ORIGINAL ARTICLE

Modeling of Gentle birth and Hypnoprenatal Integrated Antenatal Class on Birth Process in Puskesmas and Midwives Practice, Palembang City

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ABSTRACT

Every woman wants labor to go smoothly and can give birth to a baby perfectly. In theory, it was stated that 90-95% of deliveries should be able to run normally without complications. The aim of the study was to assess the effectiveness of the integrated Antenatal Class Effect of Gentle birth and Hypnoprenatal in Antenatal Classes in the Birth Process. The population is all pregnant women at the Husniyati Palembang Independent Health Center and Practical Midwife. The quasi-experimental research design with sample determination based on Federell's formula was 32 people. The results showed that there was no significant relationship between antenatal class and hypnoprenatal with labor in pregnant women but the correlation coefficient showed a strong positive relationship in time II to pain during labor. The long relationship with the level of pain in the first and second stage of labor was not significant but the value of the first time rs of the control group showed a negative positive and linear relationship in the different cases. shows a positive linear relationship, and in the control group the value of rs has a weak relationship. This means that the antenatal class and hypnoprenatal have no effect on the duration of the first and second periods but have a strong relationship in the second case group with the correlation coefficient (rs 0,000). Suggestion: Strong support is needed between officers and families to manage the discomfort experienced by mothers during the third trimester and labor
Keywords: Antenatal Class, Gentle birth, Hypnoprenatal, Birth Process

INTRODUCTION

Every woman wants a delivery to run smoothly and can give birth to a perfect baby. Childbirth should be a happy moment that does not need to be feared by a woman, but there are still many women who feel worried, anxious and anxious waiting for the time of birth arrived. The theory is conveyed that 90-95% of childbirth should be able to run normally vaginal without complications. In fact, many deliveries end in induction and Caesaria (SC) section. In Indonesia, the incidence of SC in government hospitals is around 20-25% while in private hospitals around 30-80% of total deliveries Anxiety experienced by a woman will increase the production of the hormone serotonin which can inhibit the work of oxytocin. As a result, a maternal mother who should be able to give birth normally should have a medical intervention to induce labor with drip oxytocin, which causes intense pain. Anxiety and pain can be minimized by increasing the mother's ability to relax during pregnancy and childbirth as well as physical and psychological preparations. Gentle birth is one way to prepare pregnant women during pregnancy. Dangan Gentle birth does not only look at maternity in terms of physiology but also views maternity as a client holistically as a social and cultural bio-psycho creature. The key to gentlebirthing is minimizing medical treatment with a gentle and natural delivery. Relaxation can be trained during pregnancy by doing during pregnancy, a 2013 study by Jiarti found that, by being hypnoed during pregnancy, pregnant women feel calmer and anxiety is reduced. Relaxation accompanied by gentlebirthing will get maximum results. Based on the problems mentioned above and based on childbirth care with the philosophy of normal birth, researchers are interested in taking the title of the Antenatal Class Integrated Gentle birth and Hypnoprenatal Model Research on the Process of Birth in the Class of Pregnant Women in Palembang City Health Center in 2018.

Problem Formulation: What is the process of childbirth in pregnant women who get the effect of Antenatal Class Integrated Gentle birth and Hypnoprenatal Against the Birth Process?

Research Objectives: Collecting, processing and analyzing data and assessing the effectiveness of the effects of integrated Antenatal Class Gentle birth and Hypnoprenatal on Antenatal Class in the Birth Process.

Research Output: Antenatal Class module that is integrated with gentle birth and hypnoprenatal

Purpose and benefits of research: Specific Objectives: To collect, process and analyze data and assess the effectiveness of the Gentlebirth and Hypnobirth technique in the Antenatal Class in the progress of the Birth Process.

General Purpose: To find out the relationship between Gentlebirth and Hypnobirth in the Antenatal Class in the progress of the Birth Process. To find out the differences in the Gentlebirth and Hypnobirth technique in the Antenatal Class to t

Benefits of Research: Science: Research can find the specific problems of labor in the Gentlebirth and Hypnobirth technique so that mothers can feel comfortable and secure in the face of labor.

