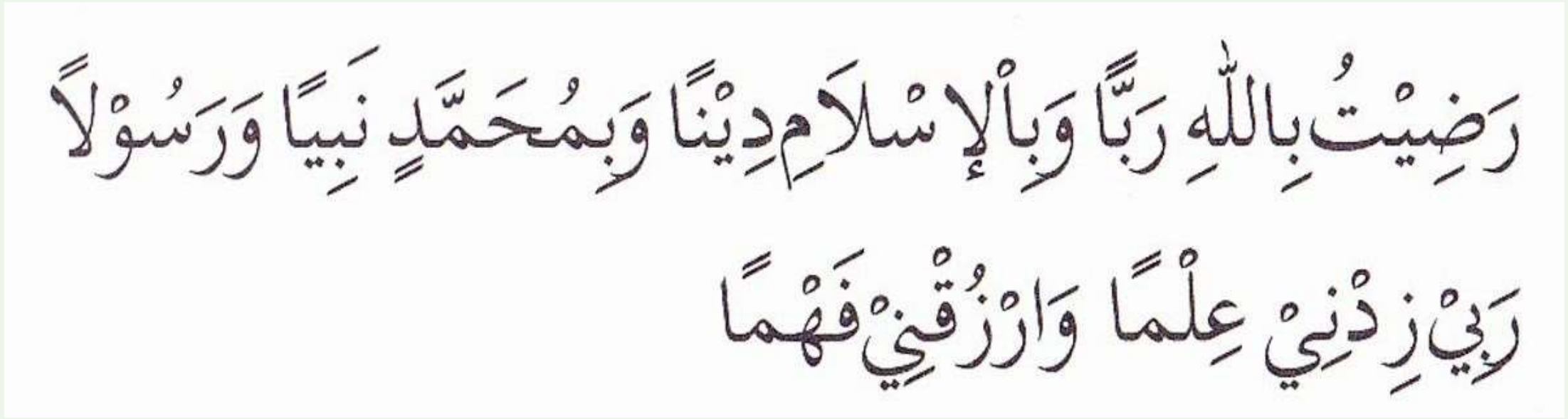
Universitas 'Aisyiyah
Yogyakarta

# PENGANTAR ILMU KEBIDANAN

# DOA BELAJAR




“Kami ridho Allah SWT sebagai Tuhanku, Islam sebagai agamaku, dan Nabi Muhammad sebagai Nabi dan Rasul, Ya Allah, tambahkanlah kepadaku ilmu dan berikanlah aku kefahaman”

# PENGANTAR ILMU KEBIDANAN

**NIDATUL KHOFIYAH**

**Disampaikan pada Kuliah MK ILMU KEBIDANAN**

**Semester Gasal 2021/2022**

# Capaian Pembelajaran

## Capaian pembelajaran MK 1

- Mampu menggambarkan dan menjelaskan kembali anatomi fisiologi ibu-janin masa antepartum (S17, PP2, PP10)

## Sub Capaian Pembelajaran MK 1

- Mampu menggambarkan tentang ilmu kebidanan, anatomi fisiologi ibu *[*C2, A2*]*

# Bahan Kajian

**Bahan kajian pada pertemuan ini :**

**Gambaran umum Ilmu Kebidanan dan Anatomi Fisiologi ibu dan janin**

# MATERI

1. Gambaran umum ilmu kebidanan
2. Statistik vital
3. Penilaian pelayanan kebidanan
4. Evidence based dalam kebidanan

# Gambaran Ilmu Kebidanan

**Ilmu kebidanan adalah suatu cabang ilmu kedokteran yang menangani masalah kelahiran bayi, perawatan dan penatalaksanaan ibu sebelum dan sesudah kelahiran (Cunningham, 2010)**

Obyek ilmu kebidanan :

Kehamilan, Persalinan, Nifas, Bayi Baru Lahir, Gangguan Sistem Reproduksi

# Statistik Vital

**Definisi rekomendasi NCHS dan CDC**

1. **Kelahiran = ekspulsi atau ekstraksi lengkap janin dari seorang ibu setelah usia kehamilan 20 minggu**
2. **Perinatal = periode setelah kelahiran bayi (janin dari usia kehamilan lebih dari 20 minggu) sampai 28 hari setelah lahir.**
3. **Neonatus = bayi baru lahir usia 0 – 28 hari**

- **Neonatus cukup bulan = neonatus yang lahir pada usia kehamilan 37 – 42 minggu (aterm)**
- **Neonatus kurang bulan = neonatus yang lahir sebelum usia kehamilan 37 minggu (preterm)**
- **Neonatus lebih bulan = neonatus yang lahir setelah usia kehamilan 42 minggu (postterm)**

| Berat badan lahir normal = neonates dengan berat lahir ≥ 2500 gr | Berat badan lahir rendah = neonatus dengan berat lahir < 2500 gr |
|---|---|
| Berat badan lahir sangat rendah = neonatus dengan berat lahir < 1500 gr | Berat lahir ekstrem rendah = neonates dengan berat lahir < 1000 gr |

