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THE 3rd INTERNATIONAL CONFERENCE ON HEALTH SCIENCE 2016

"Optimizing the Mental Health under SDGs"

Poltekkes Kemenkes Yogyakarta

PROCEEDING BOOK

Inna Garuda Hotel Yogyakarta, Indonesia
November, 6st 2016

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INNA GARUDA HOTEL YOGYAKARTA, INDONESIA
November 6st, 2016

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O-06

CORRELATION BETWEEN CHARACTERISTICS AND PREGNANCYRISK USING POEDJI ROCHJATI'S SCORING CARD

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ABSTRACT

Maternal mortality due to inadequate handling delivery complications, deaths can be prevented and avoided. Early detection is important for predicting pregnancy complications that may occur so it can be caught early risk factors that develop in gestation further. This study aimed to determine the correlation characteristics of mothers with risk pregnancies with a screening PoedjiRochjati's Scoring Card. This type of research is observasional with cross sectional design. Sample is pregnant women in Sewon II community Health centers. Sampling techniques thatsaturated the entire population of 60 pregnant women in April 2015. Data in the form of primary data collected by direct questionnaire, the results were analyzed with chi square. This study showesd that the majority of women classified as high-risk pregnancy. There are association between age (p = 0.000), parity (p = 0.040), spacing pregnancies (p = 0.034), obstetric history (p = 0.001), and history of disease (p = 0.021) with the level of risk of pregnancy. There is no relationship between the level of education (p = 0.510) and employment status (p = 0.203). From pregnancy screening indicate that the majority of high-risk mothers need a referral system and proper planning of delivery for pregnant women at Sewon II community Health centers. In conclusion, there is aassociation between age, parity, spacing of pregnancy, obstetric history, history of disease with risk pregnancy.

Keywords: characteristics, pregnancyrisk, PoedjiRochjati's Scoring Card

Background

Maternal Mortality Rate (MMR) became one of the important indicators of public health degree. Target achievement of the Millennium Developmental Goal's (MDG), namely reducing the MMR to 125 per 100,000 live births in 2015. According to PoedjiRochjati every minute of every day, somewhere in the world, one person died due to complications of childbirth. Indonesia's MMR is still very high. A total of 228 mothers die in every 100,000 live births. This condition is cemented Indonesia as one of the countries with the highest MMR Asia, the 3rd highest in the ASEAN region, and the 2nd highest in the SEAR region. Until the year 2012 Indonesia's commitment to the MDG's are still very far from the target, because it is based on the data IDHS 2012 Indonesia's MMR would rise to 359 per 100,000 live births.[1]

Mc Carthy and Mine (1992) describes the determinants of proxy / close maternal mortality are complications during pregnancy, childbirth, and postpartum while determinant between covering health status, reproductive status, access to health services, and healthy behaviors.[2] Most of the maternal deaths a tragedy that could have been prevented, avoided, and requires the attention of the international community. Maternal mortality caused by handling delivery complications were inadequate. Birth complications can occur in all pregnant women and is a manifestation of maternal risk factors that could cause a risk / hazard on childbirth.[3] While the variables associated with obstetric complications include birth attendants, parity, demeanor, pregnant complications prior history, and the place of delivery. [4]Mother's education level will affect the mother's level of

knowledge. The higher the person's level of knowledge, will allow a person or people accessing health information.[5] People who work have a mindset that is more extensive than that does not work it is influenced by a better social interaction so as to enhance the level of knowledge or experience and more exposure health information.[6]Information a woman to conceive and give birth or have a child is determined by the readiness of the three things: physical readiness, mental, and social readiness / economics. Pregnant women at the age less than 20 years and more than 35 years have an increased risk for complications 5.117 times of the aged 20-35 year.7 mothers with high parity, or more than 4 higher risk of obstetric complications is greater than the parity. [4] Spacing pregnancies also contribute in increasing the risk of pregnancy. Mothers with gestational distance of less than 2 years of 16.512 times the risk of obstetric complications compared with a distance of more than 2 year.[7] mothers who have abnormalities at birth had a 25.0 times greater risk for maternal deaths occur compared to no birth defects. Who have a history of the disease have a mortality risk 25.4 times greater than those without a history of disease.[8]

Efforts are being made to prevent the occurrence of complications is to increase the coverage of antenatal care, then all pregnant women are given care and antenatal screening with Score Card PoedjiRochjati (SCPR) for the early detection of pro-active, ie recognize problems that need to be wary and find early presence danger signs and risk factors in pregnancy risk factors that can be found growing in gestation more lanjut.3 Early detection of symptoms and danger signs during pregnancy is the best effort to prevent serious disruption of the mother's pregnancy safety.[9]

