LAPORAN

KULIAH PAKAR : ESSENTIAL POSSITIVE CHILDBIRTH EXPERIENCE

14 DESEMBER 2023

SEMESTER GANJIL 2023/2024
PROGRAM STUDI KEBIDANAN

UNIVERSITAS
FORT DE KOCK
BUKITTINGGI

VISI DAN MISI

PROGRAM STUDI

VISI

"Mewujudkan Bidan professional dengan keunggulan berjiwa entr**e**preneur dan mampu bersaing di era global tahun 2033

"

TEMA

“Essential Possitive Childbirth Experience”

NARASUMBER

dr. I Made Pariartha, M.Med.Ed., SpOG

JADWAL

Waktu : Kamis, 14 Desember 2023
Pukul : 09.00 s/d selesai

PROFIL NARASUMBER

1. Data Narasumber

Nama	**: I Made Pariartha**
Nama dan Gelar	**: dr. I Made Pariartha, M.Med.Ed., Sp.OG**
Tempat, Tanggal Lahir	**: Gianyar, 21 November 1984**
Agama	**: Hindu**
Jenis Kelamin	**: Laki-Laki**
Status Pernikahan	**: Kawin**
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Alamat sesuai KTP	**: Jln. Apel No.1 Lingkungan Candi Baru Gianyar, Bali 80511**
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2. Identitas Pekerjaan

Status Pekerjaan/Kepegawaian	**: Pegawai Tetap**
Jabatan	**: Dosen Tetap Yayasan**
Tempat bekerja	**: Fakultas Kedokteran Universitas Warmadewa Denpasar Bali**
Instansi pengusul masuk PPDS	**: Fakultas Kedokteran Universitas Warmadewa Denpasar Bali**
Alamat Instansi Asal/Pengirim	**: Jln. Terompong No.24 Tanjung Bungkak, Denpasar Bali**
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3. Riwayat Pendidikan

No.	Jenjang Pendidikan	Tempat Pendidikan	Jurusan	Tahun Lulus
1.	TK	TK Kemala Bhayangkari Gianyar	-	1991
2.	SD	SD No.6 Gianyar	-	1997

3.	**SMP**	**SMPN 1 Gianyar**	**-**	**2000**
4.	**SMA**	**SMAN 1 Gianyar**	**IPA**	**2003**
5.	**S1 dan Profesi**	**FK UGM Yogyakarta**	**Kedokteran Umum**	**2009**
6.	**S2**	**FK UGM Yogyakarta**	**Ilmu Pendidikan Kedokteran**	**2014**
7.	**Spesialis**	**Bagian Obstetri dan Ginekologi FKKMK UGM – RSUP Dr. Sardjito**	**Obstetri dan Ginekologi**	**2020**

4. Riwayat Jabatan

No.	Nama Jabatan	Nama Instansi	Kota/Propinsi	Tahun
1.	**Kepala Unit Keterampilan Klinik**	**Fakultas Kedokteran Universitas Warmadewa**	**Denpasar/Bali**	**2011 – 2012**
2.	**Kepala Medical Education FKIK Unwar**	**Fakultas Kedokteran Universitas Warmadewa**	**Denpasar/Bali**	**2020 – sekarang**

5. Riwayat Pekerjaan

No.	Nama Instansi Tempat Bekerja	Jabatan	Kota/Propinsi	Tahun
1.	**RSU Premagana Gianyar**	**Dokter Umum**	**Gianyar Bali**	**2009 – 2011**
2.	**Discovery Kartika Plaza Hotel**	**Dokter Umum**	**Denpasar Bali**	**2009-2011**
3.	**FK Universitas Warmadewa**	**Dosen tetap**	**Denpasar Bali**	**2011 – sekarang**
4.	**RSU Family Husada**	**Dokter Spesialis Tetap**	**Gianyar Bali**	**2020 – sekarang**
5.	**RSU Premagana Gianyar**	**Dokter Spesialis Tetap**	**Gianyar Bali**	**2020 – sekarang**

6. Riwayat Organisasi dan Keanggotaan

No.	**Nama Organisasi**	**Skala Organisasi (Lokal/Nasional/Internasional)**	**Tempat Kedudukan (Kota/Propinsi/Negara)**	**Jabatan Sebagai**	**Tahun**
1.	**CIMSA**	**Lokal**	**Yogyakarta**	**Local Officer**	**2005**

2.	**CIMSA - IFMSA**	**Nasional/Internasional**	**Jakarta**	**National Officer**	**2006**
3.	**KMHD**	**Lokal**	**Yogyakarta**	**Ketua Litbang**	**2006**
4.	**Ikatan Dokter Indonesia**	**Nasional**		**Anggota**	**2009 – sekarang**
5.	**Kolegium Obstetri dan Ginekologi Indonesia**	**Nasional**		**Anggota**	**2020 – sekarang**

7. Kegiatan Seminar / Simposium

No.	Tahun	Nama Kegiatan	Tempat Kegiatan (Kota/Propinsi)	Partisipasi Sebagai
1.	**2014**	**Jakarta Medical Education Meeting**	**Jakarta**	**Presentasi Oral**
2.	**2014**	**Pertemuan dan Ekspo Pendidikan Kedokteran Indonesia VII**	**Palembang, Sumatra Selatan**	**Peserta**
3.	**2014**	**Lokakarya Penyusunan Modul Blok**	**Denpasar**	**Narasumber**
4.	**2017**	**Mini Simposium "Endometriosis Update"**	**Yogyakarta**	**Peserta**
5.	**2017**	**PIT POGI Makassar**	**Makasar, Sulawesi Selatan**	**Presentasi Oral**
6.	**2018**	**PIT KOGI Semarang**	**Semarang, Jawa Tengah**	**Presentasi Oral**

8. Kegiatan Workshop/Kursus/Pelatihan/Seminar

No.	Tahun	Nama Kegiatan	Tempat Kegiatan (Kota/Propinsi)	Partisipasi Sebagai
1.	**2009**	**Advanced Trauma Life Support**	**Yogyakarta**	**Peserta**
2.	**2009**	**Advanced Cardiac Life Support**	**Yogyakarta**	**Peserta**
3.	**2009**	**Pelatihan Hiperkes dan Keselamatan Kerja**	**Yogyakarta**	**Peserta**

