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Case Report: Empowering Mothers, Protecting Newborns (The Role of Midwifery Continuity of Care in Promoting Exclusive Breastfeeding During Mother-Infant Separation)

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ABSTRACT

Background: exclusive breastfeeding (EBF) is critical for neonatal health, but complications like jaundice can disrupt early feeding due to mother-infant separation. Midwifery Continuity of Care (MCoC), where a known midwife provides consistent support throughout the perinatal period, may play a crucial role in maintaining EBF during such challenges. This case report aims to explore the role of MCoC in sustaining exclusive breastfeeding during mother-infant separation due to neonatal jaundice.

Case Presentation: a 29-year-old woman (G2P1A0) received MCoC from early pregnancy through postpartum. After a cesarean delivery due to preeclampsia, her newborn developed jaundice with a total bilirubin level of 15.31 mg/dL and an index bilirubin of 14.96 mg/dL. It required 48 hours of phototherapy and NICU admission. Despite separation, the mother sustained lactation through regular milk expression, supported by her midwife, husband, and family. The mother had received education from the midwife about the importance of breastfeeding for the baby, starting from pregnancy until after delivery. The continuous presence and support of the midwife empowered the mother to remain consistent in expressing breast milk until the baby's condition improved, allowing the infant to continue receiving exclusive breastfeeding. After receiving phototherapy, the infant's bilirubin level decreased to 9.82 mg/dL and the baby was discharged in stable condition. Exclusive breastfeeding was successfully continued post-discharge

Discussion: this case highlights the important role of MCoC in supporting successful exclusive breastfeeding in infants with neonatal jaundice. Through ongoing education and support, midwives help mothers continue to provide expressed breast milk during phototherapy, which contributes to lowering bilirubin levels. The MCoC approach

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strengthens mothers' confidence and emotional resilience, while also increasing breastfeeding success in complex medical conditions

Conclusion: MCoC is a valuable model for supporting EBF during mother-infant separation caused by jaundice. It empowers mothers through continuous clinical, emotional, and educational support, ensuring continuity of care and improved breastfeeding outcomes. This case underscores the importance of integrating MCoC into midwifery practice and policy to enhance breastfeeding outcomes and maternal-infant health.

Keywords: exclusive breastfeeding; midwifery continuity of care (MCoC); mother-infant separation

BACKGROUND

Exclusive breastfeeding (EBF) for the first six months of life is universally recommended by the World Health Organization (WHO) as a foundational strategy to reduce infant morbidity and mortality. Breast milk not only offers complete nutrition but provides immunological protection against common neonatal infections, facilitates optimal neurodevelopment, and enhances the maternal-infant bond. Despite these well-established benefits, global EBF rates remain below target, with maternal-infant separation particularly during episodes of neonatal jaundice, posing a significant threat to its successful initiation and maintenance (Brown, 2020).

Neonatal jaundice, characterized by elevated bilirubin levels and yellowing of the skin and eyes, is one of the most common conditions affecting newborns. It occurs in approximately 60–80% of neonates within the first week of life and often necessitates medical interventions like phototherapy that require physical separation of the newborn from the mother (Septiana, 2025). While medically essential, this early separation disrupts critical skin-to-skin contact and early suckling that are essential for the physiological establishment of lactation and breastfeeding behaviors. Furthermore, this disruption often results in maternal distress, perceived loss of control, and premature introduction of formula, thereby compromising EBF continuity (Areprekumor et al., 2024).

In this context, Midwifery Continuity of Care (MCoC) where a known midwife or small team provides consistent, holistic care throughout pregnancy, labor, birth, and the postpartum period, emerges as a key enabler of EBF, particularly during the emotionally taxing experience of mother-infant separation. This model is rooted in relational care, underpinned by trust, mutual decision-making, and personalized health guidance. Evidence from qualitative systematic reviews suggests that parents strongly

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value healthcare that is integrated, family-centered, and continuity-driven. Such care not only supports physical outcomes but deeply influences a mother's emotional readiness and confidence during unforeseen complications like jaundice (Hermans et al., 2025).

