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Continuity of Care in Midwifery for Mrs. S with the Application of Effleurage Massage During Third Trimester Pregnancy

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Continuity of Care; Back Pain; Massage Efflurage.

ABSTRACT
Continuity of Care (COC) midwifery care, or continuous midwifery care, is a concept that emphasizes the provision of continuous and integrated health care, aiming to deliver optimal health services to patients by building strong and sustainable relationships between patients and health service providers (1). The research reports the Continuity of Care midwifery care for Mrs. S at PMB Adibah Fitriana, S.Tr.Keb, Bdn, using Varney's 7-step thinking model and SOAP documentation. This study uses a case study approach. The research subject is Mrs. S (G1P0A0), conducted from April to December 2025. During pregnancy, Mrs. S complained of back pain; during labor, she experienced cramps and bloody mucus from the birth canal; and during the postpartum period, she reported that her breast milk production was low, while her baby was fussy at night and had difficulty sleeping. Interventions provided included effleurage massage in the third trimester of pregnancy, assisting with childbirth using 60 steps of APN, performing oxytocin massage for the postpartum mother, and providing massage therapy for the fussy baby. Mrs. S used an implant for birth control. After effleurage massage therapy was administered for 5–10 minutes, Mrs. S's back pain complaints decreased.

INTRODUCTION

Continuity of Care (COC) Midwifery Care or continuous midwifery care is a concept that emphasizes the provision of continuous and integrated health care, which aims to provide optimal health services to patients by building strong and sustainable relationships between patients and health service providers. Continuity of Care is continuous care from pregnancy to Family Planning (KB) which aims to reduce maternal mortality rates (MMR) and infant mortality rates (IMR). IMR and IMR are the most important indicators in the success of health services in Indonesia (Hidayati et al., n.d.; Liyanto et al., 2022; Manik et al., 2025; Palupi & Rizki, 2020).

The maternal mortality rate (MMR) and infant mortality rate (IMR) are priorities in the National Medium-Term Development Plan (RPJMN) (Hendrik et al., 2023; Huda & Hartono, 2024; Siagian, 2023; WILFRIDA et al., 2025). The target for reducing the MMR in 2024 is 183 per 100,000 live births, while the target for reducing the IMR in 2024 is 16 per 1,000 live births. The Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) in Indonesia are on track to reach the 2024 RPJMN target of 183 per 100,000 live births, but are still higher than those in ASEAN countries (Kurnianingtyas & Muflikhah, 2024; Nurlatifah, 2020).

To achieve the Sustainable Development Goals (SDGs), which is to reduce the maternal mortality ratio to less than 70 deaths per 100,000 live births by 2030, efforts to reduce maternal

mortality in Indonesia need to be further optimized. In line with the progress of maternal mortality, the infant mortality rate (IMR) in Indonesia has also decreased from 26 per 1,000 live births in 2010 to 16.85 per 1,000 live births in 2020. However, to achieve the SDGs targets, health services for children and reducing the risk of infant mortality also need to be continuously improved. The death of a mother has long-term impacts on the children she leaves behind (Anagnostaki & Zaharia, 2020; Fellmeth et al., 2018).

Research shows that maternal death can have an impact on malnutrition and low educational attainment of the children left behind (Islam et al., 2019; Wu & Guo, 2020; Zhou et al., 2016). Likewise, the level of maternal health, especially nutrition in pregnant and breastfeeding mothers, also greatly affects the health of children. Undernourished mothers during pregnancy accounted for 13 percent of low birth weight (LBW) births in Indonesia over the past ten years (Arsyi, 2021; Aryastami et al., 2017; Kresnawati et al., 2025; Soltani et al., 2017). Research also suggests that maternal nutritional deficiencies contribute to infant growth restriction, which can increase the risk of neonatal death and stunting at age two, and is a leading cause of non-communicable diseases in adulthood.