4.	**2012**	**Penyusunan Kurikulum Skill Laboratory**	**Yogyakarta**	**Peserta**
5.	**2013**	**Pengembangan E-Learning Dalam Pendidikan Kedokteran dan Profesi Kesehatan dalam KBK**	**Yogyakarta**	**Peserta**
6.	**2015**	**Basic Surgical Skill I**	**Semarang Jateng**	**Peserta**
7.	**2017**	**Basic Surgical Skill II**	**Denpasar Bali**	**Peserta**
8.	**2017**	**Pelatihan Resusitasi Neonatus**	**Yogyakarta**	**Peserta**
9.	**2017**	**Pelatihan Penatalaksanaan Robekan Perineum untuk PPDS I**	**Yogyakarta**	**Peserta**
10.	**2017**	**The Ultrasound Training for Resident of Obstetrics and Gynecology**	**Yogyakarta**	**Peserta**
11.	**2017**	**Kursus Metodologi Penelitian TKP PPDS FK-UGM**	**Yogyakarta**	**Peserta**
12.	**2017**	**Pelatihan Dasar Wajib Bagi Karyawan RSUP Dr. Sardjito**	**Yogyakarta**	**Peserta**
13.	**2018**	**Standardization Of Competency Electronic Fetal Monitoring Examination On High Risk Pregnancy For Obstetrician**	**Yogyakarta**	**Peserta**
14.	**2023**	**In-ALARM**	**Bandung**	**Peserta**
15.	**2022**	**Pelatihan Pembelajaran Interaktif**	**FK Unizar NTB**	**Nara sumber**
16.	**2023**	**Pelatihan Memfasilitasi Pembelajaran Klinis**	**FK Universitas Ganesha**	**Nara sumber**
17.	**2023**	**Tata Laksana Kehamilan Risiko Tinggi dengan Kondisi Preeklampsia**	**Stikes Hamzar NTB**	**Nara sumber**

9. Riwayat Publikasi

No.	**Tahun**	**Judul Publikasi**	**Jenis Publikasi (Oral/Poster/Buku/Jurnal Prosiding/dll)**	**Tempat Publikasi (Jurnal/Penerbit/Tempat)**	**Sebagai**
1.	**2014**	**Perbedaan Efektivitas Diskusi Kelompok, Motivasi Intrinsik Dan Nilai Modul Dari Mahasiswa Yang Difasilitasi Dosen Dan Tutor Sebaya**	**Jurnal**	**Jurnal Pendidikan Kedokteran Indonesia/AIPKI/ Jakarta**	**Penulis utama**

2.	**2017**	**Perbandingan rasio eutrophil/limfosit (NLR), rasio platelet/limfosit (PLR) dan volume platelet rata-rata (MPV) pada preeklampsia berat awitan dini (*early onset preeclampsia*) dengan preeclampsia berat awitan lanjut (*late onset preeclampsia*)**	**Prosiding**	**Indonesian Journal of Obstetrics and Gynecology/ Jakarta**	**Penulis utama**
3.	**2018**	**Advanced ligamentary pregnancy with live fetus and severe preeclampsia: a case report**	**Prosiding**	**Indonesian Journal of Obstetrics and Gynecology/ Jakarta**	**Penulis utama**
4.	**2020**	**Faktor-faktor yang Mendukung dan Menghambat Dilakukannya Versi Luar pada Kehamilan dengan Presentasi Bokong di Yogyakarta**	**Jurnal**	**Jurnal Kesehatan Reproduksi Indonesia**	**Penulis Utama**

10. Riwayat Penghargaan

No.	Tahun	Nama Penghargaan	Pemberi Penghargaan	Sebagai
1.	**1996**	**Siswa Teladan I Tk. SD Provinsi Bali**	**Gubernur Kepala Daerah Bali**	**Juara I**
2.	**1999**	**Siswa Teladan I Tk. SMP Provinsi Bali**	**Gubernur Kepala Daerah Bali**	**Juara I**
3.	**2002**	**Siswa Teladan III Tk. SMA Provinsi Bali**	**Gubernur Kepada Daerah Bali**	**Juara III**
4.	**2002**	**Juara I Olimpiade Matematika**	**Bupati Kepala Daerah Tk II Gianyar**	**Juara I**
5.	**2003**	**Siswa Berprestasi III Kuis Digital LG Prima Jakarta**	**Indosiar**	**Juara III**
6.	**2003**	**Juara II Olimpiade Biologi Provinsi Bali**	**Rektor Universitas Undiksha**	**Juara II**

7.	**2014**	***Best research in Medical Education - Best Oral Presentation* HPEQ-DIKTI**	**HPEQ Project – World Bank - Dirjen Pendidikan Tinggi**	***Best oral presentation***
	2014	***Awardee LPDP Kemenkeu RI***	**Kemenkeu RI**	***Awardee***
8.	**2016**	***Certificate of Appreciation***	**BkkbN – UGM - UNFPA**	***Committee***
9.	**2016**	**Penghargaan**	**FK UGM – RSUP Dr. Sardjito**	**Panitia**
	2020	**Lulusan Terbaik Program Studi Obstetri dan Ginekologi FKKMK UGM**	**FK-KMK UGM**	**Lulusan terbaik**
10	**2022**	**Penerima Matching Fund Kedaireka Kemenristekdikti 2022**	**Kemenristekdikti**	**Penerima**

HAND OUT MATERI

GRIYA KAMINI

Essential Positive Childbirth Experience

dr. I Made Pariartha, M.Med.Ed., Sp.OG
GRIYA KAMINI – FKIK UNIVERSITAS WARMADEWA

Disampaikan pada Workshop Positive Childbirth Experience
Prodi Kebidanan – Profesi Bidan
Universitas Jenderal Achmad Yani


16 17 45

Kasus 1

- Seorang perempuan 24 tahun, G1P0A0, UK 39 minggu datang ke RS dengan keluhan nyeri perut hilang timbul. Pemeriksaan obstetric TFU 32 cm, janin tunggal, memanjang, preskep, puki, DJJ 138 kpm, kepala teraba 3/5 bagian, His 1x/10’/15”/L. Pemeriksaan dalam vulva normal, vagina normal, serviks agak lunak, di belakang, penipisan 50%, dilatasi 2 cm, kepala di H2, selaput ketuban teraba. Pasien didiagnosis PK 1 fase laten, diputuskan diobservasi di kamar bersalin. Setelah evaluasi 8 jam, tidak ada kemajuan persalinan. Pasien diputuskan stimulasi oksitosin. Tidak ada kemajuan persalinan, pasien akhirnya dilakukan seksio sesarea.

