intake of iron tablets to prevent anemia. This was also done to Mrs "Y" who was given iron tablets 1 x 1 tab/day. At this visit the midwife teaches the mother breastfeeding techniques according to the theory of Ristica (2019), namely the baby's head and body are in a straight line, the baby's head is at the mother's elbow and the baby's bottom is supported by the mother's hand, open the baby's mouth by touching the corner of the baby's mouth with the nipple then after the baby opens his mouth, insert the nipple and most of the areola into the baby's mouth.

Midwives also teach the market technique which aims to make breast milk come out more optimally by Shimpuku et al (2023) theory, namely the most widely used method of massaging and stimulating the breasts using the hands so that breast milk comes out more optimally. The author also reminds and explains to mothers the procedures for taking a bath after giving birth. Mrs "Y" also understands and will carry it out. So it can be concluded that the results of the visit at 6 hours postpartum were that the contractions were going well and there was no bleeding. The midwife had taught the mother to massage the mother's stomach to prevent bleeding. The midwife also advised the mother to keep the baby warm by swaddling the baby and not placing the baby under a fan/ The AC is open, the baby has been breastfed smoothly, breastfeeding techniques and hamstring techniques have been taught and how to prevent sore nipples. At this visit no complications were found, mother and baby were in good condition, and there was no gap between theory and practice.

Postpartum Visit on 6 days Post Partum April 15 2018, 09.30 WIB

The results of the examination at the postpartum visit 6 days postpartum carried out by the author on Mrs "Y" were normal and there were no complaints, the mother's general condition was good, composmentis consciousness, Blood Pressure 110/80 mmHg, Pulse 82 x/minute, Temperature 36.5oC, RR 22 x/minute, the uterus feels hard, TFU is in the middle of the symphysis center, good uterine contractions, the perineal wound is dry, and there is lochea sanguilenta. This is by the theory of Shimpuku et al (2023) which states that at 1 week the height of the uterine fundus is in the middle of the symphysis center, and the Lochea that is released 3-7 days postpartum is Lochea sanguinolent. There were no signs of infection in the mother. This shows that there is no gap between theory and practice.

Postpartum Visit at 2 weeks 5 days Post Partum on May 8 2018, 15.45 WIB

The results of the examination at the postpartum visit at 6 weeks postpartum carried out by the author on Mrs "Y" were normal and there were no complaints. The results of the examination showed that the mother's general condition was good, composmentis consciousness, blood pressure 120/80 mmHg, pulse 82 x/minute, temperature 36.7oC, RR 22 x/minute, TFU not palpable (normal), good uterine contractions, lochea alba. This is to the theory of Yuceline, Bherta et al (2022) which states that the height of the uterine fundus at 19 days is normal and the lochea that is released at 19 days postpartum, namely Lochea alba, is the last lochia. This shows that there is no gap between theory and practice.

At the last home visit, according to Raharjo & Ishartono (2015) the author provided counseling to Mrs "Y" about contraception that can be used by mothers after giving birth and while breastfeeding, such as natural contraception (condoms/MAL), 3-month injections, lactation pills, , implants, intrauterine contraceptive devices (AKBR/IUD) and tubectomy and advise the mother to discuss this with her husband. However, if the mother does not want to use contraception, she can use MAL contraception (Lactational Amenorrhoea Method), namely contraception that relies on exclusive breastfeeding, namely giving breast milk without additional food and drink. This method will be effective if the mother has not had another period, the baby is breastfed exclusively and frequently, and the baby is less than 6 months old. There is no gap between theory and practice. After receiving an explanation about contraception that can be used by postpartum breastfeeding mothers, Mrs "Y" is still considering it and will discuss it with her husband. The author also reminds and explains to mothers the mandatory procedures for bathing after the end of the postpartum period. Mrs "Y" understands and will carry it out.

Newborns and Neonates

Mrs "Y"'s baby was born on April 8 2018 at 23.55 WIB. The baby was born spontaneously crying, healthy, no congenital defects, male, weight 3300 grams, body length 50 cm, temperature 36.70C, respiration 45 x/m, head circumference 34 cm, chest circumference 33 cm, and circumference sleeve 11 cm. This is said to be normal because it is by the theory of states that the characteristics of a normal newborn include: birth at term gestational age (37-42 weeks), normal birth weight is 2500-4000 grams, body length Normal newborn babies are 48-52 cm, breathing is 40 – 60 x/m, the baby's chest circumference is 30-38 cm, head circumference is 33-35 cm and arm circumference is 11-12 cm, and Kildea et al (2016) says that temperature Normal for a baby is not >380 C and not <36 0 C. After the birth of the baby, Mrs "Y" newborn management was carried out by Ristica, (2019), namely clearing the airway, cutting and caring for the umbilical cord, maintaining the baby's body temperature, eye prophylaxis, and administering vitamin K.