In order to reduce maternal mortality and infant mortality, the Ministry of Health's efforts are to ensure that every mother has access to quality health services, which include maternal health services, delivery assistance by trained health workers, postpartum care for mothers and babies, special care and referrals in case of complications, and family planning services. Meanwhile, efforts for maternal health include: Maternal health services, Tetanus immunization services for women of childbearing age and pregnant women, Provision of iron tablets, Maternal health services during childbirth, Postpartum health services, Organizing pregnancy classes, Childbirth Planning and Complication Prevention Program (P4K), Family Planning Services, HIV and Hepatitis B examinations. Meanwhile, according to the Minister of Health Regulation Number 25 of 2014, child health efforts can be carried out through: Fetal health services in the womb, Newborn health, Infant health, Toddler health, Preschool children's health, School-age children's and adolescent health, Child health protection (Larson et al., 2019; Perry et al., 2022; Scher, 2024).

The Central Java Health Service reported a high maternal mortality rate reaching 428 cases in 2024. This occurred in 35 districts/cities, with Banyumas, Banjarnegara, and Wonosobo being the areas with the highest mortality rates (Purnamasari, 2019). The maternal mortality rate in Pemalang Regency itself in 2024 was 49.95/100,000 Live Births (10 Cases) and the infant mortality rate was 5.94/1000 Live Births (119 Cases).

The Pemalang Regency Government has taken various steps to reduce the Maternal Mortality Rate (MMR) AND Infant Mortality Rate (IMR) in 2024. These steps include improving the quality of health services, namely continuous Continuity Of Care such as pregnancy check-ups at least 6 times during pregnancy, postpartum visits for 4 times and a series of other services, increasing special attention to high-risk pregnant women and improving the capabilities of health workers, increasing public awareness such as conducting outreach and education to the public about the importance of health check-ups for pregnant women, childbirth in health facilities, and care for newborns, as well as increasing coordination between related parties by involving community leaders and religious leaders (Ministry of Health of the Republic of Indonesia, 2024).

To reduce maternal and child mortality rates, health workers are needed who have the authority to provide services to mothers and children, one of which is a midwife. Where midwives as health workers must be creative in implementing policies that can help improve health services, especially for mothers and children, so they have an important role to help health in Indonesia, especially being able to help reduce MMR and IMR. One place that can help midwives as health workers who play a role in improving services is a Community Health Center that is close to the community, One of which is the Mojo Community Health Center, which is one of the community health centers that supports COC (Continuity of Care) and as a place for students to carry out continuous care for pregnant women, giving birth, postpartum and BBL.

From the profile data of Mojo Health Center in 2024, the target number of pregnant women in the Mojo Health Center area in 2024 was 1622 pregnant women, the number of pure K1 was 1153 or 71.1%, the number of access K1 was 1230 or 75.83%, the number of pregnant women found by health workers was 299 pregnant women or 18.43%, pregnant women found by the community was 156 pregnant women or 9.62%, the number of neonates was 1118 babies, the number of deliveries by health workers was 1106 mothers, the number of maternal mortality was 1 mother, the number of infant mortality was 3 babies.

The programs that have been implemented by the Mojo Health Center to reduce MMR and IMR until 2025 include pregnant women classes, pregnant women's classes accompanied by Jamila Asiek, toddler classes, stunting toddler classes, assistance for high-risk pregnant women by cadres, postpartum visits and visits to pregnant women with restful conditions by village midwives, Integrated Primary Service (ILP) *Posyandu*, provision of additional food for pregnant women with KEK.

In addition, students undertake Continuity of Care midwifery care, where designated midwives provide antenatal, intrapartum, and postpartum care to women. Midwives provide physical, emotional, and social support, flexible individualized care, and strong multi-agency relationships. This increases the quality of perinatal care for mothers and babies and strengthens working relationships with professionals. Currently, only a small proportion of women have access to continuity of midwifery care throughout their pregnancy.

Based on the background above, the author is interested in conducting Continuous Midwifery Care for Mrs. S aged 30 years from pregnancy, childbirth, BBL (newborn baby), postpartum at PMB. Adibah Fitriana, S.Tr.Keb, Bdn, Mojo Health Center working area in 2025.