Kasus 2

- Seorang perempuan 25 tahun, G1P0A0, UK 39 minggu datang ke RS dengan keluhan nyeri perut hilang timbul. Pemeriksaan obstetric TFU 32 cm, janin tunggal, memanjang, preskep, puki, DJJ 138 kpm, kepala teraba 3/5 bagian, His 1x/10’/15”/L. Pemeriksaan dalam vulva normal, vagina normal, serviks agak lunak, di belakang, penipisan 50%, dilatasi 2 cm, kepala di H2, selaput ketuban teraba. Pasien didiagnosis PK 1 fase laten. Pasien dipulangkan dengan KIE yang adekuat. Dua hari kemudian pasien datang kembali, evaluasi bukaan 6 cm. Pasien dievaluasi dan partus spontan.

Kasus 3

- Seorang perempuan 28 tahun, G2P1A0, UK 39 minggu dilakukan observasi di kamar bersalin dengan PK 1 fase aktif. Evaluasi terakhir pasien bukaan 4 cm. Dievaluasi 4 jam lagi pasien bukaan 5 cm. Pasien dilakukan stimulasi persalinan dengan oksitosin. Setelah habis 1 botol oksitosin 5IU/500 mL RL 40 tpm, evaluasi pasien bukaan 6 cm. diputuskan dilakukan seksio sesaria dengan diagnosis stimulasi gagal.

Kasus 4

- Seorang perempuan 28 tahun, G2P1A0, UK 39 minggu dilakukan observasi di kamar bersalin dengan PK 1 fase aktif. Evaluasi terakhir pasien bukaan 4 cm, kondisi ibu dan janin dalam kondisi baik. Dievaluasi 4 jam lagi pasien bukaan 5 cm kondisi ibu dan janin dalam kondisi baik. Dokter memutuskan pasien evaluasi 4 jam lagi. Evaluasi bukaan 6 cm. pasien partus normal 5 jam kemudian.

