PFCJ PEDIATRIC AND FAMILY CARE JOURNAL
Volume 01 Number 01 (December 2025)
p-ISSN: 0000-0000
e-ISSN: 0000-0000

Case Study

Comprehensive midwifery care for Mrs. W, 23 years old, G2P1A0 with mild anemia at Pujon Community Health Center, Central Kapuas Regency

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Abstract:
Anemia in pregnancy is defined as a hemoglobin level below 11 g/dL. Hemoglobin is an iron-rich protein responsible for transporting oxygen to maternal and fetal tissues. Anemia during pregnancy may result from iron or vitamin B12 deficiency, poor dietary intake, bleeding, or immune disorders, and it can adversely affect maternal and fetal outcomes. This case study aimed to provide comprehensive midwifery care for Mrs. W, 23 years old, with mild anemia, covering pregnancy, childbirth, newborn care, postpartum care, and family planning services. The case study was conducted at Pujon Community Health Center, Central Kapuas Regency, from February to April 2025. The subject was a 23-year-old pregnant woman at 34 weeks of gestation with a single live intrauterine fetus in cephalic presentation. Instruments included midwifery care forms, observation sheets, screening sheets, and a partograph. Data collection comprised primary data (physical examination, interviews, observation) and secondary data (medical records, ANC registers, and the maternal KIA book). Comprehensive midwifery care for Mrs. W proceeded smoothly. She completed four ANC visits in the third trimester. Labor progressed normally, with the second stage lasting 30 minutes. She received three neonatal visits, four postpartum visits, and one family planning visit, ultimately selecting a 3-month injectable contraceptive. No maternal or neonatal complications were identified. All assessments and interventions were documented using Varney's 7-Step Management and SOAP. This study highlights the importance of early detection of anemia, routine hemoglobin monitoring, balanced nutrition counseling, adherence to iron and vitamin supplementation, regular ANC attendance, and the consistent application of comprehensive midwifery care standards.

Keywords:
comprehensive pregnant women, anemia

Article Info:
Submitted:
26-09-2025
Revised:
24-11-2025
Accepted:
27-11-2025

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DOI: https://doi.org/10.53713/pfcj.vxix.xxx

INTRODUCTION

Comprehensive midwifery care is a continuum of care provided by midwives from pregnancy, childbirth, newborn care, postpartum care, to family planning. This approach aims to ensure high-quality services that prevent maternal and infant mortality by identifying all conditions experienced by the mother from pregnancy through the family planning period (Ministry of Health, 2020). Anemia is a condition characterized by a reduced number of red blood cells (erythrocytes), which contain hemoglobin responsible for transporting oxygen to body tissues. Anemia in pregnancy is defined as

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p-ISSN: 0000-0000
e-ISSN: 0000-0000

a hemoglobin level <11 g/dL in the first and third trimesters and <10.5 g/dL in the second trimester (Proverawati, 2021). It is a common global health problem and may lead to complications for both the mother and fetus. Its effects on pregnancy outcomes include miscarriage, intrauterine fetal death, stillbirth, high perinatal mortality, prematurity, and congenital anomalies (Putri et al., 2022). However, in practice, many pregnant women with anemia do not adhere to iron supplementation due to reasons such as boredom or gastrointestinal side effects, including epigastric discomfort, nausea, vomiting, and diarrhea. Iron supplementation may also cause constipation in some women (Wahyuni et al., 2021).

According to the World Health Organization (2023), the global prevalence of anemia among pregnant women is 37%, and 30% of women aged 15–49 years are anemic. The Indonesian Ministry of Health reported a 48.9% prevalence of anemia among pregnant women, with 84.6% of cases occurring in the 15–24-year age group. Iron–folic acid (IFA) supplementation is recommended to prevent anemia, with pregnant women expected to consume at least 90 tablets during pregnancy. The national coverage for distribution of at least 90 IFA tablets in 2021 was 84.2% (Ministry of Health, 2023). In Central Kalimantan, 3,774 pregnant women were recorded as having anemia (Ministry of Health, 2023). Based on the Pujon Community Health Center register, from November 2024 to January 2025, there were 330 antenatal visits, with 20 pregnant women identified as anemic.

