COMPREHENSIVE MIDWIFERY CARE WITH POSSIBLE POSTPARTUM DEPRESSIVE DISORDER IN THE GARUT DISTRICT AREA

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Abstract : Introduction : Continuity of care includes obstetric care for pregnancy, childbirth, postpartum, newborn, and family planning which is an important factor in reducing maternal morbidities such as prolonged labor which also causes asphyxia in newborn which can cause suffering in mothers which appears in the form of depression, anxiety, and post-traumatic stress.
Methods : This report used primary and secondary data collection methods. Care was provide to Mrs. B from January to April 2024, who was gestationally 40 weeks and 1 day.
Results : Care was gives to pregnant women with estimated past labor and care was given to prevent postterm pregnancy. Labor care was carried out at 40 weeks 3 days of gestation accompanied by complications in the form of prolonged labor with a baby born in a state of asphyxia which led to the death of the baby at the age of 17 hours. The physical results of the post-partum examination were good, but there were problems with the mother's psychology due to the death of the baby so that postpartum depression risk monitoring was carried out from 18 days postpartum with the score of 16. The care carried out has several gaps, including the care of prolonged labor, delayed referrals, handling asphyxia and post-resuscitation in newborn, neonatal deaths, and postpartum management in mothers at risk of postpartum depression.
Conclusion : Midwives and all healthcare workers at Health Center are expected to be able to provide care in accordance with applicable authority and can screen for early detection of postpartum depressive disorders.
Keywords : Comprehensive Care, Postpartum Depression, EPDS

BACKGROUND

Continuity of care is a continuous service starting from the period of pregnancy, childbirth, postpartum, and newborns and family planning organized with a promotive, preventive, curative and rehabilitative approach which includes support, participation in decision making, attention to psychological, needs and expectations at the time of labor, as well as information and respect for women[1].

Grieving mothers are 4 time more likely to experience depressive symptoms and 7 times more likely to experience post traumatic stress disorder than non-grieving mothers[2]. Reviews and meta-analyses show post traumatic stress disorder in postpartum is found in

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about 3-4% of all women who have given birth. 39% of these rates are found in women whose babies died[3].

Traumatic childbirth can cause psychological distress, intense fear, or helplessness for the birthing mother, increasing the risk of anxiety, depression, and post-traumatic stress disorder (PTSD)[4,5]. During the postpartum period, the mother can also experience mental health problems due to the complicated birth experience, increasing the risk of postpartum depression, psychosis, and stress disorders[6–8].

Postpartum depression has the same symptoms as babyblues. Usually postpartum depression is experienced by a mother no later than 8 weeks after giving birth. The characteristics of postpartum depression are the mother's thoughts of hurting her baby, hurting herself, feeling no interest in the baby, doubts about her ability to care for the baby, sensitivity, stress, anxiety, fantasies of being the perfect mother, loss of identity, and others. The causes of postpartum depression include emotional disappointment followed by dissatisfaction, fear of pregnancy and childbirth, postpartum pain and fatigue and anxiety about being unable to care for the baby. However, usually the main cause of depression is the fear that she is no longer attractive in front of her husband[9]. In managing postpartum depression, there are a number of treatments that must be given to patients, namely :

a) Screening test. May use the Edinburgh Depression Scale (EPDS) which is a valid depression questionnaire.
b) Psychological support from husband, parents, relatives, midwives, and other health workers.
c) Psychologist and counselor support.

Some researchers suggest a positive correlation between postpartum depression and PTSD[10]. Soderquiest, et al suggested that depression and PTSD may share the same vulnerabilities and risk factors[11]. In addition, some researchers have shown that postpartum depression is one of the things can predict the presence of PTSD symptoms in mothers later in life[12].

One of the efforts to prevent postpartum depression is to conduct early detection using the Edinburgh Postnatal Depression Scale (EPDS) instrument. The EPDS was designed by Cox, Holden and Sagovsky and can be used in hospitalizations, home visits, or at 6 – 8 weeks after labor. The EPDS consists of 10 statements and can be completed within 5 minutes. The ten questions on the EPDS are a valuable and efficient way to identify patients at risk for postpartum depression, are easy to administer and have been shown to be an effective screening tool [13]. The EPDS is not an instrument for definitive diagnosis, but it can be used to detect the possibility of postpartum depression.

Based on this, the author wishes to conduct an assessment and care for postpartum mothers with possible postpartum depressive disorders.

