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Continuity of midwifery care for a 40-year-old multigravida from 26 weeks of gestation to postpartum contraception: A case report

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Abstract:
Maternal and neonatal mortality in Indonesia remain above the Sustainable Development Goals targets, and women aged 35 years or older face additional obstetric risks. Midwife-led continuity of care (CoC) is recommended to identify risks early and coordinate timely care. This case report aimed to describe the implementation and outcomes of CoC for a 40-year-old multigravida (G2P1001) from 26 weeks of gestation through childbirth, the postpartum period, newborn care, and contraception. A descriptive single-case study was conducted at an independent midwifery practice in Kediri Regency, Indonesia, from November 11, 2024, to March 22, 2025, and reported following the CARE guidelines. Data were collected through interviews, physical examinations, the Maternal and Child Health handbook, the partograph, and SOAP documentation, and were compared with national and international standards. The woman completed 18 antenatal contacts and gave birth spontaneously at term after a rapid, uncomplicated labor. Sore nipples and low milk flow improved after latch correction, breast care, and oxytocin massage. The newborn developed mild jaundice limited to the face and neck and remained in good condition at follow-up. The woman chose a three-monthly injectable contraceptive together with her husband. Midwife-led CoC supported early risk identification and safe outcomes for mother and baby.

Keywords:
continuity of care; advanced maternal age; midwifery; neonatal jaundice; breastfeeding

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INTRODUCTION

Maternal and neonatal mortality are core indicators of a health system's quality. Most maternal deaths worldwide result from preventable causes, mainly hemorrhage, hypertensive disorders, and sepsis, and most occur in low- and middle-income countries (Say et al., 2014). Indonesia has made progress, but its maternal mortality ratio, estimated at 189 per 100,000 live births in the 2020 population census, is still far from the Sustainable Development Goals target of fewer than 70 per 100,000 live births by 2030. Hypertensive disorders, obstetric hemorrhage, and infection remain the leading causes, and many deaths are linked to delays in recognizing risk and reaching appropriate care (Syairaji et al., 2024).

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Maternal age is one of the risk factors that can be identified early. Women who become pregnant at 35 years or older have a higher risk of stillbirth, preeclampsia, gestational diabetes, fetal growth restriction, preterm birth, and cesarean birth than younger women (Lean et al., 2017). These risks rise further after the age of 40, and they are often combined with other conditions such as chronic hypertension or obesity (Frick, 2021). For this reason, women of advanced maternal age need care that is regular, attentive, and well coordinated between midwives and obstetricians, rather than isolated visits with different providers.

The management of pregnancy at an advanced maternal age requires attention not only to obstetric risk but also to the changing needs of women throughout the maternity period. Risk assessment should be accompanied by individualized counseling, birth preparedness, appropriate referral planning, and postnatal monitoring. As pregnancy progresses, clinical priorities may shift from monitoring maternal conditions and fetal growth to ensuring safe labor, supporting maternal recovery, and identifying early complications in the newborn. Fragmented care may make it difficult to maintain consistent communication and follow-up across these stages. An integrated approach is therefore important to ensure that clinical decisions are coordinated and that maternal and neonatal needs are addressed continuously from pregnancy through the postnatal period.

The continuum of care for maternal, newborn, and child health links services across time (from pregnancy to childbirth, the postnatal period, and early childhood) and across place (from home and community to health facilities) (Kerber et al., 2007). In midwifery, this idea is put into practice through continuity of care (CoC), in which a known midwife or a small team of midwives cares for a woman from early pregnancy until the postpartum period. The Lancet Series on Midwifery identified this kind of woman-centered, continuous care as a key feature of quality maternal and newborn care (Renfrew et al., 2014). The latest Cochrane review found that, compared with other models, midwife CoC probably reduces preterm birth and fetal loss, lowers the use of interventions such as epidural analgesia and instrumental birth, and increases women's satisfaction (Sandall et al., 2016; Sandall et al., 2024). Women value the trusting relationship that grows from seeing the same midwife, and this relationship helps them share concerns and follow advice (Perriman et al., 2018).

