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CONTINUOUS MIDWIFERY CARE FOR MRS.R USING HYPNOBIRTHING

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ABSTRACT

Background: Continuity of midwifery care is a comprehensive service provided from pregnancy, childbirth, postpartum, newborn care, to family planning (FP). This care is very important to enable early detection of problems, monitor development, and anticipate possible complications. Hypnobirthing is known to help reduce anxiety and improve mental preparedness. This report aims to implement continued obstetric care with the application of hypnobirthing for Mother R at the Rancaekek Community Health Center, Bandung Regency.
Methods: The report is a case study using an evidence-based midwifery management approach, starting at 37 weeks of gestation and covering antenatal, intrapartum, postpartum, newborn, and FP care, conducted at the client's home and the Puskesmas. Care was provided from July to November 2024. Hypnobirthing was conducted directly by the author during pregnancy to reduce anxiety. During the active phase of labor, hypnobirthing was also provided by the author to reduce pain, with a duration of approximately 15 minutes for each session.
Results: Results showed that all stages progressed normally. After hypnobirthing intervention, maternal anxiety decreased based on the Facial Anxiety Scale, and pain was reduced according to the Numeric Rating Scale. The postpartum period went well, marked by appropriate uterine involution, no signs of infection, and normal lochia. Lactation was optimal, as shown by effective breastfeeding, weight gain in the baby, and no breast problems. In the FP stage, the mother chose the 3-month injection and received complete counseling. Midwifery care was provided in accordance with service standards.
Conclusion: In conclusion, comprehensive midwifery care and hypnobirthing were effective in reducing anxiety and pain, and in supporting successful postpartum recovery, breastfeeding, and family planning.
Keywords: anxiety, continuous care, hypnobirthing, pain

INTRODUCTION

One of the high-risk factors in pregnancy and childbirth is pregnancy at a young age, known as the "4T" concept (too young, too old, too frequent, too close). Pregnancy in adolescents under the age of 20, especially those aged 17, is categorized as high-risk because they are not yet physically and psychologically ready for pregnancy and childbirth. Complications that can occur in young primiparas include anemia, preeclampsia, premature labor, low birth weight (LBW), and labor difficulties due to an immature pelvis (Sariati et al., 2016).
In addition to the physical complications mentioned above, pregnancy at a young age also has an impact on the psychological aspects of the mother, especially in

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dealing with the delivery process (Syswianti, Wahyuni, Mardiana, et al., 2020). Anxiety in mothers giving birth, especially young primiparas, is also a particular concern. Based on research, 75% of mothers experience very high anxiety during active labor, and 18 out of 24 respondents experience moderate anxiety when facing childbirth. This anxiety can worsen the delivery process and increase the risk of complications (Syamsuryanita, 2022).

Given the high level of anxiety among young primiparous mothers and its impact on the delivery process, a comprehensive service approach is needed to address this issue. Midwifery care is a health care model that provides comprehensive care to mothers and babies from pregnancy, through childbirth, to the postpartum period. Its main objective is to ensure continuity of quality care through a holistic approach that considers the medical, psychological, social, and cultural aspects of the mother and family. The benefits include increased maternal satisfaction, reduced complications, and the creation of a strong therapeutic relationship (Cevik S et al., 2022).

In order to optimize continuous midwifery care, especially in addressing anxiety in young primiparas, special interventions are needed that can integrate psychological aspects into maternal health services. The hypnobirthing method is one natural intervention that can help alleviate anxiety and tension during childbirth. This method is a natural technique that is used to eliminate fear, panic, tension, and other pressures that haunt mothers during childbirth. Hypnobirthing is believed to offer many benefits as it trains pregnant women to remain relaxed, calm, and emotionally stable. This technique aims to help pregnant women feel confident and calm, as well as facilitate an easier childbirth process that does not require intervention or pain relief. Additionally, hypnobirthing aims to allow mothers to give birth comfortably and eliminate the pain of childbirth without the use of any anesthetics (Syswianti et al., 2020).

Based on research involving 80 nulliparous mothers, hypnobirthing training significantly reduced fear of childbirth, intensity of labor pain, and increased satisfaction with childbirth. This study found that the group that received hypnobirthing training experienced a significant decrease in anxiety scores compared to the control group. In addition, other studies have shown that hypnobirthing significantly reduces anxiety levels in pregnant women during childbirth, indicating its effectiveness as a therapeutic intervention for managing pregnancy-related anxiety and potentially improving maternal and fetal outcomes (Buran & Aksu, 2022).

