

MIDWIFERY CARE FOR A NEWBORN BABY OF MRS. “W” WITH LOW BIRTH WEIGHT (LBW)

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A B S T R A C T

Background: Low Birth Weight (LBW) is defined as a newborn weighing under 2,500 grams regardless of gestational age. Infants with LBW face heightened risk of hypothermia, respiratory problems, infection, and impaired growth and development. Skin-to-skin contact between mother and baby through the kangaroo method is a complementary intervention that can support LBW management. **Purpose:** To provide midwifery care to Baby Mrs. "W" with LBW through application of the kangaroo method at Kanapa-napa Public Health Center, Central Buton Regency.

Subject: The subject of this case study was Baby Mrs. "W" with LBW. **Method:** A descriptive case study design was used, applying the seven-step Varney midwifery management approach with SOAP documentation. Data were gathered through interviews, observation, physical examination, and record review. **Results:** Care encompassed monitoring of vital signs and weight, maintaining warmth, ensuring nutritional intake through breast milk, educating the mother and family, and implementing the kangaroo method. Evaluation showed the infant's temperature stayed within normal range, the baby appeared calmer, breastfeeding improved, and body weight increased. **Conclusion:** Midwifery care for Baby Mrs. "W" with LBW via the kangaroo method followed the seven-step Varney approach and midwifery service standards, producing a positive effect on the infant's condition.

KEYWORDS: *Midwifery Care, Newborns with Low Birth Weight*

INTRODUCTION

A newborn is an infant who has just undergone the process of delivery, either through spontaneous vaginal delivery or by other means, with a normal birth weight ranging from 2,500 to 4,000 grams. During the neonatal period, the infant's body undergoes a series of physiological adjustments as a form of adaptation from life inside the womb to life outside the womb. Therefore, appropriate care is essential to maintain the infant's health and support optimal growth and development (Suryaningsih et al., 2022).

The term neonate refers to an infant who has undergone the birth process, either with or without the assistance of instruments, and is aged 0–28 days. This is a critical period during which the infant's organs are still undergoing maturation to enable the infant to survive and adapt to life outside the womb (Suherlin, Yulianingsih, & Porouw, 2024).

One of the neonatal conditions that requires special attention is Low Birth Weight (LBW), which is defined as a birth weight of less than 2,500 grams. The risk of mortality among LBW infants can be up to eight times higher than that among infants with normal birth weight (Isnaini, Ida, & Pihahay, 2021). In addition to the risk of mortality, LBW can also have long-term effects on children's growth and development. These effects may be influenced by various factors, including the mother's nutritional status during pregnancy, access to healthcare services, maternal infections, and genetic factors (Gemilastari et al., 2024).

Midwifery care for newborns plays an important role because this period marks the beginning of the infant's growth and development. Early detection and prompt management of adaptation disorders, including those occurring in LBW infants, are necessary to prevent more severe health problems. Systematic and evidence-based care can support infant survival while optimizing their growth and development (Yulianingsih et al., 2023).

Low Birth Weight (LBW) remains a serious global public health problem. The World Health Organization estimates that approximately 14.7–15% of all births, or more than 19–20 million infants each year, are born weighing less than 2,500 grams. This condition is most commonly found in low- and middle-income countries and is generally associated with preterm birth, fetal growth restriction,

nutritional problems, and inadequate antenatal care. Consequently, LBW infants face a higher risk of neonatal mortality and are vulnerable to long-term growth and developmental problems (Organization, 2023).

In Indonesia, Low Birth Weight (LBW) remains a challenge to maternal and child health. It is estimated that approximately 400,000 infants are born with LBW each year in Indonesia. The Indonesian Nutrition Status Survey (SSGI) in 2022 recorded a national LBW prevalence of 6.0%, while in 2021, 111,719 infants, or approximately 2.5% of total births, were reported to have LBW. This high prevalence is closely associated with maternal health conditions, including chronic energy deficiency and anemia during pregnancy. Therefore, efforts to improve maternal health status and fulfill the nutritional needs of pregnant women need to be continuously strengthened to reduce the incidence of LBW (Sartima, Andriyani, & Jingsung, 2023).