CoC is not only for low-risk women. Studies in socially disadvantaged populations and among women at increased risk of preterm birth show that continuity can be delivered safely alongside obstetric care and may improve outcomes (Homer et al., 2017; Fernandez Turienzo et al., 2020). However, most of the evidence comes from high-income countries, and less is known about how CoC works in primary care settings in low- and middle-income countries (Bradford et al., 2022).

In Indonesia, many women receive primary maternity care from independent midwifery practices. The national standard requires at least six antenatal contacts, including two visits with a physician, whereas the World Health Organization (WHO) recommends at least eight contacts for a positive pregnancy experience (Tunçalp et al., 2017). Midwifery education programs use CoC as a clinical learning model, in which students follow one woman from pregnancy to contraceptive services under supervision. Well-documented case studies are useful in this setting because they show how standards are applied to a real patient and where gaps between theory and practice

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remain (Afandi et al., 2023; Afandi et al., 2024). They also demonstrate how care can address a person's physical, psychological, and social needs (Afandi et al., 2026).

A case-based evaluation can provide practical insight into how continuity models are implemented in everyday primary maternity care. By examining the sequence of assessments, clinical decisions, interventions, and referrals, a case report can illustrate whether recommended standards are translated into appropriate care at each stage. This approach is particularly relevant when a woman presents with specific risk factors and develops clinical or postnatal concerns that require different responses over time. Furthermore, documenting both appropriate practices and areas requiring improvement can support reflective learning among midwives and students. Such an evaluation does not establish the effectiveness of CoC at a population level, but it can identify important clinical lessons and opportunities to improve the quality and consistency of maternity services.

Despite this, few case reports from Indonesian primary care describe the full CoC pathway for a woman of advanced maternal age and compare each phase with current evidence, including common postnatal problems such as nipple pain, low milk flow, and neonatal jaundice. This case report therefore aimed to describe the implementation and outcomes of midwife-led CoC for a 40-year-old multigravida (G2P1001) from 26 weeks of gestation through labor, the postpartum period, newborn care, and contraceptive services, and to compare the care provided with national and international standards.

METHODS

This study used a descriptive single-case study design with a continuity-of-care approach. The report follows the CARE guidelines for case reports (Riley et al., 2017). The same structured case-study approach has been used to examine how care standards are applied in clinical practice in Indonesia (Afandi et al., 2023; Afandi et al., 2024). The study was conducted at the independent midwifery practice (Tempat Praktik Mandiri Bidan, TPMB) of Muhartik, S.Tr.Keb., Bd., in Kandangan Village, Kediri Regency, East Java, Indonesia. The practice provides antenatal, intrapartum, postnatal, newborn, and family planning services and refers women to obstetricians and hospitals when needed. Care was provided from November 11, 2024, to March 22, 2025.

The participant was selected purposively. Inclusion criteria were: (1) a pregnant woman in the second or third trimester at the first contact, (2) receiving care at the practice, (3) living in the service area, and (4) willing to be followed from pregnancy until contraceptive services. The participant was Mrs. N, a 40-year-old woman, G2P1001, at 26 weeks of gestation with a single live intrauterine fetus. Her newborn was included in the continuum of care. Care covered five phases: (1) antenatal care, including routine and integrated antenatal care with laboratory screening and obstetrician consultations according to the national standard; (2) intrapartum care according to normal childbirth care standards, with labor progress recorded on a partograph; (3) four postnatal visits (KF1 at 6–48 hours, KF2 at 3–7 days, KF3 at 8–28 days, and KF4 at 29–42 days); (4) three neonatal visits (KN1 at 6–48 hours, KN2 at 3–7 days, and KN3 at 8–28 days); and (5) family planning counseling, which began during pregnancy and continued until a method was chosen.

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Subjective data were obtained through interviews with the woman and her husband. Objective data were obtained through physical and obstetric examinations (vital signs, Leopold maneuvers, fundal height, fetal heart rate, and vaginal examination), laboratory results, newborn examination, and visual assessment of jaundice using Kramer's zones. Records from the Maternal and Child Health (MCH) handbook and the partograph were also reviewed. The first contact was documented using Varney's seven-step management process, and follow-up contacts were documented in the SOAP (subjective, objective, assessment, plan) format.

