Case Report

MIDWIFERY CARE IN THE POSTPARTUM PERIOD FOR MRS. E IN KAJHU VILLAGE, SUB-DISTRICT BAITUSSALAM, THE DISTRICT OF ACEH BESAR IN 2026

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Abstract

Maternal Mortality (MMR) remains a major health problem globally and in Indonesia. Complications during the postpartum period, such as bleeding, infection, and eclampsia, significantly contribute to the increase in MMR. Comprehensive and continuous midwifery care during the postpartum period is necessary to detect complications early and support maternal recovery.

This case report aims to provide postpartum midwifery care to Mrs. E and document it in a SOAP format. Care was provided to Mrs. E, 34 years old, G3P2A0, 6 hours postpartum, with a history of normal, spontaneous delivery and second-degree perineal laceration in Kajhu Village, sub-district Baitussalam, the district of Aceh Besar. Subjective data indicated that the mother still experienced abdominal cramps, body aches, and cramps after delivery, and her breast milk flowed smoothly. Objective examination results indicated that the mother was in good general condition, with blood pressure of 100/70 mmHg, fundal height of two finger-widths below the umbilicus, palpable uterine contractions, and normal lochia rubra. The care provided included education on cramps and mobilization techniques, postpartum exercises, perineal wound care, breastfeeding counseling, and education on postpartum danger signs. The results showed that the mother understood all the counseling provided. Comprehensive midwifery care during the first postpartum visit is expected to support the mother's recovery and prevent complications.

Keywords: Midwifery care, Post-partum period, first visit, Kajhu Village

Introduction

The maternal mortality rate (MMR) remains a global problem. According to data, the causes of maternal deaths include congenital diseases (28%), hemorrhage (27%), preeclampsia (14%), infection (11%), prolonged labor (9%), abortion complications (8%), and blood clotting disorders (around 3%). Complications occurring during the postpartum period also contribute significantly to the increase in MMR. Approximately 75% of maternal deaths during the postpartum period are caused by severe postpartum hemorrhage, infection, and preeclampsia or eclampsia. [1] However, MMR has decreased globally by 34% in recent years, as a result of various efforts to improve maternal health services. [2]

Currently, the maternal mortality rate in Indonesia has decreased from 305 to 189 per 100,000 live births. This reflects improvements in maternal health services. The government has set a target of 183 per 100,000 live births for MMR by 2024. Maternal deaths in Indonesia are still dominated by eclampsia (37.1%), hemorrhage (27.3%), and infection (10.4%). At the provincial level, Aceh recorded 36 maternal deaths in 2024, and the majority were caused by postpartum hemorrhage and infection. 3 At the district level, there were 6 maternal deaths in Aceh Besar. Postpartum visit coverage in Aceh Besar Regency decreased from 83.4% to 73.4%. Postpartum visits in the Sub-district Baitussalam also decreased from 90.3% to 67.1%. This situation indicates that not all postpartum mothers receive complete health monitoring. [4 5]

Postpartum midwifery care is the management of care provided from the moment the baby is born until the body returns to its pre-pregnancy state. This period lasts 6 weeks (42 days) after delivery. During the postpartum period, mothers undergo scheduled postpartum visits: once between 6 hours and 2 days postpartum, once between 3 and 7 days, once between 8 and 28 days, and once between 29 and 42 days postpartum [6].

The first postpartum visit (KF-1) is conducted between 6 hours and 2 days postpartum and aims to perform a comprehensive clinical assessment of the mother's condition immediately after delivery and to detect life-threatening acute complications, such as postpartum hemorrhage and blood pressure abnormalities, early. During this visit, health workers check vital signs, uterine contractions and height of the uterine fundus, the amount and characteristics of lochia, the condition of the birth canal wound, and provide education on early mobilization, personal hygiene, postpartum nutrition, and recognition of

danger signs during the postpartum period [6,7].

Midwives play a role in reducing MMR by providing continuous services focused on health care, counseling, and health education. Midwives also play a role in early detection of risk factors and danger signs during the postpartum period and can make timely referrals to prevent complications that can increase MMR [8]. Based on this background, the author provided postpartum midwifery care to Mrs. E in Kajhu Village, sub-district Baitussalam, the Regency of Aceh Besar. The purpose of this care was to provide postpartum midwifery care at the first visit (6 hours postpartum) for Mrs. E and document it in SOAP format (midwifery documentation).