LBW cases are also still found in Southeast Sulawesi Province. Data from the Southeast Sulawesi Provincial Health Office in 2023, as published by the Central Statistics Agency, recorded 1,272 LBW cases out of 36,743 births, or approximately 3.46%. Several districts/cities recorded relatively high percentages, indicating that prenatal healthcare services and nutritional support during pregnancy need to be continuously improved (Ahmad et al., 2025). Complete official provincial-level data for 2024 are not yet available; therefore, the 2023 data are still used as a reference (Profil Sulawesi Tenggara, 2024).

In Central Buton Regency, 73 LBW cases were recorded in 2020, increasing sharply to 131 cases in 2021, before declining to 102 cases in 2022 and 84 cases in 2023. The number then decreased significantly to 4 cases among 202 births in 2024. Despite the declining trend, the incidence of LBW still requires serious attention through improved antenatal care services, pregnancy monitoring, and adequate nutritional support for pregnant women (Ningtyas et al., 2024).

Other data further support this situation. Among 327 births recorded during the period from January to June 2022, 38 infants (11.6%) were identified as having LBW. Gestational age, maternal hemoglobin levels, and pregnancy complications were among the factors that contributed to LBW. Mothers with anemia or pregnancy complications had a higher likelihood of giving birth to LBW infants compared with mothers experiencing normal pregnancies (Makkulau1, 2024). These findings emphasize the importance of early detection and continuous monitoring of maternal health throughout pregnancy.

Based on the foregoing description, the author developed a case study entitled “Midwifery Care for the Newborn Baby of Mrs. ‘W’ with Low Birth Weight (LBW) Using the Kangaroo Mother Care Method at Kanapa-Napa Community Health Center, Central Buton Regency.”

METHODS

This case study employed a descriptive observational design using the seven-step Varney midwifery management approach and documented the development of the infant’s condition using the SOAP format. A case study approach was selected to provide an in-depth description of the midwifery care provided to Mrs. “W”’s infant with Low Birth Weight (LBW), including the implementation of the Kangaroo Mother Care (KMC) method. The care process included the assessment of subjective and objective data, determination of actual diagnoses and problems, identification of potential diagnoses or problems, determination of the need for immediate intervention, development of a care plan, implementation, and evaluation. All stages were documented using the SOAP format.

The case study was conducted at Kanapa-Napa Community Health Center, Central Buton Regency, from December 2, 2025, to January 23, 2026. The subject was Mrs. “W”’s infant who had LBW and received midwifery care along with the implementation of the Kangaroo Mother Care method. This method was applied to maintain the infant’s body temperature, improve comfort, support breastfeeding, and promote weight gain according to the infant’s condition.

Data were collected from two sources: primary and secondary data. Primary data were obtained directly through interviews, observations, and physical examinations of the infant and the mother. The data included measurements of body weight, body length, head circumference, chest circumference, vital signs, general condition, and the infant’s response to the care provided. Secondary data were obtained from documentation, medical records concerning the infant’s condition, and other relevant written references. These data were used to complement information regarding the pregnancy history, delivery history, risk factors for LBW, and the infant’s development throughout the care period.

Data collection was carried out using four techniques: interviews, physical examinations, observation, and documentation. Interviews with the mother were conducted to obtain information regarding the identities of the mother and infant, pregnancy history, risk factors for LBW, delivery history, the infant's condition at birth, and the care received. Physical examinations were performed to obtain objective data, including birth weight, body length, head circumference, vital signs, signs of prematurity, Apgar Score assessment, and the presence or absence of congenital abnormalities. Observations were conducted to assess the infant's general appearance, behavior and responses, respiratory pattern, skin color, and interaction with the surrounding environment. Documentation was carried out by reviewing medical records and midwifery care records related to the case.

