

Continuity of Midwifery Care for a High-Risk Pregnancy Complicated by Hypertension and a Prolonged Interpregnancy Interval: A Case Study

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Abstract:

Continuity of care is an important approach in maternal and neonatal health services, particularly for pregnancies complicated by multiple risk factors. Maternal hypertension combined with a prolonged interpregnancy interval requires systematic surveillance across pregnancy, childbirth, the postpartum period, and neonatal care. This study aimed to describe the implementation and clinical outcomes of comprehensive continuity of midwifery care in a high-risk pregnancy involving hypertension and an interpregnancy interval of more than 10 years. A single-case study was conducted at the Cempaka Mulia Public Health Center in Cempaga District, East Kotawaringin Regency, Indonesia, from February to April 2025. The participant was a 31-year-old woman, G2P1A0, at 34 weeks of gestation. Care was provided from the third trimester through intrapartum, neonatal, postpartum, and family planning services using Varney's seven-step midwifery management approach and SOAP documentation. Antenatal assessment identified hypertension with a blood pressure of 147/98 mmHg. Labor progressed spontaneously, with a blood pressure of 119/89 mmHg at admission. A male infant was delivered vaginally with a birth weight of 2,900 g, body length of 46 cm, and an Apgar score of 9/10. No major maternal or neonatal complications were documented during follow-up. Four postpartum visits were completed, and a three-month injectable contraceptive was provided on postpartum day 48. Comprehensive continuity of midwifery care supported systematic risk monitoring, coordinated maternal and neonatal management, and sustained postpartum and reproductive health follow-up in this high-risk pregnancy.

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INTRODUCTION

Maternal and neonatal health remains a major priority in health systems because pregnancy and childbirth can rapidly shift from physiological processes to conditions requiring intensive surveillance and timely intervention (Khalil et al., 2023). The quality of maternity care depends not only on the availability of services but also on the continuity, coordination, and responsiveness of care throughout pregnancy, childbirth, the postpartum period, and the neonatal period (Symon et al., 2025). Women with identifiable pregnancy risks require particular attention because changes in maternal or fetal status may occur across different stages of care. Continuity of care has therefore become an important approach for integrating preventive, promotive, diagnostic, therapeutic, and follow-up services within a coherent maternal health pathway (Hermans et al., 2025).

High-risk pregnancy presents a substantial challenge in primary maternity care because several maternal conditions can increase the probability of adverse pregnancy and birth outcomes. Hypertension during pregnancy is one of the clinical conditions that requires systematic monitoring because elevated maternal blood pressure may be associated with impaired uteroplacental circulation, maternal complications, fetal growth disturbances, preterm birth, and deterioration of fetal well-being (Cífková, 2023). A prolonged interval between pregnancies may represent an additional reproductive risk that warrants closer assessment, particularly when it coexists with another maternal condition (Tedde et al., 2024). The simultaneous presence of hypertension and an interpregnancy interval of more than 10 years may therefore increase the clinical complexity of antenatal monitoring and childbirth preparation (Xiu et al., 2025).

Continuity of care has increasingly been recognized as a relevant model for improving the organization of maternal and neonatal services across the reproductive continuum (Sandall et al., 2024). This approach emphasizes continuous relationships, systematic clinical assessment, coordinated decision-making, health education, timely referral, and follow-up from pregnancy to the postpartum period. Midwives play a central role in this model, as they often provide antenatal assessment, childbirth support, postpartum monitoring, neonatal care, and family planning counseling, particularly at the primary healthcare level (Fox et al., 2023). Structured midwifery management can support early identification of actual and potential problems while maintaining comprehensive documentation of maternal and neonatal conditions throughout successive episodes of care (Kuipers, 2024).