The MCoC model was associated with fewer medical interventions and improved pregnancy outcomes. Midwifery continuity of care enhances maternal and neonatal health in low and middle income countries by minimizing unnecessary medical interventions and improving maternal satisfaction and breastfeeding outcomes. In alignment with MCoC, Essential Newborn Care (EENC) complements continuity of care by focusing on essential newborn practices. It emphasizing evidence-based practices such as immediate skin-to-skin contact, early initiation of breastfeeding, and rooming-in, which collectively support the physiological and emotional readiness of mothers to breastfeed. When integrated within continuity of care frameworks, EENC practices reinforce early and sustained breastfeeding, even under challenging clinical conditions (Sandall et al., 2024; Shahshahani et al., 2024).

Mothers experiencing neonatal separation due to jaundice often report feelings of anxiety, disempowerment, and confusion especially when exposed to fragmented care systems where conflicting advice and poor communication are common. Midwives offering continuity of care help buffer these disruptions by providing anticipatory guidance, emotional reassurance, and technical breastfeeding support, such as expressing milk during phototherapy or relactation strategies post-discharge. These interventions reduce reliance on formula supplementation and encourage the resumption or maintenance of breastfeeding once reunion occurs (Shipton et al., 2025).

Critically, maternal knowledge and attitudes are powerful determinants of EBF success, particularly in the face of clinical complications. In a study conducted at the Karisma Maternity Clinic in Indonesia, mothers who received structured counseling and developed positive attitudes toward breastfeeding were significantly more likely to sustain EBF even in adverse conditions (Adriati & Hidayati, 2024). Midwives, due to their continuity and accessibility, are uniquely positioned to deliver this essential education repeatedly across the perinatal timeline.

In addition to psychological and relational factors, biological mechanisms also play a role in the relationship between EBF and neonatal jaundice. Studies reveal that early initiation of breastfeeding can reduce the risk and severity of physiological jaundice by promoting regular stooling, which facilitates bilirubin excretion (Septiana, 2025). Thus, midwives not only help mothers maintain breastfeeding during jaundice-related separations but can also prevent its onset by encouraging and supporting early breastfeeding.

In low-resource or culturally sensitive settings, where traditional beliefs and low health literacy may further impede EBF, continuity of care midwives serve a dual function: clinical caregiver and cultural mediator. Through sustained relationships, they

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build trust and credibility that allows them to navigate cultural hesitations and introduce evidence-based practices in a respectful and empowering way (Putri et al., 2024).

Case-based evidence underscores this model's efficacy. Previous case report by (Shahshahani (2024) presents the experience of a 21-year-old primiparous woman who received Continuity of Midwifery Care (CoMC) from a midwife in a community setting. The study highlights how the midwife's consistent support throughout pregnancy, childbirth, and the postpartum period enhanced the mother's self-confidence, emotional stability, and control over her childbirth and breastfeeding journey—even when challenges arose. The midwife's continuous care enabled the mother to adapt and persist in exclusive breastfeeding despite initial complications (Shahshahani et al., 2024). Such outcomes highlight the humanizing and individualized approach inherent to midwifery continuity.

Beyond emotional and physiological benefits, continuity of care also addresses systemic issues. Disconnected maternity and neonatal services often delay appropriate lactation support, reduce accountability, and heighten maternal stress. By contrast, a unified care model streamlines service delivery, ensures consistency in advice, and eliminates the redundancy and delays commonly associated with siloed care systems. Mothers in continuity models are less likely to experience abrupt care transitions or provider unfamiliarity, which significantly improves their postpartum recovery and EBF commitment (Hermans et al., 2025).

However, despite the well-documented benefits of MCoC, barriers to wide-scale implementation of midwifery continuity models persist. These include midwife shortages, institutional inertia, and insufficient training on supporting breastfeeding through neonatal complications. However, these obstacles are surmountable. Health systems investing in midwifery education, integrated care protocols, and community outreach programs report better breastfeeding outcomes and maternal satisfaction metrics (Middlemiss et al., 2024).

