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Correct Breastfeeding Technique Education as an Integral Part of Continuity of Care Midwifery Practice

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ABSTRACT

Abstract: The postpartum period demands comprehensive adaptation across physical, emotional, and social dimensions, particularly in initiating lactation. Lactation disorders remain a prevalent challenge among postpartum mothers, especially primiparas. According to 2021 WHO data cited by Diah et al. (2023), over 17 million mothers worldwide experienced breastfeeding difficulties, with nipple soreness accounting for 56.4%, breast engorgement 36.12%, and mastitis 7.5%. To implement correct breastfeeding technique education within the Continuity of Care midwifery framework for postpartum mothers, enhancing their theoretical understanding, practical skills, physical comfort, and self-confidence during breastfeeding. A descriptive case study grounded in the Continuity of Care model was conducted on Mrs. R, a 22-year-old P1A0, at the Beruntung Raya Primary Health Center, Banjarmasin, from September to December 2025. Data were gathered through in-depth interviews, direct observation, physical examination, structured educational sessions, practical demonstration of positioning and attachment, and objective evaluation of breastfeeding practices. At the second postpartum visit (day 7), Mrs. R presented with primary complaints of bilateral breast pain, milk stasis, and shallow latch-on quality causing frequent nipple slippage and infant restlessness. Following continuous educational intervention comprising counseling, hands-on demonstration, individual mentoring, and visual media utilization, the mother demonstrated substantial improvement in technical proficiency, optimal latch-on attachment, complete resolution of breast pain and engorgement, and effective infant suckling. Integrating breastfeeding technique education into the Continuity of Care framework effectively enhances maternal competence, prevents lactation complications, supports exclusive breastfeeding achievement, and improves maternal-child health outcomes. This approach serves as a highly effective, education-based intervention strategy suitable for standard implementation by midwives in primary healthcare facilities.

Kata Kunci:

Ibu Nifas, Teknik Menyusui, ASI Eksklusif,
Continuity of Care,
Asuhan Kebidanan

Abstrak: *Masa nifas menuntut adaptasi komprehensif di berbagai aspek fisik, emosional, dan sosial, khususnya dalam memulai proses laktasi. Gangguan laktasi tetap menjadi tantangan yang banyak dihadapi ibu nifas, terutama pada ibu primipara. Merujuk data WHO tahun 2021 dalam Diah et al. (2023), tercatat lebih dari 17 juta ibu di seluruh dunia mengalami hambatan menyusui, dengan distribusi kasus lecet puting sebesar 56,4%, bendungan payudara 36,12%, dan mastitis 7,5%. Menerapkan edukasi teknik menyusui yang benar dalam kerangka asuhan kebidanan Continuity of Care pada ibu nifas untuk meningkatkan pemahaman teoritis, kecakapan praktis, kenyamanan fisik, dan kepercayaan diri ibu selama menyusui. Studi kasus deskriptif dengan model Continuity of Care pada Ny. R usia 22 tahun P1A0 di wilayah kerja Puskesmas Beruntung Raya, Banjarmasin, periode September–Desember 2025. Pengumpulan data melalui wawancara mendalam, observasi langsung, pemeriksaan fisik, intervensi edukasi terstruktur, demonstrasi posisi dan perlekatan, serta penilaian objektif praktik menyusui. Pada kunjungan nifas kedua (hari ke-7), Ny. R melaporkan keluhan utama berupa nyeri payudara bilateral, penumpukan ASI, dan perlekatan yang belum memadai sehingga puting kerap terlepas dan bayi rewel. Setelah diberikan intervensi edukasi berkelanjutan meliputi penyuluhan, demonstrasi praktis, bimbingan individual, serta media visual, ibu menunjukkan peningkatan pemahaman, perlekatan membaik, nyeri dan bendungan ASI hilang total, dan bayi mampu menghisap secara efektif. Integrasi edukasi teknik menyusui dalam kerangka* Continuity of Care *efektif meningkatkan kompetensi ibu, menekan risiko komplikasi laktasi, mendukung keberhasilan ASI eksklusif, serta meningkatkan luaran kesehatan ibu dan anak. Pendekatan ini menjadi alternatif*

intervensi berbasis edukasi yang sangat efektif untuk diterapkan secara standar oleh bidan di fasilitas kesehatan primer.