The essence of hypnobirthing is to break the assumption that pain is a normal and absolutely necessary part of the birthing process. When women in labor are free from fear, their muscles, including the uterine muscles, will relax, making the birthing process easier and less stressful. Mothers who are given hypnobirthing training can reach full dilation faster than mothers who are not given such training. These benefits also extend to the postpartum stage, meaning that mothers who undergo hypnobirthing training are psychologically calmer during the postpartum adaptation period and do not experience problems in the adaptation process (Syamsuryanita, 2022).

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Hypnobirthing techniques can help relax muscles so that mothers avoid anxiety and can be calmer in facing childbirth. This method can be taught to pregnant women as a midwife intervention with other anxiety management methods, in accordance with the role of midwives as health educators, where midwives can teach certain skills to patients (Paikoh et al., 2023; Siagian, Lamtiur; Anggraeni,Milka ; Pangestu, 2023).

Based on the results of a study entitled "The Effect of Health Education on the Anxiety Levels of Primigravida Mothers in Facing Labor Pain in Primary Care," it was found that 18 of the 24 respondents experienced moderate anxiety. Several studies also mention that around 118% of 118 mothers in labor experienced very high anxiety during the active first stage of labor. Of these, anxiety and expressed fear regarding pregnancy and the upcoming labor process were both observed among primiparous and multiparous mothers.

Considering the important role of continuous midwifery care in improving mothers' readiness for childbirth, especially in high-risk primigravida, as well as the benefits of the hypnobirthing method in reducing anxiety and pain, this study was conducted to examine the application of continuous care based on hypnobirthing in primary care facilities.

RESEARCH METHOD

The research method used in this study was a case study with an evidence-based midwifery management approach, documented in SOAP format. This case study was conducted at the Rancaekek Community Health Center in Bandung Regency and at Mrs. R's home. The care period began in July 2024 and ended in November 2024. The subject of this study was Mrs. R., aged 17 years, G1P0A0, 36 weeks pregnant. The care provided to Mrs. R. was continuous, starting from the third trimester of pregnancy, childbirth with the application of hypnobirthing, postpartum care, newborn care, and family planning. Hypnobirthing was conducted directly by the author, and the patient was accompanied by the author throughout the hypnobirthing care during pregnancy to reduce anxiety. During the active phase of labor, hypnobirthing was also provided by the author with continuous accompaniment to reduce pain, with a duration of approximately 15 minutes for each session.

RESULTS

1. Pregnancy Care

Data collected on August 30, 2024, indicated that Mrs. had been experiencing lower abdominal pain for the past 3 days. This was her first pregnancy, and she had no history of miscarriage, infectious diseases, or hereditary diseases. A comprehensive examination was conducted, including anthropometric measurements with the following results: upper arm circumference (UAC) 23 cm, current weight 57 kg, pre-pregnancy weight 43 kg, height 152 cm, and BMI 18.6 kg/m². Next, vital signs (VSS) were examined, with results of blood pressure 120/70 mmHg, pulse 85 beats per minute, respiration 23 breaths per minute, and temperature 36.5°C. Then, the results of the obstetric examination showed the fundal height (FHU) 29 cm, right back presentation of

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the head, and had not yet entered the upper pelvic inlet, with a fetal heart rate of 138 beats per minute. Other examination results are in good condition and within normal limits, with a diagnosis of G1P0A0 Gravida 36 weeks, single live intrauterine fetus in head presentation. Management: The management involves informing the mother that the complaints are physiological changes of the third trimester, advising her to rest adequately, recommending warm compresses on the lower abdomen to reduce pain, and providing psychological support to the mother, informing her about the signs of labor, and scheduling a follow-up visit in one week.