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Paradigma lama

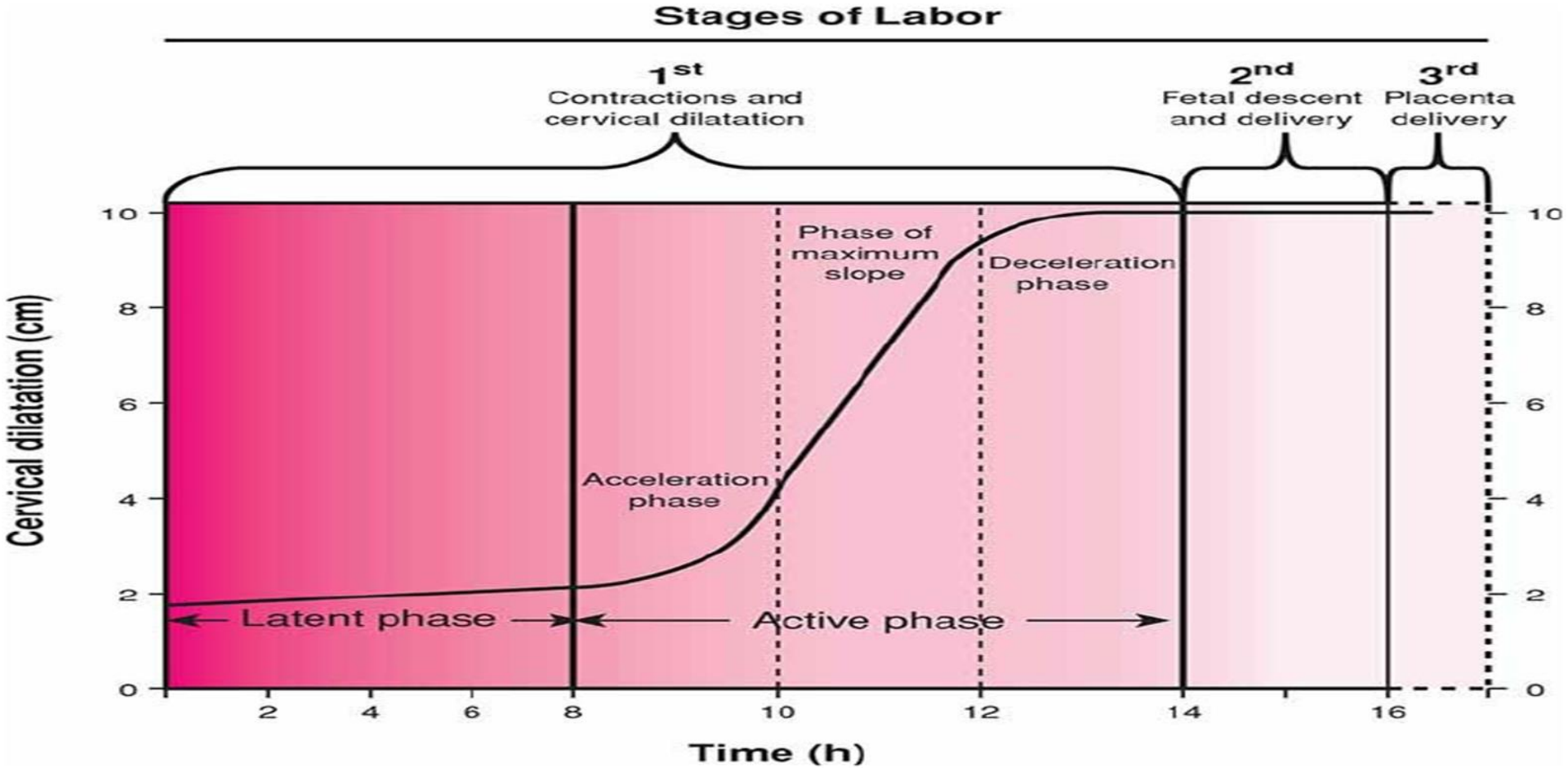


FIGURE 21-4 Composite of the average dilation curve for labor in nulliparous

Paradigma Baru

Table 2. Spontaneous Labor Progress Stratified by Cervical Dilation and Parity

	Median Elapsed Time (h)		
Cervical Dilation (cm)	*Parity 0 (95th percentile)*	*Parity 1 (95th percentile)*	*Parity 2 or Greater (95th percentile)*
3–4	1.8 (8.1)	—	—
4–5	1.3 (6.4)	1.4 (7.3)	1.4 (7.0)
5–6	0.8 (3.2)	0.8 (3.4)	0.8 (3.4)
6–7	0.6 (2.2)	0.5 (1.9)	0.5 (1.8)
7–8	0.5 (1.6)	0.4 (1.3)	0.4 (1.2)
8–9	0.5 (1.4)	0.3 (1.0)	0.3 (0.9)
9–10	0.5 (1.8)	0.3 (0.9)	0.3 (0.8)

Modified from Zhang J, Landy HJ, Branch DW, Burkman R, Haberman S, Gregory KD, et al. Contemporary patterns of spontaneous labor with normal neonatal outcomes. Consortium on Safe Labor. Obstet Gynecol 2010;116:1281–7.

ACOG. Obstetric Care Consensus Safe Prevention for Primary Cesarean Delivery. 2016.

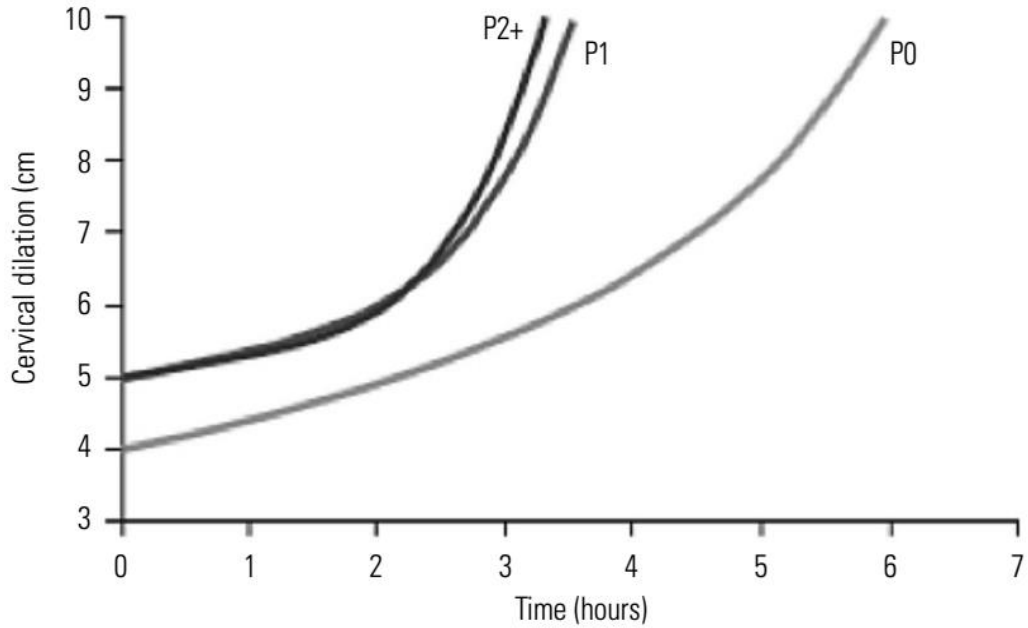


Fig. 4. Average labor curves by parity in singleton term pregnancies with spontaneous onset of labor, vaginal delivery, and normal neonatal outcomes. Abbreviations: P0, nulliparous women; P1, women of parity 1; P2+, women of parity 2 or higher. (Modified from Zhang J, Landy HJ, Branch DW, Burkman R, Haberman S, Gregory KD, et al. Contemporary patterns of spontaneous labor with normal neonatal outcomes. Consortium on Safe Labor. Obstet Gynecol 2010;116:1281–7.) ⇦

ACOG. Obstetric Care Consensus Safe Prevention for Primary Cesarean Delivery. 2016.

Table 3. Recommendations for the Safe Prevention of the Primary Cesarean Delivery ⇦

Recommendations	Grade of Recommendations
First stage of labor	
A prolonged latent phase (eg, greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women) should not be an indication for cesarean delivery.	1B Strong recommendation, moderate quality evidence
Slow but progressive labor in the first stage of labor should not be an indication for cesarean delivery.	1B Strong recommendation, moderate quality evidence
Cervical dilation of 6 cm should be considered the threshold for the active phase of most women in labor. Thus, before 6 cm of dilation is achieved, standards of active phase progress should not be applied.	1B Strong recommendation, moderate quality evidence
Cesarean delivery for active phase arrest in the first stage of labor should be reserved for women at or beyond 6 cm of dilation with ruptured membranes who fail to progress despite 4 hours of adequate uterine activity, or at least 6 hours of oxytocin administration with inadequate uterine activity and no cervical change.	1B Strong recommendation, moderate quality evidence

Second stage of labor	
A specific absolute maximum length of time spent in the second stage of labor beyond which all women should undergo operative delivery has not been identified.	1C Strong recommendation, low quality evidence
Before diagnosing arrest of labor in the second stage, if the maternal and fetal conditions permit, allow for the following: • At least 2 hours of pushing in multiparous women (1B) • At least 3 hours of pushing in nulliparous women (1B) Longer durations may be appropriate on an individualized basis (eg, with the use of epidural analgesia or with fetal malposition) as long as progress is being documented. (1B)	1B Strong recommendation, moderate quality evidence
Operative vaginal delivery in the second stage of labor by experienced and well trained physicians should be considered a safe, acceptable alternative to cesarean delivery. Training in, and ongoing maintenance of, practical skills related to operative vaginal delivery should be encouraged.	1B Strong recommendation, moderate quality evidence
Manual rotation of the fetal occiput in the setting of fetal malposition in the second stage of labor is a reasonable intervention to consider before moving to operative vaginal delivery or cesarean delivery. In order to safely prevent cesarean deliveries in the setting of malposition, it is important to assess the fetal position in the second stage of labor, particularly in the setting of abnormal fetal descent.	1B Strong recommendation, moderate quality evidence

Childbirth is one of the most challenging psychological events in a mother's life, as 10–34% of all childbearing women are faced with traumatic birth experiences.