| Abortus | matur |
|---|---|
| prematurus | postmatur |

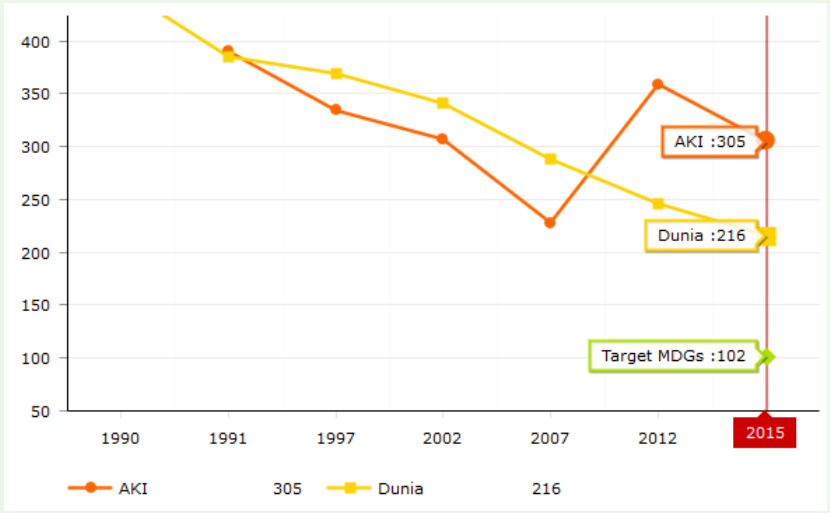
# Penilaian Pelayanan Kebidanan

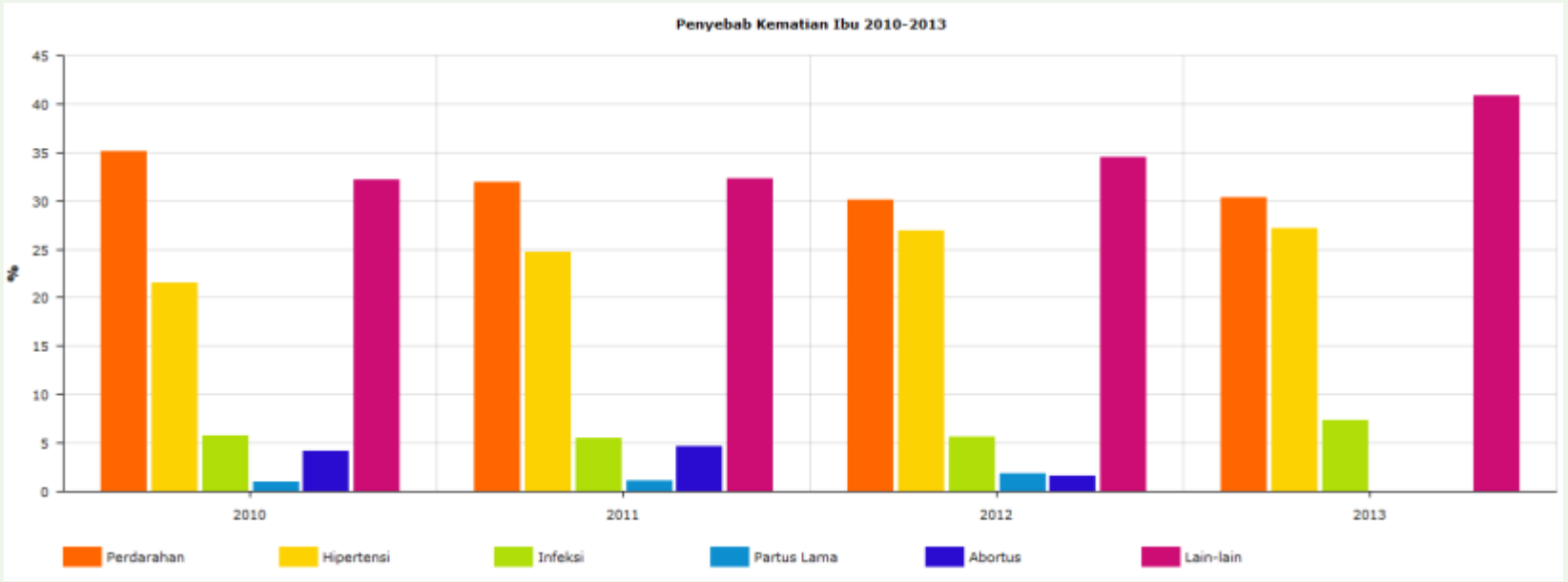
Kesejahteraan ibu dan bayi → indicator keberhasilan suatu program

Kematian maternal menurut WHO → kematian seorang wanita ketika hamil atau dalam 42 hari sesudah berakhirnya kehamilan oleh sebab apapun terlepas dari usia kehamilan dan tindakan yang dilakukan untuk mengakhiri kehamilan.

Kematian maternal langsung → kematian ibu yang terjadi akibat komplikasi obstetric pada masa kehamilan, persalinan, atau masa nifas dan karena intervensi, kelalaian, penatalaksanaan yang salah atau serangkaian kejadian yang disebabkan oleh factor-factor tersebut

Kematian maternal tidak langsung → Kematian ibu yang tidak secara langsung diakibatkan oleh penyebab bstetric. Kematian disebabkan oleh penyakit yang sudah ada selama kehamilan, persalinan dan nifas yang diperberat oleh adaptasi fisiologis ibu.




https://katadata.co.id/embedchart/50

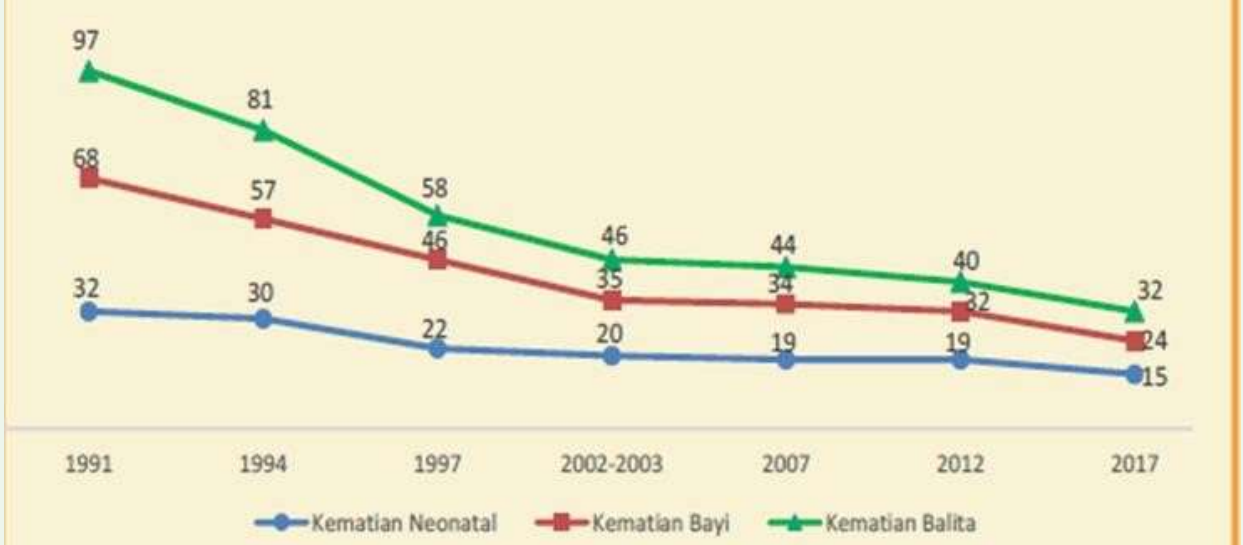
**Persentase Ibu yang Melahirkan Anak Lahir Hidup dalam Dua Tahun Terakhir dan Anak Lahir Hidup yang Terakhir Dilahirkan dengan Ditolong oleh Tenaga Kesehatan Menurut Karakteristik Ibu, 2016-2018**