Newborn 6 Hours Old on April 9 2018, 05.35 WIB

The first visit for Mrs "Y"'s baby was carried out in the first 6 hours. During this visit, the author advises the mother to keep her baby warm, keep the baby's

umbilical cord clean by changing the sterile gauze after every bath, when it is dirty/wet, recommends that the mother to breastfeed on demand or according to the baby's needs and not to put anything on the umbilical cord. baby. This is by Mose et al (2023) which state that caring for the umbilical cord involves simple actions, namely keeping the umbilical cord dry and clean and wrapping it in sterile gauze without putting anything on the area around the baby's umbilical cord.

So give HB 0 immunization IM in 1/3 of the baby's right outer thigh. HB₀ immunization was carried out on Mrs "Y"'s baby at 6 hours, by the theory of Nuryani et al (2022) which states that HB₀ immunization is given as early as possible after birth. So in theory and practice, there are no gaps found.

6 Day Newborn Visit on April 15 2018, 09.30 WIB

The second visit for Mrs "Y"'s baby was carried out on the day. The author checked the vital signs on the baby Mrs "Y" with the results of a temperature of 36.6°C, pulse 134 x/minute, respiration 46 x/minute, weight 3300 grams and monitoring the baby's condition within normal limits, no problems or complications were found, the baby was a healthy condition, reminding mothers to continue giving exclusive breast milk to their babies. There were no signs of danger in the baby, the umbilical cord fell off on the 5th day by the Ristica, (2019) which states that the length of time for the umbilical cord to fall off is said to be fast if it is less than 5 days, normal if between 5-7 days, and slow if more than 7 days.

At this visit, the midwife advises the mother to read prayers to the baby when the baby is going to sleep. This will provide calm to the baby. So it can be concluded that at this visit there were no danger signs such as possible bacterial infections, jaundice, low body weight, or problems with breastfeeding. This shows there is no gap between theory and practice.

Newborn Visit 2 weeks 5 days on April 28 2018, 16.00 WIB

The third visit for Mrs "Y"'s baby was carried out last week. The author checked the vital signs on Mrs "Y"'s baby with the results of a temperature of 36.9°C, pulse 130 x/minute, respiration 42 x/minute, weight of 3600 grams and monitoring the baby's condition within normal limits, no problems or complications were found, the baby was healthy condition, the baby is breastfed according to needs, and the baby sometimes vomits after being breastfed, which is then given IEC regarding baby burping techniques. This is by Raharjo & Ishartono (2015) who says give your baby breast milk in small amounts but often (at least every 2 hours), don't let it get too much or on demand, don't let the baby suck only the nipple, but the areola (the brownish or blackish part around the nipple) must also enter or stick to the baby's mouth, then pat the baby's back until it burps shortly after breastfeeding. Do not immediately put the baby to bed. The problem found is still classified as normal and no gaps were found with the theory.

At this visit, Mrs "Y"'s baby was given BCG and Polio 1 immunization. This is by the theory of Kildea et al (2016) which states that BCG immunization is given before the baby is 2-3 months old and polio immunization is 2 drops orally.

The author also explained to Mrs "Y" the benefits of BCG immunization, namely that it is useful for preventing tuberculosis and polio 1 immunization for preventing paralytic wilt and explained the side effects of BCG immunization, namely that there is a bubble on the baby's upper right arm and it should not be touched Shahinfar et al (2021). At this visit the author tells the mother to monitor whether there are any danger signs in the baby or not, such as faster breathing, high body temperature, red or festering umbilical cord, swollen eyes, yellow baby. If there are these signs, the mother is expected to immediately take the baby to the nearest health worker.

Conclusion

After the author carried out normal midwifery care for Mrs "Y" during pregnancy, delivery, postpartum and newborn babies at BPM Soraya, starting from 30 weeks of gestation until the postpartum period from the first day to 6 weeks post partum, it can be concluded that subjective data was obtained , objective data, analysis and diagnosis on Mrs "Y" comprehensively on pregnant women, giving birth, postpartum and newborns at BPM Soraya in 2018. Continuous planning, management and evaluation of pregnant women, giving birth, postpartum and newborn babies at BPM Soraya in 2018. Documentation of midwifery care that was carried out for Mrs "Y" during pregnancy, childbirth, postpartum and newborns using SOAP.

It is hoped that in carrying out midwifery care, students can pay attention to student activities and accompany students so that problems that occur can be immediately corrected and improved and students can learn more about the theories in midwifery that have been obtained during their education and can apply the knowledge that has been obtained as well as possible.

Conflict of interest statement

The authors declared that they have no competing interests.

Statement of authorship

The authors have a responsibility for the conception and design of the study. The authors have approved the final article.

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