METHODS

Subjects in case studies conducted on pregnant women aged 23 years with the first pregnancy. Tools and materials used in providing care include stationery, obstetric care formats for pregnancy, childbirth, postpartum, newborns and EPDS assessments formats. EPDS score interpretation :

a) Under 8

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Interpretation : Depression may not occur
Action : Continue to support postpartum mothers

b) Score 9 – 11
Interpretation : Possible depression
Action : Support, recheck in 2 – 4 weeks, consider referral to psychiatry.

c) Score 12 – 13
Interpretation : The likelihood of depression is very high
Acton : Monitor, support and educate. Consider referral to psychiatry.

d) Score 14 – higher
Interpretation : Possible depression
Action : Perform diagnostic assessment and treatment by psychiatry.

RESULTS

Antenatal Care

The results of data collection on January 29, 2024 Mrs. B came to the Health Center for a check-up, complaining of occasional infrequent contractions at 40 weeks and 1 day pregnant. This is the mother's first pregnancy and has no history of miscarriage. The mother's antenatal care history was 12 times with good results with no problems found and had done and usg by a midwife once with the results of the head position already below.

In this pregnancy examination, the author reviewed vital signs and focused pregnancy examination with the results of BP 110/70 mmhg, pulse 79x/min, respiration 23x/min, and temperature 36,5°C and on abdominal examination found the results of fundal height 30 cm, Leopold I impression of buttocks, Leopold II there is a hard resistance like a board on the left side of the abdomen, Leopold III presentation of the head has entered the pelvis with 2/5 climbing, fetal heart rate 136x/min.

The management given is to explain to the mother the difference between false contractions and his labor, encourage the mother to do natural induction such as having sex, and nipple stimulation to prevent postterm pregnancy, explain the signs of third trimester pregnancy, explain the signs of labor and advice the mother to do an usg to an obstetrician for more accurate ultrasound results.

Labor Care

Labor care was carried out when the mother's gestational age was 40 weeks and 3 days. On January 31 at 01.30 Mrs. B came to the health center with complaints of contractions since 18.30 with the results of an abdominal examination of his 2x10'x25" inadequate, fetal heart rate 136x/min, regular and the results of an internal examination of the vulva/vagina there are no abnormalities, thick rigid portio, 2cm dilated, intact amniotic fluid, head presentation, and decreased hodge I.

The mother's latent phase stage I lasted for 12 hours followed by the active phase stage I which lasted for 22 hours where at the 4th and 8th hour observations there was no change in hiss and dilated. At the 12th hour observation, the diagnosis of prolonged active phase stage I was made because there was still no change in hiss but there was an dilated progress of 4cm so that it was considered for referral but was still waiting for advice from the referral hospital. Observation was carried out at the 16th hour where the results obtained were the dilated progressed by 1cm and there was still no change in the hiss experienced by the mother. At the 17th hour observation, management was carried out according to the

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advice of an obstetrician, namely emptying the bladder, breaking the membranes and observation for 3 hours. At 3 hours after giving advice, observation was carried out again with the results that there was still no progress in dilated but the hiss felt by the mother increased. At the 22nd hour, observation was carried out again with the results of the examination there was progress in the opening of labor to be complete and a decrease in the head in Hodge III+ so that labor was led according to the advice of obstetricians, namely leading labor with a time limit of 2 hours.

The length of second stage of labor experienced by the mother was 1 hour 25 minutes and an episitiomy was performed with an indication of a rigid perineum with the result that the baby was born spontaneously at 12.55 with 1 very tight coil, not crying immediately, bluish skin, no muscle tone. Stage III occurred for 8 minutes with the results that the placenta was born spontaneously with an intact impression and the installation of Post Placenta IUD Copper-T according to the mother's wishes and in stage IV monitoring was carried out for 2 hours with normal results.

Newborn Care

A quick assessment at the time of the newborn is that the baby is not crying, the skin is bluish, muscle tone is absent so the first step of resuscitation is carried out but the baby is still not crying. Then positive pressure ventilation was carried out for 30 seconds with the results of the baby crying spontaneously, the skin began to redden, and muscle tone began to move and the heart frequency was 120 times/minute so continued with post-resuscitation care such as giving oxygen 1 liter/minute to prevent the baby from respiratory failure, warming the baby with a lamp, giving vitamin K at the age of 1 hour and giving vit. HB0 in the first 2 hours of the baby's life.

Care was continued at the age of the baby's first 6 hours at 18.15 with the results of the family's history, namely the baby wanted to breastfeed, crying strongly and active baby movements. The results of the examination of the general condition of the baby appear to cry strongly sometimes whimpering, sucking inadequate breast milk. The results of checking vital signs, the baby is within normal limits, namely heart frequency 133 times / minute, temperature 36.3 ° C, breathing 53 times / minute and SPO2 96%. On physical examination, there was chest wall retraction in the baby. The care given is to check the blood sugar according to the doctor's advice with normal results of 91 gr / dl and continue observation.