Current maternal care approaches also emphasize that risk classification should be followed by longitudinal assessment rather than treated as a single diagnostic event (Van Eekhout et al., 2025). Maternal blood pressure may change during pregnancy and labor, while fetal condition and labor progression require repeated evaluation to identify emerging abnormalities (Beltrame et al., 2023). The clinical significance of a prolonged interpregnancy interval also needs to be interpreted alongside maternal age, obstetric history, current pregnancy condition, and other individual characteristics (Sevoyan et al., 2024). Comprehensive assessment is particularly important when multiple risk factors are present, as isolated management of individual conditions may overlook interactions across the antenatal, intrapartum, postpartum, and neonatal periods.

Existing studies on maternity care have extensively discussed hypertensive disorders of pregnancy, pregnancy spacing, and continuity-based models of midwifery care as distinct areas of investigation. In contrast, global evidence on midwifery continuity has predominantly focused on the implementation, organization, and outcomes of continuity models across different maternity settings (Bradford et al., 2022). Limited attention has been directed toward detailed clinical descriptions of how continuity of care is implemented across the complete maternity pathway in women experiencing hypertension, together with a very long interpregnancy interval. At the same time, studies of pregnancy spacing have generally examined interpregnancy interval as an independent exposure in relation to adverse maternal and perinatal outcomes (Tessema et al., 2022). Case-based evidence remains valuable for illustrating how risk identification, clinical monitoring, supportive care, neonatal assessment, postpartum surveillance, and family planning can be integrated into routine primary healthcare practice. The present study addresses this gap by documenting a complete episode of comprehensive midwifery care rather than focusing exclusively on a single phase of pregnancy or childbirth.

The novelty of this study lies in its longitudinal description of continuity of care in a high-risk pregnancy involving the coexistence of maternal hypertension and an interpregnancy interval exceeding 10 years. The care process was followed from third-trimester antenatal care through labor, birth, neonatal follow-up, postpartum care, and family planning services, reflecting the broader

scope of midwifery continuity in which risk detection and management are maintained across successive stages of maternity care (Susanti et al., 2022). Varney's seven-step midwifery management framework and SOAP documentation were used to structure clinical assessment and care documentation throughout the case, with structured SOAP documentation providing a systematic approach to recording subjective findings, objective findings, clinical assessment, and planned management (Joshi et al., 2022). This integrated perspective provides practical insight into how continuity of midwifery care can be maintained across different stages of maternal and neonatal care within a primary healthcare setting.

The present study aimed to describe the implementation and clinical course of comprehensive continuity of midwifery care for a 31-year-old woman, G2P1A0, with maternal hypertension and an interpregnancy interval of more than 10 years at Cempaka Mulia Public Health Center, Cempaga District, East Kotawaringin Regency, Indonesia. The study specifically examined the progression of care from antenatal assessment through intrapartum management, neonatal care, postpartum follow-up, and contraceptive services, consistent with evidence emphasizing the relevance of continuous monitoring and family involvement in the care of women with high-risk pregnancies (Sholikah et al., 2025). The clinical importance of this investigation lies in demonstrating how continuous and structured midwifery care can support risk monitoring, coordinate management, and sustain maternal and neonatal surveillance across the maternity continuum (Shahshahani et al., 2024).

METHOD

Study Design and Setting

A single-case study design was employed to provide comprehensive and continuous midwifery care for Mrs. I, a 31-year-old woman, G2P1A0, at 34 weeks of gestation with a high-risk pregnancy associated with hypertension and a pregnancy interval of more than 10 years. The study was conducted at Cempaka Mulia Public Health Center, Cempaga District, East Kotawaringin Regency, Indonesia, from February to April 2025.

Participant Characteristics

The participant was a 31-year-old pregnant woman, G2P1A0, at 34 weeks of gestation. The pregnancy was classified as high risk due to hypertension and a pregnancy interval of more than 10 years. Comprehensive care was initiated during the third trimester and continued throughout the subsequent stages of maternal and neonatal care.

Continuity of Care Procedure

Comprehensive midwifery care was provided across the continuum of maternal and neonatal services, including antenatal, intrapartum, postpartum, and neonatal care, as well as family planning services. Clinical assessment, identification of actual and potential problems, determination of immediate needs, care planning, implementation, and evaluation were systematically conducted using Varney's seven-step midwifery management approach.