Data analysis was conducted descriptively from the data collection stage until all required data had been obtained. The results of interviews, observations, physical examinations, and documentation were organized according to the seven-step Varney midwifery management approach, while the development of the infant's condition was documented using the SOAP format. The collected data were reduced by selecting information relevant to the infant's LBW condition and the implementation of the Kangaroo Mother Care method. The data were then presented descriptively in the form of narratives and care documentation to systematically describe the assessment, identification of the infant's problems and needs, care planning, implementation of care, application of the Kangaroo Mother Care method, and evaluation of the infant's condition and progress.

Throughout the implementation of the case study, research ethical principles were applied to protect the rights and confidentiality of the subject, including informed consent, anonymity, and confidentiality. Informed consent was obtained by explaining the purpose, benefits, and care procedures to the mother or family before the care was provided. Anonymity was maintained by not including the subject's complete identity in the report. Confidentiality was ensured by protecting all information and data obtained throughout the case study.

RESULTS AND DISCUSSION

Subjective Data

The assessment of Mrs. "W"'s infant was conducted on December 29, 2025, at Mrs. "W"'s residence. It was reported that the infant was delivered spontaneously on December 25, 2025, at 06:43 Central Indonesia Time (WITA) at Kanapa-Napa Community Health Center. The infant was female, the mother's first child, with a birth weight of 2,400 grams and a body length of 47 cm at a gestational age of 38 weeks and 1 day, indicating a term pregnancy. During pregnancy, the mother attended five antenatal care (ANC) visits. The mother reported that her baby was born with a low birth weight and appeared small; therefore, Kangaroo Mother Care was initiated. At birth, the baby cried immediately and appeared reddish, although the cry was still weak.

The mother reported that she had already breastfed her baby, although the sucking and swallowing reflexes were not yet optimal at the initial assessment. The baby had already passed stool and urine but had not yet been bathed. The mother expressed her willingness to implement Kangaroo Mother Care, provide exclusive breastfeeding, and follow the recommended care instructions.

At the second visit, the mother reported that her baby was in good condition and expressed her willingness to maintain the baby's body temperature, provide exclusive breastfeeding, change the diaper or clothing when wet or soiled, maintain umbilical cord hygiene, and continue Kangaroo Mother Care. At the third visit, the baby was reported to be increasingly active and had a stronger sucking ability, routinely received Kangaroo Mother Care, was breastfed every 2–3 hours, and had regular bowel and bladder movements. At the fourth visit, the baby was reported to be more active, crying vigorously, continuing to receive exclusive breastfeeding on demand, routinely receiving Kangaroo Mother Care, having regular bowel and bladder movements, and appearing increasingly healthy and well-nourished.

Objective Data

The initial examination showed that the infant was in good general condition with a *compos mentis* level of consciousness. The vital signs were within the normal range, with a heart rate of 145 beats per minute, respiratory rate of 40 breaths per minute, and body temperature of 36.7°C. The infant's body weight was 2,400 grams, body length was 47 cm, head circumference was 29 cm, chest circumference was 28 cm, and abdominal circumference was 28 cm. The APGAR score was 8/10 at the first minute and increased to 10/10 at the fifth minute.

Physical examination revealed that the head, eyes, nose, ears, neck, and chest were within normal limits. The abdomen was soft on palpation, with no palpable masses, and no signs of infection were found around the umbilical cord. The female genitalia appeared normal, the anus was patent, and the extremities were symmetrical with active muscle tone. The tonic neck, rooting, swallowing, palmar/grasp, Babinski, and Moro reflexes were positive, while the sucking reflex was still negative at the initial assessment.

At the second visit, the infant's general condition and vital signs remained good, with body weight increasing to 2,700 grams, a temperature of 37.0°C, a heart rate of 145 beats per minute, and a respiratory rate of 40 breaths per minute. No signs of infection were observed, and the umbilical cord appeared clean and dry. At the third visit, the infant was in good general condition, with a heart rate of 140 beats per minute, a respiratory rate of 40 breaths per minute, and a temperature of 36.7°C. Body weight increased to 2,800 grams, with a body length of 50 cm, head circumference of 31 cm, chest circumference of 30 cm, and abdominal circumference of 30 cm. The umbilical cord had detached and appeared clean and dry, with no signs of infection. The rooting, sucking, and swallowing reflexes were positive.