Therefore, MCoC is essential in ensuring the success of exclusive breastfeeding, especially during medically complex situations like neonatal jaundice that often result in mother-infant separation. This study aims to illustrate the pivotal role of MCoC in supporting exclusive breastfeeding, particularly in medically complex scenarios such as neonatal jaundice, which often necessitate temporary mother-infant separation. By fostering a continuous, trusting relationship between the mother and a known midwife, MCoC provides consistent clinical guidance, emotional reassurance, and personalized breastfeeding support across the antenatal, intrapartum, and postnatal periods. This continuity minimizes care fragmentation, promotes early lactation interventions, and empowers mothers to maintain breastfeeding despite temporary challenges. MCoC transcends the notion of being a supplementary service; it is an indispensable component of responsive and equitable maternity care frameworks that prioritize maternal self-

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efficacy and neonatal health. Promoting and institutionalizing MCoC is thus critical to strengthening health systems and improving breastfeeding practices globally.

CASE PRESENTATION

Prenatal Periode: a 29-year-old woman (G2P1A0), underwent her second pregnancy with ongoing support through continuity of care provided by a midwife starting from the second trimester of pregnancy. Pregnancy was confirmed via physical examination and positive urine pregnancy test, estimating gestational age at 6-7 weeks. ANC continued regularly from the first trimester until the third trimester. The mother had a history of preeclampsia in the previous pregnancy. The midwife provided education about the risk of pregnancy complications, prevention and preparation for complications, routine exercise and regular ANC. At 33/34 weeks gestation, the mother was referred to the hospital for pre-eclampsia, a condition she had been at risk for and was better prepared to manage due to her prior knowledge and experience.

Intranatal periode: Despite close monitoring, her condition worsened, and at 39/40 weeks gestation, induction of labor was attempted due to high blood pressure and worsening preeclampsia. When the induction failed, a caesarean section was performed, resulting in the delivery of a healthy baby boy weighing 3,370 grams and measuring 53 cm in length.

Postnatal Periode: On the second day after birth, the baby developed jaundice, with a total bilirubin level of 15.31 mg/dL and an indirect bilirubin of 14.96 mg/dL, requiring phototherapy for 48 hours. As a result, the mother was discharged from hospital without her baby, leaving her feeling anxious and worried about the baby's condition and neglecting her own needs.

The midwife had provided education to mothers about the importance of breastfeeding for infants, starting from pregnancy until after delivery. The mother experienced pre-eclampsia complications, causing her baby to develop jaundice. Midwives emphasise to mothers and families that adequate breast milk intake plays a significant role in accelerating the reduction of bilirubin levels and aiding the healing process of jaundice. Midwives strive to optimise the support system for successful breastfeeding. One form of this support is collaboration with the husband and family in providing emotional support and emphasising the importance of breast milk for the recovery process of babies with jaundice. With this support, mothers are motivated to regularly express breast milk and send it to the NICU, so that the baby's breast milk needs are met during the treatment period and the mother's breast milk production remains smooth.

With ongoing support, mothers experienced improved emotional well-being, appeared calmer, felt more empowered, and had greater confidence in managing the breastfeeding process despite being temporarily separated from their babies. She

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responded by consistently pumping breast milk every two hours and sending it to the NICU. After two days of phototherapy, the baby's bilirubin level dropped to 9.82 mg/dL, and he was discharged. The family expressed joy and gratitude for the MCoC, which helped maintain lactation and emotional resilience during their temporary separation.

DISCUSSION

This case illustrates the important role of MCoC in supporting exclusive breastfeeding (EBF) during the period of separation between mother and baby due to neonatal jaundice. In this case, the mother gave birth by C-section at 39/40 weeks of gestation, and on the second day after birth, the baby developed jaundice. Neonatal jaundice is a common condition that affects up to 80% of newborns in the first week of life (Septiana, 2025). Yazdiha et al. in 2018 stated that cesarean delivery increases the risk of neonatal jaundice. The study found that babies born via cesarean delivery had a higher incidence of neonatal jaundice compared to babies born via normal delivery. This is because babies born via cesarean section do not receive the beneficial bacteria found in the mother's birth canal, which affects the maturation of the immune system, making babies more susceptible to infection (Yazdiha et al., 2021).