Data were analyzed descriptively for each phase of care. The findings and interventions were compared with relevant standards and evidence, including WHO antenatal and intrapartum care recommendations (Tunçalp et al., 2017; Oladapo et al., 2018), contemporary labor progress data (Zhang et al., 2010), and guidelines on breastfeeding and neonatal hyperbilirubinemia (Flaherman et al., 2017; Kemper et al., 2022). Any differences between the care provided and these standards were noted and discussed. Credibility was strengthened by comparing information from the woman, her husband, the MCH handbook, and the supervising midwife. Written informed consent was obtained from the woman and her husband for the provision of care and for the publication of this case report. All identifying information was removed, and only initials are used. The study was conducted in accordance with the Declaration of Helsinki.

RESULTS

Mrs. N received continuous care across all five phases between November 11, 2024, and March 22, 2025. The main findings, assessments, care, and outcomes for each phase are summarized in Table 1.

At the first contact, Mrs. N was 40 years old, G2P1001, at 26 weeks of gestation, with a single live intrauterine fetus. The only risk factor identified was advanced maternal age (≥35 years); no other complications were recorded during pregnancy. Throughout her pregnancy, she attended 18 antenatal contacts: 12 with a midwife and six with an obstetrician. These included integrated antenatal care with laboratory screening in the first and third trimesters. Care focused on monitoring maternal and fetal well-being, education on danger signs and nutrition, birth preparedness, and counseling on postpartum contraception, which was started at 35 weeks of gestation.

On February 10, 2025, at term, Mrs. N came to the practice with fluid leaking from the vagina since 13:00 and regular uterine contractions. Vaginal examination showed a cervical dilatation of 7 cm, and she was transferred to the delivery room. Cervical dilatation was complete at 15:19, about one hour after admission. The second stage lasted 5 minutes and ended with the spontaneous birth of a live baby boy. The third stage began at 15:25 and lasted 5 minutes; the placenta and membranes were delivered intact. During the fourth stage, the mother was monitored every 15 minutes in the first hour and every 30 minutes in the second hour, and no complications were recorded. The labor timeline and reference values are shown in Table 2.

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Table 1. Summary of continuity of midwifery care for Mrs. N

Phase	Key findings	Assessment	Care provided	Outcome
Antenatal (26 weeks to term; 18 contacts: 12 midwives, 6 obstetrician)	Age 40 years; G2P1001; single live intrauterine fetus; no other complications recorded	Pregnancy with risk factor: advanced maternal age	Routine and integrated antenatal care; obstetrician consultations; education on danger signs, nutrition, and birth preparedness; contraceptive counseling from 35 weeks	Mother and fetus in good condition until term
Intrapartum (February 10, 2025)	Fluid leakage since 13:00; regular contractions; cervix 7 cm on admission	Multigravida in active first stage of labor at term	Normal childbirth care; partograph monitoring; fourth stage monitoring every 15 min (1st hour) and every 30 min (2nd hour)	Spontaneous birth of a live boy; complete placenta; no complications recorded
Postpartum (KF1–KF4)	KF2: sore nipples and low milk flow	P2002 postpartum woman with lactation problem	Correction of position and attachment; breast care; expressed milk on nipples; oxytocin massage	Breasts softer; milk flowed more easily; normal involution at all visits
Newborn (KN1–KN3)	Strong cry, pink skin, active; length 49 cm; head circumference 33 cm; KN1: yellow face and neck (Kramer zone 1)	Term newborn with mild jaundice	Breastfeeding at least every 2 hours; morning sunlight exposure (local practice); education on danger signs	Feeding well and in good condition at KN2 and KN3
Family planning	Wish to space or limit further pregnancies; breastfeeding	Postpartum woman in need of contraception	Counseling from 35 weeks; shared decision with husband	Three-monthly injectable contraceptive started

KF = postnatal visit (kunjungan nifas); KN = neonatal visit (kunjungan neonatal).

Four postnatal visits were completed (KF1–KF4). At the second visit, Mrs. N reported sore nipples and said that only a small amount of breast milk was coming out. The midwife corrected the baby's position and attachment, taught breast care, advised applying expressed breast milk to the nipples and letting them air-dry after feeding, and performed oxytocin massage along the spine. After the massage, Mrs. N reported that her breasts felt softer and that milk flowed more easily. At all four visits, uterine involution, lochia, and vital signs were within normal limits, and she was assessed as a healthy P2002 postpartum woman.