The causes of anemia in pregnancy vary, with iron and vitamin B12 deficiency being among the most common. These deficiencies are often influenced by unhealthy or irregular dietary habits and the consumption of caffeinated beverages, which inhibit iron absorption. Other medical conditions, such as bleeding, kidney disease, and immune disorders, may also contribute to anemia. If untreated, anemia in the third trimester may lead to serious maternal and fetal complications. Maternal risks include miscarriage, preterm labor, prolonged labor, hemorrhage, and shock (Agarwal et al., 2021). Fetal risks include low birth weight and impaired early childhood growth (Alem et al., 2020). Anemia can also cause maternal mortality, fetal malnutrition, and neonatal death (Singal, 2018).

Efforts to prevent and manage anemia include providing health education on its risks during pregnancy, encouraging regular antenatal visits, and ensuring consistent consumption of at least 90 iron tablets throughout pregnancy to support fetal growth and reduce the risk of low birth weight. Additional interventions include promoting iron-rich foods, such as dark green leafy vegetables, and foods that enhance iron absorption, including vitamin C-rich foods like citrus juice, as well as meat and fish. Meanwhile, mothers are advised to avoid beverages that inhibit iron absorption. Providing counseling on anemia is essential for reducing maternal and infant mortality, as limited knowledge can increase risks during pregnancy, childbirth, postpartum, newborn care, and family planning. Comprehensive midwifery care throughout pregnancy also plays a critical role. Current community health center programs for managing anemia in pregnancy include the provision of a minimum of 90 IFA tablets, early screening and detection, nutrition education and counseling, home visits by health cadres or workers, cross-sector collaboration, and systematic reporting and monitoring.

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METHOD

This study employed a case study design to describe the provision of comprehensive midwifery care for Mrs. W, a 23-year-old woman with mild anemia. The study utilized an independent variable and was conducted at the Pujon Community Health Center, Central Kapuas Regency, from February to April 2025. Data were analyzed using Varney's seven-step midwifery management approach, with documentation structured according to the SOAP format.

RESULTS

Comprehensive midwifery care was provided to Mrs. W, a 23-year-old woman, G1P0A0, beginning at 35 weeks of gestation through the provision of family planning services. Midwifery care in this case was managed using Varney's Seven-Step Midwifery Management approach, with progress notes documented using the SOAP method.

Comprehensive Antenatal Midwifery Care for Mrs. W, 23 Years Old, G2P1A0 at 35 Weeks' Gestation with Mild Anemia at Pujon Community Health Center

Based on the initial anamnesis, Mrs. W is 23 years old, pregnant with her second child, and has no history of infectious or hereditary diseases. She completed seven ANC visits during pregnancy, including three visits at the health center and four home visits. Physical examination showed pale conjunctiva and lips, and laboratory testing indicated an Hb level of 10.2 g/dL.

During the first visit on February 4, 2025, the Hb level was 10.2 g/dL, and the mother reported experiencing back pain. Care included advising her to take iron supplements regularly and consume iron-rich foods such as green leafy vegetables, fruits, liver, and red meat, as well as foods that enhance iron absorption (e.g., vitamin C, citrus juice, meat, and fish). She was also advised to avoid iron-inhibiting beverages such as tea and coffee. For back pain, she was instructed to avoid frequent bending, squat when lifting objects, apply warm compresses, and get adequate rest. During the second visit on February 10, 2025, Mrs. W complained of nocturia. She was educated that frequent urination is caused by fetal pressure on the bladder and was advised to reduce fluid intake at night. During the third visit on February 17, 2025, she reported no complaints and stated that nocturia had improved. During the fourth visit on February 24, 2025, Hb was rechecked and had increased to 11.2 g/dL. She was reminded to maintain a balanced diet and continue taking iron tablets regularly.

Intrapartum Care for Mrs. W, 23 Years Old, G2P1A0 With Mild Anemia at 38 Weeks' Gestation at Pujon Community Health Center

a. First Stage of Labor

On February 27, 2025, at 09:00 a.m., Mrs. W arrived at the health center at 38 weeks' gestation with uterine contractions and bloody mucus since 03:00 a.m. Vital signs were normal; contractions were 4×/10 minutes lasting 42 seconds; cervical dilation was 6 cm; the cervix was

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e-ISSN: 0000-0000

thin, and membranes were intact. The first stage lasted one hour. Care included relaxation techniques during contractions and monitoring according to active phase standards: blood pressure every 4 hours, temperature every 2 hours, pulse every 30 minutes, fetal heart rate every 30 minutes, uterine contractions every 30 minutes, cervical dilation every 4 hours, and fetal descent every 4 hours.