The infant's bilirubin levels in this case were total bilirubin of 15.31 mg/dL and indirect bilirubin of 14.96 mg/dL. The infant required phototherapy for 48 hours in the NICU, resulting in separation from the mother. In cases of moderate to severe jaundice, phototherapy intervention is generally required, which can lead to separation between mother and infant. This physical separation has the potential to hinder skin-to-skin contact and the initiation of breastfeeding in the early stages of lactation, which plays an important role in stimulating milk production and the release of the hormone oxytocin in mothers. In addition, the emotional distress caused by this separation can have a negative impact on the continuity of breastfeeding and increase the likelihood of early formula feeding (Areprekumor et al., 2024). In this case, the mother was committed to exclusive breastfeeding, but she faced the challenge of being separated from her baby when the baby had to undergo phototherapy.

The mother received support from the midwife to continue breastfeeding her baby by pumping breast milk and sending it to the NICU. This ensured that the baby continued to receive breast milk, even though he was separated from his mother. After two days of phototherapy, the total bilirubin level was 9.82 mg/dl, and the indirect bilirubin level was 9.12 mg/dl. Bilirubin levels in babies with jaundice can decrease more quickly with regular exclusive breastfeeding (Mulyani & Futriani, 2025). Breast milk is the optimal source of nutrition for babies, providing the right balance of antibodies, proteins, carbohydrates, fats, and vitamins (Ridson et al., 2022). Breast milk also stimulates intestinal motility and introduces beneficial bacteria into the digestive tract, stimulating bowel movements and helping bilirubin be excreted through feces. Breast milk contains

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beta-glucuronidase, an enzyme that can increase the conversion of bilirubin into a fat-soluble (indirect) form. This enzyme supports infant metabolism and lowers bilirubin levels through enhanced digestion and excretion (Indanah et al., 2022).

In this case, the mother received comprehensive assistance from a midwife from pregnancy through breastfeeding. During the lactation phase, the midwife worked to optimize the support system to ensure successful breastfeeding. Through consistent emotional support and lactation education, the midwife played a role in increasing the mother's confidence, knowledge, and commitment to breastfeeding, especially in complex medical conditions.

Early essential newborn care has been shown to facilitate the timely initiation of breastfeeding and significantly increase the prevalence of exclusive breastfeeding at six months of age. In parallel, MCoC has demonstrated substantial benefits for maternal and neonatal health, particularly in low- and middle-income countries, by reducing the frequency of unnecessary medical interventions and promoting positive birth experiences. Evidence suggests that the MCoC model is associated with improved pregnancy outcomes, higher maternal satisfaction, and enhanced breastfeeding practices. By fostering a continuous and trusting relationship between the midwife and the mother throughout the antenatal, intrapartum, and postnatal periods, MCoC supports individualized care and informed decision-making, contributing to safer, more empowering, and physiologically appropriate childbirth experiences including breastfeeding (Wang et al., 2020; Adnani et al., 2025; Lundborg et al., 2025).

Midwifery Continuity of Care (MCoC) has been shown to improve neonatal health by reducing the risk of hyperbilirubinemia and enhancing exclusive breastfeeding through early intervention, home-based support, and sustained relational continuity (Dzantor et al., 2023). Compared to standard care, MCoC is significantly associated with a lower incidence of neonatal hyperbilirubinemia requiring treatment and higher rates of exclusive breastfeeding at hospital discharge (Aulia, 2025). Notably, 28% of MCoC's protective effect on hyperbilirubinemia is mediated through a reduction in preterm birth rates. Postpartum home visits, a key component of the MCoC model, may facilitate early detection of jaundice, support effective breastfeeding practices, and alleviate parental stress, thereby contributing to improved clinical outcomes (Sampurna et al., 2022). Empirical evidence from Sweden, the United States, Canada, and low- and middle-income countries (LMICs) reinforces the importance of exclusive breastfeeding guidance, early postnatal care, and home phototherapy in decreasing the prevalence of neonatal jaundice and associated hospital readmissions. Furthermore, the relational continuity and individualized care inherent in MCoC foster trust and empowerment, which are strongly linked to greater maternal satisfaction, breastfeeding success, and emotional well-being. Cross-contextual studies-including those conducted in Sweden, Australia, and Palestine-