Sumber : BPS, Susenas Maret 2016-2018

- Lahir mati atau kematian janin → tidak ada tanda kehidupan pada saat atau setelah lahir
- Kematian neonatal dini → kematian neonatus yang lahir hidup dalam 7 hari pertama setelah kehidupan
- Kematian neonatal lanjut →kematian setelah 7 hari – 28 hari
- Kematian perinatal →jumlah kelahiran mati dan kematian neonatus per 1000 kelahiran total
- Kematian bayi →jumlah kematian bayi usia 28 hari – 1 tahun

GAMBAR 5.3. ANGKA KEMATIAN NEONATAL, ANGKA KEMATIAN BAYI, DAN ANGKA KEMATIAN BALITA, 1991-2017




Sumber: Survei Demografi dan Kesehatan Indonesia, BPS

# Evidence Based Kebidanan

https://youtu.be/nahGs8soO-k

**Table 1: Summary list of WHO recommendations on antenatal care (ANC) for a positive pregnancy experience**

These recommendations apply to pregnant women and adolescent girls within the context of routine ANC

| A. Nutritional interventions | | |
|---|---|---|
| | **Recommendation** | **Type of recommendation** |
| Dietary interventions | **A.1.1:** Counselling about healthy eating and keeping physically active during pregnancy is recommended for pregnant women to stay healthy and to prevent excessive weight gain during pregnancy.[a] | Recommended |
| | **A.1.2:** In undernourished populations, nutrition education on increasing daily energy and protein intake is recommended for pregnant women to reduce the risk of low-birth-weight neonates. | Context-specific recommendation |
| | **A.1.3:** In undernourished populations, balanced energy and protein dietary supplementation is recommended for pregnant women to reduce the risk of stillbirths and small-for-gestational-age neonates. | Context-specific recommendation |
| | **A.1.4:** In undernourished populations, high-protein supplementation is not recommended for pregnant women to improve maternal and perinatal outcomes. | Not recommended |
| Iron and folic acid supplements | **A.2.1:** Daily oral iron and folic acid supplementation with 30 mg to 60 mg of elemental iron[b] and 400 µg (0.4 mg) of folic acid[c] is recommended for pregnant women to prevent maternal anaemia, puerperal sepsis, low birth weight, and preterm birth.[d] | Recommended |
| | **A.2.2:** Intermittent oral iron and folic acid supplementation with 120 mg of elemental iron[e] and 2800 µg (2.8 mg) of folic acid once weekly is recommended for pregnant women to improve maternal and neonatal outcomes if daily iron is not acceptable due to side-effects, and in populations with an anaemia prevalence among pregnant women of less than 20%.[f] | Context-specific recommendation |
| Calcium supplements | **A.3:** In populations with low dietary calcium intake, daily calcium supplementation (1.5–2.0 g oral elemental calcium) is recommended for pregnant women to reduce the risk of pre-eclampsia.[g] | Context-specific recommendation |
| Vitamin A supplements | **A.4:** Vitamin A supplementation is only recommended for pregnant women in areas where vitamin A deficiency is a severe public health problem,[h] to prevent night blindness.[i] | Context-specific recommendation |

| | | |
|---|---|---|
| Zinc supplements | **A.5:** Zinc supplementation for pregnant women is only recommended in the context of rigorous research. | Context-specific recommendation (research) |
| Multiple micronutrient supplements | **A.6:** Multiple micronutrient supplementation is not recommended for pregnant women to improve maternal and perinatal outcomes. | Not recommended |
| Vitamin B6 (pyridoxine) supplements | **A.7:** Vitamin B6 (pyridoxine) supplementation is not recommended for pregnant women to improve maternal and perinatal outcomes. | Not recommended |
| Vitamin E and C supplements | **A.8:** Vitamin E and C supplementation is not recommended for pregnant women to improve maternal and perinatal outcomes. | Not recommended |
| Vitamin D supplements | **A.9:** Vitamin D supplementation is not recommended for pregnant women to improve maternal and perinatal outcomes.[i] | Not recommended |
| Restricting caffeine intake | **A.10:** For pregnant women with high daily caffeine intake (more than 300 mg per day),[k] lowering daily caffeine intake during pregnancy is recommended to reduce the risk of pregnancy loss and low-birth-weight neonates. | Context-specific recommendation |

| B. Maternal and fetal assessment[l] | | |
|---|---|---|
| | **Recommendation** | **Type of recommendation** |
| **B.1: Maternal assessment** | | |
| Anaemia | **B.1.1:** Full blood count testing is the recommended method for diagnosing anaemia in pregnancy. In settings where full blood count testing is not available, on-site haemoglobin testing with a haemoglobinometer is recommended over the use of the haemoglobin colour scale as the method for diagnosing anaemia in pregnancy. | Context-specific recommendation |
| Asymptomatic bacteriuria (ASB) | **B.1.2:** Midstream urine culture is the recommended method for diagnosing asymptomatic bacteriuria (ASB) in pregnancy. In settings where urine culture is not available, on-site midstream urine Gram-staining is recommended over the use of dipstick tests as the method for diagnosing ASB in pregnancy. | Context-specific recommendation |
| Intimate partner violence (IPV) | **B.1.3:** Clinical enquiry about the possibility of intimate partner violence (IPV) should be strongly considered at antenatal care visits when assessing conditions that may be caused or complicated by IPV in order to improve clinical diagnosis and subsequent care, where there is the capacity to provide a supportive response (including referral where appropriate) and where the WHO minimum requirements are met.[m,n] | Context-specific recommendation |

| Recommendations integrated from other WHO guidelines that are relevant to ANC maternal assessment | | |
|---|---|---|
| Gestational diabetes mellitus (GDM) | **B.1.4:** Hyperglycaemia first detected at any time during pregnancy should be classified as either gestational diabetes mellitus (GDM) or diabetes mellitus in pregnancy, according to WHO criteria.[e] | Recommended |
| Tobacco use | **B.1.5:** Health-care providers should ask all pregnant women about their tobacco use (past and present) and exposure to second-hand smoke as early as possible in the pregnancy and at every antenatal care visit.[f] | Recommended |
| Substance use | **B.1.6:** Health-care providers should ask all pregnant women about their use of alcohol and other substances (past and present) as early as possible in the pregnancy and at every antenatal care visit.[g] | Recommended |
| Human immuno-deficiency virus (HIV) and syphilis | **B.1.7:** In high-prevalence settings,[r] provider-initiated testing and counselling (PITC) for HIV should be considered a routine component of the package of care for pregnant women in all antenatal care settings. In low-prevalence settings, PITC can be considered for pregnant women in antenatal care settings as a key component of the effort to eliminate mother-to-child transmission of HIV, and to integrate HIV testing with syphilis, viral or other key tests, as relevant to the setting, and to strengthen the underlying maternal and child health systems.[s] | Recommended |
| Tuberculosis (TB) | **B.1.8:** In settings where the tuberculosis (TB) prevalence in the general population is 100/100 000 population or higher, systematic screening for active TB should be considered for pregnant women as part of antenatal care.[t] | Context-specific recommendation |