Data from Bantul Health Profile 2014 above, the rate of maternal mortality in Bantul in 2013 increased compared to the year 2012. In the year 2013 amounted to 96.83 / 100,000 live births that a number of 13 cases, whereas in 2012 amounted to 52.2 / 100,000 or 7 cases. In 2013 PHC Sewon II, Kretek, Displays, and Pleret accounted for the largest mortality in Bantul. SewonPuskesmaas region II is relatively closest to the referral facility because it was in town. The approximate number of pregnant women with complications of pregnancy in Community health center of Sewon II was ranked the 5th largest in Bantul.[10]

This study aimed to determine the correlation characteristics of the mother is the level of education, employment status, age, parity, spacing of pregnancy, obstetric history, and history of disease-risk pregnancy in pregnant women.This study aims to determine the relationship of maternal characteristics such as age, parity, spacing of pregnancy, obstetric history, and history of disease to the level of risk of pregnancy using PoedjiRochjati's Scoring Card.

Method

This type of research is analytic survey with cross-sectional design. This research samples using sampling techniques saturate the entire population in this study were pregnant women during their pregnancy in Community Health CenterSewon II In April 2015 the number of 60 people. This research was conducted at Community Health CenteSewon IIBantul. The variables studied were the level of risk of pregnancy and maternal characteristics consist of educational level, employment status, age, parity, spacing of pregnancy, obstetric history, and the history of disease. The research instrument used was a questionnaire directly with PoedjiRochjati'sScoring Card. In this study, the data is taken directly from the respondent (primary data) consisting of age, parity, employment status, pendidikan, spacing of children, and a history of previous deliveries and secondary of KIA book form data from antenatal care including medical history. Data processing methods, namely scoring, coding and tabulating. Univariate data analysis using the chi-square with Confidence Interval (CI) of 95% ($\alpha = 0.05$).

Result

Analysis ofthe correlation betweenthe incidence women withobstetric complicationsusing thechi-square shows the resultsas shown in Table1.

Table1.Correlation between Characteristics Mother Pregnancy Risk Level Scoring Card Poedji Rochjati on Pregnant Women

Variable	Category	PregnancyRisk Level						Total		x^2	*p*
		VHRP		HRP		LRP					
		F	%	F	%	F	%	F	%		
Level Of Education	Not Schools	0	0	1	100.0	0	0	1	100	5.268	0,510
	Basic	6	26.1	12	52.2	5	21.7	23	100		
	Intermediate	6	19.4	12	38.7	13	41.9	31	100		
	Height	1	20.0	1	20.0	3	60.0	5	100		
Job Status	Not Work	10	27.0	17	45.9	10	27.0	37	100	3.185	0,203
	Work										
	Bekerja	3	13.0	9	39.1	11	47.8	23	100		
Age	≤16 Or ≥35 Years	9	52.9	8	47.1	0	0	17	100	19.087	0,000
	17-34 Years	4	9.3	18	41.9	21	48.8	43	100		
Parity	Nulliparous	4	28.6	4	28.6	6	42.9	14	100	13.182	0,040
	Primiparity	4	13.3	13	43.3	13	43.3	30	100		
	Multiparas	3	21.4	9	64.3	2	14.3	14	100		
	Grandemultipara	2	100.0	0	0	0	0	2	100		
Distance Pregnancy	≤2or≥10Years	4	50.0	4	50.0	0	0	8	100	6.746	0.034
	>2-<10 Years	9	17.3	22	42.3	21	40.4	52	100		
Obstetric History	Abortion	1	50.0	1	50.0	0	0	2	100	27.079	0.001
	PullPliers/ Vacuum	0	0	2	100.0	0	0	2	100		
	Manual Plasenta	0	0	0	0	0	0	0	100		
	Infusion/ Transfusion	0	0	5	100.0	0	0	5	100		
	Caesarean Section	4	100.0	0	0	0	0	4	100		
	Nothing	8	17.0	18	38.3	21	44.7	47	100		
History of Disease	Anemia	6	31.6	11	57.9	2	10.5	19	100	11.579	0.021
	Malaria	0	0	0	0	0	0	0	100		
	Pulmonary Tuberculosis	0	0	0	0	0	0	0	100		
	Heart Trouble	0	0	0	0	0	0	0	100		
	Diabetes	1	100.0	0	0	0	0	1	100		
	Pms	0	0	0	0	0	0	0	100		
	Preeclampsia	0	0	0	0	0	0	0	100		
	Nothing	6	15.0	15	37.5	19	47.5	40	100		

Table1 shows five maternal characteristics such as age, parity, spacingof pregnancy, obstetric history, andhistory of diseasehave a relationship($p < 0.005$) with the levelof risk of pregnancy.