At 22:00, another observation was conducted and it was found that the breath count was in sync with the heart rate. The advice from the doctor is to continue observation. Then at 05.30 there was a decrease in the baby's condition, namely the baby experienced respiratory arrest so that PPV was given for 30 seconds with the result that the baby had not breathed and fetal heart rate <100 times/minute, PPV was carried out again for 30 seconds with the result that the baby was still not breathing and experiencing cardiac arrest so that CPR was performed for 10 minutes, but the baby had no improvement in condition so he was declared dead at the age of 17 hours at 05.54.

Postpartum Care

Postpartum care for Mrs. B starts from 6 hours postpartum with the results of the examination of the mother's general condition looking good and happy with the birth of her child, the results of the examination of vital signs within normal limits, the results of the

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abdominal examination of the mother's fundal height 3 fingers below the navel and hard uterine contractions, and the results of the examination of normal bleeding genitalia, and there are no signs of infection.

Midwifery care for postpartum 5 days on February 06, 2024 with the results of the examination of psychological patterns the mother has accepted the death of her baby but wants this not to happen again. The care provided at this time is to facilitate the mother to do counseling and recommendations for stopping breast milk so that there is no breast engorgement. Then a postpartum depression risk assessment was carried out using the EPDS instrument on February 19, 2024 and obtained a score of 16 which interpreted as possible depression.

Postpartum care continued with home visit care on February 23, 2024 with the results of examining the mother's psychological pattern based on family information that the mother often cries if she remembers her baby or if there is a slight trigger such as seeing baby clothes, the mother will cry and the mother feels embarrassed by neighbors so lazy to interact. Then the EPDS assessment was carried out again with a score of 15. The care provided is to facilitate the mother to get psychological counseling so that the mother can be motivated.

The EPDS assessment was carried out again as recommended on March 01, 2024, the results of the examination of the mother's psychological pattern were that the mother felt motivated by the simple psychological counseling carried out previously and obtained a decrease in the score to 12 with the interpretation that the possibility of depression was still high. The care taken is to recommend further examination by a psychologist but the mother feels that she can still try to get better on her own.

The EPDS assessment was continued as recommended on March 08, 2024 with the results of the psychological pattern examination, the mother felt that her condition was much better and felt an improvement in her life but she still had the same EPDS score as the previous examination of 12.

Postpartum care continued at 37 days postpartum on March 09, 2024 to check the IUD Post Partum used by the mother and examine the mother's psychological patterns with the results based on family information that the mother was much better than before, was more open and had done daily activities pleasantly.

The EPDS assessment was again carried out on March 19, 2024 with the results of examining psychological patterns, the mother was very much better even though she sometimes remembered her baby and the results of the EPDS score decreased to 11.

DISCUSSION

Antenatal Care

This comprehensive care was carried out by the author starting on January 29, 2024, namely pregnancy care 40 weeks 1 day. During the antenatal examination the mother had done an ultrasound but this ultrasound was performed by a midwife where this was not in accordance with Permenkes No. 24 of 2020 that health care facilities that organize radiology

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services must have equipment and human resources. The human resources in question are radiology specialists, but if they do not have them, they can be replaced by other doctors or specialists with additional authority given through training to obtain competence in accordance with the provisions of laws and regulations. So, it can be interpreted that obstetricians also need to have a certificate from the radiology collegium to be able to use ultrasound[14].

The care provided by the author is that the author provides natural induction education to prevent postterm labor. Natural induction has several ways, one of which is coitus and nipple stimulation. Coitus is one of the ways of natural induction because of the role of prostaglandins produced by the prostate gland in sperm which is thought to contain the highest concentration of prostaglandins useful for cervical maturation and induction of labor which has been studied extensively[15]**.** Nipple stimulation techniques can also stimulate the formation of natural oxytocin in the mother's body and channeled to the uterus to cause contractions. This nipple stimulation can be done by the mother and her partner[16]**.** The advice from the author was not carried out because the mother experienced obstacles with her husband working outside the city. Based on this, the author has tried to establish a good relationship between the mother and husband to make efforts to prevent postterm labor so that labor can proceed normally and give birth to a healthy newborn.

Labor Care

The total time of latent phase 1 experienced by the mother is 11 hours, which is normal for primigravida mothers. The total time of the active phase experienced by the mother is 22 hours, based on WHO that the active phase extends is a phase that lasts more than 12 hours in primigravida[17], then the mother can be concluded to experience the extension of the active phase.