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consistently demonstrate the positive impact of MCoC on breastfeeding duration and perinatal outcomes (Shahshahani et al., 2024).

Additionally, MCoC emphasizes exclusive breastfeeding, which is not only the primary nutritional source for newborns but also important in reducing bilirubin levels through frequent stooling and hydration. Midwives provide direct, practical support to optimize latch and feeding frequency, which helps prevent dehydration-induced hyperbilirubinemia (Patia et al., 2026). This continuous guidance is crucial, particularly in the early postnatal period when breastfeeding challenges are common.

Another key advantage of MCoC is the trust and communication fostered between midwives and mothers. This relationship enhances maternal confidence and compliance with clinical advice, including phototherapy regimens or follow-up bilirubin testing. Parents are more likely to act promptly and consistently when care is delivered by a familiar and trusted provider (Sandall et al., 2024). Furthermore, MCoC models often include structured follow-up after hospital discharge, ensuring bilirubin levels are monitored and managed safely, reducing the risk of readmission.

CONCLUSION

Midwifery Continuity of Care (MCoC) plays a pivotal role in promoting exclusive breastfeeding (EBF) during periods of mother-infant separation, particularly in cases involving neonatal jaundice. By fostering a sustained, trust-based relationship between the mother and a known midwife, MCoC ensures that emotional support, individualized education, and timely clinical guidance are consistently available across the perinatal continuum. This continuity helps mitigate the negative impact of physical separation on lactation by encouraging early milk expression, preventing premature formula supplementation, and reinforcing maternal confidence and knowledge. Through early detection, consistent practical breastfeeding guidance, trust and communication fostered between midwives and mothers as well as structured follow-up, MCoC is a valuable model of care in promoting and sustaining EBF during mother-infant separation due to neonatal jaundice. It offers clinical, emotional, and educational support that empowers mothers to overcome breastfeeding challenges and strengthens continuity in maternal and newborn care.

Based on this case, several implications are evident. For stakeholders, the adoption of MCoC as a standard model across maternity care could significantly improve maternal and neonatal outcomes. This would require robust policy support, sustainable funding mechanisms, and the development of integrated care pathways linking hospitals, community services, and midwifery providers. Investment in workforce planning and infrastructure that prioritizes continuity and relationship-based care is essential. Moreover, ongoing monitoring and evaluation of MCoC implementation should be encouraged to assess impacts on breastfeeding rates, maternal satisfaction, clinical outcomes, and hospital readmissions. For practicing midwives, this case underscores the

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importance of delivering holistic, individualized care throughout pregnancy, birth, and the postpartum period. Midwives should continue to enhance their clinical competencies in risk assessment, early intervention, and counseling, while maintaining a woman-centered approach. Advocacy for MCoC and lifelong learning should remain central to professional practice. Midwifery education providers also play a critical role in advancing MCoC by embedding its principles throughout the curriculum, emphasizing continuity, autonomy, and cultural competence. Clinical training opportunities should expose students to community and continuity-based models of care, while fostering research literacy and interprofessional collaboration.

Despite the strengths of this case report, it is important to acknowledge its limitations. As a single case, the findings may not be generalizable to all clinical contexts. Further research, including larger qualitative and quantitative studies, is necessary to deepen the evidence base for MCoC in supporting exclusive breastfeeding during neonatal complications and separation. In conclusion, this case reinforces the value of MCoC in sustaining exclusive breastfeeding and enhancing maternal-infant health outcomes. It highlights the need for systemic support to ensure the widespread implementation of this model in diverse clinical and community settings.

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