At the fourth visit on January 14, 2026, the infant was in good general condition, with a heart rate of 138 beats per minute, a respiratory rate of 41 breaths per minute, and a temperature of 36.8°C. Body weight increased to 2,900 grams, while body length remained at 50 cm, head circumference at 31 cm, chest circumference at 30 cm, and abdominal circumference at 30 cm. The physical examination findings were within normal limits, the umbilical cord stump had completely dried, and all basic neonatal reflexes were positive.

Assessment

Mrs. "W"'s infant was delivered spontaneously at term at a gestational age of 38 weeks and 1 day, appropriate for gestational age, and was female. The infant was in good general condition but had Low Birth Weight (LBW) due to a birth weight of 2,400 grams. The potential problem identified during the initial assessment was the risk of hypothermia due to the infant's low birth weight. The infant was born at term; therefore, the LBW in this case was not caused by prematurity, but solely by a birth weight below 2,500 grams. The risk of hypothermia occurs because LBW infants have limited body fat reserves and immature thermoregulatory mechanisms. At the initial examination, the infant's body temperature was 36.7°C, indicating that hypothermia had not yet occurred.

Throughout the follow-up visits, the infant's condition continued to improve. The body weight increased gradually from 2,400 grams to 2,700 grams, 2,800 grams, and finally 2,900 grams, while the general condition and vital signs remained within normal limits. No signs of infection were observed throughout the monitoring period.

Management

Midwifery care for Mrs. "W"'s infant was provided comprehensively, including monitoring the infant's condition, ensuring adequate nutrition, maintaining body temperature, preventing infection, and monitoring growth and development. The initial visit focused on monitoring vital signs, maintaining body warmth using clean and dry clothing and blankets, changing diapers or clothing when wet, maintaining umbilical cord hygiene, and teaching the mother how to perform Kangaroo Mother Care (KMC). The mother was also educated on proper breastfeeding techniques and exclusive breastfeeding on demand.

Kangaroo Mother Care was selected as an intervention to maintain the body temperature of the LBW infant, considering that LBW infants are vulnerable to hypothermia due to limited fat reserves, immature thermoregulation, and a relatively larger body surface area in relation to their body weight. In this case, KMC was performed routinely to maintain body warmth while supporting weight gain. Throughout the monitoring period, the infant's body temperature remained within the normal range, with no signs of hypothermia.

Subsequent visits included monitoring vital signs and body weight, providing exclusive breastfeeding, caring for the umbilical cord, maintaining body warmth, and advising adherence to the recommended immunization schedule. As the infant's condition remained stable, with normal vital signs and no signs of hypothermia or infection, no immediate intervention or collaboration with other healthcare professionals was required.

At the third visit, the infant's body weight and body length were measured, and the mother was advised to continue exclusive breastfeeding and perform Kangaroo Mother Care routinely. At the

fourth visit, the mother was advised to continue exclusive breastfeeding until the infant reached 6 months of age, maintain the infant's hygiene, maintain the infant's body warmth, and was provided with education regarding danger signs in infants that should be monitored.

The final results of the care showed that the infant did not experience hypothermia, vital signs remained within the normal range, breastfeeding ability improved, nutritional needs were adequately met, and body weight increased from 2,400 grams at birth to 2,900 grams at the final visit. These findings indicate that Mrs. "W"'s LBW infant showed good progress.

DISCUSSION

Subjective Data

The assessment of Mrs. "W"'s infant conducted on December 29, 2025, at Mrs. "W"'s residence revealed that the infant was born spontaneously on December 25, 2025, at 06:43 Central Indonesia Time (WITA) at Kanapa-Napa Community Health Center. The infant was female and the mother's first child. The infant's birth weight was 2,400 grams, body length was 47 cm, and gestational age was 38 weeks and 1 day. The mother reported that her baby was born with a low birth weight and appeared small; therefore, Kangaroo Mother Care was initiated. During pregnancy, the mother had attended five antenatal care (ANC) visits.