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Table 2. Timeline of labor for Mrs. N compared with reference values

Stage of labor	Time (WIB)	Duration in this case	Reference value	Interpretation
Onset of symptoms	13:00	–	–	Fluid leakage and regular contractions
Active first stage (7 cm to full dilatation)	Admission to 15:19	About 1 hour	Multiparas progress faster after 6 cm (Zhang et al., 2010)	Rapid but normal progress
Second stage	15:19–15:24	5 minutes	Up to 2 hours in multiparas (Oladapo et al., 2018)	Within normal limits
Third stage	15:25–15:30	5 minutes	Usually 5–30 minutes	Within normal limits
Fourth stage	2 hours after placenta	Monitoring every 15 min (1st hour) and 30 min (2nd hour)	Standard postpartum monitoring	No complications recorded

WIB = Western Indonesian Time.

The baby was born spontaneously with a strong cry, pink skin, and active movement. His body length was 49 cm, and his head circumference was 33 cm. Three neonatal visits were completed. At the first visit, mild yellowing of the face and neck (Kramer zone 1) was observed. The mother was advised to breastfeed at least every 2 hours, and, following local practice, the baby was exposed to morning sunlight between 07:00 and 08:00 with his eyes covered. Serum or transcutaneous bilirubin was not measured. At the following visits, the baby was feeding well and was in good condition. Contraceptive counseling started at 35 weeks of gestation and covered the options suitable for a breastfeeding woman aged 40 years. After discussing the options with her husband, Mrs. N chose the three-monthly injectable contraceptive (depot medroxyprogesterone acetate), which she received at the end of the postpartum period.

DISCUSSION

This case shows that midwife-led CoC can be delivered safely to a woman of advanced maternal age in an Indonesian primary care setting. Mrs. N received continuous care from 26 weeks of gestation until she started contraception. Her pregnancy risk was identified early, labor was rapid but uncomplicated, postnatal breastfeeding problems were managed, mild neonatal jaundice was detected at the first visit, and a contraceptive method was chosen jointly with her husband. These results are consistent with evidence that CoC improves the safety and quality of maternity care (Sandall et al., 2024). The case also points to some practices that should be updated, which are discussed below.

In the antenatal period, maternal age was the main reason for closer monitoring. Women aged 40 years or older have a higher risk of stillbirth, preeclampsia, gestational diabetes, and fetal growth problems (Lean et al., 2017; Frick, 2021). Mrs. N attended 18 antenatal contacts, well above both the Indonesian minimum of six and the WHO recommendation of eight (Tunçalp et al., 2017). The combination of midwife visits and obstetrician consultations meant she had a familiar

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midwife for routine care and a specialist review of her age-related risk. This shared model is similar to continuity approaches tested among women at increased risk, where midwife continuity worked well alongside obstetric care (Fernandez Turienzo et al., 2020). However, the number of visits is only one part of quality. WHO stresses that each contact should include effective screening, clear information, and emotional support (Tunçalp et al., 2017). For a woman aged 40 years, this includes blood pressure and urine protein checks, screening for gestational diabetes, fetal growth monitoring, and a clear plan for the place of birth. Future case reports should describe these contents in more detail so that the quality of each contact, not just the number, can be judged.

An important aspect of managing pregnancy in women of advanced maternal age is the integration of risk assessment with timely clinical decision-making. Although regular antenatal contacts provide opportunities to identify potential complications, their effectiveness also depends on how abnormal findings are interpreted, communicated, and managed. Midwives in primary care have an important role in recognizing warning signs, documenting changes in maternal and fetal conditions, and coordinating consultations or referrals when specialist assessment is required. In a continuity model, this coordination can be more responsive because the midwife has an established understanding of the woman's medical history, pregnancy progress, and individual needs. This case illustrates how continuity and collaboration with obstetric services can complement each other in supporting maternal safety without unnecessarily fragmenting routine maternity care.