## B.2: Fetal assessment

| | | |
|---|---|---|
| Daily fetal movement counting | **B.2.1:** Daily fetal movement counting, such as with "count-to-ten" kick charts, is only recommended in the context of rigorous research. | Context-specific recommendation (research) |
| Symphysis-fundal height (SFH) measurement | **B.2.2:** Replacing abdominal palpation with symphysis-fundal height (SFH) measurement for the assessment of fetal growth is not recommended to improve perinatal outcomes. A change from what is usually practiced (abdominal palpation or SFH measurement) in a particular setting is not recommended. | Context-specific recommendation |
| Antenatal cardio-tocography | **B.2.3:** Routine antenatal cardiotocography[x] is not recommended for pregnant women to improve maternal and perinatal outcomes. | Not recommended |
| Ultrasound scan | **B.2.4:** One ultrasound scan before 24 weeks of gestation (early ultrasound) is recommended for pregnant women to estimate gestational age, improve detection of fetal anomalies and multiple pregnancies, reduce induction of labour for post-term pregnancy, and improve a woman's pregnancy experience. | Recommended |
| Doppler ultrasound of fetal blood vessels | **B.2.5:** Routine Doppler ultrasound examination is not recommended for pregnant women to improve maternal and perinatal outcomes.[y] | Not recommended |

| C. Preventive measures | | |
|---|---|---|
| | **Recommendation** | **Type of recommendation** |
| Antibiotics for asymptomatic bacteriuria (ASB) | **C.1:** A seven-day antibiotic regimen is recommended for all pregnant women with asymptomatic bacteriuria (ASB) to prevent persistent bacteriuria, preterm birth and low birth weight. | Recommended |
| Antibiotic prophylaxis to prevent recurrent urinary tract infections | **C.2:** Antibiotic prophylaxis is only recommended to prevent recurrent urinary tract infections in pregnant women in the context of rigorous research. | Context-specific recommendation (research) |
| Antenatal anti-D immunoglobulin administration | **C.3:** Antenatal prophylaxis with anti-D immunoglobulin in non-sensitized Rh-negative pregnant women at 28 and 34 weeks of gestation to prevent RhD alloimmunization is only recommended in the context of rigorous research. | Context-specific recommendation (research) |
| Preventive anthelminthic treatment | **C.4:** In endemic areas,[e] preventive anthelminthic treatment is recommended for pregnant women after the first trimester as part of worm infection reduction programmes.[f] | Context-specific recommendation |
| Tetanus toxoid vaccination | **C.5:** Tetanus toxoid vaccination is recommended for all pregnant women, depending on previous tetanus vaccination exposure, to prevent neonatal mortality from tetanus.[g] | Recommended |
| **Recommendations integrated from other WHO guidelines that are relevant to ANC** | | |
| Malaria prevention: intermittent preventive treatment in pregnancy (IPTp) | **C.6:** In malaria-endemic areas in Africa, intermittent preventive treatment with sulfadoxine-pyrimethamine (IPTp-SP) is recommended for all pregnant women. Dosing should start in the second trimester, and doses should be given at least one month apart, with the objective of ensuring that at least three doses are received.[f] | Context-specific recommendation |
| Pre-exposure prophylaxis (PrEP) for HIV prevention | **C.7:** Oral pre-exposure prophylaxis (PrEP) containing tenofovir disoproxil fumarate (TDF) should be offered as an additional prevention choice for pregnant women at substantial risk of HIV infection as part of combination prevention approaches.[ss] | Context-specific recommendation |

| D. Interventions for common physiological symptoms | | |
|---|---|---|
| | **Recommendation** | **Type of recommendation** |
| Nausea and vomiting | **D.1:** Ginger, chamomile, vitamin B6 and/or acupuncture are recommended for the relief of nausea in early pregnancy, based on a woman's preferences and available options. | Recommended |
| Heartburn | **D.2:** Advice on diet and lifestyle is recommended to prevent and relieve heartburn in pregnancy. Antacid preparations can be offered to women with troublesome symptoms that are not relieved by lifestyle modification. | Recommended |
| Leg cramps | **D.3:** Magnesium, calcium or non-pharmacological treatment options can be used for the relief of leg cramps in pregnancy, based on a woman's preferences and available options. | Recommended |
| Low back and pelvic pain | **D.4:** Regular exercise throughout pregnancy is recommended to prevent low back and pelvic pain. There are a number of different treatment options that can be used, such as physiotherapy, support belts and acupuncture, based on a woman's preferences and available options. | Recommended |
| Constipation | **D.5:** Wheat bran or other fibre supplements can be used to relieve constipation in pregnancy if the condition fails to respond to dietary modification, based on a woman's preferences and available options. | Recommended |
| Varicose veins and oedema | **D.6:** Non-pharmacological options, such as compression stockings, leg elevation and water immersion, can be used for the management of varicose veins and oedema in pregnancy, based on a woman's preferences and available options. | Recommended |