METHOD

This case study was conducted on pregnant women from TM III at Mojo Health Center, Pemalang Regency in 2025. This case study will be conducted to study matters related to continuous midwifery care for Mrs. S and her baby through the process of midwifery care for pregnant women, childbirth, newborns, and postpartum. With in-depth midwifery care regarding the condition of the mother starting from pregnancy, childbirth, newborns, and postpartum which is carried out continuously (Continuity of Care). This case study uses the flow of thought according to Hellen Varney and documentation using the SOAP method.

RESULT AND DISCUSSION

In the discussion of "Continuity *of Care* " for Mrs. S at Mojo Health Center, the gap and suitability between theory and practice are discussed with the hope of obtaining a real picture and the extent of midwifery care for Mrs. S from pregnancy, childbirth, postpartum and newborn. In implementing this comprehensive midwifery care, the author uses midwifery management with an approach according to Hellen Varney's thought process. The discussion is as follows:

1. Pregnancy Care
    a. Subjective data

    At each antenatal visit, staff collect and analyze data through anamnesis. In this subjective data, what will be discussed are age, complaints, past obstetric history (GPA), TT immunization, ANC examination, and nutritional patterns of the mother (Saifudin, 2014).

    The ideal age for pregnancy is 20-35 years because the reproductive organs of the prospective mother have formed perfectly. At the age of the mother >35 years or more, at that age there are changes in the reproductive organs and the birth canal is no longer flexible (Prawirohardjo, 2014). The dangers that can occur are high blood pressure, premature rupture of membranes, and irregular/obstructed labor (Prawirohardjo, 2014). From the results of the assessment, it was found that Mrs. S, who was pregnant for the first time, had never had a miscarriage, and is now 24 years old. This indicates that Mrs. S is included in the productive age category.

    Mrs. S complained of back pain at 32 weeks of pregnancy. Various problems that arise in the third trimester of pregnancy are psychological problems that are often complained of by pregnant women, such as anxiety and pain. Among these complaints, lower back pain is the most commonly reported, occurring in 60%-90% of pregnant women, and is one of the causes of the incidence of cesarean delivery (Varney et al., 2007). Back pain is caused by pain in the lumbosacral area. The increase in intensity as the gestational age increases is due to a shift in the center of gravity and changes in body posture. Back pain from the sacroiliac/lumbar can become a long-term back disorder if not immediately treated (Prawirohardjo, 2014). However, the complaint of back pain experienced by Mrs. S is still a normal effect of pregnancy.

    Pregnancy starts from the time of conception until the birth of the fetus with a duration of 280 days (40 weeks) calculated from the First Day of the Last Menstrual Period (HPHT), from the HPHT it can be used to calculate the Estimated Date of Birth (HPL) with the Naegle formula, day (+7), month (+9), and year (+0) (Saifudin, 2014). In this case the mother's HPHT is January 25, 2025, then the HPL can be calculated as 02-11-2025, and the gestational age is 38 weeks. In Mrs. S, with these results, the birth process will be approaching.

    The administration of TT1 with TT2 is 4 weeks with protection for 3 years, TT2 to TT3 interval 6 months with protection for 5 years, TT3 to TT4 interval 1 year with protection for 10 years, and TT4 to TT5 interval 1 year with protection for 25 years or for life, while in the case of Mrs. R received TT4 during this pregnancy. So Mrs. S received tetanus protection for 10 years.

Mrs. S has had 6 ANC check-ups, namely 2x in the first trimester, 2x in the second trimester, 2x in the third trimester. The antenatal care program policy stipulates that the frequency of antenatal visits should be at least 6 (six) times during pregnancy, with the following time provisions: at least 1 time in the first trimester (K1), at least 2 times in the second trimester (K2), at least 3 times in the third trimester (K3, K4 and K6) (Prawirohardjo, 2014). The assessment data shows that Mrs. S had just had a K6 examination on this visit.