Data Collection and Documentation

Data were obtained through maternal history-taking, physical and obstetric examinations, clinical observations, and follow-up assessments conducted throughout the continuity-of-care period. Maternal and neonatal clinical findings, interventions, responses to care, and follow-up

outcomes were systematically documented using the Subjective, Objective, Assessment, and Plan (SOAP) framework.

Data Analysis

The data were analyzed descriptively according to the continuity-of-care process. The analysis focused on changes in maternal and neonatal clinical conditions, identified midwifery problems, interventions provided at each stage of care, responses to the interventions, and maternal and neonatal outcomes during the study period.

Ethical Considerations

Ethical approval for the study was obtained from Universitas Eka Harap Palangka Raya. Participant confidentiality and anonymity were maintained throughout the processes of data collection, documentation, analysis, and reporting.

RESULT

Antenatal Care Findings

Comprehensive midwifery care was provided to Mrs. I, a 31-year-old woman, G2P1A0, whose pregnancy was classified as high risk due to hypertension and an interpregnancy interval of more than 10 years. Continuity of care was initiated during the third trimester at approximately 34 weeks of gestation at Cempaka Mulia Public Health Center, Cempaga District, East Kotawaringin Regency, Indonesia.

The obstetric history indicated that this was the participant's second pregnancy, with one previous birth and no history of miscarriage. The first day of the last menstrual period was recorded as June 4, 2024. A total of six antenatal visits were documented during the pregnancy.

Clinical assessment identified maternal hypertension, with an initial blood pressure of 147/98 mmHg. Midwifery care during the antenatal period included counseling on hypertension during pregnancy, the potential implications of a long interpregnancy interval, and measures to control maternal blood pressure. Maternal and fetal conditions were monitored throughout the antenatal period.

Intrapartum Care

Mrs. I presented to Cempaka Mulia Public Health Center on March 4, 2025, at 02:00 Western Indonesian Time (WIB), reporting regular uterine contractions that had started at approximately 00:00 WIB. Maternal and fetal conditions were stable at admission. Maternal vital signs were blood pressure 119/89 mmHg, pulse rate 84 beats/min, respiratory rate 22 breaths/min, and body temperature 37°C.

Vaginal examination showed no abnormalities of the vulva or urethra. The cervix was soft and thin, cervical dilatation was 8 cm, and the membranes remained intact. The fetal presentation was cephalic, with descent recorded at Hodge II+. No fetal small parts or prolapsed umbilical cord were palpated. The fetal heart rate was 140 beats/min. Uterine contractions occurred three to four times within 10 minutes, with a duration of approximately 30 seconds per contraction. Midwifery management during the first stage of labor included relaxation and deep-breathing techniques to support maternal comfort and pain management.

Second Stage of Labor

The second stage of labor lasted approximately 10 minutes. Clinical signs included an urge to push, increased pressure on the anus, opening of the vulva, protrusion of the perineum, and blood-stained mucus discharge. The fetal heart rate was 130 beats/min. Uterine contractions were regular at five contractions within 10 minutes, with each contraction lasting approximately 30 seconds.

A vaginal examination performed at 03:30 WIB showed complete cervical dilatation of 10 cm. The vulva and vagina were recorded as normal without edema, the membranes remained intact, and no umbilical cord prolapse was detected. Signs of the second stage of labor were present. Normal delivery care was subsequently performed in accordance with the 60-step normal childbirth care procedure. The male infant was born spontaneously on March 4, 2025, at 03:40 WIB and cried immediately after birth.

Third and Fourth Stages of Labor

The third stage of labor lasted approximately 5 minutes. Active management of the third stage of labor was performed. Maternal monitoring during the fourth stage included assessment of uterine contraction and vaginal bleeding. The uterus contracted adequately and was palpated as firm and rounded, with the uterine fundus at the level of the umbilicus. The maternal condition remained stable during the observation period. Postpartum monitoring was conducted for 2 hours. Observations were performed four times at 15-minute intervals during the first hour and twice at 30-minute intervals during the second hour.