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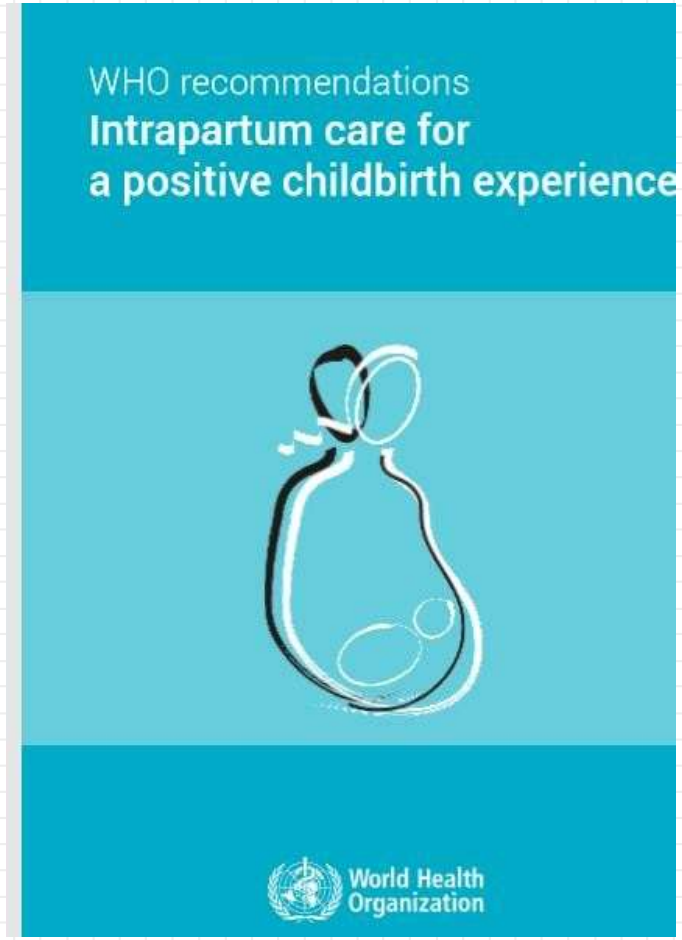
| E. Health systems interventions to improve the utilization and quality of antenatal care | | |
|---|---|---|
| | **Recommendation** | **Type of recommendation** |
| Woman-held case notes | **E.1:** It is recommended that each pregnant woman carries her own case notes during pregnancy to improve continuity, quality of care and her pregnancy experience. | Recommended |
| Midwife-led continuity of care | **E.2:** Midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well functioning midwifery programmes. | Context-specific recommendation |
| Group antenatal care | **E.3:** Group antenatal care provided by qualified health-care professionals may be offered as an alternative to individual antenatal care for pregnant women in the context of rigorous research, depending on a woman's preferences and provided that the infrastructure and resources for delivery of group antenatal care are available. | Context-specific recommendation (research) |
| Community-based interventions to improve communication and support | **E.4.1:** The implementation of community mobilization through facilitated participatory learning and action (PLA) cycles with women's groups is recommended to improve maternal and newborn health, particularly in rural settings with low access to health services.[xb] Participatory women's groups represent an opportunity for women to discuss their needs during pregnancy, including barriers to reaching care, and to increase support to pregnant women. | Context-specific recommendation |
| | **E.4.2:** Packages of interventions that include household and community mobilization and antenatal home visits are recommended to improve antenatal care utilization and perinatal health outcomes, particularly in rural settings with low access to health services. | Context-specific recommendation |

| | | |
|---|---|---|
| Task shifting components of antenatal care delivery[xc] | **E.5.1:** Task shifting the promotion of health-related behaviours for maternal and newborn health[xci] to a broad range of cadres, including lay health workers, auxiliary nurses, nurses, midwives and doctors is recommended. | Recommended |
| | **E.5.2:** Task shifting the distribution of recommended nutritional supplements and intermittent preventive treatment in pregnancy (IPTp) for malaria prevention to a broad range of cadres, including auxiliary nurses, nurses, midwives and doctors is recommended. | Recommended |
| Recruitment and retention of staff in rural and remote areas[xcii] | **E.6:** Policy-makers should consider educational, regulatory, financial, and personal and professional support interventions to recruit and retain qualified health workers in rural and remote areas. | Context-specific recommendation |
| Antenatal care contact schedules | **E.7:** Antenatal care models with a minimum of eight contacts are recommended to reduce perinatal mortality and improve women's experience of care. | Recommended |




**BOX 2.1**

## Positive childbirth experience

Women want a positive childbirth experience that fulfils or exceeds their prior personal and sociocultural beliefs and expectations. This includes giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from birth companion(s) and kind, technically competent clinical staff. Most women want a physiological labour and birth, and to have a sense of personal achievement and control through involvement in decision-making, even when medical interventions are needed or wanted.

## Summary list of recommendations on intrapartum care for a positive childbirth experience

| Care option | Recommendation | Category of recommendation |
|---|---|---|
| **Care throughout labour and birth** | | |
| Respectful maternity care | 1. Respectful maternity care – which refers to care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth – is recommended. | Recommended |
| Effective communication | 2. Effective communication between maternity care providers and women in labour, using simple and culturally acceptable methods, is recommended. | Recommended |
| Companionship during labour and childbirth | 3. A companion of choice is recommended for all women throughout labour and childbirth. | Recommended |
| Continuity of care | 4. Midwife-led continuity-of-care models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with well functioning midwifery programmes.[a] | Context-specific recommendation |

| First stage of labour | | |
|---|---|---|
| Definitions of the latent and active first stages of labour | 5. The use of the following definitions of the latent and active first stages of labour is recommended for practice.<br>— The latent first stage is a period of time characterized by painful uterine contractions and variable changes of the cervix, including some degree of effacement and slower progression of dilatation up to 5 cm for first and subsequent labours.<br>— The active first stage is a period of time characterized by regular painful uterine contractions, a substantial degree of cervical effacement and more rapid cervical dilatation from 5 cm until full dilatation for first and subsequent labours. | Recommended |
| Duration of the first stage of labour | 6. Women should be informed that a standard duration of the latent first stage has not been established and can vary widely from one woman to another. However, the duration of active first stage (from 5 cm until full cervical dilatation) usually does not extend beyond 12 hours in first labours, and usually does not extend beyond 10 hours in subsequent labours. | Recommended |

| | | |
|---|---|---|
| 7. | 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. | Not recommended |
| 8. | 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. | Not recommended |
| 9. | Labour may not naturally accelerate until a cervical dilatation threshold of 5 cm is reached. Therefore the use of medical interventions to accelerate labour and birth (such as oxytocin augmentation or caesarean section) before this threshold is not recommended, provided fetal and maternal conditions are reassuring. | Not recommended |

| Care option | Recommendation | Category of recommendation |
|---|---|---|
| Labour ward admission policy | 10. 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. | Research-context recommendation |
| Clinical pelvimetry on admission | 11. Routine clinical pelvimetry on admission in labour is not recommended for healthy pregnant women. | Not recommended |
| Routine assessment of fetal well-being on labour admission | 12. Routine cardiotocography is not recommended for the assessment of fetal well-being on labour admission in healthy pregnant women presenting in spontaneous labour.<br>13. Auscultation using a Doppler ultrasound device or Pinard fetal stethoscope is recommended for the assessment of fetal well-being on labour admission. | Not recommended<br>Recommended |
| Perineal/pubic shaving | 14. Routine perineal/pubic shaving prior to giving vaginal birth is not recommended.[a] | Not recommended |
| Enema on admission | 15. Administration of enema for reducing the use of labour augmentation is not recommended.[b] | Not recommended |