Taheri et al. Creating a positive perception of childbirth experience: systematic review and meta-analysis of prenatal and intrapartum interventions Reproductive Health (2018) 15:73
https://doi.org/10.1186/s12978-018-0511-x

A negative experience in childbirth

post-traumatic stress disorder (PTSD)

disruption to interpersonal relationships

dysfunctional maternal - infancy bonding

reduction in rates of exclusive breastfeeding

fear of childbirth and in increased desire for an elective caesarean section in future pregnancies

Factors Affecting Childbirth Experiences

midwife support

duration of labour

pain

expectations of labour

involvement and participation of labour

use of invasive methods such as episiotomies, forceps and emergency caesarean section

Studies show that fear of childbirth leads to reduce self-efficacy and increase negative experience of childbirth. It also makes to choose caesarean for the next delivery (Al Ahmar & Tarraf, 2014; Christiaens & Bracke, 2007).

Consequences of a positive experience of childbirth include increasing self-esteem, self-efficacy, skills, maternal and infant attachment and better acceptance of the maternal role (Ekström & Nissen, 2006; Goodman, Mackey, & Tavakoli, 2004).

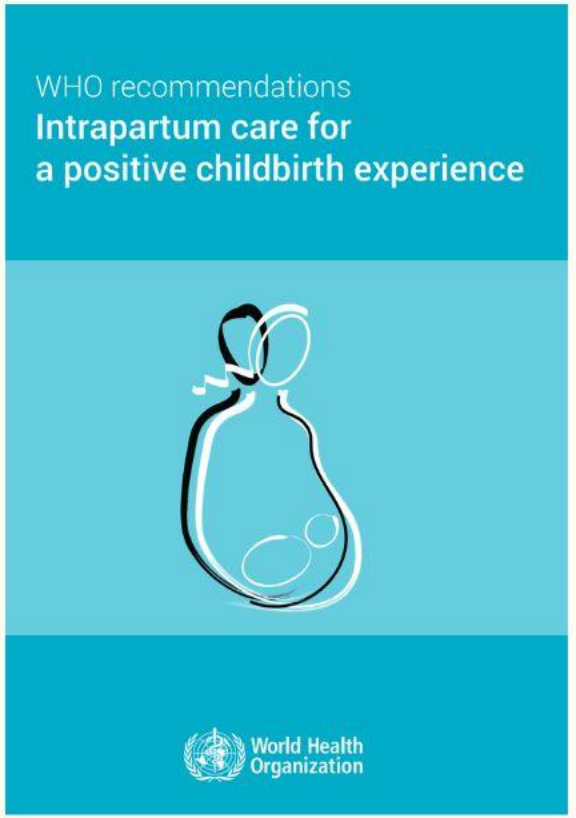
POSITIVE CHILDBIRTH

Women gain **essential experiences** during the labour process that remain with them throughout their lives.

The quality of these experiences affects the **health of the mother and her child, the mother–child relationship, as well as the spouse** (Bayrami, Valizadeh, & Zaheri, 2011).

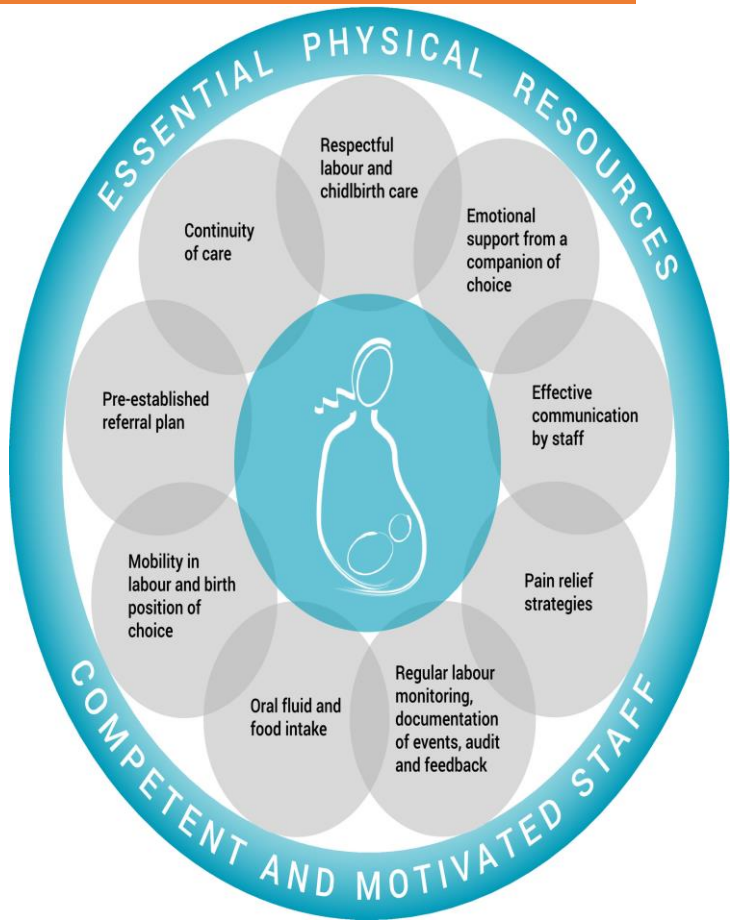
Intrapartum care for a positive childbirth experience (WHO, 2018)

- Respectful maternity care
- Effective communication
- Companionship during labour and childbirth
- Continuity of care



Intrapartum care for positive childbirth experiences

- For pregnant women with spontaneous labour onset, the cervical dilatation rate threshold of **1 cm/hour during active first stage** (as depicted by the partograph alert line) is **inaccurate** to identify women at risk of adverse birth outcomes and is therefore not recommended for this purpose.
- A minimum cervical dilatation **rate of 1 cm/hour** throughout active first stage is **unrealistically** fast for some women and is therefore **not recommended for identification of normal labour progression**. A slower than 1-cm/hour cervical dilatation rate alone should not be a routine indication for obstetric intervention.