Nutritional intake during pregnancy differs from pre-pregnancy intake to meet the needs of both mother and fetus. Based on the 2013 Recommended Dietary Intake (RDA), an additional 300 kcal per day is required during pregnancy. Additional intakes of 20 g of protein per day, 10 g of fat per day, and 40 g of carbohydrates per day are recommended during pregnancy, along with other micronutrients to support fetal growth. In the first trimester, no additional calories are generally needed. So, the calories needed are generally 1,800 calories. In the second trimester, pregnant women need an additional 200 to 400 calories per day. At this gestational age , the recommended daily calorie intake is 2,200 calories. Meanwhile, in the third trimester , an additional 450 to 500 calories are needed. Pregnant women need 2,400 calories per day. In the data from the assessment conducted on Mrs. S , it was found that the mother said she ate 4 times a day with a portion of half a plate consisting of rice and side dishes. In this case, the author does not know the total number of calories, protein, and calcium that the mother consumed during pregnancy.

b. Objective data

Objective data is information collected based on examination of the mother. The method of collecting data is through the mother's behavior, namely looking healthy or sick, conducting a physical examination and conducting additional examinations if necessary. Objective data is obtained by conducting direct observation of the patient. This objective data can be obtained through a complete physical examination or only part of it as deemed necessary using inspection, palpation, percussion and auscultation techniques.

The objective data on Mrs. S discussed were blood pressure examination, physical examination of nutritional status (height examination, weight examination, LiLA), examination related to the presence of danger signs, symptoms of anemia, obstetric physical examination including measurement of TFU, Leopold, DJJ, genitalia) and supporting examinations.

The reason behind checking blood pressure is to detect hypertension early during pregnancy. Hypertension in pregnancy can be prevented if risk factors can be controlled. These efforts include regular blood pressure monitoring, physical activity, and a healthy, balanced calorie diet with high-fiber, low-fat, and low-salt consumption. Mrs. S 's blood pressure results ranged from 110/70 to 120/80 mmHg. This indicates no difference between the theory and Mrs. S 's blood pressure, as her blood pressure was consistently within normal limits and did not lead to pregnancy-related hypertension or preeclampsia.

The first physical examination of a pregnant woman involves calculating her body mass index (BMI), which is a comparison of weight and height. If the BMI is

categorized as overweight, then she is at high risk of experiencing problems during pregnancy. Height was measured at the first visit to screen for risk factors in pregnant women. Pregnant women's height <145 increases the risk of CPD (Cephalo Pelvic Disproportion).

Mrs. S 's height was 155 cm, as determined by her KIA book. This indicates that Mrs. S 's height is within normal limits and she is not at risk of CPD.

Mrs. S's weight during her last pregnancy check was 64 kg, the assessment data from Mrs. S stated that her weight was 64 kg. Mrs. S's BMI (Body Mass Index) is calculated using the formula (BB (kg) : TB (m)2) which is (64 kg : (1.55 cm x 1.55 cm)) = 26.63, the mother is included in the overweight category. According to Prawirohardjo 2020 , excessive calories can cause obesity, so weight gain should not exceed 7 - 11.5 kg during pregnancy. So between BB before pregnancy and during pregnancy , Mrs. S experienced an increase of 9 kg. This shows that Mrs. S is normal in her weight gain.

Signs of discomfort in pregnant women are experiencing pain in the lower back in the musculoskeletal area. This musculoskeletal adaptation that needs to be considered is the increase in body weight, experiencing a shift in the center of body weight because the uterus is getting bigger, pregnant women need to relax and do mobility. The higher instability in the sacroiliac joint and the increase in lumbar lordosis causes pain. This indicates that there are muscles that experience shortening when the abdominal muscles begin to stretch, resulting in an imbalance in the muscles around the pelvis and lower back, and will be felt in the upper part of the ligament. Mrs. S experienced complaints of back pain which is in line with the theory, however, Mrs. S's complaints are still within normal limits.

TFU measurements are carried out every time a physical examination is carried out. According to Prawirohardjo 2020, if fetal growth is normal, the height of the uterine fundus at 32 weeks of pregnancy is at least 27 cm. In the case of Mrs. S , the TFU size is 28 cm. So in this case there is no gap between theory and practice. The estimated weight of the baby at 32 weeks of pregnancy is around 1.7 kg to 2.1 kg, in the case of Mrs. S, the estimated weight of the fetus is 2,480 gr, so in Mrs. S , the estimated weight of the fetus is normal.