The mother reported that she had breastfed her baby, although the infant's sucking and swallowing abilities were not yet optimal at the initial assessment. The infant had already passed stool and urine but had not yet been bathed. The mother expressed her willingness to perform Kangaroo Mother Care, provide exclusive breastfeeding, and follow the recommended care instructions.

At the second visit, the mother reported that the infant was in good condition and expressed her willingness to provide exclusive breastfeeding, maintain the infant's body warmth, change the diaper or clothing when wet or soiled, maintain umbilical cord hygiene, and routinely perform Kangaroo Mother Care. At the third visit, the mother reported that the infant was becoming more active and had stronger sucking ability, routinely received Kangaroo Mother Care, was breastfed every 2–3 hours, and had regular bowel and bladder movements. At the fourth visit, the mother reported that the infant was increasingly active, crying vigorously, continuing to receive exclusive breastfeeding on demand, routinely receiving Kangaroo Mother Care, and having regular bowel and bladder movements. The mother also reported that the infant appeared increasingly healthy and well-nourished.

The information provided by the mother indicates that LBW infants require special attention to nutritional needs, maintenance of body warmth, and growth monitoring. Exclusive breastfeeding and Kangaroo Mother Care are important components of LBW infant care because they help meet nutritional needs, maintain body temperature, and support weight gain (Mumtihan, Thamrin, & Sharief, 2023).

Objective Data

The initial examination showed that the infant was in good general condition with a *compos mentis* level of consciousness. The vital signs were within the normal range, with a heart rate of 145 beats per minute, a respiratory rate of 40 breaths per minute, and a body temperature of 36.7°C. The infant's body weight was 2,400 grams, body length was 47 cm, head circumference was 29 cm, chest circumference was 28 cm, and abdominal circumference was 28 cm. The APGAR score was 8/10 at the first minute and 10/10 at the fifth minute.

Physical examination showed that the head, eyes, nose, mouth, ears, neck, chest, and abdomen were within normal limits. The umbilical cord appeared clean, with no signs of infection. The female genitalia appeared normal, the anus was patent, and the extremities were symmetrical with a complete number of fingers and active muscle tone. The tonic neck, rooting, swallowing, palmar/grasp, Babinski, and Moro reflexes were positive, while the sucking reflex was not yet optimal at the initial assessment.

These examination findings indicated that although the infant was in good general condition, the birth weight of less than 2,500 grams placed the infant in the LBW category. Monitoring body weight and anthropometric measurements is important for assessing the infant's growth and nutritional status. This is consistent with research emphasizing the importance of monitoring nutritional status through anthropometric measurements in children aged 0–59 months. Body weight monitoring is an important component in assessing infant growth and nutritional status, particularly in LBW infants who require more intensive growth monitoring (Hilda Sulistia & Asriadi, 2024).

At the second visit, the infant's general condition remained good, with normal vital signs. Body weight increased to 2,700 grams, body temperature was 37.0°C, heart rate was 145 beats per minute, and respiratory rate was 40 breaths per minute. Physical examination revealed no signs of infection, and the umbilical cord appeared clean and dry.

At the third visit, the infant was in good general condition, with a heart rate of 140 beats per minute, a respiratory rate of 40 breaths per minute, and a body temperature of 36.7°C. Body weight increased to 2,800 grams and body length to 50 cm. Head circumference was 31 cm, chest circumference was 30 cm, and abdominal circumference was 30 cm. The umbilical cord had detached and appeared clean and dry, with no signs of infection. The rooting, sucking, and swallowing reflexes were positive.