Neonatal Outcomes and Follow-Up

The newborn was male, cried immediately after birth, and demonstrated active muscle tone. The Apgar score was 9/10. Birth weight was 2,900 g, body length was 46 cm, head circumference was 32 cm, and chest circumference was 33 cm. The anus was patent. No caput succedaneum or apparent congenital abnormalities were recorded during the initial neonatal examination. The second neonatal visit was conducted at the participant's home on March 8, 2025, at 15:30 WIB. Continued neonatal assessment was provided as part of the continuity-of-care approach.

Postpartum and Family Planning Care

Postpartum care was provided through four follow-up visits. Maternal condition was monitored throughout the postpartum period as part of comprehensive midwifery care. The final documented follow-up occurred on April 20, 2025, at 09:00 WIB, corresponding to postpartum day 48. Mrs. I attended Cempaka Mulia Public Health Center and received a three-month injectable contraceptive as her postpartum family planning method.

DISCUSSION

The present case demonstrates the application of continuity of care in a pregnant woman with two clinically relevant risk factors, namely maternal hypertension and an interpregnancy interval of more than 10 years. Comprehensive midwifery care was initiated during the third trimester and continued through labor, childbirth, the neonatal period, postpartum follow-up, and family planning. Maternal hypertension was identified during antenatal assessment with a blood pressure of 147/98 mmHg, while subsequent assessment during labor showed a blood pressure of 119/89 mmHg. Labor progressed spontaneously, and the infant was born in good condition with an Apgar score of 9/10 and a birth weight of 2,900 g. No major maternal or neonatal complications were documented during the observed care period. These findings indicate that continuity of care provided a structured

framework for monitoring maternal and fetal conditions across successive stages of maternity care (Wainaina et al., 2024).

Maternal hypertension represented the most important clinical concern during pregnancy because hypertensive disorders are associated with increased maternal and perinatal morbidity. Elevated blood pressure during pregnancy may impair uteroplacental perfusion and increase the risk of fetal growth restriction, placental complications, preterm birth, and maternal deterioration when not appropriately identified and managed (Wu et al., 2023). The antenatal blood pressure of 147/98 mmHg warranted continued clinical surveillance even though severe symptoms were not documented. The later measurement of 119/89 mmHg during labor indicated a more favorable blood pressure at that assessment. A single improved measurement should not be interpreted as a complete resolution of hypertension, because maternal blood pressure may fluctuate with physiological condition, activity, pain, emotional stress, gestational stage, and measurement technique. Serial assessment remains essential in pregnant women with previously documented hypertension.

The antenatal findings are consistent with previous research emphasizing the importance of repeated monitoring in women with high-risk pregnancies. Routine antenatal assessment provides opportunities to evaluate maternal blood pressure, identify warning signs, monitor fetal well-being, and determine whether referral or additional intervention is required (Henderson et al., 2023). Six antenatal visits were documented in this case, allowing repeated assessment and provision of health education. Counseling regarding hypertension was also an important component of care because maternal understanding may influence adherence to follow-up, recognition of danger signs, and timely use of health services. Continuity between successive visits may further strengthen communication and facilitate early recognition of changes in maternal condition.

The absence of severe maternal complications should be interpreted as a favorable clinical trajectory rather than direct evidence of the effectiveness of continuity of care. Multiple factors, including the severity and pattern of hypertension, maternal health status, gestational age, fetal condition, access to skilled healthcare providers, and timeliness of clinical management, influence maternal outcomes. Previous studies have reported that continuity models of maternity care can improve coordination, maternal satisfaction, communication, and consistency of clinical information (Shahinfar et al., 2024). The present case supports the practical relevance of these mechanisms, as information obtained during antenatal care can be integrated into intrapartum and postpartum management.