Practical

1) This research can be a reference and input for safe and comfortable delivery based on local culture

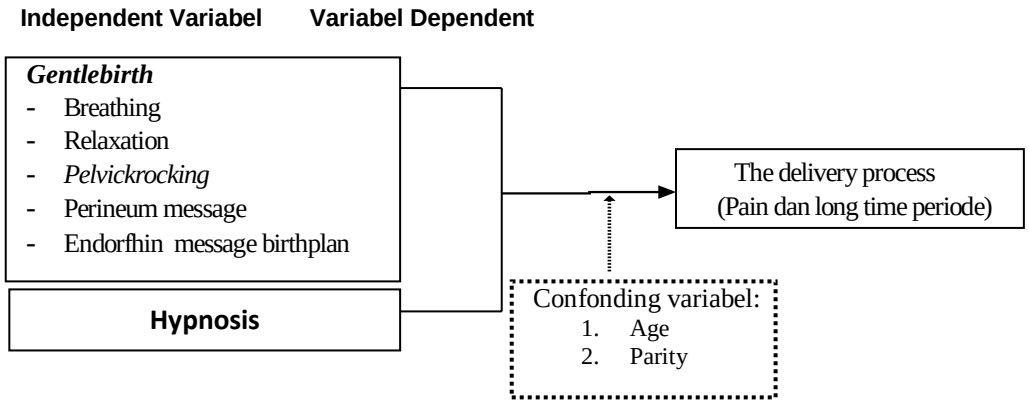
2) Gentle birth and Hypnobirth techniques can be integrated in class antenatal activities

3) Creating an applicative model for pregnant women to be able to apply the gentle birth and hypnobirth models in the labor process

RESEARCH METHODS

Design: This study uses a type of research design with posttest-only control group design method. In this design, Sugiyono stated "that there are two groups, each randomly chosen. The first group was given treatment (X) and the other group was not. The treated group is called the experimental group and the untreated group is called the control group "(Sugiyono, 2012: 76). The effect of the treatment (symbol) is symbolized by (O2: O4) and then to see the effect of treatment based on its significance is the analysis of different tests using T-test statistics. If there is a significant difference between the experimental group and the control group, the treatment given has a significant effect

Framework



Population and sample: The population is all pregnant women in the Pembinda Health Center and the Independent Practice Midwife Husniyati Palembang

Inclusion criteria

1. Normal pregnant women
2. gestational age> 37 Weeks

Exclusion criteria are as follows:

1. Do not suffer from certain diseases
2. Hypertension, Diabetes Mellitus, anemia gravis

Sample: The sample size is determined using the formula sample size in each group is using the Federrer formula, namely

(r-1) (t-1) > 15

r > 15 + 1 r > 16 Keterangan:

From the results of the above data the group sampling amounted to 16 people or more. Next the researchers determined the number of samples as many as 32 people. So that the sample size of each group amounted to 16 pregnant women

Hypothesis: there is an influence of gentle birth and hypnosis techniques with the ability of respondents in the respondent's birth process

Data collection: Types of data needed in this study are primary data and secondary data. Primary data were obtained from research results through conducting integrated antenatal class Hypnotherapy

Data processing: The data that has been collected will be processed with the following stages:

1. Collecting and coding data (Editing & Coding)
2. Give a value (Scoring)

Data obtained from ordinal scale (Likert's score)

3. Entering data (Entry data)
4. Tabulate data.

Data is processed with a frequency distribution system and testing the relationship of variables with statistical tests. The statistical test formula used is: correlation test with a significant degree if P <0.005.

RESEARCH RESULT

The results of the study were analyzed univariably including the frequency distribution and other statistical values of the independent and dependent variables. Bivariable analysis was carried out to explain the influence of anatenatal class and hypnoprenatal variables as independent variables on the birth process as the dependent variable.

The results of the analysis to test the research group based on research variables from the Kolmogorov-Smirnov test were found both in the control group and in the case group found a significant relationship with the results of age p value <α> 0.05. The conclusion of the normality test results is that the age and parity variables are normally distributed.