DISCUSSION

Correlation Characteristics Mother Pregnancy Risk Level

Level of Education

This research shows the majority of mothers with primary education and school is not high and very high risk in pregnancy, while women with low risk pregnancies majority of secondary education. From these data it can be seen the higher the risk of pregnancy more and more mothers with low education. From the results of this study also showed most mothers with higher education levels classified as low-risk pregnancy. However, in this study did not prove a relationship between level of education and the level of risk of pregnancy with p> 0.05 is equal to 0.510 and 0.284 for koefien contingency is low. Previous research has theory or mother's education level affect the level of knowledge of the mother, the higher the person's level of knowledge, will allow a person or the public access healthy information.[5] Lack of knowledge will have an impact on decisions maternal health services. Results of this study are not consistent with the theory, this is because the possibility of the influence of other factors on the health information obtained mother.

Job Status

This study shows that mothers during their pregnancy in Community health center of Sewon 2 in April 2015 most mothers did not work and classified as high risk and very high in pregnancy. While women with low risk pregnancies majority of the work. However, in this study did not prove the relationship between the status pekkerjaan-risk pregnancy with p> 0.05 is equal to 0.203 and 0.225 for koefien contingency is low. People who work have a mindset that is more extensive than that does not work it is influenced by a better social interaction so as to enhance the level of knowledge or experience and more exposed to health information.[6] These results are not in accordance with this theory, it is possible by factors other than work that is not counted as keleaan and so forth.

Age

Readiness of a woman to conceive and give birth or have a child is determined by the readiness of the three things: physical readiness, mental, and social readiness / economics. Pregnant women at the age less than 20 years and more than 35 years have an increased risk for complications 5.117 times of the aged 20-35 year.[7]Pregnant too young age of less than 16 years and are older than 35 years are more at risk than pregnant women in age 17-34 years because it was feared effect on organ maturation and possible exposure to the disease is higher than that of pregnant mothers in health reproductive age.[3]Addition pregnancies too young are also vulnerable to changes in maternal emotional and easily shaken so that the resulting lack of attention to her pregnancy, Pregnancy in older age also have a negative impact in terms of decreased endurance so that when parturition is not strong fear when push. In addition of course the function of reproduction is no longer able to bear a pregnancy resulting in the occurrence of uterine contractions are inadequate to cause bleeding and even death. According to the theory above, this study suggests women with high risk pregnancies occur in the majority (52.94%) mothers were pregnant at age ≥35 years, while mothers with low and high risk pregnancies majority aged between 17-34 years. Mothers with low-risk pregnancies were classified as no-risk age. Chi-square test results showed no significant relationship between age and level of risio pregnancy with p = 0.000 and 0.491 contingency coefficient

indicates the level of relationship is. This shows the age of the mother at risk of becoming one of the manifestations of the risk of pregnancy. Therefore, the age factor should be realized by all the mothers so planning pregnancy should be carefully thought out and planned that in healthy reproductive age. Mother's age at risk of more than 35 years must be planned carefully place and birth attendants even if necessary referral to hospital. It should be highlighted for health professionals that people still do not fully understand about the life of healthy pregnant and pregnancy planning is in the reproductive age, the child should be presented early information about reproductive health so as to minimize a pregnancy at a young age and too old. Additionally fragment family planning be a solution to minimize gestational age is too old.

Parity

Parity indicates the status of maternal childbirth. Nulliparous or women who have never given birth are more at risk because of not knowing the problems / complications in the pelvis, the mother's ability to push, as well as other complications, while grandemultipara or mothers with high parity> 4 have the risk of decline in organ function which lead to complications of pregnancy and childbirth, such as bleeding, uterine rupture, diabetes, and the other. [3] Mothers with high parity, or more than 4 higher risk of obstetric complications is greater than the parity. [4] In accordance with the above theory, this study shows that women with high risk pregnancies occur in women who gave birth to more than four times the amount of 100%, whereas mothers who had not delivered evenly in a low risk, high, and very high. Chi-square test results showed <0.05 is 0.04 so it can be concluded parity proved to be strongly correlated with the level of risk of pregnancy. Contingency coefficient shows the number 0.424 means that the level of relationship that proved only achieve moderate category. Therefore expected to mothers at risk as never before delivery could be dealt with better obstetric care or referral to health facilities are better, while the mother is at risk at high parity can be reduced or prevented by family planning (FP).