The labor was fast. The interval from the onset of symptoms at 13:00 to birth at about 15:24 was less than 3 hours; the active phase from 7 cm to full dilatation took about 1 hour, and the second stage lasted only 5 minutes. Contemporary labor data show that multiparous women progress much faster than nulliparous women once the cervix reaches 6 cm (Zhang et al., 2010), so this pattern is not unusual for a multigravida. Even so, very rapid labor is linked with perineal tears and postpartum hemorrhage, and advanced maternal age adds to the risk of hemorrhage. In this case, the fourth stage was monitored at the recommended intervals, and no complications occurred. The case also shows a practical benefit of CoC: because the woman already knew her midwife and the birth plan, she came to the practice promptly and gave birth in a facility with a skilled attendant. WHO intrapartum guidance supports this kind of respectful, continuous support with careful monitoring and no unnecessary interventions (Oladapo et al., 2018).

In the postpartum period, the main problem was sore nipples with low milk flow. Nipple pain is one of the most common reasons why mothers stop breastfeeding early, and it is usually caused by poor positioning and attachment. A Cochrane review found that no single topical treatment is clearly better than others and that correct latch and good breastfeeding support are the key elements of care (Dennis et al., 2014). The midwife's first step, correcting position and attachment, was therefore appropriate. Oxytocin massage, a back massage along the spine widely used in Indonesia, was added to promote milk flow. Gentle touch and massage can stimulate the release of oxytocin, which plays a central role in the milk ejection reflex and in reducing stress (Uvnäs-Moberg et al., 2015). The improvement reported by Mrs. N is consistent with this mechanism, but it was based on her own report rather than on objective measures such as infant weight gain, the number of feeds, or wet diapers. Supporting breastfeeding in this way is important because breastfeeding protects infants against infection and provides long-term health benefits for both mother and child (Victora et al., 2016).

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The newborn developed mild jaundice limited to the face and neck. Jaundice is common in the first week of life because newborns break down red blood cells quickly and their livers are not yet fully mature. Frequent and effective breastfeeding, 8 to 12 times a day, reduces the reabsorption of bilirubin in the gut and helps prevent jaundice related to poor intake (Flaherman et al., 2017). The advice to breastfeed every 2 hours was therefore correct. Morning sunlight exposure, however, needs careful discussion. Current clinical guidelines do not recommend direct sunlight as a treatment for neonatal hyperbilirubinemia because the light dose cannot be controlled and the baby may be exposed to sunburn, overheating, or cold (Kemper et al., 2022). A trial in Nigeria showed that filtered sunlight, using special canopies that block harmful rays and are closely monitored, can be as effective as conventional phototherapy (Slusher et al., 2018). This is very different from placing an undressed baby in direct sunlight at home. In addition, visual assessment of jaundice is unreliable, and jaundice that appears within the first 24 hours of life always requires a bilirubin measurement (Kemper et al., 2022). In this case, bilirubin was not measured, and the exact time of onset was not recorded. Midwives in primary care should therefore record the baby's age in hours when jaundice is first seen, measure bilirubin with a transcutaneous device or refer for a serum test as needed, explain the warning signs to parents, and replace advice on direct sunlight with guidance on effective breastfeeding and timely follow-up.

Family planning was discussed from 35 weeks of gestation, which is in line with evidence that antenatal counseling increases the use of contraception after birth and helps prevent short birth intervals (Cleland et al., 2015). Mrs. N chose a method together with her husband. Shared decision-making, where the provider gives balanced information and respects the woman's values and preferences, improves satisfaction and continued use of contraception (Dehlendorf et al., 2017). In Indonesia, involving the husband is often culturally important and can strengthen support for the chosen method. The three-monthly injectable is compatible with breastfeeding. For women aged 40 years or older who have completed their families, counseling should also include information on long-acting reversible and permanent methods, so that the final choice is fully informed.

Beyond the clinical results, this case highlights the relational value of CoC. Women describe continuity as more than "a friendly face"; it builds trust, makes it easier to raise concerns, and helps women follow advice (McInnes et al., 2020; Perriman et al., 2018). Continuity models have also produced good outcomes in disadvantaged communities (Homer et al., 2017). For Mrs. N, the same midwife was present across pregnancy, birth, and the postnatal period, which helped the midwife detect problems early and respond quickly. This approach matches a holistic view of care that considers the physical, psychological, and social needs of the person (Afandi et al., 2026). Structured case documentation, such as the Varney and SOAP formats used here, also makes it easier to compare care against standards and identify gaps for improvement (Afandi et al., 2024). These findings support the wider use of CoC in Indonesian primary care and midwifery education, where evidence from low- and middle-income settings remains limited (Bradford et al., 2022).