Results of data collection during the second visit on September 6, 2024, Mrs. R no longer had lower abdominal pain and complained of frequent urination. She also said that she felt anxious and worried about facing labor. An anthropometric examination was then performed, with a result of 57 kg body weight. Subsequently, vital signs (VSS) were examined, with results of blood pressure 123/80 mmHg, pulse 80 beats per minute, respiration 21 breaths per minute, and temperature 36.5°C. The obstetric examination results showed uterine fundal height (UFH) of 29 cm, right back presentation of the head, and the fetus had entered the upper pelvic inlet, with a fetal heart rate of 145 beats per minute. Other examination results are in good condition and within normal limits, but on examination of the genitals, there is clear, odorless discharge with itching, with a diagnosis of G1P0A0 Gravida 37 weeks, single live intrauterine fetus in head presentation. The management performed was to inform the mother that the frequent urination she was experiencing was a physiological change in the third trimester, advise her to reduce hydration at night to reduce urination, inform her that vaginal discharge was also normal in the third trimester, and advise her to pay attention to her personal hygiene by changing her underwear frequently. Informing the mother that she is experiencing anxiety and worry, and introducing hypnobirthing as one method to reduce anxiety, explaining the purpose and benefits of hypnobirthing, obtaining informed consent for hypnobirthing, performing hypnobirthing, and obtaining informed consent again that hypnobirthing will be performed during labor to reduce pain, and scheduling a follow-up visit in one week.

Data collection results from the third visit on September 11, 2024, showed that the mother no longer had frequent bowel movements or vaginal discharge and currently had no complaints. An anthropometric examination was then performed, with a result of 57 kg body weight. Subsequently, vital signs (VSS) were examined, with results of blood pressure 111/78 mmHg, pulse 83 beats per minute, respiration 21 breaths per minute, and temperature 36.7°C. The obstetric examination results showed fundal height 29 cm, right back presentation of the head, and already entered the upper pelvic inlet, fetal heart rate 145bpm, with a diagnosis of G1P0A0 Gravida 38 weeks, single live intrauterine fetus in head presentation. The management performed included reminding the mother about the signs of labor, providing health education on activity and rest patterns, conducting family planning counseling using the SKB method, and scheduling a follow-up visit in one week.

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2. Labor Care

Maternal care during labor is provided at 39-40 weeks of gestation. On September 16, 2024, at 2:30 a.m., Mrs. R complained of heartburn since 8:00 p.m., accompanied by bloody mucus discharge and no Rupture of membranes (ROM). Blood pressure was 132/83 mmHg, pulse rate 80 beats per minute, respiratory rate 20 breaths per minute, and temperature 36.5°C, fetal heart rate 148 beats per minute, contractions 3x10'45". Physical examination revealed the mother was restless and occasionally screaming. Internal examination showed no abnormalities. The cervix was thin and soft, dilation was 8 cm, the amniotic sac was intact, cephalic presentation, station +2, Hodge IV, no maceration, and no small parts palpable, with an initial diagnosis of G1P0A0 parturient at term in the first stage of active labor, single live fetus in cephalic presentation. Care given was to teach the mother to regulate her breathing during contractions and not to push before complete dilation, encouraging the mother to move around, and allowing the mother to eat and drink when there are no contractions, and providing hypnobirthing using pre-recorded audio listened to via headphones, followed by observation. Stage I of labor lasted 1 hour, Stage II lasted 10 minutes, and Stage III lasted 5 minutes. Stage IV was monitored for 2 hours after the delivery of the baby. The delivery proceeded normally without complications or any difficulties. The care provided was based on the standards of normal delivery care.

3. Postpartum Care

Midwifery care during the postpartum period is carried out in accordance with established midwifery care standards. Care is provided for up to 42 days for both the mother and baby. Further care is provided in the form of four home visits. Six hours after giving birth, the mother complained of slight cramps and that her breast milk had not yet come in. The management carried out was to advise the mother to maintain her nutritional needs, evaluate breastfeeding techniques, teach attachment and breastfeeding techniques, and advise the mother to get adequate rest. The mother was given vitamin A therapy 200,000 IU 1x1, paracetamol 500mg 3x1, amoxicillin 500 mg 3x1, and Fe 60 mg tablets 1x1. During the postpartum period, home visits were conducted to monitor the health of the mother and baby, including physical examinations, monitoring of uterine involution, breast milk production, and breastfeeding, as well as counseling on nutritional needs, elimination needs, rest needs, personal hygiene, exclusive breastfeeding, and family planning.

At Postnatal Visit 1 (PNV1), Mrs. R complained that she felt tired from having to stay up all night to breastfeed her baby. The management provided was to give psychological support to the mother so that she would remain enthusiastic about breastfeeding her baby, as well as encouraging her to rest according to her baby's sleep pattern. She was also informed that during the first month, babies' sleep patterns are not yet regular, so they often wake up in the middle of the night. Therefore, mothers can take advantage of their babies' sleep time to get enough rest.