b. Second Stage of Labor

At 11:00 a.m., the mother reported stronger contractions and an urge to defecate. Vital signs were normal, cervical dilation was complete, and membranes ruptured spontaneously. Mrs. W was guided to push effectively during contractions and encouraged to drink between contractions. The second stage lasted 30 minutes, concluding with the birth of the baby at 11:30 a.m. Standard APN procedures (60 steps) were applied. The newborn cried strongly, had good muscle tone, normal breathing, and reddish skin. The baby was dried, the cord cut, and immediate skin-to-skin contact was initiated for early breastfeeding initiation (IMD).

c. Third Stage of Labor

Active management included administration of 10 IU oxytocin IM within one minute after birth, controlled cord traction during contractions, assessment of placental separation signs, delivery of the placenta, and uterine massage for 15 seconds. No complications occurred, and the estimated blood loss was ±80 mL.

d. Fourth Stage of Labor

Mrs. W was monitored for 2 hours, including consciousness level, vital signs, uterine height, uterine contractions, bladder status, and vaginal bleeding every 15 minutes during the first hour and every 30 minutes during the second hour. No complications were identified.

Newborn Care for the Infant of Mrs. W at Pujon Community Health Center

The baby was born spontaneously on February 27, 2025, at 11:30 a.m., immediately crying, with good respiratory effort, muscle tone, and reddish skin. Physical assessment showed: birth weight 2,950 g; length 48.8 cm; head circumference 31 cm; chest circumference 30 cm; anus patent; no congenital anomalies; male. Newborn care included administering Genion eye ointment and IM Vitamin K1 (1 mg/0.5 mL) in the left thigh to prevent bleeding. After two hours, the infant received HB0 (0.5 mL IM) in the right thigh to prevent hepatitis B infection. The baby was roomed in with the mother to facilitate IMD.

Neonatal Care for the Infant of Mrs. W, 23 Years Old, P2A0 at Pujon Community Health Center

Three neonatal visits were conducted. The first visit occurred on February 28, 2025, at 11:35 a.m. The baby's general condition was good with a strong cry, active movements, and normal vital signs (RR 45/min, HR 125/min, temperature 36.5°C). Weight, length, and head and chest circumference remained within normal range. The infant breastfed well with normal elimination patterns. Health education was provided regarding complete basic immunization, bringing the infant for BCG and Polio 1 immunizations, and attending monthly *Posyandu* sessions for growth monitoring.

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e-ISSN: 0000-0000

Postpartum Care for Mrs. W, 23 Years Old, P2A0 at Pujon Community Health Center

The first postpartum visit (KF1) was conducted 6 hours after delivery on February 27, 2025. Mrs. W reported abdominal cramping. Examination showed stable vital signs, uterine height 2 fingers below the umbilicus, lochia rubra ±5 mL, no excessive bleeding or infection, and adequate breast milk production. She received education on causes of afterpains, early mobilization, perineal wound care, and postpartum danger signs.

KF2 was conducted on March 3, 2025, showing normal vital signs, uterine height midway between the umbilicus and symphysis, and lochia serosa without signs of infection. Breast care education was provided.

KF3 was conducted on March 21, 2025 (day 18). Vital signs were normal, the uterus was no longer palpable, lochia alba were present, and the breasts showed no signs of inflammation. Education on postpartum nutrition was provided.

KF4 was conducted on March 29, 2025 (three weeks postpartum). Mrs. W reported no complaints. Examination was normal, and family planning counseling was provided.

Family Planning Care for Mrs. W, 23 Years Old, at Pujon Community Health Center

The family planning visit took place on April 9, 2025. Mrs. W expressed readiness to use contraception but was unsure about the method. She intended to exclusively breastfeed her infant and had previously used a three-month injectable contraceptive. The examination revealed normal vital signs, a non-palpable uterus, and lochia alba. Counseling included breastfeeding-compatible contraceptive options, benefits, disadvantages, and potential side effects. After informed choice and informed consent, Mrs. W selected the three-month injectable contraceptive, which was subsequently administered.

DISCUSSION

This chapter discusses the alignment between theory, assessment findings, and clinical management based on factual observations and the researcher's professional judgment during the provision of comprehensive midwifery care for Mrs. W, 23 years old, G3P2A0 at 35 weeks of gestation with mild anemia at Pujon Community Health Center, Central Kapuas Regency, Central Kalimantan. The discussion covers all stages of care, including pregnancy, labor, newborn care, neonatal care, postpartum care, and family planning.