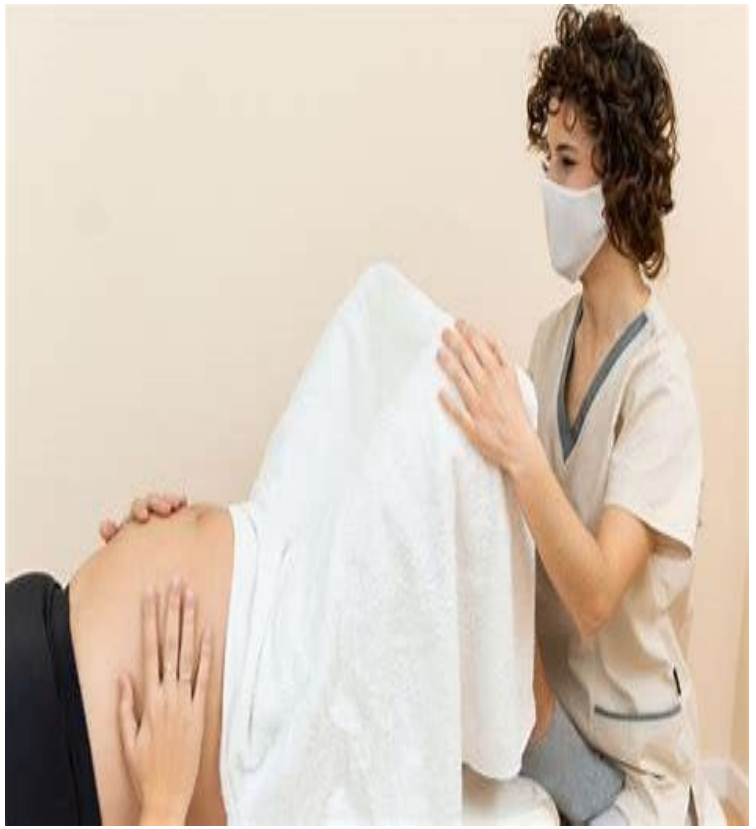


- For healthy pregnant women presenting in spontaneous labour, a policy of **delaying labour ward admission until active first stage** is recommended only in the context of rigorous research.
- **Routine cardiotocography is not recommended** for the assessment of fetal well-being on labour admission in healthy pregnant women presenting in spontaneous labour.
- **Auscultation using a Doppler ultrasound device or Pinard fetal stethoscope** is recommended for the assessment of fetal well-being on labour admission.

- Digital vaginal examination at intervals of four hours is recommended for routine assessment of active first stage of labour in low-risk women
- ***Relaxation techniques, including progressive muscle relaxation, breathing, music, mindfulness and other techniques, are recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences.***
- ***Manual techniques, such as massage or application of warm packs, are recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences***

- For women at low risk, ***oral fluid and food*** intake during labour is recommended.
- Encouraging the adoption of ***mobility and an upright position*** during labour in women at low risk is recommended
- Routine vaginal cleansing with chlorhexidine during labour for the purpose of preventing infectious morbidities is not recommended
- The use of ***intravenous fluids*** with the aim of shortening the duration of labour is not recommended

- Women should be informed that the duration of the second stage varies from one woman to another. In ***first labours, birth is usually completed within 3 hours*** whereas in subsequent labours, ***birth is usually completed within 2 hours***
- For women in the second stage of labour, techniques to reduce perineal trauma and facilitate spontaneous birth (including ***perineal massage, warm compresses and a "hands on" guarding of the perineum***) are recommended, based on a woman's preferences and available options.



- Routine or liberal use of ***episiotomy*** is ***not recommended*** for women undergoing spontaneous vaginal birth.
- Application of ***manual fundal pressure*** to facilitate childbirth during the second stage of labour is not recommended.
- ***Delayed umbilical cord clamping*** (not earlier than 1 minute after birth) is ***recommended*** for improved maternal and infant health and nutrition outcomes

INTERIM UPDATE

ACOG
The American College of Obstetricians and Gynecologists

ACOG COMMITTEE OPINION

Number 814

(Replaces Committee Opinion 684, January 2017)

Committee on Obstetric Practice

The American College of Nurse-Midwives endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Maria A. Mascola, MD; T. Flint Porter, MD; and Tamara Tin-May Chao, MD.

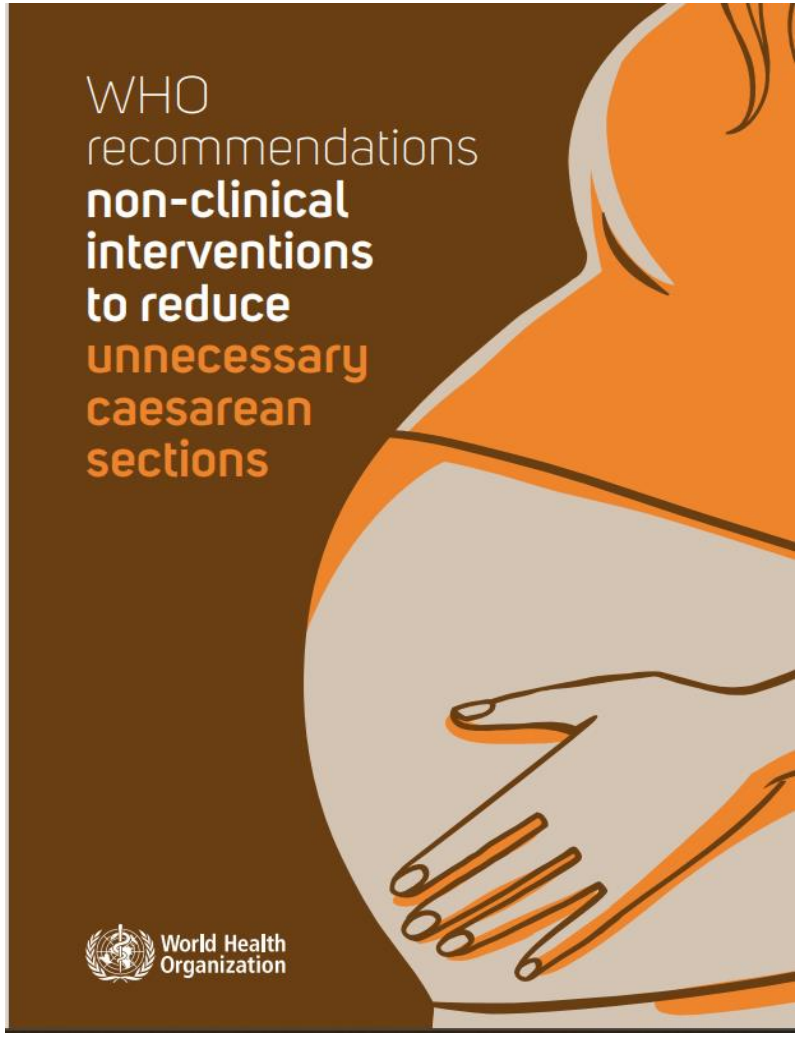
INTERIM UPDATE: The content in this Committee Opinion has been updated as highlighted (or removed as necessary) to reflect a limited, focused change in the data and language regarding cord milking.