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On PNV2, which was day 14, Mrs. R had no complaints. She had become accustomed to waking up at night to breastfeed her baby. Uterine involution was progressing well, and normally, there were no complications during the postpartum period. Uterine contractions were strong, bleeding was normal, lochia discharge was as expected, breast milk flowed smoothly, and the baby's needs were met.

On PNV3 day 32, support was provided to continue exclusive breastfeeding for 6 months, counseling on family planning was given, and the mother was encouraged to maintain a healthy lifestyle, including rest, nutritional needs, and other activities, which would then be continued after the postpartum period ended. Family planning midwifery care was provided to Mrs. R when she came to the health center, accompanied by her husband, to receive a 3-month contraceptive injection. The mother has no complaints, is in good general health, and is currently exclusively breastfeeding her baby. The mother and husband have agreed to delay the next pregnancy so that the mother can focus on caring for her first child, and she has the full support of her family. Physical examination shows vital signs within normal limits, no complaints regarding lactation, TFU not palpable, an empty bladder, and lochia in the form of lochia alba. The mother has good personal hygiene, with no signs of infection.

After conducting a comprehensive assessment and confirming that the mother is eligible as a contraceptive acceptor, education is provided on the purpose, benefits, and side effects of the 3-month injectable contraceptive using the ABPK approach. The mother understands the information provided and gives her consent by signing an informed consent form. The injection is then administered. Depo Medroxyprogesterone Acetate 150 mg/3 ml intramuscularly in the right buttock. The mother was also given information regarding the schedule for her next visit and expressed her willingness to attend according to the predetermined schedule.

4. Newborn Care

Midwifery care at the beginning of the newborn period involves keeping the baby warm by drying the baby and conducting an initial assessment of skin color, breathing, and muscle tone. Next was the handling of the newborn, starting with cutting the umbilical cord, facilitating the baby with skin-to-skin contact for one hour, and after successful skin-to-skin contact, the baby underwent a physical examination and anthropometric examination with the results of weight 2950 grams, height 48 cm, head circumference 31 cm, chest circumference 30 cm, no signs of abnormalities or congenital defects in the baby, and the baby was given vitamin K, eye ointment, and HB 0. Further care was provided during the follow-up visit to the health center. At the First Neonatal Visit, the mother was reminded to always keep the baby warm and was advised to breastfeed the baby every 2 hours.

At the second follow-up visit, the care provided included informing the mother to breastfeed her baby on demand and at least every 2 hours to stimulate milk production, advising the mother to continue monitoring the baby's umbilical cord, reminding her about the danger signs in newborns, and reminding her about the " "(mother's health card) to come to the posyandu to receive complete

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immunization for their baby. At Postnatal Visit 3, conducted at the health center when the baby is due for BCG immunization, the care provided includes explaining the BCG immunization and administering the immunization.

DISCUSSION

1. Pregnancy Care

Mrs. R is a 17-year-old who is undergoing her first pregnancy. According to obstetric theory, the ideal age for pregnancy is between 20 and 35 years, as women in this age range are generally physically and psychologically mature. Pregnancy under the age of 20 is associated with a higher risk of complications such as preeclampsia, anemia, and preterm labor, as the reproductive system may not yet be fully mature. Studies have shown that adolescent pregnancy increases the risk of adverse maternal and neonatal outcomes, including fetal growth restriction and other medical risks for the mother (Neal et al., 2012).

Continuing with the aspect of high-risk age, Mrs. R's first pregnancy checkup or antenatal care (ANC) visit was conducted when she was already 36 weeks pregnant. This indicates that monitoring of the pregnancy only began in the late stages of pregnancy, which, of course, reduces the possibility of early detection of complications. However, the results of the visit showed that Mrs. R had undergone two ANC examinations by a doctor, which is in line with the recommended minimum number of visits to a specialist during pregnancy. The results of these examinations were quite good. Although there was a slight discrepancy between the actual TFU and the theoretical TFU, according to McDonald, for a gestational age of 36 weeks, which should be 32–33 cm, the FHR results were still considered normal and did not indicate any serious problems (Aida Fitriani et al., 2022).