Indonesian Ministry of Health, if the upper arm circumference (LiLA) is less than 23.5 cm, it indicates that the pregnant woman is suffering from Chronic Energy Deficiency (CED). Pregnant women with CED are at risk of giving birth to a child with Low Birth Weight (LBW). In the case of Mrs. S, it was found that her LiLA was 30 cm, so Mrs. S is said to have good nutritional status . This shows that there is no gap between theory and practice.

According to the Indonesian Ministry of Health, DJJ assessment is carried out at the end of the first trimester and then at every antenatal visit. DJJ is said to be normal if it is 120-160 times/minute but if it is less or more than normal it indicates fetal distress. In Mrs. S 's examination , the results showed that the fetus was in a lower position, possibly with a DJJ ranging from 136-145x/minute. In Mrs. S 's examination , her DJJ was normal.

The Leopold examination consists of L1, L2, L3 L4 to determine the position of

the fetus in the mother's stomach. In Mrs. S , the results obtained were Leopold I TFU 3 fingers above the navel, one soft part was felt, not bouncy. Possibly buttocks, Leopold II The right side can be felt as small parts. It is likely a fetal extremity. On the left side, a hard, elongated part like a board was felt. It is likely the fetus's back. Leopold III Felt one part round, hard, bouncy and cannot be moved. Leopold IV both hands can meet (converge), not yet entered PAP. This shows that Leopold's examination is normal.

Genital examination is carried out to determine the presence of wounds, vaginal discharge (consistency, color, odor), condyloma acuminata, anal examination normally shows no lumps or blood discharge from the anus. In the physical examination of Mrs. S , no genital and anal examination was carried out because the mother did not want to be examined, so that abnormal genital changes were not known. This shows a gap between theory and practice.

In the supporting examination data on Mrs. S, the results were obtained on April 12, 2025, her pregnancy was 11 weeks old, namely in the first trimester with the results of blood type B, HB 11.8 gr / dL, HbSAG negative, VCT: NR, urine protein: +1. Meanwhile, according to the Indonesian Ministry of Health 2017, blood hemoglobin (Hb) level examinations are carried out to find out whether the mother is lacking blood (anemia), blood type tests are carried out to prepare blood donors for pregnant women if needed, urine tests are carried out to find out the presence of protein in the urine and other supporting examinations on pregnant women are carried out at least once in the first trimester and once in the third trimester. In the third trimester, there are no plans for the mother to have a laboratory examination at the community health center next week.

c. Assessment

1) Obstetric Diagnosis

Obstetric diagnosis is a diagnosis established by a midwife within the scope of midwifery practice in accordance with standard obstetric nomenclature. Diagnosis for pregnant women includes Gravida, Partus, Abortus; gestational age (in weeks); intrauterine; single; alive; position; presentation; right/left dorsal. The diagnosis that was established on September 22, 2025 was G1P0A0, age 24 years, gestational age 32 weeks, single fetus, alive intrauterine, longitudinal position, left dorsal (PUKI), cephalic presentation, head has not entered the upper pelvic inlet (PAP). This shows that the mother's diagnosis is normal with the theory from the Indonesian Ministry of Health which states that a full-term pregnancy is between 37-42 weeks.

According to the Indonesian Ministry of Health a normal pregnancy is said to be if the mother's general condition is good, her blood pressure is <140/90 mmHg, weight gain is at least 8 kg during pregnancy (1 kg per month) or according to the mother's BMI, edema is only in the extremities, FHR 120-160 times/minute, fetal movement can be felt after 18-20 weeks of pregnancy until delivery, there is no history of obstetric disorders, the size of the uterus is according to the gestational age, physical and laboratory examinations are within normal limits.