When the mother entered the 4-hour active phase, there was no progress of labor opening and if you look at the partograph results, it is found that it has reached the acting lane. If you look at the calculation of hiss, then the mother's hiss is less than 40 seconds long. Based on the theory put forward by R.L Siantar and Dewi Rostianingsih (2021) in the Teaching Book of Obstetric Care for Maternal and Neonatal Emergencies, it can be considered the presence of uterine inertia[18]. If there is a possibility that the cause of this prolonged labor is uterine inertia, it is necessary to break the membranes and accelerate labor with oxytocin[19]. There are shortcomings in the author's care, namely not calculating the bishop score as a criterion for giving induction so that it does not know whether the mother's condition is favorable or not to be given induction of labor. However, it needs to be emphasized in accordance with Law No.4 of 2019 article 19, that midwives only have the authority to provide uterotonics in the third stage of labor, so it is necessary to consider referral.

Observations made by the author at the beginning of care were based on the existing Ministry of Health guidelines[20]. It is undeniable that there is a negligence of duties from the author and midwife that causes delays in referral consultations to higher health facilities. It can be seen that when looking at the results of the partograph, referral management should have started at 17.30, but observation was still continued due to slow consultation. Based on this, the use of partographs as a tool for observation of labor progress has not been effective, based on the timing of decision making. The tools for observation of labor progress

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in accordance with WHO guidelines in 2018 can use the labor care guide instrument[21] (LCG) but in Indonesia the use of LCG has not been used.

The period of second stage of labor lasted for 1 hour 15 minutes where based on this referral management was not done because the mother successfully gave birth in less than 2 hours. According to Kurniarum Ari, the period of second stage of labor in primigravida lasts 1.5 hours and in multigravida on average will last for 30 minutes[22].

Followed by active management care during the third stage with the results of the placenta being born with an intact impression but no early breastfeeding initiation was performed due to resuscitation of the baby. Then the post partum IUD was installed in accordance with Mrs. B's request and sutured the 2nd degree laceration wound and monitored the time IV with the results of normal maternal conditions.

The care provided by the author is in line with the standard of care in the theoretical review so it can be concluded that there is no gap between the theory and the care provided by the author.

Newborn Care

The initial steps of resuscitation and positive pressure ventilation have been carried out on the indication that the baby is still not crying after the initial steps of resuscitation with the results of the baby crying spontaneously after positive pressure ventilation for approximately 30 seconds. After that, post-resuscitation care was carried out, namely the baby was given 1 liter of oxygen using a nasal cannula to maintain the stability of the baby's body. This is in accordance with the Indonesian Minister of Health Decree No. HK.01.07 / Menkes/214 / 2019 concerning Guidelines for the Management of Asphyxia[23] that post-resuscitation care is carried out with the STABLE principle, one of which is the administration of oxygen through a nasal cannula to prevent respiratory failure. However, it needs to be emphasized that the STABLE principle is carried out to stabilize the baby when going to make a referral considering the distance of the referral place.

Health workers should carry out resuscitation measures in accordance with the development of new existing science such as the use of CPAP which requires assessment of the Silvermann - Anderson score and Downes score[24] so as to detect respiratory distress or the risk of respiratory failure in asphyxia infants and conduct close observation after resuscitation. The authors and the health team at the health center did not assess respiratory distress using these instruments due to a lack of knowledge so that the authors could not assess the possibility of respiratory failure. In addition, there are also shortcomings in the competence of health workers and infrastructure at the health center.

If reviewing the flow of neonate resuscitation, if the baby fails to breathe and the heart frequency is less than 100 times per minute, then PPV is performed by monitoring SPO2 using a pulse oxymeter and monitoring the ECG. If it is still less than 100 times per minute, PPV is re- performed effectively by seeing whether there is chest expansion or not, if there is no then perform the correction steps (hooding, head repositioning, and mucus suction). If the fetal heart rate is less than 60 times per minute then intubation is performed, and if it is still less than 60 times per minute then chest compressions are performed[25]. Based on this, it can be concluded that there is a gap between the theory and practice of

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the care provided.

After successful resuscitation, close monitoring of newborn danger signs is required, if any of the signs are present, immediate referral is required. In this case, danger signs have been found in the baby such as the baby does not want to breastfeed, sometimes whimpering cries, there is chest wall retraction but there is still no referral management. In addition, according to the Indonesian Minister of Health Decree No. HK.01.07 / Menkes/214 / 2019 concerning Guidelines for the Management of Asphyxia[23] that post-resuscitation care uses the S.T.A.B.L.E principle, from these components, actions have been taken to prevent the baby from experiencing hypoglycemia by checking blood sugar even though this is done after 6 hours, maintaining the baby's temperature but there are limited tools so according to the author from this alone a referral should be made. Observation of heart and respiratory frequency has also been carried out but there are limitations of tools such as the absence of a pulse oximeter after resuscitation is carried out, resulting in less than optimal observation assessment. However, it needs to be emphasized that the S.T.A.B.L.E principle is carried out for pre-referral stabilization, not as a reason for not making a referral.