The transition from pregnancy to the postnatal period is another important component of effective CoC. Maternal and newborn needs may change rapidly after birth, requiring care providers to reassess priorities rather than rely solely on the antenatal care plan. In this case, breastfeeding difficulties, neonatal jaundice, and postpartum contraceptive decisions required different forms of

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assessment, counseling, and follow-up. Continuity enabled these issues to be addressed within an established care relationship, potentially improving communication and the family's understanding of recommended care. However, continuity should also include clear follow-up arrangements, documented clinical findings, and timely referral when problems exceed the capacity of primary care. Integrating these elements may strengthen the role of midwife-led CoC as a comprehensive approach to maternal and newborn care, extending beyond the safe completion of childbirth.

This report has several limitations. As a single case, its findings cannot be generalized. Several outcomes, such as improvements in milk flow and the course of neonatal jaundice, were assessed subjectively or visually rather than by objective measures. Some data, such as the birth weight and the timing of jaundice onset, were not fully recorded. Care was provided as part of a clinical learning program under supervision, which may differ from routine practice. Future studies should include more cases, use objective outcome measures such as bilirubin levels and infant weight gain, and compare CoC with standard care in Indonesian primary care settings.

CONCLUSION

Midwife-led continuity of care for a 40-year-old multigravida from 26 weeks of gestation to postpartum contraception was carried out in line with midwifery standards and resulted in good outcomes for both mother and baby. Continuity allowed the midwife to identify the age-related risk early, support a safe birth, manage breastfeeding problems, detect neonatal jaundice, and help the couple choose a contraceptive method. Practice can be further improved by measuring bilirubin objectively and replacing direct sunlight exposure with evidence-based jaundice care.

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CONFLICT OF INTEREST

The authors declare no conflict of interest. Care was provided in accordance with professional midwifery standards, and no financial, personal, or institutional interests influenced the assessment, interventions, or reporting of this case.

REFERENCES

Afandi, A. T., Fauziah, N. H., Asmaningrum, N., & Sujarwanto. (2023). An application pre-conference and post-conference in hospital: A case study. *Jurnal Kegawatdaruratan Medis Indonesia, 2(1)*, 53–63. https://doi.org/10.58545/jkmi.v2i1.4

Afandi, A. T., Maula, M., Asmaningrum, N., & Putrha, G. D. (2024). The six right principles of drug administration to patients with diabetes mellitus in hospitals: A case study. *Jurnal Kesehatan Komunitas Indonesia, 4(1)*, 21–35. https://doi.org/10.58545/jkki.v4i1.165

Afandi, A. T., Putri, P., & Asmaningrum, N. (2026). Analysis of fulfillment of basic needs of post-hospitalization patients in hospitals based on Virginia Henderson's theory. *Jurnal Manajemen Kesehatan Yayasan RS. Dr. Soetomo, 12(1)*, 48. https://doi.org/10.29241/jmk.v12i1.2466

Bradford, B. F., Wilson, A. N., Portela, A., McConville, F., Fernandez Turienzo, C., & Homer, C. S. E. (2022). Midwifery continuity of care: A scoping review of where, how, by whom and for whom? *PLOS Global Public Health, 2(10)*, e0000935. https://doi.org/10.1371/journal.pgph.0000935

Cleland, J., Shah, I. H., & Daniele, M. (2015). Interventions to improve postpartum family planning in low- and middle-income countries: Program implications and research priorities. *Studies in Family Planning, 46(4)*, 423–441. https://doi.org/10.1111/j.1728-4465.2015.00041.x

Dehlendorf, C., Grumbach, K., Schmittdiel, J. A., & Steinauer, J. (2017). Shared decision making in contraceptive counseling. *Contraception, 95(5)*, 452–455. https://doi.org/10.1016/j.contraception.2016.12.010

Dennis, C.-L., Jackson, K., & Watson, J. (2014). Interventions for treating painful nipples among breastfeeding women. *Cochrane Database of Systematic Reviews, 2014(12)*, CD007366. https://doi.org/10.1002/14651858.CD007366.pub2