The results of the examination formed the basis for the next visit in week 37, during which a comprehensive evaluation was conducted again to ensure that no additional risk factors had emerged. The examination showed that the presentation of the fetus was good, with the head already entering the pelvic inlet. Using the McDonald formula, the estimated fetal weight at week 37 was 2635 grams, which was still within the normal range. Although the fundal height remained at 29 cm, which was lower than the theoretical value, this was not a major concern because the estimated fetal weight indicated adequate growth. Given the high-risk pregnancy status, monitoring and support are crucial. Therefore, during the next visit, Mrs. R was given intensive education on the importance of maintaining nutritional intake, rest patterns, and regularity in pregnancy check-ups. This type of intervention has been supported by various studies that emphasize the importance of holistic support, especially for pregnant teenagers, in order to minimize health risks for both mother and baby. In this context, psychological aspects were also a major concern. Anxiety assessment using the Facial Anxiety Scale showed that the patient experienced moderate anxiety during the third trimester of pregnancy, particularly related to the childbirth process (Wahid et al., 2023).

In response to the patient's anxiety, hypnobirthing was introduced as a non-pharmacological intervention to manage emotional tension before childbirth. This

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technique involves relaxation exercises, positive visualization, and breathing techniques aimed at reducing stress and increasing maternal confidence. Previous studies have demonstrated that hypnosis-based interventions, including hypnobirthing, are effective in reducing maternal anxiety and improving the childbirth experience (Downe et al., 2015; Madden et al., 2016). After the first session, Mrs. R showed a significant decrease in anxiety scores based on measurements using the Facial Anxiety Scale (FAS). This assessment became the basis for continuing this approach until the time of delivery. However, a limitation of this care approach is the anxiety measurement method used, namely the FAS, which is subjective and visual, and therefore less capable of describing the complexity of emotions comprehensively. Therefore, to obtain more accurate results, anxiety measurements should be supplemented with standardized questionnaires such as the Hamilton Rating Scale (HARS) or the State-Trait Anxiety Inventory (STAI) (WHO, 2016).

As a continuation of hypnobirthing intervention, thorough birth planning is also prepared through the Birth Planning and Complication Prevention (P4K) program. This preparation includes determining the referral hospital, transportation, and education about the signs of labor. This step is important because a good referral system has been proven to reduce the risk of maternal and neonatal complications. Not only that, the involvement of the husband as a birth companion is also emphasized because it has been proven to contribute to a reduction in the mother's anxiety level and the success of the delivery process. As she approached labor, Mrs. R also complained of frequent urination, a common complaint caused by the pressure of the fetus's head on the bladder and an increase in blood volume and urine production in the third trimester. This phenomenon is a normal physiological change. Since there were no symptoms of urinary tract infection, the treatment provided was educational, such as maintaining genital hygiene and regulating fluid intake, especially before bedtime. In addition to urinary disorders, vaginal discharge was another complaint reported by Mrs. R. Increased vaginal discharge during the final trimester is a hormonal response to increased levels of estrogen and progesterone, which trigger cervical mucus production. Because there were no pathological symptoms such as unpleasant odor or itching, this vaginal discharge was categorized as physiological. Education was provided on vulvar hygiene, the use of cotton underwear, and avoiding soaps with harsh chemicals. Monitoring was carried out to ensure that the vaginal discharge remained physiological and did not develop into a pathological condition (Rufaridah, 2019).

Supporting all these pregnancy processes, Mrs. R's nutritional status is an important indicator that determines the well-being of the mother and fetus. During pregnancy, Mrs. R's nutritional status was in the optimal category. This is in accordance with WHO recommendations and various nutritional studies that state that an increase of 11.5–16 kg is ideal for pregnant women with a normal BMI. Consumption of nutritious foods and supplements such as iron and folic acid is recommended to maintain this condition until the end of pregnancy (Marshall et al., 2022).

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As the delivery date approached, Mrs. R was given family planning counseling using the Balanced Counseling Strategy (BCS) approach, which includes comprehensive information on various contraceptive methods. BCA has been proven effective in improving patient understanding and reducing misunderstandings. Mrs. R chose the 3-month injectable contraceptive method because it was considered the most suitable and practical, especially for breastfeeding mothers. Delaying the use of contraception until 6 weeks postpartum was also explained as a form of optimal reproductive system recovery (Jusliati et al., 2018).