From the number of samples determined each place of research amounted to 16 pregnant women so that the total sample was 32 pregnant women. The research are as follows

The relationship between age and labor pain in stage I and II was not significant (p value> α = 0.05), but the correlation coefficient (rs value) at the first time showed that age had a negative linear relationship that was different from the second stage pain between age and pain in the second stage showed a positive relationship of 0.405, while for the parity variable obtained coefficient coefficient (r value) = 0,000 means that it has no relationship. This means that age and parity do not have an effect on pain in the first and second stages experienced by the mother in the case group

The relationship between age and the length of labor process when I and II were not significant (p value> α = 0.05) but the correlation coefficient (rs value) at times I and II showed that the age variable had a negative linear relationship, while the parity variable obtained correlation coefficient (r value) shows a negative linear relationship while p value> α = 0.05. This means that age and parity do

not influence the length of time I and II experienced by mothers during childbirth in the case group.

The relationship between age and the delivery process when I and II were not significant (p value> α = 0.05) but the correlation coefficient (rs value) at stage II showed that the age variable had a negative linear relationship -0.078 different results with pain at stage I between ages and pain in the second stage showed a positive relationship of 0.418, while for the parity variable in the long time I obtained a coefficient coefficient (r value) = 0.898 means that the parity variable has a strong relationship and the p value <α = 0.05 which means it has a meaningful relationship the second time the rs value showed a weak relationship with p value> α = 0.05. This means that age does not have an effect on pain in stage I and II experienced by the mother, while parity influences the length of time I and II that occur during labor in the control group.

The relationship between age and the delivery process when I and II were not significant (p value> α = 0.05), but the correlation coefficient (rs value) at the first time showed that age had a strong positive and linear negative correlation on pain when the second stage was different with pain while I and II meanwhile rs shows a negative linear relationship, and for the parity variable the coefficient coefficient (r value) has a weak relationship and p value> α = 0.05. This means that parity does not influence the length of time I and II experienced by mothers in the control group

The old relationship with the level of pain in the first stage of labor was not significant (p value> α = 0.05), but the correlation coefficient (rs value) in the first stage of the control group showed a strong positive and negative linear correlation in the case of different cases. second stage pain with the correlation coefficient value in the rs case group showed a positive linear relationship, and in the control group the correlation coefficient obtained (r value) had a weak relationship and p value> α = 0.05. This means that antenatal class and hypnoprenatal do not influence the duration of times I and II but have a strong relationship in the second stage of the case group with the correlation coefficient rs = 0,000.

Table 1: Characteristics of pregnant women subject to research in the 2 study groups

Characteristics	Group					
	Case		Value p	Control		Value p
	n=16	%		n =16	%	
Age - Low	5	31,35	0,005	5	31,35	
Height	11	68,75		11	68,75	0,005
Parity - Low	12	75	0,002	6	37,5	
Height	4	25		10	62,5	0,012

Age and parity variables in both groups of cases and controls have a significant relationship with p value α <0.

Table 2: Relationship between age and parity to first stage pain and second stage pain in the case group

Correlation of childbirth processes	First Stage of Pain		Second Stage	
	r_s	Value p	r_s	Value p
Age	-0127	0,639	0,405	0,120
Parity	-3,89	0,138	0,000	1,000

Note: rs = Rank-Spearman correlation coefficient

Table 3: Relationship of age and parity to old times i and old times ii in the case group

Correlation of childbirth processes	First Stage of Pain		Second Stage	
	r_s	Value p	r_s	Value p
Age	-0,418	0,107	0,135	0,619
Parity	-0,035	0,898	0,258	0,334

Note: rs = Rank-Spearman correlation coefficient

Table 4: Relationship between Age and Parity for First Stage and Second Stage Pain in the Control Group

Correlation of childbirth processes	First Stage of Pain		Second Stage	
	r_s	Value p	r_s	Value p
Age	0,418	0,107	-0,078	0,774
Parity	0,035	0,898	0,149	0,582

Note: rs = Rank-Spearman correlation coefficient

Table 5: Relationship between age and parity to old times i and old times ii in the control group

Korelasi terhadap Proses Persalinan	First Stage of Pain		Second Stage	
	r_s	Value p	r_s	Value p
Age	0,078	0,774	-0,255	0,341
Parity	0,149	0,582	0,488	0,055