Midwifery Care During Pregnancy for Mrs. W, 23 Years Old, G2P1A0 at 35 Weeks' Gestation with Mild Anemia

The primary cause of anemia in pregnancy is iron deficiency, as iron demand increases to support fetal and placental development. In several cases, anemia during pregnancy increases the risk of bleeding before or during childbirth, preterm delivery, low birth weight, and impaired fetal development. Inadequate iron supplementation (TTD) heightens the risk of maternal anemia, and

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p-ISSN: 0000-0000
e-ISSN: 0000-0000

folic acid deficiency during the first 0–8 weeks of gestation increases the likelihood of neural tube defects.

According to the Ministry of Health (Wasdinar & Tarwoto, 2007), hemoglobin levels below 11 g/dL in pregnancy are classified as mild anemia. Anemia may contribute to postpartum hemorrhage, particularly due to uterine atony. A reduced oxygen and nutrient supply to uterine tissue impairs uterine contractility, thereby increasing the risk of hemorrhage (Aryani, 2017). Compliance with iron supplementation (Fe tablets) is strongly associated with increased maternal hemoglobin levels. Health education for pregnant women with anemia includes consuming iron-rich foods and vitamin C sources, as well as avoiding tea and coffee, which can inhibit iron absorption.

Based on ANC visits, maternal complaints, and the care provided, there were no discrepancies between theory and clinical findings. All care delivered to Mrs. W adhered to midwifery service standards, and documentation followed Varney's 7-step management framework and the SOAP format.

Midwifery Care During Labor for Mrs. W, 23 Years Old, G2P1A0 With Mild Anemia

According to Walyani and Endang (2020), labor is the process of expelling the fetus at term (37–42 weeks). The first stage (cervical dilation) tends to be shorter in multiparous women due to increased cervical elasticity. Signs of labor include strong, regular contractions, bloody show, and spontaneous rupture of membranes (Khasanah & Sari, 2022).

The first stage consists of the latent phase (1–3 cm dilation), which lasts approximately 8 hours, and the active phase, which includes acceleration (3–4 cm dilation), dilation (4–9 cm dilation), and deceleration (9–10 cm dilation). Obstetric assessments include general physical examination, vital signs, abdominal inspection and palpation, vaginal examination, and fetal heart auscultation. There were no inconsistencies between theory and practice in the management of Mrs. W during the first stage of labor.

The second stage begins when cervical dilation reaches 10 cm and ends with the birth of the baby (Indrayani & Maudy, 2016). Signs include an urge to bear down, increasing rectal pressure, a bulging perineum, and widening of the vulva. Management includes providing emotional support, guiding effective pushing, monitoring uterine contractions and fetal heart rate, and performing all steps of the Normal Delivery Care (APN) protocol. The average duration for multiparous women is 15–30 minutes. In Mrs. W's case, the duration and care provided were consistent with existing theory and standards (Prawirohardjo, 2014).

The third stage begins after the baby is born and ends with the expulsion of the placenta, typically occurring within 5–30 minutes (Ekayanthi, 2019). Mrs. W's third stage lasted 5 minutes, aligning with theoretical expectations. No discrepancies were identified.

The fourth stage lasts two hours after placental delivery, during which maternal vital signs, uterine tone, fundal height, bladder status, and vaginal bleeding are monitored regularly (Indrayani & Maudy, 2016). Early mobilization, adequate hydration, and bladder emptying are encouraged. Based on the care provided during the fourth stage, no discrepancies were found between theory and practice.

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Newborn Care for the Infant of Mrs. W at Pujon Community Health Center

According to El Sinta et al. (2019), newborn care includes physical assessment, vitamin K administration, hepatitis B immunization, and eye prophylaxis. A normal newborn weigh 2,500–4,000 g, measures 48–52 cm, and has an Apgar score of 7–10 (Noorbaya, 2019). A comprehensive newborn assessment includes airway patency, breathing, heart rate, temperature, movement, tone, and a physical examination of all anatomical systems (Ribek et al., 2018). Routine care includes maintaining warmth, delayed bathing for at least 6 hours, cleaning the airway, cord care, vitamin K injection, and HB0 immunization (Febriyani, 2019). Care provided to Mrs. W's newborn was consistent with theoretical guidelines.