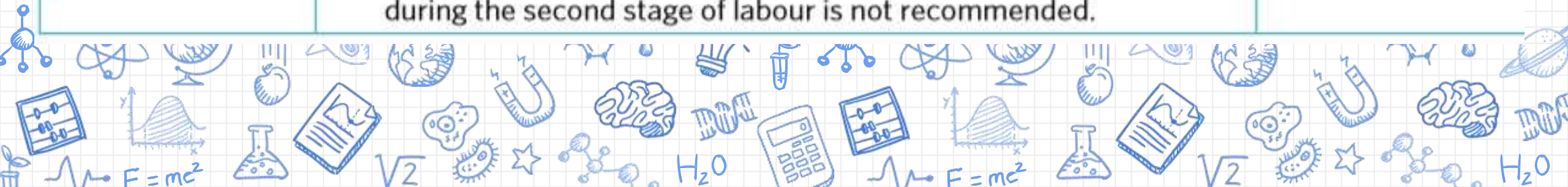
| | | |
|---|---|---|
| Digital vaginal examination | 16. Digital vaginal examination at intervals of four hours is recommended for routine assessment of active first stage of labour in low-risk women.[a] | Recommended |
| Continuous cardiotocography during labour | 17. Continuous cardiotocography is not recommended for assessment of fetal well-being in healthy pregnant women undergoing spontaneous labour. | Not recommended |
| Intermittent fetal heart rate auscultation during labour | 18. Intermittent auscultation of the fetal heart rate with either a Doppler ultrasound device or Pinard fetal stethoscope is recommended for healthy pregnant women in labour. | Recommended |
| Epidural analgesia for pain relief | 19. Epidural analgesia is recommended for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences. | Recommended |
| Opioid analgesia for pain relief | 20. Parenteral opioids, such as fentanyl, diamorphine and pethidine, are recommended options for healthy pregnant women requesting pain relief during labour, depending on a woman's preferences. | Recommended |
| Relaxation techniques for pain management | 21. 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. | Recommended |

| | | |
|---|---|---|
| Manual techniques for pain management | 22. 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. | Recommended |
| Pain relief for preventing labour delay | 23. Pain relief for preventing delay and reducing the use of augmentation in labour is not recommended.[b] | Not recommended |
| Oral fluid and food | 24. For women at low risk, oral fluid and food intake during labour is recommended.[b] | Recommended |
| Maternal mobility and position | 25. Encouraging the adoption of mobility and an upright position during labour in women at low risk is recommended.[b] | Recommended |
| Vaginal cleansing | 26. Routine vaginal cleansing with chlorhexidine during labour for the purpose of preventing infectious morbidities is not recommended.[a] | Not recommended |
| Active management of labour | 27. A package of care for active management of labour for prevention of delay in labour is not recommended.[b] | Not recommended |

| Care option | Recommendation | Category of recommendation |
|---|---|---|
| Routine amniotomy | 28. The use of amniotomy alone for prevention of delay in labour is not recommended.[a] | Not recommended |
| Early amniotomy and oxytocin | 29. The use of early amniotomy with early oxytocin augmentation for prevention of delay in labour is not recommended.[a] | Not recommended |
| Oxytocin for women with epidural analgesia | 30. The use of oxytocin for prevention of delay in labour in women receiving epidural analgesia is not recommended.[a] | Not recommended |
| Antispasmodic agents | 31. The use of antispasmodic agents for prevention of delay in labour is not recommended.[a] | Not recommended |
| Intravenous fluids for preventing labour delay | 32. The use of intravenous fluids with the aim of shortening the duration of labour is not recommended.[a] | Not recommended |

| Second stage of labour | | |
|---|---|---|
| Definition and duration of the second stage of labour | 33. The use of the following definition and duration of the second stage of labour is recommended for practice.<br>— The second stage is the period of time between full cervical dilatation and birth of the baby, during which the woman has an involuntary urge to bear down, as a result of expulsive uterine contractions.<br>— 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. | Recommended |
| Birth position (for women without epidural analgesia) | 34. For women without epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended. | Recommended |
| Birth position (for women with epidural analgesia) | 35. For women with epidural analgesia, encouraging the adoption of a birth position of the individual woman's choice, including upright positions, is recommended. | Recommended |
| Method of pushing | 36. Women in the expulsive phase of the second stage of labour should be encouraged and supported to follow their own urge to push. | Recommended |

| | | |
|---|---|---|
| Method of pushing (for women with epidural analgesia) | 37. For women with epidural analgesia in the second stage of labour, delaying pushing for one to two hours after full dilatation or until the woman regains the sensory urge to bear down is recommended in the context where resources are available for longer stay in second stage and perinatal hypoxia can be adequately assessed and managed. | Context-specific recommendation |
| Techniques for preventing perineal trauma | 38. 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. | Recommended |
| Episiotomy policy | 39. Routine or liberal use of episiotomy is not recommended for women undergoing spontaneous vaginal birth. | Not recommended |
| Fundal pressure | 40. Application of manual fundal pressure to facilitate childbirth during the second stage of labour is not recommended. | Not recommended |