Note: rs = Rank-Spearman correlation coefficient

Table 6: Effects of antenatal class and hypnoprenatal on pain based on the birth process in the Case group in BPM and Palembang City Health Center in 2018

Correlation to the Labor Process	First Stage of Pain				Second Stage			
	Case		Control		Case		Control	
	r_s	Value p	r_s	Value p	r_s	Value p	r_s	Value p
Lama	0,045	0,870	-0,232	0,386	1,000	0,341	0,000	1,000

DISCUSSION

Age: The relationship between age and labor pain in stage I and II was not significant (p value> α = 0.05), but the correlation coefficient (rs value) at the first time showed that age had a negative linear relationship that was different from the second stage pain between age and pain in the second stage showed a positive relationship of 0.0405, while for the parity variable obtained correlation coefficient (r value) = 0,000 means that it has no relationship. This means that age does not have an effect on pain in the first and second stages experienced by the mother in the case group. Based on the results of the study it can be seen that from 16 respondents who have a high risk age category of 11 people (68.75%) and low categories of 5 people (31.35%).

The results of this study indicate that the age of the respondents included in the risk category when giving birth. In this situation many problems arise and the decline in reproductive function in the face of childbirth because the reproductive organs in this category contribute to problems and complications during pregnancy, childbirth and childbirth so that the analysis is that respondents at this age must be prepared to accept and be able to overcome problems that arise at the time childbirth as well as experience are ready to accept the conception Age characteristics of respondents can affect the pain of childbirth felt, where the younger the age of pregnant women are not ready to accept a pregnancy, then the response will be negative Someone older will be able to respond to stressors faced than someone younger.

Relationship between age and parity with childbirth at stage I and II in the control group: The relationship between age and labor pain in stage I and II was not significant (p value> α = 0.05), but the correlation coefficient (rs value) at the first time showed that age had a negative linear relationship that was different from the second stage pain between age and pain in the second stage showed a positive relationship of 0.405, while for the parity variable the coefficient coefficient was obtained (r value) = 0,000 meaning it did not have a relationship. This means that age and parity do not have an effect on pain in the first and second stages experienced by mothers in the case group

Relationship of Age and Parity to Old Times I and Old Times II in the Case Group and in the control group: Age with childbirth at stage I and II was not significant (p value> α = 0.05) but the correlation coefficient (rs value) at stage II showed that the age variable had a negative linear relationship -0.078 different results with pain at stage I between age and pain in the second stage showed a positive relationship of 0.418, while for the parity variable in the long time I obtained a coefficient coefficient (r value) = 0.898 means that the parity variable has a strong relationship and the value of p value <α = 0.05 which means it has a long lasting relationship second stage r_s value shows a weak relationship with p value> α = 0.05. This means that age does not influence the pain of the first and second stages experienced by the mother, while parity influences the duration of the first and second periods that occur during the delivery process in the control group. but the value of the correlation coefficient (r_s value) at times I and II shows that the age variable has a negative linear relationship, while the parity variable obtained by the correlation coefficient (the value of r) shows a negative linear relationship while the value of p value> α = 0.05. This means that age and parity do not influence the length of time I and II experienced by mothers during childbirth in the case group The relationship between age and the delivery process when I and II were not significant (p value> α = 0.05), but the correlation coefficient (r_s value) at the first time showed that age had a strong positive and linear negative correlation on pain when the second stage was different with pain while I and II meanwhile rs shows a negative linear relationship, and for the parity variable the coefficient coefficient (r value) has a weak relationship and p value> α = 0.05. This means that parity does not influence the length of time I and II experienced by mothers in the control group.

Effects of antenatal class and hypnoprenatal on pain: The old relationship with the level of pain in the first stage of labor was not significant (p value> α = 0.05), but the correlation coefficient (rs value) in the first stage of the control group showed a strong positive and negative linear correlation in the case of different cases. second stage pain with the correlation coefficient value in the rs case group showed a positive linear relationship, and in the control group the correlation coefficient obtained (r value) had a weak relationship and p value> α = 0.05. This means that the antenatal class and hypnoprenatal do not have an influence on the times I and II but have a strong relationship in the second stage of the case group with the correlation coefficient rs = 0,000.