It is also reviewed in PMK No.21 of 2021 that puskesmas cannot provide maternal and neonatal services with complications. It can be concluded by the author that there is a delay in referral and there are limited tools provided at the Puskesmas that cause this to happen.

In this care, it is undeniable that the author also has shortcomings in providing care such as less than optimal observation such as not assessing respiratory distress using the Downe score, lack of sensitivity to the baby's condition, lack of knowledge about newborns with asphyxia, and limited authority. Thus, this case provides a great lesson to the author, especially regarding newborns with asphyxia. With this case, the author can add a lot of experience, knowledge, and insight related to this matter.

Postpartum

Postpartum examination of the mother has been carried out in accordance with the standard, which is carried out 4 times with a certain period of time. Then, the author continues ongoing clearing related to the risk of postpartum depression in mothers so that the care provided by the author still continues and care is provided remotely.

Psychological disorders experienced by mothers have a high risk of developing post-traumatic stress disorder. However, this cannot be decided simply because midwives do not have the authority to diagnose psychological problems in mothers. However, as a comprehensive care provider, it is necessary to detect any psychological abnormalities in the mother in order to provide appropriate interventions. Post-traumatic stress disorder has similar characteristics to postpartum depression so based on this, we can use EPDS to detect the risk of psychological disorders in mothers.

On the 5th postpartum day, the mother complained that the milk came out very much so the care provided by the author was the suggestion of breast binding, this can be done to mothers who are left dead by their babies so that the milk produced can be reduced and there is no milk dam. The author also facilitated the mother to share her sadness so that the mother could be open about her condition.

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Postpartum depression is usually experienced by a mother no later than 8 weeks after giving birth. The characteristics of postpartum depression are usually mothers have thoughts of hurting themselves, stress, anxiety, and have fantasies of being the perfect mother. The causes of depression include emotional disappointment followed by dissatisfaction, fear of pregnancy and childbirth and pain during puerperium. For some mothers whose babies die, this traumatic labor can cause psychological distress, intense fear, or helplessness for the mother, which can increase the risk of anxiety, depression, and post-traumatic stress disorder (PTSD)[4,5]. Mrs. B found several symptoms that refer to postpartum depression including wanting to hurt herself or having suicidal thoughts, fear of the views of the surrounding environment, causing stress which is one of the signs of depression symptoms. A midwife certainly cannot confirm the exact diagnosis related to postpartum depression, but midwives must be able to carry out early detection of the risk of postpartum depressive disorders in mothers. So based on this, the author conducted screening using the EPDS instrument at several specific time periods.

Screening using the EPDS instrument was carried out at 18 days postpartum, 22 days postpartum, 29 days postpartum, 36 days postpartum, and 37 days postpartum with the results at the beginning of the mother's screening getting 16 points with the interpretation of possible depression, but there was a decrease in scores each time screening using the EPDS instrument with the last result of the mother's EPDS score obtained 11 where at this time the mother's condition was much better even though she remembered the grief she experienced several times. No further examination to psychiatry was done when the mother scored 16 and 15 at 18 days and 22 days postpartum because at this time the mother was experiencing an anger phase in accordance with the theory of the grieving phase proposed by Elisabeth Kubler Ross (1969) so that the mother was easily offended so that before recommending an examination by psychiatry, the author did his best to conduct simple psychological counseling. Monitoring of the mother's psychological development continued by the author until 37 days postpartum with the help of her husband and family Mrs. B so Mrs. B could gradually recover well. During the last visit with the author, Mrs. B admitted that the support of her husband and family greatly influenced her recovery process.

So far, the author has tried to provide care in accordance with the standards of care, theories and guidelines. However, there is no doubt that in providing this care the author has many shortcomings such as time constraints, not involving the patient's family so that the author cannot know the patient's condition based on the views of his family and limited knowledge so that the author cannot carry out psychological counseling to the fullest.

CONCLUSION

Based on the results of the theory and has been given midwifery care in a sustainable manner on Mrs. B with possible depressive disorders. Then the author can draw conclusions, namely :

Comprehensive care was provided starting from pregnancy, labor, puerperium and newborn and early detection screening was carried out as an effort to prevent postpartum depressive disorders.

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