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A. INTRODUCTION

Following childbirth, a woman enters the postpartum period (puerperium), which demands a complex adaptation process across various dimensions of life, including physiological changes in reproductive organs, emotional and psychological adjustments, transformation of social roles into motherhood, and the initiation of lactation (Handayani et al., 2025). The smooth execution and success of the breastfeeding process in this early postpartum period play a crucial role as the primary determinant in achieving exclusive breastfeeding for the first 6 months of an infant's life. According to Anik et al. (2022), key components in mastering correct breastfeeding techniques include ergonomic positioning of both mother and infant, optimal latch-on attachment between the infant's mouth and the maternal nipple-areola complex, and the mother's ability to identify clinical indicators that the infant is swallowing milk effectively.

To date, lactation disorders remain a major challenge frequently encountered by postpartum mothers across healthcare facilities, particularly among primiparous mothers who lack prior breastfeeding experience. Various lactation complications often emerge, ranging from mechanical trauma such as nipple soreness/fissures, sensations of tension and breast engorgement, to inflammation or infection of breast tissue (mastitis). Citing World Health Organization (WHO) 2021 data referenced by Diah et al. (2023), more than 17 million mothers globally experienced breastfeeding obstacles, with nipple soreness accounting for 56.4%, breast engorgement representing 36.12%, and mastitis comprising 7.5%. The lack of practical proficiency and theoretical understanding among postpartum mothers regarding proper breastfeeding techniques can trigger severe pain during nursing, impaired milk synthesis and ejection, ineffective infant suckling reflexes, and ultimately maternal despair leading to premature breastfeeding cessation or premature formula supplementation. Therefore, educational interventions focusing on lactation techniques carry high urgency due to their empirically proven efficacy in enhancing maternal skill proficiency and self-efficacy (Hilamuhu et al., 2023).

Based on direct interviews and observations conducted alongside midwives at the clinical field site of Beruntung Raya Primary Health Center, Banjarmasin City, it was revealed that the most effective primary strategy in supporting exclusive breastfeeding success involves structured lactation counseling, direct hands-on demonstrations of positioning and attachment, and consistent individual mentoring from the onset of lactation. These field findings underscore the significance of the midwife's role within a continuous care model, particularly in providing clinical guidance, periodic monitoring, and constructive feedback aligned with the dynamic physical and psychological needs of the mother. Dongoran & Wahyuni (2025) reinforced this perspective in their research, concluding that combining verbal education with practical demonstrations within a continuous care framework significantly improves lactation quality. Similar findings were reported by Rohini et al. (2022), who highlighted the positive contribution of lactation education toward increasing exclusive breastfeeding rates, as well as Hilamuhu et al. (2023), who demonstrated that education paired with direct hands-on mentoring noticeably elevates nursing skills among primiparous mothers.

The Continuity of Care (CoC) midwifery model provides an ideal holistic framework for delivering continuous and integrated lactation education. Fundamentally distinct from conventional care models that tend to be fragmented, sporadic, and focused solely on incidental symptom management, the CoC approach enables midwives to accompany mothers intensively and personally throughout all stages of the reproductive cycle. This accompaniment spans from antenatal care (ANC), intranatal care (INC), postnatal care (PNC visits KF1 through KF4), neonatal care (KN1 through KN3), to post-partum family planning (KB). This continuous care ensures that maternal knowledge is repeatedly reinforced, practical skills are guided incrementally, and any

potential lactation difficulties are promptly identified and managed before developing into severe clinical complications (Handayani et al., 2025; Dongoran & Wahyuni, 2025).