To support the process leading up to delivery, ultrasonography examinations were performed at 36 and 38 weeks to confirm the position of the fetus, the amount of amniotic fluid, and the condition of the placenta. The examination results showed that the fetus was in good condition and ready for vaginal delivery. This examination is important in ensuring that there are no structural abnormalities that could endanger the safety of the mother and baby, as well as providing peace of mind for the patient ahead of delivery. Routine laboratory tests show that Mrs. R's hemoglobin levels are within normal limits, with negative results for urine protein and normal blood sugar levels. This indicates that there are no signs of anemia, preeclampsia, or gestational diabetes. Education on consuming foods high in iron continues to be provided to maintain stability ahead of delivery (Marshall et al., 2022).

The entire process of caring for Mrs. R's pregnancy was supported by the Continuity of Care (COC) approach, which emphasizes continuity and consistency in health services. COC includes periodic physical evaluations, psychological support, and careful family planning. This approach has been proven to improve the physical and mental readiness of mothers ahead of delivery, while ensuring that the well-being of both mother and baby is optimally maintained throughout pregnancy and postpartum (Marshall et al., 2022).

2. Childbirth Care

Mrs. R's labor began when she arrived at the health facility, complaining of increasingly strong and frequent contractions. After confirming that there were no complications, the delivery process could continue at the PONED. As a teenage primigravida, Mrs. R showed high anxiety from the beginning of the first stage of labor. This anxiety was evident from her unstable emotional expressions and difficulty managing contraction pain, highlighting the importance of emotional support and psychological intervention during childbirth for young mothers. In response to this condition, the author conducted hypnobirthing interventions to help Mrs. R manage her pain and emotional tension. This technique was carried out through deep breathing guidance, positive affirmations, and visualization of a calm delivery process. During the hypnobirthing session, Mrs. R successfully achieved an alpha brain wave state (8–13 Hz), which is a state of optimal relaxation while remaining conscious but calm. This alpha wave state triggered an increase in endorphin hormones and activation of the parasympathetic nervous system, which significantly reduced stress hormone levels and pain perception. This activation had a direct impact on reducing the activity of brain areas that

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process emotional pain, such as the anterior cingulate cortex and insula, making the sensation of pain more tolerable (Trianasari et al., 2024). (Trianasari G et al., 2024).

Mrs. R's success in achieving this condition was evident in her decreased emotional response to contractions and her increased ability to follow instructions. The reduction in the perceived pain scale was also confirmed subjectively, from severe pain to moderate pain. Although hypnobirthing was administered during the late active phase of the first stage of labor, the benefits were still significant. This is consistent with research showing that hypnobirthing remains effective even when administered during the active phase, although its maximum effect is more optimal when administered from the latent phase or third trimester of pregnancy (Febrianty & Rihardhini, 2023).

In addition to hypnobirthing, support from her husband and family, as well as breathing education, contributed to helping Mrs. R maintain calmness during labor. Mrs. R was also advised to engage in active mobilization, such as walking slowly and using a gym ball, which has been proven to accelerate cervical dilation. Previous research indicates that a combination of relaxation, emotional support, and physical activity can accelerate the progress of the first stage of labor and enhance the mother's comfort (Sitompul & Simbolon, 2024).

Entering the second stage, Mrs. R was able to push effectively after receiving guidance from the birth attendant. Full support from the family also helped create a calm and positive environment. The delivery process went smoothly, and the baby was born healthy. Immediately after birth, Early Breastfeeding Initiation (EBI) was carried out for one hour in accordance with WHO recommendations. EBI not only supports the baby's physiological stability but also stimulates the hormone oxytocin, which is important in helping uterine contractions and preventing postpartum hemorrhage. In the third stage, active management was performed in the form of oxytocin administration, placenta removal, and uterine massage. All procedures were normal without complications. Studies have shown that active management of the third stage can reduce the risk of bleeding by up to 70% and accelerate the process of uterine involution. In addition, continued IMD also helps increase naturaluterine contractions and strengthen the initial bond between mother and baby (Wulandari & Wahyuni, 2019).

The fourth stage is closely monitored according to protocol, with monitoring of the mother's and baby's condition during the first two hours after delivery. Second-degree lacerations are sutured with lidocaine as a local anesthetic, which works by blocking the transmission of pain impulses.17 After the procedure is complete, education is provided on the importance of hydration, nutritional intake, and uterine massage techniques to prevent further complications. Monitoring of vital signs, contractions, and the amount of bleeding is conducted comprehensively to ensure the mother’s condition remains stable (Syswianti, Wahyuni, & Mardiana, 2020).