Case

This case report was prepared on Wednesday at 5:14 PM WIB, at the patient's home in Kajhu Village, Baitussalam District, Aceh Besar Regency. The subject is Mrs. E, 34 years old, with a bachelor's degree, and a housewife. Her husband, F, 36, is self-employed.

Subjective Data (S): Mrs. E gave birth to her third child 6 hours ago at the independent midwife practice (TPMB) F, spontaneously with a second-degree perineal laceration that was sutured. This is her third pregnancy, and she has never had a miscarriage (G3P2A0). The mother stated that her condition has improved, but she still experiences slight abdominal cramps and body aches. She stated that her breast milk is flowing smoothly, that Early Initiation of Breastfeeding (IMD) has been performed, and that the baby is breastfeeding well.

Objective Data (O) obtained at visit I:

1. General condition is good, compos mentis consciousness.
2. Vital signs: a. blood pressure 100/70 mmHg; b. pulse 84 beats/minute; c. respiration 24 breaths/minute; d. temperature 36.6°C; e. weight 70 kg; height 155 cm.
3. Physical examination: a. eyes: conjunctiva pink and sclera not icteric; b. neck no thyroid gland swelling; c. breasts: abundant milk production and prominent nipples; d. abdomen: uterine contractions palpable, fundal height (FFU): 2 fingers below the navel and empty bladder; e. genitalia: fresh red lochia rubra, clean vagina with no lumps, normal bleeding, sutures still moist and no infection at the suture scar; f. Extremities: No varicose veins, negative Homan's sign, no edema, no tenderness.
4: Infant data: Born on March 11, 2026, at 11:14 a.m. WIB, birth weight: 3,200 grams, body length: 48 cm, Apgar score: 9, no congenital defects.
5. Assessment Results (A): Postpartum 6 hours, G3P2A0, general condition of

mother and baby good, physiological postpartum.

Management (P) of this case includes:

1. Informing the mother of the examination results that her condition is within normal limits.
2. Informing the mother that the abdominal cramps she is experiencing are physiological due to uterine contractions during the involution process during the first week postpartum. Encouraging early mobilization and warm compresses to increase comfort.
3. Informing the mother how to manage cramps through mobilization and relaxation.
4. Informing the mother how to manage soreness by choosing a comfortable position and keeping her shoulders and arms relaxed.
5. Teaching the mother postpartum exercises and monitoring lochia discharge.
6. Teaching the mother how to care for second-degree perineal sutures to prevent infection by maintaining genital hygiene, washing hands before and after care, cleaning the vulva from front to back, drying the perineum, changing sanitary napkins regularly, and wearing clean, loose underwear.
7. Informing the mother of signs of infection, such as smelly lochia, pus discharge from the suture wound, fever, and open suture wounds.
8. Encourage the mother to get enough rest by adjusting her sleep schedule to when the baby is sleeping.
9. Explaining the danger signs of postpartum bleeding, fever lasting more than 2 days, foul-smelling discharge from the birth canal, swollen breasts, redness on the feet, hands, or face, and signs of postpartum depression.
10. Teaching proper breastfeeding techniques and encouraging breastfeeding every 2 hours or on demand.
11. Encouraging the mother to gradually mobilize from lying down, sitting, standing, and walking to speed recovery.
12. The mother understands the explanation given and is able to repeat what the researcher has explained.

Discussion

The first visit was conducted at 6 hours postpartum at the subject's residence on March 11, 2026. The examination results showed vital signs within normal limits. This is in accordance with the theory that states that changes in vital signs in postpartum mothers can occur; blood pressure is said to be normal if systolic <120 mmHg and diastolic <80 mmHg, normal pulse rate ranges from 60–100 x/minute for adults, normal respiratory frequency for adults is 12–20 x/minute (in the postpartum period tends to be slow or stable), and

normal body temperature is between 36.5°C–37.2°C [9-10].