At the fourth visit on January 14, 2026, the infant was in good general condition, with a heart rate of 138 beats per minute, a respiratory rate of 41 breaths per minute, and a body temperature of 36.8°C. Body weight increased to 2,900 grams, while body length remained at 50 cm, head circumference at 31 cm, chest circumference at 30 cm, and abdominal circumference at 30 cm. Physical examination showed that the head, eyes, mouth, skin, abdomen, genitalia, and extremities were in normal condition. The umbilical cord stump had completely dried, and all basic neonatal reflexes were positive.

Assessment

Based on the results of the subjective and objective assessments, the assessment of Mrs. "W"'s infant indicated that the infant was born at term at a gestational age of 38 weeks and 1 day, delivered spontaneously, female, and in good general condition, but had Low Birth Weight (LBW) with a birth weight of 2,400 grams.

An infant with a birth weight of less than 2,500 grams is classified as having Low Birth Weight (LBW). In the case of Mrs. "W"'s infant, the birth weight was 2,400 grams; therefore, the diagnosis of LBW was established. This is consistent with the study by Gemilastari et al. (2024), which stated that infants with a birth weight of less than 2,500 grams are classified as LBW and require monitoring of body temperature, nutritional intake, and growth to prevent further complications (R et al., 2024).

Mrs. "W"'s infant was born at term at a gestational age of 38 weeks and 1 day. Therefore, the LBW condition in this case was not caused by prematurity but solely by the infant's birth weight being below 2,500 grams.

The potential problem faced by Mrs. "W"'s infant was the risk of hypothermia, which may occur because LBW infants have limited body fat reserves and immature thermoregulatory mechanisms. At the initial examination, the infant's body temperature was 36.7°C, indicating that the infant had not yet experienced hypothermia.

Management

Midwifery care for Mrs. "W"'s infant was provided comprehensively, including monitoring the infant's condition, meeting nutritional needs, maintaining body warmth, preventing infection, and monitoring growth and development.

At the initial visit, the infant's body weight was measured, vital signs were monitored, body warmth was maintained using clean and dry clothing and blankets, diapers or clothing were changed when wet, umbilical cord hygiene was maintained, and the mother was taught how to perform Kangaroo Mother Care (KMC). The mother was also counseled on proper breastfeeding techniques and advised to provide exclusive breastfeeding on demand.

Kangaroo Mother Care is one of the interventions used to maintain the body temperature of LBW infants. LBW infants are at risk of hypothermia because they have limited body fat reserves and immature thermoregulatory mechanisms. Heat loss may also occur because the infant's body surface area is relatively large compared with body weight (Nurlaila, 2018).

In the case of Mrs. "W"'s infant, KMC was performed routinely to help maintain body warmth while supporting weight gain. Throughout the monitoring period, the infant's body temperature remained within the normal range, and no signs of hypothermia were observed.

At subsequent visits, vital signs, umbilical cord condition, exclusive breastfeeding, and maintenance of body warmth were monitored. The mother was also advised to change the infant's diaper or clothing whenever it became wet or soiled and to complete immunizations according to the

recommended schedule. The monitoring results showed that the infant remained in good general condition, body temperature was stable, and body weight increased to 2,700 grams.

In LBW infants, immediate intervention or collaboration with other healthcare professionals is required when conditions requiring further management are identified, such as hypothermia. Pratiwi et al. (2026) stated that when conditions requiring further management occur, interventions should be provided according to the infant's condition and may involve collaboration with other healthcare professionals. Ismayanah, Nurfaizah, and Syatirah (2020) also stated that immediate intervention or collaboration should be carried out when conditions requiring further management are identified. In the case of Mrs. "W"'s infant, immediate intervention or collaboration was not required because the infant's condition remained stable, vital signs were within normal limits, and there were no signs of hypothermia or infection.

At the third visit, vital signs, body weight, and body length were monitored. The infant's body weight increased to 2,800 grams, and the rooting, sucking, and swallowing reflexes were positive. The mother was advised to continue exclusive breastfeeding and routinely perform KMC. The umbilical cord had detached without any signs of infection.