Distance Pregnancy

Spacing pregnancies also contribute in increasing the risk of pregnancy. Mothers with gestational distance of less than 2 years of 16.512 times the risk of obstetric complications compared with a distance of more than 2 year.7 Distance pregnancy now with pregnancy previously £ 2 years or ≥ 10 years are more at risk than the spacing pregnancies now with a previous pregnancy> 2 years or <10 years. This is because too soon pregnant again allow for complications such as contraction inadequate, uterine rupture, hemorrhage, and so forth because the reproductive organs are not yet fully returned in their original condition or the body is not optimal anymore to get pregnant and give birth, while the distance is too long too risky lead complications such as inadequate contraction due to decreased organ function and the inability mengejan.3 According to the theory, this study suggests women with high-risk pregnancies occur in the majority (66.67%) of mothers with pregnancy spacing <2 years. It is also evident from the results of the chi square test is 0.034 so that it can be concluded within the pregnancy proved strongly correlated with the level of risk of pregnancy. However, contingency coefficient indicates the number 0.318 means that the level of relationship that is evident in the low category. Therefore expected to mothers at risk for poor pregnancy spacing should be addressed in an adequate facility in order to minimize further complications or in other words referred to a planned to a higher facility as well as increased health promotion

kemasyarakat regarding family planning and birth control must be given kemasyarakat.

Obstetric History

Mothers who have abnormalities at birth had a 25.0 times greater risk for maternal deaths occur compared to no birth defects.[8]Mother with bad obstetric history are more at risk than women who have never had obstetric history includes failed pregnancy (abortion), never childbirth with forceps pull / vacuum, uridirogoh never given birth, had given birth were given infusions / transfusions and caesarean section ever. This is because the possibility of complications of pregnancy and childbirth is greater, such as mothers who have given birth to the uridirogoh, gave birth to a vacuum, forceps and caesarean section feared not being able to push, contraction is inadequate, even allowing for spontaneous labor. In accordance with the theory in this study mothers with pregnancy very high risk experienced by all mothers with a history of caesarean section (100%), women with high-risk pregnancy experienced by all mothers with a history of strain forceps / vacuum and with the infusion / transfusion (100%), whereas low-risk mothers nobody has a bad obstetric history. It is also reinforced by the results of the chi square test so that it can be concluded that 0,001 obstetric history proved to be strongly correlated with the level of risk of pregnancy. However, contingency coefficient indicates the number 0.558 means that the level of relationship that is evident in the medium category. Therefore expected to mothers with a history of poor obstetric more attention and getting an adequate labor planning with referral to a hospital with better facilities so that if any complications can be dealt with immediately.

Disease History

Pregnant women with a history of both diseases who are suffering or have suffered from before pregnancy include anemia (anemia), malaria, pulmonary tuberculosis, heart failure, diabetes (diabetes), Sexually Transmitted Diseases (STDs), and preeclampsia light more at risk than women A healthy. In accordance with the theory in this study showed mothers with high-risk pregnancy experienced by women who experienced anemia was 64.71% while the capital with very high risk occurs in women with diabetes by 100%, while women with low risk of pregnancy no one has history of disease. It is also reinforced by the results of the chi square test so that it can be concluded that 0,021 strong proven history of disease associated with the level of risk of pregnancy. However, contingency coefficient indicates the number 0.402 means that the level of relationship that is evident in the medium category. Dangers that can occur in case of anemia, among others died fetal death, preterm birth (gestational age <37 weeks), prolonged labor and postpartum hemorrhage.[3] Mothers who have a history of the disease have a mortality risk 25.4 times greater than those not have a history of disease.[8] Most mothers with a history of experiencing anemia it is at risk of bleeding during childbirth, fetal death, premature delivery, as well as the development of the child in the womb less than optimal due to lack of oxygen supply, because with early detection can determine maternal complications since early so there is no delay even in some cases the condition can be corrected if handled properly. With early detection of maternal disease early in pregnancy can overcome the disease that does not cause further complications as well as on cases that can not be repaired can be planned further action, while mothers with new health problems detected in late pregnancy is expected to be referred to receive delivery care adequate , right, and adequate. Diseases such as anemia when it is detected early on it can still be improved by improving nutrition, while cases of diabetes mellitus can be better

planned regarding nutrition, weight control infants, as well as best delivery process.

Conclusion

Most of the women classified as high-risk pregnancy and very high. There is a significant association between maternal characteristics such as age, parity, spacing of pregnancy, obstetric history and the history of disease-risk pregnancy. Maternal characteristics that are safe for pregnancy is the age, parity, spacing of pregnancy in a range that is not at risk, and no obstetric history and the history of disease.

Suggestion

Results ofthis research canbe usedtotake the policyinpromotivetoraise public awarenessabouthealthy pregnancies. Midwives are expected to facilitate the planning ofthe mother in labor and appropriate referralin accordance with the level of risk of the mother as well as improving preventive measures to educate the public about healthy pregnancy. Researchers further recommended conducting research with observation or inspection directly to the ANC not only direct in quiry and observation of data so that the data obtained subjectively better quality and accurateas well as add ing other characteristics such associoeconomic involving respondent's family.

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