Overall, the hypnobirthing intervention applied to Mrs. R, despite being implemented during the late active phase, still had a positive impact in reducing pain and anxiety. The success in achieving alpha waves indicates that the mother's

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neurological and psychological conditions can be effectively controlled through relaxation techniques. However, based on scientific evidence, hypnobirthing will be more effective if introduced earlier so that the mother has sufficient time to understand and practice relaxation techniques consistently and comprehensively. From this clinical experience, it is important for health workers, especially midwives, to proactively introduce hypnobirthing as part of antenatal education. The role of midwives in guiding mothers from pregnancy to the delivery process is crucial in creating a calmer, safer, and less traumatic delivery experience. Consistent education, emotional support, and ongoing hypnobirthing technique training can be an important part of efforts to improve the quality of holistic midwifery care (Trianasari et al., 2024).

3. Postpartum Care

Postpartum care is an integral part of midwifery services that aims to ensure the mother's complete recovery after childbirth, physically, psychologically, and socially. In this case, postpartum care begins 2–6 hours after childbirth. The primary focus is to ensure the stability of the mother's vital signs, the process of uterine involution, and the management of postpartum bleeding that remains within physiological limits. Uterine contraction examinations and lochia condition assessments are conducted to confirm that the uterine recovery process is progressing normally. Additionally, patients are taught how to perform fundal massage and fundal pressure independently and monitor warning signs such as excessive bleeding or foul-smelling lochia (Priansiska & Aprina, 2024).

In addition to physical monitoring, attention is also given to psychological aspects. The patient, who is a young mother, showed positive emotional responses postpartum but still expressed concerns about her new role as a mother. Education on breastfeeding was provided, accompanied by support during the early breastfeeding initiation (IMD) process, which proceeded smoothly. The IMD process plays an important role in enhancing the bond between mother and baby and stimulating the production of the hormone oxytocin to support uterine contractions (Priansiska & Aprina, 2024).

At PNV2, the evaluation focused on the continuation of uterine involution, perineal healing, and psychosocial adaptation. The patient complained of fatigue and reluctance to wake up at night to breastfeed, which is common in the early postpartum period. Intervention was carried out through education on the importance of regular breastfeeding and emotional validation so that the mother felt understood. Examination of the perineal wound showed no infection, and education on vulvar hygiene was provided to prevent complications. The patient began to show increased confidence and was getting used to her new role as a mother (Priansiska & Aprina, 2024).

PNV3 was performed in the second to sixth week after delivery. Uterine involution was declared complete, and lochia had turned into lochia alba, indicating the end of the postpartum period. The patient reported that she felt comfortable with her role and was successfully breastfeeding exclusively. Family support and prior education were factors that contributed to this success.

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Contraceptive counseling was also provided at this stage, and the patient chose the 3-month injectable contraceptive. Education was provided regarding the injection schedule and side effects, and the patient expressed her readiness to use this method (Priansiska & Aprina, 2024).

Care also included education on the importance of nutrition during breastfeeding and recommendations to do postpartum exercises to speed up the recovery of the pelvic floor muscles. The entire series of care showed that the patient was in good physical and psychological condition and was ready to undergo the transition to motherhood well. Continuous and comprehensive postpartum care has been proven to play an important role in supporting the well-being of mothers and babies and preventing future complications (Priansiska & Aprina, 2024).

PNV4 is conducted on the 42nd day after delivery, coinciding with the family planning visit, which is the most critical moment to ensure the mother's readiness to start a contraception program. The postpartum family planning program is an important step in maintaining the health of the mother and baby. The patient in this case received family planning counseling from pregnancy through the postpartum period, which included information on methods, how they work, benefits, and side effects of contraception. This counseling helped the mother feel confident and ready to choose the method that suited her needs (Siregar et al., 2024).

During the third postpartum visit, the patient chose 3-month injectable contraception after receiving education about the mechanism of action, injection schedule, and possible side effects such as changes in menstrual patterns or weight gain. An explanation was also provided regarding the timing of the first injection, which is in the sixth week after delivery if the mother is exclusively breastfeeding, to ensure the safety and effectiveness of progestin-only hormonal contraception. Administering contraception after 6 weeks aims to allow time for the uterus to recover through the process of involution, as well as to avoid the risk of thromboembolism that can occur if combined hormonal contraception is administered too early. Therefore, progestin-only contraception or non-hormonal methods are the primary choice for breastfeeding mothers (Chairunnisa & Widya Juliarti, 2022).