Alongside direct mentoring, integrating visual and digital educational media within the CoC framework has been shown to accelerate information retention and skill acquisition among breastfeeding mothers. Utilizing flipcharts, anatomical models/props, and instructional video guides offers concrete visual representation of breast anatomy, ergonomic positioning, and methods to stimulate the infant's rooting reflex. Fatimah et al. (2024) confirmed that video-based breastfeeding technique training is highly effective in elevating both theoretical knowledge and practical proficiency among pregnant and postpartum women. This aligns with findings by Batubara et al. (2026), who identified that combining visual media with interactive demonstrations strengthens kinesthetic memory, reduces primiparous anxiety, and fosters breastfeeding self-efficacy.

Despite numerous studies demonstrating the benefits of lactation education, the comprehensive implementation of proper breastfeeding technique education integrated across all four dimensions of Continuity of Care (theoretical understanding, practical skill, physical comfort, and self-efficacy) among primiparous mothers in primary care settings requires thorough empirical validation. Hence, this case study report aims to describe in detail the implementation and evaluation of correct breastfeeding technique education for Mrs. R within the Continuity of Care framework at Beruntung Raya Primary Health Center, Banjarmasin City, thereby contributing meaningfully to evidence-based midwifery practice.

B. RESEARCH METHODS

This case study employed a descriptive research design with a Continuity of Care (CoC) midwifery approach. This design was selected because it provides an in-depth, comprehensive, and systematic representation of implementing breastfeeding technique education and its impact on maternal postpartum competence across the reproductive continuum. The scope of CoC midwifery care encompasses five main integrated phases: antenatal care (ANC), intranatal care (INC), postnatal care (PNC), neonatal care (NC), and family planning care (FP), with the primary intervention focus centered on delivering education and demonstrations of proper breastfeeding techniques.

This case study research was conducted within the working area of Beruntung Raya Primary Health Center, Banjarmasin City, South Kalimantan, running from September to December 2025. The subject of this case study was Mrs. R, a 22-year-old primiparous mother with a parity status of P1A0 (first pregnancy, first delivery, no history of abortion). The subject was accompanied intensively starting from 29 weeks 6 days of gestation in the third trimester (ANC examination), normal labor process (INC), postpartum period (PNC visits KF1 through KF4), newborn care (KN1 through KN3), through to the selection of a postpartum contraceptive method.

Strict ethical research principles were adhered to throughout the execution of this case study. Prior to initiating care, the researcher provided detailed explanations regarding the research objectives, benefits, and procedures to Mrs. R and her family. Upon fully understanding the information, Mrs. R signed an informed consent form. The researcher guaranteed subject anonymity by securing all personal data and ensured that all midwifery interventions performed complied strictly with patient safety principles and standard operating procedures (SOPs) in midwifery care.

C. RESULTS AND DISCUSSION

1. Overview of Continuity of Care Midwifery Practice for Mrs. R

Postpartum monitoring commenced at the KF1 visit (6 hours post-partum). Physical examination revealed the mother's general condition was good, BP 120/80 mmHg, TFU 2 fingerbreadths below the umbilicus with firm uterine contraction, rubra lochia discharge of bright red color, and small amounts of yellowish colostrum/milk expressed from both nipples. The newborn (KN1 visit) was healthy with positive sucking and swallowing reflexes, having received eye ointment and Vitamin K1 injection. The mother was provided education regarding early ambulation, nutritional and fluid intake, and personal hygiene care.

Care continued through postpartum visits KF2 (day 7), KF3 (day 14), and KF4 (day 28). The KF2 visit represented a crucial turning point where primary breastfeeding difficulties were identified and intensive educational interventions were initiated. At KF3 and KF4 visits, clinical evaluations showed significant improvements: pain and breast engorgement were completely resolved, maternal nursing skills increased dramatically, and the infant demonstrated satisfactory weight gain by the KF4 visit (day 28). The care sequence

concluded with family planning counseling at KF4, where Mrs. R selected the Lactational Amenorrhea Method (LAM) combined with a planned 3-month progestin injectable contraceptive.