The results of the study in the treatment group obtained that labor pain data mostly experienced mild pain of 9 people (60.0%). This shows that respondents who were given treatment can release oxytocin so that in labor the mother feels calm and is not afraid of facing labor. Even though respondents had been given treatment, there were still respondents who experienced pain as many as 2 people (13.3%).

This is possible because the pain felt is subjective and the perception of the pain felt by respondents is different. Childbirth pain that occurs in respondents is an unpleasant feeling which is the individual response that accompanies the labor process. Pain experienced by respondents due to physiological changes in the birth canal and uterus. The pain felt by respondents varies in the control group and the treatment group. Pain that occurs due to stress in the face of pregnancy so that it can stimulate excessive uterine contractions. Uncontrolled uterine contractions will deliver pain during labor. Based on previous theories that pain depends on work and nerves large and small which are in the dorsal ganglion root. Stimulation of large nerves will increase the mechanism of activity of gelatinous substance which results in the closing of the mechanism door so that T cell activity is inhibited and causes stimulation to participate is also inhibited and causes stimulation to participate is also inhibited. Stimulation of small fibers will inhibit the activity of gelatinous substance and open the mechanism door, thereby stimulating T cell activity which in turn will deliver pain stimulation.

Pain in the first stage of labor is caused by the appearance of uterine muscle contractions, hypoxia of muscles that contract, cervical stretching upon opening, uterine corpus ischemia, and stretching of the uterine segment. During the first stage, uterine contractions cause cervical dilatation and uterine ischemia. Pain impulses during the first stage are transmitted by spinal nerve segments and thoracic accessories under sympathetic lumbar. This nerve originates from the uterus and

cervix. Discomfort from cervical changes and uterine ischemia is when visceral pain located below the abdomen spreads to the back lumbar region and inner thighs. Usually, women feel pain at the time of contraction only and are free from pain during relaxation. Pain is localized such as cramping sensation, tearing sensation, and heat sensation, caused by distention and laceration of the cervix, vagina and perineal tissue. During the active phase, the cervix dilates (Bobak, 2004).

Nonpharmacologic pain control methods are very important because they do not endanger the mother or fetus, do not slow labor if given strong pain control, and do not have allergic or drug effects. The nonpharmacology method is divided into three interacting components, thus affecting the response to pain, namely the motivational-affective strategy (a neutral interpretation of messages in the brain that is influenced by one's feelings, memory, experience and culture), cognitive-evaluative (interpretation of pain messages which is influenced by knowledge, one's attention, the use of cognitive strategies and cognitive evaluations of situations) and sensory-discriminatory (notification of information to the brain according to physical sensations) (Gadysa, 2009).

Labor is generally accompanied by pain due to uterine contractions. The intensity of pain during labor can affect the labor process, and fetal well-being (Sumarah, 2009). Labor pain can cause stress which causes excessive release of hormones such as catecholamines and steroids. These hormones can cause smooth muscle tension and vasoconstriction of blood vessels. This can result in decreased uterine contractions, decreased uteroplacental circulation, reduced blood flow and oxygen to the uterus, and the onset of uterine ischemia which causes more painful impulses. (Sumarah, 2009)

CONCLUSION

1. Most of the respondents with high education amounted to 12 respondents (60%)
2. Respondents who do not work are 16 respondents (80%) only a small proportion of respondents work for 4 respondents (20%)
3. Respondents based on high parity amounted to 8 respondents (40%) while a small proportion of respondents based on low parity numbered 5 respondents (25%)
4. Before the intervention the respondent's pain scale was mild pain 8 people (40%) and 12 people (60%) and after the intervention the respondent's pain scale was 19 people (95%) mild pain and 1 person (5%) severe pain
5. Intensity of labor pain before p value = 0.117 and pain intensity after p value = 0.429, this shows that there is no effect of endorphin massage on pain intensity in the first stage of labor, but T test results show 7.483 with p-value = 0.000 (p value <α 0.05) There is a significant difference in endorphin massage intervention on pain intensity during the first stage of labor
6. Intensity of labor pain before p value = 0.117 and pain intensity after p value = 0.429, this shows that there is no effect of endorphin massage on pain intensity in the first stage of labor, but the T test results showed 7.483 with p-value = 0.000 (p value <α 0.05) There is a significant difference in endorphin massage intervention on pain intensity during the first stage of labor