| Third stage of labour | | |
|---|---|---|
| Prophylactic uterotonics | 41. The use of uterotonics for the prevention of postpartum haemorrhage (PPH) during the third stage of labour is recommended for all births.[a] | Recommended |
| | 42. Oxytocin (10 IU, IM/IV) is the recommended uterotonic drug for the prevention of postpartum haemorrhage (PPH).[a] | Recommended |
| | 43. In settings where oxytocin is unavailable, the use of other injectable uterotonics (if appropriate, ergometrine/methylergometrine, or the fixed drug combination of oxytocin and ergometrine) or oral misoprostol (600 µg) is recommended.[a] | Recommended |
| Delayed umbilical cord clamping | 44. Delayed umbilical cord clamping (not earlier than 1 minute after birth) is recommended for improved maternal and infant health and nutrition outcomes.[b] | Recommended |
| Controlled cord traction (CCT) | 45. In settings where skilled birth attendants are available, controlled cord traction (CCT) is recommended for vaginal births if the care provider and the parturient woman regard a small reduction in blood loss and a small reduction in the duration of the third stage of labour as important.[a] | Recommended |
| Uterine massage | 46. Sustained uterine massage is not recommended as an intervention to prevent postpartum haemorrhage (PPH) in women who have received prophylactic oxytocin.[a] | Not recommended |

| Care of the newborn | | |
|---|---|---|
| Routine nasal or oral suction | 47. 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.[c] | Not recommended |
| Skin-to-skin contact | 48. 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.[d] | Recommended |
| Breastfeeding | 49. 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.[e] | Recommended |
| Haemorrhagic disease prophylaxis using vitamin K | 50. All newborns should be given 1 mg of vitamin K intramuscularly after birth (i.e. after the first hour by which the infant should be in skin-to-skin contact with the mother and breastfeeding should be initiated).[d] | Recommended |
| Bathing and other immediate postnatal care of the newborn | 51. Bathing should be delayed until 24 hours after birth. If this is not possible due to cultural reasons, bathing should be delayed for at least six hours. Appropriate clothing of the baby for ambient temperature is recommended. This means one to two layers of clothes more than adults, and use of hats/caps. The mother and baby should not be separated and should stay in the same room 24 hours a day.[f] | Recommended |

| Care of the woman after birth | | |
|---|---|---|
| Uterine tonus assessment | 52. Postpartum abdominal uterine tonus assessment for early identification of uterine atony is recommended for all women.[a] | Recommended |
| Antibiotics for uncomplicated vaginal birth | 53. Routine antibiotic prophylaxis is not recommended for women with uncomplicated vaginal birth.[b] | Not recommended |
| Routine antibiotic prophylaxis for episiotomy | 54. Routine antibiotic prophylaxis is not recommended for women with episiotomy.[b] | Not recommended |
| Routine postpartum maternal assessment | 55. All postpartum women should have regular assessment of vaginal bleeding, uterine contraction, fundal height, temperature and heart rate (pulse) routinely during the first 24 hours starting from the first hour after birth. Blood pressure should be measured shortly after birth. If normal, the second blood pressure measurement should be taken within six hours. Urine void should be documented within six hours.[c] | Recommended |
| Postnatal discharge following uncomplicated vaginal birth | 56. After an uncomplicated vaginal birth in a health care facility, healthy mothers and newborns should receive care in the facility for at least 24 hours after birth.[c,d] | Recommended |

PERATURAN MENTERI KESEHATAN REPUBLIK INDONESIA
NOMOR 97 TAHUN 2014

TENTANG

PELAYANAN KESEHATAN MASA SEBELUM HAMIL, MASA HAMIL, PERSALINAN, DAN MASA SESUDAH MELAHIRKAN, PENYELENGGARAAN PELAYANAN KONTRASEPSI, SERTA PELAYANAN KESEHATAN SEKSUAL

Bagian Ketiga
Persalinan

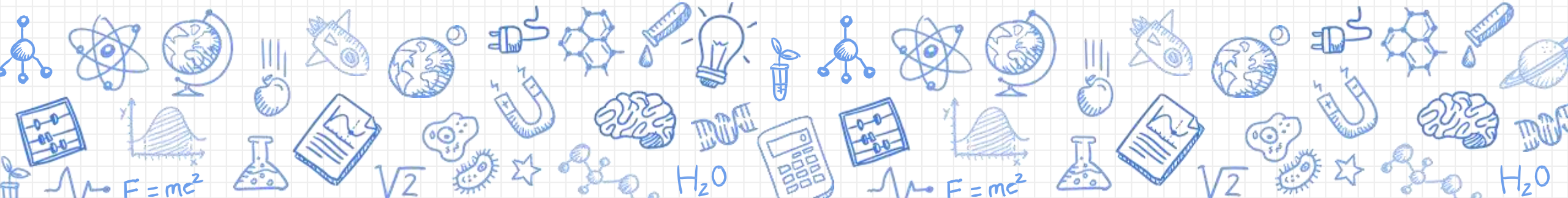
Pasal 14

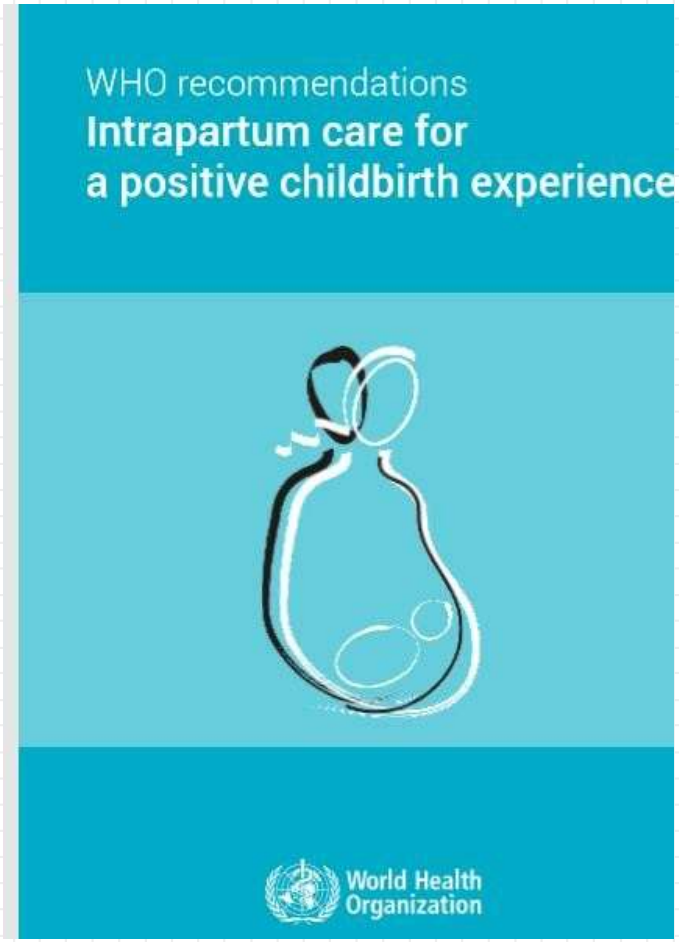
(1) Persalinan harus dilakukan di fasilitas pelayanan kesehatan.