2) Problem

Problems are things related to the client's experience found from the results of the

assessment or which accompany the diagnosis from the interview results obtained, and Mrs. S had a problem in the form of back pain. Mrs. S. According to Prawirohardjo, back pain is caused by pain in the lumbosacral area. The increase in intensity as the pregnancy progresses is caused by a shift in the center of gravity and changes in her body posture. It can be concluded that Mrs. S 's complaint , seen from practice and theory, is included in the physiological condition.

3) Potential Diagnosis
   Identifying potential diagnoses and problems is based on current problems and diagnoses regarding anticipatory measures, prevention if possible, and waiting with full vigilance and preparation for all possible situations that may arise according to Varney, in Mrs. S's case there were no potential problems and diagnoses.
4) Immediate Action
   Immediate need or immediate action is where a health worker will indicate an emergency that requires the midwife to take action quickly or while waiting for the intervention of other health workers, for example a doctor. In Mrs. S 's case , there was no potential diagnosis so there was no immediate need.

d. Planning
   Planning is developing a comprehensive plan that is determined by referring to the results of the previous steps. This step is the development of problems or diagnoses that are identified both currently and those that can be anticipated and the health care that is needed

1) Planning
   According to the Ministry of Health third trimester pregnancy care includes providing iron therapy and IEC as needed. In Mrs. S, planning was given in the form of informing the mother and family about her condition, providing health education about the mother's discomfort, namely back pain in the third trimester, reminding the mother of the danger signs of pregnancy, informing and teaching the mother and husband about efflurage massage to reduce back pain in pregnant women in the third trimester, reminding the mother of the danger signs of pregnancy, reminding her about preparing for childbirth, reminding her of the signs of labor, providing Fe, vitamin C and calcium therapy and explaining how to take them, advising the mother to return for a visit. In Mrs. S, the author found a gap, namely the author did not provide Fe tablets, calcium, folic acid and IEC about these drugs to her mother, only reminding her to take them regularly.
2) Implementation
   For Mrs. S, the author carried out the implementation according to the plan made above in the form of informing the mother and family about her current condition, providing health education again about the mother's discomfort, namely vaginal discharge and breast pain, reminding her of the danger signs of pregnancy, reminding her about preparing for childbirth, reminding her of the signs of labor, reminding her about IMD, encouraging the mother to continue drug therapy from the midwife, encouraging the mother to return for a visit.
   According to the Ministry of Health, in the case of Mrs. S, the author found a discrepancy, namely that the midwife only recommended drug therapy without

asking how long she had been taking it and explaining the benefits and how to take it, apart from that, she also did not give the mother Fe tablets.

3) Evaluation

From the planning and implementation that has been given, the evaluation results obtained are that Mrs. S can understand everything given by the author and Mrs. S and her husband have been taught and can practice eflux massage.

2. Childbirth Care

Mrs. S gave birth on October 25, 2025 at Mojo Health Center. The delivery period began on October 25, 2025, at 04.00 WIB until 13.00 WIB. Delivery data was obtained from direct interviews with the patient 40 minutes after delivery and cross-checking the medical record data of the Mojo Health Center's delivery capacity.

a. Subjective

According to the Indonesian Ministry of Health the symptoms of labor in the first stage are that the mother feels the discharge of blood mucus through the vagina, cramps occur with a frequency of at least 2 times in 10 minutes, in the second stage the mother feels like pushing along with contractions, the mother also feels pressure on the rectum and/or vagina, increased discharge of blood mucus, in the third stage the uterus feels hard and the fundus of the uterus is as high as the navel because it contains the placenta which is twice as thick as before. After that, there is a release and expulsion of the placenta so that the mother feels like pushing again along with contractions, in the fourth stage according to Mochtar the observation period for 2 hours after the baby and placenta are born to observe the mother's condition, one of which is feeling stomach cramps. The subjective data discussed in this case are age, complaints that indicate signs of labor, and developmental data obtained from the first stage to the fourth stage.