2. Identification of Breastfeeding Problems during the Postpartum Period (KF2 Visit)

During the second postpartum visit on day 7 (KF2), Mrs. R reported chief complaints of severe pain and stinging sensations in both breasts during nursing, accompanied by tension and fullness in the breasts, as well as difficulty inserting the areola into the baby's mouth. The mother expressed that the baby's latch frequently slipped off the nipple during feeding, causing the infant to become restless, cry, and fuss due to inadequate milk flow. This situation triggered anxiety and fatigue in Mrs. R, leading her to doubt her capacity to nurse her infant successfully.

Physical examination conducted by the midwife during KF2 confirmed these subjective findings. Both breasts were palpated as firm, warm, and engorged, indicating milk stasis (breast engorgement). The skin on the nipple region appeared mildly hyperemic (reddened) due to friction from improper latching mechanics. Direct observation of nursing practice demonstrated a shallow latch-on quality, where the infant grasped only the tip of the nipple without encompassing a sufficient portion of the lower areola. The baby's cheeks showed dimpling during suckling without audible swallowing sounds, signaling ineffective milk transfer.

Physiologically, improper breastfeeding techniques—specifically shallow latching—concentrate suction forces solely onto the nipple tissue rather than the lactiferous sinuses situated beneath the areola. This causes mechanical trauma to nipple nerves and microvascular structures, triggering intense pain while impairing milk ejection from glandular segments. Incomplete milk drainage results in fluid accumulation within alveoli and interstitial tissues, progressing to breast engorgement. Diah et al. (2023) confirmed a strong correlation between irregular feeding frequencies, improper technique, and an increased incidence of breast engorgement among postpartum mothers.

The problems identified in Mrs. R were analyzed deeply and are supported by research from Agustina & Pane (2026), who reported that a lack of practical knowledge and skills among primiparous mothers regarding correct techniques represents a primary risk factor for lactation complications early in the puerperium. Agustina & Pane (2026) found that most nursing mothers experiencing nipple soreness and engorgement failed to understand the importance of drawing the lower areola deeply into the infant's mouth and positioning the infant's body correctly. Without early identification and technical correction, these obstacles can escalate into severe complications such as mastitis and breast abscesses (Agustina & Pane, 2026).

Beyond physical impacts, nipple pain and breast engorgement carry serious psychological consequences for postpartum women. Pain experienced during nursing can trigger stress responses that inhibit oxytocin secretion, impairing the let-down reflex. Consequently, milk flow becomes restricted, infant fussiness increases, and maternal breastfeeding self-efficacy declines. Batubara et al. (2026) emphasized that perceived insufficient milk supply triggered by improper technique frequently serves as the main driver for primiparous mothers to prematurely abandon exclusive breastfeeding in favor of infant formula. Thus, managing lactation difficulties during KF2 was prioritized within this CoC midwifery care (Batubara et al., 2026; Jafrizal et al., 2024).

3. Implementation of Educational Interventions, Positioning & Latch Demonstrations, and Visual Media

In response to the lactation challenges identified during the KF2 visit, the midwife designed and executed a comprehensive, step-by-step educational intervention within the CoC framework. This intervention integrated four primary strategies: (1) Verbal instruction and counseling on lactation physiology; (2) Direct hands-on demonstrations of correct positioning and latch-on techniques; (3) Individual mentoring while the mother practiced nursing her infant; and (4) Utilization of visual media, including flipcharts and instructional video guides.