Fernandez Turienzo, C., Bick, D., Briley, A. L., Bollard, M., Coxon, K., Cross, P., Silverio, S. A., Singh, C., Seed, P. T., Tribe, R. M., Shennan, A. H., & Sandall, J. (2020). Midwifery continuity of care versus standard maternity care for women at increased risk of preterm birth: A hybrid implementation–effectiveness, randomised controlled pilot trial in the UK. *PLOS Medicine, 17(10)*, e1003350. https://doi.org/10.1371/journal.pmed.1003350

Flaherman, V. J., Maisels, M. J., & the Academy of *Breastfeeding Medicine*. (2017). ABM Clinical Protocol #22: Guidelines for management of jaundice in the breastfeeding infant 35 weeks or more of gestation—Revised 2017. Breastfeeding Medicine, 12(5), 250–257. https://doi.org/10.1089/bfm.2017.29042.vjf

Frick, A. P. (2021). Advanced maternal age and adverse pregnancy outcomes. *Best Practice & Research Clinical Obstetrics & Gynaecology, 70*, 92–100. https://doi.org/10.1016/j.bpobgyn.2020.07.005

Homer, C. S. E., Leap, N., Edwards, N., & Sandall, J. (2017). *Midwifery* continuity of carer in an area of high socio-economic disadvantage in London: A retrospective analysis of Albany Midwifery Practice outcomes using routine data (1997–2009). Midwifery, 48, 1–10. https://doi.org/10.1016/j.midw.2017.02.009

Kemper, A. R., Newman, T. B., Slaughter, J. L., Maisels, M. J., Watchko, J. F., Downs, S. M., Grout, R. W., Bundy, D. G., Stark, A. R., Bogen, D. L., Holmes, A. V., Feldman-Winter, L. B., Bhutani, V. K., Brown, S. R., Maradiaga Panayotti, G. M., Okechukwu, K., Rappo, P. D., & Russell, T. L. (2022). Clinical practice guideline revision: Management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. *Pediatrics, 150(3)*, e2022058859. https://doi.org/10.1542/peds.2022-058859

Kerber, K. J., de Graft-Johnson, J. E., Bhutta, Z. A., Okong, P., Starrs, A., & Lawn, J. E. (2007). Continuum of care for maternal, newborn, and child health: From slogan to service delivery. *The Lancet, 370(9595)*, 1358–1369. https://doi.org/10.1016/S0140-6736(07)61578-561578-5)

Lean, S. C., Derricott, H., Jones, R. L., & Heazell, A. E. P. (2017). Advanced maternal age and adverse pregnancy outcomes: A systematic review and meta-analysis. *PLOS ONE, 12(10)*, e0186287. https://doi.org/10.1371/journal.pone.0186287

McInnes, R. J., Aitken-Arbuckle, A., Lake, S., Hollins Martin, C., & MacArthur, J. (2020). Implementing continuity of midwife carer – just a friendly face? A realist evaluation. *BMC Health Services Research, 20*, 304. https://doi.org/10.1186/s12913-020-05159-9

Oladapo, O. T., Tunçalp, Ö., Bonet, M., Lawrie, T. A., Portela, A., Downe, S., & Gülmezoglu, A. M. (2018). WHO model of intrapartum care for a positive childbirth experience: Transforming care of women

and babies for improved health and wellbeing. *BJOG: An International Journal of Obstetrics & Gynaecology, 125(8)*, 918–922. https://doi.org/10.1111/1471-0528.15265

Perriman, N., Davis, D. L., & Ferguson, S. (2018). What women value in the midwifery continuity of care model: A systematic review with meta-synthesis. *Midwifery, 62*, 220–229. https://doi.org/10.1016/j.midw.2018.04.011

Renfrew, M. J., McFadden, A., Bastos, M. H., Campbell, J., Channon, A. A., Cheung, N. F., Silva, D. R. A. D., Downe, S., Kennedy, H. P., Malata, A., McCormick, F., Wick, L., & Declercq, E. (2014). Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care. *The Lancet, 384(9948)*, 1129–1145. https://doi.org/10.1016/S0140-6736(14)60789-360789-3)