The interpregnancy interval of more than 10 years represented an additional maternal risk characteristic requiring careful surveillance. Long interpregnancy intervals have been associated with increased risks of hypertensive disorders and other adverse pregnancy outcomes when compared with moderate intervals between pregnancies (Luo et al., 2026). Several biological mechanisms have been proposed to explain these associations, including the gradual loss of physiological adaptations acquired during previous pregnancies. Maternal reproductive physiology after a prolonged pregnancy interval may partly resemble that of a first pregnancy. Changes in maternal age, general health status, lifestyle, and socioeconomic conditions between pregnancies may also contribute to the increased risk observed in women with prolonged interpregnancy intervals.

The favorable outcome observed in this case illustrates that a long interpregnancy interval does not inevitably result in adverse pregnancy outcomes. Risk classification is intended to identify women who require closer surveillance rather than to predict complications with certainty. The coexistence of hypertension and a prolonged interpregnancy interval increased the need for systematic assessment because multiple risk characteristics may contribute to greater clinical

complexity. Continuity of care created an opportunity to integrate risk identification with ongoing observation rather than treating antenatal, intrapartum, postpartum, and neonatal services as unrelated episodes of care (Mulongo et al., 2024).

The intrapartum findings demonstrated physiological progression of labor despite the pregnancy being categorized as high risk. The participant presented with cervical dilatation of 8 cm, intact membranes, cephalic presentation, fetal descent at Hodge II+, a fetal heart rate of 140 beats/min, and uterine contractions occurring three to four times within 10 minutes, each lasting approximately 30 seconds. Progression to complete cervical dilatation occurred by 03:30 WIB, followed by spontaneous birth approximately 10 minutes later. The documented findings indicate efficient progression through the active and second stages of labor without recorded evidence of obstructed labor or fetal compromise, which is clinically relevant because interpregnancy interval has also been investigated in relation to patterns of labor progression (Burd et al., 2024).

The use of relaxation and deep-breathing techniques during the first stage of labor was consistent with supportive non-pharmacological approaches used in maternity care. Controlled breathing may help women regulate their pain response, reduce anxiety, improve coping, and increase comfort during uterine contractions (Heim & Makuch, 2023). Such interventions do not replace clinical surveillance in high-risk pregnancies but may complement physiological monitoring by addressing emotional and behavioral aspects of childbirth. Continuous supportive care also strengthens communication between women and healthcare providers, which is particularly important when clinical deterioration requires prompt recognition.

The fetal heart rate findings remained within a reassuring range throughout the documented stages of labor. A fetal heart rate of 140 beats/min was recorded during the first stage, while 130 beats/min were documented during the second stage. Regular assessment of fetal heart rate is clinically important because it remains a central component of evaluating fetal well-being during labor (Crouch et al., 2024). The absence of documented abnormal fetal heart rate findings was compatible with the favorable neonatal condition observed immediately after birth. The available documentation did not provide continuous cardiotocographic data or detailed fetal monitoring patterns, which limits a more comprehensive evaluation of intrapartum fetal status.

The neonatal outcome was favorable, as indicated by the indicators recorded immediately after delivery. The male infant cried spontaneously, demonstrated active muscle tone, and had an Apgar score of 9/10. Birth weight was 2,900 g, body length was 46 cm, head circumference was 32 cm, and chest circumference was 33 cm. No apparent congenital abnormalities, caput succedaneum, or anorectal abnormalities were documented during the initial examination. These findings suggest satisfactory early neonatal adaptation and no immediate evidence of major compromise, particularly because Apgar scores remain clinically useful for describing the newborn's immediate condition and identifying neonates at greater risk of short-term morbidity (Huang et al., 2024).