Uterine examination revealed a TFU 2 finger-widths below the umbilicus with strong contractions. This is a reflection of normal uterine involution. Uterine involution is the primary mechanism by which the uterus returns to its pre-pregnancy shape and size. This process occurs through several stages: myometrial ischemia, tissue atrophy, autolysis, and oxytocin-induced contractions that compress the uterine blood vessels, preventing bleeding. [11]. The fundal height of the uterus in a normal postpartum woman will decrease by about one finger-width per day. [12].

The lochia discharged is rubra, bright red. This is normal on the first to fourth days after delivery. Lochia rubra contains fresh blood, placental remains, uterine tissue, fetal fat, fine baby hair (lanugo), and meconium. Regular monitoring of the lochia is crucial to distinguish between normal and pathological bleeding. [13].

Complaints of abdominal cramps experienced by mothers after delivery are normal. One or two days after the baby is born, the mother will experience abdominal cramps similar to menstrual cramps. This condition is called afterpains and is caused by uterine contractions during the development of the uterus, which can lead to blood clots and the uterine wall adapting. Breastfeeding by nipple stimulation triggers a uterine reflex, improving contractions. [14].

Postpartum afterpain management involves several non-pharmacological methods, including warm compresses on the abdomen, lying face down with a compressive pillow under the lower abdomen, and regular urination and walking to relieve pain. [15]. Additionally, non-pharmacological care can include effleurage massage, sacral plexus massage, and candle therapy. Research shows a significant difference between sacral muscle massage therapy and the development of pain in postpartum mothers, with a p-value <0.05. [16].

Postpartum exercises are also taught to mothers during this first care. Postpartum exercises are physical exercises performed from the first to the tenth day postpartum to help accelerate maternal recovery. The exercises include breathing, relaxation, and gradual mobilization according to the mother's condition. Postpartum exercises are beneficial for improving blood circulation, accelerating uterine involution, and increasing pelvic and abdominal muscle strength, thus supporting maternal recovery during the postpartum period. [11].

Education on perineal wound care was also provided, as the mother experienced a second-degree laceration. Perineal wound care aims to prevent infection, improve comfort, and

accelerate healing. Principles of care include washing the genital area with soap and water (from front to back), drying the perineum, changing sanitary napkins at least every 4–6 hours, and washing hands before and after care. [17] [18].

Postpartum mothers are provided with breastfeeding counseling. Breastfeeding is well established, and early initiation of breastfeeding (IMD) has been implemented. Effective breastfeeding is characterized by a deep latch and coordinated sucking. Correct latch technique is the strongest factor associated with successful breastfeeding. Poor latch not only results in suboptimal milk transfer but can also lead to sore nipples and engorgement. The WHO recommends breastfeeding every 2 hours or on demand.[19]

Education on postpartum danger signs is an essential component of first-visit care. Postpartum danger signs include postpartum bleeding, postpartum infection, foul-smelling lochia, uterine subinvolution, abdominal and pelvic pain, dizziness and excessive weakness, a body temperature above 38°C, red and hot breasts, and fever with painful urination. Mothers who are aware of these danger signs are expected to immediately seek medical attention at the nearest health facility if they experience these symptoms. [20]

Based on the results of the first visit, it can be concluded that the mother experienced abdominal cramps, aches, and pains, which are normal postpartum physiological conditions. Her breast milk flowed smoothly, and breastfeeding progressed well. All care provided was closely related to uterine involution and the mother's adaptation to the early postpartum period. The mother understood and was able to repeat the counseling provided. This demonstrates the success of therapeutic communication in midwifery care.

Conclusion

Based on the Postpartum Midwifery Care at the First Visit to Mrs. E, 34 years old, with her second child, it can be concluded that the mother's condition 6 hours postpartum was normal with physiological complaints in the form of abdominal cramps, body aches, and cramps. The care provided included counseling on postpartum discomfort, early mobilization, postpartum exercises, perineal wound care, breastfeeding counseling, and education on postpartum danger signs. The mother understood the counseling provided. Comprehensive postpartum care is important for supporting recovery and preventing complications in the mother. The second midwifery care will be provided three days later.

Ethics approval

The postpartum mother and witnesses (the postpartum mother's family) sign informed consent before care is provided.

Conflict of interests

The research team stated that there was no conflict of interest in this research.

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