Neonatal Care

Neonatal visits (KN) are conducted three times: KN1 (6–48 hours), KN2 (day 3–7), and KN3 (day 8–28) (Raskita & Octa, 2022). Care includes HB0 immunization, cord care education, recognition of danger signs, exclusive breastfeeding counseling, and BCG immunization information (Kemenkes RI, 2020). The three neonatal visits and the interventions provided matched established guidelines; therefore, no discrepancies were observed.

Postpartum Care for Mrs. W, 23 Years Old, P2A0

Fundal height involution follows a predictable pattern: 2 fingers below the umbilicus immediately after placental delivery, midway between the symphysis and umbilicus during week 1, and nonpalpable by week 2–6 (Purwanto et al., 2018). Postpartum visits occur four times: 6–48 hours, day 3–7, day 8–28, and day 29–42 (Azizah & Rafhani, 2019). Lochia transitions normally through four phases: rubra, sanguinolenta, serosa, and alba (Machfudloh et al., 2020). Postpartum care encompasses monitoring vital signs, uterine involution, bleeding, perineal condition, signs of infection, nutritional counseling, personal hygiene, breastfeeding support, and early family planning counseling (Kemenkes RI, 2020). All postpartum assessments and care for Mrs. W were consistent with theory.

Family Planning Care for Mrs. W

Family planning is the effort to space or limit the number of pregnancies. Postpartum contraceptive options include progestin-only pills, progestin injections (3-month DMPA), implants, IUDs, and condoms (BKKBN, 2018). Three-month injectable contraception is safe during breastfeeding because it does not affect milk production (Pinem, 2014; Kusnan & Afrini, 2019). Studies also support progestin-only injectables as suitable for lactating mothers (Putri, 2022). Mrs. W's choice of the 3-month injectable contraceptive (DMPA) was consistent with theoretical recommendations and did not contradict postpartum guidelines.

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CONCLUSION

A comprehensive midwifery care study was conducted for Mrs. W, G2P1A0, from the third trimester of pregnancy through labor, postpartum, neonatal care, and family planning between 4 February and 9 April 2025 at Puskesmas Pujon, Kapuas Regency. The care process followed a standardized midwifery management framework, utilizing the seven-step Varney approach and SOAP-based documentation.

During pregnancy, Mrs. W—initially presenting with mild anemia at 35 weeks' gestation—received seven antenatal visits. Her pregnancy progressed normally, and clinical examinations remained within normal limits. Hemoglobin levels improved significantly to 11.2 g/dL at 38 weeks following targeted interventions, including communication, information, and education (CIE), iron supplementation, and dietary counseling to enhance iron absorption while avoiding inhibitors such as tea and coffee. Minor discomforts such as back pain and nocturia were managed effectively through postural guidance, warm compresses, rest, and behavioral adjustments.

Labor progressed physiologically, with a 7-hour first stage, 30-minute second stage, and 5-minute third stage. The baby was delivered spontaneously in good condition, and early initiation of breastfeeding (EIBF) was successfully accomplished without complications. Newborn care procedures—including thermoregulation, vitamin K administration, ocular prophylaxis, and umbilical cord care—were performed according to standards, and the infant remained stable.

Neonatal care involved three scheduled visits (KN1, KN2, KN3), during which no complications were identified. The umbilical cord detached on day five without signs of infection, and the infant continued to receive exclusive breastfeeding with effective suckling. Postpartum care was conducted through four visits, during which maternal recovery was normal, uterine involution progressed appropriately, and the mother received counseling on nutrition, personal hygiene, danger signs, breast care, and exclusive breastfeeding. No discrepancies were observed between theory and practice.

Following contraceptive counseling, the mother elected to use the three-month injectable method to support exclusive breastfeeding. The family planning care was delivered in accordance with established midwifery standards. Overall, the comprehensive midwifery care provided to Mrs. W proceeded smoothly, met all professional standards, and revealed no complications or deviations from evidence-based practice across all stages of care.

ACKNOWLEDGEMENT

The author acknowledges that several obstacles were encountered during the preparation of this study, largely due to the author's own limitations. Therefore, the author expresses sincere gratitude to all parties who contributed to the smooth completion of this research, from its inception to its conclusion.

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CONFLICT OF INTEREST

The author acknowledges certain limitations in this study, particularly related to the insufficient data examined.

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