Delayed Umbilical Cord Clamping After Birth

ABSTRACT: Delayed umbilical cord clamping appears to be beneficial for term and preterm infants. In term infants, delayed umbilical cord clamping increases hemoglobin levels at birth and improves iron stores in the first several months of life, which may have a favorable effect on developmental outcomes. There is a small increase in the incidence of jaundice that requires phototherapy in term infants undergoing delayed umbilical cord clamping. Consequently, obstetrician-gynecologists and other obstetric care providers adopting delayed umbilical cord clamping in term infants should ensure that mechanisms are in place to monitor and treat neonatal jaundice. In preterm infants, delayed umbilical cord clamping is associated with significant neonatal benefits, including improved transitional circulation, better establishment of red blood cell volume, decreased need for blood transfusion, and lower incidence of necrotizing enterocolitis and intraventricular hemorrhage. Delayed umbilical cord clamping was not associated with an increased risk of postpartum hemorrhage or increased blood loss at delivery, nor was it associated with a difference in postpartum hemoglobin levels or the need for blood transfusion. Given the benefits to most newborns and concordant with other professional organizations, the American College of Obstetricians and Gynecologists now recommends a delay in umbilical cord clamping in vigorous term and preterm infants for at least 30–60 seconds after birth. The ability to provide delayed umbilical cord clamping may vary among institutions and settings; decisions in those circumstances are best made by the team caring for the mother–infant dyad.

- In neonates born through ***clear amniotic fluid*** who start ***breathing on their own*** after birth, suctioning of the mouth and nose should ***not be performed***
- Newborns without complications should be kept in ***skin-to-skin*** contact (SSC) with their mothers during the ***first hour after birth*** to prevent hypothermia and promote breastfeeding
- ***All newborns***, including low-birth-weight (LBW) babies who are able to breastfeed, should be ***put to the breast as soon as possible*** after birth when they are clinically stable, and the mother and baby are ready

- ***Health education for women*** is an essential component of antenatal care. The following educational interventions and support program are recommended to reduce caesarean births only with targeted monitoring and evaluation.
  - *childbirth training workshops*
  - *nurse-led applied relaxation training program*
  - *psychosocial couple-based prevention program*
  - *psychoeducation for women with fear of childbirth*



Menurunkan angka SC….

- Childbirth training workshop (mothers alone versus control: risk ratio **[RR] 0.55**, 95% confidence interval [CI] 0.33 to 0.89; couple versus control: RR 0.59, 95% CI 0.37 to 0.94; 60 women, Low-certainty evidence) (73).
- Psychosocial couple-based prevention program (odds ratio **0.36**, 95% CI 0.15 to 0.86; 147 women, Low-certainty evidence) (75)
- Nurse-led applied relaxation training program (**RR 0.22**, 95% CI 0.11 to 0.43; 104 women, Low-certainty evidence) (80).

Meningkatkan persalinan vaginal....

- Childbirth training workshop (mothers alone versus control: RR 2.25, 95% CI 1.16 to 4.36; couple versus control: RR 2.13, 95% CI 1.09 to 4.16; 60 women, Low-certainty evidence) (73).
- Psychoeducation for women with fear of childbirth (RR 1.33, 95% CI 1.11 to 1.61; 371 women, Low-certainty evidence) (78).

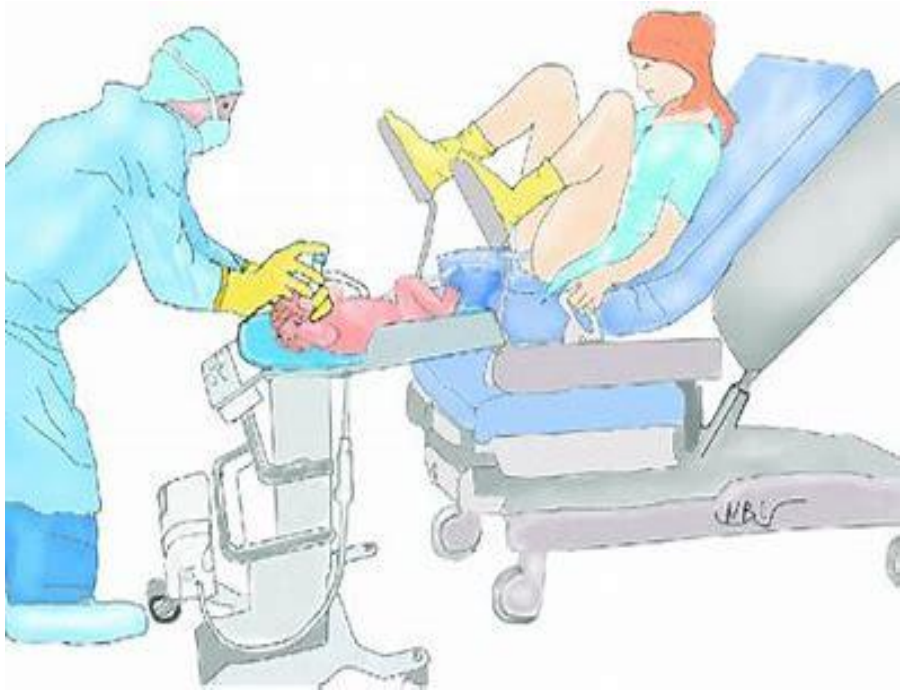


Table 4 Ranking of main reasons for delivery mode preference among 103 women preferring CS

Ranking	Reasons	N	%
1	CS is safer than VB	53	51.5
2	CS is less pain than VB	42	40.8
3	CS is better for baby's health than VB	25	24.3
4	CS is better for women's health than VB	23	22.3
5	CS is better for couple's life than VB	9	8.7
6	CS is of lower cost than VB	6	5.8
7	Other reasons	6	5.8

Note: Women were asked to choose at most three important reasons for their preference of delivery mode.
Abbreviations: VB, vaginal birth; CS, cesarean section.