Riley, D. S., Barber, M. S., Kienle, G. S., Aronson, J. K., von Schoen-Angerer, T., Tugwell, P., Kiene, H., Helfand, M., Altman, D. G., Sox, H., Werthmann, P. G., Moher, D., Rison, R. A., Shamseer, L., Koch, C. A., Sun, G. H., Hanaway, P., Sudak, N. L., Kaszkin-Bettag, M., … Gagnier, J. J. (2017). CARE guidelines for case reports: Explanation and elaboration document. *Journal of Clinical Epidemiology, 89*, 218–235. https://doi.org/10.1016/j.jclinepi.2017.04.026

Sandall, J., Fernandez Turienzo, C., Devane, D., Soltani, H., Gillespie, P., Gates, S., Jones, L. V., Shennan, A. H., & Rayment-Jones, H. (2024). Midwife continuity of care models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews, 2024*, CD004667. https://doi.org/10.1002/14651858.CD004667.pub6

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2016). Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews, 2016(4)*, CD004667. https://doi.org/10.1002/14651858.CD004667.pub5

Say, L., Chou, D., Gemmill, A., Tunçalp, Ö., Moller, A.-B., Daniels, J., Gülmezoglu, A. M., Temmerman, M., & Alkema, L. (2014). Global causes of maternal death: A WHO systematic analysis. *The Lancet Global Health, 2(6)*, e323–e333. https://doi.org/10.1016/S2214-109X(14)70227-X70227-X)

Slusher, T. M., Vreman, H. J., Brearley, A. M., Vaucher, Y. E., Wong, R. J., Stevenson, D. K., Adeleke, O. T., Ojo, I. P., Edowhorhu, G., Lund, T. C., & Gbadero, D. A. (2018). Filtered sunlight versus intensive electric powered phototherapy in moderate-to-severe neonatal hyperbilirubinaemia: A randomised controlled non-inferiority trial. *The Lancet Global Health, 6(10)*, e1122–e1131. https://doi.org/10.1016/S2214-109X(18)30373-530373-5)

Syairaji, M., Nurdiati, D. S., Wiratama, B. S., Prüst, Z. D., Bloemenkamp, K. W. M., & Verschueren, K. J. C. (2024). Trends and causes of maternal mortality in Indonesia: A systematic review. *BMC Pregnancy and Childbirth, 24*, 515. https://doi.org/10.1186/s12884-024-06687-6

Tunçalp, Ö., Peña-Rosas, J. P., Lawrie, T., Bucagu, M., Oladapo, O. T., Portela, A., & Gülmezoglu, A. M. (2017). WHO recommendations on antenatal care for a positive pregnancy experience—going beyond survival. *BJOG: An International Journal of Obstetrics & Gynaecology, 124(6)*, 860–862. https://doi.org/10.1111/1471-0528.14599

Uvnäs-Moberg, K., Handlin, L., & Petersson, M. (2015). Self-soothing behaviors with particular reference to oxytocin release induced by non-noxious sensory stimulation. *Frontiers in Psychology, 5*, 1529. https://doi.org/10.3389/fpsyg.2014.01529

Victora, C. G., Bahl, R., Barros, A. J. D., França, G. V. A., Horton, S., Krasevec, J., Murch, S., Sankar, M. J., Walker, N., & Rollins, N. C. (2016). Breastfeeding in the 21st century: Epidemiology, mechanisms, and lifelong effect. *The Lancet, 387(10017)*, 475–490. https://doi.org/10.1016/S0140-6736(15)01024-701024-7)

Zhang, J., Landy, H. J., Branch, D. W., Burkman, R., Haberman, S., Gregory, K. D., Hatjis, C. G., Ramirez, M. M., Bailit, J. L., Gonzalez-Quintero, V. H., Hibbard, J. U., Hoffman, M. K., Kominiarek, M.,

Volume 01 Number 02 (November 2025)
e-ISSN: 3164-8835; p-ISSN: 3164-8827

Learman, L. A., Van Veldhuisen, P., Troendle, J., Reddy, U. M., & Consortium on Safe Labor. (2010). Contemporary patterns of spontaneous labor with normal neonatal outcomes. *Obstetrics & Gynecology, 116(6)*, 1281–1287. https://doi.org/10.1097/AOG.0b013e3181fdef6e