The neonatal findings are clinically relevant because hypertensive pregnancies may be associated with impaired fetal growth and adverse neonatal outcomes when uteroplacental circulation is significantly affected (Damasceno et al., 2024). The birth weight in this case was above the conventional threshold for low birth weight and did not indicate an obvious growth-related complication based on the available data. Previous research has demonstrated substantial variation in neonatal outcomes among pregnancies complicated by hypertension. Such variation may depend on the severity of hypertension, gestational age at onset, maternal comorbidities, placental function, fetal growth, and quality of antenatal monitoring. The present case represents a favorable individual outcome rather than evidence that hypertension carries minimal neonatal risk.

Postpartum follow-up extended continuity of care beyond delivery and supported continued maternal and neonatal surveillance. Four postpartum visits were documented, while the second

neonatal visit was conducted at the participant's home. Postpartum surveillance remains important for women with a history of elevated blood pressure because hypertensive complications may persist, recur, or emerge after childbirth. In contrast, timely blood pressure screening can facilitate the detection of ongoing cardiovascular risk (Daubert et al., 2024). Continued contact with healthcare providers also creates opportunities to assess uterine involution, postpartum bleeding, breastfeeding, maternal recovery, infection risk, neonatal adaptation, and psychological well-being. Home-based neonatal follow-up may also improve accessibility and enable healthcare providers to assess the infant in the family environment.

The provision of a three-month injectable contraceptive on postpartum day 48 represented an important component of reproductive continuity. Integration of family planning into postpartum care enables women to make informed decisions about future pregnancies and supports appropriate spacing between pregnancies (Steenland et al., 2025). The participant's previous interpregnancy interval exceeded 10 years, making individualized reproductive counseling particularly relevant. Postpartum contraception can therefore be understood as part of a broader reproductive health strategy rather than an isolated intervention at the end of maternity care.

The clinical implications of this case primarily concern the value of maintaining continuity of care across antenatal, intrapartum, postpartum, neonatal, and family planning services for women at identifiable risk of pregnancy complications. Fragmented maternity care may result in repeated assessments without adequate transfer of clinical information, while continuity facilitates longitudinal understanding of maternal history, risk factors, clinical changes, and responses to care. Midwives in primary healthcare settings are well positioned to support this process through risk detection, counseling, monitoring, referral decisions, labor support, postpartum surveillance, neonatal assessment, and family planning services, reflecting the broader evidence supporting midwife continuity of care across pregnancy, birth, and postpartum periods (Kuipers et al., 2026). The case also emphasizes the importance of distinguishing risk identification from the actual occurrence of complications, since high-risk classification should promote vigilance and preparedness without assuming that adverse outcomes are inevitable.

The findings should be interpreted within the limitations of a single-case design. Observations from one participant cannot be generalized to all women with hypertension or prolonged interpregnancy intervals. At the same time, the absence of a comparison group prevents assessment of whether the favorable outcomes were specifically related to continuity of care, reflecting the recognized limitations of case reports regarding generalizability and causal inference (Divecha & Tullu, 2026). The available documentation did not include detailed serial blood pressure measurements, urinary protein assessment, laboratory findings, antihypertensive treatment, placental assessment, or other diagnostic parameters that would allow more precise characterization of the hypertensive condition. Neonatal follow-up information was also limited, restricting evaluation of longer-term infant outcomes. The descriptive design does not permit causal inference, although the case provides clinically relevant insight into the organization and implementation of comprehensive midwifery care across the maternal and neonatal continuum.

CONCLUSION

Continuity of care provided a comprehensive framework for managing a high-risk pregnancy complicated by maternal hypertension and an interpregnancy interval of more than 10 years across the antenatal, intrapartum, neonatal, postpartum, and family planning periods. Systematic maternal and fetal surveillance, supportive intrapartum care, postpartum monitoring, neonatal follow-up, and contraceptive counseling were associated with favorable maternal and neonatal outcomes in this

case, including spontaneous vaginal birth and satisfactory early neonatal adaptation without documented major complications. These findings underscore the clinical relevance of coordinated midwifery care for early risk identification, continuous monitoring, timely intervention, and sustained reproductive health support in women with high-risk pregnancies. Interpretation should remain cautious because the single-case design does not permit causal inference or generalization to broader populations.

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