In addition to preventing unplanned pregnancies, choosing the right contraceptive method also allows for optimal recovery time for mothers and supports the continuation of exclusive breastfeeding. Discussion with health workers is essential to ensure that the chosen method is appropriate for each individual's circumstances. Thus, postpartum contraceptive programs not only support reproductive health, but also the overall well-being of the family (Noftalina et al., 2021).

The success of family planning programs is also highly dependent on the active involvement of healthcare providers in providing comprehensive and ongoing education. Mothers' good understanding of how contraceptives work and their benefits can increase compliance and the long-term effectiveness of family planning. This is in line with the government's efforts to reduce the number of

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unplanned pregnancies and improve the quality of family life through careful pregnancy planning (Octaviani Chairunnisa & Widya Juliarti, 2022).

4. Newborn Care

Midwifery care for newborns focuses on stabilizing and helping babies adapt to extrauterine life. Immediately after birth, an APGAR assessment is performed at the first and fifth minutes, with results showing that the baby is in good condition. Initial actions such as airway clearance, drying the body, and providing warmth are taken to prevent hypothermia. Early Breastfeeding Initiation (EBI) is carried out within the first 30 minutes by placing the baby on the mother's chest, which helps stabilize the baby's body temperature and stimulates lactation hormones and the emotional bond between mother and baby. The baby showed good sucking reflexes, and education was provided to the mother regarding the importance of EBI to accelerate colostrum production and protect the baby from infection (Ropitasari & Hutomo, 2024).

A thorough physical examination ensures that there are no congenital abnormalities, and the umbilical cord is cared for using sterile clamps and education for the mother on maintaining hygiene. The baby also receives hepatitis B immunization within the first 24 hours as an effort to prevent transmission of infection from the mother. At the first neonatal visit (6–48 hours), the baby shows stable vital signs, a dry umbilical cord, and a regular feeding pattern. Education for the mother focuses on monitoring danger signs, umbilical cord hygiene, and the importance of breastfeeding every 2–3 hours (Alinaitwe et al., 2025; Semrau et al., 2016).

During the second visit (3–7 days), the baby's growth begins to show an increase in weight, indicating adequate breast milk intake. The shows a healing without signs of infection. Further education is provided regarding the baby's sleep patterns, signs of hunger and fullness, and the correct sleeping position that is safe to prevent sudden infant death syndrome (SIDS). The infant is in good condition, and the mother is given support to continue exclusive breastfeeding (Octaviani Chairunnisa & Widya Juliarti, 2022).

Third visit, third (8–28 days) emphasizes monitoring of physical growth and neurological development. Weight gain, height, and head indicate that it is optimal. Physiological reflex examinations, such as Moro, rooting, and grasping reflexes, show normal results, and the baby begins to show early social responses, such as smiling and following sounds. Education on early stimulation, such as tummy time, touch, and verbal communication, is provided to support muscle and cognitive development. The schedule for follow-up immunizations is also provided to ensure long-term health protection for the infant. With comprehensive care, the baby shows good adaptation, and the mother feels more confident in treatment (Fathony et al., 2022).

CONCLUSION

This case study demonstrates that continuous, evidence-based midwifery care provided from late pregnancy through childbirth, postpartum, newborn, and family planning services had a positive impact on maternal and neonatal

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outcomes. The application of hypnobirthing during pregnancy and the active phase of labor contributed to a reduction in maternal anxiety and labor pain, resulting in a normal delivery without complications. Postpartum care showed good maternal recovery, successful breastfeeding, and informed decision-making regarding contraceptive use. Newborn care indicated that the baby was within normal physiological limits, with appropriate growth and development. Although the overall outcomes were favorable, continued monitoring of maternal psychological well-being, breastfeeding practices, and adherence to postpartum and newborn follow-up visits is recommended to ensure sustained health for both mother and infant.

RECOMMENDATIONS

Based on the results of this case study, the following recommendations are proposed. For the patient, it is recommended to continue practicing hypnobirthing techniques independently to manage anxiety and maintain relaxation during the postpartum period, as well as to attend scheduled postpartum, neonatal, and family planning follow-up visits. For the author, it is recommended to continue applying evidence-based midwifery care, including hypnobirthing, as a non-pharmacological intervention to reduce maternal anxiety and labor pain, and to enhance skills through continuous learning and training to improve the quality of midwifery care.

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