Educational materials and demonstrations focused intensely on mastering four key elements of proper breastfeeding: 1. Mother and Infant Body Positioning: The midwife guided Mrs. R to sit in a relaxed position with her back fully supported against the chair and feet resting flat. The infant's head and trunk were kept in alignment (a straight line), the infant's body faced the mother directly (belly-to-belly contact), and the infant's face was brought to the breast with the nose positioned opposite the nipple. 2. Latch-on Technique: The midwife demonstrated stimulating the rooting reflex by brushing the nipple against the baby's upper lip. When the baby opened their mouth wide like a yawn, the mother brought the infant's head swiftly toward the breast, directing the nipple toward the roof of the mouth so that a major portion of the lower areola entered deeply

into the mouth, the chin touched the breast firmly, and the lower lip flanged outward. 3. Indicators of Effective Suckling: The midwife taught the mother to monitor suckling rhythms. Effective suckling was characterized by slow, deep sucks with pauses as milk transferred, accompanied by audible swallowing, rounded cheeks (no dimpling), and comfortable nursing without nipple pain. 4. Comfort Measures and Breast Care: The mother was taught to break suction gently by inserting a clean small finger into the corner of the baby's mouth, applying residual hindmilk onto the nipple-areola area post-feeding as a natural antiseptic, and burping the infant upright.

As an adjunctive measure to relieve breast engorgement during KF2, the midwife instructed the mother on warm and cold compress protocols. Prior to feeding, warm compresses accompanied by gentle massage from the base toward the nipple were applied to stimulate blood circulation and trigger oxytocin release. Post-feeding, cold compresses using a damp cool towel were applied for 10–15 minutes to alleviate tissue edema, fullness, and inflammatory pain.

The efficacy of combining structured education with hands-on demonstrations as applied to Mrs. R is strongly corroborated by scientific evidence from Hilamuhu et al. (2023), who proved that breastfeeding education accompanied by practical demonstrations significantly improves nursing skills among primiparous mothers. Rohini et al. (2022) similarly highlighted that mothers receiving individualized, structured lactation education achieve substantially higher exclusive breastfeeding success rates compared to those receiving standard hospital information.

The inclusion of visual media and video tutorials played a strategic role in facilitating Mrs. R's kinesthetic comprehension. Visual media provided concrete depictions of breast anatomy and correct latching, making it easier for an inexperienced mother to replicate proper movements. Fatimah et al. (2024) reported that video-based lactation training significantly enhances maternal knowledge and practical skills. This is reinforced by Batubara et al. (2026), who concluded that visual learning tools enhance memory retention and psychological readiness in applying proper techniques.

Continuous individual mentoring throughout the postpartum period enabled the midwife to deliver real-time feedback and immediate corrections while the mother nursed. If latching appeared shallow, the midwife gently adjusted the mother's hold or infant's head position. This empathetic, iterative guidance alleviated maternal anxiety, built self-confidence, and reinforced correct breastfeeding habits. Agustina & Pane (2026) recommended periodic practical demonstrations as an essential component of postpartum care in primary health facilities.

Progressive guidance delivered from KF2 through KF4 successfully prevented the recurrence of lactation complications in Mrs. R. Early technical correction eliminated mechanical friction on the nipple, preventing tissue damage and fissures. Effective breast emptying facilitated milk flow and resolved stasis, completely preventing mastitis. These clinical outcomes align with Diah et al. (2023), emphasizing technical refinement as a primary preventive intervention against breast engorgement.

4. Evaluation of Lactation Success and Multidimensional Family Support

Active family involvement, particularly from the husband and mother/mother-in-law, represents a vital psychosocial determinant of lactation success and continuity throughout the puerperium. First-time nursing mothers require a supportive environment to maintain emotional stability and self-efficacy. Handayani et al. (2025) categorized family support for nursing mothers into four main dimensions: 1. Emotional Support: Providing affection, security, empathy, and presence when the mother feels fatigued or pained. 2. Informational Support: Sharing accurate information regarding breastfeeding benefits and dispelling detrimental myths. 3. Instrumental Support: Assisting with household chores, house cleaning, and infant care so the mother can rest. 4. Appraisal Support: Offering positive encouragement, praise, and appreciation for the mother's breastfeeding efforts.