In Mrs. S, from the results of the anamnesis, Mrs. S said that her stomach ached at 21.00 WIB, and at 01.00 WIB Mrs. S had an examination at the midwife and the midwife said that the dilation was 2, then the midwife advised her to prepare mother and baby equipment and go to the health center, and at 04.00 WIB the mother arrived at the health center and was checked for 5 cm dilation. In the second stage, the mother said she wanted to defecate, had stomach aches. In the third stage, the mother said that her stomach ached and was bleeding. In the fourth stage, during the 2-hour supervision, she felt cramps and pain in the stitches. This anamnesis conducted by the author with the appropriate theoretical content so that the mother's complaints were considered normal during labor.

b. Objective

According to the Indonesian Ministry of Health signs of labor start from the first stage, namely the latent phase, namely when the cervix is 1 to 3 cm dilated, around 8 hours and the active phase, namely when the cervix is 4 cm dilated to full dilated (10 cm), lasting around 6 hours.

According to the Indonesian Ministry of Health Stage II the perineum protrudes, the vulva vagina and anal sphincter open, the cervical opening is complete and the baby's head is visible through the vaginal introitus and lasts for ½-1 hour. Stage III the uterine muscles contract following the shrinkage of the uterine cavity volume after the birth of the placenta, so that the placenta will fold, thicken, then release after the baby is born so that the TFU is as high as the center. Stage IV according to the Indonesian Ministry of

Health Stage IV Several focus examinations that must be monitored in stage IV are the fundus by feeling whether the fundus contracts hard and lasts for 2 hours after the placenta is born. The objective data discussed are the results of examinations carried out from stage I to stage IV.

In Mrs. S, general condition is good, consciousness is composmetis, blood pressure is 110/70 mmHg, pulse is 80x/minute, temperature is 36.6 °C, body weight is 64kg, present status is good and normal, genitalia has no edema, no infection, perineum is not protruding, vulva is not open, and there is no discharge, birth canal condition has no edema, no infection, perineum is not protruding, vulva is not open, and there is vaginal discharge, portio condition is still thick, effacement is 50%, opening of 5 cm of amniotic skin is positive (still there), head presentation, POD and POD UUK position are in the direction of 12 o'clock, head descent is 3/5, there are no signs of moulage, prominent/protruding part: not palpable. Contraction 3x10'x20 until complete is 5x10'x50", each additional opening is accompanied by thinning. From 4cm to complete opening or 10 cm, which lasted for 6 hours. In Mrs. S, the results of the Objective examination of Portio conditions were: 100% Effacement, 10 cm opening, Negative amniotic sac (has broken) Head presentation, POD and POD position UUK and 12 o'clock, Fetal descent 1/5 Signs of molding were absent, No protruding part, 11.35 WIB stage II for 60 minutes

In Mrs. S's third stage, strong contractions were found, the TFU was at the level of the navel, the abdomen was globular, the umbilical cord was protruding in front of the vagina, and the placenta had not yet been delivered. The third stage lasted 5 minutes. In the fourth stage, the TFU examination showed 2 fingers below the navel, strong contractions, a second-degree tear in the birth canal, and PPV of approximately 50cc. The fourth stage lasted 2 hours and 0 minutes.

During the examination of Mrs. S, the author did not find any difference between the theory and the results of the examination of Mrs. S , so that in this examination Mrs. S was in a normal condition.

CONCLUSION

This study implemented Continuity of Care for pregnancy, childbirth, newborn, postpartum, and family planning services for Mrs. S at Mojo Community Health Center, Pemalang Regency, using the Hellen Varney midwifery management approach. During the third-trimester pregnancy visit, full assessments, planning, implementation, and evaluation were completed, though a gap existed in determining exact caloric intake; labor care fully addressed assessments, actions (including 58 APN steps and partograph documentation), and evaluations, despite minor issues like incomplete PPE use, improper baby-drying cloth placement, and non-sterile materials. Newborn care across three visits and postpartum/family planning care (four visits plus Implanon insertion) showed no discrepancies with theoretical standards. Overall, Continuity of Care proved effective with only minor gaps in pregnancy and labor. For future research, investigators could explore integrating digital tools for precise nutritional tracking and standardized sterile supply protocols to eliminate such gaps in resource-limited settings.

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