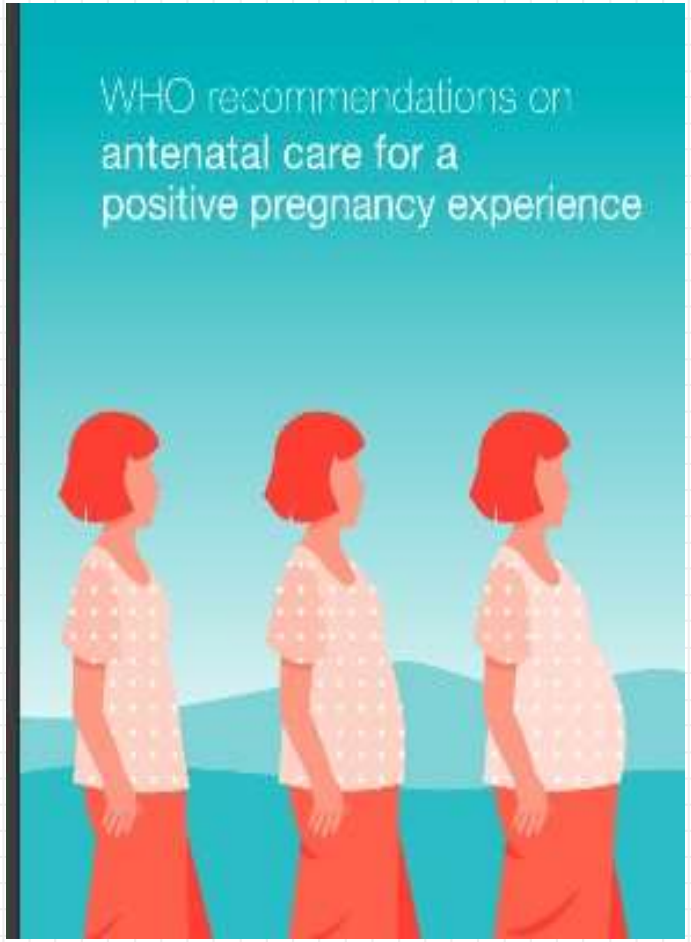
(2) Persalinan sebagaimana dimaksud pada ayat (1) diberikan kepada ibu bersalin dalam bentuk 5 (lima) aspek dasar meliputi:

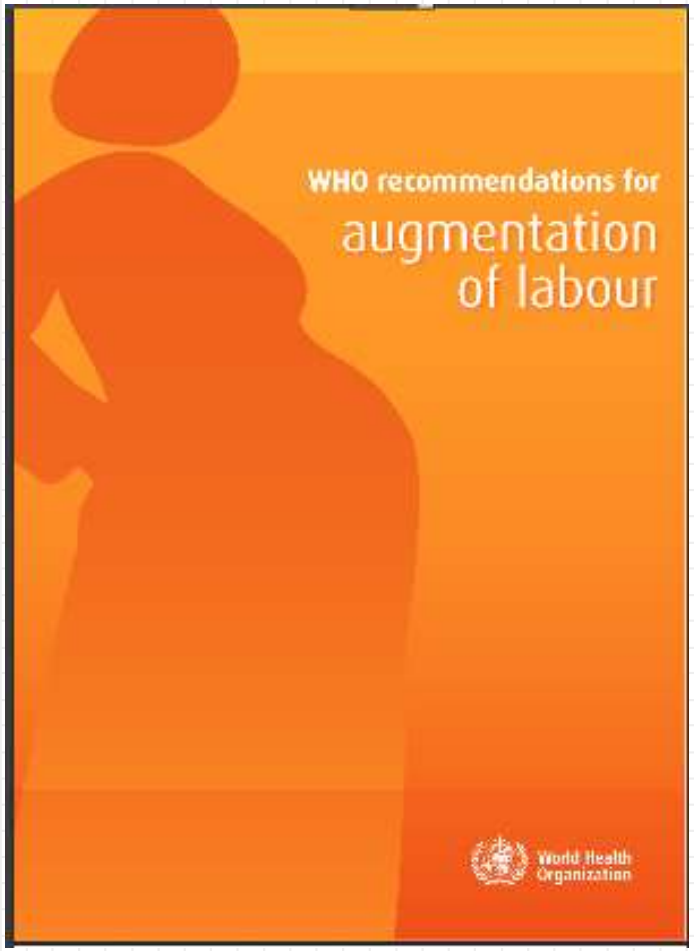
a. membuat keputusan klinik;
b. asuhan sayang ibu dan sayang bayi;
c. pencegahan infeksi;
d. pencatatan (rekam medis) asuhan persalinan; dan
e. rujukan pada kasus komplikasi ibu dan bayi baru lahir.

(3) Persalinan sebagaimana dimaksud pada ayat (2) dilakukan sesuai dengan standar Asuhan Persalinan Normal (APN).

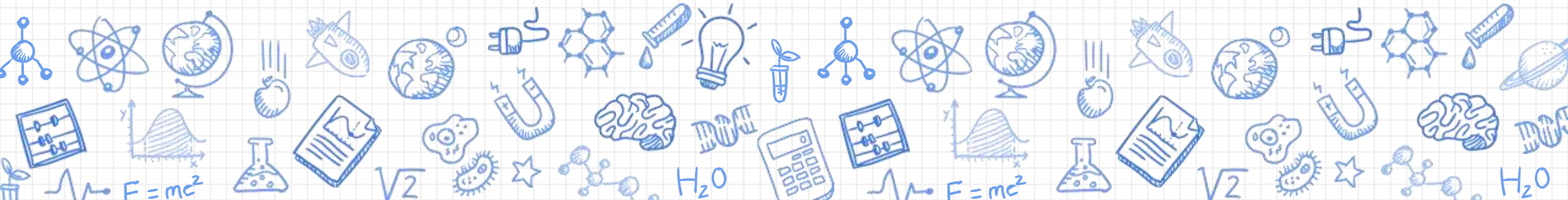



WHO recommendations
Intrapartum care for
a positive childbirth experience
World Health
Organization


WHO recommendations on
antenatal care for a
positive pregnancy experience


WHO recommendations for
augmentation
of labour
World Health
Organization

# MATURNUWUN ☺

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