Patient Preference and Adherence

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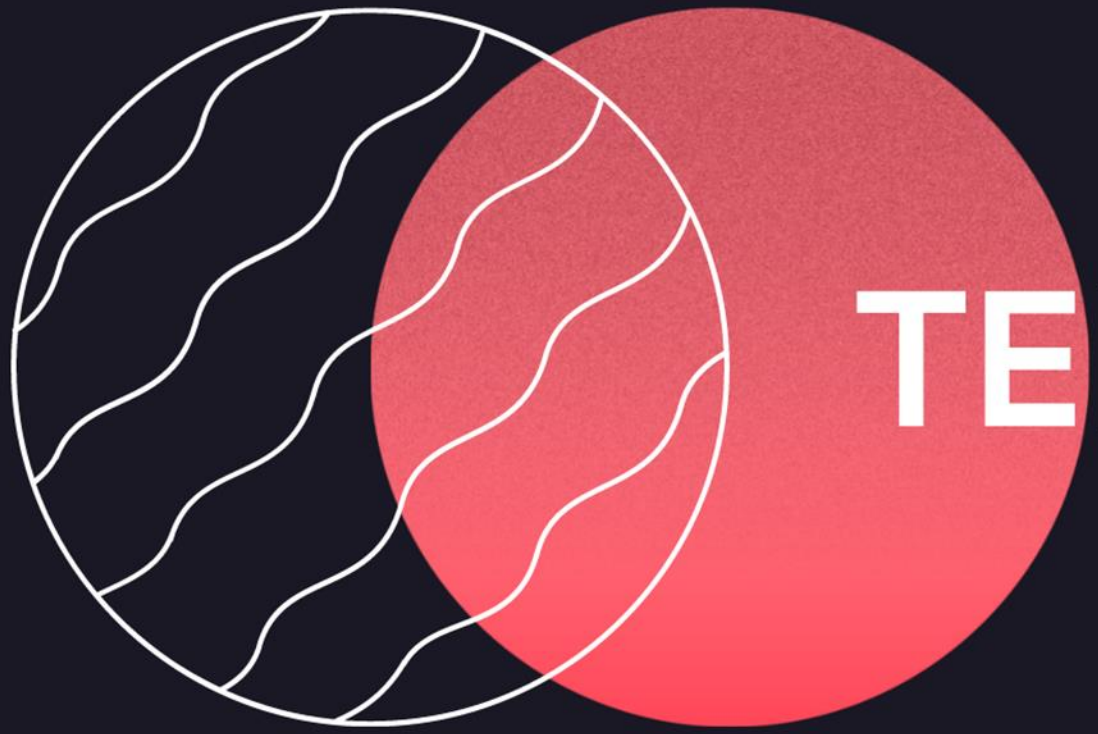
ORIGINAL RESEARCH

Women's cesarean section preferences and influencing factors in relation to China's two-child policy: a cross-sectional study

This article was published in the following Dove Press journal:
Patient Preference and Adherence

- ***Husband's*** and ***doctor's*** preference or suggestion influenced the preference of a woman on delivery mode
- ***Husband's preference for CS*** greatly increased ***women's preference for CS***. Consistent findings were reported in previous studies, which indicated that husband preferring CS influenced women's preference for CS delivery during pregnancy



TERIMA KASIH

FOTO KEGIATAN

UNDANGAN NARASUMBER

YAYASAN FORT DE KOCK BUKITTINGGI
UNIVERSITAS FORT DE KOCK
Jl. Soekarno Hatta, Kelurahan Manggis Ganting Kec. Mandiangin Koto Selayan Telp. 0752-31877 Fax. 0752-31878 Bukittinggi
e-mail : informasi@fdk.ac.id Website : http://fdk.ac.id

Bukittinggi, 20 November 2023

Nomor : 0759/ UFDK/XI/2023
Lamp : -
Perihal : Permintaan sebagai Narasumber

Kepada Yth:
dr. I Made Pariartha, M.Med.Ed., SpOG

di
Tempat

Dengan Hormat,

Sebelumnya kami mendo'akan semoga Bapak dalam keadaan baik dan dalam lindungan Allah SWT, Amin Ya Rabbal 'Alamin.

Dalam rangka pemenuhan Kuliah Pakar program Studi Kebidanan Semester Ganjil Tahun Akademik 2023/2024, maka Program Studi Kebidanan Universitas Fort De Kock Bukittinggi akan melaksanakan kegiatan kuliah pakar dengan Tema "*Essential Possitive Childbirth Experience*".

Oleh karena itu, Bersama surat ini kami mohon kepada Bapak untuk bersedia menjadi Narasumber kegiatan Kuliah Pakar yang akan dilaksanakan pada :

Hari/Tanggal : Kamis/ 14 Desember 2023
Waktu : 09.00 WIB s/d selesai
Tempat : Aula Gedung Rektorat Universitas Fort De Kock Bukittinggi

Demikianlah surat permohonan ini kami sampaikan, besar harapan kami agar Bapak dapat menjadi Narasumber dalam kegiatan ini. Atas perhatian dari Bapak kami ucapkan terima kasih.

Rektor

Dr. Eri Barlius, S.Pd, Ns. M.Kes

DAFTAR HADIR

No	Timestamp	NAMA LENGKAP	NIM
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