In addition to meeting basic needs, the infant's growth and development should also be considered in the provision of care. Muhammad Zainal, Mubarak, and Arisandi (2022) explained the importance of an approach adapted to the child's characteristics in the process of caregiving and behavioral development. This can be considered when providing education to parents regarding the infant's needs, appropriate stimulation, and parenting practices according to the infant's developmental stage.

At the fourth visit, vital signs, body weight, and body length were monitored. The infant's body weight increased to 2,900 grams. The mother was advised to continue exclusive breastfeeding until the infant reached 6 months of age, maintain the infant's hygiene and clothing, maintain body warmth, and routinely perform KMC. The mother was also educated about danger signs in infants that should be monitored.

The infant's weight gain indicates that the care provided was effective. Exclusive breastfeeding on demand helps meet the infant's nutritional needs, while KMC helps maintain body temperature and supports weight gain. This is consistent with research indicating that early and continuous implementation of KMC can improve the physiological condition of infants and reduce the risk of complications in LBW infants (Heriyeni, 2018).

Exclusive breastfeeding also plays an important role in increasing the body weight of LBW infants because breast milk contains essential nutrients, antibodies, proteins, fats, and enzymes that are easily digested, thereby supporting infant growth and immunity. In addition, appropriate infant care can contribute to more rapid weight gain. This is consistent with research showing that exclusive breastfeeding combined with appropriate care can help increase the body weight of LBW infants (Astuti, Solikhah, & Ernawati, 2022).

Over the four visits, Mrs. "W"'s infant demonstrated good progress. The infant's body weight increased from 2,400 grams at birth to 2,700 grams, then 2,800 grams, and reached 2,900 grams at the final visit. The infant's body temperature remained stable, breastfeeding ability improved, the umbilical cord detached without signs of infection, and all basic neonatal reflexes were positive.

Therefore, midwifery care for Mrs. "W"'s infant with LBW was provided according to the infant's needs through condition monitoring, exclusive breastfeeding, Kangaroo Mother Care, maintenance of body warmth, infection prevention, and growth monitoring. Throughout the four visits, the infant did not experience hypothermia or other complications, and body weight continued to increase. These findings indicate that the midwifery care provided was effective.



Figure 1. Kangaroo Mother Care Method

CONCLUSION

Midwifery care for Mrs. “W”’s infant with Low Birth Weight (LBW) was provided comprehensively and systematically using the seven-step Varney approach, which included the collection of basic data, data interpretation, identification of actual diagnoses or problems, identification of potential diagnoses or problems, determination of the need for immediate intervention or collaboration, development of a care plan, implementation, and evaluation. The entire care process was documented using the SOAP format.

Based on the assessment results, Mrs. “W”’s infant was delivered spontaneously at term at a gestational age of 38 weeks and 1 day. The infant was female, with a birth weight of 2,400 grams, and was therefore classified as having Low Birth Weight (LBW). Throughout the care period, the infant remained in good general condition, with a *compos mentis* level of consciousness and vital signs within normal limits. No signs of infection or complications were identified.

The potential risk of hypothermia was successfully prevented through measures to maintain the infant’s body warmth and the implementation of Kangaroo Mother Care (KMC). Exclusive breastfeeding on demand was also provided to meet the infant’s nutritional needs and support growth. During the four visits, the infant’s body weight increased gradually from 2,400 grams to 2,700 grams, 2,800 grams, and 2,900 grams at the final visit, accompanied by improved breastfeeding ability and increased activity.

The evaluation showed that all planned interventions were implemented appropriately according to the condition and needs of the LBW infant. Therefore, the midwifery care provided to Mrs. “W”’s infant was effective and resulted in favorable outcomes, as indicated by the infant’s stable condition, absence of hypothermia, adequate nutritional intake, and continuous weight gain throughout the monitoring period.

Nevertheless, this case study had limitations, including a limited observation period and a limited number of visits, as well as dynamic field conditions, which may have affected the completeness of data collection and real-time documentation of the care provided.

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