In Mrs. R's case, the midwife actively involved her husband and family in every education and demonstration session starting at KF2. Mrs. R's husband was assigned a concrete role as a supportive father, learning oxytocin massage techniques on the mother's back to enhance milk let-down, assisting with burping the infant, and managing light domestic duties. Mrs. R's husband and mother demonstrated excellent multidimensional support adhering to the framework by Handayani et al. (2025). This family engagement reduced postpartum stress, created a serene home environment, and fortified the mother's commitment to exclusive breastfeeding. Hu et al. (2025) confirmed in a cross-sectional study a strong positive association between high family support, elevated breastfeeding self-efficacy, and extended breastfeeding duration.

The comprehensive interventions—combining counseling, direct demonstrations, individual mentoring, visual media, and family support—yielded substantial clinical improvements and behavioral changes evaluated during KF3 (day 14) and KF4 (day 28) visits. Objective evaluation at KF3 and KF4 revealed: 1. Theoretical Understanding: Mrs. R accurately explained the 4 elements of proper positioning and latching, indicators of effective suckling, and initial management of breast pain. 2. Practical Skill Proficiency: Mrs. R independently positioned her baby and achieved rapid, deep latch-on without midwife assistance. The lower areola entered deeply, suckling was effective, and regular swallowing was observed. 3. Physical Comfort: Nipple pain and stinging were completely absent. Physical examination revealed fully resolved engorgement, soft breasts, and healthy, intact nipples. 4. Self-Efficacy and Infant Growth: Mrs. R expressed high confidence, comfort, and relaxation in nursing exclusively. Infant growth was highly satisfying, demonstrated by steady weight gain confirming adequate milk intake.

The successful clinical transformation experienced by Mrs. R—moving from a distressed, painful state at KF2 to a proficient, confident mother by KF4—aligns with empirical evidence in midwifery literature. Hilamuhu et al. (2023) and Dongoran & Wahyuni (2025) concluded that integrating breastfeeding education and demonstrations into continuous care models directly enhances lactation effectiveness and satisfaction for both mother and child. The practical mastery observed in Mrs. R reinforces findings by Romlah (2026), indicating that lactation education significantly improves knowledge, positive attitudes, and correct nursing behaviors. This is further supported by Batubara et al. (2026), demonstrating that structured education consistently enhances maternal readiness and self-efficacy.

The positive outcomes achieved in this case study clearly demonstrate that integrating proper breastfeeding technique education into the Continuity of Care framework provides comprehensive, sustainable, and superior benefits compared to conventional care models. Continuous assessment, empathetic counseling, practical demonstrations, individual mentoring, and family engagement create an optimal supportive ecosystem for lactation success and complication prevention. Therefore, this approach is highly recommended as a standard strategy for primary care midwives in Indonesia to improve exclusive breastfeeding rates and optimize maternal and child health outcomes.

D. CONCLUSION AND RECOMMENDATIONS

Implementing proper breastfeeding technique education fully integrated into the Continuity of Care (CoC) midwifery framework for Mrs. R demonstrated a highly significant positive impact across four core dimensions of maternal breastfeeding competence: (1) Enhanced Theoretical Understanding: The mother successfully understood lactation anatomy, principles of proper positioning and latching, and indicators of effective suckling; (2) Mastery of Practical Skills: The mother independently executed ergonomic positioning, deep lower areola latching, and initial management of breast discomfort; (3) Achievement of Physical Comfort: Nipple pain and breast engorgement (milk stasis) were completely resolved without recurrence; and (4) Fostering Breastfeeding Self-Efficacy: The mother experienced elevated self-confidence in exclusive nursing, objectively validated by optimal infant weight gain.

The primary advantage of the Continuity of Care model over conventional care lies in its comprehensive, planned, and continuous nature across the reproductive cycle. CoC facilitates intensive guidance spanning pregnancy (ANC), labor (INC), postpartum (PNC KF1–KF4), newborn care (KN1–KN3), and family planning (FP). This continuity allows midwives to perform ongoing evaluations, reinforce educational content at the mother's learning pace, deliver real-time technical corrections, and tailor interventions to the evolving physical and psychological needs of primiparous mothers.

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