REFERENCES

1. AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002;50 (6Suppl):S205- S224.
2. Assessment and Management of Acute Pain. Bloomington: Institute for Clinical
3. Bobak, Lodermik, jansen, (2004). Buku ajar Keperawatan maternitas. Alih bahasa, Maria A. Wijayanti, peter I, Anugrah ; editor Edisi Bahasa Indonesia, Renata Komalasri : (Edisi 4). Jakarta : EGC
4. Bieri D, Reeve RA, Champion CD, et al. The facespain scale for the self- assessment of the severity of pain experienced by children: development, initial validation, and preliminary investigation for ratio scale properties. Pain 1990;41:139-150.
5. Carr D, Goudas L, Lawrence D, et al. Management of cancer symptoms: pain, depression, and fatigue. Evidence Report/Technology Assessment No. 61 (Prepared by the New England Medical Center Evidence-based Practice Center under Contract No 290-97-
6. Gadysa, G. (2009) Persepsi ibu tentang metode massage. Diakses tanggal 02 Februari 2019
7. Kementrian Kesehatan RI (2012). *Survey Demografi Kesehatan Indonesia*, *Gigi Dan Mulut di Puskesmas*. JakartaAnatomy and Physiology, Illu strated Notebook: From Science to Life. Indianapolis: Wiley, 2007.
8. Koo PJS. Pain. In: Young LY, Koda-Kimble MA. Applied Therapeutics: the Clinical Use of Drugs , 9th ed. Vancouver: Applied Therapeutics, 2004.
9. Leeman L, Fontaine P, King V, et al. The nature and management of labor pain: part I:nonpharmacologic pain relief. Am Fam Physician 2003;16:1109-114.
10. Leeman L, Fontaine P, King V, et al. The nature and management of labor pain: part II. pharmacologic pain relief.
11. Morley-Forster PK, Clark AJ, Speechley M, et al. Attitudes toward opioid use for chronic pain: a Canadian physician survey. Pain Res Manag 2003;8:189- 194.
12. Raylene M Rospond, 2008; terj. D. Lyrawati, 2009 0019). AHRQ Publication No. 02-E032. Rockvill e: Agency for Healthcare Research and Quality, 2002; July. Fields HL. Pain . New York:
13. McGraw-Hill, 1987:32. Franck LS, Greenberg CS, Stevens B. Pain assessment in infants and children. Pediatr Clin North Am 2000;47(3):487-512. Glajchen M. Chronic pain: treatment barrier s and strategies for clinical practice. J am Board Fam Pract 2001;14:211-18.
14. Systems Improvement (ICSI), 2006. Jenkins GW, Kemnitz CP, Tortota GJ.
15. Sastroasmoro, Sudigdo (2014). *Dasar-Dasar Metodologi Penelitian Klinis*. Jakarta: Sagung Seto
16. Sugiyono, 2012, *Metodelogi Penelitian Kuantitatif, Kualitatif Dan R&D.* (Bandung: ALFABETA)
17. Sumarah, 2009. Perawatan Ibu Bersalin. Jakarta: Fitramaya.
18. Reisner-Keller LA. Pain management. In: Helms RA, Quan DJ.
19. Textbook of Therapeutics: Drug and Disease Management, 8th ed. Baltimore: Lippincott, Williams & Wilkins, 2006:1047-1072. Schnabel GA, Powrie JD. Pain assessment: the pharmacist's challenge in alternative healthcare environments. Consult Pharm 1998;7:816-822.
20. Trescot AM, Boswell MV, Atluri SL, et al. Opio id guidelines in the management of chronic noncancer pain. Pain Phys 2006;9(1): 1-39.
21. Won A. Pain in the Elderly. In: Warfield CA. Principles and Practice of Pain Management . New York: McGraw-Hill, 2004:571-581.